

Counter transference in music therapy

A phenomenological study on counter transference used as a clinical concept by music therapists working with musical improvisation in adult psychiatry

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*counter*transference in music therapy

The background of the cover is a dark, solid color. Overlaid on this are several smooth, flowing lines. One line is white, starting from the left and curving gently across the middle. Several other lines are a vibrant red, some starting from the left and curving upwards and to the right, while others start from the right and curve downwards and to the left, creating a sense of dynamic movement and intersection.

Inge Nygaard Pedersen

Dissertation submitted for the Degree of Doctor of Philosophy
Dept. of Communication and Psychology, Aalborg University, Denmark. 2006

*counter*transference in music therapy

A phenomenological study on counter transference used as a clinical concept by music therapists working with musical improvisation in adult psychiatry

Declaration

This dissertation is my own original work and has not previously been submitted elsewhere for the award of an academic qualification or a higher degree.

Inge Nygaard Pedersen

Dissertation submitted for the Degree of Doctor of Philosophy
Dept. of Communication and Psychology. Aalborg University, Denmark. 2006

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Amendments

Proposed Amendments for the PhD-Dissertation: "Counter transference in music therapy".

A phenomenological study on counter transference used as a clinical concept by music therapists working with musical improvisation in adult psychiatry.

Point 1 of proposed amendments.

To be added at page 274 in category no. 3. in 5.1.

In this study the main research question and sub questions are concerned with counter transference as a phenomenon that is part of the dynamic of the therapist/patient relationship. This phenomenon is experienced by the therapist as a reaction to the patient's transference, and it is experienced with different dimensions.

As in psychoanalytical therapy, counter transference in music therapy is primarily unconscious and persists either for a shorter or longer period of time before it is recognized as occurring. Once it comes into the therapist's awareness, it informs the therapist and in so doing, may be used intentionally as a 'therapeutic tool'. For this specific reason I asked the interviewees to describe what was occurring in the two sessions before and the two sessions after the session in which the counter transference experience was recognized.

In the interview situations a lot of emphasize was put on the moment of recognizing what was already there and what already influenced a new

direction in the musical improvisation, and in the therapeutic process. Often this recognition emerged as a surprise, and often it emerged in an embodied form.

For the same reason many of the created composite structural categories have the word 'moment' included in the titles. These titles are again mirrored in the composite themes (see p. 277) which form the creation of the global distilled essence (see p. 295) of the counter transference experience, and this is the final result of this study (see p. 299).

It could sound here as if the moment of recognition is identical with the total experience of counter transference. This is not the intention of my use of the term. To clarify this confusion of words I would like to define what is meant by "moment of counter transference".

The word "moment" emerged from the description that the interviewees gave of the client's session where they recognised what the counter transference was. The interviewees identified this moment during the interview in reference to a specific experience during a client's session, reporting it in a number of ways including surprising moments in body feelings, emotions, and in changes in the musical improvisation. It is to be seen as an active part of the counter transference experience that serves as a source for later reflection of counter transference that identifies the characteristics that occurred at the time, which links it into a the larger context of the therapy process. This 'moment of counter transference' is a finding from this study.

Thus it has to be seen as something different from using the term 'the now moment' or 'the present moment' (Stern 2004), where the issue is about a way of being present that suddenly intensified the meeting of two or more people in a kind of micro momental world of tacit events, and where the object is observation of mother/infant relationships at a micro level. I talk about these differences later in the discussion chapter 6.9. (see p. 365). In this chapter I also discuss that what is confusing here is that counter transference can be understood, and is understood in this study, as an important and intense 'meeting', which can be lived out in a short period of time. But in this study it is a presupposition that the therapist's empathic identification with the patient and the patient's transference is present in order to create the possibility of the meeting being able to emerge as a product of the therapist's counter transference reaction.

Point 2 of proposed amendments

To be added at page 301 by the end of the first paragraph.

For all parts of the discussion chapter it is important for me to state that this is a study with only four subjects, and even if there is a great degree of consistency among the composite themes, there is no intention to suggest that these experiences can or should be generalised. The experiences reported are not the only kind of experiences that might indicate a 'moment of counter transference'. A phenomenological study never asserts generalisation, because there is a fundamental acceptance that each individual is different in their lived experience. The phenomenological process looks for similarities and differences, not for generalisations.

What I found out from this study is that people can identify 'moments of counter transference' this way, but there may be many more ways in which people describe this experience. Future research or findings from clinical supervision could enable others to identify and report other types of experiences.

Point 3 of proposed amendments

To be added at page 233 by the end of the first paragraph.

One could ask if it would not be more 'objective' to leave out my own interview when deciding on what data should be included. As this study is a phenomenological study which looks at the lived experience of counter transference for the participants in the study, it was crucial that I, as the researcher, have experienced the phenomenon myself as deeply as possible. From this perspective including my own interview can be seen as a component of the phenomenological process where my own interview can be seen as an extended epoche, where I have addressed my own beliefs about the phenomenon of the study. Being that detailed in my own understanding of the phenomenon helps me being sensitive to details in other participant's subjective experiences.

Additionally my own interview was important to include in order to engage my own experience with the phenomenological analysis of others and in order to draw some similarities and differences through making connections with the first five chapters. The analysis of my own interview also helped me refine the questions for the participants in the study.

Point 4 of proposed amendments

The process of distilling the interviews derives from indwelling the meaning units of the person's interview as described in detail in the method chapter. The focus of this phenomenological study is the lived experience of the participants, and therefore I decide to let the progression as reported stay in the order in which the themes emerged during analysis.

The progression of the categories and themes was not put in order of priority for any theoretical reasons, because they emerged from the analysis of the interview. If the theoretical understanding should be prioritised for any reason, other things could as well be prioritised for other reasons.

Acknowledgements

I would like to thank all those people who have supported me in the process of exploring and completing this doctoral thesis. Over the years I have written a few scholarly books, and many chapters and articles, but this research was my first experience with a systematic, formalised and supervised study. I very warmly want to thank my supportive supervisors professor Tony Wigram and professor Denise Grocke for having guided me carefully through this process. They surely have given me space for my own ideas, though still provided the necessary challenge to bring me through the process and to come to an end. It has been a very fruitful process. They are both very professional and together they cover the whole spectrum of research methods in music therapy. They have both been very inspiring in their input, be it suggestions or comments to the chapters or discussions of the method and analysis.

I would also like to thank all of the participants in the study who have bravely provided me with very rich and personal data and who have prepared very carefully for the interview. They have been very vivid in my spirit during the process of analysis, and I am still astonished how detailed they were able to verbalise almost unconscious or preconscious aspects of their experience; also these aspects of their experience which I will call tacit knowledge. I am very grateful to their open mindedness and enthusiasm about the issue, and I do hope their contribution to this study will inspire many other colleagues to reflect open minded on this very important, but also difficult aspect in our clinical work - the aspect of counter transference experiences. In this regard I would also formulate my gratitude to The General Office of Health, County of North Jut-

land, who funded a small salary for the participants, so that they could get the necessary time for this important part of my research study – the preparation for the interviews.

Then I would like to thank deeply my dear colleagues at Aalborg University, especially professor Tony Wigram who has been able to play the dual role as supervisor and colleague in a very admirable and creative way, and associate professor Lars Ole Bonde for constantly attentiveness and warm, fruitful discussions. Also thanks to my colleagues Niels Hannibal, Ulla Holck and HanneMette Ridder for showing their interest and support and Hanne Mette for necessary help with layout the last stressful day before delivery. I would like also to thank former and present PhD-students in the group at the music therapy PhD Research School at Aalborg University, who have followed and carefully peer debriefed with me as a very important part of the process.

Further I would like to thank Christian Jantzen, Head of the Department of Communication and Psychology, to which the Music therapy Programme belongs, for his support in the process, although he told me that I, being employed as a professor September this year, did not have to finish this study as a PhD-dissertation. He immediately respected and encouraged my choice and provided a small sum of money to reduce my duty of teaching hours the last two months, so I had a chance to get finished.

The last ten days have been really inspiring in cooperating with Kirsten Bach Larsen on layout, corrections, additions, reformulations where we have had many hours of late night telephone exchange on how to 'divide the English words' and many other discoveries in looking carefully through the text. She has been totally enthusiastic about the work and creatively provided me with the layout of the cover of the dissertation in the middle of all the other tasks. Thanks a lot.

Finally I want to bring a very warm hearted thank you to my family, my husband Michael and our son Andreas who have had to do without me a lot the last few months. They have been very supportive and very caring for me when being together and I would not have had the energy to fulfil this dissertation without them being there for me.

Abstract

Although many music therapists use the clinical term counter transference, a systematic examination of the experience of this phenomenon has never been carried out, neither in psychotherapy nor in music therapy literature. This study is a systematic exploration of how music therapists perceive, react, interpret and theoretically understand counter transference experiences in music therapy contexts including musical improvisation in adult psychiatry?

A phenomenological approach was chosen as this study is researching the lived experience of the clinicians and the focus is on the therapist's perspective in examining dynamic processes in the therapist/patient relationship. Comprehensive guidelines were developed as preparation for the four semi-structured qualitative in-depth research interviews, which provided rich and complex data for the phenomenological analysis and discussion.

The results show that:

- 1 Counter transference experiences emerge as a moment of 'a surprise'.
- 2 The music therapists both identify with the mental suffering of the patient and breaks out of this identification as a part of counter transference experiences.
- 3 Counter transference experiences recall memories from the life story of the therapist.
- 4 Counter transference experiences include an unconscious change in the musical expression and a change in the musical and therapeutic

relationship between the music therapist and the patient, and the work is brought at another level.

- 5 A change in the counter transference moment can be experienced as positive or negative, the latter are identified solely at those moments when the therapist is insensitive to the process of the patient.
- 6 Music therapists tend to be informed by body sensations that something specific emerges, and they tend to translate this embodied information to psychological meaning for both parties.
- 7 Music therapists use the metaphor of being a parental figure to the patient to understand the dynamics of counter transference experiences.

From a global view counter transference experiences take place both as a moment of surprise and also for forming a procedural change in the musical expression emerging as an intuitive, unconscious and complex simultaneous process. The change in the musical process releases the body sensation or strong emotions of the therapist and informs the therapist that something specific is emerging. It also serves the counter transference reaction of the therapist and leads the music therapy process in another direction. The moment of surprise has been under preparation unconsciously in previous sessions, and the level of depth of intensity in the therapist's body sensations or feelings, combined with the simultaneous act of playing music is the source of the imminent 'surprise'. The fact, that the process of change is audible in the music, seems to serve the purpose of making unconscious reactions conscious.

The findings have several meanings to music therapy practice. They consolidate that ego weak patients can show reflections on being a part of a counter transference dynamic, even if they cannot reflect verbally on their psychological problems. It also consolidates that the therapist/patient relationship is a main tool in work with severe mentally ill patients. The findings also take the author's former research on listening perspectives as a source of information in clinical work a step further. Finally it shows that music therapists are very present in counter transference experiences and that the act of simultaneously playing music helps them to stay present, even if they experience to be partly disintegrated themselves. It also helps them to intuitively know, when it is the right time for the patient's need to act out and share the counter transference experience. The act of playing music expresses the therapist's perception, and helps him/her to make unconscious experiences conscious. It also serves the transformation process of the change in the moment of counter transference.

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Notes to the reader

The different texts in this Dissertation have been produced over a period of nine years. This means that thoughts and ideas, I produced nine years ago are still present in my theoretical reflection today, but they are adapted into new theories and other constructs for similar phenomena.

It can be advised to read chapter 2 to 6 before reading chapter 1, as these chapters are updated theoretically and also partly incorporate my previous theoretical reflections.

The five articles in chapter one are written in 'arranged' texts towards a certain issue of each chapter, whether chapter 2 – 6 are written in a systematic continuous formulated text around the phenomenon of counter transference.

As English is not my mother language I have partly translated, partly had translators to help me finishing each text. There might be slightly differences in the translation style across the texts.

The appendices count four interview transcripts, the composite categories and six music examples, all attached as a CD.

When searching for music examples 1 – 6 at the CD it shows track 3 – 8 which correspond with examples 1 - 6.

Interview texts have retained as much as possible, the authenticity of the original language when applied in the analysis.

The phenomenon of counter transference is formulated differently by different author's from countertransference to counter-transference to counter transference. I have kept the differencies in the citations.

In my own process I realised in the final phase of writing up the dissertation, that I started three years ago to formulate countertransference and during the research period moved unintended to counter-transference whereas I ended up formulating counter transference. This seems rather symbolic, but I do want to hold on to my last style and as a consequence I have retrospectively changed the formulations in the total text.

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English and Danish Summaries

English Summary

Counter transference – in music therapy

A phenomenological investigation of the experience of counter transference used as a clinical concept by music therapists working with musical improvisation in adult psychiatry.

Inge Nygaard Pedersen

A senior PhDdissertation.

Aalborg University.

Dept. of Communication and Psychology. December 2006.

Supervision by:

Prof. Tony Wigram. Aalborg University, Denmark

Prof. Denise Grocke, Melbourne University, Australia

Introduction

This dissertation is in two parts. Part one, also chapter one includes five previously edited articles, that are shortly bridged together and connected in an effort to describe their relevance for the present study. Part one leads directly into a small scale phenomenological study of counter transference as experienced by music therapists working in adult psychiatry

with musical improvisation. The focus of the study is how these music therapists perceive, react, understand and interpret the clinical term counter transference. The study is a detailed examination of psychodynamic processes in the clinical work, focussing on the therapist's perspective. The five previously published research articles are addressed again in the discussion chapter when they are relevant to the results of the study.

Motivation

In my 25 years in the field of music therapy functioning as a trainer, a clinician, a supervisor and a researcher, I have very often in my clinical work had strong experiences of and deep reflections on counter transference. As a supervisor I have experienced how important this phenomenon is for students and clinicians, as it is influencing their presence with the client in the clinical situation, and their way of relating to the client at a very deep, often unconscious level. The study is motivated by these experiences.

A further motivation for the study has been my ongoing dialogues and exchange with other colleagues working in psychiatry. I realised that counter transference experiences are often bridges in the discussions with other psychotherapists, who may not be very familiar with music therapy. One specific question asked by a psychotherapy supervisor inspired me to formulate my sub-questions in this study. I was asked whether music therapists, when getting into the often uncomfortable atmosphere of counter transference, move from the verbal process into musical improvisation in order to have an easier time and thus escaping the challenge of the counter transference. I did not have a clear answer at that time, but the results from this study provide very clear answers.

The phenomenon of counter transference has been comprehensively addressed in psychoanalytic, psychotherapeutic, psychiatric and music therapy literature. The clinical concept counter transference has survived through the developmental process of psychoanalytic theories from the original classical theory by Freud, who was the founder of the term, to post-Freudian theories, self psychology theories and more contemporary theories of inter subjective and relational psychoanalysis. Still there has been no systematic examination of the experience of the phenomenon by practicing clinicians in psychiatry, or researchers in this field. For the review I have selected literature addressing the historical development of the concept and literature highlighting theoretical and paradigmatic differences within psychoanalysis, psychotherapy, psychiatry and music therapy,

Background issues for research method

As the counter transference phenomenon is about complex 'lived experiences' in specific clinical situations, and as these experiences often emerge from an unconscious channel of communication, I have chosen to apply a phenomenological approach for the investigation, as this approach is "...illuminating intersubjective human experiences by describing the essence of the subjective experience" (Tesch 1990, p. 51). This study falls into a category of phenomenological studies that are concerned with the comprehension of the meaning of text/action, which again is concerned with 'the discerning of themes to determine commonalities and uniqueness" (ibid., p. 59).

Purpose

The purpose of this study is to propose a complementary perspective on treatment and diagnosis in psychiatry at a general level. Of importance here is the perspective of the music therapist as an active, involved participant in the treatment and assessment processes, and as a participant who also influences the outcome by the way in which the music therapist offers his/her partnership in the therapist/patient relationship during the music therapy process.

Method

As a platform for the semi-structured, qualitative in-depth research interviews, and for the phenomenological analysis, I developed a comprehensive set of guidelines for the participants as a preparation guide to the interviews in order to promote, that their experiences were based in an identified specific clinical context. Funding was raised from The General Office of Health in the County of Northern Jutland for the participant's preparation, and the interviews offered me very rich and complex descriptions of the phenomenon. My research questions emerged as follows:

Main question:

- How do music therapists perceive, react, interpret and theoretically understand counter transference experiences in music therapy contexts including musical improvisation in adult psychiatry?

Sub-questions:

- In what ways do music therapists experience counter transference as a positive influence on the music therapeutic process?
- In what ways do music therapists experience counter transference as a negative influence on the music therapeutic process?
- Are there particular features of the music in the improvisation that are present when counter transference occurs? Are there similarities across the music therapists' experiences?

Participants

All of the participants have been working in psychiatry for more than ten years, and have written thoroughly about their clinical work. They were all familiar with the phenomenon of counter transference, but still claimed during the interview that they explored and described experiences which were new to them. Out of four participants, two are men and two are woman. Two are Danish and two are foreign participants, and the researcher is one of the participants.

Data

The rich and complex data were analysed phenomenologically through a combination of two phenomenological approaches by Giorgi (1975) and Colaizzi (1978) as adapted by Grocke (1999) and listed by Forinash and Grocke in Wheeler (2005, p. 326). The two methods were incorporated into Pedersen's Extended Form of Phenomenological Analysis (PEFPA, 2006)). I first did a vertical analysis in order to obtain distilled essences, which then served as the source material for a horizontal analysis. I extended the original approaches with the following stages:

- *A listening/reading step where key statements were identified by the researcher: this involved listening to the recorded interview as a 'piece of music' identifying 'motives' while simultaneously reading the transcripts and underlining the key statements.*
- *Sending back the distilled essence a second time after a long time delay (6-12 months) for a second member check after having send both the transcript, the meaning units and the distilled essence as a packet in the first sending.*

- *After distilling the composite essence of all four interviews in the horizontal analysis and transforming it to a global composite essence, I related the global composite essence back to the individual distilled essences of each interviewee, in order to ensure that all of the, often deep personal experiences, were represented in the findings.*

In the horizontal analysis I first distilled 16 composite categories and from these categories I extracted 19 composite themes. Out of these themes 17 were consistent across all four participants, one across three, while one applied to only two.

Results

The global distilled essence which was extracted on the basis of the vertical and the horizontal analysis was formulated as follows:

A counter transference experience emerges as a moment of surprise for the four music therapists. Through the counter transference experience the music therapist both identifies with the mental suffering of the patient and breaks out of this identification. The counter transference experience recalls memories from the life story of the music therapist. The counter transference experience includes an unconscious change in the musical expression of the music therapists where they risk playing out music differently, also causing a change in the musical relationship between the music therapist and the patient. Music therapists move from one therapeutic dynamic to another in the counter transference moment and it is crucial to trust in, and verify the timing of this movement when it is noticed.

The counter transference experience causes a change in the therapeutic relationship and in the contact between the music therapist and the patient. This change can be experienced as either positive or negative. Positive experiences bring the work to another level. Negative experiences are identified solely at those moments when the therapist is insensitive to the process of the patient.

Music therapists tend to be informed by body sensations that something specific is emerging. There is a tendency that music therapists translate this embodied information to psychological meaning for both parties. Music therapists use the metaphor of being a parental figure to the patient to understand the dynamic of the counter transference experience.

So from a global point of view it is obvious that all of the counter transference experiences take place both as a moment of surprise for the participants, and they are also forming a procedural change in the musical

expression; an expression that emerges as an intuitive, unconscious and complex simultaneous process where

- the change in the musical expression releases the body sensation or strong emotions of the therapist
- the change in the musical expression informs the therapist that something specific is emerging
- the change in the musical expression serves the counter transference reaction of the therapist
- the change in the musical expression gradually leads the music therapy process in another direction.

It also became clear through the findings that the moment of surprise had been under preparation unconsciously in the previous sessions within the musical relationship. The level of intensity in the therapist's body sensations or feelings, combined with the simultaneous act of playing music, was the source of the imminent 'surprise', and of the process of change taking place. The fact that the process of change is audible in the music seems to serve the purpose of making unconscious reactions conscious.

Clinical applicability

This study is very important for music therapists working with musical improvisation in adult psychiatry as it shows that even if ego-weak patients are not able to reflect verbally on their mental sufferings, and thus not suitable for verbal psychotherapy, they are able to be a part of counter transference dynamics and they are able to reflect verbally or musically on being a part of this dynamic in musical improvisation in music therapy, a dynamic that may only be consciously understood by the therapist. It is also an important issue that the findings consolidate that the therapist/patient relationship is a main tool in music therapy with severely disturbed patients, and that this tool can promote developmental changes in the therapeutic process. This is a consolidation of my own former research into music therapy methods with schizophrenic/psychotic patients in adult psychiatry (Pedersen 1997, 1999)

It is clear that the music therapist is not only listening as a musical accompanist. He/she is simultaneously listening to the psychic presence and mental sufferings of the patient and resonating with recognizable emotions and sensations from their own life story. This finding is a step forward from my own former research into the therapist's listening per-

spectives as a source of information in working with schizophrenic patients (Pedersen 1997, 1999, 2000)

It is interesting for clinicians that the music therapists use both 1) their sense of the 'right timing' and 2) their understanding of which phase they are into in relating to the patient when being present in a symbolic parental role - as interpretation tools in the clinical situation. These sources replace a developmental theory, for instance the theory of the Oedipus Complex as developed by Freud as the main tool of interpretation. Thus the focus of interpretation has been moved away from the child (the patient) to the parent (the therapist) being in connection with the child.

Both positive and negative counter transference experiences are related to the aspect of timing, as positive counter transference experiences are related to being sensitive to the 'right timing' to the needs of the patient, while negative counter transference experiences are related to being insensitive to the 'right timing' to the needs of the patient's process. All of the participants are familiar with resonating traumatic experiences from each therapist's own life story, and they consider this as an important part of clinical information when treating the patient. All of the participants emphasize that to do such deeply relationally connected music therapy demands an in-depth self analysis or self experience, and a continuous supervision of the work. As a consequence of the participants being active in playing music in the counter transference dynamic, they do not use the term 'attached objective observer' which is applied in the music therapy literature as a part of being open to counter transference experiences. They rather talk about being 'separated in connectedness.'

The findings are very much in line with contemporary psychiatric and psychotherapy literature on relational treatment where, among others, Thorgaard & Haga (2006) have edited one and planned five reports to support psychiatric staff members in fulfilling the human values in the treatment of psychiatric patients on the basis of formulations by The Ministry of Social Affairs, Ministry of the Interior – and the Ministry of Health (Denmark 2005). The two Head psychiatrists emphasize that:

"No matter which method is used, it cannot be practised with ethical responsibility, scientific honesty or with optimal outcome, if it is not carried out on the basis of the nature of the therapeutic relationship, that includes training in, experiences through and knowledge about the relationship between the patient and the relational treatment staff person. And here essential experiences and knowledge about both counter transference and transference are placed at the seat of honour by the pro-

fessional relational treatment staff person" (Thorgaard & Haga 2006 p. 43. Author's translation).

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Dansk Opsummering

Modoverføring i musikterapi

En fænomenologisk undersøgelse af oplevelse af modoverføring anvendt som et klinisk begreb af musikterapeuter, der arbejder med musikalsk improvisation i voksenpsykiatrien.

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Introduktion

Denne afhandling er opdelt i to hovedafsnit. Det første afsnit, kapitel 1, indeholder fem forskningsartikler som har været udgivet tidligere. De er hver især knyttet sammen af korte introduktions- og overgangstekster, der redegør for artiklernes relevans for denne opgave. Dette afsnit

fører direkte over i en mindre fænomenologisk undersøgelse af modoverføring som det opleves af musikterapeuter, der arbejder med musikalske improvisationer i voksenpsykiatrien. Undersøgelsen fokuserer på, hvordan musikterapeuterne sanser, reagerer på, forstår og fortolker det kliniske begreb modoverføring. Afhandlingen er dermed en detaljeret undersøgelse af psykodynamiske processer i den musikterapeutiske behandling hvor fokus er på terapeutens perspektiv i processen. De fem inkluderede forskningsartikler i første afsnit inddrages i diskussionskapitlet i det omfang det er relevant for undersøgelsens resultater..

Motivation

I mine 25 år i musikterapifeltet som dels underviser, kliniker, supervisor og forsker har jeg i mit kliniske arbejde ofte haft stærke oplevelser af og dybe refleksioner over fænomenet modoverføring. Som supervisor har jeg erfaret, hvor vigtigt dette fænomen er for studerende og klinikere, idet det har betydelig indflydelse på den måde, terapeuten kan være til stede for patienten på i den kliniske situation. Det har også indflydelse på, om og hvordan terapeuten og klienten kan relatere sig til hinanden på et dybt og ofte ubevidst plan. Disse erfaringer er således vigtige motivationskilder for undersøgelsen.

En anden motivationskilde er, at jeg i min udveksling med andre kolleger, der arbejder i psykiatrien, har bemærket, at modoverføringsoplevelser ofte er brobyggere i dialoger med andre psykoterapeuter, som måske ikke kender så meget til musikterapi. Jeg blev på et tidspunkt under supervision hos en psykolog/psykoterapeutkollega, stillet et specifikt spørgsmål, som inspirerede mig til at udforme underspørgsmålene i denne opgave. Jeg blev spurgt om ikke musikterapeuter bevæger sig fra den verbale del af terapien til den musikalske del (samspillet i musikimprovisationen), når de mærker modoverføring som en ubehagelig atmosfære i relationen til patienten for derigennem at komme væk fra det, der kan være næsten ubærligt og for at frembringe en lettere stemning. Jeg havde ikke noget klart svar på daværende tidspunkt, men resultaterne i denne undersøgelse fremkommer med klare svar.

Begrebet modoverføring er udførligt og meget omfattende beskrevet i psykoanalytisk, psykoterapeutisk, psykiatrisk og musikterapeutisk litteratur. Det kliniske begreb modoverføring blev skabt af Freud, og det har overlevet udviklingsprocesser og forandringer indenfor psykoanalytiske teorier; lige fra den klassiske psykoanalytiske teori, skabt af Freud, til post-Freudianske teorier, selvpsykologiske teorier og mere moderne teorier indenfor intersubjektiv og relationel psykoanalyse. Alligevel har

der ikke tidligere været foretaget en systematisk undersøgelse af oplevelsen af modoverføring. På grund af omfanget har jeg måttet være meget selektiv i min litteraturudvælgelse. Jeg har dels valgt kilder der belyser begrebet i et historisk perspektiv og dels kilder der belyser teoretiske og paradigmatisk forskelligheder i opfattelsen af begrebet såvel indenfor psykoanalytisk, psykoterapeutisk, psykiatrisk og musikterapeutisk litteratur.

Begrundelse for metodevalg

Da begrebet modoverføring handler om komplekse 'levede erfaringer' i specifikke kliniske situationer, og da disse erfaringer ofte vokser ud af en ubevidst kommunikationskanal, har jeg valgt at anvende en fænomenologisk metode til undersøgelsen, da en sådan metode: ".....kaster lys over intersubjektive menneskelige erfaringer ved at beskrive essensen af de subjektive erfaringer." (Tesch, 1990, s. 51. Min oversættelse). Denne undersøgelse tilhører den kategori af fænomenologiske undersøgelser, som retter sig mod omfanget af meningen af en tekst eller en handling, som igen retter sig imod at uddrage temaer af materialet, for at bestemme hvilke temaer er sammenlignelige og hvilke er unikke. (ibid., 59. Min oversættelse)

Formål

Formålet med undersøgelsen er at fremkomme med et komplementært perspektiv på behandling og diagnose i psykiatrien på et overordnet plan. En vigtig faktor i dette perspektiv er at musikterapeuten er en aktiv, involveret deltager i behandlings- og assessmentprocessen. En deltager, der ved sin deltagelse påvirker resultatet af behandlingen. Den påvirkes af den måde musikterapeuten er til stede på og den måde musikterapeuten tilbyder sit partnerskab i terapeut/patient relationen igennem musikterapi forløbet.

Metode

Som en platform for det semi-strukturerede, kvalitative dybdegående forskningsinterview, og for den fænomenologiske analyse, udviklede jeg et meget omfattende sæt af retningslinjer for deltagerne, der viser, hvordan deltagerne skal forberede sig til interviewet. Disse retningslinjer blev lavet for at sikre at deres oplevelser er baseret på en identificeret klinisk kontekst. Jeg ansøgte og fik penge fra Sundhedssekretariatet i Nordjyllands Amt til at aflønne deltagerne for deres forberedelse til interviewet.

Alle interviewene frembragte meget fyldige og komplekse beskrivelser af deltagernes oplevelse af fænomenet modoverføring. Forskningsspørgsmålene blev følgende:

Hovedspørgsmål:

- Hvordan sanser, reagerer (på), forstår og fortolker musikterapeuter, der arbejder med musikalsk improvisation i voksenpsykiatrien deres modoverføringsoplevelser?

Underspørgsmål:

- På hvilken måde oplever musikterapeuter modoverføring som en positiv influerende faktor på musikterapiprocessen?
- På hvilken måde oplever musikterapeuterne modoverføring som en negativ influerende faktor på den musikterapeutiske proces?
- Er der særlige træk i musikimprovisationen der går igen når modoverføringsoplevelser dukker frem? Er der fælles træk imellem deltagernes improvisationer?

Deltagere

Alle fire deltagere har arbejdet i psykiatrien i mere end 10 år og de har en omfattende skriftlig produktion om deres kliniske arbejde. De er alle bekendte med fænomenet modoverføring. På trods heraf kommenterede de alle undervejs i interviewet, at de 'lige der' formulerede oplevelser, som var nye for dem. Af de fire deltagere er der to mænd og to kvinder, to danske og to udenlandske deltagere og forskeren er en af deltagerne.

Data

De fyldige og komplekse data blev analyseret fænomenologisk ved at kombinere to fænomenologiske analyse metoder af Giorgi (1975) og Colaizzi (1978), adapteret af Grocke (1999) og oplistet af Forinash & Grocke i Wheeler (2005, s. 326). Disse to metoder blev inkorporeret i Pedersen's Udvidede Fænomenologiske Analysemetode Form (PUAMF). Jeg gennemførte først en vertikal analyse for at udvinde destillerede essenser af hvert interview. Disse essenser tjente som grundmateriale for en horisontal (hvor man vender sig mod horisonten) analyse. Jeg udvidede den oprindelige metode med følgende trin:

- a Et trin hvor jeg læste et udskrevet interviewmanuskript, **samtidig med** at jeg lyttede til interviewbåndet som om stemmerne var et stykke musik, hvori jeg kunne identificere motiver, som jeg samtidig understregede i manuskriptet.
- b Efter den første udsendelse af interviewudskrifter, motivunderstregninger, meningsenheder og destillerede essenser af hvert enkelt interview, sendte jeg efter 6-12 måneder alene den destillerede essens ud igen for at checke, at deltagerens oplevelse var fuldt ud dækket ind i essensen.
- c Efter jeg havde destilleret helhedssensen fra alle fire interview i den horisontale analysedel til en global beskrivelse, relaterede jeg denne tilbage til de essenser, der blev destilleret af de oprindelige interviewtekster. Det gjorde jeg for at sikre mig, at den globale beskrivelse dækkede alle aspekter af de fire deltagers oplevelser.

I den horisontale analyse destillerede jeg først 16 sammensatte kategorier. Ud af disse fremtrådte 19 helhedstemaer af hvilket 17 var konsistente. Det betyder at de var gyldige for alle fire deltagere. Et tema var gyldigt for tre og et for to deltagere.

Resultater

Den globale essens blev destilleret på basis af såvel den vertikale som den horisontale analyse og blev formuleret således.

En modoverføringsoplevelse dukker frem som en overraskelse for musikterapeuten. I modoverføringsoplevelsen identificerer musikterapeuten sig både med patientens psykiske lidelser og bryder ud af denne identifikation igen. Modoverføringsoplevelsen resonerer med genkendelige oplevelser fra musikterapeutens egen livshistorie. Modoverføringsoplevelsen indebærer en ubevidst forandring i det musikalske udtryk mellem musikterapeuten og patienten. Musikterapeuter bevæger sig fra én terapeutisk dynamik til en anden i modoverføringsøjeblikket, og det er afgørende for musikterapeuten at stole på og senere få bekræftet timingen (det rette/forkerte tidspunkt) i denne bevægelse, når den bliver bevidst.

Modoverføringsoplevelsen bevirker en forandring i den terapeutiske relation og i kontakten mellem musikterapeuten og patienten. Denne forandring kan blive erfaret som enten positiv eller negativ. Positive erfaringer bringer terapien op på et andet niveau. Negative erfaringer er udelukkende identificerede som de øjeblikke, hvor terapeuten er usensitiv i forhold til patientens proces. Musikterapeuten bliver informeret af egne kropsfornemmelser og følelser om, at der er noget specifikt i gære. Der er en tendens til at musik-

terapeuten oversætter disse informationer til noget, der har en psykologisk forståelig mening for begge parter. Musikterapeuter anvender metaforer, såsom at de indtager en bestemt forælderrolle i relationen med patienten for at forstå og fortolke dynamikken i modoverføringsoplevelsen.

Så fra et overordnet perspektiv er det tydeligt i undersøgelsen, at alle modoverføringsoplevelserne finder sted i form af en overraskelse for deltagerne, og oplevelserne er identificerede gennem en fremadskridende forandring i det musikalske udtryk; en forandring der dukker frem som en intuitiv, ubevidst og kompleks samtidig proces hvor:

- forandringen i det musikalske udtryk frigør kropsfornemmelser og stærke følelser hos terapeuten
- forandringen i det musikalske udtryk informerer terapeuten om, at der er noget specifikt i gære
- forandringen i det musikalske udtryk fremmer terapeutens modoverførings reaktion
- forandringen i det musikalske udtryk fører gradvist musikterapi processen i en anden retning

Det blev også tydeligt, som en del af fundene, at overraskelsesøjeblikket havde været under forberedelse ubevidst i den musikalske relation i de tidligere sessioner. Dybden af intensiteten i terapeutens kropsfornemmelser eller følelser, kombineret med den samtidig spillehandling, er både kilden til den umiddelbart fremdukkende 'overraskelse', og til den forandringsproces som finder sted. Det faktum, at forandringsprocessen er hørbar i musikken fremmer processen med at gøre ubevidste reaktioner bevidste.

Klinisk anvendelighed

Denne undersøgelse er meget vigtig for musikterapeuter der arbejder med musikalsk improvisation i voksenpsykiatrien, da den viser, at selv om jeg svage patienter ikke er i stand til at reflektere verbalt over deres psykiske lidelser, og derfor ikke er egnede til verbal psykoterapi, så er de i stand til at være deltagende i modoverføringsoplevelser og til at reflektere verbalt eller musikalsk over at være en del af en modoverføringsdynamik i musikalsk improvisation i musikterapi; en dynamik der i mange tilfælde kun forstås af musikterapeuten. Det er også vigtigt at resultaterne bekræfter at terapeut/patient relationen er et hovedredskab i musikterapi behandling med meget svært psykisk syge patienter, og at dette redskab kan forårsage udviklende forandringer i den terapeutiske pro-

ces. Dette er en bekræftelse af min tidligere forskning i musikterapi-metoder med skizofrene / psykotiske patienter i voksenpsykiatrien (Pedersen, 1997, 1999). Det er klart i undersøgelsen her, at musikterapeuter ikke kun lytter som musikalske akkompagnatører til patienten. Han/hun lytter samtidig til patientens psykiske tilstedeværelse, og til hans/hendes psykiske lidelser i medklingende resonans med genkendelige følelser og fornemmelser i terapeutens egen livshistorie. Dette fører et trin videre fra min tidligere forskning i terapeutens lytteperspektiver som en kilde til information i arbejde med skizofrene patienter (Pedersen 1997, 1999, 2000).

Det er interessant at musikterapeuter bruger både deres 1) sans for den 'rette timing' og 2) deres forståelse af ud fra hvilken fase de relaterer sig til patienten i en identificeret symbolsk forælderrolle – som fortolkningsredskab i den kliniske situation. Disse to orienteringskilder erstatter dermed en udviklingsteori, som for eksempel teorien om Oedipus Konflikten, udviklet af Freud, som et hovedredskab til fortolkning. Fokus er flyttet fra 'barnet' til 'forældrepartneren'. Både positive og negative modoverføringsoplevelser er relaterede til timing aspektet (det rette/forkerte tidspunkt for handlinger), hvor positiv modoverføring er relateret til at være og handle i 'rette timing' med hensyn til at være sensitiv over for behovene i patientens proces. Negativ modoverføring er relateret til at være i en 'forkert timing' med hensyn til at være sensitiv overfor behovet i patientens proces. Alle deltagerne er bekendte med at være i en resonerende kontakt med traumatiske oplevelser fra deres egen livshistorie, og de anser dette for at være en vigtig del af den kliniske information under behandlingsprocessen. Alle deltagerne betoner at det at være forbundet i en sådan dyb relation i musikterapibehandlingen forudsætter en dybdegående egen analyse eller selverfaring og en kontinuerlig supervision af det kliniske arbejde. Som en konsekvens af at deltagerne er aktive i den musikalske handling i modoverføringsdynamikken, anvender de ikke begrebet 'deltagende observatør', hvilket begreb ellers er anvendt i musikterapilitteraturen som en del af at være åben overfor modoverføringsoplevelser. De taler snarere om at være 'adskilt i forbundethed'

Fundene i denne undersøgelse er meget i tråd med samtidig psykiatrisk og psykoterapeutisk litteratur om 'relationel behandling', hvor blandt andre Thorgaard & Haga (2006) har produceret en og planlagt fem rapporter, der skal understøtte psykiatrisk behandlingspersonale i at opfylde de menneskelige værdier i behandlingen af psykisk syge patienter som blev formuleret af Socialministeriet, Indenrigsministeriet og Sundhedsministeriet i Danmark 2005. De to chefpsykiatere betoner at:

”Uanset hvilken metode, så kan den ikke udøves etisk forsvarligt, redeligt videnskabeligt eller optimalt udbytterigt, hvis den ikke udføres på grundlag af det terapeutiske forholds natur, dvs. træning i, erfaringer gennem og kundskaber om forholdet mellem patient og relationsbehandler. Og det er her, væsentlige erfaringer og kundskaber om både modoverføring og overføring kommer i højsædet hos den professionelle relationsbehandler.” (Thorgaard & Haga 2006, p. 43).

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Introduction

This study concerns a detailed examination of psychodynamic processes in active music therapy in adult psychiatry. It is grounded in previously published research articles, and focussing on the influence of counter transference as reported by experienced music therapists using musical improvisation in the music therapy process, through a small scale, interview based study. The dissertation comprises previously documented research publications, followed by a research report with a short literature review, method, results and discussion of the phenomenological analysis of interviews from a chosen, purposive sample.

My 25 years in the field of music therapy has been much influenced by continuous tasks arising out of my status of being a pioneer/builder, although I, from the very beginning, have had an underlying and specific interest in the potential working processes of music therapy with ego-weak patients (autistic, psychotic, schizophrenic patients). Functioning simultaneously as a trainer, clinician and researcher, this interest has often led me to reflect on what specific skills of the music therapist this kind of work calls for when using music as a therapeutic tool. Therefore this interest has been a general motivation and theoretical foundation leading to this project. My interest has been focused around the following questions which have also been an inspiration for my chosen publications for this thesis:

Concerning the therapist as a tool

- Can therapeutic empathy and sensitivity be taught?
- Can personal traumatic experiences in the therapist's past be transformed into useful therapeutic containing skills?
- What kind of knowledge about the patient occurs to the therapist through the process of making counter transference experiences conscious?

Concerning musical improvisation as a tool

- Does musical improvisation mirror, facilitate or maybe even transform the therapist's reactions that are influenced by counter transference in a way that can be of a positive influence for the development of the patient?
- Does musical improvisation prohibit or distort the therapist's reactions influenced by counter transference in a way that can be of negative influence for the development of the patient?

Motivations for the project

derived from clinical practice

In my clinical practice in psychiatry I have experienced a wide range of counter transference experiences from being together with people that appear normal and have many apparent similarities with myself or anybody else in the street, and yet there are still strong sensations or emotions present which cannot just be explained. I often ask myself why they have a diagnosis as a psychiatric patient. A logical way of thinking gives me no answer. In other circumstances I have been together with people who are not in any way physically handicapped or retarded, but who just do not communicate or leave you out of communication. You find yourself using illogical ways of understanding or coping with the relationship - or else one might have no other choice than walk out of the room or be very resistant.

In my experience and understanding counter transference is a very important and complex tool to help myself remain sensitive to all sorts of sensations and emotions coming up in such situations, and to remain

open to being informed about how and when to interact, influenced by these emotions musically, verbally and nonverbally (in the best way) to facilitate a progressive process for the patient. Counter transference can also give me an awareness of when I am not coping in a good way for the patient.

Based on experiences from my clinical practice in counselling work and in psychiatry, I have developed some metaphors to help frame and encompass a nonverbal orientation. I have found these metaphors very helpful for the process of making counter transference experiences conscious and applicable for therapeutic use. I have tried to put these metaphors into words in describing how I, as a therapist, experience and react intuitively from a tacit knowledge in my clinical practice using different metaphors on my way of 'being present'. (Pedersen 1991, 1997, 1998a, 1999 2000). Through this study I want to examine if, when and how other music therapy colleagues identify and let themselves be informed by counter transference in music therapy in psychiatry. I also want to examine what value this clinical term has for the music therapy clinicians in everyday practice and how they understand counter transference in clinical musical improvisation.

Counter transference is comprehensively applied as a clinical term by many psychoanalysts, who are also psychiatrists. They have described counter transference as a very important tool in work with psychiatric patients. One such psychoanalyst and psychiatrist is Hedges (1991), who emphasized the importance of counter transference as follows:

Counter-transference: The Royal Road to understanding the merger experience.

(Hedges 1991, p. xi)

The psychoanalyst and psychiatrist Giovachini (1979) describes the phenomenon of counter transference this way:

The awareness of our sensitivities, usually referred to as counter-transference reactions, can only lead to increased integration and forbearance for the analyst. In turn, the range of patients that we can treat is broadened and the benefits of analysis will become available to a larger number of persons who have, for the most part, known only suffering and misery.

(Giovachini 1979, p. 264)

The phenomenon of counter transference has been comprehensively described in the literature of 'dynamic psychiatry' especially concerning borderline patients. For instance the psychiatrist Gabbard, (1986 p.16 in quoting Giovachini.1975) considers "Borderline patients have a special task to inflict the sweets of deep sufferings upon the therapist".

Gabbard also comments that:

The accusations of the patient can move into the marrow of the professional identity of the psychotherapist and create a form of physiological counter-transference which influences the sympathetic nervous system and provokes a beating heart, a dry mouth and shaking limbs.

(Gabbard 1986, p. 19)

I have noticed that only so called 'dynamic' psychiatrists, psychologists and other psychotherapists use the term counter transference. Famous dynamic psychiatrists like Cullberg (1993), Gabbard (1994) and Master-son (1976) have written comprehensively on the importance of counter transference in treatment processes with a number of pathologies. In the last Danish Handbook of 'Clinical' Psychiatry, Hemmingsen et al (Ed.) (1994), the term counter transference is not mentioned at all. So this tells me that music therapy in psychiatry in Denmark is mostly to be defined as a part of Dynamic Psychiatry.

Motivation derived from exchange with national and international colleagues

Through guest lecturing, and exchange and contact with other milieus, emerging knowledge about transference and counter transference has been very vital. I have realised that no matter which model of music therapy foreign students are trained within or prefer, this knowledge about counter transference holds an important value in forming a music therapist's identity, and for the music therapist to understand, what is going on in the musical and non-musical relationship between the therapist and the patient. For these reasons I consider transference and counter transference as vital foci in supervision work on all levels from a student level to the most experienced music therapist level. (Pedersen, 2000, 2002a, 2002b)

Motivation from readings

The terms transference and counter transference were originally developed by Freud. Counter transference, as developed and described by him, in classical psychoanalysis was considered as the unresolved problems of the analyst limiting his neutral perception and position. Freud himself changed this statement after 10 – 15 years when he realised that counter transference was a valuable tool in the analysis process. The term has been a subject of different definitions, and it has been transferred from classical psychoanalysis to new theoretical orientations and paradigms within psychoanalysis, analytical psychology, ego psychology and psychology of the self. Counter transference has, in this continuing process, to be seen as connected with the growing interest in developing psychoanalytic treatment for more regressive illnesses. This is very important when examining the counter transference phenomenon in music therapy in adult psychiatry, because in psychoanalytic treatment of more regressive patients the understanding of interpretation cannot stand alone as the main intervention (as in music therapy) and often it cannot be used at all. This shift in the understanding of interpretation of the patient's transference, as no longer being the main intervention, also influences the possibilities for understanding and defining counter transference in the psychoanalytic literature.

The music therapist who has first incorporated the clinical term counter transference into music therapy literature was Priestley (1975/1994). She worked in adult psychiatry for many years and made up three different categories within counter transference from her clinical experiences, where she illustrated in a very witty way counter transference experiences. She refers to theories from both Freud and Jung in understanding these processes when working with patients.

Bruscia has written comprehensively on many aspects of counter transference, including understanding counter transference, the signs of counter transference, techniques for uncovering and working with counter transference, and he has identified a series of types of counter transference, including positive, negative, empathic, complementary, somatic, emotional, behavioural, musical (Bruscia, 1998, 1998b). His definitions have provided an inspiration for many music therapists around the world. Bruscia has edited the most extensive contemporary book on the transference/counter transference issues in music therapy: **The Dynamics of music Psychotherapy**. (Bruscia, 1998). In this book music therapists who have described their counter transference experiences represent three different models of music therapy, including the Creative Music

Therapy model Nordoff/Robbins Music Therapy model, the Analytical Music Therapy model (AMT) and the Guided Imagery and Music model (GIM). These three models are identified in this text as being representative for music psychotherapy. The overall term **dynamic** is used here to cross over the three different approaches based on different philosophies. Bruscia has certainly inspired music therapists from many models and nationalities to describe their experiences of counter transference as part of a case study or as a clinical focus in itself.

Hadley (2003), who studied with Bruscia, further developed the term **Psychodynamic** to bridge the identification of these three approaches in her book **Psychodynamic Music Therapy Case studies**, where music therapists have described and illustrated their clinical work, mostly referring to the use of the phenomenon of transference and counter transference as part of many of these case studies.

Within music therapy in psychiatry Jensen (1998, 1999, 2000), De Backer (1996, 1999, 2003) Metzner (1999, 2003) and Hannibal (2000, 2000a, 2003) have carefully tried to describe their understanding and the value of counter transference influenced interaction in music improvisation in context in single case studies with psychiatric patients. At the Music Therapy Research Clinic in Aalborg Psychiatric Hospital, several music therapy clinical and research staff members have described and reflected on the term counter transference in single case studies in the journal **Music Therapy in Psychiatry** (Lindvang 1998, 2005; Frederiksen 1998, 2005; Storm 2000; Hannibal 2000, 2000a, 2002).

I have often used the term myself in talking and writing about clinical experiences, as I think it is a core construction in understanding music therapy processes in both Analytical Music Therapy and Guided Imagery of Music therapy, the two models in which I have a professional training background. But I have never really systematically examined what value this term has for music therapists working with musical improvisation with psychiatric patients in Denmark and other European countries.

Motivation from multidisciplinary cooperation

I want to focus my examination on the phenomenon of counter transference experiences coming from music therapy with adult psychiatric patients, as this is the population with whom I have been working for the last twelve years. Counter transference is a key phenomenon in the supervision, I and my music therapy colleagues undertake with either psychologists or psychiatrists. The term is thus an important bridge of

common professional understanding in communication among the clinical treatment team in psychiatry. Here I often have the feeling that the music therapist's understanding of counter transference interaction differs slightly from the understanding of the psychiatrist, as we have the musical experience to place in between silence and words. So this is also an underlying interest I want to shed more light on through this study. I was especially motivated by one supervision session, where the supervisor asked me the following question:

is it not the case, that you as a music therapist change from the verbalising part to the musical interplay when the counter transference feelings are too unbearable and you want to have a more easy time with the patient?

I did not have a clear answer at the time but this research study will bring me closer to an answer.

Music therapy in psychiatry in Denmark is recognised as a psychotherapeutic treatment and at the psychiatric hospital in Aalborg, the music therapists are incorporated as an autonomous service within the psychotherapeutic unit, taking part in courses and research meetings with psychiatrists and psychologists. For this reason I think it is important to use some of the same psychological constructions and clinical concepts as the verbal psychotherapists to be able to understand our mutual clinical contribution in psychiatric treatment. Conversely, I think it is also important for music therapists to search for those specific definitions, professional understandings and values of counter transference that are recognised uniquely in music therapy in psychiatry.

On the research level at Aalborg Psychiatric Hospital, psychiatrists and psychotherapists work mostly with outcome studies employing scores from standardised, quantitative tests. There is no research taking place that examines the process of the therapeutic work or the influence by the therapist on the treatment process. I think both traditions of research are important, and it is necessary to gain a fuller knowledge of the nature of treatment of psychiatric patients.

The Swedish psychiatrist, Cullberg (1993, p. 30) defines the **humanistic** and the **natural science** knowledge area – as 'the double content of psychiatry'. He emphasizes that he thinks both areas are needed, but it is not possible to be an expert within both traditions. Often one finds an expert within the one who makes use of tools from the other when needed. I agree on the need for both areas in music therapy research in

psychiatry, but I do identify more with the humanistic tradition, when thinking of myself as a researcher, yet still a 'subject' searching to understand (not explain) another 'subject' (not object) concerning emotions, intentions and expressions of all sorts.

Hannibal (2000) took on the task of demonstrating that transference takes place in musical improvisation with psychiatric patients. He used a common denominator of nonverbal transference, which he demonstrated had a convincing place (in a parallel way) in the verbalising parts and the musical parts of the treatment sessions with psychiatric patients. From this point of reference, I would like to take a further step by embarking on an exploration of the music therapist's perception, reaction, understanding and interpretation of the construct of counter transference when working with psychiatric patients.

The focus of this study will therefore be what understanding and value the phenomenon of counter transference has for four experienced music therapists in adult psychiatry in Denmark and other European countries. The first major section of this thesis comprises those five articles I have selected from my existing research publications as part of the material submitted for evaluation which, together with a small scale research project on **perceiving and understanding CT for four music therapists working with musical improvisation in psychiatry in Denmark and other European countries** form this dissertation.

The research publications will be prefaced and connected, and conclusions from these publications will be elicited that lead appropriately into the research questions to be addressed in the small study that follows

Chapter 1

Five pre-edited articles

Introduction to article 1

In the following article I present *my developed method* of the therapist's *listening perspective* and *listening attitude* as an important element in work with psychiatric patients. I am addressing my own experienced gap between intuitive sensations being with schizophrenic patients and the task of translating these experiences to the psychoanalytic terms of transference and counter transference. The terms of listening perspectives and listening attitudes are suggested as one way of alternative translation of affective management of boundaries to come closer to describing the clinical experiences with these patients. Corresponding reflections on difficulties in using the transference terms in work with psychotic, schizophrenic patients are brought from music therapy literature Jensen (1996) and psychiatric literature Benedetti (1983). Other replacing terms for transference issues such as **holding** Winnicott (1971), **reframing the irrational expression of the patient into something that could be understandable from a psychological point of view** Benedetti (1983), or **the therapist's ability to process and detoxify non tolerated affects from the patient without acting on them** (Gabbard 1994, referring to Grotstein 1976 and Ogden 1980) are presented.

The description of listening attitudes as a recognised change in perceived polarities in the clinical work is described inspired from similar descriptions in verbal psychotherapy, Fog (1995) and is exemplified by three case descriptions based on the following foci:

- From projective identification to listening perspective as an overall orientation
- Variations in listening to channel three – the emotional baseline
- Listening to emptiness – an extreme variation.

Using reference points from colleagues in music therapy and psychotherapy I set up **a method based on the tool of a listening perspective**, from where I have been listening to the emotional baseline of the patient to gain information of:

- possibilities for closeness and distance
- possibilities for interventions musically and verbally
- timing possibilities in the therapist' interventions.

1.1 Article 1

The Music Therapist's Listening Perspectives as Source of information in Improvised Musical Duets with grown-up, Psychiatric Patients, Suffering from Schizophrenia

First edited in: Nordic Journal of Music Therapy, 1997, 6 (2), p. 98 – 112

Summary

As a clinician working with schizophrenic patients at the Music Therapy Clinic at Aalborg Psychiatric Hospital, I want to share my reflections on the notion of replacing the agreed terms of transference and counter-transference with the terms of listening perspectives and listening attitudes in translation of my experienced practice. It is my source of information for describing dynamic processes taking place in music therapy work with grown up psychiatric patients suffering from schizophrenia. From my practice I have experienced that the agreed terms of transference i.e. used in theory of psychotherapy and music therapy does not really cover the affective moments of relatedness to those patient populations. It also seems convenient to me to use terms closer to a description of what I would call a basic tool of music therapists -- the tool of listening. I set up a method to raise my consciousness on how the listening perspectives can provide a listening attitude, which I

assume -- as the source of my intuitive information -- influences the therapist/client relationship and the musical sounds and my understanding of both. I illustrate the method and the reflections on the terms through broad based case examples from three different case studies. The reflections presented here are in constantly progress.

Introduction

My interest in the topic of the therapist` **listening perspectives** grew out of the fact that I often experienced a gap between my intuitive experiences and sensations in clinical work with schizophrenic patients and the translation of this work into the agreed terms like transference and counter-transference. Terms which are most often used in descriptions of psychodynamic process work. At the same time I experienced being part of a lot of psychodynamic based process work with the schizophrenic patients which I have been working with through the last three years at the Music Therapy Clinic at Aalborg Psychiatric Hospital.

In my reflections I realised that in a work where my situation often starts from being in a relationship, where the patients capacity for reaching out in any way towards me is typically very poor or almost non-existent, the information I got from thinking in terms of transference issues were not covering the often tiny variations in the dynamic process and I realised that what really gave me information was my awareness of my listening capacity or lack of listening capacity in this unique context with this unique patient.

I am working individually, using joint music improvisations alternating with verbal parts, and I work from an understanding of the illness of schizophrenia -- like the one in psychodynamic psychiatry -- where the symptoms (fragmentation and isolation) are understood as in some way psychologically connected and integrated with the personality. The symptoms are an enlargement of already existing personality features which can be communicated in specific bonding patterns. Basically a stressful situation is seen as a primary trigger -- the vulnerability-stress model (Bechgaard, 1997).

This means that I work from the understanding, that it might well be possible to meet the schizophrenic patient, to relate to and to be a part of a dual development (therapist/ patient) in a process work, where the long term aim is a reorganisation of the psychic reality of the patient. My experience from clinical practice is that the question whether schizophrenic patients can benefit from music therapy depends more on the capa-

city for listening and containing by the therapist in this unique context with this unique patient than it depends on an evaluation of a potential capacity of reorganising and relationship possibilities of the patient.

Filling out a gap between the terms and the experienced reality

As mentioned above I often had a feeling of a gap existing between my intuitive experiences and sensations in clinical work with schizophrenic patients and the translation of the work based on the psychoanalytically agreed terms **transference** and **counter-transference**. This gap was mostly raised in rather painful phases in the music therapy work, where I could identify myself deeply listening to emptiness -- so strong that I felt very empty myself -- and could not find the words when I tried to describe these experiences.

In such moments the use of those terms seemed not to be too convenient and I could easily identify with my Canadian colleague Carolyn Kenny, when she challenges the psychoanalytic way of describing and understanding clinical work. She raises the question:

How can we prove for example that the constructs like "self", "personality", or "transference" are real? They are figments of the imagination, invented for effective management of boundaries. They are fictions which we productively explore because they help us to make sense out of our human life, particular our suffering. And they can co-exist with other fictions, which do not have such boundaries. Perhaps this is what the subjective exploration is about in music therapy. When one is tossed up one is not limited by definitions. Now definitions can be created in the music.

(Kenny 1996, p. 121)

Still the psychoanalytical terms represent an agreed way of describing subjective experiences in psychotherapeutic work, so I do not think it will be meaningful just to reject these terms or this way of making an effective management of boundaries in most psychodynamic work taking place in music therapy. The notion here is developed with a specific patient population and it rather raises the question "can the effective management of boundaries with this patient population be extended to come closer to describing the clinical experience?"

The listening perspective as an overall orientation

The process of building bridges between the experience of some kind of relatedness with schizophrenic patients, and the translation of this experience, I think has to be connected to an overall orientation by me as a music therapist which mirrors my understanding of the illness of schizophrenia. This overall orientation can be defined as a **listening perspective** which I find a convenient term to use being a music therapist. One could also discuss the perspective of a total perception but I try here to limit the description to the listening perspective.

For me a listening perspective is a tool for orientation and information. One listening perspective can be described as listening simultaneously:

- to a foreground -- the here-and-now presence and expressions of the patient, at the same time as
- listening to a background -- the split off reality (often a reality of very strong feelings) of the patient, which also means listening to the field of tensions and movements (or lack of tensions and movements) between these polarities of foreground and background.

With schizophrenic patients this often means listening extra sensitively to tiny variations in tensions and movements between such polarities -- tiny variations which influence our being together almost unconsciously but still very strongly.

Important **listening attitudes** provided by such a **listening perspective** can be:

- to listen to and resonate authentically with the patient's way of 'being present' in the room (foreground) in order to gradually make it possible that small glimpses of the split off reality feelings (background) can come into the relatedness and the process
- to listen to and accept basic emotions in the patient -- often of a strong character -- when they show up, no matter in which form.

I extend this description of a listening perspective providing listening attitudes, later on in this article when reflecting the clinical use of the listening perspective, where I describe my experience of listening to two channels simultaneously and gaining information about the possibilities of interventions intuitively -- as if listening to a third channel in myself.

Corresponding ideas in the music therapy and psychotherapy literature

I find some similar attempts to address such issues in the very limited literature up till now on music therapy with schizophrenic patients.

My colleague Bent Jensen, working at The Psychiatric Hospital, Risskov, Aarhus writes in referring Selzer (1993):

Historically the term counter-transference is defined as the therapist` unconscious transference to the patient` transference. But here I will use a broader definition and extend it to any reaction the therapist has to the patient. Counter-transference reactions may take the form of feelings, fantasies or somatic sensations

(Jensen, 1996, p 2)

He emphasises that there often is a circular movement between four phases in the therapist/ patient relationship in their musical dialogues:

1. The patient keeps the therapist outside -- plays out in an omnipotent way -- takes the whole scenario in his musical expression. The therapist stays consciously outside -- observing.
2. The patient stays in his megalomaniac fantasies -- the therapist consciously holds and supports this identity of the patient in his musical part.
3. The patient stays in his universe -- the therapist consciously takes a more complementary role.
4. Short moments of independency -- both patient and therapist stay within their own distinct identity.

He sums up on the term counter-transference:

My personal luggage that makes me resonant and empathic with his loneliness, and the concrete loneliness which is due

to him not letting me into his world, helps me to hear his soundless cry: "help me out of this loneliness". His loneliness is transferred to me and intuitively I take the step that leads the process further. Another aspect is that I am going through a parallel process by having the opportunity to be part of this process."

(ibid. p. 6)

It is not a new idea that transference and counter-transference are difficult terms to use when describing interpersonal processes in psychotherapy with schizophrenic patients. Benedetti (1962) pointed out that the transference term does not really cover the affective moments of relatedness to psychotic patients and he suggests the more existentialistic definition of Binschwanger -- in German -- **Tragung** -- which was translated and used by e.g. Winnicott as **Holding** -- the holding attitude.

He gives an example showing the difference in working with neurotic and with psychotic patients

Transference from neurotic patients can include their infantile wishes of letting the therapists give them quick solutions to their problems in order to be cured in a magical way without going through all the processes. Such a transference will be addressed and interpreted in psychotherapy in connection with the patients history.

(ibid. p. 8)

In the case of schizophrenic patients an infantile dependency of the therapist can mean the very first step of a development. It does not have to distort the relationship -- but can be a platform to develop any kind of relationship. Concerning interpretations, it would not make any sense to confront the patients with ambivalent feelings or expressions as these feelings are the reality of the client, not only defence mechanisms.

Confrontation then is not really a useful form of intervention with schizophrenic patients, but interpretation in the sense of framing the irrational expressions of the patient into something which could be understandable from a psychological point of view. I would add also from a musical point of view. To make interpretations this way is a parallel to an ongoing deep empathy, and identification taking place is very convenient. The idea of this is to gradually lead the patient into a common sense of understanding as a kind of continuity. Such continuity can promote

the patients experience of the psychosis as being not only an overwhelming experience of some catastrophe -- but also a row of circumstances, intentions and resistances through which the patients can be active into the outer world so that psychosis can also have an exceeding dimension with deep roots in the primate of the life story.

The point is that the psychotic will be understood not from a logical way of thinking but from the therapist's special way of listening and relating to the patient.

The therapist's attitude as a curative factor

To think of the therapist's attitude as a curative factor is shared by many psychotherapists and some music therapists.

The extreme version is the one described by the existentialistic psychotherapist C. Rogers, who described the therapist's attitude -- including being present as authentic, warm, totally accepting and with empathic understanding -- as the only curing factor in psychotherapy work.

Contemporary research emphasises and documents consistently that the patient's experience of the therapist's personal way of being, combined with the relevance of the therapeutic tasks, influence the outcome of the treatment. In this documentation Roger's emphasis on the therapist's attitude seems to be understood more as a necessary playground for other interventions -- not a single curing factor in itself.

In the field of contemporary psychiatry it is also an issue especially in work with schizophrenic patients. G. Gabbard (1994, p 199) writes in description of the techniques of psychotherapy with schizophrenia that the therapist must create a holding environment. He proposes that psychotherapy should offer asylum and that patients must experience each psychotherapy session as **a safe place**, where they are encircled by the caring and concern of the therapist. Feelings and thoughts that others do not understand are accepted by the psychotherapist. He talks about the therapist having to contain both transference and counter-transference feelings and provides a new model of relatedness to be re-internalized by the patient.

Using the term of **listening attitude** this means: I have to listen to the music of the patient -- however fragmented or rudimentary it might sound -- and simultaneously create a musical frame which resonates what I hear in the patient's music. "The therapist must be able to process and

detoxify these affects without acting on them" (Gabbard, 1994, p 199, quoting Grotstein, 1976; Ogdon, 1980).

So I have to listen openly to the sounding notes of the patient, and the feelings behind, without trying to direct the music into any kind of a recognisable form from outside, which could raise the patients anxiety of once more being let down, left out, abused or betrayed. I'll illustrate this statement later in the last case examples.

Jos De Backer (1996) writes similar about the importance of the therapist's attitude:

The music therapist has the means of being with the patient, without excluding him. This, not only by his attitude but also by his empathic joining in. This means the patient can have the feeling, perhaps for the first time, that someone can make time for his experience. The emotions can be expressed and shaped. This empathetic joining in and acceptance can create a basis for trust.

(De Backer 1996, p 26)

Summing up on the idea of **listening perspectives** and **listening attitudes** I think the music therapist has to use a very empathetic listening attitude, through which s/he can openly hear the patient as s/he is present, and through which s/he can resonate the patient's basic feelings in an acceptable way for the patient. To do so I assume the therapist has to have some experience in her/his own life story that makes it possible to resonate such a different reality of the patient.

Concerning the use of listening attitudes, one cannot pretend to listen open minded as if something is disturbing the listening attitude. In this case the listening attitude -- even if based on a well-developed awareness of the listening perspective -- might very well be present as a prohibition for creating a relationship with a schizophrenic patient. The disturbance will be sensitively perceived by the patient.

The listening perspective as a method

In listening to the almost non-existent capacities of integration and of being related to other people in the psyche of a schizophrenic patient, the therapist has to be very sensitive and aware in the **listening attitude** to each tiny signal which may be present in the patient. Such experiences

have encouraged me to develop this general method in music therapy practice, where the basis for understanding the therapeutic process is a technique I define as the therapist' *listening perspective* and the **listening attitudes** provided from this perspective.

Through the listening attitude provided from an extra sensitive listening perspective, defined as an overall orientation, the therapist can gain information about:

- the depth and character of the client's basic feelings
- the possibilities of active interventions
- the timing possibilities.

I am aware that part of my method to define such almost hypersensitive ways of 'being present' in my way of listening is also a product of my own history. I have had traumatic experiences of caring persons not 'being present' in vulnerable situations of my life -- especially around my birth -- making me, in some periods of my life almost suspicious of small variations in listening. This listening capacity has gradually grown into a resource of being able to distinguish tiny variations in listening to the patients -- now mostly without being suspicious. It still is a risk for me as a disturbing factor, which can be a prohibition in my ability to work with some patients, even if I am aware of it.

The listening perspective as a primitive way of organising my listening

Another **listening perspective**, which is specific for use in music therapy work with schizophrenic patients, could be seen as a more primitive -- almost embodied and unfocussed way of listening. This way of listening can remind one of Arieti's (1955) description of the endocept -- a special kind of awareness without representation and without an emotional content. This is reflected by the Danish Clinical Psychologist, Jette Fog. She writes:

When I listen and get a feeling of something without being able to put it into words, I am organising my perception in a primitive way -- a perception which is partly activated through tiny movements in the person I perceive which are

transferred into me and resonate in my inner context build up through my own life history.

(Fog 1995, p. 384. Author's translation)

I personally think that the therapist's familiarity with such primitive way of organising, especially the auditory perception, is very valuable for music therapists' listening capacities in work with schizophrenic patients. This primitive way of listening creates a possibility for the patient to be heard and understood at a basic level. Of course the therapist needs to be able to change the perspective, and not rigidly have to stay at this primitive level, as is often the painful case of the patient.

Fog writes:

My task is to find ways of being empathic and gaining insight about the patient -- and my evaluation of the possibilities between us is dependent on my own experience of her seen in the light of what I am and can. Concretely it means that I have to be extremely sensitive in listening towards tiny signals from her that may be hidden behind her attitude of being totally closed -- wanting no contact. I have to be aware that she might want to get in contact with me anyway.

(Fog 1995, p. 379. Author's translation)

She also talks about the auto **centric** and **allo-centric** way of listening (inspired by Schachtel), where the first is the attitude where one listens directed to one's self. This auto centric way is the listening attitude, where the other person is objectivated and does not have an existence of its own. The allo-centric way of listening is the listening attitude where the human being is heard as she is, as an independent human being heard with all her qualities.

From the descriptions of allo-centric perception it has already become apparent that this attitude is one of profound interest in the object, an complete openness and receptivity towards it, a full turning towards the object which makes possible the direct encounter with it and not merely a quick registration of its familiar features according to available labels. The essential quality is the interest in, the turning towards the object in its totality and affirmativeness. The

act of interest is total and it concerns the totality of its interest.

(Fog 1995 p. 381, quoting Schachtel 1959)

Fog also points out the important fact that to listen objectively in the therapeutic relationship means 'being present' in a double movement of listening. For a **listening attitude** this means that

by listening objectively one is simultaneously empathically connected to the person one listens to. There can arise an imbalance in both poles -- it can be objecting without relational elements or it can be melting together without separation elements.

(Fog 1995, p 382. Author's translation)

I very much agree in her comments on being in a double movement of listening when one presumes to be in one of the polarities. As a therapist one has to find a way to be present in the space between the polarities of being separated from or identified with the patient, at the same time as one is focussed in one of the polarities.

I can recognize changing between polarities in my clinical work between an allo-centric way of listening and an almost embodied -- inward directed and more primitive way of listening, which provide a rather big distance to the patient at the same time as it offer connectedness on a primitive level. I have to be in a double movement; being totally inside myself and still partly being empathically connected to the patient in the one polarity, and being completely open and receptive to the patient and still being empathically connected to my self in the other polarity.

I can now define two main **listening perspectives** -- the second one based on the referred reflections of Fog;

1. Listening perspective as an overall orientation
2. Listening perspective as a primitive organisation of perception.

In the second perspective the music therapist listens in quick (or slower) shifts of an almost embodied way of listening empathically and an allo-centric way of listening. The embodied way is to be understood as the extra sensitive way of listening which especially dynamic process work with schizophrenic patients often invites you to do.

The first perspective concerns the understanding of what can be heard from the patient -- the second perspective concerns the extreme variations in the therapist's perception, which makes it possible to resonate the patient's often very primitive organisation of perception.

From the second perspective the **listening attitudes** can be:

- an open accepting attitude which resonates what is heard from a primitive -- almost embodied organisation of listening
- an attitude which resonates sensitively the patient's need for closeness and distance.

Especially the need for distance is important to hear and resonate carefully. To listen in such primitive way gives a tool to create the sufficient distance without rejecting the patient.

The listening perspectives used for clinical practice

In the practice situation I often find myself listening to the patient in what I experience as more than one channel simultaneously. This phenomenon is extremely present and recognisable in being with schizophrenic patients.

The three channels can be defined as follows:

- Channel 3: Listen to the emotional baseline of the patient
- Channel 2: Listen to my understanding of resources and limitations in the patient (possibilities of interventions -- timing elements)
- Channel 1: Listen to the patient's reality (The here-and-now expressions of the patient).

The gap between channel 1 and 3 can be very wide in listening to schizophrenic patients. These channels bring me information concerning channel 2, which I intuitively act out.

The listening channel concerning an emotional baseline is -- in my clinical experience -- a rather ongoing channel when I work with the schi-

zophrenic patients -- no matter which other kinds of interventions musically or verbally I might be into. It is an ongoing source of inner information to me concerning direction of interplay, orientation in relationship, resources and possibilities of interventions.

I use the information from listening to this channel parallel to channel 1, to try to orientate myself concerning what is possible to do/not to do in my musical interventions according to the patient's needs and resources. I will return to an example of using these two channels simultaneously later in this article.

Channel 1, which I am listening to alternating or simultaneously with channel 3, is the channel through which I listen to the patients stories -- often psychotic fantasies -- whether it be of a phantasmatic or megalomaniac character or whatever, where my interventions are mostly verbal.

In listening to channel 1, I find it very important to fully accept these psychotic expressions as the patient's most convenient way of expressing themselves in the **here-and-now**. I am mostly touched by the frequently dramatic character of these stories, which are unfolded in the sharing, but at the same time I am very aware of such moments, where a patient may inform me directly or symbolically about how afraid s/he is that s/he should be able to invade me, or how afraid s/he is to be rejected by me. I always respond directly to such signals using channel 2 as will be exemplified in case 3.

Case example 1

From projective identification
to listening perspective as an overall orientation

To illustrate the listening perspective of listening to three channels simultaneously, I want to bring a short description from a supervision watching a video excerpt with the psychiatrist supervisor.

The case is a 22 year old female patient, still not finally diagnosed. She was continually telling me horrible stories of her being beaten by her mother as a child -- being beaten until she fainted (channel 1). I felt very helpless in listening to her stories (channel 3) as it came out -- because the girl told me these stories as if she was talking about some shopping trip. She had pointed out previously that she hated clichés, and when she made a short break in her story, I suggested that we played a duet

on two pianos on the topic: **Playing what is present here-and-now between us without clichés** (channel 2).

I immediately started to play caring melodies picking up some of the patient's notes and turned it into a repeated little cradle-like melody with a deep base octave as ground care for the emotional baseline I heard as being very helpless -- a feeling which activated and resonated deeply my own feelings of helplessness. I almost forgot the client's presence during my playing, listening to my own music in an almost embodied way using Listening Perspective 2, but still sensing her being somewhere with me.



Music example 1:

The notes here only show the intervals. The neume-like signs above the notes show the movement in striking and variations in colour of timbre.

The influential factor in the situation seemed to me to be:

- 1 In my playing I was listening to the feeling of helplessness and need for caring of that feeling in an almost embodied way, with a primitive organisation of listening, not conscious about chords or melody structure etc., which might have created sufficiently distance for the patient.
- 2 My touch of each note was very influenced by my listening to my body sensations and breathing, and therefore very much subjectively expressed in an organic way regarding pulse and rhythm -- though inside the frame of a rocking rhythm in 2/2.
- 3 The flow of the melody therefore expresses an almost caressing movement, through which I still was empathically connected to the patient.

In listening to and watching the recorded duet on video, it seemed like the patient had allowed herself to be slightly moved by, and drawn into the music. Her body position and touch of the piano changed a little. She bent a little forward and seemed to listen more inwardly with the music, even if her significant musical utterances still had a rather fragmented character. She herself partly confirmed this observation and evaluation of listening after our playing by saying: "I feel good", as her only comment on the music. In other duets up till now she had been extremely distant in her way of playing and interplaying and had had no words to comment on the music.

She was under observation for being paranoid psychotic and even if her story may not be her real life story -- her feeling of being that deeply helpless, that she had to disappear (faint) from the reality, was very strongly present in my listening. I transferred it to the musical duet by listening to the joint music in an almost embodied way, where I hardly noticed the patient. I listened simultaneously to the 3 channels informing me about the need to care for the emotional baseline of being very helpless.

The use of this listening perspective of allowing an almost embodied, primitive organised way of listening throughout the music, provided the listening attitude of me resonating what I was listening to from the patient. The patient could allow herself to be a little touched by these feelings of **being helpless and being cared for**. The transformed feelings were shared in our musical interplaying. **This is a very clear projective identification**, the supervisor commented and this gave me one clear line of connection from the agreed term of projective identification in the clinical practice. From there I can now better reflect further on in terms of listening perspective and listening attitudes.

Case example 2

Variations in listening to channel 3

-- the emotional baseline

I have noticed that my listening to channel 3 significantly informs me about possibilities of interventions (channel 2), which I intuitively act out in my interplay verbally and musically. I have also noticed that listening to an emotional baseline most often brings the awareness of different phases coming up in the therapeutic process work. I have experienced emptiness as the most difficult emotional baseline to listen to. Before sharing reflections from such experiences, I would like to shortly illustrate some clinical experiences in listening to emotional baselines of more vitality feelings in channel 3 -- vitality feelings turning momentarily towards emptiness -- listening experiences which gave me a luggage to go further in listening to emptiness.

I worked with a schizoid patient, male, 41, diagnosed as having strong personality disturbances with anhedonic features (F.60.8 from ICD 10). He was a challenge to me because he agreed with coming to music therapy as his only treatment without psychoactive drugs. He was my own

age with a deep anxiety of being related to other people, especially women. So he risked a lot.

In the first session I listened to channel 3 -- his emotional baseline as being very sad -- although he expressed verbally being very frustrated. In our pianoduet on the topic: "Allowing myself to try out the instrument -- searching around", he played alternately in the bass and the treble of the piano, not using the middle part. He played fragmented single tones, but gradually there arose some submission in his listening attitude to the music which were audible in his tones being more connected and him being more concentrated in his listening. He was surprised afterwards which he expressed verbally. I played small minor melodies (inspired by my listening to a sad mood in channel 3), which I gradually turned into a repeated softly-stroke note. It sounded almost like a heart beat and gave me something to hold on to, so I could stay fully in my musical interplay and simultaneously be listening in an almost embodied way -- channel 2 informing me of the need for a stable centre.



Music example 2:

Therapist: Regularly repeated sound in a breathing pulse which makes it sound alternating distant and close even if it is the same tone. Variations in piano dynamic in an ongoing flow of timbre shown by the lines.

Patient: Staccato-like tones played in a piano dynamic. Size of tones shows variations within piano dynamic. Lines between the tones shows more flow and connection between the tones -- more melody-like.

After the music stopped he sat for a long time, his head and neck bending a little forwards, and then finally said: "I have no words." This utterance should be understood in the context that his communication pattern is verbal intellectualisation.

As I understood the dynamic in our interplay I took over the role of being a soft-sounding centre point in my musical part -- making some capacity of integration of his fragmented way of playing (here symbolised by me using the middle part of the piano and a stable repeated tone) audible to him. I made audible some "possible resources" of being able to integrate or reorganise the split in his psychic structure, as my combined listening to the three channels encouraged me to offer a musical

frame which invited him to let go off his feelings of sadness. He might experience himself being out of contact with his ability to integrate his split off feelings of sadness, and therefore he experienced an overwhelming frustration. He told me after we listened together to the recorded music that he had almost not heard my music part, but he had had a feeling of some centre point being there -- a centre point he himself wants to come closer to as an agreed working topic.

In a second phase of the music therapy process, my listening to channel 3 changed to listen to feelings of anger. I kept offering a stable centre point as e.g. keeping the basic pulse in a very intense dynamic of *forte/fortissimo*, when he acted out on the drum set and could not get into the stable feeling of pulse himself.

In a later phase, after him having started dream-activity again, he had a dream of him running on a frozen lake and coming to a fence of barbed wire. In the dream he climbed the fence and saw, just under the ice, a fossilized sea urchin, which he recognised as a part of himself. He risked using his voice, and during the first experience of dyad voice-improvisation I listened to him from a perspective of sharing with him the quality of this fossilized animal. Listening to the 3 channels simultaneously, I intervened, facilitating him breaking through the ice by use of sound qualities of my voice being very naked -- coming gradually into audible sounds being of a very fragile quality; a high pitch, *pianissimo* and an icy quality. Gradually both voices grew in sound volume and created more vibrations and sound waves, which can be understood as if the performers are becoming more and more present and related in the joint space of sound. In my listening to channel 3, I was almost overwhelmed by insecurity and I tried to resonate his expressions as icy, fragile and insecure as they came out. We were improvising side by side -- sharing the atmosphere of extreme insecurity in the room. After this improvisation he himself was reminded of the fossilized sea urchin and he was very touched by the experience.

This improvisation opened up a third phase in the music therapy process, where dreams, watercolour paintings and deep emotions were brought into our experience together. He now knew better what he was searching for. The emotional baseline gradually shifted into alternating stages of anger, frustration, anxiety, sadness etc. It was no longer frozen, as if avoiding overwhelming emotions of sadness. This made me in my listening attitude more free to let go off the position of being a stable centre point. I could flow together with him through experiences of different vitality feelings.

In the first 2 phases of this dynamic process work I felt partly frozen myself, because I, through my listening attitude of an overall orientation, kept being in contact with the emotional baseline of sadness at the same time as I listened to his more fragmented musical expressions and his anhedonic intellectual verbalisations in the first channel, to gain information about his capacity of becoming more integrated.

We worked for 1 1/2 year together. Our last piano duet summed up and mirrored the resources he gained by different musical experiences, as we in this duet both played the piano and improvised with our voices together. I felt free and delighted to be part of this improvisation as a product of a process. This had not only been a healing process for the patient, now fully rehabilitated, but also a healing process for me. I could play with him now without having to be rigidly present as a stable centre point in my perspective of listening. **I could make shifts in my listening perspectives as an overall orientation, between listening to my own music part and the joint musical phrases as a free flowing musical partnership. I could allow myself to be a spontaneous part of the music.**

Case example 3

Listening to emptiness -- an extreme variation

With this and other experiences in my luggage, I thought of myself as being ready to gradually come into the listening perspective of listening simultaneously to an emotional baseline of **emptiness** in channel 3 and a **different reality** of very vivid paranoid stories in the verbal parts in channel 1. A totally different experience -- I must say.

To illustrate such a listening perspective, I want to bring a few vignettes:

The case is about a 26 year old schizophrenic male patient, whose recent case history includes elements of more suicidal experiments -- being in longer phases in severe psychotic states having megalomaniac fantasies of him being selected to kill other people who were, in his fantasy, obsessed by demons. Also he himself had a fantasy of being a devil, who could influence everyone with his energy, including me.

In listening to his fantasies, I was aware of telling him that I could understand and identify with his feeling of wanting to control other people that strongly and dramatically. I also told him that I felt very positive about

his care and interest for me, even if I did not feel that strongly influenced by him in my experience of reality, and I told him that I wanted the same kind of respect for my individual identity as I could understand he was fighting for himself -- to be respected as he is. I listened to him in the perspective of accepting his stories and simultaneously listening to channel 3 -- to his deep need of control -- need of controlling his own fragmented chaos and extreme anxiety (experienced as demons) now staying in the state of emptiness after having -- in his reality -- exported the quality of the demons to others in order to better control them and eventually kill them.

I listened to him in a perspective of sharing the emptiness but also listening to the quality of the demons as part of him. In my listening attitude I verbalised the need of control as a common human reality, and I tried to take away his deep anxiety of being able to influence me in such extreme way.

My listening perspective of an overall orientation informed me about him being in an extreme split position between the polarities of being omnipotent and being extremely anxious in his fantasies about his influence on the surroundings, which left him with emptiness as the only possible feeling in order to survive.

After one year, when he was in an almost non-psychotic state, he could look back and remember and share again from an observer' position what he called my paranoid stories. I asked him how it felt like to share these dramatic stories with me, and he looked at me and said: "But you are the only one except for a very good friend, who is also schizophrenic, who I can share those stories with because you do not get scared about them. You told me at the beginning -- do not you remember?" This client certainly taught me a lot. I have worked with him for 32 months by now and except from seeing a psychiatrist occasionally to regulate the medication, he receives no other psychotherapy treatment. Living in the community with other schizophrenics creates social support.

In this work, the listening to three different channels simultaneously, as described above, has been very clear to me. In the beginning of our cooperation he had an idea that he should learn to play the drum set in our sessions, and that he should very quickly become as good as the one in his favourite music group: Led Zeppelin. At that point I listened to his emotional baseline as emptiness, his total lack of ego-structure and his megalomaniac fantasies simultaneously, and I encouraged him to try out the drum set in the therapy room.

In order to support him, and to give him a chance to relate to the rhythms, I asked him to play a very short and very simple rhythm which he could repeat himself. As soon as a short recognisable rhythm pattern came out in his drum-playing, I picked it up on the piano and played harmonies in his own rhythm pattern, repeated over and over again. At the same time I told him that I would keep this rhythm of his for a while, so he could repeat it with me, or he could leave it and come back again when he felt like it.

He was not able to stay stable in this simple 4/4 beat rhythm at that phase of his illness, and I did not want him to have another feeling of defeat or of being wrong or helpless. Informed by my listening to the emotional baseline as emptiness trying to keep away a very deep unbearable anxiety, I took over being the “helping ego”. I repeated and made audible some of his very first sharing of some kind of structure, something from his ego that he created himself as rudimentary as it was, not using a rhythm which was imposed on him from outside himself.

If I had followed his own musical suggestion to me, quickly teaching him some rhythms, I felt this might reinforce his distorted, but for him also real, feelings of being abused from outside by all kinds of negative objects which he could neither reject nor control. In the first phase of our playing together I held and repeated his very simple rhythm with sequences of harmonies at the piano, at the same time as he was:

- playing around on the drum set not being able to follow the rhythm
- still having the feeling of being heard in his personal way of trying to structure some music from his rudimentary ego, as I kept on repeating the simple rhythm of his
- still being part of the music where he could choose freely if he wanted to stay in the rhythm or to play around.

After more than one year he seemed overall to be less psychotic and to have gained more insight about his illness. I suggested that we should start the rhythm playing together as usual, verbalize the rhythms and then I would gradually retire from our common activity leaving him to continue his rhythm-playing alone. He found it extremely difficult, but he was ready to try and to accept the rather weak and insecure expressions of his voice and body sounding alone in the room. He still realised this experience was an enormous step towards being more independent. He also started gradually to be able to memorise and to echo small melodies and rhythms in his inner perception. Up to now, this perception of listening to music or music activities was, for him, something absolutely

here-and-now. The music disappeared when the sound faded out, and he was not able to memorise any sound or rhythm for his inner ear.

We continued making rhythms together in duets or with him as a soloist for several months. Alternately we played the congas combined with dance-like body movements confirming the rhythm patterns. He gradually succeeded in feeling his body momentarily in this activity. These experiences gave him the courage of gradually wanting to improvise on the piano in piano duets.

Before I present a few examples of our piano duets, I want to quote one of the numerous written statements of his which he brought to the sessions on small pieces of paper. He allowed me to read these statements for him -- slowly and accentuated -- in order to give him a chance to listen to his own written words and fantasies which, just like in his music memory, were absent when they did not sound concrete in the room for him. In this activity of me reading his own words he had a chance to internalise them a little. One such written statement of emptiness was:

When I was brought to the psychiatric hospital the first time I was convinced that I was the most evil human being in the world. I was the only one who had isolated my self totally. It was my fate to be on a psychiatric ward until I died. I would walk up and down the halls and be tortured by evil thoughts and demons. When I died I should be thrown out in the coldness of the universe and float around, all alone, in all eternity.

At one point of this working process I became rather unclear about direction. At that point my listening to emptiness did not bring any tiny dynamic movements or signals which could give me some information of possibilities of intervention. Consulting my supervisor I was asked the question: "Which possibilities for transformation can you think of here-and-now concerning the feeling of emptiness?" I intuitively answered: "Experience of silence". But I was not sure. Later on the patient gave me the answer.

In the second year of the music therapy my listening to the channel of emotional baseline changed from feelings of emptiness to those of suffering and extreme restlessness. I suffered with him as he gradually shared some pains and restlessness with me. Some of his words from this phase sounded like this written statement:

It can be very painful when I am listening to a music CD -- painful to think of that I have to listen to it all -- so very often I take it off after some minutes. When I am lying on my bed covered by my blanket, I must several times force myself to stay there. It is very painful to stay there. It is very painful to meet some of the other patients because I want to leave again immediately -- but I force myself to stay for at least ten minutes. It is very, very painful.

In the beginning of the third year of the work he was more and more able to let the music express his imaginative world. We started playing duets on two pianos. After he once had told me that his total energy was rigidly concerned about if his music adapted to my music in the right way, we started playing soloist/accompanist structures. This gave him small glimpses of 'being present' in his own music part. The last session we agreed on him being the soloist first, and he wanted to play on the topic of "the good and bad parts coming together", summing up on previous talking. I listened carefully and followed the mood and shape of his music. For the first time he played rather fluent melodies. From our verbalisation after the music I want to quote the following excerpt as it shows clearly his way of listening to and understanding the interplay:

P: I wanted to be between the good and the bad energies.

T: Do you have any name for this place you wanted to be in?

P: Yes, the light or something.

T: Do you recognize certain qualities in the music?

P: Yes, something very searching.

T: I felt it rather fluent and with quite a lot of melodies there.

P: I didn't realize that (a bit surprised). I think there were lots of intellectual intentions behind my playing. Some things I play automatically, but most of it is very intentional. It might sound rather light and fluent, but it is not.

T: Do you remember some of your intentions?

P: Yes, it shouldn't sound too much the same in the music -- there should be a variation between light and dark sounds.

T: I can follow those intentions rather easily when I reflect on the music. Did you have moments of no intentions?

P: Yes -- it was when I tried to play some melodies.

T: What happens when you have no intentions?

P: Then I feel totally empty in my head -- it happens rather often and actually this was what I experienced as being ill the first time. I

became ill because I thought there should be activities going on all the time. But sometimes now nothing happens.

T: How is the feeling of “nothing happens”?

P: Then there is a kind of peace.

T: Are you telling me that what you experienced before as emptiness maybe has been transformed into an experience of peace?

P: Yes I suppose this is what I have been experiencing for some time.

T: So in those moments of peace and silence you played some fluent melodies?

P: Yes (very thoughtful), I suppose so.

This was the ending of reflecting on the music in this session.

Conclusion

Using reference points from many colleagues in music therapy and psychotherapy in the first part, setting up a method in the middle part and illustrating through examples from three case studies in the third part, I have tried here to reflect and illustrate how I assume that the music therapist's awareness of **a listening perspective** and the **listening attitudes** provided from this perspective significantly influences the therapy process and the therapist's understanding of the process.

Through the listening perspectives one can gain overall information of the possibilities and limitations of the patient's capacity for reorganisation and integration of the psyche, and information of the possibility for distance and closeness. Through the listening attitude, one can resonate the understanding of the patient in an authentic way, framing possibilities for development of the patient.

What I have not illustrated in this article is my own experience of listening perspectives providing listening attitudes, where these tools could not create or frame any possibility for the patient. In my understanding this can be a sign of lack of capacity by me as a therapist of being able to offer a non-disturbed listening attitude in this unique context with this unique patient.

I have tried to set up a method based on the tool of a listening perspective, to raise my own awareness of the process starting from listening to something without being able or ready to put it into words. From this point I have tried to listen to the emotional baseline of the patient, to gain information of possibilities for distance and closeness, of possibilities for interventions musically and verbally, and for timing possibilities.

I hope also to have thrown some light on my suggestion that the question whether schizophrenic patients are able to communicate or relate to other human beings should not be evaluated or rated by the expressions of the patient isolated, but could be connected with an evaluation of the listening capacity of the therapist towards this unique patient in this unique context.

1.1.1 A transition from article 1 to article 2

So back in 1997 I was questioning the applicability of the term counter transference in work with ego-weak patients, and I was presenting alternative terms for the phenomenon created by other music therapists, verbal psychotherapists and psychiatrists. I also presented my own method of compassing nonverbal orientation in the counter transference experience. Retrospectively I see that this method only cover the perceiving part of counter transference – how I perceive and how I understand counter transference. But I also assumed that the music therapist's deep level of awareness of a **listening perspective** and of **listening attitudes** provided significantly influences on the therapy process as it deeply influences **the therapist's way of being present** which again, I assumed, is replacing interpretation as the main curing element in music therapy work with ego weak patients.

As I was developing this model of listening perspectives with ego-weak patients, I was very much concerned with the experience that I found it possible to work very much in the relationship with these patients and that I, as the therapist, was an important part of the curing tools.

I noticed that the mainstream notion of music therapy work with schizophrenic patients was more recreational and activity based. A report was created from members of EMTC edited by Prof. Henk Smeijsters (NL) based on a European questionnaire examination back in 1996. In this report four methods in music therapy, which were applicable in psychiatry, were listed, and I was inspired to develop and add a further fifth method, where the therapist was a part of the curing element in work with schizophrenic patients, as such a model was missing in the report.

I described this fifth method based on my own model of the **listening perspectives** and **listening attitudes**, so that I was meeting the structure used for the four already listed models in the report.

The following article is bringing this 'fifth method' called 'a holding and reorganising method'.

In article 2 I am describing and adding a new treatment model to the number of four models identified by Smeijsters (96) from his questionnaire examination, made for the European Music Therapy Confederation (EMTC), on treatment models developed by music therapists working in psychiatry. Out of four, two models were defined as available for schizophrenic, psychotic patients within this examination:

- Supportive Music Psychotherapy and Recreational Therapy
- Music Activity Therapy.

The definition of the four treatment models are based on following five parameters: 1) aim, 2) therapist/ patient relationship, 3) level of treatment, 4) play forms and 5) area of work. For the above mentioned models the therapist/ patient parameter is described as either not important, the activity can be carried out by different therapists as there are no real interventions or it is described as indirect or directive where personal aspects of the intervention are held back.

So from these definitions of the models, transference and counter transference are not used as either investigation tools or as curing elements.

Due to the experiences from work with schizophrenic or psychotic patients and due to the experiences of my music therapists working at the Music therapy Clinic at Aalborg Psychiatric Hospital, I developed and added a third model to the collection of models for this specific patient group: I called this model:

- *A Holding and Reorganising Model.*

The definition of this model is based on the same five parameters as the four identified models from Smeijsters 96. **The Holding and Reorganising model** differs in taking into account the therapist' way of 'being present' and the therapist's listening perspectives and attitudes as an active part of the therapist/ patient relationship also in work with psychotic/ schizophrenic patients.

1.2 Article 2

Music Therapy as Holding and Reorganizing Work with Schizophrenic/Psychotic Patients

First edited in: J. De Backer, & T. Wigram. (Eds) (1999)
Clinical Applications of Music Therapy in Psychiatry.
London. Jessica Kingsley Publishers, p. 24-44.

Introduction

In individual, improvisational music therapy work with schizophrenic/psychotic patients I have experienced varied possibilities for holding, developing and re-organizing work with the psychic potential of the patients as rudimentary as it mostly is. When I use the word re-organize I am referring to my theoretical understanding of the psychological problems of schizophrenic patients, which I will define later in this chapter.

At my place of work as head of The Music Therapy Clinic at Aalborg Psychiatric Hospital, music therapists have researched and developed music therapy as a special treatment modality for schizophrenic/psychotic patients. Most of those patients are formerly evaluated as being not indicated for psychotherapy. The main aim of the work is to break the isolation of the patient and to gradually build up a consistent working alliance by working at a very basic level of communication and relationship carried out by a sensitive holding attitude from the music therapist. Another aim of the work is to motivate the patient for further

developmental treatment by establishing a meaningful relationship from which the patient has the possibility of making a real choice about further treatment. Without having experienced a meaningful relationship such a choice might seem meaningless in itself.

I can identify this work as the very first stage of psychotherapy work and I will start to fit the treatment modality into the list of treatment modalities identified in the Identification Report: **Indications in music therapy. Criteria, examples, definitions and categories** (Smeijsters, 1996) which is worked out in the frame of The European Music Therapy Confederation. In this report Smeijsters brings the outcome of questionnaires answered by Round Table members at the 3rd European Music Therapy Conference in Aalborg, 1995, on the topic of Indications and also of the summary of further discussions on the same topic at a follow up Round Table at the 8th World Conference of Music Therapy, Hamburg 1996.

The report identifies four treatment modalities of music therapy work in psychiatry in a wide spread:

- 1 Supportive Music Psychotherapy and Recreational Music Therapy
- 2 Music Activity Therapy
- 3 Re-educative Music Psychotherapy
- 4 Re-constructive Music-Psychotherapy.

One of the most significant differences of the four identified modalities is that the importance of the therapist/client relationship grows from one to four and that the aim of the therapy changes from being more supportive and balancing to being more focussed on insight and personality changes.

The client population for my focus here is listed in the Indication Report only under the first two treatment modalities, where it is emphasized that the therapist/client relationship is either direct or indirect but personal aspects of the interaction stay in the background. It is also emphasized that the play forms in those two modalities are mostly assimilating (incorporating the client in play forms), musical games and music listening and discussing the mood which is expressed by music - discussing personal non-conflictual thoughts and feelings as a result of active music therapy.

I want to describe a fifth treatment modality in this chapter the title of which I identify as a *Holding* and *Re-organizing Treatment Modality*. This modality differs from the four listed modalities in the Indication Report, as it addresses schizophrenic/psychotic patients at the same time as it emphasizes very much the therapist/patient relationship as an important tool of the treatment.

At the same time the evaluation criteria of the patient's indications for therapy are less demanding than is the case in developmental and insight-based treatment modalities (number 3 and 4) in the Indication Report.

A TREATMENT MODALITY FOR SCHIZOPHRENIC/PSYCHOTIC PATIENTS

Assessment

The description of the indication criteria for music therapy work with schizophrenic/psychotic patients here is based on the Criteria listed in the Indication Report mentioned above to describe reasons why music therapy is being recommended. I follow the five Criteria:

1. The disturbance and/or symptoms on which the treatment focus.
2. The general and specific treatment modality which should be used.
3. Effects of music therapy as a result of research in clinical practice.
4. The theory and/or hypothesis which might explain the effect.
5. Necessary resources of the patient.

To start working with a Holding and Re-organizing Treatment Modality the following Criteria have to be fulfilled:

Criterion 1

In work with schizophrenic/psychotic patients, where the disturbances are within the spectrum of schizophrenic/schizoid diagnosis, borderline and severe personality disturbances (with symptoms like anhedony) the aim of treatment often is focussed on breaking a partly or total isolation in the patients relation to the surroundings. The work can include reduction of symptoms such as flattening of affect, being overwhelmed by thoughts, social withdrawing and being without any initiative. But the main focus is breaking the isolation.

Criterion 2

The patients mostly receive medication treatment, social support and activities parallel to music therapy treatment. They do not receive any other psychotherapeutic treatment. The music therapy treatment is the primary treatment and can in this respect be recognized as a modified form of Re-educational Music Psychotherapy or Re-Constructive Music Psychotherapy (Smeijsters, 1996). I still think the disturbances which are in focus of the treatment here need an identification of a treatment modality of its own - a modality which can be seen as the very first stage of psychotherapy work with this patient population.

Criterion 3

From analysis of music therapy case-material, I have observed that out of seven cases of individual music therapy with patients former evaluated as not indicated for psychotherapy treatment five patients have actually benefited positively from the music therapy treatment. This positive effect is further to my own evaluation documented in the answers of a questionnaire given to the patients 3 - 18 months after finishing the treatment. (Pedersen 1998)

In two cases the treatment was terminated after a short time. One of those patients never achieved a beginning of a relationship or working alliance - the second had a few glimpses of breaking the isolation and being related to the music, but she was obviously not prepared to go further on at this moment. She decided to stop the treatment.

Criterion 4

The theoretical frame of reference I have found most helpful in this work of breaking the patient's isolation and motivating the patients for further developmental treatment is a psychodynamic understanding of the patient's problems.

This theoretical frame of reference presumes that I understand schizophrenia and psychosis as also being a psychological phenomenon - not only a neurobiological phenomenon as is the main stream understanding of those diagnoses at this time in Denmark.

It also presumes that I think personal development and personal change is possible in working on psychological problems with these patients. I base my psychodynamic understanding of schizophrenic/psychotic patients on statements from a prominent Danish psychiatrist (Sørensen

1998) and several prominent Danish psychologists. Theoretically I find the phenomenon most clearly defined by Dr. Grotstein 1994, where he reformulates an archaic psychopathological state of being. This state of being can be understood as the infant's earliest negative experiences of relating to a primary person. He writes:

From the infant's failure to achieve significantly success in attaching to its bonding mother, it prematurely organizes its failure into an amalgam, and then seemingly undergoes an implosion into itself characterized by a reflexive return to its own sensomotor self, where it establishes a pattern of an alternative relating to itself and only hesitantly a pattern to the needed mother or to others after her.

(Grotstein, in Hedges, 1994 p. xix)

Seen in a broader psychopathologic perspective Grotstein (1994) advocates that psychopathology hitherto has been based mostly on the neurotic model, where the dialectic of mental illness was between neurosis and psychosis. The rise of interest in narcissistic and borderline disturbances have raised another dialectic between the narcissistic or 'self' disorders on the one hand and object-related disorders on the other hand. So here Grotstein suggests a third dialectic between the narcissistic and object-related disorders on the one hand and ontological insecurity on the other hand. In the latter definition of ontological insecurity the patients suffer from both no object relationship and no narcissism. This disturbance addresses the concept of a lack of sense of self as a continuing entity.

In my work I try to combine this understanding of the psychopathology as being an ontological insecurity with the recently developed branch of psychodynamic theory called the cyclic dynamic understanding of psychological problems. In this understanding the patient is not only understood as relating to the therapist from a certain phase in the early childhood. The patient's psychopathology has developed through self-generating destructive circles grounded in the very first path of life but further developed through later and contemporary patterns of experience and actions. This indicates that the work in a psychotherapeutic process - here the music therapy process - does not emphasize so much identification, re-living or re-experience of significant early traumas. The work emphasizes more that the therapist himself/herself participates in the patient's patterns **here and now** and together with the patient works on changing and developing those patterns of experience and actions.

Criterion 5

The necessary resources of the patient to receive treatment in the Holding and Re-organizing Treatment Modality are as follows:

- the patient has to agree on music therapy as the primary treatment, not necessarily because of any affinity with music for the patient; but mainly chosen because of the aim of work.
- the patient must be able to attend music therapy on a regularly weekly basis (compliance).
- the patient must agree on the aim and topic for the work.

Assessment - observations

The assessment phase of the work with schizophrenic/psychotic patients lasts from three to six sessions. During this phase I have met a variety of individual characteristics in music therapy further to the diagnose of being schizophrenic such as:

- The patient playing a “wall” of sounds with no start and no ending, obviously not listening to the music therapist playing with him.
- The patient wanting very quickly to become a famous percussionist - as famous as the one in his favoured music group, (i.e.Led Zeppelin).
- The patient wanting to do nothing else than playing around on a drum-set.
- The patient playing the piano and totally devaluating her playing - trying to confirm her absolutely negative picture of herself, lacking self-esteem or even the right to live.
- The patient playing fragmented sounds on the piano and rather quickly starting to listen inwardly to the sounds and allow those to be related to each other.
- The patient playing with all his attention fixed on the music therapist` music - to be sure if his/her playing is “right” compared to the music therapist` music.
- The patient not wanting to play in the beginning, but allowing the music therapist to play for her.

I have read about similar experiences in music therapy work with schizophrenic/psychotic patients at other psychiatric hospitals: (Priestley 1994, Jensen 1996, Loos 1986, Deuter 1996)

Understanding the psychological problems of schizophrenic/psychotic patients

As I mentioned above I try to combine a cyclic dynamic understanding of the psychological problems with a reformulated understanding of the pathology as an ontological insecurity. In the cyclic dynamic way of understanding psychological problems, the organization of the conflict perspective from classical psychoanalysis (an inner psychic conflict is the source of disorder) and the organization of the defect perspective, (a term from the post-freudian psychoanalytical understanding of psychological problems, where an object-related conflict is the source of disorder), are seen as being both simultaneously active and working together in the disturbance (Høstmark Nielsen 1993). Both perspectives are seen as a movement of self-generated vicious circles, which can be understood in the interaction 'here and now' between two or more persons. Through these vicious circles self-validating social interaction patterns contribute to reinforce problems in the patient's way of being and functioning. Such vicious circles were started by early traumas, which have created a certain path of life in each person. This process is further developed by the person in the patterns of those circles by constantly drawing in new experiences and patterns of action. A true insight based on interpretation in the understanding of exploring the right trauma and understanding one's dynamic from this is not important in the cyclic dynamic way of understanding psychological problems. Here the focus is on attitudes to life, maladaptive thoughts and patterns of interaction and fixed ways of coping with your life-situation. Focus is also on the **solutions** the patient has developed in his way of taking part in the cyclic dynamic patterns of interaction. Paradoxically the solution the patients have often developed to cope with their life-situation, may at the same time be an important part of their psychological problems. In this understanding the cause of dysfunction is circular. **Cause and effect determine each other in self-maintained sequences.**

It means that life-conditions and human relationships in the **here and now** become much more emphasized in theory and therapy. The patient's patterns are not only understood from his early life-story, but also as a part of his later phases of development and actual patterns of cooperation, where the participants constantly influence each other.

The patient's externalisation of unconscious conflicts in the **here and now context** is just as important for a clinical understanding as is identification of repressed material from the experience through interaction

in a form, where the therapist is in a state of disciplined subjectivity. From childhood development the difference from more traditional psychodynamic theories and experiences primarily concerns **the way earlier experiences are supposed to influence contemporary experiences and behaviour.**

How was the first path of life created as a strong force where the person may choose certain patterns of action more than others? It is the accumulative effect of many negative experiences which can create maladaptive patterns of interaction and thus explain the psychological problems in a cyclic psychodynamic perspective. What I find useful myself as a music therapist in understanding psychological problems is the emphasis on the aspect of action - the meaning of the therapist` interactive participation in the process. Also the fact that due to this understanding the **here and now interaction** and an intentional change in interaction over time can open possibilities of re-organizing further paths of life for experiences which can influence the whole spectrum of a persons way of relating to the world.

I think music therapy needs theories, which emphasize the aspect of action and interaction and which invite and include the therapists being actively involved in the patients world of this theoretical base. I will try to describe the role of the therapist in work with the **Holding and Re-organizing Treatment Modality** with patients who present a disturbance of ontological insecurity.

The Role of the Music Therapist in work with Schizophrenic/Psychotic Patients

It is my experience in clinical work with this treatment modality hitherto that the role of, and presence of, the music therapist is essential to make schizophrenic/psychotic patients refer to music. I have also noticed that I myself as a music therapist in this kind of work am listening in an ultra sensitive way. I have tried to verbalise my listening attitude as I find it a very important tool in my role as a music therapist.

The listening attitude and the listening perspectives of the music therapist

I have defined the music therapist` **listening attitude** and **listening perspective** as an essential part of treatment in general (Pedersen, 1997).

Here I want to describe the listening attitude and listening perspectives as very essential elements in building up the very first stage of a working alliance - breaking the isolation of the patient. I describe the listening attitude as a state of **being very aware - as if I am in a state of extreme preparation for resonating any possible signal or vibration coming from the patient at the same time not invading the patient**. I regard the listening attitude in this work with schizophrenic/psychotic patients as a technique through which I as a music therapist can invite the patient to be listened to and met. Through this attitude I can gain information about:

- the depth and character of the patient's basic feelings
- the possibilities of active interventions
- the timing possibilities.

My use of the term **listening attitude** means I have to listen carefully to the music of the patient and the feelings expressed through the music; however fragmented or rudimentary the music might sound; and simultaneously create a musical frame which resonates, what I hear in the patient's music in a way which is acceptable for the patient, without trying to direct the music into any kind of a recognizable musical form from outside. With these patients direction could raise anxieties of once more being let down, left out, abused or betrayed.

To be able to use such an empathic listening attitude, and through this to resonate the patient's basic feelings in an acceptable way for the patient, I assume the music therapist has to have some experiences in his/her own life-story, reflected at a level that makes it possible to resonate the very different reality of the patient. Concerning the use of the term listening attitude, I cannot pretend to listen in an open minded way. If something disturbs my listening attitude, it might very well be there as a barrier against creating a relationship with a schizophrenic patient. Being in such state of extreme preparation in one's listening attitude can create the base for the therapist to change the awareness towards two different listening perspectives.

I identify one listening perspective as an **allocentric way of listening** (Fog 1995), where the human being is heard as he/she is, as an independent human being with all his/her qualities no matter which psychological problems are involved. She writes:

From the descriptions of an allocentric perception it has already become apparent that this perspective is one of pro-

found interest in the object, a complete openness and receptivity towards it, a full turning towards the object which makes possible the direct encounter with it and not merely a quick registration of its familiar features according to available labels. The essential quality is the interest in the turning towards the object in its affirmativeness....The act of interest is total and it concerns the totality of its interest.

(Fog 1995, p. 381, quoting Schachtel 1959)

A second listening perspective can grow out of the state of being very aware. I identify this second listening perspective as a variation of what Fog describes as **the auto-centric way of listening** (Fog 1995). In this auto-centric perspective one's listening is directed to oneself. It is defined by Fog as the perspective where the other person is made an object and does not have an existence of their own. This definition could, in my opinion, be more clearly defined as being directed to one's registering ego, not to one's self. In order to listen to someone as an object, I think one has to listen to one's registering ego; not to one's self, which to my way of understanding can at be at a purely objective level.

In a listening perspective, where one is directed to one's self my experience is that it is a broad-based almost embodied way of listening, which can be specifically experienced in the encounter with schizophrenic/psychotic patients as simultaneously:

- a more primitive and unfocussed way of listening and
- an almost transpersonal way of listening causing the listener to move into a slightly altered state of consciousness.

I identify this second listening perspective of listening to one's self as an expanded version of the general definition of the auto-centric listening perspective, making the other person an object.

So the expanded version where the therapist is very aware and listening from a slightly altered state of consciousness can, in my clinical experience, be an important part of the 'here and now' interaction of the therapist and of the curing factor in the process of breaking the isolation and developing and re-organizing the rudimentary psychic structure of schizophrenic/psychotic patients.

What I am trying to confirm is that I think we as music therapists may be able to define some of the transferring elements in the therapeutic relationship by help of terms of listening perspectives because listening is a basic tool for all music therapists. This is clearly evident with schizophrenic/psychotic patients, where a transference feeling can be the one of total emptiness - a state of not being - even a state of not having the right to be in this world. To give these patients a chance to be met and to give them a chance to re-organize inner psychic structures one has to listen in a dramatically sensitive way and to work through the phase of giving them a chance to choose the basis for the relationship.

So I understand the process, the event of experience of being listened to, as a basic experience for the patients to be able to actually use music in their growth and development. Sometimes listening and playing can go together and create intensive encounters and openings of isolation in the musical dialogue. Sometimes as a music therapist I have to listen to the patient **just being present** in the room or to the patient's fantasies for some time, before the patient can gain enough security to play music at all. My focus on the listening attitude and listening perspective of the music therapist also influences my understanding of assessment with these patients. Except from offering very broad interpreted indication criteria the assessment should also in my way of thinking include the listening capacity of the therapist with this unique patient in this unique context.

The function of the music

Music is a medium which can reach the patient; almost touch the patient; without the patient having the feeling of being physically touched. It can be meaningful to be together in situations where the music therapist improvises for, and to, the patient without the patient having the pressure of being obliged to play back or to give anything back in the first place. This intervention can be a turning point for the patient to gradually gain the courage to move into relationship in his own tempo and form without feeling controlled by the therapist.

The non-verbal context of music makes it possible to express and act out feelings and sensations, **also tiny movements or impulses of feelings and sensations**, without using words. Musical improvisations create a frame where it is possible to interact, to be met and to share without the pressure of being expected to explain or defend your expression.

The basic and body-like elements in the music, like pulse, rhythm, movement and sound, are all very essential for developing human communication in general from the beginning of life. Expressing feelings or sensations through the basic musical elements is mostly combined with an experience of inner movement and changes of vitality and can be identified as a shift in awareness and a pre-form of expressing emotions.

In interaction with the music therapist the patient can develop basic vitality changes of small variations, which can be identified and listened to in the sounding music. A starting of wakening up the non-accessible emotional capacity can happen through the musical playing - in cases where the music therapist through the listening attitude and listening perspectives is able to create a potential space which is safe enough.

Through the musical interaction the music therapist can very concretely move in and participate in both the patient's defence mechanisms and in the patient's attempts to develop micro movements in the capacity of expression and relationship.

For the patient the musical interaction can create an experience of being listened to and contained with his/her expression as it is. The function of the music will be exemplified in the case material.

Case example

Music therapy with Frank – a schizophrenic patient

General information on Frank

Frank was a 26 year old male patient diagnosed hebephrenic schizophrenic. He has been in and out of the hospital three times within two years and has attempted suicide a couple of times. He was assessed and not indicated for psychotherapy. Frank was motivated for music therapy because he often listens to music CDs, but he could not listen for more than a few minutes, before he had to walk restlessly in and out of the flat. He also felt very isolated during listening to music.

The aims of music therapy were defined as:

- 1) Breaking the isolation, including having a focus on concentration disturbances.
- 2) Establishing a potential space where the patient can allow himself to stay for a longer period of time together with another person.

Frank was not admitted to hospital during the music therapy treatment which was continuing for two and a half years.

Frank agreed on the aim of music therapy, but it was not reflected. He came to each session at the beginning expecting me to teach him magically as quickly as possible to become as good a percussionist as the one in his favour music group Led Zeppelin.

Phase 1

Frank creates his own simple rhythm

To work with Frank I had to think in terms of crossing his self-generating circles of expectations of himself, learning magically, and to his surroundings, me being a magical teacher, without rejecting him. I tried to understand his interaction with me from a cyclic dynamic way of understanding. I accepted his fantasy by asking him to develop a simple rhythm in his playing around at the drum-set - to play a rhythm so simple that he could gradually repeat it. After some time Frank developed a simple 4/4 beat rhythm, and as soon as it was almost recognizable, I played it with him in chord schemes on the piano. At the same time I told him that I would now keep this rhythm of his so he could choose to move in and out of the rhythm. Frank was not able to stay in a pulse or to hold on to a rhythm at this time. I tried to create a frame, where he could experience himself as being part of a musical interaction and at the same time have the freedom to choose his position in our interaction. When he was not playing in a pulsed and rhythmical way, it was not experienced as being wrong or different. At the same time the rhythm I played was created by him - by his rudimentary ego. Frank was not musically denied or corrected at any point.

In my experience of being part of the musical interaction I found it difficult to keep the rhythm regularly throughout the playing, as Frank did not play a regular pulse at any time. I often allowed myself to be seduced to be irregular in my repetition of the rhythm. At the same time our joint musical improvisation sounded rather static as I tried to keep the pulse for both of us.

I took over the role of being a helping ego in this first phase of the music therapy process. At the beginning I was present as a flexible helping ego as I did not, in contrast to him, keep a regularly pulse. I allowed myself

to be seduced a bit by Frank's chaos and at the same time I tried to create an inviting frame for the unstable pulse.

Gradually as Frank felt more secure in the musical interaction I could take over a stable pulse and he could gradually, step by step, recognize when he was with the pulse and when he was outside the pulse in the interaction. Frank recognized it in a tempo where he could also accept it.

At the same time as we worked mainly with the musical element of rhythm, I was aware of his deep, deep emptiness as it came out when Frank told me that when the music stopped, everything stopped and he felt as if he did not exist. There was no inner resonance taking place. Frank felt as if he was the most evil human being in the world.

He thought of himself as being the only one who had isolated himself totally. He thought it was his fate to be at psychiatric hospital and walk up and down the halls and be tortured by evil thoughts and demons until his death. Even after death he thought he should be thrown out in the coldness of the universe and float around all alone, in all eternity.

Phase 2

Frank allows himself to be listened to from outside

We repeated this form of musical interaction in a part of each session for almost a year. At the same time we expanded rhythm activities by clapping and vocalising the rhythms and making body movements. Frank brought several simple rhythm-patterns into the musical interaction; all produced by his rudimentary ego. After six months therapy I started to withdraw from repeating rhythms, when we had repeated the same rhythm over and over again for some time. Thus Frank was playing all alone in the room with his simple rhythm, vocalising it with an almost inaudible voice. He started to realize where he was in his picture of being suddenly a famous drum player. He also realized what a big step he had allowed himself to take, when he had the courage to play alone in the room with his self-made simple rhythm for a few seconds; being seriously listened to by me as a partner.

In this phase Frank often talked about demonic fantasies in the verbal parts and about how he influenced other people at a spiritual level. I listened carefully to his fantasies and asked him if he also influenced me. He confirmed this idea. I tried not to deny this aspect and told him

that I was happy about his interest and care for me, and that I could follow his need to control other people in such extreme manner. A general and recognizable human problem. I also told him that in my reality I did not feel influenced by him and that I had as much need to be taken seriously as I supposed he was fighting for, for himself.

Frank did not answer, but after one year he showed me that he had been aware of my comments. At that time he was out of his psychotic state, and he started to look back and to verbalize his psychotic memories. All of them were clear in his memory. When I asked him how it was to share these stories with me, he answered in surprise: But you were the only one who did not become afraid of them - you told me then – do not you remember?

In this phase my function as a therapist was very much a holding function where I was aware of using an ultra sensitive listening attitude and an expanded listening perspective.

Phase 3

Reflection and the beginning of separation from the music therapist

In the second year of music therapy treatment, we had, as far as I understand the process, passed the first stage of psychotherapy. This stage was about breaking the total isolation of this unique patient. Frank tried in phase one to compensate for his isolation in a form of megalomaniac fantasies of one extreme and underlying feelings of emptiness and restlessness of the other; a constellation which prevented him from relating to someone.

Frank started in the second year of the music therapy process to reflect back on the first phase and he brought a lot of written notes to the sessions. Among others he brought the one describing his 'terrible fate' mentioned above. Through these notes and our joint process, he fought against his own tendency to hide on a peaceful planet, where there was only God and no Devil or no bad forces. One day, a significant one, he brought a note with the following sentence: **Now I have realized that both God and The Devil exist and they both also exist inside me.**

In the musical interaction Frank had the courage to gradually improvise freely on the piano. He most frequently played intentionally light frag-

mented sounds at the upper part of the piano symbolizing God (good forces) and played dark fragmented sounds at the lower part symbolizing the Devil (bad forces). No matter which playing rules we used as an inspiration for improvising such as: **I play how I feel here and now** or **I play the bad and good parts in me**. Frank repeated after each improvisation that he had his whole attention towards what I was playing in my music part. He had, throughout the improvisation, fixed his attention on the question on whether his sounds were correct in comparison to my music. Frank took the whole responsibility for whether the music (our common product) sounded the right way. He could not reflect on my repeated statement that there was nothing right or wrong in the music.

I suggested after some months, when Frank seemed more secure in improvising on the piano, that he should be the leader (the soloist) and I should be his accompanist. This playing rule, introduced at that time, significantly influenced his fixed attention towards my music part of the interaction.

In the last part of this third phase we improvised one day on a double playing rule saying that, at the same time Frank should be the leader in the music and we should both play our experience of: **Let Frank's good and bad parts come together**.

I listened in an ultra sensitive way to his music and carefully followed his fluent melodies. I felt like being able to relax in my music part and to be centred in my accompaniment role in the music.

After the improvisation we reflected verbally on the musical experience:

P: I wanted to be between the good and the bad energies.

T: Do you have any name for this place you wanted to be in?

P: Yes, the light or something

T: Do you recognize certain qualities in the music?

P: Yes, something very searching

T: I felt it rather fluent and with quite a lot of melodies there

P: I did not realize that (a bit surprised). I think there were lots of intellectual intentions behind my playing. Some things I play automatically, but most of it is very intentional. It might sound rather light and fluent, but it is not.

T: Do you remember some of your intentions?

P: Yes, it should not sound too much the same in the music - there should be a variation between the light and the dark sounds.

T: I can follow those intentions rather easily, when I reflect on the music. Did you have moments of no intention?

P: Yes, it was when I tried to play some melodies.

Then I feel totally empty in my head - it happens rather often and actually this was what I experienced as being ill the first time. I became ill because I thought there should be activities going on all the time. But sometimes now nothing happens.

T: How is the feeling of “nothing happens?”

P: Then there is a kind of peace

T: Are you telling me that what you experienced before as emptiness may have been transformed into an experience of peace?”

P: Yes. (Very thoughtful); I suppose so.

This was the end of reflecting on the music in this session.

I want briefly to describe the music in this session. It started by Frank playing rhythmically and dynamically forte in either the upper or lower part of the piano. At the same time he gradually started to play more melodies in the middle of the piano in a quick tempo without breaks, but with a kind of flow in the melodies. Gradually both Frank and I played in the middle of the piano in a very symbiotic way at the beginning but growing more and more into a dialogue form with fluent melodies, where we both introduced and continued melody figures from each other. A clear figure/ground experience in listening to the music was established. A firm stable pulse created a clear ground, and at the same time the melodies developed and created the figures. Both Frank and I created figure and ground. There was an intensive mood in the interplay, as if there was an attraction between the sounds. This created an elastic dynamic and a natural balance between building up tension and releasing tension during the improvisation.

The description here is a summary of my own notes and those of my colleague from listening to the recorded music.

Summary

In my work with Frank being a schizophrenic, the treatment in the first year can be understood as a first stage of a psychotherapeutic treatment. In this phase Frank developed gradually the courage to be listened to and to listen to him self without using megalomaniac fantasies. His restlessness was reduced and he started to open himself towards experimentation (improvising at the piano). A beginning in breaking the isolation had taken place.

In the second and third phase **the Holding and Re-organizing Treatment Modality** was followed more and more by a so-called moderated Empathic Music Psychotherapy Treatment Modality according to the identification of treatment modalities in psychiatry in the Indication Report. In this phase Frank gradually loosened up his fixed attention towards my music part and had the courage to reflect verbally (to look back) on his psychotic phase.

My role as a therapist in the first year was partly the one of being a flexible, resonating helping ego and partly a holding figure who should create a continuing safe frame for being together and for the interaction.

In the latter parts of the therapy process my role as a music therapist gradually changed. I could start the separation process and change between being the promoter to being the accompanist in the musical interaction. Frank became conscious of this and changed his fixed attention towards my music part. We could both move towards more flexibility and equality in the interaction as the music gradually contained more and more melodies and more flow in the melodies.

In the role of being the therapist I started in the first year to use and to remain in an ultra sensitive listening attitude. In the last part of the therapy process I could let go of this approach a little; I could make it more flexible and changing more playfully between the two listening perspectives.

My method in the first year I have defined in this chapter as *a Holding and Re-organizing Treatment Modality*.

A Holding and Re-organizing treatment Modality

The title refers to my role as being a holding figure and to my understanding of the psychological problems of the patient - especially in the form of Grotstein's reformulation of an archaic psychopathological state of being. (Grotstein,1994 p.xxii). It also refers to a state of being where the child's earliest development is understood as the child's own way of organizing their experiences.

In traumatic cases of development the organizing of **not being related experiences** are organized in an amalgam of negative experiences, which create an invasion into the child from where it continues to create self-generating vicious circles in future attempts of relationship.

Using the term **re-organizing** indicates, that, as a music therapist, I presume that the patient has the possibility to re-organize the forces of movement from his earliest paths of life. I can participate and be a part of those vicious circles in a forthcoming process with this unique patient in this unique context.

This does not mean that the treatment will always be a success.

Definition of a Holding and a Re-organizing Treatment Modality

To fulfil the circle from where I started this chapter, I want here to finally define **the Holding and Re-organizing Treatment Modality** using the same five parameters as is used in the definition of the four identified treatment modalities in the Indication Report. Unfortunately I cannot cover the full definitions of the other four modalities here, but I can define my modality here by the similar following parameters:

A. Aim of therapy: to break the isolation, to create frames for the patient to get the courage to be listened to and taken seriously. To support and develop the patients capacity for expression and communication and to motivate the patient for further psychotherapeutic treatment, verbally or musically.

B. Therapeutic Alliance: The patient / therapist relationship is a main tool of change in the process. To build up basic trust in the patient / therapist relationship and in the patient` self awareness and capacity for relationship.

C. Level of Treatment: The very first stage of psychotherapy, here in the form of music therapy, the primary therapy. The treatment focuses on primary symptoms (isolation, social withdrawal and lack of relationships). The music therapist has the responsibility for treatment together with the referring psychiatrist.

D: Play forms: The play forms are adapted to the need of the patient and to the role of the therapist being either a helping ego or a holding person. Free improvisation techniques are used or isolated musical elements, the use of an ultra sensitive listening attitude and listening perspectives as a function of being a sensitive platform for sound-resonance.

E: Patient Population: Schizophrenic/psychotic patients in the spectrum of schizophrenic/schizoid diagnosis, borderline and severe personality disturbances.

Conclusion

As mentioned at the beginning of this chapter I try to identify, describe and exemplify a new treatment modality in work with schizophrenic/psychotic patients demonstrated by a case study. The treatment modality is meant to give a chance for patients, who often would be evaluated as non indicated for psychotherapy. This treatment modality offers the very first stage of psychotherapy in the form of music therapy. During the chapter the reader has been presented with the different curative factors I have experienced as important for a successful therapy process. Even if all curative factors are available one cannot say for sure that the aim of therapy will be achieved but up till now a very positive picture has emerged when analysing the clinical material from using this treatment modality.

GLOSSARY

Allocentric

Being very open minded towards the other - sensing the other as an independent human being.

Anhedoni

A condition of being without pleasure and interest in any actions in life (especially sexuality).

Auto-centric

Looking inward towards ones ego registering, analysing the other in perceiving the other being an object or analysing in a state of feeling expanded:

Looking inward towards one's self where you sense from a slightly altered state of consciousness. You are simultaneously subjective and objective in your sensing the surroundings.

Hebefren Schizophrenia

Affective changes, hallucinations and distorted fantasies are fragmental, incalculable, disorganised thinking incoherent speaking, social withdrawing. Only a diagnose for adolescents and adults.

Listening Attitude

A basic technique in music therapy, that includes a very sensitive and empathic way of listening. A state of being very aware as if in a state of extreme preparation for resonating any possible signal or vibration

coming from the patient or from oneself. An awareness where one can gain information on the depth and character of the patient's feelings, the possibilities of active interventions and the timing possibilities.

Listening Perspective

An orientation technique in the listening attitude, as i.e. listening in an allo-centric way.

Play form

This term I have taken from Smeijsters Indication Report (1996) where he uses the term as a category describing possible playing activities with a particular patient population.

1.2.1 A transition from article 2 to article 3

The clinical work with this **Holding and Re-organising Model**, we call at the Music Therapy Clinic: **Music Therapy as a first step of psychotherapeutic treatment of psychotic/schizophrenic patients**. (Lindvang 1998, Storm 2002). This is to be understood so that the main aim of this work is to find a port of entry to break the patient's isolation. We have experienced that using the awareness of the listening attitude and listening perspectives offers a non threatening method for the patients to gradually risk to share some experiences with the listener musically or verbally, and that they also gradually risk to be seen and heard in their present state of mind in a way, where they can start to be the owner of their feelings and low self esteem instead of splitting it off.

In presenting a fifth model to the European catalogue of possible models and adding a third model applicable for psychotic/schizophrenic patients, I argue that from my own clinical practice and from clinical exchange with colleagues working with psychotic/schizophrenic patients, the therapist/patient relationship is considered as an active curing factor in the therapeutic process. Thus the use of counter transference or counter transference-like experiences are just as important in work with ego weak patients as with neurotic and borderline patients. Only the character and intensity of the experience may vary with this patient population.

To me counter transference seems to be a very important tool in work with patients having all types of psychiatric diagnosis, and I can easily follow Priestley (1975, 1994), Gabbard (1994, 1994c), Hedge (1989) and others who have prescribed that not only is it extremely important to

undertake self analysis, and supervision to prepare oneself for working in psychiatry and be able to handle counter transference feelings. **Counter-transference is also the Royal Road to understand the merger experience which can be very intense when one opens up sensitively to or get hooked by the transference of the ego-weak patients.**

So in the first two articles brought here, I am defining and describing work with ego weak psychiatric patients both from a treatment technical point of view experienced from the therapist's perspective in the interaction, and from a methodology point of view - from the notion of what I consider as applicable, necessary and useful if you as a music therapist aim at lessening the total isolation on the patient's part.

In the following years I kept being occupied with reflecting the therapist's role as part of the curing process. When training students to develop their identification as a future music therapist the topic of **the therapist's way of 'being present' with the patient** was coming up all over again. In 2000 I wrote the following article about **the therapist's way of 'being present' in the clinical setting**. I reflected what can be experienced from inside and what can be experienced from outside when 'being present' as a therapist in the clinical situation. I also wondered how it could be, that there was much written about transference and counter-transference but not so much about, whether everybody is just resonant to counter-transference or, whether it is something that can be trained. In my own clinical work, I had developed some imagined helping tools, which I understand as metaphors in orientating myself at a nonverbal level. One of these I called *the three 'being present' - and communication spaces.*

In using this metaphor, **I imagine myself 'being present' either in a private, a social or a soloist space experienced from inside with closed eyes.** I trained the students to use these imagined metaphors in order to be more aware of their way of 'being present' in their verbal, nonverbal and musical relation to other people. Today I can see these tools as a part of preparing oneself as a therapist to be resonant to counter-transference. In the following article I present my own and other therapist's reflections on the therapist' different ways of 'being present' and I also present my developed orientation tools for clinical use.

1.3 Article 3

“From in-side or from out-side”¹ - The therapist’s orientation in therapeutic presence and attentiveness

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Abstract

In this article I reflect on the therapist’s way of ‘being present’ as an orientation tool in the therapist/patient relationship. This includes an examination of concept formations such as therapeutic presence, professional empathy and disciplined subjectivity. I refer to other music-, art-, and psychotherapists as well as I deepen the understanding of my own former descriptions of Listening Perspectives and Listening Attitudes. I also further develop my previous descriptions of orientation in the therapeutic presence in the form of three imaginary perceived communication spaces; the private, the social and the soloist space. Finally I bring three vignettes from my clinical work with psy-

1 When translating from the original Danish the terms “Indefra” and “udefra”, it is not easy to find logical English comparable words for these terms. Here in the title, this is translated as In-side and Out-side, while elsewhere the terms with-in and with-out may be used.

chiatric patients, where I illustrate how the therapist's orientation in the therapeutic presence can function in practice.

Introduction

During the last six years of clinical music therapy practice with music therapy in psychiatry I have experienced and learned, that especially in this area of clinical work, my way of **'being present'** as a therapist is rather important and is highly influencing on the processes I am a part of in the therapist/patient relationships. As a therapist I wonder if this is a **'state'** that I can only register from within, or if it can be observed or registered from the outside by others. Similarly I wonder if I have to do something actively to become more present, whether it is possible to identify and verbalise **transitions between 'being present' and not 'being present'**, and whether my inner registration of a shift in my orientation is heard in the music?

In the Experiential Training in Music Therapy (ETMT) at Aalborg University music therapy students have been asking me the relevant question: **But can't I just be my self in the role of being the therapist?** In the following I would like to examine this and the above mentioned questions about therapeutic presence and attentiveness.

Am I present as myself?

The first question I want to throw light on is if the therapist must do something actively to become more present and if s/he has to do so, is s/he then still authentic. Robbins (1998), a professor of Art Therapy in the USA, describes the phenomenon of **becoming fully present and centred in the therapeutic process as a state of 'basic self'**. He further describes the necessary phases of **getting into, and out of, the 'basic self' state**. He emphasises that in giving attention to these inner movements and phases, the therapist can obtain important information of the therapeutic process. Robbins underlines, as many other psychotherapists do, that self experience is necessary to train the preparedness to be attentive in a therapeutic presence.

I find it important to examine what we are training in the Experiential Training in Music Therapy (ETMT) that can raise the therapist's attention towards knowing when s/he is fully centred in a therapeutic presence? Is this state of **being** of any difference from **'being present'** with

friends or others in general? In order to answer this question I, in the following, want to involve the concept '**disciplined subjectivity**'. Overall the concept covers the idea that the therapist is subjectively present as him/herself but in a disciplined preparedness in relation to the process and relationship of which s/he is a part.

Disciplined subjectivity and professional empathy

Through a short definition, I describe **disciplined subjectivity as being subjectively present, and simultaneously fluctuating in the inter-relation to the patient's universe**. This implies that the therapist is extra sensitive and attentively 'being present' in the situation, and can oscillate in and out of the shared field. In order to be in a state of disciplined subjectivity the therapist must be able to ...

- actually perceive the vibrations (non-verbal sensations) of which she is a part.
- take responsibility for not being overwhelmed by the vibrations/emotions/experiences of which she is a part.
- be aware of and takes responsibility for the **transitional space** of which she is a resonant part.
- be committed to continuously finding ways of understanding the processes that take place in the transitional space of which she is a part.

Thus several layers of attention are actively into play at the same time.

The Danish psychologists J. Fog and L. Hem write about intuition and empathy and see this as the ability to sense the emotional overtones in a conversation as well as in the invisible connections in emotional, cognitive and action patterns by another human being. They distinguish between an 'out-side' and an 'in-side' perspective:

... in order to make it possible for the therapist to apply this empathy in the therapeutic work, it has to be supported by a well integrated (theoretical and practical) knowledge about psycho dynamic conditions. This is a kind of knowledge that does not let the "raw" empathy be untouched. We see

the ability of empathy and the integrated dynamic knowledge as two aspects which through self experience and training can be cultivated to become a professional empathy. If there is a balance between the empathy and this dynamic perception, then there is a platform to see the other person clear and realistically - objectively - one could say.

(Fog & Hem in: Hougaard et al 1998, p. 89)

I prefer to use **the concept of 'disciplined subjectivity' instead of objectivity** in this description. I think that you, from a purely analytical attitude to the dynamic knowledge, can possibly develop the ability to see connections without a well developed professional empathy. This is not what the citation describes. In contrary it is emphasised that the empathy is the assumption to obtain an integrated dynamic knowledge. Therefore I think this knowledge is picked up through the presence of disciplined subjectivity.

It is emphasised that empathy is a necessarily developed ability, but empathy as such is not sufficient to guarantee professional empathy. In other words the therapist has to learn to be extra sensitive and empathic from within, and simultaneously to be able to sense from out-side, e.g. when it happens that the therapist is overwhelmed (or the opposite, not being touched at all) by the patients reactions, as this might be important "raw" insight to integrate with theoretical and practical knowledge. Finally the therapist has to try to understand and to raise her/his consciousness towards the ultimate danger of empathic and sensational distortions.

Such danger is seen when the therapist is so empathic that s/he becomes confused by the experiences of the patient and thus loses the ability to be able to give the necessary grounding, or to give other perspectives to the patient's experiences as a witness from out-side. When this happens the therapist does not come to a conscious understanding of the situation. Another danger might be that the therapist is so deeply involved in a strong perception of her/his own inner life, that s/he might believe that the patient fluctuates with the therapist, even if the patient's experience is totally different.

In spite of such dangers the music therapist's empathic perceptions are one of the most important information tools in order to be present in, to understand, to intervene or to interpret the process in the therapeutic relationship, specifically in the musical interaction and communication with the patient.

This leads to the following question: **How does the therapist know if there is a 'sensing flow' going on between her/him and the patient, and how can the therapist understand what happens non-verbally in the relationship?**

Therapeutic presence and centring

Robbins describes, as mentioned above, therapeutic presence. I find the way he describes the concept of centring very important, and in order to follow the complexity of his description, I will include a relative long quotation from Robbins. Later in the text I will include similar quotations from two other authors, Casement and Priestley, who present an analytical view on therapeutic presence.

It is likewise essential for me as a therapist to find and use my centre in relating to the patient. As the process unfolds, I try to listen to my centre. This is the most authentic place that I can engage with another. It is the essence of myself and the source of my energy; it is that place deep inside the solar plexus of my body; it is what some call the soul. I try to address my patients from this deep place, while remaining aware of my therapeutic position. Authenticity or 'being real' should not mean being oblivious to the therapeutic stance and why we are there. Of course this is more easily said than done, and often I speak from my head or from a tension place that I cannot locate. I realize that I am not always making contact with my therapeutic centre, or even aware when I move away from it. This source, or soul, or basic self is the most fundamental organizing force that I possess. If I were to be seen as a work of art, the centre is the aesthetic magnet to which the eyes are drawn; it is where sensations flow in and out of my personal network. This most central force contains no words, but fuels enormous power to my vision. Yet I must and I do find the words to express the experience of relating from my centre. Only when I am in a centred place can I offer the patient a structure that truly makes sense out of our interaction. I confess that a good deal of what I offer emanates from a decentred place that does little for the patient, and tends to create a false structure which happily, soon is discarded or collapses! It may be a necessary phase of our relationship, as I am

captured by introjections or projections, that I lose my centre and seek to regain it as part of the process.....I must be able to move figuratively from inside to outside, hovering somewhere between the patient and myself, organizing material into form, and allowing the communication to have its own chaotic energy that will eventually find its direction.

(Robbins 1998, p. 21-22)

In the same way as Fog and Hem, Robbins emphasises that the intense empathy and container function has to be combined with a psychodynamic knowledge. He is open to the belief that this knowledge is not necessarily given back verbally to the patient, as he emphasises that a part of the cognitive and structuring work of the therapist can be carried out in a symbolic form. This form can further act in reorganising the patient's balance between inner and outer perception. He formulates it as follows:

Although I relate on several levels of consciousness, ranging from pragmatic to spiritual, I may at the same time be aware of a heightened sense of my own body. In this intersubjective connection, affects may spill into one another. I offer a container to receive and organize projections and introjections, defences and adaptations, and the many affects that are part of the therapeutic workspace. As the therapeutic interaction develops and changes, my container also changes in form, volume and perspective. As affects and images arise out of this container, I must first identify and express them in symbolic form. After I regain my own separateness, I must translate these symbols into a language or framework that the patient can use in the effort to differentiate self and others. These images will facilitate a mirroring and a resonance that it is hoped will generate a transformation of energy and form. With this transformation, ultimately a new balancing of inside and outside, of form and energy, will evolve out of this therapeutic dialogue.

(ibid. p. 28)

Robbins emphasises a reorganisation of the patient's perceptual experiences as an important product of the therapeutic process, and in the following quotation this is formulated in a clear way:

Within the creative workspace we can go to move, dance and sing with the particular inflections, intonations and body movements that are part of the field of therapeutic contact. A cognitive insight may be a product of therapeutic movement, but the most important outcome is a rebalancing and reorganization of one's perceptual, cognitive network, ultimately affecting our sense of self and other.

(ibid. p. 31)

Even if Robbins works from an integrated understanding of therapeutic presence, he is capable of fundamentally describing the meaning of perceptions, and the meaning of being centred in the therapeutic presence as a precondition - so that the therapist can offer a container function, and through this offering become conscious about the phenomenon of transference. He describes therapeutic presence as follows:

Thus, if we are to be present with our patients, we must be open and receptive to both primary and secondary modes of communication process. To achieve these goals, much work must be done to enlarge our capacity to shift ego states. We must be comfortable with a holistic, intuitive and receptive orientation that is essentially spatial, while always being ready at any moment to shift to a more synthesizing mode in which the choice of words gives structure and definition to non-verbal flow. This ability to synthesize and articulate the multiplicity of levels in the patient-therapist dyad goes to the heart of what I describe as therapeutic presence.

(ibid. p. 19)

What I find important in Robbins' work is that he describes **states of being centred contra to being not-centred**, and the therapist' ability to change the awareness in the rhythmical flow in connectedness and separateness as some inner dynamic phenomenon one can be attentive towards in the training of being sensitive through an inner orientation. He also points out, like Fog and Hem (1998), the importance of the ability of being able to shift ones level of consciousness between an intuitively based empathic condition experienced from within, and a synthesising condition experienced from out-side that create structures in the non-verbal flow.

An interactive level of emotions

Psychoanalyst and psychotherapist P. Casement gives a very relevant view on the therapist' ability to be emotionally resonant, which I find important to integrate with Robbins' ideas.

A therapist' receptivity towards the patient's unconscious is visible in his way of being resonant to the pressure in the interaction. This resonance grows out of an adaptation between what is personal for the therapist and what comes over from the patient. How inclined a therapist is to respond to the patients on this interactive emotional level in relation to the cognitive understanding depends especially on two conditions at the therapist.

First he must have access to these unconscious resonance phenomenon covering as broad a spectrum as possible. Therapists are not always limited to their own way of experiencing and feeling..... secondly each therapist has to learn to be open to the other person's "being different" - so he is ready to sense/feel many different emotions which follow from being related to another person no matter how different the person is from the therapist himself.

Empathic identification is not sufficient, as it can limit the sight of the therapist and let him see only what is familiar to him or what is similar to his own experiences. Therefore therapists have to develop an openness and a respect towards feelings and experiences which are rather different from his own experiences and feelings. The bigger freedom the therapists have to resonate these unknown "modes" or dissonant "harmonies" in other people, the more their receptivity will be promoted towards these unconscious leading notes in the interaction, which are often very central to understand the patient.

(Casement 1987, p. 98)

Casement places a focus on the receiver function as a general phenomenon. The receiver function implies handling the very difficult emotions of another human being. Emotions that, if not contained, would be overwhelming.

Of course there are situations where medicine will be the right treatment - or a treatment at a hospital where the pa-

tients can gain an asylum on a secure place when they need so. Nevertheless it is very important to pay attention to the fact that these patients normally need a personal form for container function.

(Casement 1987, p. 131)

Casement introduces the concept **the inner supervisor** as an orientation in getting to know what the therapist receives as a therapist in the therapeutic process, and how s/he can be present with this material and handle it. He emphasises that the therapist seeks to extend his emotional field of resonance from within by being as open-minded as possible in his way of being resonant towards both well known emotions and more foreign emotions. Thus, instead of describing physical sensations in the moment as experiences of empathic resonance, Casement put focus on empathic resonance being recognisable and non-recognisable emotions in an emotionally interactive field.

Counter transference and therapeutic presence

I have consciously avoided to use the concepts of **transference** and **counter transference** up till now even if the idea of a container function is a central part in the therapeutic use of counter transference dynamics, and even if Casement connects the ability to expand one's emotional field of resonance with the training into making oneself receptive for consciously handling counter transference reactions. This equally applies to Robbins differentiation between being centred and not being centred, that can be understood as a movement from being influenced by unconscious counter transference to a conscious handling of counter transference. I personally miss descriptions of perception experiences in most definitions of counter transference. Mostly these definitions are limited to what Casement calls the emotional interactive field.

One of those who does include perception experiences in descriptions and definitions of counter transference reactions is Priestley. She has defined three different modes of the phenomenon of counter transference. One of these modes she calls **e-counter transference or emphatic identification**. She describes this as psychological perceptions, which come up in the therapist from an emphatic identification with the patient - where this emphatic identification in fact mirrors and reproduces the psychological problems of the patient. The therapist's attitude towards the patient has to be like a resonance from something outer to some-

thing inner, like striking a chord of a stringed instrument (the patient) whose music resonates through its emphatic strings (the therapist). Priestley's description of e-counter transference is in the following quotation connected with somatic awareness:

The therapist may find that either gradually as he works, or with a suddenness that may alarm him, he becomes aware of the sympathetic resonance of some of the patient's feelings through his own emotional and/or somatic awareness. Often these are repressed emotions that are not yet available to the patient's conscious awareness but they can also be feelings which are in the process of becoming conscious, in which case they may be very dynamic and fluent in the therapist, especially when he is improvising.

(Priestley 1994, p. 87-88)

Priestley further sees e-counter transference or emphatic identification as a therapeutic tool that depends on the therapist's ability to integrate in-side and out-side orientation:

The therapist's e-counter transference depends on his sensitivity and his freedom to experience the incoming emotions. But his ability to formulate it consciously and use it to the benefit of his patient depends on his clarity of thinking.

(Priestley 1994, p. 90)

Priestley warns against letting the therapeutic process unfold solely through the use of intuition. If the patient's feelings are not becoming conscious and are not verbally formulated as an important part of the process, it might result in the therapist being overwhelmed by emotions, or that the therapist has to be deliberately non responsive towards the patient's feelings. It is important that the feelings are transformed from intuitive perceptions in the therapist to a clear and conscious information and gestalt in the relationship between the therapist and the patient. This transformation can set the therapist's intuitive perception free, and offer a possibility to share the feeling with the patient, while at the same time giving the patient the possibility to internalise the feeling and to take responsibility for sensing it and for living with it.

Summing up, this means that in therapeutic presence one can talk about both a raised emotional and perceptual readiness. I find it important to relate this to the concepts of the inner dynamics of the listening sensa-

tion. I have worked with these concepts in my clinical music therapy work and described them in previous work. In the following I will elaborate on listening sensations and the inner dynamics of the listening sensations within the related polarities and movements in this dynamic.

Listening perspectives and listening attitudes

In previously writings (Pedersen 1997, 1999) I have tried to verbalise different **listening perspectives and listening attitudes** in my description of therapeutic presence and the professional empathy with a schizophrenic patient. I have defined a listening perspective as a clinical tool:

For me a listening perspective is a tool for orientation and information. One listening perspective can be described as listening simultaneously to:

- the foreground – the here-and-now presence and expressions of the patient.
- the background – the split-off reality (often a reality of very strong feelings) of the patient, which also means listening to the field of tensions and movements (or lack of tensions and movements) between these polarities of foreground and background.

With schizophrenic patients this often means listening extra sensitively to tiny variations in tensions and movements between such polarities – tiny variations which influence our being together almost unconsciously but still very strongly.

(Pedersen 1997, p. 100)

Within such a listening perspective the therapist can move between two different attitudes in her/his way of listening. The therapist can, as an example, be **in an allo-centric attitude** where:

- the therapist listens with full attention to the patient and resonates authentically and consciously on the patients physical presence in the room (the foreground), from where s/he gradually facilitates small glimpses of emotions from the patient's split off reality (the background) to enter the relation and enter the 'connectedness' in the process.

The other attitude can be identified as being in **an almost physically embodied, inwardly directed and primitive listening attitude**, which both generates a larger distance to the patient, at the same time as it offers a **'connectedness' on a primitive level**. The therapist might be present through heightened awareness of his/her sensations in a type of dual position, where s/he fluctuates between being totally inside himself/herself or his/her self and still be partially connected with the patient at the one polarity – to the other polarity that implies being totally open and receptive towards the patient, as well as being partially emphatically connected to ones inner self.

In the first description of the listening attitude the therapist focused on what can be directly heard from the patient; what the patient tells or plays – while in the second the focus is on the more extreme variations in the therapist's listening perception, which makes it possible to be resonant in relation to the patient's primitive way of organising sensorial experiences.

In the second polarised attitude one can talk about:

- an accepting attitude which is resonating with what one hears from within oneself from a primitive - almost physically embodied organisation of one's perceptions
- an attitude which is sensitively resonating with the patient's need for closeness and distance

The physically embodied - more primitive listening attitude can be understood as an extra sensitive way of listening, which the particularly dynamic processes in work with schizophrenic patients evoke or invite for. The need for distance is particularly important to hear. To listen in such a primitively organised way can give you a tool to create the sufficient closeness and the sufficient distance without invading or rejecting the patient. This means that through the listening attitude, "...one can resonate the understanding of the patient in an authentic way, framing possibilities for development of the patient" (Pedersen 1997, p.110). I want to add here that by the word authentic, I mean that the patient experiences the therapist as authentic in the way s/he tries to extra sensitively move towards an attitude which makes it possible for the therapist to stay resonant with the patient's primitive way of organising sensorial experiences. This phenomenon is very much based on a **disciplined sub-**

jective way of ‘being present’ in the listening process, and it can be totally different from how the therapist is normally listening.

In my own work as a clinical music therapist I find it important to put focus on establishing a milieu where patients feel they are being heard, no matter which forms of relationship the patient otherwise needs to use. ‘Being heard’ I understand as not only being heard in the content of the words, but also as being heard on a deep inner level. As a trainer and teacher I emphasise that the music therapy student develop an ability to listen to one-self on a deep inner level, and an ability **to listen to oneself listening to the patient**. I expect such an intense listening attitude will allow many uncontrollable feelings float into the relationship. But the ability to be so sensitive in listening to the patient helps creating an orientation within transference relationships.

I therefore regard listening perspectives and listening attitudes as sensorial metaphors that give an orientation within the therapeutic presence. For the therapist to be present in his/her inner space can be seen as a parallel to what Robbins calls **‘to be present in one’s centre’**. I call it an inner space as it for me is connected to a clear inward turned spatial sensation. Through my clinical practice I have experienced that my convincing presence in my own inner private space - when it is centred - can help giving the patient the possibility to be more present in his/her own inner psychic space. I now want to describe how I seek to train such an imaginary spatial consciousness myself and how to train music therapy students in this process.

Training of three imaginary ‘being present’- and communication ‘spaces’ as an orientation for developing a therapeutic presence

One method of training myself and future music therapy students in this specific way of ‘being present’ in listening is through training on how to listen to and be present in three imaginary spaces identified as:

- the private space
- the social space
- the soloist space

I have described this training module earlier in my articles on Psychodynamic Movement (Pedersen 1996/2002a, 1996/2002b).

Briefly, this training takes place in groups of students of between six to eighteen participants, who are then put together in smaller groups of three students. One participant in each small group is instructed by the group leader to stand with closed eyes and imagine **a private space** inside and around him/herself; a space, where the performer can retire and be recharged if s/he has been too much present in the universe of others. It is also a space where s/he can hide if there are other people s/he doesn't want to confront. The students are instructed to make vocal improvisational sounds to this space at the same time as they are listening in-side and around themselves. The exercise is performed with closed eyes and together with the helpers, who listen to the performer's private space such as it is expressed through the voice. One of the helpers imagines the space through inner imageries which s/he writes down during the performance. The second helper paints a picture and lets the sound impressions be expressed simultaneously by the colours. The timing of moving from the private space to the next space - the social space, is directed by the group leader by a clear beat on a drum for starting and for stopping.

In performing **the social space** focus is placed on how to listen to and express the way of being related to the other participants in the exercise. Everybody has closed eyes. In this form of 'being present' the performer can intentionally let him/herself be inspired by the sound of the other participants and try to inspire the others by his/her own sounds. Often dialogues arise which lead the participants away from being intentionally inspired by others and which lead the participants into a simultaneously dynamic fluctuation in the sounds with a lot of variations of tempo, pitch, dynamics etc.

In the instructions it is stressed **that the performer does not lose the connectedness to the private space even when the sound improvisation is at its highest point**. If the performer senses that s/he is losing this contact, it is permitted to step out of the improvisation in order to consciously re-establish the contact to the private space. Also in this exercise, the listeners are listening and creating 'inner' imageries, 'outer' pictures, and associative words.

In performing **the soloist space** the focus is to allow oneself to take up space without paying attention to the others as they have permission to do the same. It is about listening to and expressing one's energy, to find

a form for filling out the total room. The performer is asked to imagine s/he is standing on a stage and is going to find his/her own way of filling the room with his/her sound - to find his/her way of reaching the latest row in the concert hall. It is also emphasised here, that it is very important that the performers keep the connectedness to the private space so that the perception of taking that amount of space comes right from within and is put out in the outer world in a way that it is penetrating the world. The focus here is not as much on listening to the others as on manifesting oneself very clearly and significantly without losing the ability to listen to oneself from deep within. The helpers are listening and describing/painting their imageries.

In the verbal reflection in the small groups after the vocal improvisation it is stressed that the voice performer first tells his/her experiences in the three imaginary spaces. Not until then can the two helpers express their feelings, associations and imageries about what they heard during the improvisation. The exercise shows the different ways of 'being present' of the student and the many layers in perceiving from with-in and from out-side.

A raised sensorial readiness – extra sensitive listening and spaciousness as a platform for coping with counter transference

As described in the exercise with the three spaces (private/social/soloist) it is an important part in the training of music therapists that the student learns to listen to and be familiar with her/himself from within, and especially learn an 'inner' presence that is recognized from the private space.

For most students the verbal descriptions following the exercise mirror experiences which seem to be parallel with what Robbins calls the centre or the basic self. Personally I have recognised and verbalised my own sensorial experiences in relation to the embodied and floating listening attitude by means of this exercise. I have experienced a centring which can both be localised in the body, and which is connected to a clear inward spatial sensation.

In the exercise with the **three 'being present'- and communication spaces** formalistic separation between listening to oneself from with-in with closed eyes and listening to what others have heard while listening to

one's sounds from out-side is implied. It is the responsibility of the performer, and even a possibility of personal development, to identify with and integrate what the two different fields of experiences can offer. In the clinical situation it is not always possible or realistic to separate the perception from with-in and the perception from out-side that clearly. Here it is also about – as Robbins expresses it – being aware of if I, as a therapist is present from with-in or from partly out-side my centre and to use this awareness as a compass for what kind of work I am into just now. For the therapist it is crucial to "...try to sense the direction and the nature of the energy: if it comes from deep inside or from outside" (Robbins 98, p. 19). He writes that he is aware of a raised perception experience of his body simultaneously with a state of 'being present', and he points out that if one part in the therapeutic relationship is not fully present, the aim of the treatment is to try to make both parts present simultaneously. This is, among other things, what the therapist has been trained to be able to distinguish. This ability cannot be expected by the patient. **Therefore the therapist has to make use of a disciplined subjectivity in her way of 'being present'.**

This is another way of describing the therapist/patient relationship than describing it primarily through the transference/counter transference relationship. I find this view on the therapist/patient relationship as applicable for music therapists, firstly because it is close to sense perception and secondly because it indicates that the therapist is an acting part in the presence and not only passively letting him/herself be 'transferred' by the patient.

Even if counter transference is described as a tool to gain information on the patient's way of 'being present' and a way of relating to the therapist, there exists – in the description of the awareness on one's centre, on the position in the three spaces, and in the awareness on one's listening attitude – a verbalisation showing an active movable awareness by the therapist. I see here a parallel to Priestley's metaphor of the patient being a stringed instrument. The metaphor indicates that the strings can be more or less actively tuned before and during the therapeutic relationship. This makes me pose the questions: **Can our awareness be more or less actively tuned, when we try to be present or to use professional empathy or disciplined subjectivity? Is there any other form for mobility in the awareness if it is actively tuned?**

Casement talks about the therapist's resonance as something which is dependent on an adaptation between what is personal for the therapist and what comes from the patient. He points out that each therapist has

to learn to stay open for the other persons **'being different'** and develop an ability to respond on an interactive emotional level in relation to, or in spite of the cognitive understanding of the emotions. He expresses this in musical terms, such as giving resonance on **unknown 'tunes'** or on **dissonant 'harmonies'** in other persons. He considers this necessary to raise the therapist's receptivity towards unconscious **'leading notes'** in the interaction which seems central in order to understand the patient. He talks about raising the therapist's receptivity by extending the field of emotional susceptibility.

I talk about an extra sensitive listening attitude by extending the field of listening susceptibility (for instance the therapist does not only listen with the ears but with the total body and s/he does not only listen to her/himself or to somebody else. S/he moreover listens to her/himself listening to the other.) In the exercise with the three 'being present' and communication spaces the purpose is to extend the field of being centred, instead of only being connected to the private space. **By 'tuning' the awareness in a way that it resonates the connection to the private space – also when the performer is present in the field of awareness in the other spaces – then the centring is extended to be fluctuating in all three imaginary 'being present' and communication spaces.**

From in-side or from out-side

In short, the conditions **from in-side** or **from out-side**, have to be understood as ways of trying to differentiate between what comes from within the therapist of thoughts, emotions and perceptions and what comes from out-side - from the patient. This deals with **what comes from within the therapist's centre, private space or 'soul' – in opposition to what the therapist can identify as a false (not centred) structure in the presence.** A non-centred presence where something from out-side prohibits an experience of one's centre/space.

When it comes to differentiate the listening perspectives I find it very important to identify

if I am listening from with-in a deeply embodied floating experience in the body and understand something from the patient through this experience (listening to myself listen to the patient), or if I am listening to the patient's physical presence in the room (the foreground) and from that point make it possible that small glimpses of emotions from the

patient's split-off reality (the back ground) can enter my private space, and from there enter into the relationship and in our connectedness.

The three spaces expressed in the voice improvisation create – as I understand them and have experienced them in many levels of perception and consciousness – a metaphor of orientation which is very applicable in the understanding of what takes place in the relationship no matter if I am primarily aware of something emotional, something sensorial or something cognitive.

In the clinical work with patients, I metaphorically experience that I have to be present deep in my inner centre, in my private space, and have to close the door to the social space to make it possible to be present with, for example, an autistic patient. We can be physically present in the room, together, but my field of awareness is centred deep inside my private space, and it does not let my energy or attention flow towards the patient before an actual possibility emerges. In other situations I am aware of 'being present' in identification with the patient's private space in both what is recognisable to my own emotions and experiences, and to what I do not know and have to learn from and be informed by.

In both cases I need continually to have **a clear sense of keeping my grounding in the field of awareness to my own private space**, so I do not invade the patient, or let the patient eliminate my own private space. I can allow myself for a while to lose the clear sense of my own private space, but **the disciplined subjectivity demands that I seek it back again and make myself conscious of what is happening – also on my return.**

Therapeutic presence in clinical practice

Three vignettes

I now want to illustrate the application of the three imaginary 'being present' - and communication spaces and the use of listening attitudes as orientation tools in my clinical work.

I will do so by bringing three vignettes that describe musical improvisation with three different patients, where I had to orientate and re-orientate myself in the here-and-now way of 'being present'. The descriptions of the episodes are summaries from my clinical notes:

Vignette 1

I am standing in the music therapy clinic room with a 28 year old psychotic and autistic woman, who is also retarded and described as not possible to contact. She expresses herself through simple sentences of echolaly language. We play music separately but in the same room and at the same time. She is standing at a metallophone and I am standing at a wooden xylophone. I am distant in my awareness of her sounds being brought away with my own sounds – although I am always aware of not invading her through my music or take up too much space in the music – she strikes a key now and then but do not invite for interplay at all. I have tried a couple of times to intentionally invite her to a dialogue, but without response. All of a sudden, while I am in the middle of a melody we hit the same two keys at the same time and in almost the same dynamic. They come to vibrate together through the fact that we both move on in either direction on the instrument with a little displaced rhythm. This creates a sense of springiness between the keys. I immediately feel my body becoming tense. I feel I am moving into a readiness. I listen carefully and I continue with an inviting melody movement which the patient answers very clearly – we move on and develop a dialogue with turn-taking in small melody sequences which kind of dance together both concerning tune, rhythm and form. We end up by creating a joint crescendo which explodes on the cymbal for my part and on a drum for her part and she bursts out OH INGE!!

It was the first time she ever spoke directly to me in the one year we had worked together in music therapy.

My experience in relation to the three 'being present' - and communication spaces was that my private space was, suddenly filled out with tension and springiness when the two keys met, and my space opened up very intensely toward the patient in the social space, where I could, for the first time, sense a flow in our being together in the music between the spaces. **It was like a huge extension of our field of being together.** Earlier I felt an increasing narrowing in my private space when I intentionally tried to get in contact with her in the social space through the music or verbally, as if I had been resonating with her increasing withdrawing from the contact.

This experience reminded me that often, when people try to motivate the autistic patient to be in a social coherence based on an idea that this is good for the patient, they obtain the opposite. The autistic patient often probably experiences that being in a social coherence is connected

with a pressure, which makes her/him withdraw even further away in her/his private space. Initially when the surroundings can stay present in their private space without putting pressure on the patient, s/he can relax and may let go for an impulse, which brings her/him in a temporary social interplay as described in the vignette.

Vignette 2

I am improvising on the piano together with a hebephrenic schizophrenic patient who plays on a second piano. I am listening very carefully to the patient's music and I am present in the embodied physically floating primitive listening attitude, where I listen to myself listening to the patient in a way, where I might experience being connected to the patient. I try to match the tune, the pulse, the dynamic, and the tempo in the patient's music. I am very much identified with the patient in my awareness and it is rather exhausting, as I am sensing through listening to myself. Simultaneously I am aware of not playing anything dissonant or something which stands out from the joint flow in the melodies we gradually create together. Suddenly I notice that I am playing around with some melody sequences and am no longer listening that sensitively to the patient's music. At the same time I feel physically more relaxed and I sense we are together in the music that has a larger degree of lightness in the melodies. We supply each other in the inter play, so the music as a whole sounds like floating baroque-like music with a harmonic light sound quality.

A student, an observing apprentice, is watching the session through a video system in the adjacent room. He describes the joint improvisation this way in his notebook before we reflect the session together:

It is the first time I experienced seeing the patient at the piano, and it is the first time I experienced him play with a personal expression in his music, where he at the same time let himself be 'seduced' by the music therapist. His body language is still totally stiff and like a 'prison'. But the music tells another story. It is not anonymous and boring as his drum play, but it is seeking, with a light playing quality and what I consider as very important – it is new!

(Apprentice music therapy student. 1997)

I experienced that the shift has to do with that the patient. This patient is normally very much flowing out in his perception of reality and who

is present in his awareness solely in the third soloist space without any connection to the private space. In this moment he achieves a bit more connection to his private space by allowing himself to play flowing light melodies, and allowing himself to be a bit more present physically and sensorily in a joint flow in the music. It is still not so much that it can be observed from outside through his gestures and body languages, but the patient himself feels it a little from with-in, and the music gives here a possibility for starting a movement in the therapist/patient relationship even if modest.

It means for me that from having tried to follow the non movable patient from my own third space through my sensational awareness without loosing contact to my own private space, I was now able to take up more space in my first, private space. Our connection in the third space is now established through the joint melodic flow. We both manifest ourselves and flow along together. Simultaneously it is clear one can't speak of an intentional dialogue, as could be the case in the social space. **The patient's manifestation is still almost unconscious and 'being more present in the private space' is still a new and vulnerable experience for him.**

Vignette 3

A female borderline patient who has poor self awareness and serious identity confusion arrived for her twenty fourth music therapy session. All music therapy sessions are recorded. The patient formulates the problem that she is not able to put relevant borders towards experiences that she feels as assaults from her surroundings, and we agree to play with the following playing rule: "I play like I feel like here and now". The music is melodic and contains quite some repeated sequences at the end. During our interplay I recognise/sense that I have to have extra sensitive awareness in keeping my position of 'being present' in my private space and simultaneously be listening to the patient's rudimentary experiments in creating a melody. In my music I offer her a simple melodic structure for this attempt. After the music the patient tells me that she gained a better feeling during playing and she pointed out that she can almost remember some of the melody sequences. I suggested that she now played a solo in the form of creating and repeating a short simple melody, which she may allow to consider as her melody. The patient succeeded in demarcating, remembering and repeating a short simple melody, of which she became very fond. She thought it sounded rather elegant. She is open in trying to remember it and to bring it with her in her memory outside the therapy room like an 'anchor' – a firm base to

return to. In session 25, one week later, the patient wanted to start the session listening to her melody from the recording. The reason she gave was **this melody can give me a base from which I dare say NO.**

I listened to the melody together with the patient and acknowledged that it is very valuable and meaningful. The patient did not remember anything transferring over from previous sessions until that day.

The patient's wish to listen to the melody again gave her a possibility for creating a bridge between the inner and outer listening. She feels the melody as a vibrating form in her body and it becomes a bridge between body, consciousness (as a firm base) and the surroundings – as something she can gradually trust will be present. The melody becomes the tool which gives both of us a chance that I can acknowledge her in experiencing something real and stable in her way of experiencing herself - something that is meaningful to her. **She considers the melody as elegant – she wants to hear it again and she calls it my 'anchor'.** With the help of the melody the patient experiences something that can be identified as a rudimentary part of her private space. Previously this space did not exist and she could not identify it. Everyone could invade it/her without her noticing before it was too late. Simultaneously there was nothing being expressed from her inner experiences from the private space, that others could listen to or acknowledge. If they tried to acknowledge her she would consider it as false. I find it interesting that even if she could catch the attention from a whole group of people by entering a room she herself did not have the experience of being seen or heard by anyone from outside.

My role as a therapist is now changed.

Up to that session my role was to offer her a firm base in the music, 'being present' in my own private space during our interplay. Now I become a person who listens to her while she expresses herself from her own private space the way she experiences it from with-in. Her melody shows she is "someone" whom other people can listen to and acknowledge. Her inner experience of herself basically changes in character through her creation of this melody and she experiences an incipient, but still delicate, sensation of knowing her own worth.

Conclusion

The title of this article '**from in-side or from out-side**' indicates, that it is based on the idea that to create conditions where the patient as well as the therapist can be fully present in the relation the following condition has to be met:

- the therapist as well as the patient must be able to experience and to be experienced, to understand and to be understood – from with-in as a subject with subjective experiences, where inner psychic structures, the self and the inner dynamic forces are emphasized – as well as from out-side in the interaction with the surroundings.

This fact mirrors the ongoing discussion during the last decades whether science should be based on subjective or objective data material. It also mirrors the development in understanding the concept of counter transference either as something connected to the patients inner psychic structure and the transferences derived from these, or connected to an inter subjective understanding of the concepts of transferences. **For me it is natural to think in terms of 'both and' instead of 'either or'?**

In many of the quotations in this article concerning the therapeutic presence, concepts starting with 'inter' have been applied. For example, Inter subjective connections, inter subjectivity, inter active level of emotions and inter active communication and others.

Robbins concludes concerning the therapist's presence that:

... presence then, encompasses inner and outer reality and is part of that intermediary space that is neither inside nor outside but somewhere between. It is in this area that therapeutic work takes place.

(Robbins 1998, p. 32)

I emphasize that therapeutic presence and professional empathy are based on sensations which are connected to the deepest layers in one's inner psychodynamic forces (**e.g. through an embodied 'flowing through' listening attitude, or from the inner centre of one's private space**), and from here the inter active flow between the patient and the therapist resonates in a common pulse and a common dance.

So when considering the question put forward from students at the beginning of this article: **can't I just be myself in the role of being a therapist?** I will end up concluding:

that the therapist often has to be extra sensitive in her/his way of being authentic and simultaneously be ready for quick shifts in the ego condition, in the state of consciousness, in the inter active field of emotions, in the movements between the listening attitudes and in the floating between the three sensational imaginary being- and communication spaces.

That is why a deep understanding of the concepts of disciplined subjectivity, professional empathy and therapeutic presence is needed, while recognizing that in some situations, inside or outside the therapy room the condition of 'being yourself' is seen – in small glimpses.

1.3.1 A transition from article 3 to article 4

So this previous article is specifically addressing how to navigate through intuitively gained knowledge with a range of client populations. Definitions and metaphors from psychotherapists (Fog/Hem 1995), (Casement 1987), (Madsen 1996), Art therapists (Robbins 1998) and music therapists (Priestley 1994) and my own developed metaphors of **1) imagined 'being present' and communication 'spaces'** together with my method of **2) 'listening perspectives' and 'listening attitudes'** are described and exemplified through case vignettes. The article is inspired by students questioning me in InterTherapy training: **Can't I just be myself in the role of being a therapist?** Also the term **'disciplined subjectivity'** is offered to give an overall term for nonverbal navigation metaphors to explain, that the answer to the students question is neither yes nor no.

The article presents well defined pre stages for a systematic analysing work of counter transference episodes from my own clinical practice in psychiatry. The metaphors and navigation tools described, defined and illustrated in the vignettes as clinical tools will be of major importance in developing the questionnaire to further examine the experiences of counter transference of my colleagues in the study.

After having developed my own metaphors of orientation and navigation through intuitively gained knowledge in the clinical situation I again came back to the history of psychoanalysis, to the development of the terms transference, counter-transference, neutrality and resistance. First of all I did this to fulfil a task for the handbook of music therapy (Bonde

et al. 2002) translated by the authors into English (Wigram et al. 2003), but in writing this I became interested in, what the different psychoanalysts and psychotherapists had been thinking about these terms. I realised how these terms have been differently interpreted due to questions of ethics like: **is it OK to use strong emotions in counter-transference responses or reactions? Should counter transference experiences be sustained or eliminated.**

The terms were also interpreted due to recognition of science. Freud and others tried to describe how to get to know about the patient's unconscious in an objective scientific tradition, whereas many other later psychoanalysts prescribed a much more subjective humanistic scientific way of researching the unconscious. In the following chapter I refer to selected significant authors in the history of psychoanalysis from its classical form to the self psychology. In my literature review in this elaborated proposal I have worked more in detail on this historic development of psychoanalysis specifically focussed on the understanding of counter transference.

1.4 Article 4

Analytical, Psychodynamic and Transpersonal Theories

First edited in: Wigram, T., Bonde, L.O., Pedersen, I. N. (Eds)
A Comprehensive Guide to Music Therapy. Theory, Clinical
Practice, Research and Training. London. Jessica Kingsley
Publishers. (My part p. 71-85)

Introduction

It is characteristic for many music therapists in Denmark and other European countries to base their professional identities on a humanistic, psychodynamic and music-psychological foundation. From this foundation the Aalborg University music therapy program teaches students basic skills and knowledge in the areas of music, psychotherapy and special education, as well as basic scientific tools for undertaking their work.

The theoretical background for understanding clinical work includes psychodynamic theories, theories of communication, and theories of learning, as music therapy always involves work with contact and communication, whether or not the therapy is focused on training more specialised functions. For this reason music therapy includes, uses and develops theories from psychoanalysis and its offshoots in developmental psychology, Freudian based psychoanalysis, ego psychology, object relations theories, self-psychology, and transpersonal psychology. In addi-

tion, music therapy has found inspiration and models for understanding from many different theories of therapy and from the psychology of music. Depending on the client population receiving therapy, it can also be relevant to understand and describe clinical practice through communication theory and theories of learning.

Thus, music therapy theory and the growing science of music therapy rest on a compound theoretical foundation. The profession of music therapy must continually apply, critically regard and develop from existing theories in psychology, psychoanalysis, education, musicology, medicine and communication. Music therapists work and identify professionally within a field that is both art and science, a fact that can make establishing an identity as a music therapy 'scientist' complicated and many-faceted.

In this chapter we will address some of the theories applied and developed by the music therapy profession.

Classical Psychoanalysis

Music therapy in Denmark and Europe has been inspired by psychoanalytical and psychotherapeutic theories in the attempt to understand and describe the complex processes in music therapy with clients who are diagnosed with psychological and psychiatric problems.

Freud's description of the unconscious and his division of the psyche into id (containing drives and primitive wishes), ego (directing drives outwards in an acceptable form) and super-ego (controlling morals and values), has helped create a basis for the further development of psychoanalytical and psychotherapeutic theories.

Music therapy, however, has primarily used the **technical rules** and **clinical concepts** developed within classical psychoanalysis, rather than Freud's theories on the structure of the psyche. Within music therapy theory an attempt has been made to adapt these technical rules and clinical concepts to the reality of the music therapy setting, where the main instrument is music.

The aim of classical psychoanalysis (as originally described by Freud) was and is for the patient to discover him/herself. The model of the therapist as helper is taken from the medical models of that time. The therapist is compared to the surgeon, who must be able to act in a neutral way, in order to discern clearly and determine when and how to intervene.

Psychoanalysis is primarily described and documented through these technical rules and clinical concepts and to a much lesser degree through psychological/theoretical concepts.

Technical rules such as **neutrality**, **abstinence**, **free-floating awareness** and **active listening** are the basis of the practice and understanding of classical psychoanalysis. Music therapy can be characterised as analytic, because these original technical rules and clinical concepts underlie the music therapist's questions concerning his/her role as therapist, and the therapeutic relationship - especially when working with psychological and/or psychopathological problems.

Technical Rules

One of the fundamental technical rules, **the rule of the therapist's neutrality**, is emphasised in psychoanalysis as a precept, whereby the analyst can create the right conditions for the analytical process to begin. The therapist must be without ambitions on his/her own or on the patients behalf, in order to be available for the patient's needs, and she must maintain an objective, non-judgemental attitude and value-neutrality in relation to the patient's material. According to the psychoanalytical view, the therapist is expected to keep an emotional distance, showing at the same time an attentive and aware, non-involved interest in the patient. The analytical view is characterised by **a balance between closeness and distance**. The reason for the rule of neutrality is that the therapist should be able to create a projection screen for the patient's transference. The therapist must maintain a clear identity and autonomy and must not let himself/herself be drawn into the patients disturbed object relations, but consistently represent reality to the patient.

In music therapy this rule of neutrality has to be redefined. The music therapist is an active participant in improvisational duets, and therefore cannot maintain neutrality in the same sense as in psychoanalysis. Instead the music therapist must be aware of the way in which she is drawn into the patient's patterns of relationship and into his/her fantasy world. In music therapy there is a different form of balance between closeness and distance, as the music therapist is active - she reacts to the patient's music and at the same time participates in creating the shared musical expression. The music is not the patient's music alone. **Distance is therefore not created by holding oneself outside of appeals or emotional outbursts from the patient, but rather by listening attentively to what is happening at each moment in the music, and by structuring the mu-**

sic, so that it can accompany and make clear the patient's patterns in building and sustaining relationships.

Case Examples:

1. A patient plays fragmentally and moves quickly from one musical key to another on the piano. There is very little cohesion between the notes and the patient seems uninvolved in the music.

Here the music therapist can create a fixed point in the music (a repeated rhythm, a note or a short melodic phrase) and try to 'lure' or 'call' musically, so that the patient becomes aware of the music. At the same time the therapist can vary the dynamics in order to reinforce the music's centring function around the fixed point. In this way the patient can experience feeling more connected to the music and to the therapist while playing together. The patient's pattern of interaction, characterised by a fear of relatedness, can be changed through the non-verbal contact of the musical situation.

2. A patient is afraid of powerful expressions/outbursts (for example loud or angry-sounding music) and always plays softly in a slow walking tempo. The music therapist can gradually increase the tempo and the volume and thus confront the patient with the difficulty of keeping a slow tempo, while someone else plays in a faster tempo. The patient can experience frustration and stop playing, which can then become the object of analysis and negotiation, or the patient can be seduced to play louder or faster and discover that it isn't dangerous to express oneself powerfully in a musical improvisation. This pattern of relating in a patient is most often characterised by a reluctance to express feelings and a fear of being rejected or of violence towards others if he/she expresses emotions. This pattern can change as the patient gradually has the courage to express him/herself more dynamically in the music and discover that it isn't as dangerous as he/she believed.

3. A patient plays a melancholic melody on an instrument. The therapist can play sad, minor-sounding chords that give the music weight and substance, while at the same time amplifying its emotional intensity and ability to contain and accompany sorrow and pain. In this case the patient can transform a feeling of resignation (everything is depressing, and I don't know what to do - I feel so small and powerless) into a feeling of having more 'inner space' to contain emotions (I can allow myself to contain suffering and can feel strong by taking part in a more complex and grand expression of these feelings). This patient's pattern of relating

is characterised by a lack of belief in own self-worth and a failure to find the support of others meaningful. The musical involvement of the therapist can help the patient to transform his/her resignation into a feeling of substance and meaning - being able to contain and express difficult emotions in an aesthetically acceptable manner.

As can be seen in the above examples, the second **original technical rule** in classical psychoanalysis is **the rule of abstinence**. Here, the therapist must refrain from satisfying the patient's infantile needs and demands of love, and let needs and longings remain with the patient as a motivation for therapeutic work and change. This is also modified in music therapy. Again, it is rather the awareness of **how** the therapist satisfies the patient's needs, that is the focus of analysis, as well as a clarification of the development in the relationship.

The third and last of the **original technical rules**, **the rule of free-floating awareness** (where the therapist remains in a free-floating awareness and refrains from prioritising certain themes) is also modified in music therapy as it is in many other types of psychotherapy, especially short-term therapies. In music therapy there is generally an '**agreed upon objective or aim**', and often partial aims during the process. Often **playing rules** are the starting-point for the free improvisations. The improvisations originate from inner images, connected to memories or to emotions and moods that emerge in the moment. The musical improvisation can, however, also cause new images, emotions or moods to emerge, so the musical improvisation can be said to both express the theme/problem and at the same time work through and change the problem through the musical process and performance.

The music therapist, just as the analyst, must be aware of which themes give way to new ones and which themes are repeated. The music therapist can often direct and hold the patient's attention to musical themes - by using the patient's themes in the shared improvisation and by further developing them.

Pedersen, (1997, 2000) has attempted to describe the music therapist's balance between closeness and distance with the concepts **listening perspectives** and **listening attitudes**. She describes listening attitudes and listening perspectives as tools for orientation and information.

A listening perspective can be described as listening simultaneously to:

- a foreground - the patient's here-and-now presence and expression, and
- a background - the patient's split reality (often a reality with very strong emotions)

For the therapist this involves listening to the field of tensions and movement (or the lack thereof) between these two polarities - the foreground and the background.

The therapist can move between two different listening attitudes. The therapist can, for example, assume an allo-centric attitude:

Here the therapist listens with her full awareness directed towards the patient and resonates deliberately and authentically with the patient's physical presence in the room (the foreground). Gradually she then makes it possible for small "sparks" of emotion from the patient's split reality (the background) to become a part of their relationship (both with-in the music and out-side of it).

The second listening attitude can be identified as:

an almost embodied, flowing, inward and more primitive state of listening, that ensures more distance from the patient, while at the same time making relatedness possible on a more primitive level. The distance created here is different from the distance created when the therapist assumes an observing attitude, making the patient the object of observation from a neutral therapeutic position. The therapist is in a state of acute sensitivity and 'heightened readiness', and strives to be open to all nuances of vibrations that might flow between the therapist and the patient. This listening attitude can make it easier to be resonant to the patient's need for closeness and distance.

For some patients, it can be especially important that the therapist perceives their need for distance. Listening in the primitively organised way described above can give the therapist the means to create the necessary closeness or distance - without invading or rejecting the patient. The balance in each particular case is defined by the patient's presence.

The technical rule of neutrality in music therapy is best defined as **disciplined subjectivity** - described here through listening attitudes. Disciplined subjectivity is defined as:

Being subjectively present and at the same time resonant to the patient's universe. This means that the therapist is acutely sensitive and attentive, and can move in and out of the transitional space. This sensitivity is necessary, for the therapist to:

- actually perceive the vibrations (non-verbal sensations) of which she is a part.
- take responsibility for not being overwhelmed by the vibrations/emotions/experiences of which she is a part.
- be aware of and takes responsibility for the **transitional space** of which she is a resonant part.
- be committed to continuously finding ways of understanding the processes that take place in the transitional space of which she is a part.

(Pedersen 2000, p. 88)

In this way many fields of awareness are activated simultaneously; and as it appears, there is a similar focus on the therapist's technical way of '**being present**' in music therapy as in psychoanalysis with its rules of neutrality, abstinence and free-floating awareness. In music therapy as a whole, one can say that movement and actions are an important part of the therapist's presence, and that a distanced form - as described here through neutrality - is only one of many possible forms. The context determines the music therapist's way of 'being present'.

Clinical Concepts

Transference and counter transference

The technical rules of classical psychoanalysis are logically associated with **clinical concepts** such as **transference, counter transference, resistance, and repetition compulsion**. Music therapy also uses these clinical concepts to a great extent - here related to the fact that music is the main therapeutic agent, balancing and alternating with verbal parts of the therapy.

Transference is Freud's radical discovery and the pivotal point of psychoanalysis. The forerunners of the original concept of transference are hypnosis and the power of suggestion - where subconscious wishes for specific objects are actualised in the analytic relationship, which is perceived as reality. However, the term transference no longer holds the same meaning as it did originally. This change has happened gradually, as psychoanalysis has moved from being perceived as **purely monadic** (all conflicts take place intra-personally within the patient's psyche) to being **perceived as dyadic**. In dyadic therapy the premise is that early experienced relationship patterns, object relations, defence strategies, etc. are played out here-and-now in the patient/therapist relationship. Counter-transference refers to the therapist's way of 'being present' and her reactions to the patient, and needs to be taken into account in understanding the therapeutic process.

Today most therapists see transference as phenomenon to do with relationships, to which both patient and therapist contribute. Transference, as a clinical concept, is still crucial in understanding the therapeutic process - both in the verbal and the musical parts of the therapy. Therefore the therapist should be aware of the emotions that the patient projects on him/her. However, she must not always directly express the emotions that emerge.

The therapist must '**contain**' or '**carry**' these emotions and in this way understand the patient at a deeper level. According to Heimann (1950), these counter transference reactions and feelings can guide the therapist in his/her interventions. Heimann describes how the therapist should use not only free-floating awareness and active listening, but also a spontaneously awakened emotional sensitivity. She discusses that emotions often are closer to the heart of the matter than intellectual reasoning, and that

counter transference can be used as an instrument of orientation in over-determined material. The counter transference represents a product that is not only connected to the therapist's personality, but also to that of the patient. The therapist's conscious and active use of counter-transference can help to counteract her subconsciously becoming an actor on the patient's stage.

Transference is a very central concept in the treatment of psychological problems through music therapy. It can guide not only verbal interven-

tions and clarifications, but also musical interventions and the therapist's way of relating to the patient generally.

The music therapist often contains and carries primitive projected feelings from the patient through the music. He/she is trained to listen with great sensitivity. Music as a means of contact and communication aids the music therapist in developing a spontaneously awakened emotional sensitivity. The music makes it possible for the therapist to feel the emotions and at the same time use them consciously as a tool for orientation. The music therapist can then **'return'** the emotions to the patient, because they are made audible. She can present the emotions in a **'processed'** form through the improvised music.

The therapist must be able to sense when the patient is ready to see the **split-off elements** - in an altered form - and to integrate them into his/her consciousness. In this way he/she aids the patient's development and integration process. He/she must also be aware of how long it is necessary to be the **container** for the emotions in the relationship.

In psychoanalysis and psychotherapy, the focus of the therapist's observation has changed from being directed purely towards the patient. It has moved to being directed partly toward the patient in relation to the therapist, and also partly toward the therapist herself in relation to the patient. This is another way of studying the unconscious.

Transference and counter transference in music therapy theory

Priestley (1994) has defined transference from a music therapy perspective, where she distinguishes between two kinds of counter transference - **empathic counter transference (E-counter transference)** and **complementary counter transference (C-counter transference)**.

She describes E-counter transference as a psychological awareness that emerges in the therapist through an empathic identification with the patient. This empathic identification can be understood as a resonance from something outer to something inner - just as the music of a vibrating string (the patient) is amplified by the sympathetic vibration of the string instrument (the therapist).

Priestley describes the therapist's experience of gradually, during interaction with the patient- or suddenly like a bolt from the blue - becoming aware of this empathic resonance with the patient's emotions through

his/her emotional and physical presence. These are often repressed emotions, not yet accessible to the patient's consciousness, but they can also be emotions that are close to becoming conscious. In the latter case, the emotions can be very dynamic and almost '**flow through**' the therapist, especially when she is improvising with the patient.

Priestley emphasises further, that the therapist's counter transference is dependent on her sensitivity and openness to experiencing the emotions that emerge. But the ability to articulate these emotions consciously and to use them in the therapy is dependent on clarity of thought. She warns against letting the therapy process unfold through intuition alone, as it can easily lead to the therapist being overwhelmed by emotion, or having to 'block off' the patient's emotions (as they aren't made conscious and articulated verbally as an important part of the process). It is important that counter-transference experiences be transformed from an intuitive sense in the therapist or patient, to information that can be shared with the patient, making it possible for the patient to internalise the emotion and take responsibility for feeling it and living with it.

Priestley describes C-transference as something that occurs when the therapist identifies with one of the patient's close relationships (for example a sheltering mother or a strict father). It is a subconscious process, that the therapist can make conscious by continually asking herself: **why am I speaking/playing/acting as I am?** And by being aware of being put in another role than she normally would take. This counter transference can be played out consciously, when it is recognised (role-play), and can gradually be dissolved, as the patient becomes ready. Or it can be played out with reversed roles (the therapist reacts in a way contrary to the patient's expectation).

Lindvang (1998) emphasises the importance of letting the two counter transference reactions work together. The therapist often acts out a complementary counter-transference (nurturing for example), while at the same time feeling an empathic identification with the patient's emotions - sorrow or loneliness, for example. The empathic identification can strengthen the therapist's capacity to be nurturing, and it can also be a tool for orientation, as to which kind of nurturing is necessary. Lindvang compares this to Stern's theoretical description of the way in which parents attune to and identify with the infant, in order to understand how the child feels and thereby fulfil his/her needs (Stern 1995). Lindvang points out that by studying communication between child and primary caregivers it becomes clear that these two ways of identifying are closely connected and mutually support each other.

Resistance and repetition compulsion

Two other original clinical concepts from psychoanalysis, later adopted by other psychotherapists and music therapists, are the concepts of **resistance** and **repetition compulsion**. In classical psychoanalysis, resistance is understood as the forces in the patient that subconsciously resist treatment. Resistance is a central phenomenon in psychiatric illness - the patient wishes to be well, but works at the same time against his/her own treatment.

The concept of resistance has developed theoretically since Freud. It is assumed that **resistance is born of the same forces that caused the disturbance, and that now maintain the repression**. Resistance is no longer seen as a **'dangerous drive from the id'**, as originally defined by Freud, but also as **'a force related to the ego'**. The dangers to which the ego is exposed come not only from the libido, but also from the ego, the super-ego, and from the outer world.

In psychoanalysis it is assumed that resistance emerges as a reaction to danger, and that the original source of danger is the child's helplessness. This helplessness can manifest itself in subconscious anxiety and fantasies of annihilation (if others reject me, I won't exist), or fantasies of not being worthy of others' love (if others don't express their love for me, I am worthless) or a feeling of being 'paralysed' and unable to act (I can't live out my energy or act as I feel, without being harmed by my surroundings) - fantasies that can colour any danger experienced in the moment.

These forms of anxiety can be seen in serious psychiatric illness. In psychosis, annihilation anxiety dominates, while in neurosis it is the fear of being harmed, if the client lives/acts out his/her desires.

The ego mobilises resistance against the emergence of anxiety. One can only understand the power of resistance if one understands the anxiety behind it. If fear of annihilation is the cause of the illness, then it is also the cause of the patient's resistance to change. The therapist must identify empathetically with this locked position that is often the patient's only security. The suffering related to the illness is less than that of the patient's imagined alternative, if he/she were healthy. The patient is, in this way, bound to his/her illness. The therapist must at the same time realise that the patient's closed world isn't impenetrable, and that there is a reason for the patient's participation in treatment.

In music therapy, because of the therapist's active participation in music-making with the patient, it is often difficult to distinguish between trans-

ference, counter transference and resistance. A resistance to change can, for example, show itself in the following way: The therapist is stuck in a characteristic style of playing - so much that the patient refuses to play if the therapist changes her style of playing. In this case there is a merging of the conscious use of complementary counter transference on the therapist's part with the clarification of the patient's resistance. As exemplified in case example no.2 in this article, the therapist here has one possibility - allowing the patient's resistance to act as a structuring factor in the musical improvisation, as long as the patient's fear of change is greater than his/her desire for change. At the same time, the music creates a framework, within which the patient can experience being 'heard' and 'met' - with his/her resistance as an essential element of the musical expression. This acceptance of the resistance and the therapist's conscious gratification of the patient's needs can contribute to sufficiently reducing the patient's anxiety, so that he/she can be coaxed to change his/her style of playing and in that way gradually 'loosen' the resistance.

Often the concept of resistance is accompanied by another clinical concept - **repetition compulsion**. According to classical psychoanalysis, **repetition compulsion describes a phenomenon whereby the patient re-enacts the traumatic experience, rather than remembering the original trauma**. In new relationships and in therapy the patient acts subconsciously in a way that seems to bring about the same interpersonal problems again and again. The patient relives the experience unknowingly and this constant repetition blocks the memory of the original trauma. The psychiatric illness is seen, not as an historical development, but as a demonic force the patient is subjected to.

Repetition compulsion is a force that, according to Freud, lies beyond the 'pleasure principle'(eros) and is connected to the 'death instinct' (Thanatos) - the patient re-enacts the experience even though it is unpleasant. The patient exercises self-punishment, which becomes very pronounced in the self-destructive behaviour of psychotic patients.

Repetition compulsion has become a pivotal point in the later development of theories on psychic structures, especially theories that integrate aspects of developmental psychology.

In this way, music therapists have made use of newer developments in psychoanalytic theory - from object relations theory and dynamic psychotherapy theory to cyclic dynamic theory. This means that present life events and relationships have gradually begun to play a larger role in theory building and therapy than they have previously. The patient's

actions are not only understood as a product of his/her early history and possible traumas, but also as connected to later developmental phases and to current inter-action patterns where each person continually influences each other. This means that the patient's presentation of sub-conscious material in the specific context is just as important as identification of repressed material from childhood. This view differs from more traditional psychodynamic theories primarily in the way in which early experiences are seen to form current experiences, emotions and behaviour. Early experiences are significant because they put the person on a life-path, where the force of movement is strong, and this makes certain types of experiences more probable than others. It is the accumulative effect of many such experiences that eventually results in maladaptive patterns of interaction - and in this way becomes the cause of the psychological problems in a cyclic dynamic perspective (Høstmark Nielsen 1998; Pedersen 1998a, 1999). D. Stern further develops this idea (that the accumulative effect of early experiences influences present patterns of interaction) from the perspective of developmental psychology.

In a music therapy context, it is important that verbal as well as non-verbal interactions are made audible, and that they, in tangible form, can become the object of analysis of interaction. This is currently a focus for many music therapists, in clinical practice as well as research.

Is music therapy psychoanalytic?

There has been a great deal of discussion within psychotherapeutic circles on whether or not a therapy can be described as psychoanalysis or analysis, when interpretation and insight no longer are central curative factors, and when the structures of the mind are no longer understood through Freud's libido theory. According to Wallerstein (1998), it is the **clinical theory** (the combination of technical rules and clinical concepts) rather than the **meta-theory** that is the decisive factor for whether or not therapeutic work can be seen as psychoanalytic. What is crucial, is whether or not the clinical work builds on fundamental concepts such as transference, counter transference and resistance - phenomena that can be observed and described with reasonable clarity. According to Pine (1990), four psychological theories have been developed that can underlie psychoanalysis; **libido theory, ego psychology, object relations and self-psychology**.

Interpretation or empathy?

During the last twenty years there has been a growing interest in developing psychoanalytic treatment for more **regressive illnesses**. Here it is clear that interpretation as the main intervention cannot stand alone and in many cases cannot be used at all. It must be supplemented with, or replaced by a more empathic way of relating on the therapist's part. At the same time she must clarify and confront - in order to remedy the patient's tendency to divide the world into black and white, and in order to strengthen the primitive ego function.

This has caused many psychoanalysts to suggest that classic psychoanalytic understanding be supplemented with a developmental psychological frame of reference, and direct itself towards an understanding of the therapist/patient relationship as a healing potential. Interventions are called for that are either ego supportive or directed towards development of the self. Interpretation is not the main technique, but rather '**Containing**' (Bion), '**Holding Environment**' (Winnicott) or '**Affirmation and empathic identification**' (Killingmo).

It is difficult to observe and clearly define these techniques, and to grasp their therapeutic meaning, because these methods are not only directed toward the patient's symptoms, but toward the patient as a whole person. For the major part of the therapy, the therapist needs to take an affirmative approach and to direct the treatment towards establishing the patient's identity through stabilisation of the ego and development of the self. The patient must first achieve considerable development in this area before the therapist can continue with more insight-oriented therapy, where the patient obtains insight into his/her own participation in the psychodynamics - through ways of relating and subconscious playing out of primitive wishes.

Music therapy has great potential for offering 'containing' and a 'holding environment', as the sounding music often can act as a facilitating co-therapist. Consequently, music therapy is primarily directed towards the patient as a whole, rather than towards the patient's symptoms. What we are talking about here, is the further development and definition of the technical rules - through description of the therapist's way of relating - and of clinical concepts such as transference and counter transference, as they are played out in music therapy. Winnicott emphasises that when the patient's ego function is not intact, no transference neurosis (as originally described by Freud) will develop. The patient's primary condition is absolute dependence. In this case transference is charac-

terised, not by the degree of irrational emotions on the therapist's part, but by the degree to which the therapist can allow the patient's past to be present in the relationship (a symbolic realisation). On these grounds Winnicott believes that the theoretical and technical modifications in therapy with regressive disturbances are fully compatible with the analytic frame of reference.

In the treatment of regressive disturbances, the third clinical concept **resistance** is used in a modified form. Every relationship strategy that the patient chooses must be considered the best solution, if he / she is to survive the threat of total annihilation.

Generally one can say that the clinical concepts and technical rules in classical psychoanalysis, as described and delimited in relation to regressive disturbances, are more applicable and directly transferable in music therapy than in verbal psychotherapy. The relationship between the reality of the moment and the originally experienced inter-action patterns (that guide the patient's choices and relationship potentials today) merge together and are less separated in musical interaction than in verbal psychoanalysis / psychotherapy. In this way there is often a 'regressive' aspect connected to the music therapy process.

This also means that music therapists can use newer psychoanalytic theories more easily - theories developed through a gradual paradigm shift via object relations theories, ego psychology, self-psychology, interpersonal theories and inter-action theories. This development reflects the fact that psychoanalysis has moved from a monadic to a dyadic form. It also reflects a change in the understanding of mental structures and psychopathology, and in the significance of the early mother / child relationship as a metaphor for the therapist / patient relationship. Libido theory has therefore no importance in modern music therapy theory.

Two prominent psychoanalytic schools of thought were developed in work with regressive disturbances: Kernberg's expressive psychodynamics and Kohut's self-psychology.

The development of psychoanalytic theories via ego psychology and self-psychology

Kernberg (1975) did not follow the psychoanalytic trends in the 1960s and 70s concerning the use of affirmative techniques, especially in **treatment of regressive disturbances**. He developed a meta-theory based on Freud's libido theory, but with a more differentiated view on psycho-

logical development. For example, he did not believe that there was a linear development from id functions to ego functions. He believed that there was a hierarchical development within each function - a development that wasn't necessarily related to the other functions. During the time that this theory was developed there was an increased focus on other types of personality organisation than neurosis and psychosis - borderline and narcissistic disturbances, among others. These personality types did not fit into a classical, linear understanding of development.

Neurotic, borderline or psychotic organisation is reflected in characteristics that dominate the personality concerning:

- degree of identity integration
- type of defensive strategies
- capacity for reality testing

Neurotic personality organisation is characterised by an integrated identity - contrary to the other two types of organisation - and resistance is actualised primarily in repression of reality. In the two other types of organisation, there is a deep "split" in the experiencing of reality, that is seen as alternately black or white. Reality testing is intact in neurotic organisation and in borderline organisation, but not in psychotic organisation.

The aim of therapy with borderline patients is to **integrate split-off object relations while at the same time neutralising libido-related affect, which strengthens ego functions**. In the transference situation the therapist will be seen as alternately good and evil. According to Kernberg, the therapist's task is to identify these projections and interpret the dyads that occur in the moment. Kernberg (1975) emphasises the importance of the therapist's authentic interest in the patient's emotional reality. The therapist's interest is a healing factor in the therapy. Kernberg does not believe that supportive therapy or traditional psychoanalysis is suitable for these patients. He believes that affirmation must be imparted as a precise and well-timed interpretation of the patient's basic conflict. An intervention of this type shows the patient that the therapist has understood something very important about him/her. Kernberg, therefore, does not use affirmation as an intervention in itself. Quite a few music therapists from Germany, Holland and other mid-European countries

have described cases where this theory is brought into practice in music therapy.

In contrast to this is Kohut's self-psychology. Self-psychology departs radically from the meta-psychology of Freudian psychoanalysis by disputing the theory that drives are the basic elements of a child's experience. Heinz Kohut (1984) believes instead in basic mental functions that are related to the creation of self and to the first experience of a sense of self. The basic mental functions are defined as **'healthy self-assertion in relation to the mirroring self-object and healthy admiration for the idealised self-object'**. Moreover, a continuous sense of identity over time is an important characteristic of the healthy self.

In Kohut's hypothesis on the restoration of the damaged self, disintegrated structures disappear and a healthy self is re-created. Childhood memories are revised, because recalling the past in a therapeutic context helps to re-establish continuous sense of the self in time. The purpose of memory in this context is not to make the subconscious conscious, but to strengthen the cohesion of the self. In analysis, the genetic roots of the self are sought; the way in which the core self originally was consolidated (or not consolidated) is reactivated, and the patient's capacities and skills are re-experienced. The core self is defined as a delimitation of the self - creating a basis for a sense of being an independent centre for initiative and perception. This sense of independence, along with the person's most central ambitions and ideas and his/her experience of body and psyche, create a unit in time and space.

During musical improvisation clients often experience that they can express themselves from a level of inner resources that seem healthy and assertive despite many other 'layers' of self-devaluation in the personality. In long-term music therapy it is often meaningful to see personal growth as establishing contact to 'healthy self-assertion', though this can only be stabilised through mirroring and repetition over time. In the 1950s, Kohut wrote two (now classic) articles, about the psychological and therapeutic functions of music (Kohut 1994a, 1994b), showing how musical activities can nourish 'healthy narcissism'.

Stern also uses the term **'the core self'**, as one of the **'domains'** of development in his interpersonal theory. His understanding of the mental structures differs however, as it is based solely on observation of mother/child interactions. Because ways of relating and experiencing in musical improvisation are sometimes similar to those of early mother/child interaction, and because Stern writes in language similar to musical de-

scription, his theories have often been used in describing processes in music therapy. It is therefore relevant to look in more detail at Stern's theories and how they relate to music therapy

1.4.1 A transition from article 4 to article 5

Article 4 broadly outlines the development of classical psychoanalysis via ego psychology and self-psychology to interaction theory and transpersonal and integral psychology. Music therapy in Denmark and Europe, especially as it is carried out in mental health, has been inspired by the running development of classical psychoanalytical and psychotherapeutic theories with a specific emphasis on how the understanding of the technical rules and clinical concepts of these theories have changed with the development of the psychological theory.

The changing understandings of these rules and concepts are presented and related to current development of theories of similar rules and concepts in music therapy theory, among others my own method of listening perspectives. Counter transference, as a clinical concept, is described as an important element following the process, where psychoanalysis has moved from being perceived as purely monadic (all conflicts takes place intrapersonal within the patient's psyche) to being perceived as dyadic. Here the premise is that early experienced relationship patterns, object relations, defence strategies etc are played out here and now in the patient/therapist relationship

The article concludes that Counter transference both in psychoanalysis, psychotherapy and music therapy has changed the focus of the therapist's observation from being directed purely towards the patient. It has moved to being directed partly towards the patient in relation to the therapist, and also partly towards the therapist himself/herself in relation to the patient. This is another way of studying the unconscious.

I have in this article overall followed the development of clinical concepts in current psychological theory perspectives derived from psychoanalysis, where the main shift of paradigm is the one of moving from a monadic to a dyadic understanding. This article will be a cornerstone in further literature review and theory building in the study.

It is not directly connected to article 5. But in article 5 I am describing the area of music therapy in psychiatry in Denmark and my own clinical experience in this area. It is especially in this area of my clinical experience, that my interest in how to understand and use counter transference has been raised. The review of psychiatrist's writings on use of the clinical concept counter transference in dynamic psychiatry is of major importance to get to understand the patients. To be aware of counter transference is also very important in order to be able to stay sufficient sensitive and yet survive as a therapist in psychiatry.

I therefore held the understanding and use of counter transference for very important for music therapists working in psychiatry. I myself am one of the subjects for the semi structured questionnaire and I thus consider it as important to present my knowledge of this working area of music therapy. I also present a case where counter transference is playing a major role although this clinical term was not the primary focus of this article when first edited.

1.5 Article 5

Music Therapy with Psychiatric clients

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Introduction: Pioneers of music therapy in Psychiatry

In Europe, music therapy as a psychoanalytically based psychiatric treatment started in England in the beginning of the 1970s, when Priestley was employed at several hospitals in London. Further pioneers include Lecourt (1994) was developing work in France from a psychoanalytic perspective, Di Franco in Italy (1993), Odell-Miller (1999), and Streeter (1999). Many have been inspired by Priestley's model and approach, and have further developed this (De Backer & Van Camp, 1999; Langenberg, 1996; Pedersen 1997, 1999; Scheiby 1998).

However, the roots of her professional work go back to Juliette Alvin, who established the first actual training program for music therapists (a one-year post-graduate diploma at the Guildhall School of Music and Drama). This program started in 1968. One of the main disciplines was the study of musical techniques, where improvisation was seen as the key element in establishing musical contact between therapist and patient. Alvin's clinical practice was primarily based on work with children

in psychiatry - especially autistic children, but she also worked within the field of hospital psychiatry.

Priestley further developed elements of Alvin's improvisational methods. At the same time, her work was based on a psychoanalytical background and understanding of psychological symptoms. She felt that these symptoms were rooted in traumatic experiences of early childhood. Priestley comprehensively developed Alvin's ideas about a psychoanalytic approach, and formulated psychoanalytic and psychodynamic theories for her music therapy practice in the 1970s.

Priestley's methods and techniques were developed through her work with adult psychiatric patients. A characteristic procedure for Priestley is the use of **'playing rules'** or **'titles'** to stimulate improvisations. The playing rule is defined before the start of the improvisation, either by the therapist herself or with the help of the patient. Another characteristic of the Priestley model is that the therapy session alternates between improvisational parts and verbal, reflective parts. During the musical improvisation, the therapist uses disciplined subjectivity, described in classical psychoanalysis as techniques developed through work with regressive patients: **'Containment', 'Holding Environment', 'empathic affirmation'** or **'professional empathy'**. During verbal reflection the therapist also uses **clarification** and **interpretation**, including interpretation of transference phenomena, as described in classical psychoanalysis. These techniques are primarily used with neurotic patients.

Priestley emphasises that professional empathy and involvement in the patient's situation are the therapist's most important ways of relating. At the same time, she uses the classical technical rules of interpreting and seeking insight together with the patient. She does not see the principle of neutrality as central to the therapist's way of 'being present' in therapy. In this way, her theory differs from that of classical psychoanalysis. The patient's experience of continuity and his/her possible insight are the primary goals for the therapy. **She emphasises the therapist's sense of timing in interpretation (intervening at the right moment) as an important factor, if the interpretation is to have a healing and integrating effect.**

Analytically (oriented) music therapy in psychiatry

In order to practice analytical music therapy (as developed by Priestley), a therapist must, in addition to her music therapy education, complete

a psychotherapy-training module with music as the therapeutic agent. In Denmark, this training module is an integrated part of the 5-year masters program at Aalborg University. After completion of this module, a music therapist can call herself an analytical music therapist, according to Priestley. The psychotherapy training module creates a basis for understanding, that is very suitable for work with psychiatric patients, and it can also be applied to other clinical areas, such as special education and medicine.

The training module is based on theories from classical psychoanalysis, ego psychology, object relations theories and self-psychology, as well as transpersonal psychology.

As mentioned earlier, Priestley worked in psychiatry for many years. She believes that uncovering and re-experiencing early childhood traumas are the healing factors in the therapeutic process. Music plays an important role in this process, by stimulating memories and by generating emotions and fantasies in the moment - and thereby actualising and making audible early traumas, both in actual relationships and in transference relationships between the patient and the therapist. **Priestley developed the use of musical improvisation as a 'stage' for the re-enacting of early relationship experiences - as a specific psychotherapeutic method.**

From her clinical experiences, she developed a differentiated definition of **empathy** and **counter transference**. Priestley was a pioneer, in that she never used interpretation of transference alone - she was very conscious of the need for a warm alliance and a deep and authentic involvement in the patient and his/her conflicts.

As early as the 1975, Priestley developed her differentiated definition of counter transference from a psychoanalytic frame of reference, primarily through her work with psychiatric patients (Priestley, 1975). She distinguishes between **empathic counter transference (E-counter transference)** and **complementary identification or counter transference (C-counter transference)**.

The influence of classical psychoanalytic therapy

As mentioned above, music therapy in psychiatry (analytically oriented music therapy) focuses to a great extent on transference relationships between the therapist and the patient, and on the music therapist' way of 'being present' in the therapist/patient relationship.

Seen from a classical psychoanalytical point of view, the music therapist relates to a wide variety of patients, including neurotic patients, in the same way that a classical analyst would relate to patients with regressive symptoms. This means that the patient can develop and strengthen the Self - by continually being seen and heard through the therapist's empathic affirmations and through the musical duets, where the therapist identifies with the client's psychological reality.

For the music therapist, it is often **less relevant to act as a neutral 'projection surface'**. It is more important to create a setting, where the patient feels secure enough to interact with the therapist here-and-now - through the music and with the resources he/she possesses. **Music therapists are, however, trained to use neutrality as it is described and developed in classical psychoanalysis, when the clinical situation demands this.** This can be in situations where the therapist is in danger of becoming 'trapped' into the patient's re-enactment of compulsive relationship patterns. But neutrality is one of many possible techniques that can be used in music therapy - it is not a characteristic of a specific method.

At the same time, interpretation of transference is often very relevant for the therapy process. The clinical concepts of **resistance** and **repetition compulsion** are used in interpretation, but with a focus on the fact that they represent the best possible solutions the patient could choose, in order to survive earlier anxiety-producing situations. The aim is not to break the resistance, but to regulate it, by developing new patterns of behaviour. This often weakens the repetition compulsion.

One of the distinctive features of music therapy is that **improvisation is described as an (inter)active process**. Experience shows that especially patients with severe relationship dysfunctions and weak egos can benefit from music therapy. These patients' tendencies to interrupt dialogue can be 'played out' with great effect in musical improvisations. **The setting created by the music can make it possible for the patient to oscillate between primary and secondary processes.** The therapist follows these processes empathically, but at the same time he/she must - with a disciplined presence - listen from 'outside' this state. In this 'floating' state, the patient can re-experience early relationship patterns that he/she repeats in life. The 'split-off' or 'locked-in' affective world can be re-experienced and transformed.

For patients who are stuck in this fantasy state, music represents the possibility of meeting and relating to another person in the music - without

the demand of having to leave the fantasy world first. A playing rule for a musical duet could be: **We play what comes to us, and we let the music grow out of that which is inside of us, that wants to be expressed!**

Music therapy in psychiatry doesn't look exclusively to psychoanalytical models in order to understand the emerging phenomena in therapy. But a psychoanalytical orientation creates the basis for establishing a therapeutic space, where subconscious fantasies and inter-action patterns can be made audible - and where embodied, perceptual experiences are a part of the whole - within the mutual dialogue.

The transference relationship in music therapy - regardless of theoretical basis - has a particular quality, by virtue of the sensory experience: the direct resonance of the music is perceived physically. **This sensory aspect vitalises the 'meeting' between the therapist and the client, which is a crucial part of the relationship process.**

Although active music therapy - primarily improvisation, but also performance and composition - is the most widely used method in psychiatry today, receptive music therapy is being developed as a systematic treatment modality and as a tool for improving quality of life. In receptive music therapy, the patient and the therapist listen to selected pieces of music and reflect on their experiences afterwards. Here GIM (Guided Imagery and Music) is most prevalent often conducted in a modified form for use with patients with weak egos. After finding a psychological issue as a focus for the session, the patient listens to specially selected music and verbalises his/her experiences during music-listening. The GIM therapist accompanies the patient empathically, by affirming and exploring the patient's experiences. During the music-listening phase, he/she writes a log of the patient's experiences/images and helps to integrate the preconscious images into the patient's self-identity.

Music Therapy in Hospital Psychiatry in Denmark

Music therapy as **psychiatric treatment** is relatively new in Danish hospital psychiatry.

Music has been used as a **recreational activity** in psychiatry for many years, in the form of music groups playing mainly pop, rock and jazz. Musical arrangements and levels of difficulty are adapted to the skills and strengths of the individual group.

A well-established example of this is the **Chok Rock project** at the Psychiatric Hospital in Risskov (Århus). Music groups are a service offered to patients in several psychiatric hospitals in Denmark.

The purpose of music groups is to create a setting where the patients can express themselves musically and where they can maintain or develop the musical skills they already possess. A prerequisite for joining the group is either having played music earlier (and feeling 'at home' on an instrument) or having the desire and courage to participate in a simple arrangement of a song or piece of music. The individual patient becomes an equal and valuable participant in the group social activity of music-making. Each participant plays an equally important role in making the music 'work'. A safe and secure atmosphere is important for these activities.

During the last 10-15 years, the use of music as a therapy form in psychiatric treatment has become more common in hospitals in Denmark, so that music therapy is now one of the services offered in their total treatment plans. At this point in time there is music therapists employed in nine psychiatric hospitals in Denmark. Several of them are alone in representing music therapy at their hospital. The music therapist can act as a **centrally placed treatment 'unit'**, offering services to all patients in the hospital, depending on resources available. The music therapist can also be associated with one particular ward in the hospital, and at the same time offer treatment to patients from other wards. The music therapist works as a part of a 'treatment team' together with psychiatrists and psychologists. Some hospital music therapist's salaries are funded through both the budgets of the ward staff (nurses and other caregivers) and of the 'treatment team'. This can cause some confusion as to where music therapists 'belong' and under which conditions they should work. In most hospitals, music therapy is now understood as a potential substitute for verbal psychotherapy. This means that the patient cannot receive other types of psychotherapy while participating in music therapy. However, the patient can receive medication and psychosocial activities/treatments along with music therapy.

The music therapist can also offer group activities of a more supportive nature on closed wards, often open group activities such as active music-making with simple improvisations, singing familiar songs or listening to the patients' own preferred music.

Patients who begin in individual music therapy or more insight-oriented music therapy groups are referred by a psychiatrist. Often the psychia-

trist has discussed this with the music therapist prior to the referral. If the referral is deemed relevant, the music therapist and the patient have a preliminary conversation. After this, if the patient is motivated, the music therapy begins with a trial period of three to six sessions. When the trial period is over, it is determined whether or not short-term or long-term music therapy is relevant for the patient.

During the trial period, the music therapist presents different playing rules and 'givens' that structure the improvisations. These 'givens' are chosen, so that the patient can try a variety of musical instruments and playing techniques. In addition, they help to uncover the patient's potential for relating to the therapist musically. The focus is on the patient's relationship to music and musical instruments - his/her involvement in the music and ability to experiment. Additionally, there is a focus on the patient's ability to relate or listen to the music therapist in the music, and on the relationship between non-verbal and verbal expression and interaction.

The music therapist participates in the trial period, and tries out different music therapy techniques, such as matching the patient's personal musical expression and supporting the patient's music. She also uses more confronting techniques in relating to the patient and his/her music. Some music therapists make it a rule that the patient's doctor or contact person is an observer during the trial period (Jensen, 1999). Musical improvisations are recorded on audiotape or video, to the extent that the patient allows it. This makes it possible for the patient to hear the music later, and is also useful for the therapist's analysis (De Backer, 2003).

Music therapists regularly receive professional supervision/consultation from psychiatrists or psychologists, where transference and resistance issues can be addressed, based on the cases presented. During supervision, the therapist can also identify which of the patient's issues that are suitable for music therapy work.

Issues in treatment and criteria for treatment

Important themes for music therapy sessions in psychiatry are: **intimacy/distance, aggression/non-aggression, dependence/independence, acting out/emptiness, 'being present'/disappearing, moving from one position to another, creating boundaries/breaking or testing boundaries.** Although music therapists work with the patient's whole personality, there are certain symptoms that seem to be common for patients who

benefit particularly from music therapy. Some of these are: **intellectualising, severe communication disturbances, weak emotional contact, obsessive-compulsive symptoms and productive psychotic symptoms.**

If the patient is to benefit from music therapy, these basic requirements must be met:

- The patient must be able to attend therapy regularly.
- The patient must be able to reflect verbally or musically.
- The patient must be able to articulate goals for the therapy or to have an opinion regarding the music therapist's suggested goals.
- The patient must be able to enter into a therapeutic alliance or wish to work with his/her problems in entering into such an alliance.
- There should be careful awareness of any risk of psychotic relapse.

Previous experience has shown that it is often easier to establish a positive working alliance in music therapy than in traditional psychotherapy, among non-productive psychotic patients with communication disturbances, intellectualisation, obsessive-compulsive symptoms and difficulties in expressing emotions. A positive working alliance in this case is defined as the motivation to co-operate within the structure of the music therapy session and with its goals.

Among productive psychotic patients it has been especially beneficial to use music therapy to establish a working alliance with patients who have dominating autistic traits, megalomania and/or self-devaluating thoughts. Common themes for these patients in therapy are establishing an alliance, moving in and out of contact, etc... In quite a few cases, this has helped to motivate the patient to move forward in a treatment plan, with or without music therapy.

Music therapy in child psychiatry has been developed in Denmark in the form of a two-year project, funded by private grants. In this project, the music therapist worked with music therapy assessment and individual sessions with pre-school children. (Irgens-Møller 1998). Goals for the individual sessions varied - from working through emotional issues, to development of communication skills, impulse regulation or increasing self-esteem. For half of the children, a visible development in relation to child's important problems was seen, and in half of the cases, observations from music therapy sessions contributed to new information about the child.

In addition to music therapy practice, the music therapists regularly attend case conferences and referral meetings, when relevant, as well as meeting with the individual patient's psychiatrist and 'contact person'. Music therapists also teach other psychiatric colleagues, through workshops and lectures, about music therapy and its uses. An important part of the music therapist's job in psychiatry is communicating about, and documenting, their work.

The Music Therapy Clinic at Aalborg Psychiatric Hospital - Centre for Treatment and Research - publishes the annual journal **Musikterapi i psykiatrien (Music therapy in Psychiatry)** with case presentations and theoretical articles on aspects of music therapy, written by music therapists in Denmark. This group of music therapists has also formed the group MIHP (Music therapists in hospital psychiatry in Denmark) that meets four times a year to exchange ideas, experiences and methods for assessment and research.

Case example and patient narrative

A male patient (41 years) was referred to psychotherapy at a psychiatric hospital. During the referral meeting it was decided that he be offered music therapy. He was referred with the diagnosis 'personality disorder / disturbance of personality structure', which was the conclusion after an evaluation using the following tests: Wais, Luria's 10 word test and the Rorschach test.

Characteristic traits were intellectualising, obsessive-compulsive behaviour, and very little contact with his emotional life. The patient attended hour-long music therapy sessions as an outpatient once a week for two years. The aim of the therapy was defined as follows: to work towards the patient establishing better contact to himself and to others - primarily women. Partial aims were working with boundaries and autonomy, and supporting the patient in clarifying future employment possibilities.

In the following, excerpts from the case are described, illustrated through music examples 1 - 6 on the enclosed CD.

CD example 1: track 3

The therapist and patient both improvise on the piano
(separate pianos)

The excerpt is from the first music therapy session. The patient has been asked to choose an instrument (he chooses one of the two pianos in the

music therapy room). He is asked to play a note, listen to it carefully and let the note lead him to the next note. In other words, he is asked to try to direct his attention to the sound of the note, instead of focussing on his preconceived idea of how it is supposed to sound. The patient plays alternately in the high and deep register, avoiding the middle register. He seems to become gradually more absorbed in listening - to immerse himself in the sound.

The music therapist plays a simple repeated note as an accompaniment during the whole improvisation (one note in the middle register of the piano). The notes of the therapist and the patient join together and create harmonies that invite them to focus inwards and listen. The patient's body language shows intense concentration in the improvisation. The music therapist hears quite a lot of intentional contact between the patient and the therapist in the music.

In the conversation after the improvisation, and after hearing the tape of the music, the patient states that he barely heard the therapist's music. However, he had a sense of a musical centre somewhere that he felt drawn to. He knew he needed this centre, in order to allow himself to be aware and present in his own music. In this case, the patient gave his permission for the examples to be used for analysis and research. When he was invited to the clinic 4 years later and listened to this example, he was asked to focus on the contact between the patient and the therapist. He was asked to score his interpretation of the contact on a scale of 1 to 10, where 1 meant no contact and 10 meant very close contact. The music in this example was scored at 9. This shows that the patient's perception had changed significantly through the treatment.

CD example 2: track 4

The therapist plays a metallophone - the patient plays the piano. This example is from session 14. The patient himself now asks the therapist to act as a focus point in the music - or in this case: to be a lifeline, while the patient challenges boundaries - allows himself to take up more space and allows more aggressive energy in the music.

CD example 3: track 5

Both the therapist and the patient improvise vocally.

This example is from session 32. The patient has started to dream very intensely, after not having had dream activity for many years. The patient often starts music therapy sessions by relating a recent dream. He also paints watercolours between sessions. He brings these with him and

says a few words about them in the sessions. Finally, he writes a journal, that he gives to the therapist (his own idea) so that she can read it between sessions. Comments on the watercolours and the journal notes come primarily from the patient himself.

In this session, the patient relates a dream. In the dream he is running around, looking for something. He comes to a barbed wire fence and climbs over it. On the other side there is a frozen lake. In the middle of the lake there is a patch of ice so thin that the patient can see a petrified sea urchin through it. He says that the sea urchin is a part of him that needs to come alive. We decide to try to use our voices to express the sea urchin. This is the first time that the patient improvises with his voice. The therapist attempts to match the patient's pitch and expression. There is a movement from very little vibrato to much more vibrato in the vocal sound towards the end of the improvisation. This can be understood as 'something that is frozen, beginning to thaw'. The therapist matches empathetically and supports the patient in his expression.

CD example 4: track 6

Both the therapist and the patient improvise vocally

This example is from session 42. The patient is now much more familiar with vocal improvisation. The night before the session he has dreamt of a black panther, and this is the symbol that we attempt to express together through our voices. This makes the patient use a much deeper voice, and he experiences this as an expression of something masculine. He also finds that it is much easier for him to make himself heard and "stand alone" with his voice when using the deeper pitch. This gives him the confidence to express himself as intensely and "primitively" as he does in this case. The therapist matches his expression and, through her sounds, she tries to encourage the patient to explore his own boundaries in the vocal improvisation.

CD example 5: track 7

The patient improvises alone vocally

This example is from session 44. The patient uses in this case an integrated vocal sound, which contains both 'light' and 'dark' (vs. high and deep) sounds. The patient feels surer of expressing himself and can do so independently. He feels that his feminine and masculine sides are more alive and present and that they are more integrated.

CD example 6: track 8

The therapist and the patient
both improvise with voice and piano

This example is from the last session - number 57. The therapist and the patient play freely in the **'flow'** of the music. Both of them contribute to the music with new ideas and let themselves be immersed in the music of the moment. There are no defined roles. The therapist feels free to express herself and play her own ideas, inspired by the joint improvisation and without thinking of supporting, amplifying, or accompanying the patient in another way. The music sums up many of the elements that have been expressed in earlier sessions. This is the first time that both the therapist and the patient have improvised vocally and played the piano at the same time.

The patient made his own decision of when to end music therapy. He felt that he now was ready to go out into the world and try out his strength - using his experiences from music therapy. The same patient wrote, by request, the following patient narrative, 3 years after the music therapy ended (patient narratives are not very common in music therapy literature. A good anthology is Hibben (1999). As seen in the following narrative, the music helped the patient to achieve a more "spacious" self-identity and greater personal freedom. Regarding the aims defined at the start of the therapy, **the patient developed more flexible, yet clear, boundaries and a greater degree of autonomy, in this way improving his contact to himself and others - including women. The patient was fully rehabilitated shortly after the termination of music therapy.**

I have included seven of the patient's watercolours, with his permission, as an illustration of some of the inner processes he went through during the course of music therapy. The seven paintings are selected out of a collection of 63 watercolours that the patient brought with him to therapy sessions.

7 of the patient's watercolourpaintings



1



2



3



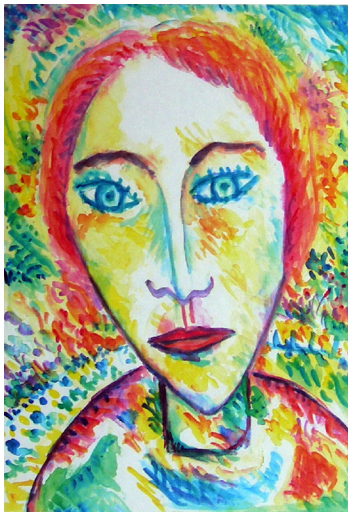
4



5



6



7

1. A little boy reaches out to a mother figure, who is distant. The green man, who is an observer of reality, is the most important figure here.
2. The petrified sea urchin that appeared under the ice in a dream has become a face here. It is still under the surface of the water.
3. The face has now come up above the surface of the water - this creates insecurity in relation to other people.
4. An indescribable anxiety has broken loose and is manifested in dreams and fantasies of devils and snakes.
5. The devil is growing. It can be experienced now both as dangerous and as an important, not acknowledged source of energy.
6. I now experience a better balance between the feminine and masculine sides.
7. I feel much younger now, but much more integrated.

Patient narrative

"The background for my participation in music therapy was a very long period of illness and absence from my job as pre-school teacher; a job that got on my nerves more and more, where I became more and more stressed, nervous and confused from having to relate to so many people and new impressions. Finally, I completely lost perspective, and as a result I constantly forgot what I was in the process of doing. A thorough psychological test confirmed that this job wasn't the right one for me. Based on this, it was suggested (and I accepted) that I start psychotherapy in the form of individual music therapy once a week.

I was nervous when I went to the first session. I wasn't sure of what music therapy was, had never heard of it before. I had also grown up in a very unmusical family, and my experiences in school were limited to getting hit on the head for not singing or for singing out of tune. It took some time, about a half-year, before I started feeling like I could find my own space in the music. Early on, it was the piano that I was drawn to; the piano with its many keys ranging from the very deep to the very high. In the beginning I was most drawn to the dark, sorrowful, melancholy sounds, later lighter, higher notes appeared. First they were opposed to each other, later they began to relate to each other, to play together and dance in and out and around each other. I experienced more and more that there was a space in the music; at the same time my daily life seemed more and more sad and full of anxiety. After a good while, in the course of the therapy, I started using my voice as an instrument; this I especially felt was a breakthrough - something that was difficult but that also gave me direct contact with/access to my deepest feelings. Shortly after this, dreams poured forth, long dream sequences that I wrote down as they came - among others, dreams from the time when I was on LSD, dreams of persecution, dreams where there were strange creatures and animals like crocodiles, panthers, snakes, etc... A lot happened during this period; I felt like a child again, "Palle alone in the world" in a good, new and exciting way. I started being more aware of where I was and what I wanted. Three or four months later I made the decision to end therapy, felt that it was finished, now the time had come to go out into the world again and test my strength.

About three years have gone by since the music ended. Quite a lot has happened since then. I feel that I have changed quite a bit, in some

ways I'm still the same person, but at the same time I have a feeling of being able to "fill myself out" much more today. Earlier I felt like I was a sad, lonely and misunderstood "steppenwolf", sitting in a waiting room, and when I was with other people, I often felt like the spy who came in from the cold. I'm still a "steppenwolf", but now a much freer, more spontaneous, active and cheerful one - instead of a silent and speculating wolf I'm now a wolf, who joins in, barking with pleasure. I've become much better at being aware of my own needs, and the fear of hurting others has moved into the background. The morning crises I used to have, crises that could last all day, and where I felt that catastrophe was lurking right around the corner, have more or less disappeared. Although music therapy officially has ended, I feel that it is still going on. All the experiments, notes and themes that I played out in the music, I now use in different encounters with other people, and it gives me a great feeling of freedom; freedom understood in the way that I have many different keys to play in - many different ways to tackle situations. I still do voice exercises to become aware of how I feel right now, deep inside. This is a good tool for me to relax knots and tensions that are forming.

1.5.1 A transition to the literature review.

A coda

In this article I have written about the transference issues in the psychiatric context illustrated by a detailed case description. Of importance here is my statement, that music therapists in a psychiatric setting relate to a wide variety of patients, including neurotic patients, in the same way a classical analyst would normally only relate to patients with **regressive symptoms**. This means:

.....that the patient can develop and strengthen the self – by continually being seen and heard through the therapist's empathic affirmations and through the musical duets, where the therapist identifies with the client's psychological reality.
(Wigram, T., Bonde, L.O., & Pedersen, I.N., 2002 p.155)

The article further describes how patients with severe relationship dysfunctions and weak egos can particularly benefit from music therapy, as these patient's tendencies to interrupt dialogues can be 'played out' with great effect in musical improvisation. It also addresses how transference relationship in music therapy in psychiatry has a particular quality, by virtue of the sensory experience. **The direct resonance of the music is perceived physically. This sensory aspect vitalizes the 'meeting' between the therapist and the client, which is a crucial part of the relationship process especially with ego weak patients who cannot just verbalise their sensations and feelings. (ibid.p156 – 157)**

Further is the idea developed that the music therapist's way of relating is the key instrument in work with all groups of psychiatric patients by

means of the music therapist being containing, framing and clarifying the here and now relationship musically and verbally. Thus this treatment differs from verbal psychotherapy, where interpretation is the main tool with ego strong patients. Music therapists can be said to relate to all groups of psychiatric patients more similar to the way verbal psychotherapists solely relate to regressive patients. This fact influences both the understanding of, and interactions within counter transference.

So from here I now want to **examine more in detail how other music therapists in psychiatry perceive, react, understand and interpret counter transference in their clinical work**. This has lead me to read and re-read the historical development of the clinical terms **counter transference** and **empathy** through different phases of psychoanalysis and self-psychology.

My clinical experience and readings have helped me develop the preparation guidelines for the semi-structured interviews.

The background of the page is white, featuring several abstract, flowing lines. A single grey line starts from the left edge, curves gently upwards and then downwards, ending on the right. Overlaid on this are several red lines of varying thickness and curvature. Some red lines curve upwards from the bottom left towards the top right, while others curve downwards from the top left towards the bottom right. These lines intersect and overlap, creating a sense of movement and depth.

Sound connectedness

Inner sensations - embodied listening
Sounds emerge from being 'we' and me
surprise and wonder!
disorientation and disintegration
strong emotions waving in and through
the mutual act of playing.

I am present and being informed
I am following the flow of the musical change
a new relation – a new direction?

sounds have the lead
Time is telling – can we both be free?
Are we moving towards a new beginning?

Inge Nygaard Pedersen

Literature review

Introduction

The phenomenon of counter transference is well documented in the literature, and attempting to review the extensive and comprehensive literature would take a disproportionate amount of space for this study. I have therefore tried to be selective and structured the literature in the following way.

- 1 A historical view defining the classical, the totalist and the specifist understanding of counter transference by psychoanalysts and psychotherapists from the theoretical foundations of classical psychoanalysis, object relations theory and interpersonal psychoanalytic theory. Use will be made, where appropriate, of existing reviews and meta-reviews of the phenomenon of counter-transference to avoid duplication of previous research in this area. Each period will be illustrated by more detailed descriptions of a few authors, as counter transference has been understood in many ways (and with many details) derived from theoretical and personal sources, all of which have influenced the clinical practice.
- 2 As the phenomenon of empathy is closely connected to the understanding of counter transference, I will try to demonstrate a linear development in the various definitions and understandings of this phenomenon in a separate part of the chapter.
- 3 As the main focus of my clinical work is within psychiatry, I will try to cite the most relevant and important literature from well known psychiatrists writing on counter transference.

- 4 Finally I will review the music therapy literature with an emphasis on counter transference as understood in clinical work in adult psychiatry.

2.1 Counter-transference in psychoanalysis: a historical view

Langs (1990) summarised introductions to reprints of classical writings on psychoanalysis, among which he found an original paper from the complete psychological works of Freud, where the concept of transference was one of Freud's fundamental discoveries and a major stimulus for discussion of psychoanalytic techniques. In Freud's paper on psychoanalytic technique (1912b) he identifies and clarifies the transference dimension of the patient's relationship to the analyst, and also clarifies the difference between positive and negative transference and how transference is understood to mean a form of resistance on the part of the patient:

thus transference in the analytic treatment invariably appears to us in the first instance as the strongest weapon of resistance, and we may conclude that the intensity and persistence of the transference are an effect and an expression of the resistance. The mechanism of transference is, it is true, dealt with when we have traced it back to the state of readiness of the libido, which has remained in possession of infantile imagos; but the part transference plays in the treatment can only be explained if we enter into its relations with resistance.

(Freud 1912 in Langs 1990, p. 6)

With this revolutionary discovery of transference Freud, on the one hand, added an understanding of mental illnesses based on a psychological explanation and on the other hand gave a definitive meaning and function to psychoanalytic therapy. So even if this clinical concept has been modified through the years it is still at the heart of analytic work.

Freud described transference as a process, through which libido related wishes in relation to certain objects are actualised in the analytical relationship and are experienced with a character of reality.

As pointed out by Diderichsen (1998) Freud's first reaction was to consider transference as a hindrance to the therapeutic process, but he later realised that the force of transference was very valuable in the treatment process in so far as the analyst could interpret the transference phenomenon as an unconscious wish by the patient. Freud based his understanding of transference on the theory of libido and drive theory, and he explained the transference as infantile sexual fantasies transferred from the patient to the therapist. He distinguished between the positive transference which derived from love to the analyst or from a more mild adjustment to cooperation in therapy. The concept of negative transference was derived from the client's 'hate' feelings towards the therapist. This discovery also underlined his clinical understanding of the therapist being in a neutral position to provide a 'clean shield' (which means not showing any emotions or signs of being influenced by the patient's transference) for transferences and using a free floating consciousness. The relation between the therapist and analyst was of an authoritarian nature.

Although Freud did change his attitude and realised that transference, instead of being a hindrance, could be a valuable tool to understand the patient's unconscious dynamic, he never really developed the clinical term **counter transference** in the same way as **transference** - although the development in understanding transference should have an influence in the understanding and function of counter transference.

Back in 1910 Freud introduced the term counter transference in 1910 as follows:

We have become aware of the "counter-transference," which arises in the physician as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize his counter-transference in himself and overcome it.

(Freud 1910, p. 144)

In the same paper Freud prescribed a warning of the self-analysis for the analyst, stating that:

Any one who fails to produce results in a self-analysis of this kind may at once give up the idea of being able to treat patients by analysis

(Freud 1910, p. 145)

Apart from this paper Freud wrote very little on counter transference. But in 1912 he wrote the following widely quoted advise, which I think together with his rather pessimistic idea of self-analysis has coloured and still colours the view of neutrality and counter transference within psychoanalysis and psychotherapy even today:

I cannot advise my colleges too urgently to model themselves during psychoanalytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skilfully as possible....

The justification for requiring this emotional coldness is that it creates the most advantageous conditions for both parties. For the doctor a desirable protection for his own emotional life and for the patient the largest amount of help we can give him today.

(Freud 1912a, p. 115)

So Freud is the creator of the classical view of counter transference which can be described as the therapist's unconscious pathological reactions to the patient that reflects unresolved conflicts which needs to be overcome by self-analysis in order for the therapist to work well with the patient. It is based on an understanding of both transference and counter transference as intra psychic phenomenon and of the therapeutic relationship based on a sick person and a healthy one, where the curing elements are reduced to the analyst's intellectual '**free of emotional influence**' interpretation of the patient's transference neurosis and of the analyst's capacity to be a neutral screen.

2.2 Post Freudians

Several authors have reflected on the lack of literature on the term counter transference for almost four decades after Freud's discovery of the phenomenon, until it came into discussion again.

Tansey and Burke (1989) have found offers of explanation in the literature as the one from Roland (1981) stating that psychoanalysis wished to differentiate itself from **unscientific**, artistic and literary efforts to probe the human mind, and also that the absence of counter transference studies reflected the desire for a strictly objective stance on the part of the analyst so as not to submit patients to the harsh Victorian morality that pre-

ailed at that time. Therefore there can be both a **scientific** and a **cultural** explanation mirroring Freud's training background and milieu. Racker (1957) suggested the 40-year neglect of counter transference was due to a persistence of infantile ideals passed along from one generation to the next, and he argued that transference had been much more carefully studied than counter transference for the same reason that the Oedipus complex of the child toward his parents had been much more closely examined than that of the parents toward their child.

2.2.1 Klein and Object Relations Theory

During the four decades from 1910-1950, three influences gradually established a foundation for raising interest in counter transference. According to Tansey & Burke (ibid. p. 19) these were:

- The development of object relations theory in England.
- The burgeoning interpersonal psychoanalysis movement in America.
- The widening application of psychoanalytic theory and practice to the treatment of children and severely disturbed adults.

The development of object relations theory during the 1930s and 1940s provided a major shift in developmental theory from a '**drive/structure**' model to a '**relational/structure**' model (Greenberg and Mitchell, 1983). Here the work of Melanie Klein had the greatest impact. Klein, unlike important colleagues like Winnicott, Fairbairn and Heimann, remained firmly intra-psychic in her focus throughout. She kept her focus on the child's efforts to adapt to and to defend against instinctual drives emanating from within at '**a fantasy level**' and overall she ignored what could be an impact of real, external objects on the child's developmental experience. She first took over the same idea as Freud, where he considered counter-transference to be a hindrance to treatment. It is not discussed, whether she could also have scientific or cultural reasons for doing so, or if it was solely a matter of idea or belief.

Overall Klein is identified with her creation of the term **projective identification** from 1946 which she described as:

.....a defence mechanism by which the infant attempts to rid the self of destructive, aggressive impulses by projecting these impulses in fantasy into an internalized object, which in turn is experienced as persecutory. By controlling

the object, the infant then feels a sense of control over its own instinctual aggression. The threat is felt to be coming from the outside rather than from the inside.

(Klein 1946, p. 434)

This definition was already modified by Klein's followers – almost contemporary object relation theorists such as Winnicott, Racker and Heimann, who extended the work of Klein first to an exploration of the influence of actual interactions with real objects on the child's psychological development, and second to an examination of the therapist's counter transference as influenced by the patient's projective identification. Thus Klein's definition was much later suggested by Sandler (1987) to be a **first stage projective identification**, while Sandler himself in his own writings refers to his understanding of projective identification as indicating the patient's actual influence in causing the therapist to identify with either the patient's internalised self or object representation – a status of real influence on the therapist's counter transference as a **second stage projective identification**. So Klein's followers shifted from the intra psychic to the interpersonal arena and as such provided a useful bridge between the two realms. They thereby opened up the process for the legitimacy of the therapist to make use of strong, often negative, reactions to a patient, where previously such responses were generally regarded as impediments indicating pathological counter transference.

2.2.2 Heimann

While it could be said that Klein spawned the seed of the later totalist view on counter transference, one of her followers Paula Heimann is credited as the first one who viewed counter transference as constructive rather than troublesome (Diderichsen 1998, Langs 1990). Even though some other contemporary authors such as Reik (1948) and Fliess (1942, 1953) and later Searles (1975) are mentioned in different historical overviews (Langs, 1990; Tansey & Burke 1998), Heimann is remembered as the one who cleared the way for extensive investigations of the analyst's responses to his patient. She uses the term **counter transference to cover all of the responses of the analyst to the patient**, and she suggests that the analyst's pathological responses, while interfering and in need of self-analysis and rectification, can also be used as a means of understanding the patient. According to Tansey and Burke (ibid. p. 23) she is widely cited as having made the landmark statement of the totalist perspective.

She described the analytic situation as **'a relationship between two persons'** (Heimann 1950 p.81) characterized by the presence of strong feelings in both partners. She argued that the term counter transference would properly refer to all the feelings that the therapist has for the patient, since the distinction between **'realistic'** responses and **'distorted'** responses based on past experiences is a very difficult one to make. She applied the same argument to the term transference.

(ibid. p. 23)

She describes her thesis as the therapist's emotional response to his patient within the analytic situation as representing one of the most important tools for his/her work and **the analyst's counter-transference is an instrument of research into the patient's unconscious**. She emphasizes that the analysis presents a relationship between two persons which is recognised by **the degree of the feelings that are experienced, and the use that can be made of them**, these factors being interdependent. As something important for clinicians in training, she states that the aim of self-analysis is to:

enable the analyst to sustain the feelings which are stirred in him/her, as opposed to discharging them (as does the patient), in order to subordinate them to the analytic task in which he functions as the patient's mirror reflection.

(Heimann 1950, p. 81)

She also adds that the analyst, along with his working in a free floating attention,

....also needs a freely roused emotional sensibility so as to follow the patient's emotional movements and unconscious fantasies. Our basic assumption is that the analyst's unconscious understands that of his patient. This rapport on the deep level comes to the surface in the form of feelings which the analyst notices in response to his patient, in his 'counter transference'.

(Heimann 1950, p. 82)

She is warning clinicians not to misunderstand her idea so that self-analysis is no longer necessary. Having said that, she proposes a less author-

itarian or perfectionist view on the purpose of self-analysis in stating that when the analyst has worked through his infantile conflicts and anxieties, he will not impute to his patient what belongs to him self – he will be in a kind of balance where he can carry the roles of the patient's projections. She also re-direct the idea of Freud's demand that the analyst must recognize and master his counter transference - to the idea that the analyst must use his emotional response as a key to the patient's unconscious instead of becoming unfeeling and detached by the '**disturbing**' counter transference. She is pointing at the fact that psychoanalytic techniques came into being when Freud, abandoning hypnosis, discovered resistance and repression. When Freud in his seminal discoveries tried to elucidate the hysterical patient's forgotten memories

.....he felt, that a force from the patient opposed his attempts and that he had to overcome this resistance by his own psychic work. He concluded that it was the same force which was responsible for the repression of the critical memories and for the formation of the hysterical symptom. The unconscious process in hysterical amnesia can thus be defined by its twin facets, of which one is turned outward and felt by the analyst as resistance, whilst the other works intra psychically on repression. Whereas in the case of repression counter-transference is characterized by the sensation of a quantity of energy, an opposing force, other defence mechanisms will rouse other qualities in the analyst's response.

(Heimann 1950, p. 83)

Heimann believes that this way of understanding counter transference experiences will open up investigations to more fully understand '**the way in which the character of the counter transference corresponds to the nature of the patient's unconscious impulses and defences operative at the actual time**'. So she maintains the understanding of the patient's problems to be derived from instinctual drives and defences, but then neglects the idea from Freud, as she understands that this unconscious communication can be in any way understood solely by intellectual interpretations derived from a neutral screen position. She advocates that the therapist is in a fully emotional contact with the patient's unconscious communication. She is therefore the first to introduce the phenomenon of '**sustaining**' the emotions and '**subordinating**' them to the analytic task.

2.2.3 Racker

Another major contribution to the understanding and definition of counter transference comes from a follower of Klein. According to Tansey and Burke, Racker did:

.....illustrate the manner in which a therapist could be induced by his patient to identify either with the patient's self, which he termed **a concordant identification**, or with the patient's internalized objects, which following Deutsch (1926), he termed **a complementary identification**. He argued that although concordant identifications alone constituted the basis of empathy, **both forms of identification should be considered counter transference in its totalist sense**.

(Racker in Tansey & Burke 1989, p. 25-26)

So here the focus is starting to include empathy as a cornerstone for being able to be resonant to counter transference. I also consider empathy as a very important base in my own understanding of counter transference, and I will try to work through the different perspectives and understandings of empathy in the psychoanalytic literature and the literature of the self psychology in a separate part of the chapter.

Racker emphasises that ".....the key is for the analyst to strive to maintain a **'deep and continuous'** contact with himself so as to be as aware as possible of his counter transference position in relation to the patient" (Racker in *ibid.*, p. 26). He argues that without counter transference awareness the analyst was very likely **'doomed to drown'** in his responses to the patient, and destructively repeat the patient's vicious circle, whereas through the counter transference awareness, the analyst is better able to avoid the vicious circles that constitutes the patient's primary problems in human relationships. The awareness of counter transference lays the groundwork for the therapist to become aware of the patient's unconscious efforts to repeat their relational behaviour, which leads to an interruption of the vicious circles and an opportunity to internalize a more positive outcome with the therapist.

Racker also points out that:

.....not only does the counter transference disturb or help the analyst's understanding and capacity to interpret the patient's unconscious conflicts, but by determining the analyst's attitude towards his patient, it also determines the des-

tiny of the transference; for the analyst is the object of the transference and the analyst's attitude represents that object's attitude, which in its turn influences the transference. The counter transference is thus decisive for the transference and its working- through, and is also decisive for the whole treatment.

(Racker 1968, p.18).

His basic understanding of treatment is still the classical '**making conscious the unconscious**' and '**overcoming the resistances**' and he considers psychic problems to be conflicting more than defective. But he is the first psychoanalyst to point out the core importance of the therapist's attitude to be able to be a receiver for the transference of the patient. But he is still, as the former psychoanalysts, emphasizing that both what has happened in the past and what happens in 'here and now' between the analyst/analysand are in play in the counter transference. Therefore he suggests it is necessary to take into account the total counter transference as well as the total transference. I will bring here a longer quotation of Racker bringing a clinical example of a total counter transference situation to connect the clinical terms to a practice situation. The example is Racker's interpretation of a clinical situation described by Wilhelm Reich (1933).

The analysis had long centred on the patient's smile, the sole analysable expression, according to Reich, that remained after cessation of all the communications and actions with which he had begun treatment. Among these actions at the start had been some that Reich interpreted as provocations (for instance, a gesture aimed at the analyst's head). It is plain that Reich was guided in this interpretation by what he felt in counter-transference. But what Reich perceived in this way was only a part of what had happened within him; for apart from the fright and annoyance (which, even if only to a slight degree, he must have felt); there was a reaction of his ego to these feelings, a wish to control and dominate them, imposed by his '**analytic conscience**'. For Reich had given the analysand to understand that there is a great deal of freedom and tolerance in the analytic situation, and it was this spirit of tolerance that made Reich respond to these '**provocations**' with nothing but an interpretation. What the analysand aimed at doing was to test whether such tol-

erance really existed in the analyst. (Author's accentuations).

(Racker 1968, p. 151-152)

In considering this position, Racker goes on to suggest:

Reich himself later gave him this interpretation, and this interpretation had a far more positive effect than the first. Consideration of the total counter-transference situation (the feeling of being provoked, *and* the '**analytic conscience**' which determined the fate of this feeling) might have been from the first a guide in apprehending the total counter-transference situation, which consisted in aggressiveness, in the original mistrust, and in the ray of confidence, the new hope which the liberality of the fundamental rule had awakened in him. I have referred above to the fact **that the transference, insofar as it is determined by the infantile situations and archaic objects of the patient, provokes in the unconscious of the analyst infantile situations and an intensified vibration of archaic objects of his own. (Author's accentuation).**

(Racker 1968, p. 151-152)

It shows some parts of how the analyst or therapist is also struggling with resistances in his own psychic structure of id, ego and superego. Racker emphasizes that **the analyst should avoid as far as possible making interpretations in terms that coincide with those of the moral superego** and also that there is a bigger danger to do so when there is an unconscious identification of the analyst with the patient's internal objects and, in particular, with his superego.

He extends the idea of '**sustained**' emotions in the counter transference as described by Heimann with a further warning:

In our analytic work it occasionally happens that we see and understand something in the patient which seems important to us, but we do not reveal it to him. At times this abstention seems advisable: we feel we are complying with the rules governing interpretation. But at other times this is not the case; we are aware of an emotional factor within us which prevents us from communicating what we have perceived, as for instance, a fear of hurting the patient or caus-

ing him too much anxiety, a fear of losing him or provoking an excessive '**positive**' or '**negative**' transference response. In such cases the doubt may arise as to whether our abstention was really objectively justified or was merely a rejection produced by subjective factors, a '**counter resistance**' opposing the interpretation. (Author's accentuation).
(Racker 1968, p. 149)

He thus brings in the term of **counter resistance** concerning the analyst and rather clearly challenges the classic ideas that a healthy person, the doctor, analyses the pathologic person, the analysand.

As a counter reaction from the so-called classical camp to this proliferation of ideas and publications, exposing the usefulness of counter transference, papers were edited re-emphasising the view that strong emotional reactions by the analyst were to be viewed strictly as a problem. But some kind of integration of the classical and totalist views came from Reich pointing out, that a therapist could indeed learn something about what is going on in the patient's unconscious, through an awareness of what is happening in the therapist's own mind through the process of empathic identification, but it had to be '**partial and short-lived**'. If there existed too strong emotions on the part of the analyst, she believed this was evidence of counter transference, which should narrowly be defined as the analyst's unresolved conflicts and which had nothing to do with the patient.

So emotional intensity became a critical distinguishing factor between the two camps, and Reich argued that therapist's hypotheses concerning a patient, based on emotional responses to the patient, require clinical validation to know if the hypotheses are correct or not. She uses the same word as Freud, the word '**overcome**', in her statement.

The counter-transference as such is not helpful, but the readiness to acknowledge its existence and the ability to overcome it is.

(Reich 1960, p. 392)

The meaning of the word '**overcome**' is not clear just as it was not really clear in the way it was used by Freud. Tansey and Burke (ibid.) discuss whether '**overcome**' means to eliminate a feeling or does it mean to recognize it as being in some way meaningful? Recognizing and understanding the source of the feeling can in some way make it less intense

so the doubt of interpreting the word '**overcome**' also tended to reduce the substantive differences between the classical view and the totalist view. Still beyond a certain point there is a clear difference, and the classical camp argues that an intense response to a patient has passed from the realm of useful trial identification into the realm of pathological counter transference, emanating strictly from the analyst's own past history and having nothing to do with the patient. The totalist view holds open not the certainty but the possibility that, if the therapist is able to pull back and begin to examine the experience of even a strong response, there is the potential to learn something useful about the patient.

So while clarifying the two polarities in understanding counter transference, for me the question still remains as to how a therapist knows whether an emotional response, either mild or intense, is a private problem or a useful clue?

2.3 Kohut and Self Psychology

According to Tansey and Burke (1989), there was a second dormancy of significant papers on counter transference from 1960 to the mid-1970s, but throughout this period a gate opened for the next period where the focus changed from the more moralistic way of arguing to an examination of the therapist's experience of the therapeutic interaction in terms of refining definitions of empathy and projective identification. One major contribution to the understanding of empathy was Kohut (1959). Kohut is the founder of the self psychology based on his emphasis and redefinition of empathy as the operation that defines the field of psychoanalysis. He describes it as:

.....a value-neutral tool of observation which (a) can lead to correct or incorrect results (b) can be used in the service of either compassionate, inimical, or dispassionate-neutral purpose, and (c) can be employed either rapidly and outside awareness or slowly and deliberately, with focused conscious attention. We define it as 'vicarious introspection' or, more simply, as one person's (attempt to) experience the inner life of another while simultaneously retaining the stance of an objective observer.

(Kohut 1984, p. 174-175)

He argues that self psychology has not provided psychoanalysis with a new kind of empathy but it has provided it with new theories which broaden and deepen the field of empathic perception. Kohut does not see the value of automatic confrontations '**confrontations should be used sparingly**' in psychoanalysis, and he argues that the patient's need is to be recognized and accepted in his reality. Kohut emphasizes that with the advent of self psychology

.....the analyst for the first time is able to be empathic not only with the patient's inner experience of the analyst as a target of love and hate, but also with the patient's transference experience of himself as a selfobject. Thus, through self psychology, the analyst acquires the ability to be empathic with the patient's inner experience of himself as part of the analyst or of the analyst as part of himself.

(Kohut 1984, p. 173)

The self psychologist confirms that ".....the validity and legitimacy of the patient's own reality, however contrary it might be to the accepted view of reality held by most adults and by society at large..... It is not the task of the analyst to educate the patient via confrontations, but via the consistent interpretation of the self object transferences, to cure the defect in the self." (ibid. p. 172) **Thus the patient's reality is the only reality that matters in the clinical situation.** He also stresses that in the analyst's continuously repeated move in position from understanding to explaining, his essential activities in each of these positions are based on empathy.

Trained as a doctor, psychoanalyst and psychiatrist, Kohut emphasizes that in work with severely traumatized patients, the understanding phase of treatment must remain the only phase for a very long time and sometimes only the analyst's willingness to be an attentive silent listener will be tolerable to the patient. Kohut was developing his theory primarily from work with patients with narcissistic personalities and behaviour disturbances but he has also described his understanding of self psychology in work with other patient populations.

So Kohut emphasized the important role of **empathy as the therapist's mode of observation for scientific inquiry** in psychoanalysis as did Freud with his term of **neutrality – the blank screen** – about 50 years earlier. Kohut is aware of the risk for popular misunderstanding of the word empathy which could on the one hand be compared with sympa-

thy, being friendly etc, while on the other hand could be seen as something mysterious - as a sixth sense. He is trying to define the term very exactly and takes it for a scientific term. According to Karterud (2000) Kohut draws a parallel in stating that we talk about **physical phenomenon when our senses are the mode of observation**, whereas we talk about **psychological phenomenon when introspection and empathy are the most important parts of our observation method**. Kohut further ".....develops the clinical terms '**vicarious introspection**', '**transmuting internalization**' and '**phase adequate optimal frustration**' (Thielst, P. 1998, p. 49, author's translation). Kohut had a specific and scientific definition of the term empathy and his theory served as a springboard for the increased interest in the perspective of self psychology and the role of empathy.

2.4 The Specifist Movement

Before I enter the next section of this chapter focussing entirely on the role of empathy in understanding counter transference, I will briefly present a third camp: '**The specifist movement**'. (Tansy and Burke 1989, p.33) This movement can be seen as a second re-awakening of strong interest in counter transference in the mid-70s. This interest has been stimulated by developments in the area of understanding empathy and projective identification and described by among others Grotstein, (1981), Schafer (1983) and Sandler (1987). These authors once again seemed to try to classify the therapist's experience of identification as counter transference where empathy and projective identification increasingly are conceptualized as '**aspects of counter-transference**'. Here again there is a belief, as the one existing in the totalist view, that strong emotional reactions to a patient are not necessarily pathological and the whole discussion seems to aim less towards whether a therapist should or should not have a given reaction to his patient, and more towards the specific kinds of identifications the therapist has undergone, the manner in which they arose in the therapeutic interaction, and their degree of applicability to the patient's problems.

So overall there seems to be a reduction in viewing these terms strictly as belonging to a defined science, the science of psychoanalysis, to a more phenomenological and pragmatic view of the terms. The aims of the '**specifist movement**' are: **to categorize and classify the varieties and identification experiences for therapists under the overarching rubric of counter transference**. Examples are:

- Winnicott (1949) classifying **objective** versus **idiosyncratic** counter transference
- Reich (1951) classifying **sublimated** versus **pathological** counter transferences.

Other categorisations of counter transference responses were brought by Cohen (1952) who differentiated three types of responses arising from situational factors

- in the analyst's life,
- from the analyst's neurotic vulnerabilities,
- from anxiety generated by the patient that the analyst has incorporated in some manner.

Overall since 1970s the specifist movement has employed five dimensions for differentiating types of therapist identifications:

- 1 The degree of the therapist's consciousness or lack of consciousness of the experience;
- 2 The degree of the therapist's control over the intensity of the experience;
- 3 The degree of separateness or differentiation of ego boundaries maintained by the therapist through the different stages of the identification process;
- 4 The type of introjection involved;
- 5 The question of whether the identification is with the patient's internalized self-representation (concordant identification) or with the patient's internalized object representation (complementary identification);

(Tansey and Burke 1989, p. 35)

So the specifist movement seems to come closer towards looking at the different variables in the counter transference situation and is not so much being influenced by belief systems or moralistic ideas questioning,

whether strong emotions are allowed, or whether they are useful or not useful.

I will come back to further categorisations of counter transference during the thesis. Back in the 70s some efforts in the area of validation of counter transference took place concerning demonstration of the existence of counter transference or on the impact of these reactions on the psychotherapeutic process among others Singer and Luborsky (1978.) There was no attempt to develop a procedure for validating hypotheses concerning responses as they occur in the clinical setting. According to Tansey and Burke one reason for that may be, that the counter transference material is the most difficult to work with in a reliably way, because of all the varieties of source material from which clinical hypotheses are constructed. This is because the therapist is at the experiential centre of that which he is attempting to examine with a necessary degree of 'objectivity' so:

.....he is required to objectify his own subjectivity, a task that is fraught with many more and deeper pitfalls than other sources of clinical inference.

(Tansey and Burke 1989, p. 112)

2.5 The definition and role of empathy

As mentioned above Kohut was the one who emphasized the role of empathy as the research tool in psychoanalysis and he is the founder of self-psychology, which has provided psychoanalysis with new theories, which makes it possible to broaden and deepen the field of empathic perception.

Maroda (1998) reflects in her book **The Power of Counter-transference. Innovations in Analytic technique** on the analytic authority and also on the major use of intellectualization in psychoanalytic techniques;

.....The overemphasis on intellectualization often resulted in analysts who focussed inappropriately on thoughts when it would have been more therapeutic to understand and communicate how their patients were feeling

(Maroda 1998, p. 20)

She points out that Kohut was giving an emotional relief to many therapists because of his emphasis on using and defining empathy. But she is also critical towards his notion of empathy as one important aspect of self-psychology, because she thinks it has been over-used and over-applied. She points out that

.....Empathy is of tremendous value in the early stages of treatment, particularly in the first six to twelve months when the patient is often in acute distress and needs to know that the therapist understands him before proceeding to other analytic tasks.

(ibid. p. 20)

She also emphasizes that use of empathy can become anti-therapeutic and can be a hindering for the emotional growth of the patient and she warns against many analyst's simplistic application of Kohut's ideas with an over-emphasis on empathy. She argues that neither being truly neutral or being truly empathic all the time may meet the needs of the patient and she advocates that:

.....to focus on the nature of the interaction and the emotional states of the therapist and the patient at the moment to determine what approach is most helpful within the realm of what is genuine and humanly possible. The idea is to approach treatment with no absolute rules about, how it should be done and no assumptions about what a given individual needs. This is done in the interest of being optimally responsive rather than fixing on a specific stance, like neutrality or empathy.

(ibid. p. 18-19)

Further she emphasizes the problem of the confusing way of using the term 'empathy'. She points out:

.....A dichotomy exists between an empathic stance, which could conceivably be reflected in any type of intervention, and an empathic response, which typically means that the therapist communicates to the patient what he believes the patient is feeling at the time. Some are even now insisting that empathy is a kind of interpretation, adding further confusion to an already existing mess.

(ibid. p. 18-19)

She is an advocate of active use of strong emotions in counter transference responses and she presents an example showing, how Kohut was very angry at a patient (calling him 'You idiot'), when the patient told about his self-destructive behaviour. This is an example of use of an empathic stance with a confronting technique. The patient felt good about the analyst's care for his life even if it was expressed in a confrontational way.

She is into the discussion of the use of empathy as a psychological term which can be misunderstood and misused, while at the same time as it is absolutely a core term in the understanding of psychoanalytic treatment.

2.5.2 Empathy as a psychological process

In the book on '**psychology of empathy**' written by The Danish Professor Judy Gammelgaard (2000), she argues that the term empathy originally developed from descriptions of experiences of art, and that the German Philosopher Theodor Lipps took up the term and further elaborated it in order to systematically explain, how human beings could enter the spirit of, understand and experience the emotional life of another human being. He was neither romantic nor religious and his basic understanding is, that it is through empathy, that human beings understand each other, and that it is the ability of empathy, that convinces human beings that they have a self and that other human beings exist with their own self.

Lipps was living contemporary with Freud, and Freud admired him. Freud took over the term empathy from Lipps and made it a technical term in his analytical method. For Freud it remained an intellectual operation to empathically understand and interpret the unconscious of the analysand. Lipps made the term **a core term in explaining how human beings are able to familiarize oneself with the emotions of another human being** and it is in connection to Lipps' notions of empathy, that the discussion of kinaesthetic perception as part of the empathic action has arose. Lipps himself did not consider empathy as being based on kinaesthetic perception though. For Lipps' **empathy was a matter of understanding through emotionst.**

Lipps (1903 in Gammelgaard 1990) refers to three areas of 'knowing something' or science with three corresponding sources of knowledge:

- 1 The substantial (materialistic) things/ perception of senses.
- 2 My self/ inner perception.
- 3 Other human beings/ empathy.

But empathy is also present in the first area, it is only absent in the second. So he is similar in thinking to Emanuel Kant, who is talking about a **'subject who perceives'** and about an **'object for the subject's perception'** ".... we neither hear nor see other peoples feelings, thoughts or drives we only register our own." (Lipps in Gammelgaard, p. 22)

2.5.3 Empathy as emotions

Lipps defines empathy as emotions, but we as human beings experience empathy as something belonging to another human being, or a subject, or a piece of art – something outside ourselves. Thus he is introducing the new idea that the access to another human being's inner life has a dimension of experience, which has nothing to do with intellectual evaluations or interpretations and which is in no way a rational event. Empathy is a matter of feeling and not a matter of understanding or evaluation. Thus the results of empathy cannot be a subject for validation in the traditional means of proving it as a truth, as the demand for truth is always rational.

In this aesthetic and humanistic form for empathy the emotions are absolute and the knowledge and reflection are partly suspended, as the aesthetic and relational realities have an illusory character. Therefore meetings with art and other human beings can be a mirror for a depth in the register of emotions in our soul, which we normally do not experience in every day life actions.

He is defining his understanding of the lively expression as based on the instinctual drive of the human being to imitate on the one side - and the instinctual drive of the human being to express one's own psychic experiences in a distinct way on the other side. These two instincts are always cooperating and presupposing each other He defines the action of empathy as follows:

.....when I see a facial expression A – it might be sorrow – it happens that this expression awakes an impulse in me to imitate the movements which are present in the sorrowful face. These movements are on their part the natural ex-

pression for a certain emotional condition – in this case sorrow. The condition and the movement impulses in question constitute a kind of unit. Consequently the movement impulses, which are induced in me through my observation of the sorrowful face, will also contain the tendency towards this emotional condition. This tendency will be acted out when possible, which might be when I have already once experienced this condition, and this condition thus has become my mental property.

(Lipps 1903, p. 193, in: Gammelgaard 2000, p. 24.
Author's translation)

So when I (the author) can reproduce an emotion, which is expressed through the body language of another human being, in my inner life, then this is because of the fact, that emotions will express themselves spontaneously, and in their expression I see the contour of the emotions. I know that this emotion is created by a mental activity, which I re-create in my experience in my own inner life – not as a copy – but as a sensed contour with a certain emotional quality. To enter the spirit of the emotions of another human being it is, according to Lipps, not necessary to reproduce the movement impulses, I sense, into the other human being's expression. So for Lipps empathy is not based on kinaesthetic perception, as it was for other contemporary philosophers and psychologists (i.e. Lehmann 1913). For him **empathy is something original and fundamental in the human psyche, which is not dependent on anything outside the self – it is simply an emotion which is entering into the spirit of someone else or something else**. So just as Lipps is suggesting that the instinctual impulse to movement imitation is something that is not actually taking place, Gammelgaard is emphasizing this pre-action of empathy more concrete in stating, that she is being influenced by someone or something from outside. Gammelgaard suggests that **the bodily imitation is understood as the first step of empathy**, as she often registers a bodily imitation or the tendency to an imitation by herself, when she sees a certain expression in her analysand. She is not in doubt that **through this bodily imitation she can gain access to an emotional condition in the inner life of the analysand. But she empathises that this imitation is only a first step and not real empathy**.

So in Gammelgaard's description I (the author) can see an attempt to include perceptual and emotional experiences in entering the spirit of another human being, in what I would call **a way of understanding the experience of counter transference experience as a step by step experi-**

ence in the clinical setting. In my article **From in-side or from out-side** from 2000 I am setting up different descriptions of being influenced in the act of entering the spirit of another human being in the therapist role. I am reflecting on '**therapeutic presence**' defined as '**disciplined subjectivity**' or '**professional empathy**' and I am also reflecting on '**being present**' as an **interactive level of emotions**, where the therapist and patient resonate in a common pulse and a common dance:

.....through an embodied 'flowing through' listening attitude, or from the inner centre of one's private space.
(Pedersen 2000, p. 115)

Gammelgaard further describes the second step in her understanding of empathy in saying that although she is entering into the spirit of another human being through movement imitation and the following contour of a stance of emotion - as for instance angeriness - she might not experience the angeriness of the patient. **The analyst needs to have access to his/her own emotional life and here he/she must know about being angry to be able to be really resonant to the emotion of the analysand.**

.....although I have to be able to tune my emotional strings of my psyche to be able to accompany the emotions of the other person, I must be able to distinguish, what belongs to me and what belongs to the other.
(Gammelgaard 2000, p. 28. Author's translation)

Gammelgaard distinguishes between:

- 1 a positive sympathizing empathy where the impulse to experience a certain emotion is not in conflict with what I know about or can easily accept and
- 2 a negative empathy where my impulse to experience a certain emotion is strange to me or in conflict with what is tolerable to me.

In the first case – the experience of the positive empathy only I, as my self, exist, and I am projecting my self into the other – this is also what is called an identification.

In the second case - I feel separated from the object and I am dividing into 'me' and 'you', where I am conscious about the existence of the other individual. As in close relationships one doesn't have to care about the other, when there is love and no conflict, but when anxious or hostile emotions are present, the other is taken over more space in my inner life than my own self, which is likewise over-shadowed by the former.

As a very clear illustration of the different steps in experiencing empathy Gammelgaard recalls a story by Hoffmann from 1981. He says:

A small child A is observing another child B crying. The reaction of the child A in this early phase of development is, that child A also starts crying. Here we can talk about emotional infection. Then child A tries to help the crying child B: The help includes in the first time that the helping child A calls for her own mother. Child A is now distinguishing between me and the other, and she understands that she is not the one who is unhappy. But except from knowing, that she is not the one who is unhappy, the child also seems to understand that child B needs something. Child A has obtained the ability to place itself in the place of the other. Or otherwise expressed it can sympathize with the feeling, which is awakened in its own emotional life. Still it cannot use this sympathy for an objective registration of what child B needs. For child B needs it's own mother and not the mother of child A.

(Gammelgaard 2000, p. 55-56.

Summarising a story by Hoffmann 1981.

Author's translation)

This story can be seen as a metaphor on how several levels of empathy exist and also that a more complex form of empathy is developed through a more simple form of empathy.

So generally one can say, that the simple form, where we spontaneously can experience a face as happy or angry, there the face is a sign, which for our spontaneous experience is pointing towards a certain emotion. Whereas in the more sophisticated form of empathy which especially Lipps has studied, concerning aesthetic experiences, the difference is that **empathy is not experienced through a sign but through a symbol – not through a lively human expression but through a symbolic expression** as for instance a picture, a sculpture or a piece of music. So this descrip-

tion I think is very important and helpful in understanding how we, as music therapists, can empathically seek to understand what is going on in the patient through musical improvisation in our counter transference experiences.

Likewise Kohut is talking about two forms of empathy – the one which concerns an emotional connection between human beings, which makes us capable of meeting other people in a containing and accepting way. The other form of empathy is an experience or form of observation applicable to study the inner life of human beings. The latter form is also described as a professional, sophisticated ability which means, that through a well developed access to one's own inner emotional and fantasy life, one can have the ability to vicarious (through vicarious inspection) sense and understand, what is going on in the inner life of another human being. The development of this ability is dependent on **a balanced relation to one's own emotions and fantasy creating on the one side – an openness towards one's inner life - and on the other side - creating an ability to temporarily use oneself in order to become absorbed in the other.**

2.5.4. Empathy as Affective Attunement

Another term in self psychology which is close to empathy is Daniel Stern's (1991) term of **affective attunement**. This phenomenon also starts with emotional resonance or emotional infection but **in affective attunement the emotional resonance is adapted to another form of expression and thus it doesn't have to move to an empathic knowledge or reaction**. It is, according to Stern, an independent form for affective interaction or communication, but still it is the basic source for the child's further development of empathy. So, as affective attunement takes place in an emotional dimension, **empathy as defined by Kohut and Lipps in Gammelgaard (2000) takes place also within cognitive processes and is a far more advanced development of a child's self.**

So using empathy in psychiatry means to work with human beings, who often cannot express their emotions lively as signs that other human beings can be connected to. They are isolated and we as therapists have to use a sophisticated form for empathy to understand the symbolic expression of the patient's music. Also the music therapy work includes work with their inner fantasy world, which often seems to be filled with strong emotions like anxiety, hatred, rage, fantasies of attacking others and anxiety for the revenge of others. But I also often experience em-

pathically that the patients desperately want reparation and desperately are deeply longing for reconciliation and integration.

In the next chapter I will review what some of the most known psychiatrists have written about counter transference in psychiatry.

2.6 Counter transference in psychiatry

The theory book *Dynamic Psychiatry* by the Swedish psychiatrist and psychoanalyst Johan Cullberg (1993), which is used as a foundation text in many educations in Scandinavia (among others the Master Programme of Music Therapy at Aalborg University), counter transference is divided into three identified elements, namely; **empathy, counter reactions and real counter-transference**. Through this differentiation the problem of whether a classic or a totalistic understanding is applicable in psychiatry can be addressed. Cullberg emphasizes the fact that listening to one's own emotions during treatment of patients is very important. He points out that a therapist using empathic reactions or complementary reactions can't replace a 'parent who was not there', but **the way the therapist interprets his/her complementary emotions and relates them to the patient's needs in the here and now relies on the therapist's insight, tact and experience**. He recognises counter reactions as the emotions which can be activated by the therapist as a reaction to normally neurotic or borderline needs that are not expressed through words, but through a position or behaviour. Particularly threats of suicide can activate strong emotions of rage which need to be contained within supervision or in the team. He also emphasizes that a good training, understanding of oneself and supervision is important in order to control such emotional reactions. Finally he defines real counter transference as the therapist's transferences towards the patient and he points out that **the therapist's unconscious problems are just as important to understand from the reaction as is the problem of the patient**. As an example he mentions that older psychiatric patients may often be indicated for more medical treatment and less talking and being listening to, as they might be identified as representations of parent figures, which in the fantasy of the psychiatrist cannot have 'normal' psychological needs. Overall he emphasizes **the importance of making emotional reactions conscious to be able to use the emotional life of the therapist, as this is the most important instrument in psychiatric work**. This indicates that the therapist must achieve as good a developed self-understanding as possible through self-analysis or psychotherapy and through sufficient super-

vision when working with different patient populations (Cullberg 1993, summarization of p. 498 – 502).

From the field of dynamic psychiatry Glenn O. Gabbard emphasizes the thinking of Racker in saying:

.....just as patients have transference, treatment staff have counter transference.

(Gabbard 1994, p. 12)

Since every current relationship is a new addition of old relationships, it follows logically that counter transference in the psychiatrist and transference in the patient are essentially identical processes – each unconsciously experiences the other as someone from the past. The difference lies in how the feelings are handled in the therapeutic encounter. Gabbard points out that **dynamic psychiatrists do not respond to the transference with the same actions as everyone else**. Instead an attempt is made to determine what past relationship is being repeated in the present. In that respect he says:

.....dynamic psychiatrists are defined by what they do not do as much as by what they do.

(Gabbard 1994, p. 12)

In his short review of the considerable evolution the concept of counter transference has undergone since Freud he accentuates Winnicott who noted

.....in work with psychotic patients and those with severe personality disorders a different kind of counter transference appears, namely what he called **objective hate** because it was not a reaction stemming from unresolved unconscious conflicts in the treatment staff person, but rather a natural reaction to the patient's outrageous behaviour. It is objective in the sense that virtually everyone would react similarly to the patient's provocative behaviour.

(Gabbard 1994, p. 13).

Gabbard highlights the fact that a broader definition due to Kernberg (1965 in Gabbard 1994, p. 13) is gaining greater acceptance particularly

.....because it helps characterize the work with severe personality disorders, which are an increasingly common segment of the dynamic psychiatrist's practice.

(Gabbard 1994a, p. 13)

So the idea of viewing counter transference as unresolved problems in the treater that require more analysis – is replaced by a conceptualization that views counter transference as a major diagnostic and therapeutic tool “.....that tells the treater a good deal about the patient's internal world.” (Gabbard p. 13).

He further defines that the dynamic psychiatrist's personality is acknowledged as having an influence on the patient. This is a principal area and this area often remains miserable in spite of better medication and knowledge in neuroscience. He also proposes ideas regarding which patients could benefit the most from dynamic psychiatry, and for whom it is particularly useful:

.....with personality disorders, the paraphilias, some anxiety disorders, most eating disorders, and with treatment-resistant Axis I patients, who do not respond to conventional biological treatments. Patients with dual diagnoses on Axis I and Axis II are also in need of a dynamic approach.

(Gabbard 1994a, p. 24).

He refers to a survey made by Langley and Yager (1988 in Gabbard 94) where it was found that the second most highly regarded skill among both private psychiatric practitioners and academic psychiatrists was the ability to:

.....recognize counter transference problems and personal idiosyncrasies as they influence interactions with patients and be able to deal with them constructively

(Langley and Yager, p. 471 in Gabbard 1994a, p. 24)

Finally Gabbard identifies the dynamic approach within psychiatry as the only one that systematically addresses the psychiatrist's conscious and unconscious contributions to the process of treatment and evaluation. Gabbard has comprehensively written about the understanding and use of counter transference with a great number of psychiatric patients illustrated with clinical examples (Gabbard 1989, 1994a, 1994b).

2.6.1 Counter Transference and Borderline Patients

Most literature on counter transference in work with borderline patients is written by Gabbard and Kernberg. Gabbard is advising therapists, working with borderline patients, to empathise with the patient's impulse to split off good and bad self- and object representations, and to project the bad outside the self as a way to control it and keep it from destroying the good representations. Thus the therapist should contain the patient's projected hateful parts and not interpret until the patient is once again able to own these projected aspects. Until that time, transference interpretations are unlikely to be understood by the patient. **So containing the projected parts of the patient and reflecting on the nature of these projections will help the therapist understand the patient's internal world** (Gabbard and Wilkinson 1994). Therefore ongoing attention to the limits of one's own feelings, regarding how much hatred or anger is tolerable, is necessary. Gabbard states that if the therapist closely monitors counter transference feelings, this limit can be handled constructively rather than destructively. He also admit that the most difficult task in work with borderline patients is the task of realising and controlling one's own identification with the patient's projections, as these projections can create a strong force experienced by the therapist as being into a 'freezed dance' with the patient, where none of them can get out again. So it is important for the therapist to learn to 'carry' and 'contain' the primitive emotions coming up instead of acting them out automatically. The therapist can feel like been possessed by the patient's force and in this case the therapeutic task, for the therapist, includes to find a way to come back into his/her own thoughts and emotions again. So further to be able to contain one should also be able to 'free oneself from the possession' well knowing, that it is a very important part of the therapeutic process and thus not just a defensive act by the therapist.

Simultaneously therapists must be real in genuine with borderline patients, or they will only increase the patient's envy of them as saintly figures that are basically nonhuman.

Many psychiatrists and psychoanalysts have emphasized the usefulness of counter transference in work with borderline patients. The first real handbook in this area was *Psychodynamic Psychotherapy of Borderline patients*, (Kernberg et al 1989/ in Danish 1992). This treatment is based on an ego-psychological, object relations theory approach creating a psychoanalytically oriented psychotherapy based on transference interpre-

tation. Concerning current understanding of counter transference, the totalist understanding includes categorizing different areas of the totalist view. In the handbook, the categories include '**neurotic**' reactions and '**realistic**' reactions. The former is similar to classical reactions, that are here differentiated into:

- a Reactions towards the transference
- b Reactions on the patient
- c Reactions on the treatment process

The latter (realistic reactions) is differentiated into:

- a Reactions on the patient during therapy sessions.
 - b Reactions on the events in the patients life.
 - c Reactions on events in the therapists life.
- (Summarization of Kernberg et al. 1992, p. 76-77.
Author's translation)

It is said that almost all counter transference reactions are a mixture or a combination of more categories and that the broad definition are there to promote the analysis of the components of counter transference. They also use Racker's differentiation of concordant or complementary reactions to empathically get information about the patient's inner self and object representations. They point out that the therapist's ability to get something constructive out of emotional reactions to the patient depends on learning to impede the impulses to act on the counter transference, and to obtain information from it to avoid repeating vicious circles from the patient's past. They also emphasize as an important ability on the therapist's part, that he should be able to accept all kinds of emotions and thoughts coming up to avoid repression or acting out. The risk of such unconscious counter transference reactions could be:

- A lack of empathy towards the patient.
- Too much involvement or neglect of the patient.
- Being drowsy.
- Being bored.
- A wish to get rid of the patient.

- Paranoid reactions or guilt feelings.
- Sexualising the relationship.
- A feeling of paralysis.

(ibid. p. 79. Author's translation)

There is a follow up by the group around Kernberg concerning this kind of psychotherapy based on transference interpretation with borderline patients in **A Primer of Transference-Focused Psychotherapy for the Borderline patient** (Yeomans et al., 2002). In this book they clarify three channels of communication in the treatment work:

- 1 The verbal content of the patient's disclosure, or simply put, what the patient says
- 2 The patient's nonverbal communication: how patients say what they say (tone of voice, speech volume etc) and patient's body language (posture, facial expressions, gestures, eye contact, etc)
- 3 The therapist's counter-transference, which may be the most subtle channel of communication.

Counter transference is defined as the therapist's total emotional reaction to the patient at every point in time. It is complex phenomenon in that it is determined by four factors:

- a The patient's transference to the therapist.
- b The patient's objective reality (the therapist may be concerned about or have other reaction to the circumstances of the patient's life).
- c The therapist's own transference dispositions as determined by his or her internal world (it is because of this aspect of counter-transference that a therapist must be aware of his or her own habitual reactions. In order to ensure such awareness, it is advisable for therapists to have their own psychoanalysis or psychotherapy).
- d The reality of the therapist's life (e.g., is the therapist's practice "slow," and is there pressure to "keep" a case because of the income involved?)

(Yeomans et al 2002, p. 111)

It is emphasized that the more primitive the pathology, the more important are the second and third channels – the nonverbal and the countertransference. Therefore counter transference is a particularly important source of information in working with borderline patients, because of their split internal world. Even if borderline patients are aware of what they are saying and feeling they are not aware of the internal contradictions or of split-off parts which never pass through their awareness, but are only expressed through action or somatization.

These statements clearly support my own experiences from more than ten years of experience of working in adult psychiatry.

The counter transference may either be concordant or complementary where the former will occur when

.....the therapist experiences an affective identification with the patient's current subjective affective experience (which the patient may be more or less clearly aware).

(Yeomans 2002, p. 112)

In summary, they talk about a communication between the patient's current self-representation and the therapist's empathy and the therapist learns how the patient feels through a trial identification. When a complementary counter transference takes place there is an identification with the object representation included in the currently active dyad, and it may provide a better feel for the patient's split-off internal objects, and thus, for the totality of the current dyad.

They are emphasizing that **therapists who are trained to listen carefully to the patient's associations, but who are not attuned to precise and subtle observation of the patient's interaction with the therapist and of the counter transference, can go for long periods without making any progress in therapy.**

2.7 Counter transference in music therapy: an introduction

Research in music therapy in psychiatry has been done using both QUANTITATIVE AND QUALITATIVE PARADIGMS OF ENQUIRY. As this study is researching events in improvisational music therapy as experienced by the therapists, I will only mention a few examples of studies within the different

traditions of research in music therapy, which have been identified and reviewed by (Wigram et.al 2004), before I review the literature primarily concerning counter transference in music therapy in adult psychiatry.

In the research tradition of RANDOMIZED CONTROLLED TRIALS, Odell-Miller et al.(1996) have been measuring symptomatic and significant life changes for people between the ages of 16 – 65 with continuing mental health problems. In this study the numerical conclusions were not conclusive but the qualitative data revealed interesting facets of the process, for example that the therapist and patients perceptions of the treatment coincided in all treatment cases.

Within the tradition of CASE-CONTROLLED TRIALS several sources are available among others Kahan and Calford (1982) who examined the influence of Music on Psychiatric patients' immediate attitude change toward therapists. Significant attitudes changes were found when the therapist conveyed a preference for the particular music to the audience. Another example is Pavlicevic. et al. (1994) who examined whether improvisational music therapy can play a significant role in improving the general clinical status and interactive capacity of chronic schizophrenic patients receiving improvisational music therapy for 10 weeks. They showed that subjects who attended regular, weekly individual sessions showed a statistically significant improvement in their clinical state as measured by the BPRS, compared to the control group.

From CLINICAL NON-CONTROLLED TRIALS, Heaney (1992) made an evaluation of music therapy and other treatment modalities by adult psychiatric inpatients, where participants were asked to rate music therapy compared with other activity therapies, traditional therapies, medication and general aspects of care providing during hospitalization through multiple evaluation scales. Results from one-way analyses of variance showed that music therapy was rated significantly higher than art and recreation therapies on the pleasurable / painful scale, but not on other scales. Activity therapies taken as one aspect were rated higher on several scales than other therapies, and they were not rated significantly less important or successful than medication, which was rated highest on these scales.

Within QUALITATIVE RESEARCH Moe (2000) did a study concerning music psychotherapy based on Group Music and Imagery method. The model used is based on patients' listening experiences during selected primarily classical music specifically designed for an inpatient setting. The music listening is supported by verbal guiding from the therapist to help the patients to focus. Nine patients diagnosed as schizophrenic or with

schizotypal disorders participated in a therapy group during 6 month period and the study focused on restitutional factors in the therapeutic process and the patients' evaluation of their therapy.

Research studies in the tradition of CLINICAL PROTOCOLS have been published on many different patient population such as acute psychiatry (Davies & Richards 1998; Goldberg 1989), for people with eating disorders or anorexia nervosa in an inpatient setting (Justice 1994; Parente 1989).

Within the tradition of CASE STUDIES Aigen (1990) reported a case of two years of individual music therapy with a woman diagnosed with elective mutism where he aims to illustrate an alternative approach to describing the clinical process, where the therapist's experience is of central importance, rather than interpretation through existing psychological systems. Many therapists have edited THEORETICAL PAPERS with case examples either in the form of articles or book chapters. One important text in this field is **Clinical Applications of Music Therapy in Psychiatry** (Wigram & De Backer 1999) which illustrated theoretical thinking in the context of individual cases that also report music therapy method to a certain degree. A recently edited book, **Psychodynamic Music Therapy: Case Studies** (Hadley 2003) is a good example on how case studies are mostly brought with a specific theoretical perspective. I have already in my five pre-edited articles reviewed De Backer (1996) and Jensen (1996).

2.7.1 Transference and Counter Transference in Music Therapy in Psychiatry

I want here to briefly mention Hannibal (2000, 2003), Storm (2002) and Metzner (1994, 1999, 2003), before going more deeply into the three music therapists who have written most comprehensively focussed on counter transference as it relates to psychiatric and other traumatic sufferings (Bruscia 1998a-d; Priestley 1975, 1994; Scheiby 1998a-b, 2005.)

Hannibal wrote a dissertation (2000) investigating methods to describe transference processes in the music therapy context in general and in the musical interaction specifically. His primary focus is the connection between theory and clinical practice and the secondary focus is the development in the therapeutic process. His work is primarily based on the theory of Stern. He found that Stern's theoretical concepts can be used as a common theoretical basis to describe relational patterns in both the verbal and the musical interaction; that transference patterns in the verbal

context emerge in the musical context, and that transference patterns developed in the musical context, also appear in verbal dialogue. Finally he found that both conflict and other relational patterns emerge in the musical context. He concluded that musical interaction has a psychotherapeutic potential because the client/therapist relationship will reflect typical relational conflict patterns. The musical relationship is moreover able to enhance both conflict- and positive transference. He also found that the client's development can be observed in the music. Hannibal (2003) elaborated on these findings when applying his theories to a case study with a speechless and self-destructive woman. In an oral patient report three months after termination of therapy, she expressed that the music, and the interaction in the music with H as her therapist had been a key factor in the development of her ability to communicate and interact. The article focused on the way her transference relationship with the therapist emerged in the relationship both within and outside the musical context and how it changed.

Storm (2002) developed a four phase model in her work with a deeply psychotic woman going into psychiatric treatment for the first time who was without any awareness of time and space and with severe problems with word mobilization. She analysed three improvised musical examples from three perspectives:

- A self developed voice assessment analysis.
- A morphological analysis.
- An analysis based on the theory of Stern.

She synthesized her results from the analysis into what she called a re-organisation into four phases where these phases present themselves in the form of a developmental spiral. The four phases she calls:

- 1 A space to be present and relate.
- 2 A containing and holding space.
- 3 A potential space.
- 4 A space for separation / termination.

(Storm 2002, p. 92-93)

Storm particularly illustrated the therapist's conscious way of being present and applying what could also be called counter transference material in a professional timing towards this specific patient.

Metzner (1999, 2003) focussed on varying perspectives of differences between psychoanalysis and psychoanalytically informed music therapy. She is reflecting very much on the action aspect of music therapy and how this act of playing differs music therapy from verbal psychotherapy. She points out that the “---- mutually dependent interactional and intrapsychic processes emerging during musical improvisation are phenomena not found in traditional psychoanalytic thought. Psychoanalysis lacks an action model –encompassing more than mere physical action – which could provide a direct link to the meaning phenomena discovered by Freud.” (Metzner 1999, p. 104).

Metzner offers the idea that if “.....psychoanalytic therapy in general can be regarded as an interactional mediation of inner psychic conflicts, one can say that music therapy merely constitutes a modification of the procedure, the special characteristics of which need to be uncovered from the viewpoint of psychoanalysis.” (Ibid. p 104) Metzner is further inspired from Treurniet (1996) who claims that “... the theory that it is possible for a fantasy to become conscious without any activity whatsoever having occurred simply lacks evidence. The transition from acting...to enactment, actualisation, preverbal expression and play is gradual, and much experience and sensitivity is required to differentiate between these” (Treurniet 1996, p. 16 in Metzner 1999 p. 104).

Metzner has edited several detailed and theoretically reflected case studies from her work in psychiatry. In reporting on counter transference in her work with early disturbed, psychotic patients, she comments on an experience she had with one specific patient as follows:

.....Although I was aware of my patient’s increasing ability to deal with minor refusals, for a long time I was tormented by a feeling of counter-transference that I could do nothing about, namely that whatever I did was wrong – just like a mother who, for some reason, has lost her imitative competence. And so we found ourselves in a state of absolute separatedness.

(Metzner 1999, p. 115)

She described how the clinical practice turned out to establish a transitional object and how she recognised modulations in the relationship inside and outside the music, so that a first step towards being related in the music therapy for the patient took place. In Metzner (2003) she also emphasized the significance of triadic structures in a multidisciplinary

treatment team of a psychiatric ward in work with schizophrenic patients to minimize negative influences of splitting mechanisms.

2.8 Analytical Music Therapy

Mary Priestley, the founder of Analytical Music therapy, was the first music therapist who took on the task of trying to define and illustrate the clinical terms of transference and counter transference to make them available for music therapists. She herself undertook a lengthy psychoanalysis besides being a professional violinist and a music therapist. Back in the mid-70s, she wrote her first book on music therapy practice **Music Therapy in Action** (1975), where she advocated, parallel to the psychoanalysts and the verbal psychotherapists, that the music therapist needs a personal analysis. This could involve individual psychotherapy and a following Intertherap training to be able to translate the individual client experiences into the music, or individual music therapy followed by the Intertherap training. Priestley points out:

.....the therapist is selling his capacity for healing and caring. He should at least endeavour to know what he is about and be aware of the dangers en route. He cannot be perfect (and no amount of analysis will remove every weakness and blind spots) but at least he can do his best to prepare himself for the work responsibly. So much he owes to himself, the client and the work.

(Priestley 1975, p. 33)

This concern is connected to Priestley's definition of the main aim of analytical music therapy which she summarises as follows:

.....Analytical music therapy is a way of exploring the unconscious with an analytical music therapist by means of sound expression.....analytical music therapy is also a way of synthesising the energies freed from repressive and defensive mechanisms and giving them a new direction through rehearsal of action in sound.

(Priestley 1975, p 32)

So she very closely defined music therapy as a form of psychoanalysis but with the possibility of action in sound during joint exploration of the unconscious.

Priestley was influenced by Freud and Racker, and she also divided transference experiences into positive and negative experiences. She held that these were connected (inspired by Racker, 1968) in the way that the negative transference was a resistance to positive transference. She pointed out that it is the therapist's work to resolve negative transference as soon as it appears, as it blocks further progress emphasizing that the positive transference is one of the energetic sources of healing. It is within such a warm relationship that a patient makes use of the interpretations or musical responses that will help her to help herself.

Priestley's meaning of counter transference back in the 1970's solely related to:

.....the therapist's identification with unconscious feelings, self-parts (instinctive self, rational self or conscience) or internal objects of the client, which, being conscious in the therapist, can serve him as a guide to the client's hidden inner life.

(ibid., p. 240)

She carefully described which kind of receptiveness and awareness is called for by the therapist to be a resonant channel for counter transference experiences:

.....It is essential for the music therapist to divide himself inwardly into an inner, detached observer, who can objectively review counter transference intimations, and an open irrational receiver who can turn them, or their opposite, into sound patterns. But with one ear on the client and two hands on the piano and an awareness of the flooding counter transference, it takes a great deal of practice to preserve this observer intact.

(ibid., p. 241)

She was aware that working with counter-transference in music was different from doing so in verbal psychotherapy or psychoanalysis. She emphasized that the loving feelings of the positive transference do not have the same aim-inhibited quality as in psychoanalysis, as playing music

together can totally or partially relieve physical tensions and can be an unconscious symbolic equation for such basic impulses as **feeding, making love or killing**. But as she said:

.....Music therapy transferences are therefore deep but more manageable, both in their positive and negative aspects.
(ibid., p. 243)

Another aspect she describes as different from psychoanalysis is the client's experiences of emotional confrontations through the music with a part of herself from which she had been split off. As soon as there is an opening through a musical experience the client can begin to admit and own her feelings. They are there concretely and she can hear them over and over again on the tape, and it is very hard to deny their existence.

Concerning music therapy in psychiatry Priestley was aware that most music therapists are drawn by some personal motivation which has its origin in the therapist's own life story. For her own part she confessed:

.....As soon as I started my practical training in the psychiatric hospital I knew that this was what I wanted to do. It was the emotional pain that drew me. Here was something to work with, a kind of fuel which could be used to give a new direction to a life. Perhaps it sounds sinister but I felt that this was a sensitivity that I could use.
(ibid., p. 40)

About choosing a field of work for the forthcoming music therapists she pointed out for the area of psychiatry that:

.....The changing emotional state of the short-stay patients demands an extra-sensitive and adaptable response from the therapist who also needs the capacity to be able to accept rejection and acute emotional distress in others, coupled with a firm anchor in his private life.
(ibid., p. 43)

She reflected on this description in pointing out the need for a long training to be sensitive to counter transference for different client populations, stating that with some populations a superficial knowledge of transference and counter transference as obtained from reading might be enough coupled with a stable personality, plenty of intuition, common

sense, reliable advisers and an awareness of the transference process. But she pointed out:

.....If, however, he intends to do analytical music therapy, work on his own in private practice or to specialise in psychiatric work, then a deeper, individual experiencing and dissolving of his own transference is of great value.

(Ibid., p. 240)

As Priestley is one of my own primary trainers from my music therapy education in Herdecke 1978-80, and as I can easily identify with her motivations for working in psychiatry – what she refers to as being empathic and sensitive to psychic pain and anxiety and helping patients and finding it meaningful to give their life a new direction – I feel very inspired by her writings about counter transference and her illustrative examples in her books. I do not quite agree on her definitions of coping with negative transferences, as I have experienced that these can also give very valuable information to the clinical work. I also think that all music therapists need to have deep experiences of counter transference in their training no matter which population they come to work with, as they have to be receptive to deep emotional and other extreme state of minds. Priestley stated that for her, the work carried out by music therapists is an action based field involving music where we cannot defend ourselves behind a neutral screen or behind the words.

Priestley further developed her understanding of counter transference and divided counter transference in her second book (Priestley 1980 - edited in German in 1980 and later, in a revised version translated back into English 1994) into three parts all belonging to the phenomenon of counter transference. She identifies those parts as:

- a Counter transference,
 - b Complementary Identifications or C-Counter transference
 - c Concordant Identification or E-Counter transference.
- (Priestley 1994, p. 80)

The first definition a **Counter transference** she took over from Freud, and she was wondering (like Racker and other psychoanalysts), why Freud had only four references to counter transference in his complete works

but seventy seven references to transference (excluding the notes). Priestley also called the first definition for '**A Freudian Counter transference**'.

Priestley discussed the obvious need (not so much mentioned in the early counter transference literature by psychoanalysts) that not only negative counter transference, but also positive counter transference needs to be analysed carefully by the therapist. She described the experience of this kind of counter transference parallel to the classical views as follows:

.....The music therapist will probably first be aware of counter-transference 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 finds that he is having inner arguments with himself about it at odd private moments. It is then necessary to examine the case and to see whether there is anything in it that could suggest that his unconscious is seeing this patient as a figure from his past.

(Priestley 1994, p. 83-84)

The second definition of **C-Counter transference** is an experience of identification namely where the therapist identifies with one of the patient's introjects: or when he:

.....introjects his patient's introject and is taken over by it.. For example he might behave like his patient's spoiling mother or strict father. It is, of course an unconscious process so how does it make itself known to the therapist? In some cases, he is not consciously aware of it and the unfortunate patient is subjected not to a "corrective emotional experience" but a negative affirmatory experience as the therapist and patient re-enact an unfortunate relationship from the patient's past.

(ibid., p. 85)

Priestley emphasized what was pointed out already by Racker (1968), that there seems to be **a relationship between C-Counter transference and E-Counter transference in the way, that the less the therapist is**

aware of E-Counter transference the more likely he is to be taken over by the C-Counter transference.

The third definition by Priestley, the **E-Counter transference** is described as follows:

.....The therapist may find that either gradually as he works, or with a suddenness that may alarm him, he becomes aware of the sympathetic resonance of some of the patient's feelings through his own emotional and/or somatic awareness. Often these are repressed emotions that are not yet available to the patient's conscious awareness but they can also be feelings which are in the process of becoming conscious, in which case they may be very dynamic and fluent in the therapist, especially when he is improvising the therapist's e-counter-transference depends on his sensitivity and his freedom to experience the incoming emotions. But his ability to formulate it consciously and use it to the benefit of his patient depends on his clarity of thinking.

(ibid. Summarizations from p. 87-88, 90)

Thus Priestley here defines e-counter transference parallel to the definition of empathy where it is a two step experience of being emotionally '**invaded**', '**identified with**' or '**influenced by**', and also being able to use this information at a cognitive level to get to know what is the need of the client. This is related to the earlier discussion of empathy by Gammelgaard (2000 p 55-56).

Many other music therapists have written comprehensively on counter transference. The two most significant are as mentioned above Kenneth E. Bruscia and Benedikte. B. Scheiby. As Priestley was the first one who attempted to transfer the clinical terms from psychoanalysis into music therapy, she is the source of inspiration for the further writers.

Kenneth E. Bruscia has written comprehensively on both transference and counter transference and he has widely listed and described:

- Which definitions of counter transference are available?
- Which sources can cause counter transference?
- How can counter transference be handled?

Together with Priestley he is a very used source of literature among students writing on transference topics in reports or master theses. Examples are (Borch Jensen 2000; Høy Laursen 2006).

Bruscia's overall definition of counter transference is as follows:

.....Counter transference 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 relationships 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, impulse, drives and fantasies through identification.

(Bruscia 1998b, p. 52)

In his edited volume **The Dynamic of Music Psychotherapy** (Bruscia 1998), he collects 18 chapters on transference and counter transference in music psychotherapy from a variety of contributors, of which seven chapters are written by the editor. He emphasizes in the foreword that transference and counter transference are constructs, not realities:

.....they are merely ways of describing and making meaning out of the relationships that emerge in psychotherapy; they are not objective facts or verifiable truths.....they are constructions that a therapist makes to analyze and interpret what is happening in the clinical situation; even more accurately they are images or metaphors for the client-therapist relationship.

(Bruscia 1998a, p. xxii)

Of importance for this study is that Bruscia claims that defining an event as counter transference does not make it so:

.....it is only the author's way of looking at the event on the basis of his or her own definitions of transference and counter transference within a context.

(ibid., p. xxii-xxiii)

He also points to the fact that not everything within a client therapist relationship can be defined as transference or counter transference and an important issue is to distinguish:

.....between events that do indicate their presence and those, that cannot be interpreted as such, Bruscia also proposes that transference and counter transference are not applicable or relevant to all music therapy approaches or to every client population. Using these clinical terms demands certain assumptions or basic beliefs that “.....cannot be proved but that form the foundation for a particular way of being in the world.”

(ibid., p. xxiii)

He summarizes his reflections of the applicability and relevance for the terms of transference and counter transference as follows:

.....In short, transference and counter transference are most applicable when the goals are psychotherapeutic in nature, the therapist is trained and competent in the form of music psychotherapy used, the method is capable of accessing the transference and counter transference, and the therapy contract gives client and therapist sufficient time opportunities to work through the dynamic.

(ibid., p. xxiv)

Bruscia is trying to clarify the processes of the complex phenomena of counter transference by construing five constituents which he carefully defines as

- **Sources of counter transference:** the original experiences and relationships in the past that form the foundation for the counter transference, including those of both client and therapist.
- **Activators of counter transference:** all experiences and encounters the therapist has during therapy that can trigger counter transference.
- **Identifications of counter transference:** those persons or things from the past that the therapist replicates or assimilates into his own way of being in the present.

- **Objects of counter transference:** those persons or things toward which the therapist directs the counter transference.
- **Outcome of counter transference:** the extent to which the therapist uses counter transference to facilitate rather than obstruct therapy.

(Bruscia 1998b, p. 53)

He is very clear in distinguishing the understanding of counter transference by the totalist camp and how it is understood within the **inter-subjective** theory. In the first understanding the emphasis is that counter transference is everything coming up in the therapist when being with the client. In the intersubjective theory counter transference is a much more mutual act. It simply is “..... activated and shaped by what is happening moment to moment within the interactions of client and therapist and counter transference also influences what is happening between client and therapist. Thus, the therapist and his counter transference shape and are shaped by the client and her transferences; and the client and her transferences shape and are shaped by the therapist and his counter transferences.” (Bruscia 1998b, p. 52-53)

Bruscia presents a remarkable overview of defining counter transference in the different phases in psychoanalysis, and this, combined with his comprehensive clinical experience, marks him out as one of the experts in describing the phenomena of counter transference in music therapy. He is very aware of the varied definitions through the different ‘camps’ within psychoanalysis and psychotherapy and, for example, in his descriptions of the source he himself chooses to differentiate the descriptions of the therapists reactions towards the client’s transference and towards the client’s projective identification in a way where **he only uses the term counter transference specifically as a description of the reaction towards the client’s transference** because he says:

Projective identification is different from **transference** in that it involves a loss of boundaries or confusion between the self and others and between client and therapist and that it involves an **unconscious manipulation** of the therapist to perceive and react to the ongoing therapy situation in a certain way. It is therefore **a much more insidious encounter** for the therapeutic process than transference is. **The client’s unconscious hooks the therapist’s unconscious**

in a way that affects their identities, their relationship, and their work together.

(Bruscia 1998b, p. 56)

So in line with many psychoanalysts, and in contrast to Tansey and Burke, Bruscia defines the reaction towards projective identification as **introjective identification** and he uses counter transference in a specialised way not as an overall term. He points out though that:

Keep in mind, however, that although we can use the term counter transference very specifically in this way, it is usually used very broadly to include all forms of therapist response.

(ibid., p. 56)

Bruscia also points out that the sources for counter transference for the therapist are more numerous and more complex than the sources for transference:

The reason is that compared to the client, the therapist has many more relationship patterns from the past to deal with, including not only those from his own life but also those from the client's. As a result, the therapist can be drawn into identifications with many more different positions and roles in the relationship patterns that he or the client –or both – have experienced.

(ibid., p. 54)

Concerning possibilities of identification for the therapist in a counter transference response or reaction again he is describing **constituents** such as **concordant** and **complementary counter transference** (first defined by Racker, 1968) and **concordant** and **complementary introjective identifications** (as defined by Tansey and Burke 1989). Bruscia adds **the therapist's identification with the therapist's own life story** ".....identifying with his own **self- or object-introjects** rather than the client's. When this occurs, it is a contamination of the therapeutic process by the therapist's unconscious." (ibid. p. 60).

Bruscia warns against the therapist's contaminations where they occur as distorted identifications as the therapist's responses can be even dangerous to the client and the therapeutic process although he is also pointing out that:

.....once the therapist knows that he is operating from a counter transference experience, he can use several criteria to determine when the experience is appropriate, non-neurotic, and useful versus inappropriate, neurotic, and obstructive. These criteria are the time focus, the therapist's level of awareness, the intensity and duration of the counter transference experience, and the degree of distortion in the experience itself.

(ibid., p. 63)

In these reflections he is close to the ideas of Tansey and Burke, who think one should define counter transference not as positive or negative but as **descriptions of certain degrees of intensity in the experience, in keeping borders, not keeping borders, the duration or certain degrees of identification.**

Bruscia is critical to the idea that positive versus negative counter transference experiences should be determined by the duration of the experience or by the degree of intensity of the experience or the degree of distortion of the experience. He points out that Racker's distinction, between "---brief reactions also called 'counter transference thoughts' and the ingrained patterns called 'counter transference positions'" (ibid. p. 65) being identified as either something creative or something the therapist may drown into, is not a valid judgement for either positive or negative counter transference experience today, as these criteria belong to a time where the idea of the therapist's presence was the one of a blank screen. Therefore it cannot just be transferred to contemporary distinctions. Concerning the degree of intensity, Bruscia also points out that it is not:

.....logical to assume that more intense reactions are more likely to be obstructive and distorted manifestations of counter transference.....intense reactions seem more likely to grab the therapist's attention and thus require some kind of self-analysis, but the less intense reactions are more likely to go unnoticed and unattended. One could also argue that when the therapist's ego is uninvolved, it may be a function of his splitting and denial mechanisms.

(ibid., p. 66)

He is also emphasizing the discussions in the literature on how one can distinguish counter transference from non counter transference and he

refers to Gill (1988) who claims that it is about rigidity versus flexibility and counter transference is a situation where the reactions is rigidly repeated whereas non counter transference is “.....amenable to modification by the therapist and situation.” (ibid., p. 67). Bruscia himself concludes that for him it is not a question of counter transference versus non counter transference but more a question of positive versus negative counter transference which he defines as follows:

Counter transference may lead to positive or negative outcomes, depending on the nature of the therapist's reaction and his ability to use it to facilitate rather than obstruct the therapy process. Counter transference is obstructive when the therapist persistently responds to himself and his own past with little awareness of doing so while failing to respond to the client and the ongoing here-now interactions. It is facilitative when the therapist is responsive and adaptive to the client and to what is happening in the here-now while being aware of and understanding how the past of both parties is being replicated.

(ibid., p. 68-69)

Bruscia is further writing about signs of counter transference and offering techniques for uncovering and working with counter transference. In his descriptions of signs of counter transference he differs between **intra subjective signs** and **inter subjective signs**, where the former belongs to all the choices and preferences the therapist acts out and brings into the session before the real meeting with the client in the therapy situation. Examples could be choice of population (specializations and preferences) theoretical orientation such as philosophical notions “..... about health, pathology and the nature of therapy, the work style concerning assessment, treatment and evaluation; the significance and role a therapist gives to music.” (ibid., p. 90)

Bruscia describes inter subjective counter transference examples as the style of interacting the therapist develops in relating to the client. Here again he overall construes **three constituents** to help clarifying the phenomena, namely:

- 1 The body sense of the therapist.
- 2 The emotional aliveness of the therapist.
- 3 The role parameters the therapist typically takes in the situation.

Bruscia exemplifies role parameters such as **unwarranted or inexplicable reactions, impulsive decision-making reactions or drastic changes in the use of music**. He also points at the following negative role parameters such as **inappropriate roles and relationships, ruts and routines** and **burnout**. As an example he describe as follows:

Burnout and counter transference are linked reciprocally. Burnout is a sign of counter transference, and counter transference leads to burnout. When we burn out, we become more susceptible to counter transference turmoil, and the more counter transference turmoil we have the more burned out we become. In this regard burnout can be likened to a compromised immune system.....the more we take care of ourselves as therapists and human beings, the better able we will be to ward off the attacks of burnout and the resulting counter transference turmoil.

(Bruscia 1998c, p. 90)

Bruscia claims that using counter transference to advantage involves three challenges for the therapist, namely:

1. Recognizing those signs that are already present.
2. Uncovering those counter transference issues that are outside of awareness.
3. Working through the myriad of feelings and response patterns that come with the counter transference.

Thus the most important issue for the therapist to encounter the myriad of messages coming from the client to the therapist and the multiple reactions the therapist experiences **is for the therapist to be present to the client, to himself and be presence in mind to make clinical decisions**. Thus ".....counter transference can help to clarify, follow, and direct this stream of encounters." (Bruscia 1998d, p. 94)

In order to use counter transference to its best advantages Bruscia describes the needed ability, to be developed by the therapist, as the ability to move one's consciousness into and out from different spaces and layers in the client/therapist relationship to avoid an obstructive use of counter transference developing in that the therapist gets stuck in one of these spaces and layers.

Bruscia carefully describes techniques for uncovering and working with counter transference where one of these techniques suggests the following procedural cycles including. What follows is a summary of the steps he identifies in this circle and a summary of his explanation for each step:

- 1 **Floating** (open oneself to whatever is happening in the moment – a phase of passive presence to gain an overview)
- 2 **Checking in** (to direct ones awareness – to anchor oneself in a particular experiential space either in the client's or ones personal world focussing on either the sensory, affective or reflective layer of experience – entering a phase of directed active presence to deepen the experience)
- 3 **Shifting** (when having the experience deepened in one experiential space it is time to shift either from one world to another or from one layer of experience to another layer within the same world)
- 4 **Reflection** (here it is time to move out of whatever worlds and layers has been experienced and move into the therapist's world at the reflective layer of experience – into the position of professional observer)
- 5 **Action** (Here the therapist “.....implements the decisions made in the previous phase and thereby shapes the direction of the session.)

(summary of Bruscia 1998d, p. 96 – 100)

I return to this procedural cycle of Bruscia's in 6.3.4 (p. 326)

Bruscia distinguishes between techniques that can be used for being inside the therapeutic relationship and techniques that can be used outside of the therapeutic relationship either in reflection on the session or in supervision. In the latter he suggest several techniques that the therapist can use such as creative images or musical techniques to better understand what is taking place intra psychic in the therapist and in the client and interpersonal between the therapist and the client. He defines these techniques as techniques for monitoring counter transference that have been present and he suggests exercises that the therapist can do while working with the client or away from the client. The second set of exer-

cises he divides into experiential self-inquiries and reflective self-inquiries.

In top of the huge amount of ideas and reflections Bruscia has contributed to the understanding of the terms of transference and counter transference he has also written comprehensively about his own clinical experiences of both positive and negative counter transference in clinical practice.

In a working paper from 1994 he is identifying steps to be taken to ensure that counter transference has a positive rather than a negative effect. One of these steps can be seen as very similar to Priestley's description of applying e-counter transference (Priestley,1994 p. 87) It can also be seen as similar to the earlier discussion of empathy brought up by Gammelgaard (2000 p. 55-56) Bruscia writes:

Another method is to establish a sequence for understanding and responding to the client. The therapist first enters into the client's world to identify and empathize with the client's experience. After sufficient time has elapsed, the therapist separates from the client to get in touch with his/her own personal reactions. Once separated, the therapist compares the client's experience with his/her own experience, and distinguishes between what the client needs and what he or she needs. On the basis of these similarities and differences with the client, the therapist then determines the most appropriate intervention.

(Bruscia 1994, p. 3)

He also talks about that one of the most effective ways of handling counter transference is.

.....for the therapist to experience music therapy as a client
..... to be aware of what personal issues arise when improvising, singing, playing instruments, composing, or listening to music, for it is within these experiences that the most important interactions take place with the client.

(Bruscia 1994, p. 4)

Last, but not least, I want to bring Bruscia's important statement that:

.....to ignore what is happening in the therapist is to ignore one-third of the process. Music Therapy is more than the therapist using music to help the client, it is the therapist's use of his/her entire being..... the personal transformations of the therapist are therefore integrally tied to the client's therapeutic growth. To ignore them is to largely miss what the therapist has actually given the client.

(ibid., p. 4)

The third music therapist who have written comprehensively on counter transference is Scheiby, was also trained by Priestley. She has written very thoroughly and personally on her experiences with musical counter transference. She is a primary trainer of Analytical Music Therapy in the United States of America today, where she emphasizes counter transference as an essential part of training, clinical practice and supervision within the Analytical Music Therapy approach, although she points out in her article from 2005 that:

Consciousness about and effective work with musical counter-transference / transference techniques can be applied to any music therapist's method / style of working and is not limited to a particular method or clinical population.

(Scheiby 2005, p. 14).

Scheiby (1998a) worked further on from the three dimensions of counter transference, classical counter transference, e-counter transference and c-counter transference as defined by Priestley and she defines what she calls **musical counter transference** and **traumatic counter transference** based on 20 years of practice as an analytical music therapist as follows:

Musical counter transference 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 / her transference. The medium through which these are conveyed is the music played in the session.

(1998a, p. 214)

She also emphasizes that playing counter transference out in the music is one of the unique aspects of music therapy which includes:

to work with the manifestations of transference and counter transference as they arise in concrete forms, structures, dynamics, articulations, rhythms, tone colours, affective qualities, phrasing and idioms. By means of recordings, music therapists, their clients, and supervisors can review these phenomena and discuss the insights they provide, when warranted.

(1998a, p. 214)

Scheiby illustrates her clinical understanding of the phenomena of counter transference in describing detailed clinical examples in work with victims of physical, emotional, or sexual abuse. She defines her experience from this work as **traumatic counter transference**. She has experienced such traumatic counter transference as a helpful tool to understand her clients and she is close to Heimann in stating that such experiences should not “..... be removed or looked upon as a hindrance or obstacle to the client’s growth.” (Scheiby 1998a, p 227).

In such case studies she talks about projective identification in a musical gestalt where:

.....the therapist unconsciously identifies with these projected parts of the client’s inner world, and experiences him/herself in a way that is ego-alien but perfectly congruent with the projected contents. And of course these identifications come out in the therapist’s musical expressions and actions. When the therapist realizes what is occurring, the split-off material can be drained of its destructive power and reflected to the client if clinically warranted musically processing non-verbal communication can lead to verbal communication about the trauma. The client sometimes might have somatic sensations which can be explored musically and lead to important realizations.

(ibid., p. 226-227)

Scheiby talks about the phenomena of counter transference as “.... being **an emotionally reality** even though the counter transference reactions may not be warranted by the actual events of the therapy session” (Scheiby 1998 b, p 186). She also talks about **countertransferential music** that can have the following characteristics:

.....it can be music that does not seem to belong in the musical context at that moment; music that does not seem to be appropriate from the therapist's perspective; musical expressions from the therapist, that surprise him / herself or, a sense of not knowing where the music comes from.

(Scheiby 1998 b, p. 187)

Scheiby integrates theory and clinical practice experiences in an ideal way, through sharing her own traumatic life story and she illustrates her application of the term counter transference through comprehensive case descriptions (Scheiby 1998a). She has reported her own deep experiences with both musical classical counter-transference with a depressive client, and musical e-counter-transference through projective identification in a musical gestalt with a traumatized client. Through her case descriptions she confirms what Priestley was defining that:

.....the therapist's e-counter-transference depends on his sensitivity and his freedom to experience the incoming emotions. But his ability to formulate it consciously and use it to the benefit of his patient depends on his clarity of thinking.

(Priestley 1994, p. 87-88)

Scheiby (1998b) emphasizes the highly subjective nature of using music as a medium where music is a mirror of what is going on inside the therapist and she emphasizes that the therapist learns to listen:

.....not only to the outer and inner music of the client, but also to a deep place within oneself, where thoughts and feelings are acknowledged as they arise. Yet one must also learn to put these reactions aside in order to maintain attention to and contact with the client.

(Scheiby 1998b, p. 187)

Here she is in line with the descriptions of Heimann (1950) about sustaining and using the emotions for the purpose of the therapeutic process. Scheiby very much emphasizes the importance of the therapist **being present**, and **being present for the patient**, and she is discussing and illustrating what being present means:

- 1 Listening with all of one's senses.
- 2 Intervening in the right moment or not intervening.
- 3 Being authentic in the musical response to the client.
- 4 Listen to the music in the client's words and to the music behinds these words.

(Scheiby 1998b, summary of p. 188-189)

In one case description she shows how she as a therapist experiences the difference of '**being present**' and '**not being present**', and discusses the clinical value of a movement between these two polarities and also the awareness of such steps in her inner movement:

When the therapist becomes aware of being lost in the musical counter transferential ocean, it is often also the situation of the client (lost on musical transference), and it is time to get the compass out and make a conscious decision about where to go from there.

(Ibid., p202)

Scheiby (2005) elaborates further on her extended understanding of what it means as a therapist **to be there with the client in a deep way**. It can:

..... Elicit counter-transference. Creating space and room for clients to be and to discover themselves can sometimes best happen when the music therapist allows himself/herself to be. This often means suspending some control so the Self of the music therapist can be there for and with the client. This is a place where **separation and connectedness exist simultaneously**. It is a place where the client can listen to and connect with the unconscious (unexpressed grief and sadness in this case) as the music therapist is doing the same thing.

(Scheiby 2005, p. 9. Author's accentuation)

So she points out and illustrates very clear and carefully through descriptions of musical and verbal interactions how:

.....the roles of the music therapist functions are many and varied (Scheiby 2001) and, as described above, being there

for the client is one of the most important ones. The identification and management of counter-transference is necessary in order to be able to perform this vital role.

(Scheiby 2005, p. 10)

2.9 Conclusion

The review in this chapter has attempted to select out important threads and positions in the understanding of the clinical term counter transference. Writings of significant clinicians and researchers involved in the development of the clinical term of counter transference have been reviewed with emphasize on, how understanding of the term has changed and developed over time. This reveals that the understanding of the term has changed over time and several differentiations of the overall understanding within certain phases and in certain camps have been developed. Counter transference originates from classical psychoanalysis where it had a specific meaning such as the therapist's unconscious reaction to the patient's transference. This specific understanding has been expanded and in its broadest sense it covers all of the therapist's reactions to the patient as formulated by the totalist camp.

In the last two decades discussions around the term counter transference have been more focused on differentiations of **negative** versus **positive** experiences of counter transference and about **when and how application of counter transference can benefit appropriate to the need of the patient**. A tendency to present descriptions of counter transference much more detailed and differentiated has emerged such as how it is influencing the therapist, how the therapist reacts and understands the phenomena and which actions have come out of the experience. An emphasize has been put on duration and the degree of intensity of the experience as presented by the specifist camp back in the eighties and former discussions on whether counter transference should be removed and whether counter transference should be seen as a hindrance for the therapeutic process have disappeared. Today it seems that clinicians and researchers within psychoanalysis, psychotherapy, psychiatry and music therapy all agree that counter **transference is a very important source of information about what takes place in the therapeutic process both at an conscious and an unconscious level and also an important source of information about in which direction the therapeutic process can be conducted to serve the process positively**.

Several ideas have been presented regarding whether counter transference is an **overall term** including projective and introjective identifications as sub terms, or whether counter transference is a **specific term** limited to be used as a reaction to the patient's transference parallel to introjective identification which should then be used describing the therapist's reaction to the patients projective identification. All authors agree **that the dynamic is different in reacting on transference or projective identification** where the last one challenges more the borders and ego control of the therapist.

Both in psychoanalysis and in music therapy literature there is a significant division of counter transference into three definitions namely:

- 1 The classical counter transference (identified as the first specific understanding created by Freud).
- 2 Counter transference as concordant identification or E-counter transference.
- 3 Counter transference as complementary identification or C-counter transference.

The last two categories were first created by Racker, and further developed by Priestley, Bruscia and Scheiby.

So instead of rejecting the first definition made by Freud this is now understood as one way of experiencing counter transference and most often a negative experience seen in relation to the growth of the therapeutic process. So the clinical term counter transference is seen in a much broader perspective where the target of identification seems to be the source for distinguishing different definitions. The therapist can be identified either with the self object of the patient, or with the patient's mental sufferings, or the therapist can be identified with the object representation of the patient which is often the polarized part of the suffering. These identifications can be, more or less, in resonance with the therapist's own self objects and object representations.

It seems like the attempts, made by Priestley (1975, 1994) and Bruscia (1998a-d), to describe counter transference as a procedural cyclic event are generally including:

- 1 an identification with the experience of the other
- 2 a separation from this identification and

- 3 reflection on what is the need of the other - which kind of information emerged to me as the therapist through this identification.

This sounds rather similar to the attempt to define empathy as a procedural cyclic event within the frame of psychology of empathy as described by Gammelgaard (2000).

The term counter transference has originally been introduced to the field of music therapy in the tradition of Analytical Music Therapy (AMT) into which tradition it is emphasized, that a precondition to be able to apply and understand counter transference is, that the therapist's has his/her own self experience being a client in music therapy, as counter transference experiences are played out by the therapist through the music.

Counter transference has also been taught and described in Guided Imagery and Music (GIM) and in both AMT and GIM counter transference is an important and integrated clinical element in both training, clinical work, supervision and reporting. These are the two approaches that have defined themselves most clearly as music psychotherapy.

Among music therapists there seem to be different ideas about whether the term counter transference is relevant to other approaches – Scheiby states that it can be transferred to either approach, but it needs that the therapist has a certain training. Bruscia limits his idea of the application of counter transference to music psychotherapy with relevant clients where there is enough time to process the information coming up by making counter transference conscious.

All of the authors agree that no matter which field music therapist's work into, an important part of the work will be left out, if the understanding of the therapist's counter transference experiences in the therapeutic process is not a part of the analysis and an integrated part of the understanding of the music therapy clinical work.

The task of the literature review in this study is to prepare the theoretical foundations for the research questions, and as background information for the semi-structured interviews which are the data source of this study. Throughout the study I intend to highlight what is actually missing in our knowledge base rather than just summarizing what we know. I will return to the different perspectives on counter transference presented here in my discussion chapter.

Method

Introduction

Our psychotherapeutic connection to the mentally ill patient contains affective moments, which are not sufficiently expressed by the psychoanalytic term counter transference, but is better explained in Ludwig Binschwanger's term '*be carrying*' (Tragung). It includes the psychotherapist's refusal to become a victim of the emotions which so often take place, when you are situated next to the mentally ill patient. Emotions which occur as soon as we get close to the patient, emotions which we would not consider when we objectify the patient and specialise the frame of communication.

(Benedetti 1983, p. 30)

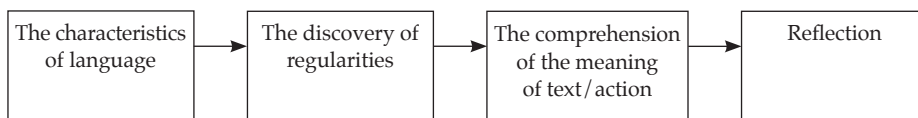
Counter transference is a controversial term in that it has been due to many different ways of understanding during the history of psychoanalysis and psychotherapy. As it is a lived experience, which often cannot be put into words during the lived experience, it is also a term which is closely connected to each individual therapist's development of **empathy, clinical understanding, ethical rules** and **openness to self analysis**.

It is a very subjective phenomenon and as such I have chosen to examine this phenomenon as a lived experience by myself and my colleagues within a qualitative research method, which I think is sensitive enough to grasp as much as possible of the experience. One could say that an interview on counter transference is contraindicated as counter transference

is primarily an unconscious experience. I have experienced though in the clinical field - having received and given supervision in groups of colleagues - that the process of making unconscious counter transference material conscious is a corner stone in the therapist's understanding of the clinical process. It is where chaos, strong feelings or sensations or irrationality can become meaningful. So in order to dive into this unconscious experience and dive into, which kind of meaning it might have or not have for music therapists, I realised that a qualitative research tool is required.

Within qualitative research discussions are running whether to believe in 'objective' results achieved in the much older natural sciences, or whether to believe that 'human' sciences need a different approach because of their complexity and the existence of a phenomenon unknown in the mechanical world. This study belongs to the last category because of its complexity. I am further applying a phenomenological research method because it is "illuminating inter-subjective human experiences by describing the essence of the subjective experience" (Tesch, 1990, p. 51).

Overall qualitative research can be mapped into four major types, which Tesch presents as lined up in a continuum from more structured types to less structured and more holistic types. From left to right this continuum can be seen as follows:



The study of counter transference experiences in music improvisation in adult psychiatry belongs to 'the comprehension of the meaning of text/action' category, which is concerned with ".....the discerning of themes to determine commonalities and uniqueness" (Tesch 1990, p. 59). Phenomenological enquiry is appropriate to explore this, and the next section provides a short historical context of this research approach, and how it became relevant in the field of music therapy.

3.1 Phenomenological Methodology

Edmund Husserl (1859 – 1938) is generally considered to be the father of modern day phenomenology. He was the one to articulate phenomenology as a philosophical viewpoint.

This viewpoint holds that the phenomenon of experience is products of the activity and structures of our consciousness (Lavine, 1984, p. 393). In other words, Husserl's basic starting point is that anything that we experience is directly related to our consciousness of the experience. There is no separate event unrelated to human consciousness.

(Forinash & Grocke 2005, p. 322)

Husserl thus rejects scientific approaches that exclude the role of consciousness in perceiving the world and he claims the view, that structures of every day experiences should be described as common experiences in the life-world of everyday affairs.

Phenomenological researchers study the ordinary '*life-world*'. They are interested in the way people experience their world, what it is like for them, how to best understand them. In order to gain access to others' experiences phenomenologists explore their own experiences, but also collect intensive and exhaustive descriptions from their respondents. These descriptions are submitted to a questioning process in which the researcher is open to themes that emerge.

(Tesch 1990, p. 68)

So the researcher is seeking the essence or crystallizing the constituents of the phenomenon to come to the result which will be a description of the essence of the whole or of the general structure of the phenomenon under investigation.

In the field of music therapy Forinash & Grocke, 2005, point out that Kenny was the first one to

".....articulate that one's philosophical stance or burning question should precede the actual research method." (Kenny 1987). She presented phenomenology as a method in her presentation at the Canadian Association for Music Therapy already back in 1983, titled: **Phenomenological Research: A Promise for the Healing Arts**. Ruud (1987) further adapted a phenomenological method for music analysis, developed by Ferrara 1984, in his doctoral dissertation. The most applied text for phenomenological analysis by music therapists, I think is the one by Forinash and Gonzalez (1989), where they developed seven steps to study the experience of a music therapy session with a hospice patient.

This method has been applied by several music therapists, among others Amir (1990) in a case study where she explored the subtle nuances of human experiences in two music therapy sessions, where the patient improvised song lyrics, while the therapist improvised music.

In research based on a phenomenological perspective one can say that ".....the usual purpose of data gathering is to collect naïve descriptions of the experience under investigation." (D.E. Polkinghorne 1989, p. 46). It is important to select informants who can provide rich data, and characteristically interviews are open-ended and unstructured or semi-structured, requiring enough time to explore the topic in depth. In the analysis process the phenomenological inquiry is to reveal and unravel the essential structures, logic and interrelationships that obtain in the phenomenon under investigation. There are several steps in the analysis process and specific issues of validity to be aware of for phenomenological research.

This doctoral study falls into the category of empirical phenomenology, which was originally developed at Duquesne University ".....the proponents of which were van Kaam, Giorgi and Colaizzi." (Forinash & Grocke 2005, p. 323)

Empirical phenomenology means to:

.....understand the general psychological meaning of some particular human way of being-in-a-situation..... through a number of descriptions of this way of being-in-a-situation from people who have lived through and experienced themselves as so involved

(W. Fischer, in Valle and King 1978, p. 177)

It is different from empirical studies in natural science, in that both scholars work with data experienced by the senses; but a traditional natural scientist is open to the phenomenon insofar as they show themselves to the researcher. In empirical phenomenology empirical means that the researcher is ".....open to all perceivable dimensions and profiles of the phenomenon that is been researched. Hence, the experiences of the participants, as well as those of the researcher, are ... acknowledged as potentially informative" (Fischer, in Valle and King, 1978 p. 168).

One could also say that natural science is occupied with the outer senses whereas phenomenological research is concerned with both the outer and the inner senses.

For my part I started this study by letting myself be interviewed in order to get a sense of all perceivable dimensions and profiles of my own experiences of counter transference. My preparation for this interview then became a method, which I transferred to my interview of the other participants. The fact that I was interviewed first helped me to also identify and bracket my own bias in the process of me being the interviewer.

3.2 Epoché and examination of personal bias

The term **Epoché** is used for the process of becoming aware of the influence of personal beliefs being a qualitative researcher using a phenomenological approach. To be aware of and suspend these beliefs during the process of collecting and analysing data is an important part of examining the life experiences of other people.

Moustakas describes the Epoché as a phenomenon that:

.....includes entering a pure internal place, as an open self, ready to embrace life in what it truly offers. From the Epoché, we are challenged to create new ideas, new feelings, new awareness and understandings. We are challenged to come to know things, with a receptiveness and a presence, that lets us be and lets situations and things be, so that we can come to know them just as they appear to us.

(Moustakas 94, p. 86)

So in working with the Epoché, ones energy, attention and work are:

.....involved in reflection and self-dialogue, the intention that underlines the process, and the attitude and frame of reference, significantly reduce the influence of preconceived thoughts, judgements, and biases.

(Moustakas 94, p. 90)

Working on making those beliefs, biases and assumptions explicit helps the researcher to come to terms with them rather than ignore them. In my preparation for the research interview I created open guidelines from my own experiences which helped me clarifying also my assumptions and also provided a framework where the counter transference experiences of myself and my colleagues could be placed and thereby extending my understanding of counter transference.

3.2.1 Subjectivity: Learning from my own life story

During my different educations I have experienced and reflected on my own blocks, limitations and potentials. I have experienced in my training as a relaxation pedagogue, that I have a very sensitive body receptor system and that I can experience being almost transparent through my skin in giving and receiving physical massage. In my self experience in an analytical music therapy training and in Guided Imagery and Music training I experienced very strong images and feelings often of a spiritual quality in playing or listening to music; and I realised that I have a very vivid inner life which also correlate with my common self picture of being basically an inward personality but also very containing. I also realised that I have had some traumatic experiences around my birth and in my first year of life, which gives me easy access to anxiety feelings and strong body sensations. All of these life experiences of course influence my own experience and understanding of counter transference and my interest in this topic.

3.2.2 Counter transference experience being a therapist

My own understanding of counter transference has been developed through many years of clinical practice, where I have experienced strong bodily, imagery and emotional experiences and reactions, which I have tried to understand either through self analysis and/or tape listening after the session or in supervision. For example, I have experienced an almost unbearable pressure in my breast or a big knot in my stomach or a headache all of a sudden, which I could not really localise or connect to my current life situation. I have also experienced feeling very heavy or sad, or very hurt or angry in, or after a session. In my reaction to it, I have had to either sustain these feelings for my own analysis, when I felt the alliance was not strong enough for self disclosure towards the patient; or I could express my emotional or other experiences as something, we (I and the patient) could explore together and learn from. I have also been very conscious about, how my awareness can be influenced by my way of listening. This means that I am aware if - on the one hand I am listening to the concrete content of the words, to voice qualities, to the concrete musical expression or to the performance style of the patient - or on the other hand I am listening to something behind the words or behind the music. **It has been very important for my own counter transference experiences to identify when I have been listening to my**

own identification with a patient (to listen to myself listening to the patient).

I have tried also in former publications to discuss this descriptive term **counter transference** and to offer alternative descriptions for the term such as **listening attitudes** and **listening perspectives**. I have also invented metaphoric tools for nonverbal orientation of the therapist being present in the intense field of the patient's transference or the therapist's experiencing counter transference especially with psychiatric patients.

I have taught and shared these tools with many groups of music therapy and art therapy students, and I have had very much feed back on the personal and clinical meaning of these orientation tools for the students. (see: p. 105)

So for me it is an exiting challenge to put my own ideas in a bracket here and to listen to the deeply lived and exciting experiences of the participants recruited for this study. I have noticed that the term counter transference is often used in case studies written by music therapists but it is often contextualised within the classical understanding made by Freud, and sometimes I do not find this really correlated with the empathy and sensitivity in the presentation of the case by the music therapist. I have missed advanced reflections on what happens when I identify so much with a patient, that I rush into some vulnerable part of myself other than the idea that it is something to overcome.

3.3 Summary

I have tried to be aware of and bracket out these different experiences, ideas and values, and I have tried to be careful not to transfer my own ideas/experiences on to the participant's experiences. Where I did not succeed it helps me to understand and to explicit my own influence on the process in having formulated my biases, which can be summarised as follows:

- 1 I have a training background where dealing with counter transference was an emphasized focus of training and supervision.
- 2 I have many years of clinical practice in psychiatry where I have tried to be aware of what I understand as counter transference and where I have brought my counter transference experiences to be further explored in my personal supervision.

- 3 I have supervised students and colleagues through many years where counter transference has been an important part of the supervision material.
- 4 I have been concerned with creating valuable metaphors to understand counter transference as a way of gaining information about my relationship with the patients (I have presented these metaphors in lectures and articles)
- 5 I have had traumatic experiences in my early life-story which possibly allows me to have an easy access to sensorial and embodied counter transference experiences. I have worked through these experiences in personal therapy during many years in order to better contain and understand the quality of my own identification processes with the patients.

As Kvale proposes “.....it is not a question of being free from bias, but a question of being open and curious and sensitive to what is said and also to what is not said by the participant. It is also a question of being critical towards your own assumptions and thoughts during the interview. Being free of assumptions does not mean that they are not there but that one develops a critical consciousness about them.” (Kvale 81, p. 166. Author’s translation)

3.4 Rationale for the Research

The purpose of my research is to examine how music therapist colleagues, working with music improvisation in adult psychiatry, experience, understand, react and interpret the clinical descriptive term **counter transference**. I want to know if it is a term that has some influence on their music therapy practice and I also want to know if they experience counter transference as positive or negative. Part of my curiosity was raised in clinical supervision, where my psychology supervisor asked me if it could be the case, that I moved from the verbal part of the therapy into the musical part of the therapy in order to escape an unbearable counter transference experience. I was a bit upset at first but realised that I could not just answer yes or no. So I decided to let it be an open question, which is also part of the rationale for this study. Together with my research supervisor I formulated the following main- and sub-questions for my investigation:

3.4.1 Research questions

The **main research question** is:

- How do music therapists perceive, react, interpret and theoretically understand counter transference experiences in music therapy contexts including musical improvisation in psychiatry?

Subquestions:

- In what ways do music therapists experience counter transference as a positive, influence on the music therapeutic process?
- In what ways do music therapists experience counter transference as a negative influence on the music therapeutic process?
- Are there particular features of the music in the improvisation that are present when counter transference occurs? Are there similarities across the music therapist's experience?

I knew from the very beginning that I wanted my participants to be as detailed as possible and I wanted them to relate to and reflect on a specific identified, context based clinical experience of counter transference. For this reason I developed comprehensive guidelines for the preparation of material for the interview, and I let myself be interviewed by my supervisor as a pilot project to evaluate the usefulness of the guidelines. The guidelines functioned effectively, and resulted in the production of meaningful data, so it was decided to include this interview from the pilot project as one of the interviews for data analysis in the study. I collected data from the following sources:

- interview with myself by my supervisor based on my preparation from the guidelines.
- interview with four colleagues by me based on their preparation from the guidelines.

As these guidelines included tape listening and tape transcription, the participants were funded for the time necessary to prepare for the interview. The guidelines were outlined as described below (see p. 233) and sent to the participants together with the main- and sub-questions. All the participants recruited for the study had been invited and had accepted to participate before they got the material, and they had shown positive interest in participating. After having received the material they had to confirm in written by signing the contract and return it to me. Everybody confirmed and no one else got the material.

During the analysis process I realised that I had far too much data and I had to leave out one of the transcriptions so it ended up with analysis of four interviewtranscripts.

3.5 A semi-structured qualitative research interview method

As part of my choice of a **Qualitative Research Interview** I have studied the modes of understanding this method as defined by Kvale (1981, 1997) and I have also studied the advantages and disadvantages of this interview method as defined by Marshall & Rossmann (1995) The modes of understanding in the Qualitative Research Interview according to Kvale (1979, 1997) are the following:

- TECHNICALLY SEMI-STRUCTURED OR NON-STRUCTURED (BOTH OPEN INTERVIEWS)
- AN INTERVIEW GUIDE IS FOLLOWED
- FOCUS ON CERTAIN THEMES MORE THAN EXACT QUESTIONS
- TAPED AND TRANSCRIBED WORD FOR WORD

Tape recordings and transcriptions form the material for analysing or interpretation of meaning.

In the interview situation the following twelve aspects may be briefly outlined. S. Kvale (1981) uses them as an attempt at describing the main structure of the interview method.

- | | | |
|---|------------|--|
| 1 | LIFE-WORLD | (is the subject of the qualitative research interview.
Purpose: to describe and understand the central themes
the participant experiences and lives for) |
| 2 | MEANING | (to describe and understand the meaning of central
themes in the life-world of the participant – the meaning
of what is said.) |

- | | | |
|----|-----------------|---|
| 3 | QUALITATIVE | (obtaining nuanced descriptions, not quantifiable responses. Precision in description and stringency in meaning interpretation) |
| 4 | DESCRIPTIVE | (aims at obtaining non-interpreted descriptions in order to have detailed and relevant material for analysis or interpretation) |
| 5 | SPECIFICITY | (describe specific situations and action sequences in the world of the participant – not general opinions) |
| 6 | PRESUPPOSITIONS | (an openness to new and unexpected phenomena – not coming with ready-made categories or schemas. Sensitive to what is said / not said) |
| 7 | FOCUSED | (aim to guide the interviewee towards certain themes, not to guide towards certain opinions about these themes) |
| 8 | AMBIGUITY | (clarify if ambiguities are due to a failure or reflect real inconsistencies, ambivalences and contradictions by the participant) |
| 9 | CHANGE | (be aware of new aspects the participant may discover during the interview which may change his descriptions about a theme) |
| 10 | SENSITIVITY | (seek to employ the varying abilities of sensitivity of different interview persons towards the themes to employ depth and differentiation) |
| 11 | INTERPERSONAL | (be conscious about the inter-personal dynamics within the situation interaction and take it into account by interview and analysis) |
| 12 | POSITIVE | (be aware that the interview may be a favourable experience for the participant which neither of the two want to terminate.) |

(Summarization of Kvale 1981, p. 164 – 169. Author's translation)

So these twelve aspects represent an attempt to describe the specific mode of understanding of the qualitative research-interview.

Moving on from these twelve aspects it is important also to be critical and to reflect on the advantages and disadvantages of this method. Marshall & Rossmann (1995) discuss the advantages of qualitative Interview method compared with questionnaires where they emphasize the alliance between the partners in the interview situation as important for extracting information that seems private or personal for the participant. The participants might be afraid of being misunderstood or misused if they write the information in a questionnaire. Also questionnaires put limits to what can be expressed which can give the feeling of not really

being able to express what is the most important for the participants understanding of the topic.

In this respect the following aspects listed by Marshall and Rossman can be seen as positive for collecting data in the form of a qualitative semi-structured research interview:

- 1 CONTACT (A SITUATION OF FACE TO FACE).
- 2 THE INTERVIEWER QUICKLY OBTAINS A HUGE AMOUNT OF INFORMATION ABOUT THE THEME AND THE CORRELATION BETWEEN THE THEME AND THE LIFE-WORLD OF THE PARTICIPANT.
- 3 EASY TO WORK OUT IMMEDIATE FOLLOW-UP BY OBSCURITIES AND TO FILL OUT OMISSIONS.
- 4 THE INTERVIEW IS A USEFUL METHOD TO EXAMINE COMPLEX CONNECTIONS BETWEEN RELATIONSHIPS IN THE SOCIAL WORLD (*AND IN THE INTIMATE WORLD BETWEEN TWO PERSONS*¹)
- 5 DATA COLLECTION TAKES PLACE IN NATURAL SURROUNDINGS
- 6 THE INTERVIEW MAKES ANALYSIS, VALIDITY AND TRIANGULATION EASIER
- 7 THE METHOD MAKES IT EASIER TO NOTICE NUANCES IN THE STUDIED CULTURE OR *IN THE CLINICAL SITUATION*²
- 8 THE QUALITATIVE INTERVIEW GIVES POSSIBILITIES FOR FLEXIBILITY IN SETTING UP HYPOTHESES
- 9 THE METHOD GIVES INFORMATION ABOUT THE CONTEXT OF THE BACKGROUND WHICH CAN BE USED TO FOCUS BETTER ON ACTIVITIES, BEHAVIOUR, EVENTS AND *EXPERIENCES*³
- 10 THE ANSWERS ARE USEFUL TO NOTICE THE SUBJECTIVE PERSPECTIVE OF THE PROCESS OF AN ORGANISATION AND *TO NOTICE THE SUBJECTIVE PERSPECTIVE OF THE PROCESS OF A RELATION*⁴

(Marshall & Rossmann 1995 in Kruse 2001, p. 134.

Author's translation.)

In this study where the concern is a complex description of nonverbal relationships, it is fairly clear, that the semi-structured Interview method is much more applicable than a questionnaire. The participant even comes to formulate tacit knowledge from their reflection in making unconscious experiences conscious and this requires a safe face to face situa-

1 The authors addition to contextualise the situation of this study

2 The authors addition to contextualise the situation of this study

3 The authors addition regarding the participant's experiences

4 The authors addition to emphasize that the focus in this study is on the therapist/patient relationship

tion, where the interviewer can guide the participant carefully to formulations often based on life story experiences.

As well as advantages this method also has disadvantages, as it is dependent on the interview ability of the researcher and of the quality of the technical equipment applied. Also it is very time consuming and the researcher needs to be familiar with the area of the interview. It can also be difficult to stay focussed at the topic, when exploring a complex area of experiences and it produces a huge amount of data.

Disadvantages of the Qualitative Research interview method are also listed by Marshall & Rossmann (1995):

- 1 THERE ARE RISKS FOR MIS-INTERPRETATIONS BECAUSE OF CULTURAL (OR INDIVIDUAL⁵) DIFFERENCES
- 2 THE VALUE OF THE INFORMATION IS DEPENDENT ON A SMALL GROUP OF KEY PERSON'S MOTIVATION FOR CO-OPERATION
- 3 THE INTERVIEW IS DIFFICULT TO REPEAT – THE PROCEDURE IS NOT ALWAYS EXPLICIT/DEPENDENT ON THE INTERVIEWER'S CHANCES AND CHARACTERISTICS
- 4 THE ANSWERS CAN BE INFLUENCED BY OBSERVATIONAL EFFECTS AND THE INSISTENCE OF THE INTERVIEWER
- 5 THE INTERVIEW MAY CAUSE DISCOMFORT – WITH UNCOMFORTABLE CONSEQUENCES FOR THE RESEARCHER
- 6 THE INFORMATION IS STRONGLY DEPENDENT ON THE HONESTY OF THE PARTICIPANT
- 7 THE VALIDITY OF THE RESULTS IS STRONGLY DEPENDENT ON THE INTERVIEWER'S CREATIVITY, BEING SYSTEMATIC, HONESTY AND CONTROL OF POSSIBILITIES OF MISTAKES.

(Marshall & Rossmann 1995 in Kruse 2001, p. 135.
Author's translation)

In my situation I knew the participants professionally beforehand, which might have put pressure on them to give me extra rich data or the opposite. I am a well trained and experienced therapist and I have been using therapeutic interview methods for years. This can be both an advantage and a disadvantage as the purpose of the interview in this study is primarily to get information – not to give the participants more insight about themselves. In practice these aspects are not totally separated. After the interview some of the participants spontaneously claimed, that they had formulated knowledge which was new and important for them both at a professional and at a personal level.

5 Author's addition concerning clinical subjective variations in this study

So according to Kruuse (2001) in my study I were undertaking a semi-structured interview using a comprehensive Interview guide where I asked the participants to identify a certain counter transference event in musical improvisation in clinical work in adult psychiatry. The identification of the relevant material for the study was achieved as follows:

- *I ask the participant to use material from a music therapy session which is recorded*
- *The session has to be recorded in order for an accurate transcription and qualitative description of the music to be made*
- *Participants are also asked to supply 'rich descriptions'⁶ of the two sessions before and two sessions after the chosen session.*

I did this to be sure the descriptions and reflections on an counter transference experience was primarily grounded in a clinical context. All participants signed a written contract and they had detailed guidelines sent from me, no less than a month before the interview. The guidelines for the interview were described in detail below (see p. 233).

The characteristics of this interview according to Kruse (2004) is as follows:

- 1 *A focussed interview focussing on the participant's experience of a certain event*
- 2 *Focus on a certain event which I want to have illustrated from different perspectives*
- 3 *Aiming at having the event illustrated from perspectives I anticipate are important, while at the same time remaining open to new perspectives coming from the participants*
- 4 *Searching for qualitative descriptions which are differentiated, precise and descriptive (the participants are invited to describe what s/he experiences and how s/he act to and understand the event). Explanations and interpretations are made in a dialogue with the participants*
- 5 *A mini in-depth interview (a personal one to one interview with a duration of 2-3 hours) – an explorative examination of an event*
- 6 *An empathic interview: An empathic listening attitude to the stories of the participants – stories about an event guided by me based on a checklist The checklist is there to help the participants con*

6 A rich description is a phenomenological term, and in this case requires a detailed description of important parts of the verbal and musical material with a focus on the therapist patient relationship

tinue when they lose their flow in the story they are telling, and to help me bracket my own presuppositions

- 7 *Using the checklist with a side check to be sure that a holistic picture of the event is presented.*

So in my preparation for gathering the data I have been very concerned with how to obtain rich data and how to gain as fully as possible knowledge from all perceivable senses of the participants. I have tried to prepare myself to be sensitive and open to the interview method, at the same time as I prepared myself to be critical to eventual disadvantages of the method and to my own presuppositions. In the detailed descriptions of the guideline for the interview, I describe how I learned from using direct question types in the interview situation, as I reflected on the first and second interview before carrying out the last two.

3.6 Participants

There are several criteria which have to be met when selecting and including participants for involvement in a phenomenological study. Kaam (cited in Polkinghorne, 1989) recommend the inclusion criteria as follows.

- 1 **The ability to express themselves linguistically with ease**
- 2 **The ability to sense and express inner feelings and emotions without shame or inhibition**
- 3 **The ability to sense and express the organic experiences that accompany these feelings**
- 4 **The experience of the situation under investigation at a relatively recent date**
- 5 **A spontaneous interest in the experience**
- 6 **An ability to write or report what was going on within themselves at the time.**

Further to this, I applied three additional inclusion criteria in this study:

- 1 *Clinically experienced qualified music therapists*
- 2 *Experience of working in the field of adult psychiatry for at least five years*
- 3 *Familiarity with using musical improvisation in their clinical work.*

Because this study was identified as a small scale study and because I presupposed the topic could hold vivid and comprehensive detailed descriptions, I decided to limit the number of participants to five. The data coming from my own interview in the pilot process counted as one of the

five 'cases'. In the study all of the participants met all the 9 inclusion criteria listed above.

3.6.1 Recruitment and inclusion criteria

I first invited potential participants whom I thought could fulfil all the inclusion criteria. Two of the participants have the same training background, whereas the three other participants have different training backgrounds.

So my choice at the end was based on:

- 1 *Selecting a small number of participants – here five as I supposed this topic would provide very rich and comprehensive material and because this is a small scale study*
- 2 *A gender balance – including me - three women and two men*
- 3 *A nationality balance - three from Denmark (including myself) and two from abroad*
- 4 *The fact that they all use music improvisation as their primary musical tool in music therapy treatment in the session where counter transference was identified*
- 5 *Selecting colleagues who had the possibility to identify counter transference in a recorded session – either tape recorded or video recorded*
- 6 *That the participants could meet the inclusion criteria of Van Kaam (see p. 231).*

Later in the process I was encouraged in a peer debriefing to set up a contract informing that the interview might include personal questions.

3.7 Interview protocol

I did not ask for a specific diagnosis of the patient with whom they identified their counter transference experience. I myself was interviewed at my working place by my research supervisor. I travelled to the place of the participants for the other interviews, which were held in their home (for three participants), and at the working place (for one participant). All interviews were taped on mini disc and transcribed by myself except one, which was transcribed by a research assistant from detailed instructions from me.

The interviews were carried out in English which is not my mother language and which is only the mother language of one participant.

One participant was allowed by me to talk in Danish, although I unfortunately had to leave this interview out at the end to keep the size of the study proportionate. I analysed data from four interviews, which included two women and two men, two Danish (including myself) and two foreign participants⁷.

3.7.1 Guidelines for the interview preparation to be worked out by the participants

As I wanted the descriptions to be context based I asked the participants to prepare for the interview going out from the following guidelines:

- 1 *Identify an event/phase within a musical improvisation from a recorded session where you recognize counter transference*
- 2 *Transcribe the session in English. Transcribe fully the verbal parts and bring a qualitative description of the musical improvisation/s (instruments, playing rule, length, form, character, dialoging progression, qualities of expressions, recognition of musical events) and bring an illustrative description of the music around the counter transference event.*
- 3 *Write up a summary of 2 sessions before and 2 sessions after the counter transference session (If not a first or a final session). Guidelines for summary:*
 - a *Focus of verbalisation before and after improvisation/s (verbal bridges to counter transference session)*
 - b *Qualitative descriptions of musical improvisation (musical bridges to counter transference session)*
 - c *Reflection on the pt/tp relationship (changes from/connection to counter transference session)*
 - d *Biographical and clinical data of the patient: sex, age, civil situation, psychiatric diagnosis, psychiatric history (number and rhythm of hospitalisations, medication, treatment offers), music therapy history (number of sessions, referral criteria, relevant assessment, information, aims and time planning of music therapy, stability of attendance)*
 - e *Relevant issues of patient's life-story like psychiatric illnesses in the family, issues of life-story that could possibly influence the progression of a psychiatric illness, character of symptoms of the illness*

⁷ See Amendments p. vii.

- f Any connectedness between issues of life-story of the patient, symptoms and the aims of music therapy*
- g Identification of specific relationship patterns in being with the patient from clinical practice or from other information.*
- h Information on sources of the data*
- 4 Send the written material including the contract (see later) to the researcher no later than 1 week before the interview*
- 5 Listen to the recorded counter transference session the day before the interview*
- 6 Plan for 3 hours for the semi-structured interview*
- 7 Be prepared for questions about your theoretical stance concerning the structure of the psyche, of pathology, and your use of clinical concepts and it's influence on your understanding of counter transference*
- 8 Be prepared for eventual member check and/or of a clarifying smaller interview later in the research process.*

The guidelines presented here were sent to the participants together with the main- and sub-questions. Everyone had been asked orally before getting the material and had shown positive interest in participating. After having received the material they had another chance to consider their participation before confirming in written by signing the contract and returning it to me. Everybody confirmed.

3.7.2 Contract for the interview

A contract for the interview was developed in order to address the issues of confidentiality of information. The material in this thesis will be examined and defended in public, and the text will be available at Aalborg University for further study. Therefore it was necessary that the participants identity was protected, in order for the material from the interviews to be available for future use. It was also necessary that the participant were made aware of this, and that they could sign an agreement regarding this. The following clauses were used in the contract:

Names of therapist/patient will not be disclosed

- 1 I hereby agree that the interview may include personal questions (questions concerning eventual connections between counter-transference experiences and the therapist's own life-story)*
- 2 I hereby agree that the researcher records the interview on minidisk*
- 3 I hereby agree that the researcher can use the data for the thesis, for other publications, for conference presentations and for teaching.*

Full name and date of signature

3.7.3 Internal criteria for the interview

Reflecting on which information I wanted to have included in my interview, I formulated three check lists to ensure breadth and depth of inquiry that would illustrate the layers of the situation of experiencing counter transference phenomena. These check lists formed the basis for the criteria of the interview, concerning how the music therapists can express, explain or describe the following experiences.

Checklist 1. The perception of counter transference

- *Physical reactions*
- *Emotional reactions*
- *Clear images*
- *Change in state of consciousness*
- *Change in listening perspective*
- *Change in communicative expressiveness*
- *Change in experience of closeness/distance in the relationship*
- *Change in the mood or in the atmosphere between the therapist and the patient*
- *Change in the musical material*
- *Change in the dynamics in the relationship*
- *Other phenomena*

Checklist 1 is mainly concerned with sensations and recognitions of change of different arts in the complexity of the experience. The list is not inclusive but contains the main areas of interest for this particular study in exploring counter transference phenomena.

Checklist 2. Reactions to and understanding of counter transference experiences

- *How is the counter transference event adapted and reacted/transformed in the musical relationship?*
- *In what way is the music therapist being consciously/unconsciously informed through counter transference?*
- *Has anything taking place in the two former sessions that could facilitate the counter transference event?*
- *Does the counter transference event influence the following two sessions?*
- *Is the information caused by counter transference fused with the*

life-story of the therapist/patient?

Checklist 2 is mainly concerned with how the participant identifies what happens actively in and around the counter transference moment, and how it can be understood in the clinical context. Again the list is not inclusive but based on experiences from my own clinical practice and from music therapy literature on counter transference phenomena.

Checklist 3. Interpretation of counter transference experiences

- *By theoretical stance and/or use of specific clinical concepts*
- *By creation of orientation tools (like constructs of metaphors of the landscape illustrating the musical relationship)*
- *By recognition of former musical experiences with this patient/other patients?*
- *By specific understanding of the structure of the psyche*
- *By specific understanding of the patient's pathology and possibility of development/healing*
- *By specific understanding of personal relationship patterns and reactions inside a music therapy clinical setting*

Again this list is not inclusive, but it is a good starting point, and I explore how the participants clarify or interpret for themselves or for the patient, what happened psychologically or musically in the counter transference experience.

3.7.4 Reflections on Guidelines and checklist

I worked out the checklist and the guidelines before I let myself be interviewed as the first trial participant by my second supervisor Dr. Grocke. I experienced that for my own part they covered a huge amount of information and also brought out information which was new to me. I decided to keep the guidelines and checklist in the form presented here as the final method for the interview.

3.7.4.1 Inspirational questions

I also developed a number of questions which I had found helpful in my own interview. I did not use them rigidly in the interview process, but I used them as an inspiration in trying to gain a holistic description of the participant's experience of counter transference in a clinical situation.

Primary Questions for semi-structured interview

1 *Going back in your mind to the session in which counter transfer-*

- ence was evident, can you describe what happened in the session?*
- 2 *Focussing on the moment/s in the session where you were aware of counter transference, what did it feel like for you?*
 - 3 *Can you elaborate on the phrase (on any phrase that stands out in the way the participant describes the session or reactions.)?*
 - 4 *How did the counter transference influence the therapeutic process (e.g. the following sessions?)*
 - 5 *How did the sessions previous to the one being described, influence the counter transference experience?*
 - 6 *Could you say anything else about counter transference with this patient?*
 - 7 *Have any of the patient's responses activated parallels in your own life-story?*
 - 8 *Do you look forward to sessions with the patient?*

These questions are concerned with descriptions of the actual counter-transference experience – the session in which it took place and eventual events which could be understood as leading up to this experience. They are also concerned with intra psychic and interpersonal aspects of the experience.

Supplementary questions for semi-structured Interview

- 1 *Which theoretical framework informs your understanding of counter transference?*
- for this specific patient? - for your work generally speaking?
- 2 *How much does pathology contribute to counter transference?*
- 3 *Have you used music to avoid counter transference in therapy with this patient? (with other patients?)*
- 4 *Is there a particular model of improvisation that you use within the session, which is related to your theoretical framework?*
- 5 *Are there cultural aspects that influence counter transference?*
- 6 *Does the stage of the therapy influence counter transference? (e.g. early/late stages of therapy?)*
- 7 *Does counter transference and the therapeutic alliance influence each other? If yes - how?*
- 8 *What is the value of counter transference for clinical practice?*

These Questions are mostly concerned with aspects outside the session that may influence the experience and understanding of counter transference. Here also theoretical references and choice of clinical approach are included. Neither the lists of primary or supplementary questions are inclusive but they cover meaningful aspects of the clinical work that will

be important to reflect on in understanding fully the phenomenon of counter transference.

3.8 Data collection

I have described in detail how the interviews were based on the participant's preparation from guidelines developed by me. These guidelines also include different question types. After having carried out my first interview, I categorized my questions and those of my supervisor interviewing me, to become more conscious of the risks of **'leading' questions** – and to learn how to use my therapeutic skills without this being a disadvantage. As an inspiration I studied areas for question types in qualitative interview (Kruse 2001), where an important example for me would be ".....questions on experience-/behaviour which are concerned with what a person has experienced and done. It can be helpful here to ask oneself: "if I had been present what would I have seen the interviewee do?" (Kruse 2001, p. 144. Author's translation). I also studied different types of question (Kruse 2001). From this literature, an important example of a type of question that helped me to get a full sense of the complexity of the topic would be: "Open questions which can be defined as questions where the interviewer tries to avoid predetermined answers, so the interviewee can answer independently and freely.....one can ask. "what do you think about...?" which provides an opportunity for a full range of possibilities for answers compared with asking "How much do you like...?". There are two more types of open questions: "How do you like...?" and "What do you feel about...?" (Kruse 2001, p. 146. Author's translation).

3.8.1 Question styles in interview 1 and 2 in the data collection

Together with my primary supervisor Dr Wigram, we identified a number of different question or comment styles from the first two interviews that were carried out. We then went through all the questions of the two interviews and started to categorize them, finally concluding with the following question or comment styles:

- 1 *Straight factual questions*
- 2 *'Encouraging' style of questions*
- 3 *Questions originating in something the interviewer said earlier*
- 3a *Questions originating in something the participant said earlier with interpretation or explanation*

- 4 *Questions or comments where you repeat what the participant said (confirming)*
- 5 *Forced choice questions based on interviewer's ideas*
- 5a *Forced choice questions based on participant's information*
- 6 *Comments that re-focus*
- 6a *Comments that suggest an explanation*
- 6b *Comments that relate to something different*
- 7 *Supplementary questions – (teasing out additional information)*
- 8 *Clarification of the interviewee's comments*
- 9 *Comments that confirm the participant's analysis & conclusion.*

Some of the questions or comments can be seen as close to therapeutic questions such as 2) 'encouraging' style of questions and 4) Questions or comments where you repeat what the participant said (confirming). Both interviewers in this study (Dr Grocke and myself) have practiced as clinicians for many years, and these kind of questions come naturally, although we both were very aware that this context was not intended as a therapy context.

I counted how many times different questions or comments were used and compared the two interviewers. In many cases, the number of times questions or comments were applied seemed to be quite similar, but in case 2 and 8 my supervisor didn't use a style, which was used by me and in case 4, 5a and 9 she used a style, which I did not use.

Table 3.1. Analysis of applied questions and comments in Interview 1 and 2

Question	1	2	3	3a	4	5	5a	6	6a	6b	7	8	9
Dr. Grocke	15	0	1	7	1	1	3	2	5	1	11	0	1
Prof. N. Pedersen	10	2	2	7	0	2	0	2	2	1	4	1	0

We both have the highest number on straight factual questions.

The following examples of questions and comments illustrate some of the styles which were applied:

Question Style 1. Straight factual question

Examples:

G: "So maybe if you can just put yourself back into that session - session x and perhaps just describe to me what took place in that session?"

P: "Could you now try to put yourself back into the session, back into the situation and just try to tell with your words what you understand as counter transference?"

Although a straight factual question it is also a leading question in the understanding (leading back into a situation - not leading the meaning in any direction).

It can be categorized as an experience/behaviour type of Question and a style of an open question.

The question presupposes that the interviewer knows that the participant has had experiences concerning the theme.

Question Style 2. 'Encouraging' style of question

Two examples only used by myself:

1 "Yes that would be nice. Try to put your own words to how you know that there was a counter transference - just your own words?"

This was an encouraging style of question, but it has to be seen in context - the question/comment is coming after the participant asked me - do you want me to talk about the moment - the actual moment I chose.

2 "So what was left in you?" Coming as a follow up on a further question: "have you ever had negative musical counter transference experiences with clients?" (A Question style 1)

Overall this is a question on experience/behaviour but also an emotional question (to get the emotions uncovered). This formulation could be called a therapist's 'slang expression' which was helpful here to get a fuller description.

Question Style 5a.

Forced choice question based on participant's information

Example only used by supervisor:

G: "So going back to this reaching out for the drum - might that have come from a sense of feeling hopeless or might it have come from another sort of ----"

A forced choice question with several options. This question style is seen as difficult according to Kruse, as it can create diffusion if you have to think about several specific answers. Here, it is a question of emotional recognition, and the question felt very useful to me as the participant. It is actually focussing towards straight factual subjective knowledge.

In general I started all of the interviews off by asking the participant to imagine sitting in the session and being into this counter transference

experience. I did not follow my developed questions in any regular way, but I used all of my guidelines and my developed lists of questions to ensure that according to (Kruse 2001), I got the event illustrated from perspectives, I suppose are important, at the same time keeping myself open to new perspectives coming from the participants in my search for qualitative descriptions, which are differentiated, precise and descriptive. (Here the participants were invited to describe what s/he experienced and how s/he acted to and understood the event). I also aimed at explanations and interpretations were made in my dialogue with the participants.

I was aware in the situation that I am an experienced therapist and I can see my questions are momentarily coloured by therapeutic ways of asking. I see this retrospectively, and as one of many possible explanations for, why the data were very intense and very rich of information. I transcribed the interview content in the participant's exact words and also repetitions and hesitations were marked in the raw transcript.

3.9 Data analysis

The purpose of my data analysis is, in the first place, to find the essence of my participants' experience of the phenomenon of counter transference in music improvisation in clinical work in adult psychiatry. According to Dr Grocke ".....this process might be called either **a reduction, an explication or a distilling.**" (Grocke 1999). In the current study it is most meaningful for me to use the term **distill**.

For this part of the research process I spend much time immersing myself in the data, and much time listening and re-listening to the tapes simultaneously as I read the transcripts. As a musician it felt easy for me to listen to the interview as a kind of 'music', where the **key statements** stepped forward as **motifs**. I achieved closeness to the data and got a sense of the whole for each interview before, I started the vertical analysis of each one. As the interviews were carried out with lengthy intervals in between, I had the possibility to really dwell into the data of each one at a time. This was important, as all the interviews are very complex and very full of rich data.

Because of the quality of the data I delineated all key statements (see inclusion criteria p. 231) throughout the entire interview transcript and afterwards decided which ones were relevant to the research questions asked (as described by Giorgi 1975, p. 87). I could have looked for material that

pertains to the phenomenon and then bound the key statements that contain them - as illustrated by Colaizzi, (1978, p. 59) There are several models of dividing the analysis into steps. Forinash and Grocke have made an overview of five different models, where they have adapted, three from Polkinghorne (1989, pp 52-56), and two from Moustakas (1994) as illustrated in Forinash & Grocke (2005, p 326). Here it is clear that the process includes the stages of extracting and finding the meaning of the text, then grouping it together and finally finding a more holistic meaning. The first part of the process can be titled differently (**classifying samples into categories, highlighting key statements, extracting the phrases, creating individual textural-structural descriptions or extract significant extracts**) dependent on the perspective which seems most important to the topic and to the researcher.

I have chosen to follow the structure of Giorgi-Colaizzi where they combine two approaches in phenomenological data analysis. Thus I am following the same stages of analysis as Dr. Grocke in her dissertation on pivotal moments in GIM although I do extend this method in adding two further stages in the analysis (stage 7 and 12) and add further dimensions to other stages in this analysis method (to stage 2 and 3). As a lived experience, counter transference can, in its essence, be seen as rather parallel to pivotal moments in GIM (Grocke 1999). Therefore I see it as very meaningful to use a similar structure in my way of analysing each interview transcript. We differ though in our ways of triangulation. So the following steps are the systematic progression I have followed in my procedure.

3.9.1 Stages in analysis

Combining two approaches by Giorgi and Colaizzi present the following stages in analysing phenomenological Interview protocols. My extension of the model including some additional stages and dimensions are reported in bold.:

- 1 Each recording was listened through and written out word by word including extraneous words such as 'oh' and 'ah' and including noting spontaneous laughter
- 2 Each transcript was read through several times *while also listening to the tape* to gain a sense of the overall experience
- 3 In the second listening of the recording I stopped at key statements to underline these in the manuscript. *As I was also listening to the spoken words I came to hear the narratives as music with motives*

which helped me identifying the key statements. The first underlining process I did with black lines. The second with red lines, the third with green lines and the fourth with blue lines so that I could go back and forward and follow what was my first and what was my later impressions and choice of the data.(see also Appendix 1 – 4 at the attached CD).

- 4 The key statements were placed together and grouped into units of meaning which I called meaning units. Each unit was given a category heading
- 5 The meaning units for each manuscript were transformed into a distilled essence of the experience
- 6 The interview transcript underlined in different colours, including brackets (where I have filled in parts from the question of the interviewer to provide the meaning of the answer), and including the ellipses (where I have added words to provide meaningful sentences), together with the meaning units categorized in headings and also the distilled essence were then sent in total by mail to the participants for verification. Changes and omissions were noted
- 7 *After 6 – 12 months time distance to the first sending, only the distilled essence were sent again with the question: “does my final distilled description capture the essence of your experience? Is there any aspect of your experience that has been left out”?*
- 8 When the participants had returned the material, any changes or omission were noted
- 9 When all four participants (including myself) had verified the distilled essence of their experience, I undertook a horizontal⁸ distilling process, whereby the common meaning units across all four interviews were laid side by side and composite structural categories were developed
- 10 Composite themes were distilled from the categories, and distilled into the composite essence which is also the global essence in the study
- 11 This global distilled essence describes the essence of counter transference in musical improvisation in adult psychiatry
- 12 *This final global description alias the findings of the study was related back to the distilled essence of each of the participant to ensure all of the experiences were fully covered*

⁸ The term horizontal I have brought over from Dr. Grocke, as I do emphasize closely with her definition: *Horizontal* is similar to *Horizontal*, but horizontal is intended here – as if looking to the horizon to capture the wider view (Forinash & Grocke 2005, p. 329)

- 13 These findings were then related back to my research questions *and to relevant aspects of my five edited articles and former theory building* as a part of my discussion chapter.

3.9.2 Example of Phenomenological reduction

I will like here to present an example of my process of reduction from the raw material in the transcript to the distilled essence. The example here is from the transcription of an interview with C.

The **key statements** of the interview are underlined in different colours. The phrases and sentences that are not underlined were excluded in the second stage of reduction, because they did not relate to the experience of counter transference. Because of the comprehensive preparation, the participants were all producing very rich material. In the beginning they 'spoke themselves' into the experience. These speaking transitions were left out of the key statements. Also when they were more generally talking about watching the video or listening to the tape it was not specifically related to the counter transference experience, this was also bracketed out. Retrospectively, appropriate criteria were formulated in order to choose the key statements

Selections of Key Statements

To go in:

- 1 *Statements where the participant is talking while putting her/himself back into the experience of counter transference*
- 2 *Statements where the participant is talking about her/his experiences of counter transference in connection to the actually interview question*
- 3 *Statements of memories connected to the counter transference experience starting with I: I remember--, I felt – I realised etc*
- 4 *Statements where the participant is actually talking of something that had an impact on her/his experiences of counter transference*
- 5 *Statements that are directly connected to the main- and sub questions of the thesis*
- 6 *Statements that fit into the structure of Giorgi/Colaizzi*

To leave out:

- 1 *Statements where the participant is explaining something in order to begin to talk about the counter transference experience*
- 2 *Statements starting with: ---- I am supposing ----- or ----maybe it could be like*

- 3 *Statements where the participant gets carried away with associations in trying to answer the questions*
- 4 *Statements which are unrelated to or not specific to counter transference.*

In the first underlining procedure I was listening to the disc at the same time as I was reading the transcript and I felt like listening to music. I also felt that I could sense in the spoken language, where the motifs were, and where phrases were building up to the motifs or where motif parts or motif variations were placed and should be underlined.

In later readings, after having explored the interview as a whole, it appeared that some of the first selections of key Statements (which I initially did not underline) were of deeper importance for my understanding of the experience of counter transference. Other statements appeared to be of no importance. So this moving forwards and backwards changed the picture several times.

In my work with the interview with C, I tried very hard to distinguish, when C was talking from being into the experience and when talking from memory around the experience or talking from later reflections on watching the video.

3.9.2.1 Interview with C

In order to clearly explicate the phenomenological process of the analysis of interview data, an example of the colouring of key statements is given here in relation to participant C. The transcript is written in C's exact words. Brackets mean writing in literal formulations from the question of the interviewer to give meaning to the answer. Ellipses mean filling in words to give meaning to a sentence. The colours show the progression of identifying key statements (which are underlined), working through in the following order: black first time, red second time, green third time and blue fourth time.

I: (the interviewer)

So we are going to talk about counter transference. You have already picked out a session and you have sent me material about this session. You have written about what is going on in this session and you have written about the music and you have pointed out to one point in the music where you have identified counter transference. Could you now try to put yourself back into the session, back into the situation and just try to tell with your words what was going on - what was your experience of the counter transference experience.

- C: First thing that came back to being in the session which also became clear to me when I was writing about this is, it is very difficult to say exactly how long the moment lasted. So I chose a particular time which I remember in the session even though it is a long time ago, and<which> I have seen in the video and heard several times. When I listen to the whole session I then thought well this counter transference moment is going on for perhaps fifteen minutes or something. So if I think back to being in the session - well it was a very significant session because it was near the end of the therapy, and the ending I knew would be very difficult for him and also for me probably, because endings are always difficult. And - so what I remember in this session was a feeling of consolidation - a feeling that every thing that happened had more meaning than usual - and the interesting thing for the counter transference here - was that I as the therapist - I was putting more meaning on to it because I was more aware consciously of the ending than he was probably because - I really don't think he is the sort of man who would be having the ending consciously in the forefront of his mind. So in the session I can remember also that we always taped - audio taped part of our session but only the music part but this time I asked him if we could use video the whole session – the last view - and he agreed so this is another point of interest because we did not normally videotape, so I did wonder if he was giving me more of himself because he moved a bit more into a sense of performance – you know – I had a sense that we were both on camera - I have to say that - but I think actually it was very useful, so it was very useful but not in the way you might think, not because it inhibited but I think - because it made it more meaningful - it meant that both he and I were saying more and expressing more than maybe we might have done if we had not been on video - rather than censoring what was happening --- so do you want me to talk about the moment that bit - the actual moment that I chose.
- I: Yes that would be nice. Try to put words on how you know that there was a counter transference?
- C: Yes
- I: Just your own words.
- C: Well because my definition of counter transference is not necessarily everything that the therapist is feeling, but it has to do with the therapist' unconscious - so - how do I know? - I know that - well I knew < about counter transference> because he waved at me - so what happened was we were in parallel – - we had been playing like this for about 15 minutes and we had been moving in and out of <how we

played at> - this very early stage that we had been in at the start of the therapy; where it was impossible to get out of - well without a huge amount of understanding of counter transference from my part because - what always happened was - that he would start to play in a fixed rhythm and I <would>just go along with it for half an hour or - you know this is how the sessions were.

I: Yes.

C: So I suddenly found that I was playing the same chordal progressions that I'd been playing four years before. And I knew it because I'd listened to the tapes because I used them for teaching so I have to admit it is not because my musical memory is so brilliantly. It was also because I knew it. But I suppose it was also that - this symbiotic - lullaby type of music has always been a theme, that came back time and time again so I was aware suddenly that this is what was happening, but it had a different quality and the different quality was that he kept looking at me - he kept checking out rather than just being fixed going up and down on the metallophone and occasionally responding to my harmonic progressions, because I was very musically in interventions -- almost like a Nordoff/Robbins way of using improvisational chord structures - to hold - to contain and sometimes to provoke and intervene. - That's how I was working, so this moment was the first time I can remember him acknowledging some thing I had done musically.

3.9.2.2 Reduction of the key statements into meaning units

The **key statements** were grouped into **meaning units** which again were given a **category heading**. Redundant material was removed. As you can see already on this presented page of interview transcript there were a number of categories (headings) of meaning units underpinning the rich and complex material this topic seems to evoke. This richness of material also mirrors the many years of clinical experience of the participant.

The first two category headings are related to statement number 4 in my listing of selection criteria for key statements to go in. The last six headings are related to statements number 1, 2, 3, and 5 of my selection criteria. All headings are related to statement number 6. (see p. 2454).

Meaning Unit 1. Sense of time

"....it is very difficult to say exactly how long the moment lasted....."

"....When I listen to the whole session I then thought well this counter transference moment is going on for perhaps fifteen minutes or something...."

"....we had been playing like this for about 15 minutes and we had been moving in and out of <how we played at> - this very early stage that we had been in at the start of the therapy; where it was impossible to get out of - well without a huge amount of understanding of counter transference from my part because - what always happened was - that he would start to play in a fixed rhythm and I <would> just go along with it for half an hour or - you know this is how the sessions were."

Meaning Unit 2. Videoing the session

"....this time I asked him if we could use video the whole session – the last view - and he agreed so this is another point of interest because we did not normally videotape...."

".... I did wonder if he was giving me more of himself because he moved a bit more into a sense of performance – you know – I had a sense that we were both on camera...."

"....because it made it more meaningful - it meant that both he and I were saying more and expressing more than maybe we might have done if we had not been on video...."

Meaning Unit 3. Therapist's feelings

"....what I remember in this session was a feeling of consolidation - a feeling that every thing that happened had more meaning than usual -"

Meaning Unit 4. Reflecting on the Counter transference reaction

"....and the interesting thing for the counter transference here - was that I as the therapist - I was putting more meaning on to it because I was more aware consciously of the ending than he was...."

Meaning Unit 5. General thoughts on counter transference

"....my definition of counter transference is not necessarily everything that the therapist is feeling, but it has to do with the therapist' unconscious...."

Meaning Unit 6. An equal meeting

“....well I knew < about counter transference> because he waved at me - so what happened was we were in parallel –”

Meaning Unit 7. The music of the counter transference moment

“....I suddenly found that I was playing the same chordal progressions that I’d been playing four years before.....”

“....it was also that - this symbiotic - lullaby type of music has always been a theme, that came back time and time again so I was aware suddenly that this is what was happening, but it had a different quality and the different quality was that he kept looking at me – he kept checking out rather than just being fixed going up and down on the metallophone and occasionally responding to my harmonic progressions, because I was very musically in interventions -- almost like a Nordoff/Robbins way of using improvisational chord structures - to hold - to contain and sometimes to provoke and intervene. - That’s how I was working,....”

Meaning Unit 8. Describing the difference

“....so this moment was the first time I can remember him acknowledging some thing I had done musically.....”

3.9.2.3 The distilled essence

After I had finished the distillation of all of the meaning units in one interview I wrote a distilled essence of the participant’s experience. As I had been dwelling into the text for a long time the formulation of the distilled essence was done easy and in a few minutes. I bring here the distilled essence of the interview with C.

Distilled Essence of a semi-structured qualitative interview with C

In the counter transference experience C realises that she is playing the same chordal progressions that she played with the same patient four years ago. It is this symbiotic – lullaby type of music. But it has a different quality because the patient keeps looking at C. C is not so much with the patient in the counter transference experience but she is trying to play around the patient. The patient then stops with one hand and waves and smiles at C in a very warm way.

C becomes conscious that this is almost like an equal meeting rather than C following and nursing the patient. It is like two consenting people going along together. The quality of the music after that takes on a really quiet, sad mood and C starts to play in a minor key. C feels like saying as a counter transference reaction through the musical expression: ‘we are going to be parted, we are saying good bye.’ The patient is listening in the moment

rather than just playing on musically and the music is shaped by both therapist and patient together.

This moment touches C and puts C in touch with some quite powerful feelings. This helps C take more risks and be more adventurous. C speeds up in the music and plays some passionate chords. C lets the patient go and risks not having the patient constantly staying with her in the music. C makes different atonal sounding music which on that day does not bring the patient out of control. C imagines taking a risk might help the patient express something more about the range of feelings the patient has had about this therapy. C feels like acting out in the music in expressing to the patient: 'this is where you had feelings of love and passion – you had feelings of distress, of disquiet and of being out of control.'

C experiences the moment very powerfully. C has two **young** sons at the time of seeing the patient which according to C might have tuned C in for the counter transference reaction. For C it seems natural to be very nurturing – often to very violent quite disturbed male patients. C seems to tag into this and to get in touch with the patient's needy parts. These parts C compares with a needy two year old baby between a rage and a wish for love. The counter transference experience enables the patient to access a needy soft expressive side, and it really seems like the patient is acknowledging this intertwined relationship which obviously the patient is feeling; and it has not really been stated before. The patient is able to talk about C as a separate person for the first time.

The work is more into flow now. C wants the patient to acknowledge the ending and really experience it, because the patient has had many dreadful endings. After the counter transference session, C does not want to take another risk. The therapy ends two sessions before it is contracted, **because the patient negotiates this**. C experiences this like two people negotiating in a quite mature way

3.10 Verification of the data

An important part of the **verification of the data** in this study is, for the researcher, to be aware of and critical towards his/her bias. In examining my own bias I have drawn on many years of different experiences of counter transference from working with musical improvisation in adult psychiatry. I have also reflected on episodes in my life story during many years of self experience in training modules, which may have made me more sensitive to certain counter transference experiences than others. This conscious knowledge helped me at first to work out very detailed guidelines for the participants and later, in the interview situation, to step back and listen openly to the experiences of the participants. The authentication of my analysis is made through the **verification process**,

where I send the material twice to the participants. First they were asked to identify the full meaning of the interview transcript and the headed meaning units. Second - within a time more distant from the interview situation – I sent again solely the distilled essence to verify if the participants could identify every part of the experience or if something had been left out. Here I followed the two questions created by Grocke (1999) in her dissertation on pivotal moments:

1. DOES THE DISTILLED DESCRIPTION CAPTURE THE ESSENCE OF YOUR EXPERIENCE?
2. IS THERE ANY ASPECT OF YOUR EXPERIENCES THAT HAS BEEN LEFT OUT?

Again the participant could suggest a change of wording, if I as the researcher had not reflected the experience accurately. All these suggestions were added to and emphasized in the text.

In the verifying process with C, the following addition in the last sentence of the distilled essence above was suggested to clarify the meaning:

“..The therapy ends two sessions before it is contracted, **because the patient negotiates this**. C experiences this like two people negotiating in a quite mature way...”

The suggested sentence was added before the next analysis step and it is accentuated in the text above.

3.11 Issues of Validity in Phenomenological Research

The term **validity** derives from the Latin term ‘validitas’ which means truth, reliability, validity, and strength. There is a difference in examining validity in qualitative compared with quantitative research. Validity in qualitative studies deals with the authenticity and trustworthiness of the manner in which, the researcher has carried out the research process including the interview process (collection of data) and the process of analysis. It is very important here, that the steps of progression during the study are transparent. Aldridge (1996) formulates it this way:

“The basis of establishing trustworthiness..... is to show that the work is well grounded (and) to make transparent the premises that are being used” (Aldridge 1996, p. 125).

In my study I have been careful in writing my epoché to stay critical and conscious about my bias; I have been subject to several peer debriefings

and have been careful with participant verifications. I have had a prolonged engagement with the descriptions which the colours in the transcript mirror and I have made use of triangulation (interviewer triangulation and theory validity). A specific element of trustworthiness here is that I have been dealing with the examined phenomenon for more than twenty years, and I have chosen very experienced participants for the research interview. My interest grew out of deep and indwelling experiences in my own clinical practice and I have tried here to explore the essence of such experiences and the experiences of my colleagues in a systematic way.

3.11.1 Peer debriefing

In developing this method, I have brought my research at different stages to a peer group for feedback. It has been very obvious for me to take my work to the group of co-PhD-students at the Music Therapy Research School at Aalborg University. Due to the head of this research school, Dr. Wigram, this process has always been very creative and fruitful. Other colleagues and guest teachers have been familiar with phenomenological studies and I have had different advice in the process of developing this method. One example is that I was advised to make up a contract for the participants to sign before the interview, as these interviews might include personal questions. I wanted to record all interviews, so the contractual agreement ensuring confidentiality was important. This procedure also gave the participants another chance to consider if they really wanted to participate. I also had creative ideas from the group in filling out my checklist for the interviews and I had careful advice in not including too many participants for such a complex theme of examination. At one point we worked in smaller groups, where I had the possibility to delve further down into the process of creating headings for key statements from a few pages of interview transcripts and to discuss this procedure with the group. I was encouraged to make as many headings as needed, whereas I had been worried to confuse the analysis process in making up too many headings. I found it easier after this debriefing to just go with the process.

3.11.2 Participant verification

As already mentioned I have been very careful to send the material back to the participants. All of them are professional clinicians and researchers, so they were very rich in reflexive formulations during the interview and they could easily understand what I needed to have verified at different

research stages. Each of them had the opportunity to follow my steps of progression in the analysis of transcriptions and to suggest changes or add corrections to the transcript if it was not understandable or not covering their experience. In some cases there were a few misunderstandings of language which were corrected. I found it important to give the participants a chance to reread the distilled essence in its own right, before the horizontal analysis, to be sure the essence of their identified experience of counter transference were accurately unfolded. According to Aigen (1995) and Creswell (1998), this procedure is also called '**member checking**'.

3.11.3 Prolonged engagement with the descriptions

As I have been full time working along the research process in the period of collecting data and starting the analysis, I have used quite a long time for the vertical part of the phenomenological analysis. I have had to leave the data after one analysis and come back days, or sometimes weeks after. This is why I have chosen to make the number of times of 'working through the data' visible through different colours in underlining key statements. These circumstances have made me sometimes feel like starting all over again - as if seeing the text for the first time again. In this way I almost felt like verifying my former chosen key statements once more. I have had the chance though, with each transcript, to have a few long days at the end, where I could dive into the text and be sure that I found that this analysis was fully grasping the meaning of the text. For each text I succeeded, at the end, in coming to a point of being almost inside the text and this made it easy for me to write up the distilled essence which mostly was done within 10-15 minutes. I always only worked with one text at a time, as each text is such a full and complex narrative. In the process of distilling the global experience, I moved back and forward many times between these complex narratives of each individuals experience, and it was an exiting and almost detective process of having my understanding continuously deepened.

3.11.4 Triangulation

During the process of preparation for carrying out the interviews, I was interviewed by my supervisor based on my developed guidelines. All the other interviews were carried out by me, so the experience of counter transference is examined by two different interviewers. As a foundation for the interview each participant had a recording of the music of the counter transference experience, which they have listened to several times be-

fore the interview, and which they have qualitatively described in the preparation work. This musical material thus can be seen as a third source of information in the triangulation even if it is not included in the dissertation.

I also bring in theory triangulation, as I – in the discussion chapter – shortly bring the findings back to my own formulated theories in five former edited articles on experiences of counter transference and let the findings dialogue and extend the theoretical understanding as presented in the articles.

3.11.5 Trustworthiness

As mentioned above I came to a point of almost being inside the text and inside the experience of the participant, so that it was an easy task for me to create a trustworthy and authentic distilled essence.

My own clinical experiences and my self reflective work on my life story made it easy for me to get to know the experience of the phenomenon of counter transference, as if I was there present in the situation. Although I work here in the role of a researcher my twenty six years of clinical practice experience, where I have had to be very open and sensitive to understand the ‘strange life-world’ of schizophrenic or infantile autistic patients, have raised my empathy and my ability to move in and out of the experience of others to a degree of ‘**indwelling**’ these experiences.

I have had strong and vivid counter transference experiences in adult psychiatry for many years. It was easy for me to get inside the experiences of the others and the participants responded positively to my distilled versions of their experiences. As proposed by Kvale (1983) in phenomenology, trustworthiness is enhanced when several people conduct the interviews so that there is a broader and more richly nuanced picture of the themes.

The data presented in subsequent chapters are based on the transcripts of the original interviews, and the reductions of the protocols into meaning units. These are brought in full length on the attached CD.

Vertical analysis

The Distilled Essence of the four participants' experiences of counter transference

Introduction

This chapter addresses stage 1 - 5 in the phenomenological analysis which includes the vertical analysis of each of the interviews. The focus here is on the context around the interviews, including a short presentation of the diagnosis of the patient, with whom the interviewed therapist experienced the identified counter transference event.

The **distilled essence** of each of the interviewees is presented in its total to give the reader an imagination of each of the four counter transference experiences, before entering the stages of the more complex horizontal¹ analysis in chapter 5.

Stage 1

Five people were interviewed about their experience of counter transference in musical improvisation in adult psychiatry. They were interviewed separately and each interview was recorded on mini disc. I then transcribed the interview word for word except for one interview which

1 The word horizontal is intended here, inspired from the definition of Grocke (2005, p. 329), where she defines it as similar to horizontal but slightly different – as if looking to the horizon to capture the wider view.

was carried out in Danish. It was transcribed by a research assistant from detailed prescriptions from me. I decided to leave this transcript out of the study because of the amount of data.

In the transcripts I retained the exact sentence structure that each participant used, even though many sentences were in 'speech' language form. I also indicated hesitations, laughter and repetitions etc. I included the interviewer's questions in brackets, when necessary, to clarify the meaning of the answer. I filled in words with ellipses, when part of the spoken language included omissions that prohibited meaning.

Stage 2

In this stage I started the process of distilling meaning of each participant's experience. I read through the interview transcript to get a sense of the person's experience. I then read through the transcript again at the same time as I listened to the minidisk and identified in the reading/listening process what I heard as '**musical motives**' in the spoken language and underlined these as *key statements* in the transcript. This procedure I call a '*musical listening of spoken language*' procedure. I did three readings and underlined with different colours (black, red and green) for each reading. The fourth colour (blue) is used for correction suggestions from my supervisor who checked the text in detail in a fourth reading through.

The interview protocols with underlined key statements in four different colours are compiled in the attached CD, appendix 1 to 4.

Stage 3

In this stage of the analysis, I gathered the key statements of the participant's experience and grouped together statements, which were about one aspect of the experience, as a *meaning unit*. Four of the meaning units are inspired by my main question namely:

- Perception of counter transference
- Understanding counter transference
- Reaction on counter transference
- Interpretation of counter transference

Also the guidelines, sent to the interviewees, influenced the identified meaning units, in that each participant was told to describe in detail the

moment, they identified as a counter transference moment. Also each participant was told to make a shorter description of two sessions before and two sessions after the identified counter transference session, if not a first or a last session. (see also chapter 3, p 233). Still the answers are so individually brought forward, that no meaning unit overlaps more than the meaning units of two participants. Those that do overlap are:

- Describing the counter transference session
- Describing two pre-sessions to the counter transference session
- Understanding counter transference
- Interpretation of counter transference
- Listening through the body
- Music versus words
- Counter transference as a negative experience
- Theoretical understanding of counter transference

For each participant further meaning units were derived to cover the unique quality of the expression of the lived experiences. All together the number of the meaning units varied from 14 to 33 among the four participants. Thus the titles of the meaning units for each participant mirror their language and variation in experiences. Several meaning units covered overall themes such as: different ways of listening, different ways of playing, different ways of being present or the influence of the context on the counter transference-experience.

Stage 4

In the fourth stage of analysis, I instilled the meaning unit of each participant's experience over a period of time (sometimes over a period of several weeks, but always over a few long days in the final part of the process). I then transformed these meaning units into the *distilled essence* of the person's experience.

Stage 5

In the fifth stage of data analysis, I sent the material to each participant for *verification*. I choose to send the material twice. Each participant first received by mail a copy of the interview transcript, with key statements underlined, a copy of the meaning units I had derived from their transcript, and a copy of the distilled essence, I had written in my own words. They were invited to go through the whole text and see if the transcript,

the key statements, the meaning units and the distilled essence were meaningful and if the distilled essence was capturing the essence of their experience of the identified counter transference moment. None of the participants wanted corrections on this text send as a total packet.

About six to twelve months later, the time distance was a bit varying among the participants, I sent solely the distilled essence, without the interview transcription, to have verification, if it was meaningful for the participant to read this text as standing alone. I also wanted to further verify if the text still captured the essence of their experience in a time distance to the first verification. In the second verification they were asked the following questions about the distilled essence:

**Does the distilled description capture the essence of your experience?
Is there any aspect of your experiences that has been left out?**

In this second phase of verification one addition was suggested by one participant. All four participants commented that it had been a touching experience for them to read the distilled essence again after a period of time from the interview, and from the preparation work they did before the interview. I want to emphasise, that when I sent the material for verification the first and second time, the distilled essence was written with the initial of the participant's first name to keep the text as close to the personal experience as possible. In order to keep the participants as anonymous as possible for the future, I have changed the initials in the final text here to A, B, C and D for the four participants.

What follows is the distilled essence of each participant's experience of a counter transference moment in musical improvisation in adult psychiatry preceded by an introductory comment, to place the participant's experience in context. One participant's verification of the essence is printed in **bold** type to indicate this participant's own words as she was the only one who wanted corrections. I then reflect on the participant's experience and comment on any methodological issues in respect of each participant. In presenting the distilled essence of the participant's experience I have used the present tense. According to Colaizi (1978) and Racette (1989) this is consistent with phenomenological descriptions in other studies. It should be noted, that I had read the participant's prepared material before the interview, so that I could have a sense of their situation and context. I did not refer directly to the material during the interview process, but the preparation process made the interview experience very vivid and present for the participants and for me as the interviewer.

4.1 Participant no 1 – A

The first person who was interviewed was me as a therapist being interviewed by my supervisor. I have been working in adult psychiatry for twelve years and I have often been aware of strong counter transference experiences, which were also partly my motivation for my research topic and questions. The female patient, forty years old, with whom I identified the counter transference experience described in this interview, was diagnosed as F419.0 (from ICD 10, the International Codes of Diagnosis) **'anxiety condition without specification'** plus F606.0 **'anxious evasive structure of personality'** simultaneous suffering from social phobia and other single phobias (strong wind, spiders). She also suffered from a cyclic depressive condition.

As reflected in my epoché, I know I easily receive sensations, tensions and emotions through my body in the clinical situation. I have comprehensively written about **the therapist's way of being present** (Pedersen 1991, 2000, 2006), and about **the therapist's listening perspectives** (including an embodied perspective) (Pedersen 1997, 1999, 2000). These writings include descriptions of basic elements of the counter transference experience. I have tried to develop terms which I find more applicable for music therapists than counter transference, such as **listening attitudes** and **listening perspectives**. So reflecting on counter transference experiences was well known to me. I was surprised how deep and intense the interview was experienced, even if most of my answers were not new to me. I still came to formulate ideas, which I had never formulated before and I felt enriched by the interview situation – as if I came one step closer to formulate implicit tacit knowledge. In the distilled essence from my interview, it felt very natural to authenticate my emphasizing embodied experiences. In order to keep my therapeutic and research parts of myself separated I chose here to write A instead of my first initial I in the form of present tense. I also present myself as being in a third position.

Distilled essence of a semi-structured qualitative interview with A
The counter transference experience for A is banging a drum unintentionally during a dual piano improvisation with her patient. It is something her hand does on its own.

A identifies strongly with the patient's condition of flying away (out of the body), and she also identifies with the feeling of simultaneously being tied up in a big rope. Banging the drum gives A a body sensation of a shock and she feels like hitting the patient.

For A there is a connection from this counter transference experience to similar shock effects experienced in her body and also connections to experiences of sensations of being tied up from outside in her own life story.

In the counter transference moment A is changing her attitude from being carefully listening to herself and to the patient, to an attitude of being unintentionally provocative to the patient and to herself.

After the counter transference experience A is now able to express the pressure in her breast in the music between herself and the patient.

A uses the music to bring the patient and herself into this shock effect and she also uses music to bring both parties back to an easy place in the music (the dancing girl motif).

A easily connects to the patient's inner tensions and anxiety and she understands her role as both being a healer and a fighter partner to the patient.

The counter transference experience brings the work at another state where the patient, for the first time, can feel connected to her body, to the music and to the therapist. She is expressing this in music, in words and in her drawings.

The counter transference event brings A a more relaxed body feeling when being with the patient, and more enjoyment in her work.

Verification

In carrying out my research study I wrote this distilled essence in 15 minutes. I had nothing to add not even one and a half years later. I still rush directly into the situation and re-experience my body feeling and the understanding of the situation, as if it was an experience from yesterday. I am currently writing up a single case study on my work with this patient and the preparation, I did for the interview, is of tremendous help in being emotionally in touch with the three and a half year case work.

Discussion

The interview took place in the music therapy room where the identified counter transference experience had taken place. The identified counter transference session was session number 52, so A knew the patient very well. The therapy sessions were still in process at the time of the interview. It was interesting to notice how this helped A to really get back into the session almost physically. A easily forgot, that her interviewer was also her supervisor and her former GIM therapist for some training sessions. A felt a firm and warm discipline in the interview process and A felt very serviced by the guidelines. Still A came to talk about much more material around the counter transference experience, than the ma-

terial she had addressed in the guidelines. For instance she commented on some drawings, the patient had made during the therapeutic cooperation, and on how they also mirrored the dynamic implicit in the counter transference experience. For A, the music identified as a counter transference reaction, came out as a surprise for her, as if 'all of a sudden' there was a change. It is also characteristic for the interview as a whole, that A is commenting on having the feeling of being a container of emotions like impatience, emptiness, being withdrawn and strong tensions. Already in the sessions before the counter transference session, A had tried out some playing rules with this patient. These rules included an ABA form in the musical improvisation. This form offered a space where the therapist and patient moved from an A Part) in the music, mirroring the patient's here and now atmosphere (playing pianissimo and very harmonic, stepwise melodies) into a B part), where the patient was challenged and encouraged by the therapist to move into a more forte and dissonant way of playing. Thus the patient was offered the authority to show by her self when she needed or wanted to return to the A part) in the music, and when she wanted to come back to the more piano and harmonic quality in the music.

Still the therapeutic progression was very slow and the counter transference experiences of being a container were obvious present in many sessions before the one described here, in that the therapist experienced strong body sensations such as a strong pressure in her breast. The two sessions leading up to the counter transference session brought some small openings, which might have unconsciously or pre-consciously inspired the therapist to react at that specific situation. The new experience, and the surprise for the therapist in the identified session, was this strong body reaction to the counter transference sensations like a shock reaction, where the therapist broke out of the field of tension and pressure. Here she created a space, where these emotions could be shared with the patient. From the interview it is obvious that A allows herself to be very much influenced by the evasive, and 'hardly being present atmosphere' created by the patient. It is obvious that the timing of the therapist's outburst is positive, in that the patient is ready to look at and work on the difficulties being there in the relationship.

4.2 Participant no 2 – B

The second person who was interviewed was a male therapist being interviewed by me. He has been working in psychiatry for over twenty years and has written several articles about his work. He immediately

accepted being interviewed and the interview took place at his home. The male patient, a man in his thirties, with whom the therapist identified the counter transference moment described in the interview, was in psychiatric treatment because of a strong alcohol dependency and he is described as having symptoms such as: dependency of alcohol, tendency of isolation and depressive traits. The therapy sessions were still in process at the time of the interview, and the counter transference experience was very vivid in B's memory.

In the preparation papers for the interview sent to me by B, he reported on the improvisations carried out in the second previous session to the counter transference session. He wrote that **the patient seems occupied by acting out and by expressing aggressive feelings**. From the previous session to the counter transference session he reported that: **At times, during the improvisation, the client plays very loud, insisting and aggressive, but a saturated, mellow feeling seems to take over in the last part.**

Characteristic for B's distilled essence is the rich detailed, step by step description in which he reports his counter transference experience of adding a voice quality into the musical improvisation.

Distilled essence of a semi-structured qualitative interview with B

The counter transference experience for B is him intuitively adding voice qualities to a drum/piano improvisation with his client, while they are both building up to a peak. The voice grows out of the peak. He intuitively has a feeling that he is surviving something. He gets the image, that if he is not starting to sing, maybe they will both drown. B immediately gets the feeling **'Yes it is right to do this'**.

He repeats using the voice four times, changing the voice qualities in a range from a 'survival quality' to a quality of feeling more safe with his voice, to a 'victorious quality': he is ending in a more soft and distant quality with his voice.

B is identifying with the chaos and violent way of playing – where the patient is playing more and more at the deep level of the piano. Subsequently he is building up to a peak like almost getting out of control – as if he cannot get out.

B recognizes being afraid of dying and of not being able to get out of a dangerous situation from his own life story. He can easily connect to this kind of survival situation. He intuitively has a kind of readiness to react in such situations.

In the counter transference moment, B is changing his attitude from being just a follower, who is mirroring the client's music, to an attitude of intuitively both mirroring and adding something to the music at the same time.

After the counter transference experience, B feels like being more freely with the patient and plays completely differently. He plays much more harmonious in broad major chords, where he builds up to peaks in a more soft way.

The counter transference brings the work at another state, where the patient plays in a more structured way. The patient feels uplifted and he comments that in this way he gets energy and also takes energy from the music. So it is transforming his way of playing. For B it changes the colour of the atmosphere being with this client.

Verification

Also this distilled essence I wrote very quickly as the interview had brought me very vivid inner imaginations of the counter transference event taking place. B had nothing to change - neither when he had the first member checking on the total material (interview, meaning units and distilled essence) - nor in the second member checking a year later, where he looked through the distilled essence a long time after the termination of the case.

Discussion

This interview took place at B's home, which for me was very adequate being an interviewer. I know B from mutual therapeutic and supervisory activities in the past, which always took place in a therapy room. These more private surroundings here symbolised for me the new roles of us being together here as interviewer and interviewee.

The case, chosen by B for identification of a counter transference experience, was a short term case, planned for twelve sessions, as a follow up after the patient's participation in ten group music therapy sessions. These sessions were also carried out by B, so the patient was well known to B. The focus of the therapy was the patient's low self esteem and shyness towards the opposite sex, rather than focussing directly on his dependency problems. The identified counter transference session was session number ten. As the counter transference session had taken place the week before the interview, B still was very much involved with the patient. He emphasized how the preparation for this interview had helped him to really understand, what had happened in the last session. As a consequence of the session that took place the week before, B did not have to describe two sessions after the counter transference session in his prep-

aration for the interview. B told me a couple of times during the interview, that just now, he was formulating thoughts he had never expressed before. It happened especially when he was talking about how the therapist might be the one, who unconsciously receives primitive sensations through the body for both the patient and the therapist. Another characteristic of this interview was the easiness, in which B was talking about, how he applied traumatic experiences from his own life story, in order to understand, why and how he unconsciously reacted by adding his voice as a symbolic sound for a surviving quality. He also applied these experiences to understand his role of saving both the patient and the therapist from drowning in the counter transference situation. Finally the change in the musical relationship, emerging from the counter transference experience here, took place already in the counter transference session. This shows that the patient seemed to be very prepared for the counter transference reaction and for the change in the music, where he changed from playing in a very chaotic way to a more structured way. So the musical drama took place within a short span of time altogether.

4.3 Participant no 3 – C

The third person to be interviewed was a female music therapist being interviewed by me. She has also been working in psychiatry for more than 10 years, and she has written several articles on her work. She also immediately accepted being interviewed but she had the problem that only a few of her sessions had been recorded. So she needed time to go back and be sure she could clearly identify a counter transference experience. Her recording was on video. This is mirrored in the interview, as she often refers to the video and to what could be seen on the video.

The case, she chose for identifying a counter transference event, included a patient suffering from manic depression and the counter transference event took place in the second last session. The patient was described as having a constant underlying affect of rage towards everyone coming into contact with him.

In this interview the interviewee emphasized her role in playing music with the patient. She also emphasized, how she realised in the two previous sessions to the counter transference session, that she was playing music in a similar style as she did four years earlier with this patient. She felt as if coming back to something familiar, but in the 'here and now', it sounded different, and she recognized that things had changed. In preparation for this interview, she saw this recognition as a pre step to the fact that, she suddenly dared to separate herself from the patient's

music. Subsequently this created space for the counter transference experience to emerge. The therapist experienced to be recognized as a separate person and not as an object for the patient's projections in the counter transference experience..

Distilled essence of a semi-structured qualitative interview with C

In the counter transference experience C realises that she is playing the same chordal progressions, that she played with the same patient four years ago. It is this symbiotic – lullaby type of music. But it has a different quality because the patient keeps looking at C. C is not so much playing along as a follower to the patient in the counter transference experience, but she is trying to play around the patient. The patient then stops with one hand and waves and smiles at C in a very warm way.

C becomes conscious that this is almost like an equal meeting rather than C following and nursing the patient. It is like two consenting people going along together. The quality of the music after that takes on a really quiet, sad mood, and C starts to play in a minor key. C feels like saying, as a counter transference reaction, through the musical expression: 'we are going to be parted, we are saying good bye.' The patient is listening in the moment, rather than just playing on musically, and the music is shaped by both therapist and patient together.

This moment touches C and she gets in touch with some quite powerful feelings. This helps C to take more risks and be more adventurous. C speeds up in the music and plays some passionate chords. She lets the patient go and risks not having the patient constantly staying with her in the music. C makes different atonal sounding music, which on that day does not bring the patient out of control. C imagines that taking a risk might help the patient to express something more about the range of feelings he has had about this therapy. C feels like acting out in the music in symbolically expressing to the patient: 'this is where you had feelings of love and passion – you had feelings of distress, of disquiet and of being out of control.'

C experiences the moment very powerfully. She has two **young** sons at the time of seeing the patient which she thinks might have tuned her in for the counter transference reaction. For C it seems natural to be very nurturing – often to very violent quite disturbed male patients. She seems to tag into this and to get in touch with the patient's needy parts. These parts C compares with a needy two year old baby between a rage and a wish for love. The counter transference experience enables the patient to access a needy soft expressive side and it really seems like the patient is acknowledging this intertwined relationship. The patient is obviously feeling it, which he has not really stated before. The patient is able to talk about C as a separate person for the first time.

The work is more into flow now. C wants the patient to acknowledge the ending and really experience it, as the patient has had many dreadful

endings. After the counter transference session, C does not want to take another risk. The therapy ends two sessions before it is contracted, ***because the patient negotiates this***. C experiences this like two people negotiating in a quite mature way.

Verification

C has a small correction when she receives and carefully reads the distilled essence one year after having gone through the full material.

The first correction is a factual one that her sons were not 'small' but 'young' at the time for the counter transference experience. Maybe this time aspect was a little bit confusing for me, as the therapy had taken place several years ago and lasted for four years. The second correction was in the second last sentence where C wanted the following addition: ***'because the patient negotiates this'***. Thus she wanted to emphasize the role of the patient in the mutual decision on ending the therapy a few sessions before it was decided, which seems to be an important issue in the therapist's experience of the ending as a mature mutual decision between the therapist and the patient.

Discussion

This interview took place at C's home which I found very appropriate, as I have had mutual supervisory activities taking place with C in the past in music therapy rooms. The privacy here thus represented our new roles. Even if C had the session recorded on video, we decided not to watch the video together in the interview situation, but to let the video be the preparation material for C.

The therapy sessions spanned four-and-a-half-years of individual music therapy, which had taken place some years ago. C has also written about this case. This was mirrored in the interview, where C offered many layers in her way of experiencing and understanding her relationship with the patient. The counter transference experience was presented very vividly in spite of this time distance. The focus of the therapy was to offer the patient a space, where he could express himself and where he could get an experience of being accepted. It also offered a space where he could react alternatively to his previous patterns, in which he had to leave each situation, when being with other people, searching to be understood in his own manner, without success.

One characteristic of this interview was that, because of the time span, C had the possibility to also mention the importance of other professionals

reporting back to her, what they saw as positive outcomes of the music therapy. A second characteristic was that C focussed on problems with ending long running, therapeutic relationships. A third characteristic was the interviewee's consciousness of using music for expressions of different moods in the musical relationship. The change, pointed out in the description of the counter transference experience, seemed here to be less of a change in the therapeutic relationship and more a change that led the therapy to an ending. Consequently the ending could be experienced as an equal and mature decision from both the therapist and the patient.

4.4 Participant no 4 – D

The fourth person who was interviewed was a male therapist being interviewed by me. He has been working in psychiatry for more than ten years, and he has written several articles from his work. He immediately accepted being interviewed and the patient, chosen for identifying a counter transference event, was a female patient, twenty five years old. She was described as existing with a vital depressive image and functioning on a psychotic level (Manual of Diagnostic Symptoms: DSM-IV R: Axis I: 309.28: **Adjustment disorder with mixed anxiety and depressed mood differentiated from schizophrenia, residual type 295.60**).

The patient was referred to music therapy for a psychotherapeutic treatment of her underlying psychotic problems. According to D, no manifestly psychotic traits were to be seen, but her attitude of 'cutting off' people and her apathy could be interpreted as negative symptoms. In particular, the patient had a consumer's question: she wanted information. She had unrealistic goals and very little self-reflection.

In the preparation material D is describing the music of the patient, in the previous session to the counter transference session, as being: **aleatoric and repetitive sounds where there is no representation, no musical form. There is no intention to build up the music from a memory, from a psychic space; everything is moving on the traumatic level. The image emerging from the patient is one of an abused, traumatized woman.**

The case had finished a couple of years before the interview took place. As D has been into microanalysis of this case and other cases as well, the interview was characterized by detailed descriptions of the gestures and the body sensations of the therapist. He commented on physical experiences and showed how these were visible on the video recording. D was also emphasizing very much the importance of silence and the importance of what he calls **listening through the body**.

Distilled essence of a semi-structured qualitative interview with D
For D counter transference is something in process. In the improvisation D stopped playing the Kalimbaphone and he is listening through his body. His body resonates something that is coming from the patient. For him it is just a way of listening on a level of affect – not trying to understand or to react. D feels isolation and he feels like he does not exist, so why shall he play.

D likes listening through his body to the body of the patient. He feels relaxed and he is imprisoned at the same time. It is like something heavy comes to him. He can't move. D feels the helplessness when he stops playing. He feels he can do nothing for her or for himself. When D hears the helplessness in his body he is like stoned – sitting there like an object and in this position the fantasy starts. Here D is in his own silence. He hears the patient like screaming: 'let me not alone. Help me – I cannot help myself'.

D is listening to it and it comes into movement inside him, When D intuitively moves to the piano he knows nothing about what to play. What D remembers is, that he is really into the piano, into the music – listening to what he is playing – and wanting to give some form to it. He wants to come to exist through the music. It is like listening to him self – he is here. He exists – D can exist and he plays for life, like to be alive, and to stay there as a subject. He feels as if he is playing: 'You can't destroy me – I exist.' For him It is also thinking through the music. D lets the music show him the way – and he exists.

Interesting for D is that he plays no chords and he develops the descant-line role in the bass-line. Normally the therapist is playing the bass-line role, but here D plays very clearly the melody. And the melody was also a kind of antidote – against all the poison that affects him. In this way it comes closer to him self in the situation.

D is sitting just opposite to the patient – and in the beginning, when he does the first tone, the tone is almost in tune. The tones are so connected. Later it is a little bit different. D is not playing as accompaniment to her, he just makes a position

D wants to give form to the music – to bring some time structure into it – like a phrasing act.

He hears her inner sound – not the kind of sound she is playing. D wants to be in resonance with him self but something happens with the patient, so he is sure that he is also influencing her.

This improvisation was very soft – we ended together

Playing the piano for D is more a continuation of not playing and it is like not being heard from outside. This is the big difference from playing the Kalimbaphone, where he wanted to come into contact with her and with what he can hear, with the social part. Here he just starts to play on the piano – and then it develops and D is following the music – fully unconsciously. And it is so soft the playing, that D has the experience you can not hear, when he

starts to play. He is playing not to be heard by the patient but for him self, like when you listen to the inner music of people, who can talk and talk. You feel that they can talk of happiness and you feel sadness and destruction and this is the quality of him playing on the piano.

Coming from a life story of no silence, D knows that for him silence is playing or listening to the music. The sound around him gives him a space. This is his silence and a silence he finds back when he is listening to his patients. And D prefers it that way. He prefers to take the risk of silence. D wants to find the silence – to listen to it – it is timeless.

In the next session D experiences that the patient is ready for another way of playing, and he is sure here, because he knows him self – he can make jokes, so he can be more in his therapeutic freedom. D can provoke something therapeutically. He can improvise in his style. She lets him free.

Verification

It took me a little longer time to be clear in my mind about this distilled essence. I think now it might be a consequence of the interview partly being talking, partly being watching the video, where I had my mind at two different sources of information simultaneously in the interview situation.

D had no correction suggestions in any of the two member check correspondences we had.

Discussion

This interview took place at D's office and I have had no therapeutic or supervisory activities taking place with D. In this interview situation we decided to bring in video excerpts, as this is a very familiar way for D to present and to tell about his work with patients. Also part of the identified counter transference experience, for him was a situation of silence where the video could show what was presented through the body posture of the patient and the therapist, as well as what took place in the music.

In the beginning of the interview, we were interrupted shortly, and as I shut off the microphone for that, I forgot to turn it on again for about twenty minutes when we continued. As soon as we realised it, we tried to repeat the first questions again, but the answers were a bit different. The interview transcript therefore presents exactly what was recorded.

The case was a short term case and the counter transference session was the second session. D knew the patient from her participation twice a week over eight months in group music therapy, conducted by D. The pa-

tient referred herself to individual music therapy, which simultaneously terminated her participation in the group therapy after the patient's wish. Her argument for wanting to enter an individual music therapy was, that she felt totally blocked in her creative expressive sides (she had been writing poems before becoming psychotic). She wanted to work on lessening these blocks if possible. The case went on for four months but the counter transference experience opened up for the patient to be able to play a musical form already in the fourth session. This was a major step concerning therapeutic work on breaking her isolation and breaking her sensorial way of playing, where she was not connected either to the music or to the therapist.

Characteristic elements of this interview are the detailed descriptions of the therapist's experience of being present in the body; and in this attitude receiving projected material from the patient who is in a psychotic state. These descriptions served the interviewee in putting this tacit knowledge into words.

4.5 Conclusion

This chapter shows that music therapists, working with musical improvisation in adult psychiatry, do have very different working styles and also different ways of understanding their work from a theoretical viewpoint.

The chapter also briefly presents the different patients, included in the act of identifying a counter transference moment. The diagnosis of the patients are shortly presented as these patients are the partners with whom the music therapists have their counter transference experience. So even if the focus of this study is not, whether the diagnosis is potentially determining the quality of the counter transference experience, this is still an interesting aspect to bring into the discussion of the findings in chapter 6.

Finally this chapter brings in factual information in the individual cases about the duration of the therapy, which session number is identified in the case, and what was the aim of the music therapy treatment in the different cases, where a counter transference event was identified.

I have tried here to present some glimpses of the subjectivity and originality of each of the interviewees. In the next chapter I look for common traits across the interview transcripts and composite meaning units and distilled essences.

In spite of their differences, all four interviewees seem to be very familiar with the use of the clinical term '**counter transference**' and I am very thankful for getting such rich descriptions of their understanding of this clinical term.

Horizontal analysis

Composite Categories, Composite Themes, Composite Essence and Global Essence

Introduction

In this chapter I present stage 6 to 8 of the phenomenological analysis, where I have done a horizontal analysis.

Stage 6

In stage 6 the common meaning units across all four interviews were laid side by side and **composite structural categories** were developed. (see appendix 5). In this phase I placed together all of the meaning units which related to a specific aspect of the counter transference moment and from reading these meaning units several times I found one category covering the number of meaning units. Some of these categories came out very quickly and were related to the research questions and my sub-questions (see p. 223). Other categories first became clear after several readings through the individual meaning units of the four participants.

5.1 Composite Structural Categories

Categories one to four are related to my **main research question**:

1. Counter transference perception and reaction of the counter transference moment
2. Understanding counter transference
3. Interpretation of the counter transference moment¹ from a time aspect
4. Interpretation of the counter transference moment from the perspective of using the metaphor of being a mother figure to the patient

Categories five to eight are related to my **sub-questions**:

5. Positive effect of counter transference experiences
6. The therapist's negative experience of counter transference
7. The music of the counter transference moment
8. The musical relationship in the counter transference moment

Categories nine to fourteen are related to my check list of questions for the interview and the guidelines I worked out and send to the interviewees as preparation for the interview (see p. 233):

9. Feelings of the therapist
10. Levels of consciousness in the counter transference experiences
11. The impact of the therapist's life story on the counter transference moment
12. Moving from one experience to another in the counter transference moment
13. A theoretical perspective on counter transference
14. Differentiation of counter transference feelings

Categories 15-16 grew out of the interview situation. **Categories 1- 14** represent meaning units from all four participants. The last two categories represent meaning units from three participants (category 15) and from two participants (category 16):

1 See Amendments p. v.

15. Not all feelings experienced by the therapist in the therapy situation are counter transference
16. Using music instead of words in the counter transference moment

In this phase of placing the lists of meaning units together it also turned out that some of the units were not really relevant for the composite experience. They were rather issues related to general notions of the subject. These units were left out. An example of such a meaning unit is a unit from the individual meaning units created in the analysis of the interview with D where one unit is called 'Using a filter'. This unit, although important to D's experience, was not found in the descriptions of the other three participants, and it was not related to the research questions. Therefore it did not become a composite experience.

5.1.1 Development of composite themes

Stage 7

After I grouped together the meaning units, which represented a certain aspect of the experience of counter transference, I read the composite categories and the meaning units related to each composite category several times. I then tried to distil composite themes from these composite categories. Bruscia describes this process as follows:

At this point, the researcher may begin to look at the relationship between the codes on the next level of abstraction. More specifically, can different codes be subsumed under the same process, condition, property or dimension? The purpose at this level of coding is to move upward from the descriptive details of each case to larger themes that might resolve superficial differences between cases.

(Bruscia, 2005, p 184)

For example it stood out for me both in the composite category '**Feelings of the therapist**' and in the composite category '**The music of the counter transference moment**' that the counter transference moment emerged as a surprise for the therapist. This condition thus became a composite theme.

- 1) *The counter transference moment is a moment of surprise for the music therapist*

All categories were analysed in the same fashion both as single standing categories and across the categories and a number of composite themes emerged.

In the process of grouping the meaning units of the participants into composite structural categories, I have been aware of, which categories were actually represented by all four participants. This was interesting here, as 14 categories were representing all four participants and only two categories represented less than four participants, even if the subjects were very original and subjective in their style of answering the questions. The four interviews were very different in style as described in chapter 4 (see p. 235)

In phenomenological research studies those themes, which are represented by all participants, are identified as themes that represent **consistency**. This is apparent "when the researcher finds regularities, or repetitive patterns which reveal what appears to be typical of or essential to the phenomenon" (Bruscia 1998, p. 185)

In developing the composite themes I first looked for those which represented consistency and they will be presented first. After this the **themes of variation** are presented, which means that I looked for themes, which were not represented by all four participants. Still these themes added further meaning to the answers of the research questions, and they also added further understanding to the phenomenon of counter transference in a larger perspective.

In phenomenological research each theme is considered to hold equal importance. **This means that even if one theme is represented by all four participants and another theme is represented only by two participants, this does not imply that the former is more factual or probable.** Bruscia explains this as: "Higher frequency is not necessarily stronger evidence of fact than lower frequency and conversely, lower frequency is not necessarily weaker evidence" (ibid. p 185)

It is important, is that the emerging themes remain faithful to the participant's experience of the phenomena. So **the themes presented here illustrate both the consistencies in the experience and the variations of the experience. The order of the numbers is also not representing any difference of importance.**

In this study most of the composite categories were consistent to all four participants namely fourteen out of sixteen identified here, which fact also influences the consistency of the composite themes. In the process

of distilling the composite themes seventeen themes showed to be consistent and two themes showed to be various and non consistent.

It does not mean that they are evaluated in a rank order of frequency. Rather it might mirror the important preparation work each of the participants did for the interview. Even if the participants were very individual in their answering style they were all very prepared to share information around all the questions; also those questions inspired from my internal check lists of possible information which I used with a side check during the interview. (See chapter 3. p. 235).

5.2 The Composite Themes

Composite themes

which were consistent for all four participants in the study were:

- 1 *The counter transference moment is a moment of surprise for the music therapist*
- 2 *The counter transference moment recalls recognizable experiences from the music therapist's own life story*
- 3 *The music therapist identifies with the mental suffering of the patient as part of the counter transference experience*
- 4 *The music therapist breaks out of the identification with the mental suffering of the patient as part of the counter transference experience*
- 5 *The music therapist takes a risk in the music as an effect of the counter transference experience*
- 6 *The counter transference moment includes an unconscious change in the music therapist's musical expression which also causes a change in the musical relationship*
- 7 *The counter transference moment includes a positive change in the therapeutic process*
- 8 *The counter transference experience includes a positive shift in the music therapist's contact with the patient*
- 9 *Discovering, that something specific is emerging, is a part of the counter transference experience*
- 10 *Being informed by body sensations or emotions is a first step in the counter transference experience*
- 11 *Translation or transition from physical sensation to psychological understanding takes place in the counter transference experience*
- 12 *Moving from one dynamic to another is a part of the counter transference experience*

- 13 *To trust the timing aspect is a crucial element in the counter transference dynamic*
- 14 *Music therapists use the metaphor of being a mother figure in the counter transference dynamic*
- 15 *Music therapists experience negative counter transference as being insensitive to the process of the patient*
- 16 *The understanding of counter transference is based in theoretical beliefs*
- 17 *Counter transference feelings are hard to differentiate for music therapists*

Composite theme representing three participant's experiences was:

- 18) *Counter transference is a specific experience*

Composite theme representing two participant's experiences was:

- 19) *Music is understood at a sensate level in the counter transference moment*

5.2.1 Further elaboration on the Composite Themes

- 1 *The counter transference moment is a moment of surprise for the music therapist*

All participants talked vividly about how they were surprised both in what happened in the music in the counter transference moment and also, how surprisingly strong they were either sensationally or emotionally influenced by the moment. Each of the participants could very easily recall the experience of surprise and describe it in details no matter, if the therapy sessions were still in process or if the therapy was terminated several years ago.

For **A** it was a surprise that her hand made a movement of its own in the music and she was surprised when she unintentionally banged a drum. Also A was surprised about the shock effect it raised in her body.

For **B** he was surprised about suddenly hearing his voice expressing a 'survival quality' and he also was surprised about how strongly his experience of death anxiety was recalled in the moment. Finally he was surprised that his voice stopped singing this quality after about ten seconds.

For **C** she was surprised that she suddenly played music in a style she had done four years ago with her patient, and she was surprised that the patient kept looking at her rather than just being fixed going up and down on the metallophone. She was also surprised how she suddenly dared to

play very passionate chords in the music and thus expressed her inner emotions without fearing that the patient would leave the room.

For **D** he was surprised how he unconsciously and unintentionally moved from one instrument to another and how the act of him playing the piano was more like a succession or a continuation of, when he was not playing. He was also surprised about the strong feeling of being imprisoned and being like stoned in the body in the counter transference moment.

2 *The counter transference moment recalls recognizable experiences from the music therapist's own life story*

All of the participants were open to reflect their experience in the counter transference moment as something they could easily recognize and recall from their own life story. Some of the participants, such as B, could identify a certain episode in his life story, which had been important for his recognition of emotions in the counter transference moment. Other participants could, at a more general level recognize body sensations or role positions, that they knew very well from their personal life experiences.

For **A** she recognized the experience of a body sensation of being tied up in a big rope from outside, as a sensation of not being able to express her self freely in her surroundings. She recognized this as a feeling of being restricted from the lively things she wanted to do.

For **B** he recognized the feeling of being afraid of dying from an episode as a child, where a bigger boy was sitting on top of his head in the snow and he was not able to breathe or to get out. B recognized the experience of being very afraid of how to get out of a situation.

For **C** she recognized the experience of being naturally nurturing to quite violent, disturbed male patients. She also realised that she might be particularly attuned to this because she had two young sons to raise at the time of the counter transference moment.

For **D** he recognized the experience of being silent in the music where he just listened to the patient. This position he knew from being a member of a big, never silent family. In the family, he learned to survive by being silent in order to come to exist and to feel that he existed.

3 *The music therapist identifies with the mental suffering of the patient as part of the counter transference experience*

All of the participants talked about an identification with the mental suffering of the patient as a part of noticing the counter transference moment.

For **A** she comments about identifying with the patient's body sensation of being tied up in a big rope, where the only way out is to mentally leave the body. In this position A was not able to be really present in the situation. At other times she talks about identifying with the suffering of feeling a lot of pressure in her body. She felt like suffering this body sensation for both the patient and the therapist. She also uses the metaphor of pulling the wagon for both parties.

For **B** he comments about resonating strong feelings in his stomach, which he recognizes as an identification of the patient's fear of dying. It is an experience of not being able to breathe and not being able to get out of the situation. It is like getting stuck and being lost.

For **C** she comments about the feeling of identifying with the patient's passionate and sad feelings resonating in her body, as she is managing the ending for both parties. At other times she is having the patient to stay with her constantly in the music in an almost symbiotic way. Here she is identifying with a state of feeling like not being a separated person to him.

For **D** he comments about identifying with the patient's experience of being left out, as if neither of them really existed. Later he comments about listening to the patient's inner music from an affect level where he can hear the helplessness of both the patient and himself.

4 *The music therapist breaks out of the identification with the mental suffering of the patient as part of the counter transference experience*

All of the participants talked about how they recognised the counter transference moment in that, they broke out of the identification with the patient's mental suffering. In this unconscious act they broke out of the position of being empathically suffering with the patient as a part of the counter transference experience.

For **A** she unintentionally banged a drum in the middle of an airy piano duet which gave her a body sensation of a shock which immediately made her feel more present in her body. This encouraged her to play out the pressure in her breast in a more dissonant and violent musical style with the patient. She broke out of the almost symbiotic empathy for the patient which brought her a more relaxed body feeling and more enjoyment in her work.

For **B** he all of a sudden added a 'surviving voice' quality to the piano/drum duet which made him feel like he was creating a birth channel. He experienced that this channel gave birth to another direction in the music, and thus it saved both him and the patient from drowning. The next quality in his voice improvisation sounded more safe, the third more 'victorious' and the fourth more soft and distant.

For **C** she started to play out her strong passionate feelings, and thus she broke out of the position of being a follower to the patient's music. This act created a space for an equal meeting between the therapist and the patient, where C was recognized as a separate person to the patient.

For **D** he unconsciously moved from a position of being into the silence where he resonated the helplessness from both the patient and him self. He stopped allowing his own helplessness to resonate in the empathic listening attitude, and he unconsciously offered a musical form by playing the piano, where he let him self play melodies. Playing the piano made him feel like he existed for himself and for the patient.

5 The music therapist takes a risk in the music as an effect of the counter transference experience

All of the participants commented on having unintentionally changed their musical expression in and after the counter transference moment. They experienced this change as taking a risk, as they did not know about the effect of taking this risk in the moment.

For **A** she risked to continually play in a more dynamic and dissonant way with the patient after the counter transference experience. She used the metaphor of moving away from being in the role of the positive protecting mother - to being in the role of a negative demanding mother. The later musically made both the therapist and the patient break out of the big rope. She also talked about being the one, who spat the patient out of the volcano.

For **B** he risked adding his voice to the improvisation four times, and he continued to offer more structure in the music. The voice quality changed from having a 'survival quality' to a quality of sounding more safe the second time; more 'victorious' the third time and more soft and distant the fourth time. B also used the metaphor of freeing the fire in a volcano.

For **C** she risked separating herself in the music by continually playing her own inner passionate feelings out into passionate chords. She used the metaphor of having been in a mother role to the patient, as if he was

a two year old needy boy between a rage and a wish for love. C is now continually risking to bring the patient into a dialogue as an adult to adult in the music.

For D he risked to play the piano, an instrument not chosen by the patient, and he also risked to play melodies more for himself, in order to play himself out of prison. He used the metaphor of being in a listening mother role. This role meant for him, that he was just present, confirming the child until more form came into the music. At that point he risked to separate himself by continually offering the patient more form in the music.

6 *The counter transference moment includes an unconscious change in the music therapist's musical expression which also causes a change in the musical relationship*

All four participants commented on an unconscious change in the therapist's musical expression in the counter transference moment, which also caused a change in the musical relationship. The change in the musical relationship seems to appear in the transition from the therapist being identified with the mental suffering of the patient - to the therapist breaking out and being more free of this identification. The change in the music appears as an unconscious change for all four participants.

For A it meant a change from playing along with the patient in an airy piano duet to an unconscious act of banging a drum. Through this act the music changed to a character of symbolically offering a demand: "I want to be with you". The patient could now respond to this demand.

For B it meant a change from playing loud and chaotic music along with the patient in a drum/piano duet, where they both were building up to a peak - to an unconscious act by B, where he added a voice quality and made a change in the music. Through this act he changed his music part to a position, where he both played the drum and used the voice. He offered a structure in the music, which he symbolically understood as giving birth to another direction. For B the created structure in the music seemed to build up to peaks on different levels and with different qualities in the experiences. B recognized these experiences as a progression in the improvisation.

For C it meant a change from having the patient staying constantly with her in the music - to the act of unconsciously playing passionate chords. C also changed the key and dynamic in the music which indicated that, she was breaking out of the role of being a nurturing mother of a needy

child, who is getting out of control. So the therapist separated her music part from the music part of the patient. The patient reacted by staying in the improvisation, which provided an equal meeting in the music between the therapist and the patient.

For **D** it meant a change from him being in a position of first playing the trauma instrument, the Kalimbaphone - to being in the position of stopping playing. He listened to the silence and the inner music of the patient and he unconsciously started to play the piano, where he felt like playing himself out of prison. He continually played a musical form at the piano, and he gradually made the patient play as a subject being there with him.

7 *The counter transference moment includes a positive change in the therapeutic process*

All four participants commented that a change in the therapeutic process emerged as an outcome of the counter transference moment. All of the participants referred to this change as a positive experience and referred that a positive effect emerged from the counter transference moment. None of the participants experienced the identified counter transference moment as a negative experience. All of the participants talked about this change as something that brought the therapy process at another level.

For **A** it meant a change from a position of either feeling a heavy pressure in her breast or having the experience of partly flying away (leaving the body) together with the patient - to a process where both the therapist and the patient were constantly more present in their body. In this position they were both able to reflect on the atmosphere in the therapy room and both could understand the strong body feelings of the therapist as something belonging to both parties, and something they could share in the therapeutic process. The change brought the process at another state.

For **B** it meant a change from being with the patient in a loud and chaotic music improvisation building up to a peak - to a process where they now could both introduce structuring elements in the music which they could both recognize and apply. This change uplifted the patient and changed the colours of the atmosphere.

For **C** it meant a change from being in the role of the nurturing mother for the patient in the music - to be in a position of separating herself from the patient and being able to play out her inner feelings. The therapist and patient could now play like adults and negotiate in a quite mature way. The change brought the work more into flow in the therapeutic process.

For **D** it meant a change from being a listener to the patient and feeling he was not being heard by the patient - to a state of playing himself out of this prison. He played some melodies at the piano and created a musical form, where he did not hold back any more. The change made the patient ready to another way of playing in the next session. The therapist could improvise in his own style and he felt like being let free by the patient.

8 *The counter transference experience includes a positive shift in the music therapist's contact with the patient*

All of the participants commented on a positive shift in the contact between the music therapist and the patient as a part of and also as a consequence of the counter transference experience. For three of the participants A, C and D, the shift included being in a state of feeling like not being in contact with the patient – as if being left out – to be in a state of feeling like being in a more mutual contact with the patient. For one participant B, it was a shift from a feeling of almost being lost in his contact with the patient - to a feeling of being in a more dynamic contact with the patient.

For **A** she was, for a long time, in a contact with the patient, where she felt she was the one, who was pulling the wagon for both the therapist and the patient. At the same time she felt, she was being almost as sensitive as with a baby in the contact with the patient. In the counter transference experience there was a shift in contact including, that they could both take responsibility for and reflect on the different tensions and emotions being present in the therapy situation. A felt like being present in a contact with the patient, where she could sense and resonate with the patient's baby side and the patient's adult side at the same time.

For **B** it was a feeling of being in a level of contact, where he was the one who had to create a frame into which they could both survive. The shift in the contact created a situation, where they could both give and take energy in the music.

For **C** it was a feeling of being in a contact with the patient in the role of being a nurturing mother taking care, that the patient was always playing along with her like in a symbiotic way of playing. In the music she felt, she was not recognized as a subject. The shift in the contact provided a feeling of being present in an equal meeting, where they could play together as adult to adult.

For **D** it was a feeling of being in a contact with the patient, where he was left out. This feeling was so strong, that he felt like he did not exist. The shift in the contact provided a feeling for him of being in a contact, where he could start to offer a musical form. He could be there as a subject and the patient could gradually put herself into the interplay as an existing subject. She could play her transference towards the therapist in the following sessions.

9 *Discovering, that something specific is emerging, is a part of the counter transference experience*

All of the participants commented that something specific was emerging in the counter transference moment. For three participants A, B and D body sensations were suggested as something they experienced as a pre step for the discovery that something specific was emerging. For one participant C strong emotions were suggested as something, she experienced as a pre step to the discovery of the fact that something specific was emerging.

A sensed a shock effect in her body like an electric shock, which made her discover, that something specific was emerging during her drum playing. After the first beat at the drum, causing the shock effect, she continued playing the drum, at a more conscious level, in a way like knocking on a door, before she returned to the piano. What emerged as specific for her, was the state of being 'all of a sudden' presence in the body and in the music for both the therapist and the patient

B sensed his own voice quality in his stomach as something dangerous, which made him discover, that something specific was emerging. He continued the act of adding his voice four times in the improvisation. What emerged was, that his voice improvisation added a structure to the music, and they could now build up to peaks in another quality.

C felt strong passionate embodied feelings during the act of playing strong passionate chords, which made her discover, that something specific was emerging. She continued to play music in a sad mood and in another key and dynamic. What emerged was that the patient waved at her as a sign, that he saw her as a separate person, and he could stay in this relationship.

D sensed the act of moving from silence to a state of almost continuing the silence in his piano music. He was into a level of physical listening, which lead him to the sounds and made him discover, that he was playing melodic forms in the music. He discovered, that something specific

was emerging. What emerged was, that he was creating a psychic space with the patient, where she could play in a more symbolic way and where the music seemed to belong to her.

10 Being informed by body sensations as a first step in the counter transference experience

All of the participants commented on experiencing strong sensations either as body sensations like a pressure or a tension or - as sensations of the therapists not being really present in their body. These sensations were recognized as possibly a first step in the counter transference experience.

A sensed a strong pressure in her breast, which she understood as being informed by her body telling her, at an unconscious level, that she can break out of the big rope, and release the pressure by hitting a drum.

B experienced a strong feeling like if he was almost drowning. He felt this in his stomach, and he understood the feelings as if his body was informing him, at an unconscious level, that he should add his voice to the music in order to be able to take better control over the situation.

C experienced that she had strong passionate feelings in her body. These feelings she understood like being the origin for her act of unconsciously playing strong passionate chords in her music part in order to be able to separate herself from the symbiotic contact with the patient in the music.

D experienced a sensation of him being like stoned in his body. From this condition it seemed for D as if inner movements started to make him listen to the helplessness of the patient and himself. This 'state of being' helped him to be open for his counter transference reaction, through which he stopped this feeling of helplessness within himself, and he give it form through the music.

11 Translation or transition from physical sensation to psychological understanding in the counter transference experience

All of the participants talk about listening at a primitive level to the patient through their body. As a way of understanding a counter transference experience, they talk about translating these body sensations into something, which can be psychologically understood by the therapist.

For **A** the physical sensation was that of a shock effect in her body, which informed her about, how strongly the patient and she, in her empathic listening state, were flying away (leaving the body). It also informed her that she had to take the responsibility of being present for both the pa-

tient and for herself. Psychologically she came to understand that it was the time where they both had to reflect on and take responsibility for the atmosphere in the therapy situation.

For **B** it was a physical sensation in his stomach, which informed him, that he should add a 'survival voice quality' to the music. It also informed him, that the loud and chaotic music was getting out of control. Psychologically he understood, that it was time to offer some structure to the music to save both him and the patient from drowning.

C felt strong passionate emotions in her body, and she was informed unconsciously, that she could now play these emotions out in the music. She was also informed, that she could now separate from the patient in the music. Psychologically she realised that they could now play as adult to adult without the patient having the need to leave the room. They could also both negotiate the ending.

D was listening at an affect level through his body simultaneously **being** in resonance with himself at a primitive level and **hearing** the helplessness from both the patient and himself. Psychologically he understood, that he had to stop allowing his own helplessness to resonate in the state of being empathically listening in the situation. He also understood that he had to take the responsibility of offering a musical form and he added some time structure to the music.

12 *Moving from one dynamic to another as a part of the counter transference experience*

All participants commented on moving from one dynamic to another in the musical interplay or in the therapeutic relationship as a whole. They talked about this movement as being related to the counter transference experience. As an example some participants moved from 'being present' in a painful place in the music to 'being present' in a more easy place in the music and vice versa. They also talked about moving from an intra psychic awareness to an interpersonal awareness. In each case they moved from 'being present' in a dynamic, where the therapist was empathically following the expression of the patient - to 'being present' in a dynamic, where the therapist was separating him/herself from the expression of the patient.

For **A** it was a movement away from an airy way of playing in her music part, where she had been mirroring the patient. In this way of playing, she felt like being as sensitive as being with a baby, and she felt being very aware at an intra psychic level. She experienced a movement to a

dynamically more dissonant and violent way of playing, where she felt like being a fighter partner to the patient. From this position, she experienced a third movement into another, more easy dynamic in 'the dancing girl motif' in the musical part. In being present in the last two described dynamic qualities, she felt very aware at an inter-subjective level. In these movements the therapist allowed herself to move in and out of empathically following the patient.

For **B** it was a movement away from playing loud and chaotic on the drums, where he had empathically followed the patient, and he had been in resonance with the patient's music at an intra psychic level. He experienced a movement into another dynamic quality, where he was adding his voice to the improvisation offering different sound qualities, at the same time as he continued to play the drum. In the movement he emphasized with the patient's need of being out of control at the same time, as he created a form (imagined as a birth channel) in the music, which saved both of them from drowning. In the movement he became gradually aware in the music at an inter-subjective level.

For **C** it was a movement away from a symbiotic way of playing with the patient, where she had been empathically following the patient's need and being aware at an intra-psychic level. She experienced a movement into another dynamic, where C was playing more separately. She played dissonant, atonal music, where she felt like playing the patient's passionate feelings out in the music in the way she was resonating these feelings in her own body. In the movement she played her intra psychic experience of strong passionate feelings out in the music and shared them at an inter-subjective level between the therapist and the patient.

For **D** it was a movement away from playing along with the patient's mechanical way of playing, where he felt like not being heard. In the movement he stopped playing and he was just listening to the patient, and he felt like being stoned. In this position an intra psychic movement started, where he could let a fantasy in his inner life exist, that could help him to contain the counter transference feelings. This movement led the therapist further on, and he started almost unconsciously to play on the piano. Here he played musical form being aware of an inter-subjective psychic space.

13 *To trust the timing aspect is a crucial element in counter transference dynamic*

All of the participants commented on the importance of 'trust in the right timing' aspect as an element of interpreting counter transference. For in-

stance they talked about being almost unconsciously informed about the right timing for the act of separation in a symbiotic relationship. They also commented on the right timing for the act of offering some structure in the musical improvisation. Finally they talked about how they trusted the right timing in the experienced counter transference moments. An important issue is the right time for the patients in order to start to share their own part of the transference/counter transference exchange. It is not always possible to have the patient's verification of the 'right timing' aspect in the counter transference 'here and now' moment, so it is important to be aware after the counter transference experience if a verification comes up.

A talked about being the one, who was pulling the wagon for both parties, where she felt a lot of pressure in her breast. She felt, that she was carrying the pressure for both parties. She also felt the pressure of having to be physically present for both parties. After having unintentionally banged a drum, she trusted it was the right timing, that she could now break out and provoke the patient by playing in a more dissonant and violent style. She trusted the timing aspect in separating herself out of the almost symbiotic empathy, and both the therapist and the patient took responsibility for the atmosphere in the therapy situation. For her this shift was a verification of the timing aspect.

B talked about a strong feeling in his stomach, where he was in resonance with the loud and chaotic music improvisation being played as almost out of control. He unintentionally added a 'survival voice quality' and he gradually created a structure in the music, where they could both be safe. He trusted 'the timing' aspect in separating himself out from being just a follower to the patients chaotic music. In the following improvisations they both added more structure to the interplay. The structured music uplifted the patient and changed the colour of the atmosphere in the therapy situation. For B this shift was a verification of the timing aspect.

C talked about resonating strong passionate feelings in her body and this made her unintentionally separate herself from having the patient to stay with her constantly in the music. She started to play sad music in a minor key and with passionate chords in the act of letting the patient go. She trusted the timing aspect in separating herself from being a symbiotic follower and she experienced, that they could meet in the music at an equal level. This experience for her was a verification of the timing aspect.

D talked about stop playing like the patient, where they both played in a mechanical way and he felt that neither of them really existed. In the silence, he listened to the patient's inner music at an affect level. During the listening phase, he stopped allowing his own helplessness to resonate in the body and he started to give it form. He trusted 'the right timing' in separating himself out from being a follower to the patient. He started to give his own feelings a form in the music, and he offered a psychic space in the musical form. The patient gradually followed the musical form, which for D was a verification of the timing aspect.

14 *Music therapists use the metaphor of being a mother figure in the counter transference dynamic*

In the interview all four participants used the metaphor of being in the role of a listening mother to their patient as a way of interpreting the counter transference experience. They also talked about being in the role of an empathic mother, who risked to take the role of not being solely empathic to the 'child patient' in the counter transference moment.

A used the metaphor of moving away from being in the role of the positive protecting mother - to being in the role of the negative demanding mother. The later symbolically got both parties out of the big rope and spat the patient out of the volcano.

B used the metaphor of creating a birth channel in the music, and he also used the metaphor, that he symbolically expressed four steps in giving birth with his voice sounds. The last step he described with the metaphor of 'like the baby laying in the mothers arm'. Finally he used the metaphor of being in a role of a more demanding mother who was freeing the fire in the patient's volcano.

C used the metaphor of being in the role of a mother to the patient as if he was a two year old needy boy between a rage and a wish for love. As she risked to play out her own passionate feelings in the music, she separated herself from this mother role and they both moved into an adult to adult relationship.

D used the metaphor of being in the role of the listening, accepting mother; just being there; confirming the child until the form comes into the music. He also used the metaphor of 'playing himself out of prison', from which act he created a psychic space, where he separated himself from the mother role.

15 Music therapists experience negative counter transference as being insensitive to the process of the patient

None of the participants had negative experiences of the counter transference moment, which they identified for the interview. All four participants could easily identify another counter transference moment, which they had experienced as negative. All of the participants commented on identifying a negative experience as one, where they have been insensitive to the patient's process. The negative experience could for some participants be connected to an attitude by the therapist, where s/he had the feeling of being overburdened by carrying the patient's transference. In this case the therapist could want to get rid of this burden too early for the patient's readiness. For other participants, the experience of negative counter transference could be one, where they first wanted to get rid of the burden of carrying the patient's transference feelings too late, in order to trust the patient's process.

For **A** the negative counter transference experience was one of being emotionally impatient to the patient. She had felt rejected by the patient and she felt strongly overburdened as she was the one, who had to keep the process going from session to session. The patient could not (refused to) remember, what had taken place in the previous session. She had irrational fantasies about ending the case too early for the patient's process. The continuation of the case verified that the feeling was insensitive to the timing of the patient.

For **B** the negative counter transference experience was one of getting an impulse to progress too quickly. He wanted to play too complex music in a music therapy case with a patient, who was only able to play with one musical element at a time. The therapist's impulse was too far away from the patient's experience of being in the world. The continuation of the case verified that the therapist's impulse was insensitive to the timing of the patient.

For **C** the negative counter transference experience was a feeling of being strongly hated by a patient and not being able to overcome this feeling in the session. The therapist's experience was that she was being left with an intense negative feeling providing no safety for the patient's process. The experience provided an ending of the therapy in this case and it can be discussed if it is a case of what Winnicott calls '**objective hate**' (see p. 184), where the therapist's reaction is to be seen as a natural reaction rather than an unresolved conflict by the therapist. C does not discuss that aspect in the interview.

For **D** the negative counter transference experience was one of being repetitive in the musical play form using the same musical interventions in order for the therapist to solve his/her own problems. **D** was speaking of a negative transference experience at a more general level. He was dividing the distinction between positive and negative counter transference experiences more into graduated steps than into a totally positive or a totally negative experience. Still being repetitive can be seen as being the timing aspect of the patient.

16 *The understanding of counter transference is based on theoretical beliefs*

None of the music therapists had one clear theoretical frame of reference for their understanding of counter transference. All four participants talked about being in the middle of the different theories or thoughts being presented in the literature on counter transference.

Three of the therapists **A**, **B** and **C** commented on being inspired by, grounded in, or being critical towards object relation theory if based on a Kleinian concept. They combined an application of this theory with other theoretical understandings of counter transference, such as an understanding from the perspective of the theory of inter-subjectivity, from the perspective of projective identification, from existentialistic theory and from communication theory.

Two participants **B** and **C** emphasized, that not all of the therapist's experiences could be identified as counter transference. Counter transference is to be understood as a specific experience related to the situation.

Two other participants **A** and **B** talked about using local theories, that they had created themselves such as: a theory of listening perspectives, a mother/infant theory of a therapeutic progression of healing, holding and handling, and also a theory of three 'being present' - and communication spaces.

One participant **D** talked about understanding counter transference as simply unconscious communication. He was partly distinguishing between counter transference in clinical work with psychotic or non psychotic patients, and he suggested the use of the term projective identification to define a counter transference experience in work with psychotic patients. Still he thought, that the therapist could make use of both the phenomenon of introjective identification and counter transference to describe the experience in which the therapist creates a form in the

music out of the introjected feelings, in order for the patient to start creating transferences.

17 *Counter transference feelings are hard to differentiate*

All four participants commented that they found it hard to differentiate, whether the feelings in the counter transference experience derived from the patient or from the therapist. It was hard for them to differentiate, whether the feelings were projected on to the therapist from the patient or whether they were emerging from the therapist's inner life or both.

A was talking about, that she felt she was fulfilling both her own need to go back to an easy place in the music, and also the patient's need to go back at the same time. She also talked about a feeling of being cut off by the patient, at the same time as she felt like the patient was repetitively binding the rope around both the therapist and the patient.

B commented that for him it could derive both from the way the client was playing in the moment, the patient's projection and the therapist's reaction to it, which he experienced as also an impulse coming from inside the therapist. Finally he commented that it was the way they built up the music together that was the source of the counter transference reaction.

C commented that her experience was that she was both managing a sad feeling inside herself and the sad feelings of the patient about the ending, so it was hard to differentiate whom the feelings belonged to and where they came from.

D commented that for him it was clear, that the moment, he was playing from the transference of the patient, he was in an unconscious way also playing from his own counter transference feelings, so they could not be differentiated.

Composite theme based on three participant's experiences was:

18) *Counter transference is a specific experience*

Three of the participants commented, that they find that not all feelings which arise in the therapist can be identified as counter transference.

For **B** only significant feelings can be identified as counter transference feelings, and in addition they also have to be verified in therapeutic process.

C commented that some of the things or thoughts she could experience in a session, such as a sudden memory of a meeting in the evening, belonged solely to her. She emphasized that these thoughts were independent of the therapy situation.

D commented that things or feelings, emerging in work with psychotic patients, he would not just call counter transference but projective identification. He also differentiated feelings coming up in work with non psychotic patients to be either positive or negative. He believed he could distinguish these feelings because of his personal analysis in psychoanalysis.

Global theme that represent two participant's experience was:

19 *Music is understood at a sensate level by the patient in the counter transference moment*

Two participants believed that, the use of music in the counter transference moment had another quality than counter transference experiences where only words were used. They both could not imagine how they could have used words in their identified counter transference moment. They emphasized that music seemed to be understood at a sensate level by the patient.

B commented that music generally is understood from the way the sound is perceived in the mind which is at another level than understanding words. He exemplified, that even if he did not verbalise the dramatic experience in his counter transference moment, it showed to have the effect, that the patient felt uplifted by the music and could both give and take energy in the music as an outcome of the transference experience.

C commented that she was using music in a particular way in the counter transference experience as she interpreted for the patient in music instead of using words. She believed that music is more accessible for the patient, who struggled in understanding meaning in words. The patient easily became defensive and ignored verbal intervention. She believed the patient had often sensed things in the transference/counter transference dynamic in the therapeutic relationship, but he was not able to form words. The music helped him break this down a bit. **C also believed that musical transference is particular powerful and useful, as it affects the psyche and merge into the spiritual.**

5.3. Developing the global distilled essence

In the interviews, the participants offered several significant descriptions of their experience of the counter transference moment, which could be representative in distilling the essence. As I have been interested in, how music therapists experience counter transference, and as I know, that they all use the term in their published articles, I have not set up a definition model of counter transference in the beginning of this study. I prefer that a definition might emerge from the distilled essence of this study.

In the discussion chapter (see 6.3.4) I will relate this distilled essence back to existing definitions in the music therapy literature such as the definition of Bruscia, Priestley and Scheiby.

5.3.1 The global distilled essence of the counter transference experience

In dwelling into the significant descriptions presented above and into all of the composite themes I formulated the following global distilled essence:

A counter transference experience is emerging as a moment of surprise for the four music therapists. The counter transference experience includes that the music therapist both identifies with the mental suffering of the patient and breaks out of this identification. The counter transference experience recalls recognizable experiences from the life story of the music therapist. The counter transference experience includes an unconscious change in the musical expression of the music therapists, where they risk playing out music differently, also causing a change in the musical relationship between the music therapist and the patient. Music therapists move from one therapeutic dynamic to another in the counter transference moment, and it is crucial to trust in and verify the timing of this movement when it is noticed.

The counter transference experience causes a change in the therapeutic relationship and in the contact between the music therapist and the patient. This change can be experienced as either positive or negative. Positive experiences bring the work at another level. Negative experiences are identified solely as these moments, where the therapist is insensitive to the process of the patient.

Music therapists tend to be informed by body sensations that something specific is emerging. There is a tendency that music therapists translate

this embodied information to psychological meaning for both parties. Music therapists use the metaphor of being a parental figure to the patient to understand the dynamic of the counter transference experience.

Stage 8

In stage 8 I now want to place the developed essence against the experience of each of the participants, to further investigate whether the developed essence fully represents the authentic original significant experience of each participant.

A's counter transference experience was certainly one of a surprise, when her hands suddenly hit a drum as if they had a life of their own. A identified strongly with the patient's condition of flying away (out of the body), and also with the patient's suffering (a strong pressure in her breast). Subsequently A broke out of this identification by playing more dissonant and violent music. The counter transference experience caused A to recall a sensation in her own life, external to the therapy, reminiscent of being tied up in a big rope. A changed her musical expressions from pianissimo and airy, to a more dissonant and violent style of playing, in order to follow the patient. This changed the musical relationship to a more dynamic one, where both parties were more present in the music.

A moved from a therapeutic dynamic of acting as a protective mother; following the patient safely; to a dynamic where she was in the role of a more demanding mother figure. She trusted the timing of this shift and this was also verified within the following sessions. For A there was a change in the relationship and in the contact with her patient, as they now both took responsibility for the atmosphere in the situations. For A the counter transference experience was very positive and it brought the process to another level. A had had a negative counter transference experience earlier with the same patient, where A felt impatient and had fantasies of ending the case too early for the patient's process. In the counter transference moment, identified for the interview, A seemed to be informed by the sensations in her body of flying away, and the pressure in her breast got stronger, informing her to break out. She came to understand these feelings of breaking out from the identification as information, that the patient could now take more responsibility and share the feelings and tensions that were present in the room. A could understand the counter transference reaction as a shift from acting as a protecting mother figure - to becoming a more demanding mother figure for the patient.

For A the global essence is relevant and encompasses all the significant elements of her counter transference experience.

B's counter transference experience was certainly one of a surprise where he suddenly added a 'surviving voice' quality to a drum/piano duet. B was identifying with the chaos of the patient to a point where he felt like drowning. Thereafter in the counter transference he identified both with the chaos and also with the feelings of breaking out from being just a follower. He moved towards also becoming a rescuer, who saved both parties from drowning. The counter transference experience caused B to recall strong memories from his childhood where he experienced being unable to breathe, unable to get out and being afraid of dying. B changed his musical expression from solely drumming to both drumming and using his voice. This also changed the musical relationship as it added some structure to the music and offered a 'birth channel' through which, they could both be saved. B moved from being just a follower to being both a follower and a rescuer at the same time. He trusted this shift of being needed, and noticed that it uplifted the patient who could now also bring some structure into his music. The reaction caused a change in the relationship which created another colour in the atmosphere and the change was experienced as very positive for the therapeutic process. B did not bring in negative counter transference experiences from this case into the interview, but experiences from another case. In this other case he had felt impulses to move too quickly into more complex musical playing, being insensitive to the patient's need of playing only one musical element at a time.

In this counter transference case B was informed by strong feelings. He was feeling like drowning, and his body seemed to tell him at an unconscious level to add his voice to the music. He understood the information psychologically, that the patient needed another structure in the music to progress. B was using the metaphor of creating a birth channel and of an image of a baby lying in the mother's arms to describe the last of the four voice qualities, in order to understand the counter transference experience.

The global essence above fully encompasses all the significant elements in B's description of his counter transference experience.

C's counter transference experience was certainly one of a surprise as she suddenly realised that she was playing music in the same style as she had done four years ago. She identified with the suffering of not being understood or heard within the patient. She broke out of this identi-

fiction to move into a new relationship, which she understood as an adult to adult relationship. Here they were both subjects, and both mutually understood. C changed her musical expression from playing along as a follower to the patient, feeling not heard - to playing out sad music in a minor key with passionate chords. This also changed the musical relationship into one, where C had the feeling that the patient was listening to her. He even waved at her with one hand, and they became two consenting people making music together. C moved from a dynamic of empathically following the patient to becoming more separate from the patient. She trusted that this shift would continue, and realised that the patient would stay in the room and even listen to her. This change caused a shift in the therapeutic relationship, where C moved from being a nurturing mother to being an adult partner to the patient. This was experienced as a positive experience for both parties and they could now negotiate an ending at a mature level. C did not recall negative counter transference experiences from the case, she reflected in the interview. She recalled negative experiences from another case. Here she felt she had been insensitive to the patient's hatred, and therefore had not been able to overcome it, and thus had not been able to provide safety for the patient.

In this counter transference case, C was referring to strong feelings, rather than to body sensations. She talked about strong passionate feelings in her body which she played out in the music. This act she understood as showing the patient that she accepted all the strong feelings he had presented in the therapy process in the music, instead of showing him in words. C talked about her role as being like a nurturing mother to a two year old baby between a rage and a need for love, in order to understand her counter transference experience.

The global essence above fully encompasses all significant elements in C's description of his counter transference experience.

D's counter transference experience was certainly also one of a surprise, as he did not understand at a conscious level why he suddenly changed from being silent, to playing the piano. He identified strongly with the patient's suffering through a feeling of not existing, and he broke out of this identification by stopping playing. Subsequently he listened to his own helplessness by giving it form through playing melodies at the piano. D moved to the piano and gradually made the patient listen to him as a subject.

The unconscious change in the music led to D and the patient playing more in a musical form within the relationship. D trusted that the musical form was needed even if the patient did not react positively until the next session. The therapeutic relationship changed as D moved into the musical form, where he could play more in his own style, and he felt liberated by the patient. D experienced the shift in the therapeutic relationship as very positive. He did not talk about a negative counter transference experience from the same case, but talked about negative counter transference experiences in general as experiences where the therapist repeats the same interventions to solve his or her own problems.

In the counter transference case D talked vividly about listening at an affect level, as if listening through his body to the body and the inner life of the patient. The sensations D had from this listening led to an understanding of the patient's need to move to musical form instead of playing at a 'sensorial' level. D talked about being in the role of a listening mother; just being there; not giving the patient anything. He understood this position as a 'reverie' and as a way of understanding part of the counter transference experience.

This formulated global essence encompasses the significant elements of D's counter transference experience.

This formulated global essence seems to cover all the significant elements of a counter transference experience for all the participants in this study.

This global distilled essence is the final result of this study!

Discussion

A Discussion of the Study

Introduction. Summary of the findings

In this chapter I will discuss the final results of this study, the findings, in relation to the research questions and to the psychiatry literature, to the music therapy literature, and with some reference to the five articles that are presented earlier in the thesis where relevant. I will indicate the contribution this study makes to the field of music therapy, and make recommendations for future studies. I will also discuss the limitation and methodological problems that I encountered¹.

The purpose of this study was to explore and understand the experience of the phenomenon of counter transference, when used as a clinical concept by music therapists working with musical improvisation in adult psychiatry.

The research questions for the study were:

Main question

- How do music therapists perceive, react, interpret and theoretically understand counter transference experiences in music therapy contexts including musical improvisation in adult psychiatry?

1 See Amendments p. vii.

Sub-questions

- In what ways do music therapists experience counter transference as a positive influence on the music therapeutic process?
- In what ways do music therapists experience counter transference as a negative influence on the music therapeutic process?
- Are there particular features of the music in the improvisation that are present when counter transference occurs? Are there similarities across the music therapist's experiences?

The study was carried out through qualitative semi-structured interviews with a purposive sample of practitioners with more than five years experience of work using improvisational methods in adult psychiatry. The interviews have been analysed through a phenomenological method, that first made a vertical analysis finding key statements and meaning units from each interview. These meaning units have been the basis for formulating a distilled essence in my own words for each interview. (See p. 249). In chapter 5 I have made a horizontal analysis by placing the meaning units from each interview side by side, finding composite categories, and from these categories extracting composite themes. Out of these I have formulated a global distilled essence which constitutes the conclusion to the phenomenological analysis, and which together with the composite themes offer the main findings of this study. The global distilled essence was then connected back to the four distilled essences in the vertical analysis to verify that all of the participant's experiences are fully covered in the global distilled essence.

The majority (17) of the composite themes were consistent and represent the understanding of all the participants, and are listed below:

- 1 *The counter transference moment is a moment of surprise for the music therapist*
- 2 *The counter transference moment recalls recognizable experiences from the music therapist's own life story*
- 3 *The music therapist identifies with the mental suffering of the patient as part of the counter transference experience*
- 4 *The music therapist breaks out of the identification with the mental suffering of the patient as part of the counter transference experience*
- 5 *The music therapist takes a risk in the music as an effect of the counter transference experience*

- 6 *The counter transference moment includes an unconscious change in the music therapist's musical expression which also causes a change in the musical relationship*
- 7 *The counter transference moment includes a positive change in the therapeutic process*
- 8 *The counter transference experience includes a positive shift in the music therapist's contact with the patient*
- 9 *Discovering something specific is emerging is a part of the counter transference experience*
- 10 *Being informed by body sensations or emotions is a first step in the counter transference experience*
- 11 *Translation or transition from physical sensation to psychological understanding takes place in the counter transference moment.*
- 12 *Moving from one dynamic to another is a part of the counter transference experience.*
- 13 *To trust the timing aspect is a crucial element in the counter transference dynamic*
- 14 *Music therapists use the metaphor of being a mother figure in the counter transference dynamic*
- 15 *Music therapists experience negative counter transference as being insensitive to the process of the patient*
- 16 *The understanding of counter transference is based in theoretical beliefs*
- 17 *Counter transference feelings are hard to differentiate for music therapists.*

All four participants, working with musical improvisation in adult psychiatry, described the experience of the phenomenon of counter transference as a **significant change**, which occurs as a **surprise** to the therapist. The change includes both a change in the type of identification the therapist had with the patient, and a change in the musical expression which also changed their musical relationship with the patient. As a consequence the change was also experienced as a change in the therapist's contact with the patient, a change in the therapy process and a change in the atmosphere in which the therapeutic process can unfold. So the counter transference phenomenon seems to be very important for the therapeutic process.

It is interesting that all four participants emphasized that **they are being informed by body sensations or emotions**, and that **these body sensation or emotions are played out unconsciously as a surprise to the therapist in the music**. This act of **playing out** body sensations or emotions through the music improvisation **seems to help the therapist to become**

aware that something specific is emerging. It also seems to serve the change occurring in the dynamic of the therapeutic relationship.

These aspects of the findings seem to be unique to music therapists who have music as a medium to act through together with the patient in the transference/counter transference dynamic.

In relating back to psychoanalytic, psychodynamic and psychiatric literature reviewed in chapter 2, the following aspect, described by the participants of the experience of the phenomenon of counter transference, was specifically experienced and understood differentially.

Improvising music as a mutual action in the therapeutic situation seems to serve the process of making unconscious counter transference experiences conscious for the music therapist and also to serve the act of giving the counter transference moment a meaningful change in the therapeutic relationship.

This finding shows that none of the participant experienced that unconscious counter transference reactions were something they should overcome. On the contrary they commented on the importance of this unconscious communication taking place as a pre step to be informed about the dynamic in the relationship. The act of playing in musical improvisation is emphasized as something that is serving the process of making unconscious communication conscious.

The **aspect of timing** was very important for the outcome of the counter transference reaction. Both positive and negative counter transference experience were related closely to a timing aspect in that a counter transference reaction was experienced as positive, when it occurs at a time where the patient was ready to adapt to the change in the musical and therapeutic relationship. A counter transference reaction was experienced as negative, when the therapist was unconsciously reacting too early or too late for the patient's readiness to adapt to a change in the musical and therapeutic relationship.

All four participants were very **sensitive and nurturing** towards their patients and recognized the therapist role as one of a **mother figure**. All of the participants were **ready to empathise with the patient's mental suffering and to help carry the mental suffering through the musical improvisation until the patient was ready to let go of part of or all of the mental suffering.**

Two further composite themes were found. The first was found in the experiences of three of the participants:

18 *Counter transference is a specific experience*

These three participants reported that not all sensations, emotions or thoughts experienced in the relationship with the patient were to be identified as counter transference.

B commented that the experience had to be specific and strong and also that the experience had to be verified within the therapeutic process with the patient over time.

C commented that she had a more realistic view on the relationship than the one categorizing everything as counter transference, which she thought is included in the Kleinian tradition of object relations theory. She gave an example that if, in a therapy situation, she began to think about a meeting she had to attend in the evening, it had nothing to do with the patient.

D mentioned that he distinguishes between counter transference in work with psychotic or non psychotic patients, as he would use the term therapeutic reaction in work with psychotic patients. D also reflected that one can say that everything is counter transference because we are people with our own history which influences everything. In this respect D distinguished more between positive and negative counter transference. D pointed out that when the therapist has been into analysis him/herself, he/she knows a lot about his/her own reactions, and he/she explores his/her own unconscious and then both positive and negative counter transference reactions will be reduced and the therapist will be more into a neutral position.

It seems for D that positive counter transference, as an adequate therapeutic reaction to the patient's transference, is more to be understood as unconscious communication. Only when personal stuff is present, which is not adequate for the patient's transference, it is to be seen as counter transference, which D also identified as a negative counter transference phenomenon. D concluded by commenting that instead of seeing the therapeutic reaction as either coming totally from the patient or coming totally from the therapist, it can be seen more in steps where parts may come from the patient and other parts from the therapist and thus it can mostly be identified as counter transference. So at a general level D seems to use the term counter transference also to describe adequate unconscious communication.

A further composite theme represented two participant's experiences:

19 *Music is understood at a sensate level in the counter transference moment*

Two subjects commented that they found that using music in the counter transference moment was unique as they experienced that the music was understood at a sensate level by the patient. They believed that they could not have established the contact that was established by using words instead of music.

B commented that the sound of the music (here B's own voice quality) had an effect on the interplay and created a kind of structure, where they could both survive without words in the counter transference moment. B could not imagine describing the drama of his anxiety - or of him unconsciously taking the role of being a rescuer or expressing the quality of victory and safety **in words** with this patient. This was partly because it was an unconscious reaction, which he could not put into words himself in the situation, and partly because the patient would not be able to follow this interpretation. The patient seemed to experience the new structure added in the music at a sensate level, commenting that the music now uplifted him and that he found, he could now better both give and take in the music.

C reported that her patient was suffering from not being able to stay in a room where he could be confronted with the strong influence he (the patient) had on the atmosphere in each room or each situation he found himself into. The therapist showed him in the last sessions - **during the music** - a sad quality and strong passionate chords, which she understood as **an interpretation** of what had been presented by the patient in the therapeutic work between the therapist and the patient. The therapist had been very containing in her work with this patient for four years, and now she felt that she could express the strong feelings she felt inside herself in her counter transference reaction. She could not imagine that she could have used words to express these feelings, partly because the patient had difficulties in understanding words, and partly because he might have left the room. Through the music they succeeded in sharing the feelings at a mutual level without talking about these strong feelings.

These two therapists are reporting core, complex issues which are also indirectly addressed in the composite themes. I want to mention these comments specifically because they are important for answering the sub-questions.

After having distilled these composite themes I formulated a global distilled essence which was reported in chapter 5 section 5.3.1. and presented here as part of the summary of the overall results.

Global distilled essence!

A counter transference experience emerges as a moment of surprise for the four music therapists. Through the counter transference experience the music therapist both identifies with the mental suffering of the patient and breaks out of this identification. The counter transference experience recalls recognizable experiences from the life story of the music therapist. The counter transference experience includes an unconscious change in the musical expression of the music therapists where they risk playing out music differently, also causing a change in the musical relationship between the music therapist and the patient. Music therapists move from one therapeutic dynamic to another in the counter transference moment and it is crucial to trust in, and verify the timing of this movement when it is noticed.

The counter transference experience causes a change in the therapeutic relationship and in the contact between the music therapist and the patient. This change can be experienced as either positive or negative. Positive experiences bring the work at another level. Negative experiences are identified solely as those moments where the therapist is insensitive to the process of the patient.

Music therapists tend to be informed by body sensations that something specific is emerging. There is a tendency that music therapists translate this embodied information to psychological meaning for both parties. Music therapists use the metaphor of being a parental figure to the patient to understand the dynamic of the counter transference experience.

6.1 Addressing the research questions

I will go back to my research questions starting with the main question and continuing with the sub-questions, and examine which answers the composite themes and the global distilled essence provide for these questions. To do this, I will divide the main question into two parts and discuss which ideas from the significant statements of the participants,

from the composite themes, and from the literature review can provide answers to the questions.

In my main question I ask how music therapists perceive, react, interpret and theoretically understand counter transference experiences. I will divide this question here in order to first address which findings came out on the **perception** of and **reaction** to counter transference and secondly, which findings came out on the **understanding** and **interpretation** of counter transference. This does not suggest that such issues can be separated in clinical practice, where such a distinction is not relevant.

6.2 The link to the main question. First part

The link between the **perception** and **reaction** to the counter transference moment to the interview data and composite themes

Concerning the perception of and reaction to counter transference experiences, the findings from the semi structured interviews show that music therapists overall seem to be very perceptive and open to listening to their body sensations and their feelings as a source of information showing them that a counter transference phenomenon is alive. Three participants reported that body sensations were the source of information, which seemed to serve the therapist's 'acting out' in the form of a change in their musical expression, which made the counter transference reaction audible. This phenomenon again supported the process of making the unconscious experience conscious to the therapist. One participant seemed to be informed through her feelings, which were also 'acted out' unconsciously in the music providing a change which again made the counter transference experience audible.

What follows is a short description of how each of the participants experienced the phase of perception and reaction in the counter transference moment in the form of presenting and discussing significant formulations² from each interview. I choose to bring these statements here in the discussion chapter as the interviews were very complex and rich in information, and I will never be able to draw all levels of meaningful information out of the data. They will continually bring new experiences and associations for the reader, also for the readers of this dissertation.

2 The term formulation(s) is used throughout this chapter in reference to statements or groups of statements made by participants during the interviews

Simultaneously parts of these data are mirroring how to put subjective words to a kind of tacit knowledge by each of the participants. It would not be so meaningful for me to reformulate for these parts. So I want the reader to be connected again to the rich descriptions of the participants.

A formulated how she experienced a strong pressure being present in her breast, which made her unintentionally bang a drum in the middle of a piano duet, and through this musical act she became surprised and realized something specific was emerging, which she later identified as a counter transference moment. Significant formulations in her interview emphasized this process:

- it is also very often the body sensation – the pressure in the breast, plus the body sensations that inform me - that kind of start the reaction – yah is the start of any reaction of counter transference – very often the body - the action was partly conscious – in the way that I felt it so strongly in my body so I had to do something - my body told me what to do –

- I remember myself as also physically reacting to it to the sound of the drum - I was surprised how strong it was and how penetrating the sound was -----it was just something my hand did----- So there I think the music was facilitating the expression of and reaction on my counter transference experience.

B was into a chaotic, loud and almost out of control drum/piano duo improvisation with his patient, where he felt like his body was part of building up to a peak in the music. Out of this peak his voice emerged as a surprise with a sound which he heard as having a worried and a warning quality. The act of the voice coming out informed him, that something specific was emerging which he later identified as a counter transference moment. B had the following formulation which emphasizes this process:

- it is my body in a way building this to the voice coming out, so in that way the drums are also a part of the counter transference

- I remember the way I recognized it was “Where am I?” I was in the middle of something - you know - and “who am I?” you know and “who is he?” and I couldn’t really - I couldn’t see him, and it was connected to a drowning feeling.

- in this situation my remembering of it was that I had a sense of that I should add something to the improvisation and it should be the

voice. So that was the level of the consciousness of it. It was intuitively to add something.

- I remember I felt that the voice was worried - it was -- the other instruments were very loud just before like a peak and it was like growing out of the peak and - the client played on the piano and I played on the drums -but the way that the client played was very chaotic - very intense and very violent also in a way - so it was the voice which was in a way warning to survive this situation - I was not fully aware of that maybe this was a threat- but it was kind of a reaction also to the very loud played - and chaotic playing before

C was improvising on the piano with a patient playing on a metallo-phone. She had the feeling of not being heard as a subject by the patient, as she surprisingly realised that she was playing in a musical style, that she had done four years ago with this patient, but this music had a different quality. C was informed through the music and through strong feelings coming up that something specific was emerging, which she later identified as a counter transference moment and she had the following formulations emphasizing this process:

- what I remember in this session was a feeling of consolidation - a feeling that every thing that happened had more meaning than usual

- I suddenly found that I was playing the same chordal progressions that I'd been playing four years before.

- I noticed that my music shifted or that I just realised, that my music shifted and then I start to think: oh what was the meaning of this

- but what this moment did - because it touched me - what I did not necessarily realise consciously straight away – was that it put me in touch with some quite powerful feelings both personally and consciously.

- So that is why I feel that this counter transference moment is very significant

- I had to feel it a lot in order to help him feel it and I think, I tried to set that up through the music by playing back very pointed music to him, and then be quite passionate in my playing and let him go - I risked not having him to stay with me constantly in my music –

D was in a situation with a psychotic woman who played at a sensorial level without paying attention to what the therapist was playing, and the therapist felt as if he did not exist. He stopped playing and he listened through his body at an affect level to the patient's inner sound. During the listening attitude he surprisingly turned to the piano and started to play melodies. He realised something specific was emerging in the transition from listening to playing the piano, which he later identified as a counter transference process. He had the following significant formulations in the interview emphasizing this process:

- What I felt was that I was listening through my body - I was not conscious about how I was sitting in the therapy session

- I felt isolation - it was a kind of listening like what you (the interviewer) describe as 'listening through the body to the body of the patient.'

- I felt I was listening on a level of affect - that I was not listening to understand something - to react to something - it was a receptive way of listening, where my body was affected through the body or through the situation of the patient.

- I was playing with my body or from inside - I was playing but I heard her sound - her inner sound - not what she was playing - or what kind of sound I hear in her way of playing - not the sound that she produced but a sound what she was not producing –

- I had a kind of reaction like why should I play

- And maybe at an unconscious level I could hear something about this but it was totally unconscious - and I had the reaction of moving to the piano –

- then I moved and it was this body movement I did when I moved to the piano - I was really knowing nothing about what I should play

- I had nothing in my head - it was just - it was movement from the listening to the sound

- and I started a very sober melody and then it developed into a more choral way of playing

- what I am there doing is – it is also thinking through the music – I let the music show me the way and I exist.

- I knew nothing - it is just intuitively that I am doing something - because I never ever experienced things like: 'now I am aware of that now it is counter transference'

From a global view, all of the counter transference experiences take place both as **a moment of surprise** and **a procedural cycle of change in the musical expression** emerging as an intuitive, unconscious and complex simultaneously process where

- the change in the musical expression releases the body sensation or strong emotions of the therapist
- the change in the musical expression informs the therapist that something specific is emerging,
- the change in the musical expression serves the counter transference reaction of the therapist
- the change in the musical expression gradually leads the music therapy process in another direction.

The surprise moments seem to have been **under preparation unconsciously in the musical relationship** in the sessions prior to the counter transference sessions. The **level of depth of intensity** in the therapist's body sensations or feelings together with **the simultaneous act of playing music** seem to be the source of the upcoming surprise and of the process of change taking place. The process of change is audible through the musical expression, which again serves the process of making unconscious reactions conscious.

The following composite themes in the findings of this study are relating to the answers of this first part of the main research question concerning perception of and reaction over counter transference:

- 1 *The counter transference moment is a moment of surprise*
- 3 *The music therapist identifies with the mental suffering of the patient as part of the counter transference experience*
- 6 *The counter transference moment includes an unconscious change in the music therapist's musical expression which also causes a change in the musical relationship*
- 9 *Discovering something specific is emerging is a part of the counter transference experience*

10 Being informed by body sensations and emotions is a first step in the counter transference experience.

6.3 The link between the **perception** and **reaction** to the counter transference moment to the theoretical framework

6.3.1 Psychoanalytic literature

Freud, the founder of the term counter transference, first claimed that counter transference was connected to the patient's influence on the therapist's unconscious emotions and impulses derived from unresolved conflicts by the therapist, which should be recognized and overcome (see p. 161). His description of the counter transference moment did not emphasize the therapist's self-experience in the 'here and now' meeting with the patient as a valuable therapeutic information tool (this should be overcome). He emphasized the therapist's intellectual (free of emotional influence) interpretation of the patient's transference and the therapist being a neutral screen. So all the answers to the first part of my research question (to perceive and react on counter transference) was seen by Freud as a hindrance for the therapeutic process which should be overcome – whereas the second part, understanding and interpreting the counter transference moment was seen by Freud as the curing element in classical psychoanalysis. This meant that the interpretation was based on a monadic, developmental theory likely for all sorts of patients, and not based on a theory concerning the dynamic taking place in the specific therapist/patient relation as experienced by the therapist. From an empathic viewpoint, one could say, that in Freud's first definition the therapist neglected to be touched by and also neglected to be identified with unconscious feelings of the patient. None of the findings in this study relate to this viewpoint of Freud. He later modified his ideas, but his first definition still seems to be valid for many therapists, and also for those who do not want to include the phenomenon in their understanding of clinical practice.

This first definition has been questioned in a debate going on since 1910, and the opposite notion was clearly advanced by Heimann back in 1950, where she advocated that the therapist is in a fully emotional contact with the patient's unconscious communication. She claimed that the therapist's emotional response to his patient is one of the most important

tools for his/her work and the analyst's counter transference is an instrument of research into the patient's unconscious. The aim of self-analysis for her is to ".....enable the analyst to **sustain** the feelings which are stirred in him/her, as opposed to discharging them in order to **subordinate** them to the analytic task." (Heimann 1950, p. 81) Her basic assumption is that the therapist:

.....also needs a freely roused emotional sensibility so as to follow the patient's emotional movements and unconscious fantasies and that the analyst's unconscious understands that of the patient. This rapport on the deep level comes to the surface in the form of feelings which the analyst notices in response to his patient, in his counter transference.

(Heimann 1950, p. 82)

Generally the findings in this study are very much in line with Heimann's ideas back in the fifties. The strong reactions described in the four interviews can be seen from the perspective of all four participants being sensitive to an emotional responsiveness. This is due to being in full emotional contact with the patient's unconscious, when working with psychiatric patients who are severely traumatized and thus providing very strong unconscious reactions in the transference or in their projective identification towards the therapist. For the music therapists **the act of improvising music with the patient mirrors the act of this rapport at a deep level, coming to the surface where the music is simultaneously expressing something from the unconscious and making it conscious. So music therapists are connected to these feelings both before and during their response.** Composite themes number 1, 3, 4, 6, 9, 17 can all be related back to the viewpoint of Heimann. Her viewpoint defines the therapeutic stance concerning counter transference as an opposite viewpoint to Freud, whereas a later important figure in the counter transference debate, Racker 1968, is more concerned with the categorisation of identification types in the counter transference experiences.

The composite themes and global distilled essence are also consolidating what Racker (1968) contributed to the experience of counter transference, where he claims that the therapist can be induced by his patient to identify either with the patient's self, which he termed a concordant identification, or with the patient's internalized objects, which he termed a complementary identification. He argued that although concordant identifications alone constituted the basis of empathy, both forms of identification should be considered counter transference in its 'totalist'

sense. Contrary to Heimann, he emphasises that the key for the analyst is to strive to maintain a **'deep and continuous'** contact with himself so as to be as aware as possible of his position in relation to the patient (see 2.2.3 p. 167). He argues that without an awareness of counter transference, the analyst was very likely **'doomed to drown'** in his responses to the patient and in the danger of destructively repeating the patient's vicious circle, whereas through awareness the analyst is better able to avoid the vicious circles that constitutes the patient's primary problems in human relationships. He claims.

Both repression of these internal processes and 'drowning' in these feelings hinder or prevent the analyst from opening a breach in the patient's neurotic vicious circle by means of adequate transference interpretation, either because the analyst does not himself enter far enough into this vicious circle or else because he enters too far into it.

(Racker 1968, p. 176)

In the findings of this study the participants both experience that they identify deeply with the mental suffering of the patient and that they break out of this identification through their counter transference reaction. I see this movement as **a movement covering both** Heiman's description of **"....following the patient's emotional movements and unconscious phantasies"** where **"....this rapport on the deep level comes to the surface in the form of feelings"** (Heimann 1950, p. 82) **to** Racker emphasising **".... for the analyst to strive to maintain a 'deep and continuous' contact with himself** so as to be as aware as possible in relation to the patient" (Racker in Tansey & Burke 1989, p. 26).

In this study music therapists do not seem to strive to maintain a "deep and continuous" contact with him/herself during the musical improvisation as the music seems to be there to serve the therapist being aware when he is in danger of being "doomed to drown". **So in the flow of improvising music the therapist can move deeply into identification with the mental suffering of the patient and from there – when the identification seems to be too strong for the body or the emotions – the therapist can move to an awareness of his/her reaction to, and position within this identification.** I think this is one of the specific differences between verbal psychotherapy and music therapy, as music therapists do not consciously persist with a position to avoid being overwhelmed, as the musical improvisation itself serves the process of being aware

when necessary, both for the body and emotions. **This is a seminal finding from the present study**

In the literature review I also brought in the view of Reich (1960) who claimed that the therapist's process of empathic identification had to be 'partial and short-lived'. If too strong emotions existed on the part of the analyst she believed that this was evidence of counter transference, which should narrowly be defined as the analyst's unresolved conflicts and which had nothing to do with the patient. So here **emotional intensity became a critical distinguishing factor**, and in the literature it can be said to be a distinguishing factor between the understanding of counter transference in the classical camp and the understanding in the totalist camp. Composite theme number 2 is experienced in opposition to the notion of Reich as all four participants have had strong emotional reactions which they can recall from their life story, and which they consider as being a presupposition to be able to resonate with the sensations and emotions coming up in the identification with the patient. Thus life story experiences can be said to have a positive value in the counter transference experience when they are accessible for the therapist to this kind of resonance through empathic identification. **All four music therapists seem to accept being 'doomed to drown' in strong reactions in order to be informed by the unconscious of the patient through the musical improvisation.**

The experience for all four participants were, that exactly the raised level of intensity served to enable the counter transference to be acted out in the music, which again provided a change. A and C talked about being present in an empathic identification with the patient for a long time, where they sustained their reaction in order to subordinate them for the analytic task as described by Heiman. **In this process the raised level of intensity informed the therapist unconsciously about the adequate timing for the analytic task which was then played out in the music as a surprise, and thus the therapist became aware.**

So in the finding here **the intensity of the identification** – it can be very intense – is certainly connected to the therapist's resonance with the patient and **is a cornerstone in the unconscious mutual communication, where the music therapist, in trusting the music, becomes aware of, and learns from the identification.**

Back in the seventies a gate was opened to change the focus allowing strong emotions to be part of positive counter transference experience to refining definitions of empathy and projective identification. Kohut (1984)

redefined empathy as ‘**vicarious introspection**’ or, more simply, “.....as one person’s attempt to experience the inner life of another, while simultaneously retaining the stance of an objective observer.” (Kohut 1984, p. 174-175). So in defining self psychology he attempted to broaden and deepen the field of empathic perception. In doing so he argued that the patient’s need is to be recognized and accepted in his reality, instead of being an object for confronting interpretations by the therapist. Kohut emphasized that “.....the analyst’s continuously repeating move in position from understanding to explaining, his essential activities in each of these positions is based on empathy. (Kohut 1984, p. 172). Kohut is trained as a doctor, psychoanalyst and psychiatrist and thus he is an analyst, which seems to be very familiar with the experiences, which are also described in this study based on therapeutic work in adult psychiatry. For instance he comments that sometimes only the analyst’s willingness to be an attentive silent listener will be tolerable to the patient. He also talks about a psychological phenomenon, in cases where introspection and empathy are the most important observation method, as opposed to a physical phenomenon in cases where the senses are the most important observation method. He is talking about ‘**transmuting internalization**’ and ‘**phase adequate optimal frustration**’ (see p. 173), which are very much consolidated in the findings of this study in the composite themes 6, 7, 8, 11, 12 and 13.

I think Kohut, who was also a musician, has very important viewpoints and formulations for music therapists working in adult psychiatry, as he seems to emphasize the empathic stance as a professional method, which all four music therapist comment that they apply as an overall ‘curative element’ for such traumatized patients. He also seems to have formulated actions in the therapeutic dynamic, that can sound very similar to the dynamics formulated in the global distilled essence. His formulation of ‘empathic perception’ is very close to **music therapists being informed by body sensations that something specific is emerging**. His formulation on ‘vicarious introspection’ is close to **in the counter transference experience the music therapist both identifies with the mental suffering of the patient and breaks out of this identification**.

Kohut talks about one person’s attempt to experience the inner life of another, while simultaneously retaining the stance of an objective observer. Music therapists move more from one stance to another, and they risk leaving this ‘objective observer’ partly out in the musical moments experienced as counter transference. Simultaneously they seem to be very flexible in moving gradually into this objective observer stance as a con-

sequence of being surprised. I wonder if one can say that music therapists, rather than playing and listening from a specific stance, are **moving flexibly from one position to another, rather than 'being present' in a double position of being identified simultaneously as retaining an objective observer**. Priestley has also discussed this issue which I will return to in relating the findings to her viewpoints.

Kohut's formulation on 'transmuting internalization' and 'phase adequate optimal frustration' seem to fit very well into the following formulations in the global distilled essence:

There is a tendency that music therapists translate this embodied information to psychological meaning for both parties and negative experiences are identified solely at these moments where the therapist is insensitive to the process of the patient. (See p. 296-296).

6.3.2 Theories of empathy

The composite themes very much consolidate the contemporary emphasis on describing empathy and using empathy as a mode of observation, where among others Maroda (1998) is both crediting Kohut for having given an emotional relief to analysts, in opposition to what she considers as over-intellectualization in psychoanalytic techniques. On the other hand she is also critical of the overspecialized emphasis Kohut seems to give to the phenomenon of empathy, in that she warns, that empathy can be anti-therapeutic when used as a fixed stance. She advocates a focus on ".....the nature of the interaction and the emotional states of the therapist and the patient, so that the therapist in the moment can determine, which approach is most helpful, instead of being fixed on a specific stance, such as neutrality or empathy". (Maroda 1998, p. 18-19). She also points at the confusing way of using the term empathy, and she distinguishes between an **empathic stance** which could be reflected in any type of intervention and an **empathic response** which typically means that the therapist communicates back to the patient what he believes the patient is feeling at the time.

In the composite themes and significant statements we find descriptions on empathic listening which I see as different from an empathic stance – as it is rather a presupposition for what Maroda calls empathic response. Empathic listening is described as something very valuable and applicable in music improvisation, where the therapist can communicate through the music, what s/he believes the patient is feeling through musical improvisation both consciously and unconsciously. (in themes 6, 5 and 13). Participants B and C comment on **interpreting through the**

music what they think could not be meaningfully interpreted in words with their patients. So they use empathic listening and empathic response not only as a mode of observation, but also as a tool of interpretation. This is another seminal finding in this study.

Of specific interest for linking the composite themes with theory is the link to the theory of the psychology of empathy as found in the theory of Lipps (in Gammelgaard 2000). He discusses whether empathy is based on kinaesthetic perception. He claims that empathy is something original and fundamental in the human psyche, which is not dependent on anything outside the self – it is simply an emotion which is entering into the spirit of someone else without a bodily imitation taking place as a pre-step to this experience. Gammelgaard suggests that a bodily imitation of, for example, a sad face is the first step and a more simple form of empathy. The suggestion of Lipp is recognized as a more sophisticated form of empathy. The difference between the two forms are described as the difference of experiencing empathy through **a sign** (something that can be perceived from sensing in the outer world) or through **a symbol** which means not through a lively human expression but through a symbolic expression of the inner world (i.e. a picture, sculpture or piece of music).

I think this distinction is interesting as one can say that in the counter transference experience in this study, music therapists experience empathy through following the quality of the music (as a sign) of the patient in a simple form of empathic imitation. Further through their empathic listening, they intuitively follow a change in the musical expression where the empathy seems to be resonating with a symbolic expression of another layer in the patient's inner life, expressed in the musical improvisation in the counter transference experience.

As an alternative to this differentiation between experiencing empathy through a sign or through a symbol, Gammelgaard talks about different steps in the experience of empathy where the steps can be summarized as:

- 1 emotional infection (identification with someone as if I am the one)
- 2 distinguishing between me and the other (realising I am not the one)
- 3 placing oneself in the place of the other (realising the other is in need of something)

- 4 objective registration of the needs of the other (realising what is the need of the other which may be different from what might have been the need of me in a similar situation)

(Gammelgaard, summarization of page 54-57)

In relation to the composite themes in this study Gammelgaard's step 1 is related to composite theme 3 and 10, while step 2 and step 3 are related to theme 4, 9, 11 and 17. Finally step 4 is related to theme 5, 6, 12 and 14.

None of the participants of this study ever use terms such as '**objective registration**' of the needs of the other. Thus a question can be raised to whether the word objective is an adequate word to describe the fourth step of movement in the empathic experience. For the participants of the study this attitude is dependent on having been both in a previously deep identification with the other person and also having been subjectively touched by the person. Objective does not mean being neutral - rather it seems to be the act of realising what was learned about the other in the state of deep identification, and in being subjectively touched by the other. I think the term 'objective' in a common sense way belongs more to, what Kohut called the outer senses as the mode of observation, whereas in this study the term objective seem to be connected to being separated - maybe even "separated in connectedness" as formulated by Fog (1995a). So maybe this is a more appropriate term. I think the use of this term is a natural consequence of the findings.

6.3.3 Psychiatry literature

Relating back to the review of psychiatric literature the findings in this study consolidate that music therapists are aware of the importance of being informed by counter transference experiences in clinical work in adult psychiatry, in order not to respond to the patient's transference with the same reactions as people in the life of the patient, as stated by Gabbard (1994). He advocates that counter transference be conceptualised and considered as a major diagnostic and therapeutic tool, that tells the therapist a good deal about the patient's internal world when the therapist is able to contain the patient's projected parts and reflect the nature of these projections. Theme 3, 4, 14, 12, 15, 11, 2 can be related to these thoughts.

I will discuss further relevance of the findings in relation to the contemporary psychiatry literature in the section on the clinical relevance of the findings, in order to ensure that the results of these studies are related to what is happening now in the clinical field, rather than what was believed in the past.

6.3.4 Music therapy literature

In relating back to music therapy theory I would like here to relate those of the composite themes and these parts of the global distilled essence, which provide answers to the first two aspects of the research main question - namely **perception** of and **reaction** on counter transference in this study - to some definitions already made by Priestley, Bruscia and Scheiby in order to discuss, what is consolidated and what is eventually emphasized differently from the findings of this study.

Priestley reflected on counter transference in music therapy where music improvisation is the tool already back in 1975. She claimed that:

When he (the music therapist) is improvising with clients, these counter transference feelings leak up from the unconscious almost as if they were the therapist's own. Being unconscious, their primitive quality makes it difficult to deal with. But awareness and practice can make a useful tool out of what threatens, at first, to be dangerous disturbances. The musician has his mind wide open when he improvises and it is at this time, that he becomes aware of feelings that he did not notice during the verbal preamble.

(Priestley 1975, p. 241)

She also comments on the issue of being in a position of double awareness as she points out that:

It is essential for the music therapist to divide himself inwardly into an inner, detached observer, who can objectively review counter transference intimations, and an open, irrational receiver who can turn them, or their opposite into sound patterns. But with one ear on the client and two hands on the piano and an awareness of the flooding counter transference, it takes a great deal of practice to preserve this observer intact.

(Priestley 1975, p. 241)

I can relate Priestley's use of the term of 'a detached objective observer' here as being very similar to the definition above where a part of the therapist is more separated and still deeply connected to the empathic identifying 'other' part of the therapist – thus **being separated in connectedness**.

Priestley wrote about unconscious feelings being conscious as a consequence of the improviser having his mind wide open when he is improvising and, in this act, being better able to become aware of unconscious feelings which s/he did not so easily become aware of in the verbal part. S/he is kind of unprotected during improvising. This perspective is an interesting one, because it first of all explains why music therapists can never be neutral when improvising with clients.

It also offers an explanation about how to be prepared for being a receiver for counter transference, namely by listening as a trained, self-experienced musician, who is improvising. It is a way of listening, where one's mind is kept open to the musical atmosphere including also the psychic atmosphere, at the same time as one searches to grasp what is in there. Priestley therefore warns music therapists that they have to be trained to keep that open attitude, at the same time as they have to be aware of sorting things out in their mind during, or shortly after, this act of open minded improvisation. She admits that it takes a great deal of practice to be able to operate at these complementary levels simultaneously.

According to the composite themes in this study, the participants do not experience these processes of receiving and observing as a simultaneous process. They report that in their experiences these processes take place in quick steps or quick movements in the awareness. It is interesting that Priestley very much emphasizes, almost as a fact that musicians who improvise are open minded in listening when playing. I think this can be understood as both listening to the very act of playing and listening to the influence that the improvised expressed music is having back on the improviser.

In the composite themes the counter transference moment is a moment of surprise, and all participants report, that the way they improvise in the counter transference moment is the source of being surprised. They also talk about an unconscious change in the musical expression, which causes a change in the musical relationship. I think there is a consolidation of the statement of Priestley here, that the music therapist has to have his/her mind wide open and to be divided into an open irrational receiver while playing, in order to experience being surprised (theme 1)

by a change in the musical expression (theme 6) and in order to be informed by body sensations or emotions as a first step in the counter transference experience (theme 9). What she calls a detached objective observer is reported slightly different in this study as, for instance, **'discovering something specific is emerging'** in the composite theme (9) or **'translation or transition from physical sensation to psychological understanding'** (theme 11), so the participant's experiences in this study seem to be more reported as **a process of being gradually informed and through an emerging awareness come to understand the psychological meaning**. None of the participants use the term **'an inner objective observer'**.

The composite themes correlate mostly with Priestley's definition of empathic counter transference, e-counter transference, which she defines as follows:

..... The therapist may find that either gradually as he works, or with a suddenness that may alarm him, he becomes aware of the sympathetic resonance of some of the patient's feelings through his own emotional and/or somatic awareness. Often these are repressed emotions that are not yet available to the patient's conscious awareness but they can also be feelings which are in the process of becoming conscious, in which case they may be very dynamic and fluent in the therapist, especially when he is improvising the therapist's e-counter-transference depends on his sensitivity and his freedom to experience the incoming emotions. But his ability to formulate it consciously and use it to the benefit of his patient depends on his clarity of thinking.

(Priestley 1994, summarizations from p. 87-88, 90)

The first part of this definition, which depends on the therapist's sensitivity and freedom is particularly clearly consolidated by the composite themes in the study. In addition, three of the participants are reporting on counter transference experience,s where they have strong sensational experiences at a time where they do not find it possible or adequate to formulate them in words to the patient. It is interesting here that Bruscia classifies exactly this part of Priestley's method as **Embodied Phenomenology as an art of First-Person Research**, where:

.....she relied upon that her body was revealing to her to understand her own experience of the client, as well as the client's experience of him or herself.

(Bruscia 2005, p. 385)

Three of the participants B, C and D also report on using the counter transference experience to the benefit of the patient during a change in the music, which of course also demands a cognitive understanding of the experience. One could question whether the cognitive understanding is emerging more gradually because the whole dynamic is taking place in the music and not formulated in words? I will return to this issue when relating the findings to the second part of the main question concerning the **understanding** and **interpretation** of counter transference.

Bruscia is the leading author in the music therapy literature on counter transference, and he has written comprehensively and carefully about all possible issues concerning sources of counter transference, signs of counter transference and how to handle counter transference. He distinguishes between intra psychic sources and signs, which also includes ones history, cultural background, life situation, style of work, choice of client population and many more.

All these categories are of course presuppositions for the participant's experiences in this study, where I have selectively chosen subjects from the same patient population. The criterion for me to choose this population is my own experience with strong counter transference experiences in my work in adult psychiatry. All of the participants in the study were aware of the influence of their own life story and self experience training back ground, as demonstrated in composite theme 2. As this study is based on the therapist's experience of an identified counter transference moment, Bruscia's categories within interpersonal sources and signs are of most interest for this discussion. It is important to mention here that even if the participants have different training backgrounds, and are living in three different countries, there is still surprisingly consistency in the composite themes.

Bruscia also reports on somatic reactions of counter transference as an important sign. He refers to Priestley as the one who has primarily described somatic signs of counter transference in the empathic counter transference or the concordant or echo form. Bruscia reports on somatic signs in a complimentary identification where he formulates:

..... my whole body began to ache, as if I was completely drained. It became such an effort for me to play that I had to consciously "hold" myself up in the chair. When I listened carefully to what each of us was contributing to the improvisation, I could hear why I was trying desperately to provide the musical glue and support that she needed to form herself musically my body was informing me of the extent of her needs en letting me know how overwhelmed I would be in trying to meet those needs.

(Bruscia 1998 p. 80)

Composite themes 3 and 4 relate to and consolidate this issue. Bruscia identifies two main somatic indicators: "any change in body energy or tension, or a sudden appearance of physical discomfort." (Bruscia 1998, p. 80) Both indicators are represented in the participant's experiences in this study. Other indicators he classifies as polarized emotional reactions (ibid. p. 81), which is present in C's experience, where she is concerned about being carefully nurturing mother while simultaneously having quite strong passionate feelings. She is also concerned with having very strong boundaries just to realise that, where they come to an equal meeting she can let go of some of her boundaries and negotiate with the patient in a mature way.

Bruscia also talks about love as the "main commodity of the therapeutic transaction ... it is the key ingredient of every corrective emotional experience. Without it, therapy is empty and superficial; with it, therapy is joyful and uplifting." (ibid. p. 83). None of the participants use the word love in their formulations, but their engagement in the case and in their identification with the patient, I think would not be possible without the presence of a deep human love towards the patient.

He also talks about drastic changes in the use of music and of unwarranted or inexplicable reactions (ibid. p. 86-87), the latter of which seemed to be present in the cases of A and D. A all of a sudden banged a drum where she felt like in Bruscia's formulation "--- that her perception of the situation was not distorted but felt that this reaction "came from nowhere" or was "completely off the wall" When interpreted as counter transference turmoil, her reaction did come from somewhere – her own unconsciousness; if the reaction was explored further, it would become quite evident that within that context, the reaction was not at all "off the wall". What seemed bizarre could actually be explained in terms of the therapist's psyche rather than the client's or the here and now. "(ibid. p. 86)

It is interesting to note here that in the art of interpreting what lies behind the descriptions seems to indicate, that **it is a negative experience to act out in an unwarranted way from the therapist's unconscious.** Actually the findings here show that all of the therapists start to act out in what could be called an unwarranted way from their unconscious, which then informs them that something specific is emerging, and also that the acting out seem to be very quickly verified as being in the right timing in relation to the patient's process, and thus warranted.

So I think it is very important to distinguish between warranted reactions which seem to be timed correctly, and unwarranted reactions which seem to be insensitive to the timing of the patient. Theme 13, 9, 6 and 5 are showing that positive counter transference experiences are actually based on what could seem like unwarranted and inexplicable reactions by the therapist in the first place.

Another important issue to discuss from Bruscia's comprehensive descriptions of manifold aspects of the phenomenon of counter transference is, where he offers a procedural cycle of the counter transference process. He comments how therapists can consciously avoid getting stuck by movements within an experience where ones mode of consciousness changes. Bruscia (ibid. p. 96-97) has developed a procedural cycle including: floating, checking in, shifting, reflection and action. (see chapter 2.8, p. 207). The headings and movements of these steps are:

- 1 **Floating** (opening oneself to whatever is happening in the moment – a phase of passive presence to gain an over-view)
- 2 **Checking in** (to direct ones awareness – to anchor oneself in a particular experiential space either in the client's or ones personal world focussing on either the sensory, affective or reflective layer of experience – entering a phase of directed active presence to deepen the experience)
- 3 **Shifting** (when having the experience deepened in one experiential space it is time to shift either from one world to another or from one layer of experience to another layer within the same world)
- 4 **Reflection** (here it is time to move out of whatever worlds and layers have been experienced and move into the therapist's world at the reflective layer of experience – into the position of professional observer)

- 5 **Action** (Here the therapist “.....implements the decisions made in the previous phase and thereby shapes the direction of the session).

(Bruscia 1998, abbreviation of p. 96 – 100)

Bruscia’s procedural cycle seems to be partly cognitive. These techniques seem not to be equivalent for the participants in this study working with ego weak patients, where the act of a partly disintegration in the identification with the patient is a source of moving ahead in the counter transference dynamic. The patient’s projections and transferences are very strong and can be felt as almost paralysing. The idea though of verbalising such procedural cycles of the therapist’s experience of counter transference is very important and I can see a future research area related to this idea. Bruscia mentions that a gender difference in carrying out such procedural cycles might be a fact, which could also be interesting to further explore.

In the findings here a parallel procedural cycle could be outlined as including:

- 1 *Floating (the therapist is open minded to the nature of the therapist/patient relation being present in the here and now)*
- 2 *Identification (the therapist empathically identifies with the mental suffering of the patient, often for a long time if needed, allowing the past to be part of the here and now)*
- 3 *Surprise (the therapist is unconsciously breaking out of and separating from the mental suffering of the patient at the right time for the patient’s need)*
- 4 *Digestion/information (the therapist is unconsciously translating or transforming from physical sensation to psychological understanding)*
- 5 *Flow in the change (the therapist follows the change of the music and the therapeutic process in a process of making unconscious communication conscious).*

This whole cycle is included in the composite themes and is lined out throughout the discussion chapter

Finally I do agree with Bruscia’s statement on self- experiences in music psychotherapy, where he

emphasizes that music therapists should take care to heal themselves by ‘taking their own medicine’, and he points out that: “Any music therapist who has not, cannot, or will not experience music therapy as a client needs to change professions. – To practice music psychotherapy

for any length of time, the therapist will inevitably need to return to his own form of therapy as a client, not only to benefit himself personally, but also to keep counter transference issues at the forefront of his awareness." (ibid. p 116) This statement is very important and very much resonates with all of the themes of this study.

Scheiby is the third music therapy author I want to bring into the discussion. She developed the terms **musical counter transference**, **traumatic counter transference** and **counter transferential music**. In her definition of musical counter transference, she formulates that:

.....musical counter transference 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/her transference. The medium through which these are conveyed is the music played in the session.

(Scheiby, 1998, p 214)

Even if Scheiby, in this definition, is commenting on counter transference as a specific reaction to the patient's transference and is not including the empathic identification, where the therapist's music cannot be separated from that of the patient, her ideas of the function of the music are very much in line with the findings in this study in theme 6. She emphasizes, what is also part of the findings in this study that **the uniqueness of music therapy is, that we work with unconscious counter transference experiences as a manifestation in a concrete form in the music, and the possibility to reflect this dynamic form from recordings of the improvisations.**

Scheiby is very much in line with the findings in this study where she identifies cues to determine whether music is manifesting counter transference phenomena. She lists the following cues:

- Music that seems out of context with the client's expression at that moment
- Music that does not seem to be appropriate from the therapist's perspective
- Musical expressions the therapist makes that take her by surprise
- A sense of not knowing where the music is coming from

Musical expressions that the therapist feels pushed into producing

(Scheiby 1998, p. 216-217)

These formulations is very much consolidated by theme 1 and theme 6 in this study.

Of vital importance for the findings here is Scheiby's elaboration on the term **being there** for the patient. Here she is very much in line with the participant's experiences of being part of the patient's disintegration and she is almost formulating the stance of observing this state of being by the therapist **similar** to my description of the detached observer where I discussed the findings in relation to the ideas of Priestley:

"Creating space and room for clients to *be* and to discover themselves can sometimes best happen when the music therapist allows himself/herself to *be*. This often means suspending some control so the Self of the music therapist can *be there for* and *with* the client. This is a place where separation and connectedness exist simultaneously. It is a place where the client can listen to and connect with the unconscious (unexpressed grief and sadness in this case) as the music therapist is doing the same thing.

(Scheiby 2005, p 9)

So as a summary of this section: **the unique act of playing the manifestation of unconsciously emerging counter transference is coming as a surprise in the music and allowing some control to be suspended - seems to create a stance of being 'separated in connectedness' for the music therapist in the counter transference experience.**

6.4 The link to the main question. Second part

The link between the **understanding** and **interpretation** to the counter transference moment to the interview data and composite themes

As mentioned above the distinction of the main question into two parts is really an artificial one and a lot of understanding of counter transference is implicit in the comprehensive answering of the first part. This

section will involve a less comprehensive discussion, as less attention was paid to this aspect in the data from the interviews. The act of interpretation seems to be more connected to a listening procedure by the therapist and to an awareness of the role and role responses the therapist are into in the 'here and now'. It is also connected to the "right timing" of acting the counter transference out in the music.

According to the findings, none of the participants had one clear theoretical frame of reference in understanding or interpreting the counter transference moment. All of the therapists talk about the timing aspect as the indicator for, whether the counter transference moment is to be interpreted as positive or negative. The participants make use of metaphors such as a mother/infant metaphor to understand their role of participation in the transference/counter transference dynamic and to recognize the phase of development by the patient. None of the music therapists include interpretation based on classical psychoanalysis (such as the theory of Oedipus complex, strategies of resistances etc) in their experience and understanding of counter transference.

All four participants comment on object relations theory as a theory they can relate to, but not a theory that can stand alone. Other theories such as interpersonal psychoanalytic theory are mentioned. C and D talk about being in the middle of polarities in the jungle of theories around counter transference. **None of the participants are led by a specific theory** in their clinical practice. A and D have created **local theories**, which help them to be orientated in the act of moving into the unconscious, and partly into disintegration, and also help them in the act of moving back into consciousness and structure. **This is an important finding**, and will be further addressed in the section on relevance to clinical practice.

As commented in the section on future research, I hope this study can provide building blocks to a further step in synthesizing a more comprehensive theory on this specific dynamic in the therapist/patient relationship applicable for clinical practice in music therapy in psychiatry.

Concerning the metaphor of a mother/infant dynamic, all of the participants comment on being identified in a specific mother role, which also indicates that they feel like being connected to the patient in a containing and holding way. They all seem to realise that helping patients with such severe mental illnesses calls for this kind of connectedness, where the therapist is empathically listening to the patient. At the same time they also seem to identify with the childish part of the patient, so that **they offer a resonating 'child/infant' connection and simultaneously a**

‘mother/parental’ connection. In an analogy to the role of a mother they also seem to be very aware of the growing or not growing process of the patient and to be ready to follow this process.

I see a close connection between themes 13 and 14, namely the participants focus on being very aware of the ‘correct timing’ according to the patient’s need, and the strong focus on identifying themselves with a caring mother figure.

Overall the participants talk about the following mother roles:

A uses the metaphor of being in contact with representations of inner childish parts and inner parents parts **of** and **in** the patient and also **of** and **in** her self. She understands changes in the therapeutic relationship as changes in the dynamic between these representations of inner childish parts and inner parental parts in both the therapist and the patient. She speaks about being the one, who cares for both parties and who pulls the wagon for both parties. She also recognises that she is taking over the role of the patient’s real mother in protecting the patient ‘to a point, where she cannot move forward.’ The counter transference moment provides the necessary change in this dynamic. **A** understands that the change could not have been at the right moment for the patient, if she had not provided such a protective frame through offering a possibility for the patient to relive the past in the here and now. After the counter transference moment, **A** speaks about being in contact with both a baby side and an adult side of the patient. She also talks about being able to share the pressure in the breast so they both take responsibility. **A** understands the dynamic to be - as if the healing careful mother is changing into a demanding mother.

B understands counter transference as a phenomenon that covers all significant emotions that arise in the therapist, but he emphasizes that they have to be significant. He also thinks they have to be validated in the further process of the therapy. **B** uses the metaphor of being in a mother position indirectly by talking about creating a ‘birth channel’ with the voice, symbolising four phases of the birth process, which he experiences, that he is living through together with the patient. So he is the mother giving birth, at the same time as he is being born himself together with the patient. He talks about empathically following the patient in the chaotic playing at the beginning of the counter transference session, being aware, through the voice sound, that a saving or ‘rescuing mother role’ is needed.

C comments that not all emotions or thoughts coming up in the sessions are counter transference. What makes it counter transference is that you, either during the interplay or after the ending, become conscious of a sudden shift in the music in a shared musical improvisation between the therapist and the patient and **that you make use of it**. C. talks about being the nurturing mother containing the patient's neediness of needing love and needing connection. She was consciously offering a musical symbiosis for a long time, where she understood herself as being a tool that symbolically could show him the way, in which he could be there with these feelings. So it was 'like a baby learning how to play' in Winnicottian terms. She is moving with the change of the counter transference experience, further understanding herself as a mother, who is letting the child free to go on its own. And she realises the patient is now able to go on his own. He can stay in the music as an adult to adult.

D understands the phenomenon of counter transference as a position connected to the idea, that the psyche and the body are one, and the counter transference for D is always felt in the body, never in his mind. He understands it like a physically intuitive listening, in which he is letting the music show him the way. He talks about being a mother figure - just being there listening and providing a safe space for the patient. He understands this role in the term of reverie where the mother understands the unconscious of the baby and gives it form. But he is uncertain about if it can be called counter transference. D is the only one of the participants who distinguishes between work with psychotic patients and non psychotic patients, in that he is primarily calling the work with psychotic patients a therapeutic reaction instead of counter transference. At the same time he is imagining that the therapist is the one who can influence that projective identifications are transformed into transference by the patient through counter transference reactions to the psychotic patient by the therapist. And this influence he calls counter transference. Musically he is talking about the psychotic patient playing in a sensorial way and the therapist is unconsciously creating a form for the patient through the music - **for the baby the mother is doing the work** (D's formulation). Thus he can influence the patient to gradually play with musical form, and in this way they can create an intermediary space between the therapist and the patient together. D, like the other participants, believes that the most important part of the therapy is the process of making unconscious counter transference conscious, because when the therapist is scared about the counter transference - he can not meet the transference from the patient.

6.4.1 The link between the **understanding** and **interpretation** to the counter transference moment to the theoretical framework

As none of the participants seem to use the classical psychoanalytic interpretation, I want to primarily relate to the literature of contemporary psychoanalysis and the music therapy literature.

Concerning contemporary psychoanalytical literature and literature on the theory of the self, I find it interesting that none of the participants seem to be influenced by the theory of the self developed by Stern as an applicable theoretical approach for the understanding of counter transference. At first many of the participant's formulations of experiences of counter transference seem to be very close to, what Stern (2004) calls 'now-moments' of meetings. Stern also defines meetings as unfolding within procedural cycles, and his theory is frequently cited in the music therapy literature concerning descriptions of musical meetings and procedural cycles in the therapist/patient relationship (Hannibal 2000, 2000a, Trondalen, 2004). I think that this has to be seen as a consequence of the fact that Stern is moving away from using the term **unconscious**, a term which seems to be very important to all of the participants in this study

They all seem to believe in the unconscious as an active dynamic factor in the therapist/ patient relationship. They also believe that the past is influencing the present, in the way that repetitive experiences have made certain relational patterns by the patient possible and other patterns not possible. So there is a clear psychodynamic foundation present for the understanding of counter transference for all of the participants. This is shown very clearly in the way, they understand their role as a therapist changing from that of a more supportive mother figure to that of a more demanding, separated or structure creating role figure at the 'right timing' for the patient's process. It is also shown that they, when resonating at a deep level of identification with the mental suffering of the patient, rely on their own unconscious and subconscious as an important source of information.

A and **B** understand counter transference primarily from an object relations framework and also from the theory of inter subjectivity.

A has further developed different local theories in order to understand her different roles in the therapeutic relationship and in order to use these local theories as an orientation and clarification tool in the act of following the changes in the musical relationship.

B comments that counter transference covers all significant and important emotions that arise in the therapist during the session. So the term is relevant only for the outstanding emotions. B is comments that the therapist can be like a transitional object helping the client to understand himself/herself better.

C comments that counter transference is not necessarily everything that the therapist is feeling, but it has to do with the therapist's unconscious. She points out that counter transference includes, that there is an unconscious channel to the patient's unconscious and then the therapist starts to use it more consciously. C further comments that she is using a mixture of theories (object relations theory, other developmental theories) She emphasizes, that she simultaneously believe in the unconscious being a strong power, but also believes that all people, including people with a mental suffering, are looking for contact with a desire to be known and to be connected.

D comments that counter transference simply is unconscious communication and that the most important part of therapy is the process of making the unconscious counter transference conscious

D emphasizes that when you have had your own analysis you know yourself and know how you are reacting. You are exploring your own unconsciousness.

All four participants are viewing the counter transference experience as something in process and they all comment on their experiences as a procedural cycle. They also talk about the importance of the therapist being aware of his/her role and the way he/she both unconsciously and consciously influences the relation and the therapeutic process. They all seem to need to combine an intra-subjective understanding of development and pathology with an inter-subjective understanding of development and pathology. But there is no common ground for a theoretical framework where all these perspectives are included:

- the importance of the past and the present
- the importance of intra-subjective and inter-subjective dynamics influencing development and pathology
- the importance of the unconscious as a channel of contact and communication
- the importance of the level of listening and of awareness
- the importance of the act of playing music as a dynamic factor in the counter transference dynamic

It seems to be a task for future music therapy research to further develop applicable comprehensive theories covering the field of the dynamic of counter transference in musical improvisation in adult psychiatry. Theme 16, 14 and 11 are relating to this second part of the research question.

In the music therapy literature both Priestley and Bruscia seem to adapt to a classical psychoanalytical or object relation understanding integrated with other understandings such as a Jungian understanding of the development of the patient as a basis for their comprehensively described method and techniques in understanding and handling counter transference.

I can see the possibility of a comprehensive theory in what is called the theory of relational psychoanalysis, which is a contemporary psychoanalytic perspective on interaction, the unconscious and the self primarily under development in Scandinavia by Nielsen (2005, 2006). This theory integrates the belief in the unconscious, the influence of the past on the present, at the same time as the focus for therapy is on the here and now and on procedural cycles in the therapist/patient relationship. It also ingrates those parts of psychodynamic theory, and self psychology theory, that are mostly concerned with procedural cyclic movements in the therapist/patient relationship. . To contribute to a development of such a comprehensive theory for the understanding of counter transference including the understanding of the action of playing and the function of the improvised music certainly will be at top of my list of future research writings from my hand.

6.5 Relating the findings to the sub questions

6.5.1 In what ways do music therapists experience counter transference as a positive influence on the music therapy process?

All of the counter transference moments identified for this study were experienced as positive, and the positive influence of the therapeutic process is described in the interview. All four participants were familiar with being touched by traumatic experiences from their life story in the moment, and that they understood this as positive as far as they became conscious about what was going on. The musical improvisation served the purpose of making unconscious dynamics conscious. All four participants reported having an intuitive feeling that it was the right timing

and the right thing to do at the moment of the counter transference reaction. The musical improvisations also served the process of knowing it was the right timing and also the process of making unconscious dynamics conscious. Themes 13, 2, 5, 7 and 8 answer this part of the sub-questions. All of the changes experienced as positive in the identified counter transference moments were focussed on the issues of closeness/ distance, absence/ presence and chaos/ form.

For A the positive influence of the experience of her unintentionally banging a drum in the middle of a piano improvisation turned out to be that both the therapist and the patient perceived the sound of the drum as a physical shock and the patient reported 'you got me out in reality.' A immediately had the feeling in that moment, that it was the right thing to do. The positive influence of the change in the dynamic of the musical relationship was that the patient started to dialogue verbally on her sufferings, which again encouraged the therapist to be more provocative in her musical part. The therapist could now share the pressure and tension in her body and emotions being there in the atmosphere between the therapist and patient in the music. As a metaphor A commented that she could now connect to the patient both with a baby side and an adult side at the same time. So even if the counter transference seemed to be connected to traumatic experiences in the life story of A, the timing was right for acting it out. So the change made both the patient and the therapist more present in the relationship. I want to bring just a few formulations from the interview to verify the experience.

- I remember she said 'when you banged the drum, you got me out in reality'. And I asked her if this was good or bad for her and she said that - she did not like it but she felt it was good for her.

- so - in this moment I felt immediately a feeling of satisfaction like OK so it was right

- as soon as I feel all that pressure - having this rope coming up again - I try to find a way to put it in between us and to verbalise it and to put it into the music

- it started our dialogue on her different ways of being present

- we could start to explore together what does it mean, when she is timeless, what does it mean when she is present - what is good what is bad- I felt a connection to her both as being a baby and an adult at the same time, and I could be with her with a baby part and an adult part at the same time

For **B**, adding a surviving voice quality to a piano/drum duet promoted that the patient started to play more structured and he started to connect to the music of the therapist. The therapist repeated the voice sound four times and felt gradually more safely. He had the feeling in the moment - yes it is right to do this. The positive influence of the change in the dynamic in the musical relationship promoted the patient to play more freely and really concentrated, and the therapist could play completely differently. They could build up to peaks more harmonically, and endings to the improvisations were clear. The therapist found himself playing as if in gospel music, and the patient reported that he felt uplifted, got more energy and also took energy. The music transformed into something more settled and coloured the atmosphere, so it was like growing together. So the positive change provided the necessary structure and form in the chaos. A few formulations from the interview reported:

- when I started singing again the second, third and fourth time, I knew this was from another perspective because I knew that now I was singing again and I had a more cognitive sense of what I was doing and I was partly aware of that there was a different quality in the voice than there was the first time.

- I got the feeling: Yes it was right to do this!

- the patient was very clear in the four notes of these half notes going down. So it was more structured than he was playing before, and you can hear at least that it was connected to my singing.

- but it was transformed into something that was more settled and more coming out in a structured way - so it changed the colour of the feeling of the atmosphere, and it was changing during the rhythm in almost the same notes but with a different quality of it

For **C** playing again some early music, she had been playing four years ago with the patient at a time of a symbiotic relationship, made her realise that it now had a different quality, and that she no longer played symbiotically with the patient, but was separated her from him in the music. The patient acknowledged this positively, and the therapist was encouraged to play back in very pointed music strong negative emotions with very passionate chords, which had been there in the therapy room. She trusted, that the patient would stay in the situation. The patient stayed and it felt like an equal meeting where the patient talked to the therapist as an adult to adult for the first time. So the positive change provided the necessary distance to be in an equal meeting. A few formulations from the experience reported:

- this moment was the first time I can remember him acknowledging something I had done musically,

- prior to this I have been staying in this rather symbiotic parallel safe space, which was a bit like the early music when he was very regressed and I had to just follow, but it had a different quality -

- It then consciously made me take more risks, so I became more adventurous and I changed the speed I speeded up - I played more passionate chords and I sort of actually put something of - I suppose you could say a musical interpretation

- I remember being conscious that this was almost like an equal meeting rather than - you know - me as I had been previously - looking after him and having to nurse him - it was more like a "Here we are" two consenting people that are playing together - going along together -

- interestingly in the talking part and for the first time and only time in the whole of the therapy, it had the quality of him talking back to me as an adult to adult -

- it is into flow more

For D it was the act of 'stopping playing', being in the silence, and feeling the inner helplessness of the patient and himself which unconsciously made him start playing on the piano, and which influenced the patient, (even if the patient was not aware of it). D played a sober melody unconsciously following the music; he played for himself, as he wanted to give the inner feeling to come to exist and to transform the feeling of being destroyed by the patient. The therapist felt, that the patient was ready for another way of playing and the ensuing music showed that they were playing together and ending together. D felt a greater therapeutic freedom and he could 'lean back' more. He did not have to hold on to the patient any more, and instead he could become a container. An intermediary space emerged and the patient could have fantasies and memories, and create more structure in the music. So the positive change allowed both the patient and the therapist to be more present and exist. A few formulations from the experience reported:

- and I started a very sober melody and then it developed into a more choral way of playing

- and I wanted to give some form to it to exist as if I am playing: 'You cannot destroy me - I exist!'

- I wanted to be in my playing in resonance with myself but something is happening with the patient yah - and in this way I am sure that I influenced or affected in some way the patient - she was not aware about it

- I experienced that she is ready to another way of playing –

- there we had contact and we were playing so in the transference it is more playing – two people are playing this improvisation – it was very softly - we ended together

6.5.2 In what ways do music therapists experience counter transference as a negative influence on the music therapy process

None of the identified counter transference experiences in the study were experienced as having a negative influence of the music therapy process. Three of the participants reported negative counter transference experiences from their clinical practice. One participant defined negative counter transference in general. All of the participants reported that a negative influence of a counter transference experience is related to the timing aspect of the reaction. It was also emphasized that a negative experience is one which is out of tune with the patient's need.

For **A** the negative counter transference experience was the therapist fantasising on ending a case to serve her own needs, because the therapist felt impatient and felt like being cut off by the patient. The irrationality of the feeling was worked on in supervision and the case went on. The irrationality also resonated with the therapist's life story but this resonance was not in time with the patient's need. The consciousness of the negative reaction gave more energy to the work.

For **B** the negative counter transference experience resulted in impulses to play more complex music, being impatient, and wanting to serve his own needs in work with a patient who could only concentrate on one musical element at a time. The therapist's impulse was realised and negotiated with the patient and B went on being more attuned to the need of the patient. B comments on moving from negative to positive counter transference experiences when the negative reaction is made conscious and acted upon.

For **C** the negative counter transference experience was from having worked with patients who had been so frozen that they had not been able to play music, and they manifested this by hating anybody includ-

ing the therapist. The therapist felt overwhelmed, in a way where she felt she could not provide safety for the situation, and she felt like failing in never getting over it and, as a consequence, the patient stayed away from therapy. She had supervision to help work through the strong, negative emotions coming up. The feeling of 'having failed' for C was related to her intuitive knowledge about the strong need of the patient to be respectfully confronted and contained, which was not possible for C in that moment.

For D negative counter transference is generally related to therapists who stick to a method repetitively without paying attention to the patient's need. For D this is a problem of the therapist working through his/her own problems instead of those of the patient. He formulates it this way:

– when you do always the same intervention – then I speak about negative counter transference – because that make us clear that you want to solve something about your own problems into the therapy with the patients

So while summarising the ways the participants experience counter transference as a positive influence on the music therapy process seem to be more connected to the act of improvising music, the experience of the negative influence of counter transference is more related to bad timing, where the therapist's own needs are being the focus instead of the patient's needs in a way which is not serving the progress of the therapeutic process.

In the literature it is much debated, whether the therapist's own impulses or emotions should be kept out of the therapy process or whether they are important sources of information of the patient's unconscious. For the participants in this study this debate seems not to be of importance as acting out of personal impulses for them can be both a positive experience and a negative experience. The crucial condition is the timing in relation to the patient's need.

Another issue related to the question of negative versus positive influence of counter transference is the participant's comments on movements from negative to positive counter transference experiences. Themes 5 and 13 are related to this issue. A, C and D comment on consciously moving the therapist and the patient away from an uncomfortable atmosphere into a more comfortable atmosphere through the musical improvisation, as well as conversely moving the therapist and the patient from a comfortable atmosphere to an uncomfortable atmosphere through musical improvisation. In such cases the therapists take a conscious lead,

or manipulate the atmosphere by help of the music. The important thing here is that it is conscious, and in tune with the patient's need. It is also important that it is not a method to use music to avoid uncomfortable atmospheres or conflicts, but as formulated by C:

I think a good music therapist would actually sometimes use the music to get away from the heavy counter transference feelings or experiences. I think that's why music is so useful particular for really severely mentally ill patients. And I think that's quite necessary - the more disturbed patients are the more they need that. So I think it's 'YES this will be happening' I think where the worry is, this is, if someone was saying that while they were doing music therapy they always just moved away from negative counter transference experiences - then you might say then it is almost more like a leisure thing, where you are going and feel a bit better. But there isn't really the second bit which is the understanding, and the moving on and putting it into context.

6.5.3 Particular features of the music in the counter transference moments across the experiences of the participants

This study has shown that the participants do not report any recurring or consistent characteristic features in the music in connection with the counter transference experience. The musical parts are totally different in the identified moments, including banging a drum, adding a voice, playing differently at the piano and stop playing the Kalimbaphone, makes a pause and start playing the piano. All of the participants talk about how they touch the musical sound in a certain way of listening, and how they are intimately connected to the produced sounds and being led by the produced sounds. However they do not comment on the syntax of the music, only on the symbolic representation of, and function of, the act of playing music. On the other hand they do comment vividly on how the produced music seems to be a 'co therapist', leading their intuition in the unconscious experience of counter transference in a way where they trust in just following the music they are acting out in the interplay with the patient.

6.6 Phenomenological analysis as a paradigm for this study

This study required a frame for systematically analysing experienced music therapists' formulation of counter transference experiences in clinical practice, which often emerge unconsciously in the clinical practice, and which are often very difficult to articulate in words. Phenomenology is a suitable approach to ensure the best possible frame for the participants to unfold their lived experiences of counter transference in musical improvisation in adult psychiatry. Phenomenology is a suitable approach as it suggests that "--subjects are chosen who are able to function as *informants* providing rich descriptions of the experience being investigated ---- the subject has had the experience that is the topic of the research --- the subject has the capacity to provide full and sensitive descriptions of the experience under examination." (Polkinghorne 1989, p. 47)

During the research process I found that undertaking several processes of distillation in the analysis procedure have been a meaningful way for me to get a sense of the whole of the rich, comprehensive data. The phenomenological approach allows the participants to remain authentic to their experiences and in this study I have been inspired to come back again and again to the phase where I as the "---researcher immerses her/himself in the data, reads and rereads, and dwells with the data, so s/he may achieve closeness to them and a sense of the whole." (Tesch 1990, p. 93)

I think of this inspiration in two ways. First, the data was very complex, and needed several readings to be able to grasp meanings for a further categorisation. Second, the data was very rich and I was inspired from the exact subjective formulations of what I would call 'tacit knowledge in clinical practice'. Each repetition in reading elicited new aspects of the experience. So both the qualitative semi-structured interview form, and the distilling processes have been effective for this study.

6.6.1 The interview method

Counter transference is a descriptive clinical term which has been drawn from a range of different experiences, ideologies and theories since it was developed by Freud at the beginning of the last century. As I wanted the participants to explore deeply a specific, context based counter transference experience, and to unfold their own formulations around this experience, I asked them to make a comprehensive preparation for the in-

interview, where they were told to place the identified experience in a clinical context instead of just talking about counter transference at a more general and philosophical level. This preparation also closely connected the participants to the identified specific experience, and ensured familiarity with the musical details. Thus they were able to describe their counter transference experience in a very rich and detailed language.

While a list of guidelines and a check list of issues for my interview were prepared, all of the subsequent interviews were carried out in an open ended way, and often the interviewee had very long passages, where they could unfold the depth of their experience without interruptions. One example is when D is talking about the strong bodily sensations and inner movements emerging in his counter transference experience. Another example is when B is talking about how his voice, when intuitively added to a piano/drum improvisation, had four totally different qualities within a very short time span. Questions tended to lead on from what the participants had said, unless there was a natural break, whereas yet unaddressed questions or issues from the check list could be brought up.

So in terms of studying the quality of the participant's experience of counter transference in musical improvisation in adult psychiatry the phenomenological interview seemed to provide space and freedom for the participants to answer in a very subjective way, and the order and pacing of the questions remained open for each of the participants. Three of the interviewees commented during the interview that they were surprised about certain formulations, which they had not previously articulated.

6.6.2 The distilling process

The process of distilling meaning has been interesting, difficult and multi layered. Each of the participants had very deep experiences, and the experiences were connected very much both to the life story of the participant, to the clinical context of the participant's experience, and to the patient population with whom the counter transference experience has been identified for each participant. In addition, all of the participants are very experienced clinicians, have been researching themselves and they are very reflective towards their clinical practice.

In the phenomenological process of distilling, the researcher is required to sustain the authenticity of the participant's experience and to both extract regularities or repetitive patterns and also variations of the ex-

periences. In the distilling process I returned to the transcript repeatedly to check the authenticity of the process, and with each re-reading it seemed like new layers in the experience stood out. Not only passages of meaning but also stand-alone formulations could be attributed to several layers of meaningful regularities and patterns. One example is the formulations of experiencing counter transference as a change, which evidently is an essential part of the experience of counter transference for all four participants. But the pattern of change was experienced variously in the level of awareness by the therapist, in the musical expression, in the musical relationship, in the contact between the therapist and the patient, and in the therapeutic process. All these layers were experienced as taking place simultaneously although they were also formulated as different layers of the pattern of change.

The distilling process of each participant's interview data ended with a synthesis of the experience of this interview. As I was very deeply into the data during the phase of distilling meaning units it was a natural process for me to formulate the distilled essences of each interview. The formulation was self-structuring, and I had a feeling that each of the distilled essences fully covered the essence of the participant's experience. I chose not to expand the interview process as I felt the data was sufficiently rich and comprehensive for this small scale study, and the experience of each participant was clearly covered. Still there are so many aspects around the phenomenon of counter transference, that several interviews could be carried out, and many more aspects around the descriptive clinical term counter transference could be studied. Bruscia (1998) suggests a numerous range of aspects around the phenomenon of counter transference, all of which could not be covered in this study. So in this respect it is more a consolidation of existing formulations on the experience of counter transference in psychiatry as presented by Priestley (1975, 1994), Metzner (1994, 1999, 2003) and in work with other traumatized patient populations (Bruscia 1998, Scheiby 1998a, 1998b, 2005).

However, this is the first study to systematically study counter transference experiences across several music therapists. It is the first study to look at similarities and differences in music therapists' experiences, and it is the first study to explore both positive and negative counter transference experiences across several music therapists.

I can identify with the statement of Moustakas (1994) when he comments that "the essences of any experience are never totally exhausted" (p.100). The global essence extracted in this study is true only for the subjective

experience of the four participants, but provides valuable information on which future studies can be placed.

The distilling process in the horizontal analysis was also very complex as I extracted composite categories across a huge number of meaning units. (See appendix 5 at the attached CD) Then I extracted composite themes from these categories. I was surprised how much consistency was represented within the composite themes. It confirms for me, that even if the experience of counter transference is very subjective, there are a lot of commonalities around the patterns of the counter transference experiences. I also see that the very act of distilling these common patterns provides the in-depth understanding of the importance of the counter transference experience for each of the participants and for the outcome aspects of this study.

6.6.3 An additional step in the phenomenological analysis

When I came to the phase of having formulated the global distilled essence, I felt a deep need to relate this essence back to each of the four distilled essences from the vertical analysis to ensure that the authenticity of the experience of each participant was fully covered. I think the nature of the data and the willingness of the interviewees to bring their deep personal experiences, and even relate these to their own life story, inspired me to this last verifying step in the distilling process. This additional step is a seminal contribution of the study, and future studies using a phenomenological process may adopt this additional process of authentication.

6.6.4 Verification of new insights

At this point I would pause and reflect on the major factors involved in qualitative research, regarding trustworthiness. Creswell identifies eight criteria of rigour in phenomenological research and all eight criteria were met in this study.

1 Prolonged engagement with the participants material

Throughout the study the interview text has been read again and again and has been very incorporated in my way of reporting the participant's experiences. This is also visible in this chapter where I, in my extended stage in the phenomenological analysis do relate the findings back to

the real data as they are that rich. They further illustrate the findings, although the findings do distill very complex composite essences out of the data.

2 Triangulation

Although I have used only one method and only one main source of data – the interview text – in this study, there has been some steps which are to be seen as triangulation. First the participants were derived from different training methodologies and from different cultures (different countries) which provided a professional and cultural dispersion. Second the interviews were based on a comprehensive preparation where the participants had to listen to recordings of their therapy case and also analyse the music around the counter transference moment. Therefore the interview text is based on both exact data from recordings and journal notes and from the participants memories and associations. That is to be seen as two different sources of knowledge. Third two different persons were carrying out the interviews which provided some difference in the questions styles as discussed on page 238.

3 Peer review

I have taken part in all PhD meetings at the Music Therapy Research School at Aalborg University, twice a year since I started this study in august 2003. I have presented my study in very different stages of the work, and I have had very constructive feed back from both fellow PhD-students and many international guest professors within the field. It has been a very important part of the work to prepare for these presentations, as I have done this study on top of full time work during the first two years and the presentations made me be centred in the phase, I was just into, at the time of the meetings.

4 Negative case analysis

As the counter transference experiences for all the participants turned out very positively I found it important that the sub-questions were also part of the interview material. One of the findings verify that all of the participants know about and could easily identify negative counter transference experiences. What was exiting here was that they all consistently identified these experiences as being connected to the 'right timing' aspect. So they did not identify negative counter transference experiences as either negative feelings coming over from the patient or as irrational emotions being touched by the therapist. These two signs for ne-

gative counter transference experience have been very much emphasized in both psychoanalytic and music therapy literature.

5 Clarifying researcher bias

I have been very careful in describing my epoché and I have many years of self experience and experience in training music therapists. I think this help me not to project my own ideas too much into the participants. Still I am surprised how similar the experiences of the other participants were to mine concerning their sensitive way of listening and in identifying recognizable experiences from their own life story as sources of information.

6 Member checks

I have added a further step to this stage in that I choose to send the material twice to the participants. I first send the total full transcript, my distillation of key statements and my developed meaning units within each transcript. After a time distance of 6-12 months I send only my formulation of the participant's experience a second time to ensure this description still grasped the full experience of the participant.

7 Rich, thick descriptions

I was very careful in selecting the participants and had developed a list of inclusion criterias (see p. xx). So the combination of selecting very experienced clinicians who are also researching their clinical work and the comprehensive preparation work they all did very careful for the interview enriched me with such detailed, complex and rich data.

8 External audit

The presentations at the PhD-Meetings had two different functions. The first and most important was the presentation of where I was at the moment in my research process and where and how to progress. The second function was that each presentation in the form of a power point presentation and hand outs presented my different layers of analysis, so the group could follow the steps and feed back on each one of them. I have presented six times altogether and even the last time when all the findings were clear, I had constructive feed back on the formulation of one composite theme to further the meaning in relation to the data.

This study therefore meets all eight criteria for authenticity and trustworthiness as listed by Creswell. He recommends (1998 p. 203) that qual-

itative researchers engage in at least two of the eight procedures so this study fully meet these rigorous standards thereby giving further credibility to the conclusions of this study.

6.7 Limitations of the study

As this was intended as a small scale study, I decided not to make a phenomenological analysis of the music around the counter transference moments, even though this music was available for me. I realised very quickly in the process, that the participants did not talk so much about the music as a sign or as syntax. They commented more about their connectedness to the music in the moment and the music as something that symbolically expressed their sensations and emotions. So I see that **the act of playing and the function of the music**, rather than the actual syntax of the music, are important for this study, as discussed above.

I also started off this examination wanting to interview ten music therapists using my own interview as a pilot study for the interview process. I realised after my own interview, how much information I could gain from just one interview, and I limited the number of participants to five, and finally four due to of the amount of data. My own interview could stand as part of the data, as no changes in method were applied. I actually formulated several passages in my interview which I had not formulated or spoken out that way before. I also chose not to return to the participants for further questions, or for further aspects of their experience, primarily because the first data collection was so rich, and because they all verified a year after the interview that the distilled essence fully covered their experience and that they had nothing to add. They all commented that they were actually touched by reading the distilled essence again after a year had elapsed, and they felt as though they were placed authentically back in the counter transference situation again.

6.7.1 Limitations of the paradigm of Phenomenology

Even if phenomenology seems to be the best of the qualitative approaches for this study, it also has its limitations in comparison with other research approaches. In the phenomenological approach there are no rules for a certain numbers of subjects as ".....regarding the number of subjects selected, this depends on various factors that must be tried out in each research project." (Colaizzi, 1978, p. 58). Creswell (1998) suggests "up to 10 people" (p. 113), but even so the findings in phenomenological studies cannot be generalised, as is the tradition in experimental studies. The

comprehensive distilled essence of such studies only represents the truth for the particular participants in the study.

The advantage is that a rich and in-depth description from a small number of people can provide a level of being very detailed. In this study I have explored music therapists understanding of the phenomenon of counter transference in musical improvisation in adult psychiatry. It is apparent to me, that this experience is of great importance for therapists in their clinical practice, and that it emerges as a surprise for the therapist and provides a change in the therapeutic process. The global distilled essence provides me with information from which I can now take a further step and develop a questionnaire to undertake a larger study for music therapists working with musical improvisation in adult psychiatry.

What has been a challenge rather than a limitation in this study has been to stay immersed in the data, as I actually have four intentions deriving from my research questions. I want to know –

- 1 How the subjects perceived and reacted in their experience of counter transference
- 2 How they understood and interpreted their experience of counter transference
- 3 If they experienced counter transference as negative or positive for their clinical practice
- 4 If there are common characteristics of the music in the counter transference moment

My main intention was to gain information about the music therapist's experiences, but I tried simultaneously to categorize the wholeness of the experience into specific foci at the same time, as I tried to keep the experience together as a unit. It was easier in the first phase of the analysis, in the phase of the vertical analysis to get to the point of verifying each of the participant's experiences. It was more difficult in the horizontal analysis to keep all the strands together, and to distil out the composite repetitive patterns or themes, while still maintaining the experience as one unit, because the unit here was a lot larger, containing the total experience of four participants.

The unity of the global distilled essence is very important for the here and now gained knowledge about the quality of the experience of the four subjects. I also think any further differentiations of certain aspects of the

experience of counter transference, more than is provided in this study, would require future enquiry drawn from the findings provided in this study.

6.7.2 Biases as potential limitations

As reported in chapter four, I knew all of the participants very well beforehand. This can certainly be seen as a limitation of the study. Giorgi “....proposes that the original data for psychological studies should consist of naïve descriptions, prompted by open-ended questions, of experiences by subjects unfamiliar with the researcher’s theories and biases” (Giorgi 1985, p. 69).

As I have been in music therapy practice for twenty five years, and my subjects have all been practitioners for either the same period of time or a slightly shorter time, it would be an artificial choice for me to search for lived experiences from unknown subjects. Music therapists in general are very international and meet regularly at international conferences, and I know most of the music therapists working in psychiatry in Europe. To be as conscious as possible about the biases connected to my own theories and clinical experiences I formulated my epoché very clearly before the interviews took place. I was aware in the interview situations that I have a certain way of perceiving counter transference (a very embodied way of perceiving), which I did not expect from the interviewees. Actually I am surprised and reassured how closely related some of the described experiences by the participants are to my own experiences. As I reported earlier in this chapter (see p. 346) we have different training backgrounds and come from three different countries. I have never been a therapist for any of the participants, although we have had experiential workshops together concerning the development of clinical and supervisory techniques. I do consider the participants as very experienced colleagues who would not just tell me what I want to hear. Also I consider the preparation work based in my guidelines as a guarantee that the subject’s experience was deeply grounded in his/her daily clinical practice and not in speculations about my ideas or viewpoints on the term counter transference.

I did feel very close to each of the participants though, when I immersed myself into the data of a colleague, which I knew very well. I felt a bit like being connected to this person during the time of analysis of the data. I did not find it difficult in distilling the essences, as I found that all of the participants had been very open minded in the interview situation, and I never had any concerns that they would feel negatively about

my analysis of their personal data. Most interestingly I found it quite easy to formulate my own distilled essence, and I did not realise how deeply I was touched about it, until the day I had to do a peer debriefing presentation in the PhD-group, where I was reading this essence out to the audience. The night before I pre-imagined this situation, and I realised that I had to change using I (reading in the first person) with the initial letter of my Christian name, which unfortunately is also the letter 'I'. But it is read out differently. At the very same peer debriefing it was suggested I changed all of the initials of the subjects with A, B, C and D to protect the subjects for future negative responses based on their open mindedness. None of the subjects demanded to be anonymous, even though this was offered when making the contract. I did keep the initials of the participants during my analysis work to stay connected to the subjects, and I first changed the names to initials for the writing of this thesis and for presentations during my research study.

Another bias was that I was interviewed by my research supervisor, who was also my former GIM therapist and supervisor. As I reported earlier I forgot about that immediately and I felt very comfortable in the interview situation. Using different interviewers is also recommended as a part of a phenomenological method to provide a wider range of perspectives of the formulations of the experience. In the method chapter (see p. 239) I have made a comparison of our question styles as the results need to take into consideration that two different interviewers were involved. The comparison showed that at a general level we have a very common style, but we have some slightly different emphases in our styles. The length and depth of the interviews seem to be similar though, and I did never feel like having different data sources during my analysis due to different interviewers. Although this could be seen as a limitation, as different interviewers in phenomenological research is suggested to provide a broader sense of the experience, I think in this study the trustworthiness is more to be seen in **the depth of the subjective experiences** which still provided a comprehensive consistency across the experiences.

6.8 Clinical applications

When we look at the finding of this study, the global distilled essence, it is very clear that all four music therapists working in adult psychiatry are very occupied with the phenomenon of counter transference, and also that it is an important phenomenon in their understanding of the therapeutic relationship, and of therapeutic progression in music therapy. This is important considering the four participants are educated at four

different music therapy training courses in four different countries and with different trainers. So even if they all call themselves analytical or analytically oriented music therapists they have significant differences in their original training backgrounds. The number of years of the music therapy training differs from one (post graduate) to four (bachelors/ masters). Two of the participants undertook analysis outside the training program and two had analysis in the form of self experience as an integrated part of their training programme. All of the participants had supplementary psychotherapy training, and all of the participants are part of the **treatment staff group** in the hierarchy of adult psychiatry staff group. They are not part of the activity groups. In this section of the discussion chapter I also refer back to the theories and models from my five articles to look for possible consolidation or differences.

6.8.1 Theories and models:

Assessment criteria in clinical practice with ego weak patients in adult psychiatry

All four participants have identified counter transference experiences from music therapy with patients who were evaluated as being not indicated for psychoanalysis nor for verbal psychotherapy. In the guidelines for the interview of this study there were no rules regarding which type of patient population should go into the study. Evaluation processes for patients are taking place in adult psychiatry, assessing whether patients are suitable for verbal psychotherapy or not. At the Music Therapy Clinic at Aalborg Psychiatric hospital, articles have reported the difference between suitability for verbal psychotherapy and music psychotherapy (Lindvang 2000, Lindvang & Frederiksen 1999), and the authors call the evaluation of suitability for music therapy a dynamic evaluation. One of the main differences is that in verbal psychotherapy the patients are expected to be able to reflect psychologically on their own life situation and sufferings in words. None of the patients in this study were able to do so at the beginning of the music therapy treatment. In the music therapy assessment, the patient is expected to be responsible and motivated to attend sessions and to find it meaningful to express him/herself in music, or to find it meaningful to listen to music. So the evaluation requirements are less demanding concerning intellectual reflection.

In this study it was found that even though patients are not able to reflect intellectually on their life situation, they are able to be a part of a transference/ counter transference dynamic taking place, and they are able

to show musically (and to verbalise on their musical experiences) that a change has taken, place which is perceived by them. In the case of A the patient became more free in verbal reflections on a psychological understanding of her situation, and a psychological understanding of the relationship with the therapist after the counter transference experience. In the cases of B, C and D the patients either formulated verbally that they related differently to the mutual musical improvisation, or they showed it in their musical part of the improvisation. B's patient reflected that the music was uplifting him, and he felt he could now both give and take in the music. D's patient could now join in playing in a musical form, and she also started to gradually reflect verbally on her situation. C's patient showed that he was present in the music, and he was aware of the therapist being there as a separate musical partner. So the reflection can be a verbal reflection, related to a psychological understanding of the patient's situation, or it can be a verbal reflection related to a new understanding of being related in the music.

It can also be a nonverbal reflection, which is shown in the patient's way of 'staying present' and way relating in the mutual musical improvisation. Hannibal (1999, 2000) has documented that the act of transference from the psychiatric patient towards the therapist in the verbal interaction is comparable with transference patterns in the musical interaction in music therapy. This comparability has not been the focus of this study, but it is still interesting here to see that the consequential response to counter transference by the patient towards the therapist can be communicated clearly both in verbal and musical form. In other words, the patients can show that they perceive counter transference in different ways - verbally, through the musical experience, through a change in their musical expression, or through following a change of the therapist in their (the therapist's) music.

6.8.2 Music therapy modalities in clinical practice

In an identification of European modalities of music therapy in psychiatry based on questionnaires and reported in the article: "Indications in music therapy. Criteria, examples definitions and categories, Smeijsters 1996, (see p. 70) this survey found, it was suggested that patients with psychotic or schizophrenic diagnosis should be offered only supportive music psychotherapy, recreational music therapy and music activity psychotherapy. It was defined that the "...therapist/client relationship is either direct or indirect, but personal aspects of the interaction stay in the background" (see p. 70). So the deep identification by the therapist

to the patient's trauma or a deep connectedness between the therapist and the patient is not considered a part of this modality.

However the findings of this study suggest the opposite! All four participants have very deep identification with the mental suffering parts of the patient, and all of them consider this as an important part of the treatment and an important curing element in the music therapy process. Back in 1999 I offered an alternative model to one suggested in the Indication Report on European modalities in music therapy work with schizophrenic/psychotic patients. I called this modality a "Holding and Re-organizing Treatment Modality" (see p. 86). What is highly relevant to the discussion here is my description of the Therapeutic Alliance in identifying this modality after the same criterion as the other modalities. Here I define the Therapeutic Alliance as follows:

The patient/therapist relationship is a main tool of change in the process. To build up basic trust in the patient/therapist relationship and in the patient's self awareness and capacity for relationship.

(See p. 87)

This definition of the therapeutic alliance is very much consolidated in the findings of this study. Methodologies based on such a deep therapist/patient relationship are evidently part of the clinical practice of the participants of this study. This is important to further encourage music therapists to work on a deep psychotherapeutic level with ego weak patients, and to be aware of the importance of counter transference as an important tool for insight both into the unconscious of the patient and the therapist. It is also a tool of information about symbiosis, closeness and distance. Finally it is an important tool for positive changes in the therapeutic process when the awareness of timing is alive and accessible.

6.8.3 To listen as a source of information in clinical practice

The identification with the mental suffering part of the patient is found here to be a part of the musical expression, as all four participants are empathically following and identifying with the musical character presented by the patient. The important issue here is that the participants do not only stay present and listen as a musical accompanist, but simultaneously identify with and listen to the psychic presence and suffering of the patient in resonance with recognisable emotions from their own

life story. The music seems to be an expression of an unconscious communication channel. D talks about an affected way of listening and he simply calls counter transference an unconscious communication. A and D comment on listening through the body to the body of the patient, and talk about this as a primitive way of listening.

I have described the act of listening in form of *listening perspectives* and *listening attitudes* in my attempt to describe 'therapeutic presence' and 'professional empathy'. I also described, as a listening attitude, the process of being informed by the unconscious of the patient as an act of listening. (See p. 46 and p. 54). I have defined listening perspectives and listening attitudes as sources of information in my work with schizophrenic patients as follows:

For me a listening perspective is a tool for orientation and information. One listening perspective can be described as listening simultaneously:

- to a foreground – the here-and-now-presence and expressions of the patient,
- to a background-the splitted-off reality (often a reality of very strong feelings) of the patient, which also means listening to the field of tensions and movements (or lack of tensions and movements) between these polarities of foreground and background.
- extra sensitively to tiny variations in tensions and movements between such polarities - tiny variations which influence our being together almost unconsciously but still very strongly.

(See p. 46)

In reflections on these listening attitudes I also argue:

Through the listening attitude one can resonate the understanding of the patient in an authentic way, framing possibilities for development of the patient.

(See p. 65)

The findings in this study consolidate the importance of listening attitudes, and the participants value the act of listening as a presupposition for the therapist being able to apply counter transference adequately to the patient's process. They use formulations such as 'an affective way

of' listening or 'an embodied way of' listening or 'an empathic way of' listening or 'listening to myself listening to the patient'

I have described three different attitudes (see p. 46, p. 51 and p. 53) with two different foci. One focus is where the therapist is focused on what can be directly heard from the patient, or what can be directly heard in the patient's music. Another attitude is where the focus is listening to the more extreme, small variations in the therapist's listening perception which make it possible to be resonant in relation to the patient's primitive way of organising sensate experiences. The second attitude is in work with ego weak patients, where I divide the attitude into two simultaneous parts being dynamically alive:

- 1 A part which is resonating with what one hears from inside an almost physically embodied organisation of one's perception and
- 2 A part which is sensitively resonating with the patient's need for closeness and distance.

When I relate these further definitions of listening attitudes to the findings in this study, then it is meaningful for me to think of this last defined attitude as the one, where the therapist is 'almost' unconsciously informed about when to react in the counter transference experience. The channel where the therapist is resonating with his/her own traumatic life tracks also resonates with the patient's primitive way of organising sensate experiences. It is meaningful for me to realise that the therapist's experiences of counter transference feelings are something that are hard to differentiate from his/her own traumas, and the patients mental sufferings, because the therapist seems to resonate both parts at the same time. Theme number 14 in the findings connected to theme 2 and 3 seem to be related to this unconscious channel of information and communication in the counter transference experience, where feelings from both the therapist and the patient are resonating simultaneously but still providing intuitive information for the therapist.

6.8.4 Sensitivity to the patient's process in the music

All the participants are unconsciously sensitive to the 'right timing' aspect of being able to make a change in the music, where they can separate from being identified by the mental suffering of the patient. All of the participants comment on recognising something from their own life story, and they also talk about the importance of their own analysis or music

psychotherapy in the form of self experience as a presupposition for them, in order to be able to be sufficiently sensitive to this recognition. They also comment on being sensitive to traumatic dynamics in their own life story without having to split it off in the therapy situation, until they have been unconsciously informed about which kind of dynamic in the relationship they are into in the 'here and now' in the musical improvisation. The possibility of the counter transference perception, being expressed or acted out unconsciously in the music, seems to serve, that the therapist intuitively acts out in the music at the right moment for the needs of the patient and the therapeutic progress.

A described vividly that she was playing a 'breaking out' dynamic in the music by banging a drum in the middle of a piano improvisation while she sensitively felt as being at the edge of being tied up too strongly for her body sensations. She felt like being informed by her body about what to play at the moment and also about the timing aspect of when to act out. She knew about the dynamic of having the feeling of being tied up from her life story.

B described clearly how he was lost when musically building up to a peak where he sensitively felt he was at the edge of losing control, and of drowning. He felt like being informed by his voice coming out which was added to the music and the continuation of him using the voice informed him, that it was the right timing and the right thing to play. B knew the dynamic of being lost and the of fear of drowning from his own life story.

C described how she suddenly realised, that she was playing the same chords as she did four years ago, but they had a different quality. She felt strong passionate feelings in her body, informing her that she could now play these feelings out in the music without risking that the patient was leaving the room. C knew the feeling of being nurturing in following a needy person from her own life story and she also knew the need of expressing passionate feelings about it.

D described how he moved from playing along with the patient - to all of a sudden stopping playing, where he was listening sensitively to the helplessness of himself being isolated by the patient and the helplessness of himself. He intuitively moved to a self chosen instrument, the piano. Normally he always let the patient choose an instrument for him. He knew the feeling of being left out and feeling helpless and seeking silence from his own life story.

As an aspect to this part of the discussion I want to bring in a quotation from chapter 1, article 4, where I write as follows:

Winnicott emphasises that when the patient's ego function is not intact, no transference neurosis (as originally described by Freud) will develop. The patient's primary condition is absolute dependence. In this case transference is characterised, not by the degree of irrational emotions on the therapist's part, but by the degree to which the therapist can allow the patient's past to be present in the relationship (a symbolic realisation). On these grounds Winnicott believes that the theoretical and technical modifications in therapy with regressive disturbances are fully compatible with the analytic frame of reference.

(See p. 132)

All of the participants were sensitive to be both identified with the trauma of their patient, and sensitive to let the patient's past be present in the 'here and now' in a symbolic realisation. They seem to locate both processes under the overall term counter transference. This sensitivity of the therapists seem to be a cornerstone in the counter transference experience, where they all recognised, that they separated from this symbolic realisation at an adequate timing for the patient's process. The therapists were acting out unconsciously in the music as an act of recognition of being in touch with traumatised dynamic patterns from their own life story.

So there is a connection between the therapists on the one hand being open to and being in touch with traumatic personal dynamics and on the other hand having the ability to be sensitive to the patient and to unconsciously know about the timing of change in the therapeutic process.

Thus they do actually act out in a way which, seen in the perspective of the definition of classical counter transference (as defined by Priestley after the prescription from Freud), is described as pathological and described as something one should be aware of and overcome.

The big difference here is, that:

the therapists in this study are not rigidly staying in the role of acting out – they become surprised through acting out in the music as it is a physical act, where they can immediately sense their action, which

is also a reaction towards the patient at an outer, audible, sensational and emotional level and they realise something specific is emerging.

The participants in this study can work with ego weak patients in adult psychiatry at a deep, psychotherapeutic level, where the therapist can identify with the trauma of the patient, and can allow the patient's past to be present. Music therapists rely on the fact that having a personal analysis or music therapy self experience serves the therapist's sensitivity to be able to resonate one's own traumatic dynamic, without having to split it off, and further that this resonance is important for the act of being informed unconsciously about the timing of creating a change in the musical relationship through application of counter transference experiences. Music therapists in this study can bring the work to another level, and they can provide progressions for the patients.

The findings also show that all of the participants of the study seem to follow what Bruscia (1998c) calls "...taking a more clinical approach, basing their responses to the client on their personal and professional experience and intuition" (p. 75). He argues this in opposition to music therapists who "... take an empirical approach to what they do with clients, basing every intervention on research or theory." (ibid. p. 75). He calls both approaches a part of an intra-subjective counter transference by the therapist and he continues to classify many more aspects of clinical practice as counter transference as it always involves the cultural background, education and life view of the therapist. This is also the fact for the participants in this study.

Here the focus has been the therapist's experience inside the clinical practice thus limiting the phenomenon under study to what Bruscia (ibid. p. 71) calls intersubjective counter transference. Still I think it is important to keep in mind that counter transference always contains both an attitude **and** a method or technique, and often in the historical discussions these two parts of the phenomenon have been fused together. This is obvious in the discussions on whether the therapist should take a stance of either a neutral or an empathic attitude. Also in the discussions on whether emotions are allowed to be acted out or not allowed and the discussions on, if purely acknowledgement or also confrontations should be the focus of the therapist/patient relationship in the 'right' understanding of the counter transference dynamic. The fusing of attitude **and** method also mirror different views on hierarchy in the therapist/patient relationship (from the view that a healthy therapist cures a sick patient at the one end of the continuum to the view that two equal persons are exploring together at the other end of the continuum).

The findings in this study show that all participants are aware, that they cannot just be equal partners to their patients suffering from psychiatric illnesses. They are aware, that they have to be conscious about the patient's transference derived from often extreme relational patterns, at the same time as they have to be aware of the necessity for the therapist to consciously fulfil the needs of ego weak patients in order for them to be able to exist. At the same time they have to be aware of the 'right timing' in changing this act of fulfilling the patients need as to the fact of when this fulfilling no longer provides any help for the patient's progress.

This act they experience as an act of a counter transference dynamic, and it is within this act they experience musical improvisation to be a valuable information tool. To come to the feeling of being equal partners can be a product of the progression in the therapy process, but the therapists are working with people who may have extreme relational patterns and the therapists have to use specific techniques to be of any help for the patients to develop further relational resources. As shown in this study one of these techniques is counter transference, where the therapist offers his/her sensitivity to make it possible to identify with the sufferings or the trauma of the patient in a way, where this identification can resonate with recognisable life experiences by the therapist. This dynamic helps the therapist to know when to carry the suffering *for* the patient or when to carry the suffering *with* the patient; when to carry the sufferings *up with* the patient and when to carry the sufferings in a slightly transformed form *back to* the patient at the right timing for the patient's process. These distinctions of the word carrying like 'carrying for, carrying with or carrying up or carrying back to' I have brought in from Nielsen (2001) who is a clinical psychologist working in psychiatry. And he is thus bringing me to the next section.

6.8.5 Relevance for contemporary psychology and psychiatry clinical practice

In relation to Cullberg (1993) the findings in this study resonate very well with his view of dynamic psychiatry where he points out that in the counter transference experiences where the therapist is transferring towards the patient
.....the therapist's unconscious problems are just as important for understanding the reaction as is the problem of the patient..... overall he emphasizes the importance of making emotional reactions conscious to be able to use the emotio-

nal life of the therapist, as this is the most important instrument in psychiatric work. This indicates that the therapist must attain as well a developed self-understanding as possible through self-analysis or psychotherapy and through sufficient supervision when working with different patient populations.

(Cullberg 1993, p. 501-502)

He further points out that "... when the therapist first learns to recognize and interpret the signals from his inner life, he/she is able to apply these "inner ringing bells" in the direct therapeutic work in contact with certain patients." (ibid., p. 502)

Jørgensen (2006), Associate Professor at Aarhus University, and a clinical psychologist who works psychotherapeutically (within dynamic psychotherapy) with borderline patients at the Psychotherapy Clinic at Aarhus Psychiatric Hospital, distinguishes between three channels of communication from the patient to the therapist, following the thinking of Kernberg. These three channels I would like here to compare to the three channels of listening attitude, I have defined previously at pages 54, 103 and 188. This comparison is illustrated below in Table 6.1.

Table 6.1: Comparison of Jørgensen's (inspired by Kernberg) channels of communication with Pedersen's listening perspectives

	Jørgensen's 3 channels of communication	Pedersen's listening perspectives
1	The explicit verbal communication – what the patient explicitly explains about his experiences	To listen to the foreground – to what the therapist and the patient is actually playing and in which way they are connected in the music
2	The nonverbal communication which is implicit in the way the patient is talking about his experience, body gestures, tone of voice and other indirect signals about which kind of relationships the patient invites the therapist to join into	To listen to the background, the split of reality – to the symbolic meaning of the music and how the act of playing provides a resonance for the psychic presence of the two parts
3	The therapist's counter transference which he defines as the emotions, impulses to actions, imaginations, fantasies which are activated by the therapist in the interplay with the patient here and now	To listen to the extremely small variations in the therapist's listening perception, which make it possible to be resonant in relation to the patient's primitive way of organising sensate experiences

I consider that all three different listening perspectives contribute to counter transference, while for Jørgensen, only the third channel is identified as counter transference. He claims that explicit verbal communication is often of far less importance than the nonverbal communication, and the therapist's counter transference, which contains very important information of the patient's inner object relations. He also points out that the more severe the disturbances in the patient's personality, the more obviously will the patient act out his/her inner pathological object relations in the interplay with the therapist. Simultaneously the strength of the therapist's emotional reactions on the patient in itself will contain important diagnostic information.

As the participants in this study all identify counter transference experiences with patients with severe disturbances in their personality, who are not able to explicitly explain their sufferings and it is obvious in the comparison that the three channels of listening perspectives is formulated as very embodied. It looks as if Pedersen's channel 1 is more comparable to Jørgensen's channel 2 and that Pedersen's channel 2 and 3 are further divisions to Jørgensen's channel 3. They operate at a more primitive level.

Jørgensen is addressing these differences as something connected to the diagnosis of the patient and he brings this citation:

The counter transference experiences which are released in work with severely personality disturbed patients often have another character than what one can experience in interplay with less disturbed (neurotic organised) patients. They are much stronger, more difficult to contain and can not be directly verbalised. One can experience unspecific tensions, uncomfortable and "unknown" bodily sensations and cognitive or emotional blockings (when you lose the ability to think clearly and to raise yourself mentally above the actual situation, one can feel like being tied to the chair, which can also activate an impulse to act (to do something) or to run away.

(Rudolf 2004, p.143 in Jørgensen 2006, p. 346)

On the basis of the findings in this study all four participants experience exactly this double position of being extremely stuck (blocked, tied up, 'stoned' etc), which provides an impulse to break out of this position, which again can be acted out unconsciously and constructively in the

music without the therapist running away from the situation. The feelings of 'being stuck' are reported in the interviews as having been extremely strong, and having been present enough for the necessary information about the patients unconscious to be clear in the therapist's mind.

So the very act of playing it out in the music seems to be both an act of seeking balance for the therapist at the same time as it is constructively transforming the act of transference from the patient towards the therapist and offering another structure in the music.

In the latest version of Matrix, the Nordic Journal of Psychotherapy, there is a thematic focus on the therapist/patient relationship. Jensen & Nielsen (2006) are writing on counter transference with psychotic patients. They discuss their theory of object relations with a focus on Bion's theories. They comment on the digestion process on the part of the therapist and claim:

It is absolutely necessary that the therapist receives the unwieldy emotions, digests them and gives them back. It is this process which in work with psychotic patients sometimes can be felt as unbearable.

(Jensen & Nielsen 2000, p. 232. Author's translation)

They also refer to Nielsen (2000) where he is commenting that in the field between the therapist and the patient there must be "...a 'non-understanding' or a 'non-ego' as something disintegrative, not meaningful and not verbalised material that are made meaningful, personal and integrated in the very act of verbalising. He argues that there must be a space for the therapist to let him/herself be exposed to the lack of meaning of what comes from the patient, and thus allows him/herself to be partly disintegrated, and through this act to be able to receive and digest the difficult material of the patient. Then integration can happen through verbalisation when it is exactly in the receiving and digesting process that you find the source of counter transference feelings or reactions. So it is in a field of disintegration we must understand that these counter transference reactions emerge and this field is necessary to create a re-integration." (Nielsen 2000 as summarized in Harpsøe & Nielsen 2006, p. 231. author's translation).

I think these formulations are very interesting in comparison with the findings of the study, as the participants experiences are formulated very

similar. For example in the case of B, the disintegration emerges and is immediately expressed with the voice - the sound of which is also further digesting and re – integrating.

So the findings in this study demonstrate that the participants experienced both the disintegration, the digestion and the re-integration in the music, where the music is the channel through which the unconscious of the therapist and the patient are expressed and transformed.

Last, but not least, it is also important to know that in the publication, “Joint values in the contribution for people with a mental health suffering” The Ministry of Social Affairs, Ministry of the Interior – and the Ministry of Health, (Denmark, 2005) it is emphasized that “ Assessment, treatment, social support and care should be carried out in an atmosphere of attentiveness and respect.” (Thorgaard & Haga 2006, p.11). To help fulfil this humanistic value in the field of psychiatry, the two contemporary Head Doctors and specialists in Psychiatry in Denmark and Norway try to describe in their latest book what is a good ‘relational treatment staff person’ and what is a good ‘milieu therapy staff person’ in psychiatry. They emphasize that:

No matter which method, it cannot be practised with ethical responsibility , scientific honesty or with optimal outcome, if it is not carried out on the basis of the nature of the therapeutic relationship, that includes training in, experiences through and knowledge about the relationship between the patient and the relational treatment staff person. And here essential experiences and knowledge about **both counter transference and transference are placed at the seat of honour at the professional relational treatment staff person.**

(Thorgaard & Haga 2006, p. 43.

Author’s translation and accentuation)

6.9 Future directions for research

The first issue that comes into my mind here is that I had the intention as a part of this study to develop a comprehensive theory, including my former models of listening perspectives and listening attitudes, my developed method of a holding and reorganising method for ego weak patients, my local theories providing help for orientation in the field of musical improvisation, which can also include chaos and disintegration, to provide a synthesis of all of the ideas I have brought in my five articles.

I thought of myself creating maps and figures in synthesizing all these ideas with the findings of this study and the contemporary theories coming up around interpersonal psychoanalysis, cyclic dynamic theory, self psychology theory and theory of empathy. Another synthesising process would be to integrate theories:

- of the act of playing (action as a dynamic element) in the therapeutic process
- of the therapist's connectedness to the music
- of the function of the music
- to experience music as a symbolic representation.

Here and now I will leave this study as a 'small scale study' giving important information on the experience of counter transference of four music therapists as professionals in clinical practice in music therapy in adult psychiatry. I have systematically developed a pile of building blocks which I am convinced can bring me lots of well grounded ideas for further theory building.

One of the hot issues for the moment in the research of the therapist/patient relationship in psychiatry, and also generally, is the different viewpoints on the 'way of being present' by the therapist, the definition of authenticity, the definition of 'important meetings or moments' between the therapist and the patient. An inspiring article for me in this respect is (Esbjørn & Væver 2006) on 'Moments in the psychotherapeutic process.'

Obviously counter transference can be understood, and is understood in this study, as an important 'meeting' and experience of change in the therapeutic process. It is a presupposition though, that the therapist's empathic identification with the patient and the patient's transference is present in order to create the possibility of the meeting being able to emerge as a product of the therapist's counter transference reaction. In other psychological traditions meetings are defined without the idea of transferences or identifications taking place as so called 'real' meetings in opposition to transference meetings. These differences are connected to both philosophy, psychological theory, understanding of clinical practice and of course to which patient population is in focus. I am burning to create further theoretical syntheses from the numerous building blocks in this study.

Basically this study has also raised again my interest in debating alternative metaphors for the phenomenon of counter transference. I agree

with Ruud (2005) when he calls counter transference "...a 'root metaphor' which within the last hundred years has been described and filled with so many different meanings and variations of meanings that some times the term in between can be experienced as being reaching the bursting point." I might not agree with Ruud on the direction of the further development of this metaphor, but I look forward to being part of the process.

I think the next few years will be very important for the development of psychotherapy and music therapy theory, and I think much more synthesizing theories will emerge and the classical clinical terms will no doubt be further debated and researched.

Another important research area would be to use the findings in this study which, even if they are very consistent, cannot be generalised, and develop questionnaires for assessment of counter transference experiences of music therapists working in psychiatry, both as a working tool for clinical practice and for research. Such questionnaires could be applied in larger samples to get more knowledge of the different parts of the experience, such as the five dimensions developed by Tansey and Burke 1989. I think the findings here can help formulate questions that can shed more light on how music therapists working with musical improvisation in adult psychiatry recognise

- 1 the degree of their consciousness or lack of consciousness of the experience
- 2 the degree of their control over the intensity of the experience
- 3 the degree of separateness or differentiation of ego boundaries maintained by the therapist through the different stages of identification process
- 4 the type of introjection involved
- 5 the question of whether the identification is with the patient's internalized self-representation (concordant identification) or with the patient's internalized object representation (complementary identification).

(summarised from Tansey & Burke, 1989 p. 35)

I will add here a sixth dimension from these findings which I will call:

6 *The degree of connectedness to the music as a channel of unconscious communication.*

I think further research in these recognitions will be of huge importance both for music therapy practice, music therapy supervision, and indeed beyond the discipline of music therapy into our sister disciplines in psychotherapy and psychoanalysis.

6.10 Epilogue

I knew when I started this study three and a half years ago, that I was moving into an area where a huge amount of literature was available, and I had to be selective. This is an area where there have been, and still are, interesting and conflicting debates for years in psychoanalysis, psychotherapy and music therapy milieus on this phenomenon. I also knew that this study focusing solely on the therapists' experience of counter transference, and not on the outcome for the patient, is controversial in the clinical milieu of psychiatry.

What I did not know was that just within the last three years so much more focus is being raised over the importance of the therapist/patient relationship, rather than on the outcome of one specific method. As a result of that interest, the empathic involvement of the therapist is very much more debated and described in psychology journals and in scholarly books for treatment staff in psychiatry. One clear example is Thorgaard & Haga 2006 (see p. 364), who have recently edited volume one out of five volumes planned for about relational treatment in psychiatry, with an emphasis on the professional experience with, and knowledge of counter transference being the seat of honour for the staff members.

I think music therapists, at least the participants of this study, but also therapists in general educated in several European countries, are at the same high professional level as psychologists and psychiatrists in being experienced in, and having knowledge about transference and counter transference issues, especially in working with severely disturbed and ego weak patients.

The music in this study is shown to function as an unconscious channel of communication where the therapists

- **can release body tensions and strong emotions**
- **can be informed about the unconscious communication**
- **can transform the disintegrated material emerging from the patient and the therapist**
- **can give a new direction to the therapeutic process.**

In this study I have systematically examined the counter transference experiences of 4 music therapists. The findings of the study build on what has been written by experts and pioneers in the field, such as for example Priestley and Bruscia. But this study is the first to compare and contrast the experiences of a chosen sample, and to explore similarities and differences in their experiences. The study has lead to formulating an additional step in the phenomenological process to strengthen authenticity and trustworthiness, and the study has identified new areas of exploration, based on the findings.

The study makes a contribution to music therapy clinical practice in regard to how music therapists describe counter transference moments, what they consider to be positive and negative counter transference moments, and importantly that no one single theory underpins their practice. This is particularly significant as the four music therapists came from different philosophical trainings.

6.10 Closure

I hope this study will inspire music therapists all over the world to reflect as openly as the participants in this study on their counter transference experiences, also those experiences which might be uncomfortable and disintegrative for the therapist, both within clinical practice and in supervision, with the certain knowledge that these experiences are very important for the curing process of the patient.

Inspired from the experience of counter transference by all of the participants in this study, and also from the life view brought into music therapy research by Kenny (2006), I would like to end this dissertation with two small poems, where I try to symbolically express the core essence of the experience of counter transference in musical improvisation for music therapists in adult psychiatry. (See back of the cover and p. 157).

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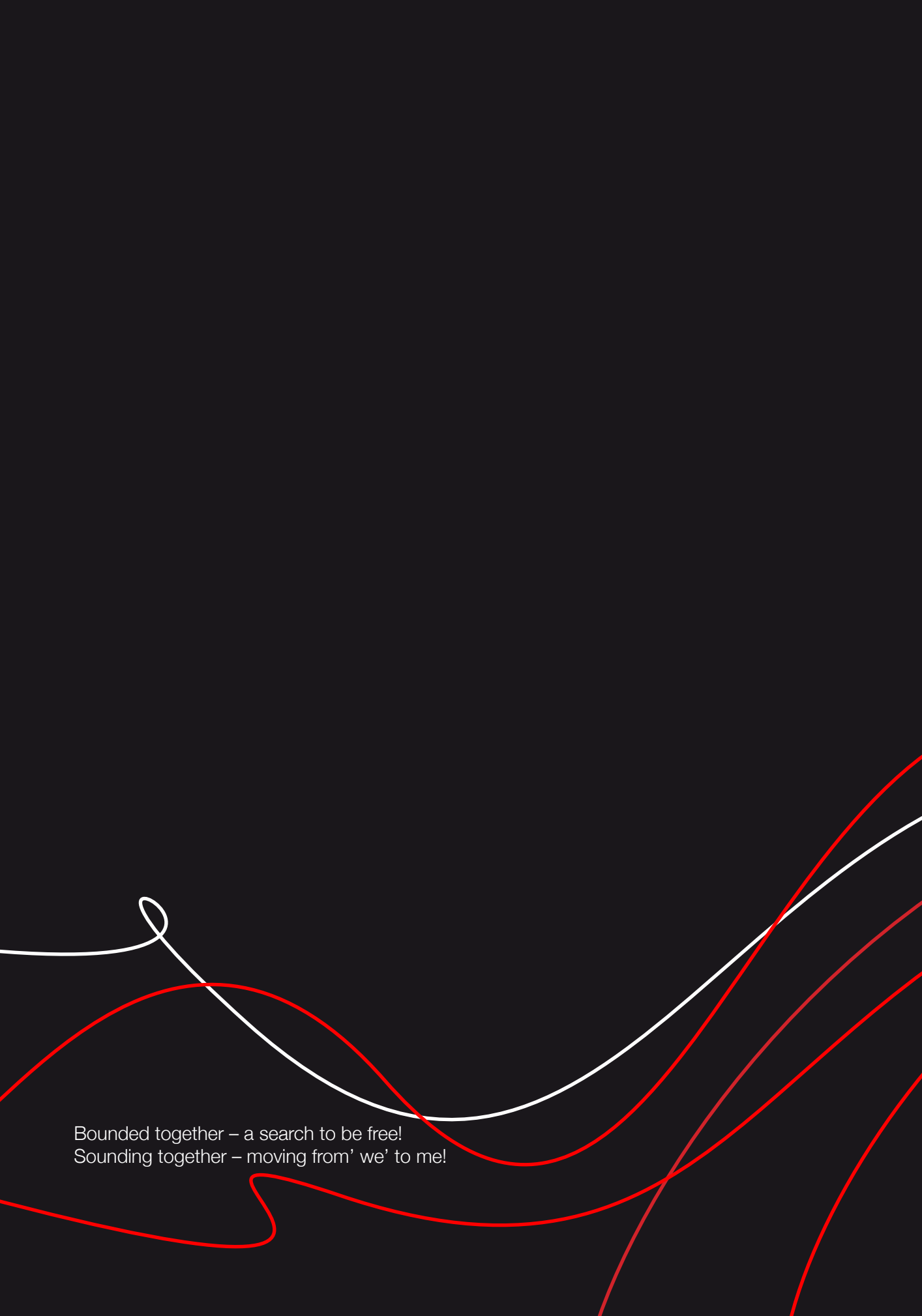
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The image features a dark, textured background. In the lower half, there are several flowing, wavy lines. A single white line starts from the left, forms a small loop, and then curves downwards and to the right. Several red lines also flow across the bottom, some overlapping the white line and others remaining separate. The lines have a hand-drawn, organic quality.

Bounded together – a search to be free!
Sounding together – moving from 'we' to me!