The Experiences of Music Therapists with Mental Illness Working with Clients with Similar Diagnoses

Adam Makofske

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Abstract

This phenomenological research study examined music therapists’ experiences of working with clients when both are diagnosed with a mental illness. The following research questions were addressed:

What is the experience like for music therapists with psychiatric illnesses to treat clients who have the same or similar diagnoses? What are the specific challenges regarding the therapeutic dynamics in this unique situation?

How is the countertransference defined, experienced and handled by the music therapist, including the specific role of the music and its impact on the therapy process?

In person, phenomenological interviews were conducted with three participants, each self-identified as having been diagnosed with mental illness. Interviews were audio recorded, transcribed verbatim, culled, and divided into 68 meaning units (across all three participants). The meaning units were then grouped into 19 categories, and an essential description of the phenomenon was formulated.

Outcomes of this study include 1) providing a greater understanding about specific dimensions of music therapy work involving therapists diagnosed with mental illness (a topic about which there is minimal information in the music therapy literature), 2) providing music therapists who are diagnosed with mental illness with more knowledge which will inform their work with others with similar diagnoses, 3) help those not diagnosed with mental illness gain insight into the dynamics of work with those who have been diagnosed, 4) to help lessen the sense of stigma for therapists and other professional caregivers with mental illness.
The Experiences of Music Therapists with Mental Illness Working with Clients with Similar Diagnoses

by

Adam Makofske

A Master's Thesis Submitted to the Faculty of

Montclair State University

In Partial Fulfillment of the Requirements

For the Degree of

Master of Arts in Music: Concentration in Music Therapy

August 31, 2012

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THE EXPERIENCES OF MUSIC THERAPISTS WITH MENTAL ILLNESS WORKING WITH CLIENTS WITH SIMILAR DIAGNOSES

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By
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August, 2012
Acknowledgments

I would like to express my deepest gratitude to Professor Abrams and Professor Goodman for their belief in this project from the start, as well as the invaluable knowledge I have gained in studying with them at Montclair State University for the last 4 years.

A thank you also goes out to Amy Clarkson, whom I also had the good fortune of taking classes with at Montclair.

This study never would have been possible without the participants, who graciously and bravely shared with me their personal histories with illness and how this might have impacted their work with clients in music therapy. Thank you for all of your help and insight!

I am extremely grateful to those who have suffered from psychiatric illnesses and have come forward about it as stronger, wiser, and more compassionate people. You have inspired me to not be afraid of the stigma surrounding mental illness. Besides, there are a lot more of us than you think!

To all of my students over the years: Thank you for reminding me to always approach things with a beginner’s mind and to never stop learning. You have taught me as much as I have taught you.

To my musician friends (my 2nd family): Thank you for the inspiration, moral support, insight, friendship, laughter, and all the music and joy you have given me over the years.

I would like to express my supreme gratitude to my teachers of music: Dan Verbeke, Bob Bernstein, Mike Kenny, Mark Dziuba, Jeff Ciampa, and Vic Juris. I can never fully repay you for the inspiration you have given me to be an eternal student of music. If I can have an effect on one person in a similar manner and change someone’s life for the better, I would be a happy man. Thank you.

To my friends: You know who you are. Thank you for putting up with me. Dan, Jen, and Evie: Thank you for the end of thesis celebration. You have made it extremely special.

A thank you goes out to my brother for the musical introduction at a young and impressionable age.
To David, Margie, Jacob, and Zach: Thank you for just being who you are.

To my parents, who always believed in me (even when I didn’t believe myself) and encouraged me to follow my own path. Thank you for your continued love, guidance, and support.

A shout out to Mingus, Lulu, and Stanley: The jazz “cats” I enjoy hanging with the most.

Finally, to Zoë, who appeared just in time. Thank you for being my best friend, musical comrade, confidant, and for inspiring me to keep pushing through even the most difficult of times. Your voice has inspired me to find my own. Thank you for existing, and better still for being my wife and embarking on this journey together.
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Introduction

The objective of this study is to examine the experiences of music therapists with psychiatric illnesses treating others with similar diagnoses. Since there is little to no literature addressing this topic, this study will hopefully bring to light an aspect of music therapy has not yet been given its due. This qualitative study examined the experiences of these therapists such as level of connection, professional boundaries, feelings of anxiety, responsibility, powerlessness, hopelessness, self-doubt, defensiveness, frustration, empathy, resonating too strongly with the client, and identifying with the client’s experience of mental illness.

Various personal problems, including psychiatric diagnoses, can impact on the treatment that the therapist is providing. This is true whether the provider is a mental health worker or music therapist with a psychiatric illness. The countertransference aspects of the work will be affected, even if the client served does not suffer from mental illness. The influence of discrimination and stigma concerning mental illness may also become an important issue. Many mental health workers or therapists (also deemed consumers/survivors) may not want to reveal their illnesses for fear of discrimination, which may affect their jobs and personal lives. However, over the years many workers in the mental health field have come forward and disclosed that they were suffering from the same or similar illnesses as their clients that they are treating (Everett, 2000). Although this is true, those in this position still face many challenges. How does the therapist facing these obstacles overcome them in order to best help those in their care? What is unique in the case of a music therapist treating a client who also suffers from mental illness? Finally, how do the therapists care for themselves while managing to navigate through the countertransference dimensions presented by the therapy settings that they find themselves in?
Personal Interest in Study

I feel that I have a unique vantage point regarding these matters as I have struggled with bipolar disorder myself. Although I felt at certain times that I was alone in my predicament, I have since discovered that indeed, many others have had similar experiences to my own. Of interest to me concerning my studies in music therapy is the significance of a psychiatric diagnosis in a therapist, and how this might impact on their work with their clients. I found myself wondering how this could influence the countertransference aspects within the context of the therapeutic relationship when working with different populations, particularly with clients who shared a similar diagnosis to the therapist. These issues became evident to me during my internship, which happened to be in adult psych and geriatric populations (who also had various mental health diagnoses). I found myself struggling with over-identifying with certain clients, and trying to define clear boundaries with them. It is very different to be in the midst of countertransference than it is to simply read about these experiences. After much consideration, I consulted my supervisor who was able to help me work through some of these feelings, enabling me to feel more grounded and present for my clients. I do not regret this decision, as it brought things out into the open and undoubtedly helped me to become a better therapist in many ways. I strongly believe that my personal experiences with bipolar, including hospitalizations, medication issues, stigma of the disease, relationship difficulties, and insurance policies has enabled me to be more empathic with those struggling with these same problems. Furthermore, my graduate school studies, Practicum placements, internship, and additional work experience all allowed me to gain a new understanding of my illness and to be better equipped to help others in similar situations.

My main interest in this study is to explore what it is like to have a psychiatric illness and still be the helper in a therapeutic relationship. Some people have referred to this as the concept of the “wounded healer” (Cain, 2000). It has often been thought that it requires a certain type of person to be a therapist. Someone who has had personal experiences with illness may have an advantage when helping another who is in a similar
predicament, as opposed to someone who does not have any personal experiences to draw from. The countertransference dimensions in therapy may become more pronounced in this situation. Even in situations where the patient does not have a psychiatric illness the fact remains that the therapist who does have one may experience countertransference differently because of it.

It was quite an arduous process to determine the method of conducting and planning this project, whereby the focus began to shift subtly over time. While I knew from the beginning that I was going to approach this study from a phenomenological perspective, once the data had been collected it seemed evident that there were many aspects that I had not even considered. Although I initially intended for the study to really focus on the therapist's unique experiences of working with client's with a similar/same diagnosis, I also tended to consider the significance of the countertransference dynamics to be extremely important. While countertransference certainly played a role and was discussed on some level by all three participants, the focus of this study was to find out what was the experience like for the therapist: What they felt, saw, heard in the music, reactions to their clients, somatic symptoms experienced, as well as the different ways that this manifested in their countertransference reactions. The tenet of phenomenology guided this study, with its strong emphasis on the subjective experiences of the therapist, which included, but was not limited to countertransference dynamics. For this reason, the scope of this project tended to be much wider and all encompassing in the beginning, whereas it narrowed and changed slightly as the data was analyzed and my understanding of the phenomenology process grew.
Literature Review

Mental Health Care Providers with Psychiatric Diagnoses

There has been a growing movement of providers in the mental health field that have been diagnosed with psychiatric illnesses and have come forward concerning their own struggles (Everett, 2000). While this phenomenon is not new, what is new is the degree of openness of one’s own experiences, and the sharing of what has been most important or significant in these clients’ own recovery. Furthermore, “people who have experienced severe emotional difficulties and who have shown significant recovery bring unique insight and understanding to the helping role” (Fisher, 1994, p. 2). This is not unlike groups such as Alcoholics Anonymous, where a leader of a group has experienced the same things as the consumer, and therefore is considered more qualified to help the person for this reason. However, for those working in the mental health field, having a psychiatric illness does not come without its own set of unique problems, including discrimination and stigma.

In her book, An Unquiet Mind, Kay Jamison (1995) chronicles her difficulties of having bipolar disorder while at the same time pursuing a career in academic medicine. In spite of her illness, she has become a very prominent psychiatrist in her field, writing several books on manic depression, including co-writing Manic- Depressive Illness: Bipolar Disorders and Recurrent Depression. Jamison has experienced first-hand the impact that bipolar disorder can have on one’s life. She experienced severe manic and depressive episodes throughout her life, all the while working her way through school and work environments where she was in the mental health profession responsible for helping the very people that suffered from the same illness. Jamison went through periods of non-compliance with medications, as is very common in those with bipolar disorder. In a depressed state she even attempted to take her own life by overdosing on lithium. She also reported spending sprees, as well as having issues affecting work, friendships, relationships, and so on. In spite of all of this, Jamison was brave enough to come forward with her illness and let it be publicly known. Through the combination of
therapy, medications, and lifestyle changes she was able to find balance in her life, and
ultimately continue to help others suffering from the same affliction as she was.
(Jamison, 1995). It is not only through her book that she gives hope to others suffering
from bipolar disorder, but also in knowing that someone with such a debilitating illness
can still accomplish so much and lead a relatively “normal” life. Jamison (1993) also
touches upon the link between the artistic temperament and manic depressive illness in
her book *Touched With Fire*. This may be relevant as many artists and writers suffer
from some form of mental illness, and this may be equally true for those in music or even
perhaps the field of music therapy. It is not uncommon for those in mental health and
therapy situations to have experienced similar situations to the clients that they serve.

In *Wounded Healers*, (1985) Rippere and Williams let mental health workers who
have experienced depression tell their own stories in their own words. Describing the
positive effect of having the illness, one worker claims that it made her less judgmental of
others, gave her a measure of humility, and enabled her to become a better listener in
helping others. She also claimed that her experience helped her to see others as having
human frailties that were not unlike her own. She was able to give them hope that they
too could get through difficult times and come out the other side, as she had done.
Another worker had claimed that in many ways she benefited as much from her patients
as they benefited from her. A doctor claimed that her experience of depression helped her
to be more sensitive to others’ wants, needs, and feelings. According to one worker, her
depression helped her to see how people have the ability to heal themselves with the right
guidance and understanding from others. If the mental health worker is able to ask the
right questions of the patient, the patient may be able to really hear the words and then
identify what changes they want to make in their lives regarding their behavior. In her
own experience, what really helped her was having a psychiatrist that believed in her as a
person, who was able to convey this belief. A clinical psychologist admitted that although
she always thought of her herself as having a humane attitude towards patients, this
notion was drastically altered when she became a patient herself. It was then that she
realized that she “had seen patients as a race apart, incapable, helpless, and pitiful”
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(Rippere, Williams, 1985, p. 103). She also claimed that she felt that she was a hypocrite concerning her presumption of being a therapist when she had mental health difficulties herself. In many other cases, it seemed to be universal that having others in the field supporting and believing in them enabled workers suffering from depression to get well and strive for new goals moving forward. One former patient believes that her experience made her aware of how many nurses and doctors do not really understand the extent of one’s suffering concerning mental illness. A psychotherapist claimed that his illness was one of the reasons that he ended up in his profession, influencing his approach to working with others with similar problems. He also sometimes found it difficult to not disclose his illness to a patient whenever the patient would insist that the therapist didn’t fully understand because he had not experienced things of a similar nature. One former patient believed that others sometimes can’t understand mental illness, as they often believe that physical illness is far worse than an affliction such as depression. A general practitioner and former patient believes that in order to better emphasize and understand their patients, one must draw from individual experience, which could include mental illness as well as other issues. “For example, those who have suffered physical illness, bereavement, divorce, racial prejudice, sexual discrimination, religious doubts, use the insight gained to supplement the theoretical knowledge gained by formal medical education” (Rippere, Williams, 1985, p. 174).

In Undercurrents (1994), Manning describes her struggle with depression, and how this affected her life as a psychologist. One of the points she made had to do with the stigma attached to the labeling of those with mental illness, concerning what she called the “shorthand” way of describing patients. She argues that this is not usually the case with other serious illnesses outside of the mental health spectrum. For example, “people say, “I have cancer.” They don’t say, “I am cancer.” People say, “I have heart disease,” not “I am heart disease.” (Manning, 1994, p. 169). She finds that labeling someone “a schizophrenic,” for example, does not take into account the totality of ones being or experience. When one is labeled in this manner, it tends to compromise the person’s individuality. It defines who a person is, obscuring the multifaceted person who happens
to be suffering from an illness. Manning also found it difficult to be on an inpatient unit as a patient, and did not find the structure and order of the groups to be all that helpful. She also found that the groups and activity therapies tended to be very routine, and likened this to giving the same medication or approach to psychotherapy to each person. Although the health care providers may have the best of intentions, it does not mean that their actions will be helpful. Order and compliance are the emphasis on psychiatric units, and this can feel rather oppressive to the patient. In her book, Manning's therapist is Kay Jamison, who helps her see that depression is not a sign of personal weakness, or something under one's own control. Jamison also points out that "some of the best therapists are the ones with the most darkness in their lives and that some of the greatest artists have known the terrible torments of depression" (Manning, 1994, p. 70).

In *A Shining Affliction* (1995), Rodgers chronicles her life as a therapist working with a child who had been through traumatic experiences. As the trauma of this child’s past is explored, Rodgers finds that her own history of abuse surfaces, which ultimately leads to her hospitalization. Rodgers often questions how she can be effective as a therapist when she has similar issues that she has not dealt with herself. However, she found healing to be two-sided. In her play therapy with this particular child, she found herself receiving as much from the therapy as the child. Personal psychotherapy was able to help Rodgers through her ordeal, and although she initially felt that she should not reveal aspects of her life in her role as therapist, she felt that it was important to be honest about her experiences. Because of the similarity of the loss experienced by Rodgers and the child, there was a bond between them in which they both played the role of survivor. In their relationship they were both able to heal one another in some way. For fear of being judged as pathological, Rodgers points out that clinicians are hesitant to reveal aspects of their own lives. In dealing with countertransference in therapy, many times the therapist may want to eliminate this or see this as a problem to eradicate. This false belief may continue during the course of clinical training, supervision, and clinical practice. In situations where the therapist is uncomfortable or frightened, the tendency may be to place the blame on the patient. "Yet, in the act of defending ourselves, we are most likely
to pass on our deepest wounding to our patients" (Rodgers, 1995, p. 319). Rodgers emphasizes the importance of the two-sided psychotherapy relationship, and how each person brings with them their own set of influencing factors, including unapproachable aspects of their lives as well as a desire for knowledge. Because of the openness of such a relationship, there tends to be a rather fragile line which can be crossed, causing both members of the relationship to experience hurt and loss. “Yet if it is possible to remain open to our fears and make reparations for our mistakes, our vulnerability can be used in the service of healing” (Rodgers, 1995, p. 319).

**Discrimination and Stigma**

Even though many of those labeled as consumers/ survivors of mental illness have had the courage to come forward, they still face many challenges. This is not only true of workers in the mental health system, but could also be in the case of music therapists who may happen to be diagnosed with a psychiatric illness. Many people in this situation end up fearing the mental health system, including being committed to a hospital. They may also fear the inevitable discrimination that goes along with the label of mental illness. They may be denied jobs as a result of their psychiatric disability and because of this may have to try to hide the fact that they are mentally ill (Fisher, 1994). The person may also wonder how they can help others if they do not feel as if they are stable themselves.

Many of those in the mental health profession do not feel comfortable disclosing their illness to their colleagues or supervisors because of this stigma that is attached to the mentally ill. Deutsch (1985) conducted a study concerning psychotherapist’s personal problems and treatment, and how their emotional and mental health affected their work with clients. The results showed that 47% of the subjects had been in therapy for relationship problems at one time or another, while 57% had reported having suffered from depression. About 34% of the subjects admitted that they had considered going into therapy but have never followed through with it, possibly believing that they should be able to solve their problems on their own. Many of these therapists may believe the myth that the therapist has to be superhuman, and that admitting their own problems is a sign
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of weakness and failure on their part. For many therapists, it is unacceptable to seek therapy themselves due to the stigma attached to the label of mental illness. They may also believe that they should not have their own problems, and should be the perfect model of mental health. Additionally, there may be issues such as being able to find a therapist that they do not already know in their professional life. (Deutsch, 1985).

Although the stigma of mental illness can have negative connotations, sometimes disclosing information may prove to be beneficial for someone in the helping role. Fox, Strum, and Walters (1984) examine the perceptions of therapists who have disclosed that they once were clients themselves. It was found that the therapist who had disclosed this information was viewed more favorably by the client, both for his role in the therapeutic relationship as well as from a more personal standpoint (Fox, Strum, & Walters, 1984).

Dickstein and Hinz (1992) examine situations when medical students and residents suffer from mental illness and are hesitant to disclose it to others. In order to best provide for them it may be beneficial to address personal, professional, sociocultural, and situational concerns. It is even recommended that students or residents should work with a family that has a member with mental illness, and continue to follow their progress for four years. This would insure that the student was given a chance to see the effectiveness of inpatient and outpatient programs, as well as to witness the possible positive effects of psychiatric treatment. Of great importance is the fostering of a nonjudgmental approach to mental illness, as well as dispelling the many myths that abound concerning this subject. “Students and residents should be given well-disguised examples of impaired medical students and residents from many years past to repeatedly impress the fact that it is legitimate and safe to be mentally ill, to receive treatment, and to recover” (Dickstein & Hinz, 1992, p. 162). Everett (2000) interviewed many consumers/survivors, who were now working as mental health care professionals. In the words of one interviewee, this population of consumers/survivors “are people who probably had a breakdown once in their life and recovered and can make a contribution. Vincent Van Gogh had a mental illness. Winston Churchill, too, and the list goes on” (Everett, 2000, p. 142). This offers proof that mental illness is not always a life-long
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burden, as “the respondents of this study each received such a sentence, yet they stand as living proof that things do change and people can get better” (Everett, 2000, p. 216).

While it is true that clients may be discriminated against due to their illness, some jobs in the mental health field may hire people specifically because of their psychiatric histories. In a study by Cain (2000), participants who had histories of psychiatric hospitalizations stated that “consumers/professionals who were free from the restraints of stigma contributed valuable information to the profession and enhanced treatment for clients” (Cain, 2000, p. 27). As a way to lessen the fear of stigma, these participants suggested that education and exposure would be beneficial. Clearly, it would be a positive attribute to have consumers in the mental health field functioning as professionals. Frese and Davis (1997) referred to these people as prosumers, and discuss the inherent challenges that they face. Although they may be vulnerable due to their disclosure and their credibility may be lessened by their role as a client, prosumers have many positive qualities concerning their role in helping others. They may possess more insight, wisdom, empathy, and may serve as role models for other clients (Frese & Davis, 1997). Likewise, music therapists with psychiatric illnesses might have an advantage or be better suited to work with others who are mentally ill, despite the many challenges that they may face.

There is clearly a fine line that many people in the health care system draw, perpetuating almost an “us and them” way of looking at mental illness (Everett, 2000). It is as if there is a clear division between patient and staff that does not allow for human-to-human interactions. Many times staff members may not want to admit that they have had similar problems in the past, and sometimes for good reason, as they may fear that they may lose their jobs for being so honest about their experiences (Everett, 2000). When a colleague in the field discloses that they have an illness, it may affect the way others in the field view them professionally or personally. This stigma could be lessened through more support and supervision for these consumers/professionals in the field. If these consumers/professionals remain silent about their illness, it has negative
implications on their treatment as well as in understanding illness itself. On the other hand, it seems that many of the dedicated professionals in health care settings have in many cases had personal experiences that have sensitized them, and enable them to work better with clients with mental health issues. However, these professionals may still not want to be labeled as mentally ill, causing a further chasm between “us and them.” (Everett, 2000).

**Transference and Countertransference**

Transference as regarded by Freud has to do with the patient ascribing a role onto the therapist, usually of a parental nature, though it could also be another person or relationship from that patient’s life. This material that stems from the patient’s past life can be employed by the therapist to assist the patient in working through issues that still exert an influence on the patient’s life. For instance, in the case where the patient is a man, he may ascribe the role of the father onto the analyst (Freud, 1924). Transference provides the patient the opportunity to experience a corrective emotional experience, as issues from the past can be resolved with a different outcome in the here and now, provided that the therapist recognizes the transference and can work with it. These interactions are common in therapy, though they may also be prevalent in interactions with other people in one’s life outside of the therapy setting. Bruscia (1998) calls transference “the reliving of significant relationships from the client’s past within the therapeutic setting” (Bruscia, 1998, p.14). Regarding the phenomenon of transference, it can be thought that “everywhere we go, we are ceaselessly replaying some aspect or other of our early life, manifesting in our authority relations, romances, friendships, and business dealings.” (Bruscia, 1998, p.17).

Countertransference is a similar dynamic which is enacted by the therapist. Freud used the term countertransference to refer to “the analyst’s unconscious and defensive reactions to the patient’s transference” (Hayes, et al., 1998, p. 468). Countertransference may enable the therapist to use him/herself as a therapeutic instrument. Some of the negative effects of countertransference have to do with the therapist perceiving the clients
in a distorted manner, acting defensively with their own needs in mind, or displaying poor clinical judgment. On a positive note, countertransference may enable the therapist to gain new insight into the dynamics of the relationship as well as how to approach the course of treatment. Freud viewed countertransference as something that the therapist had to overcome, thus being detrimental to the therapeutic process if it was not dealt with. In later years, the concept of countertransference is used in broader terms, referring to all reactions to a client, including conscious and unconscious processes (Hayes, et al., 1998). Varga (2010) states that “all conscious relating is seen as having unconscious transferential meaning to both patient and analyst, thereby perpetuating and/or transforming the pathogenic enactment” (Varga, 2010, p. 536).

Scheiby (2005) talks about how musical and verbal countertransference is something that the therapist should embrace and use to their advantage, in that it can help the therapist to be able to be there for and with the client. Scheiby mentions two types of countertransference: intrasubjective countertransference and intersubjective countertransference. Intrasubjective countertransference includes all of the therapist’s identity before meeting the client, including their life experience, culture, education, philosophy, musical preferences, professional identity, interpersonal relationship style, and so on. Intersubjective countertransference would include all of the issues that come up in the work with the client in the music therapy setting.

Mary Priestley (1994), a pioneer in the field of music therapy who herself has experienced psychiatric illness during most of her life, refers to several types of countertransference, including c-countertransference (complementary transference) and e-countertransference (concordant identification). These terms were also described by Racker (1957), who defined complementary identifications as being a result of the patient treating the therapist as an internal projected object, after which the therapist would identify himself with this object. According to Racker, concordant identifications consist of the therapist’s “identifying each part of his personality with the corresponding psychological part in the patient- his id with his patient’s id, his ego with the ego, his
superego with the superego-accepting these identifications in his consciousness" (Racker, 1957). Priestley's general definition of countertransference is the "therapist’s identification with unconscious feelings, self parts (instinctive self, rational self or conscious) or internal objects of the client, which, being conscious in the therapist, can serve him as a guide to the client’s hidden life" (Priestley, 1975, p.240). A negative countertransference could present a problem in that the therapist might have feelings of hatred towards a client whom he is supposed to be helping. This may obviously affect the therapist’s view of himself as a clinician as well as a person. At the same time, a positive countertransference may make it difficult sometimes to attain a degree of separateness necessary to the process of therapy. In working with a client that does not progress (and is resistant), the therapist may take this as a sign of his inability to heal others. This may ultimately affect his view concerning his self-worth as a therapist. In some cases, the therapist may actually resent the patient because of this. The therapist may in some cases have to ask himself if the client reminds him of someone from his past (an unconscious process). In bringing the unconscious into the conscious, a therapist may be seeing things from a more realistic viewpoint. If the therapist can’t do this, he is not viewing the client as his own unique and individual self, and this will certainly affect the course of the therapy if not addressed (Priestley, 1994).

C-transference (complementary transference) happens when the therapist identifies with one of the client’s introjects. For example, a therapist may take on the role of a mother or father figure, and may act accordingly in a manner that is damaging to the process. Instead of providing the client with a new way of being, the therapist could be acting in a manner that is detrimental to the therapy, which reinforces a negative experience. The therapist may also feel as though he is acting out of character, and may be forced into a role that is not comfortable for him/her. The introject could be a relative who is deceased, but who still exerts a powerful influence on the patient’s life. By developing a better relationship with the therapist who is in this role, the client is able to develop a better relationship with the introject, providing an emotional corrective
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experience. It may enable the client to have a better relationship with others as well as to live with themselves more easily (Priestley, 1994).

E-countertransference (concordant identification) has to with a particular type of empathy experienced by the therapist when working with a client. Bruscia (1998) discusses the signs of this type of countertransference, including “somatic reactions, polarized emotional reactions, unwarranted or inexplicable reactions, impulsive decision-making, inappropriate roles and relationships, ruts and routines, and burnout” (Bruscia, 1998, p. 90). The therapist may feel the patient’s pain somatically in the form of a sudden discomfort in his/her own body. In some cases, it may prove difficult for the therapist to separate his own emotions and feelings from that of the patient. Because of this, it behooves the therapist to work on his own emotions, so he realizes when he is encountering this type of countertransference. The therapist must be free to experience the client’s emotions, but not become overwhelmed by them. The patient may often project feelings onto the therapist, ranging from feelings of inadequacy, sadness, anger, or panic. These may be manifested in a verbal as well as a musical context. Priestley states that this kind of situation on the part of the therapist “involves both willingness to experience deep and often uncomfortable states of emotion and also to develop mind control in the face of these experiences” (Priestley, 1994, p. 92). These countertransference reactions are common in music therapy, as well as in social work, psychology, and other related fields.

Priestley (1994), talks about how there can be transferences that are positive and negative in nature. Negative transference may include disliking or doubting the therapist, and may cause the client to become resistant to the therapeutic process. It is the therapist’s job to try to uncover the source of the negative transference if possible. The behavior of the therapist has a lot to do with the type of transference reactions that manifest. Behavior that is interpreted as “cold” may cause a negative transference, as could an approach by the therapist that is overly friendly.
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Countertransference Experiences

In music therapy and other related disciplines, countertransference can be experienced by the therapist in many different ways. It is important that the therapist is able to use the countertransference in a manner that is effective in the therapeutically relationship. In many cases this may prove to be difficult, as the client and therapist may share personality traits, backgrounds, similar issues, or even diagnoses. In Cain’s study (2000), participants with a history of psychiatric hospitalizations shared their countertransference experiences, which involved concerns about hospitalization of clients, comparison of the therapist with the client, identification with clients, and over-identification with the clients. The participants in the study consisted of social workers, psychologists, and psychiatrists. Half of the participants had extremely negative hospitalization experiences, where they had feelings of powerlessness, shame, being coerced, and traumatized. Depending on whether they had a negative or positive hospital experience, the participants wanted to provide services for their clients that were either very similar or different to their own experiences. Those who felt that their own hospitalization was a setback tended to want to keep their clients from having negative experiences of a similar nature. This was especially true for those participants who viewed involuntary hospitalization as a trauma. While some participants bonded with clients over common experiences, some felt farther removed from them. Participants could relate to their clients about common issues such as stigma, discrimination, insurance benefits, and relationship problems. At least half of the participants had felt that they over-identified with their clients, and as a result lost their perspective on the therapeutic relationship. This could happen when a client shares similar traits with the therapist, such as being the same social class, age, religion, and so on. On the other hand, some participants proposed that “any level of strong identification with the client enhanced the relationship, the alliance, and the healing” (Cain, 2000, p. 25).

Countertransference reactions to a patient could include frustration, anxiety, and discomfort because the therapist is reminded of his/her own difficulties in the past. For
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some therapists, it becomes difficult to separate their own feelings from the feelings of the patient. For some, they are never able to forget that they were once in the same position as the patient. For those therapists who are not comfortable sharing their histories, it may prove difficult when other colleagues make disparaging remarks about a patient, which might also affect the patient negatively in turn (Cain, 2000).

Cooper (2010) discusses countertransference issues when working with a patient who is extremely self-critical, with an underlying grandiosity. In this case, the self criticism could be the only way that the client can deal with his rage or anger. The patient may wear down the analyst by their inability to accept the fact that the analyst thinks highly of them, mainly due to their degree of self-criticism. The therapist may also find that he may tend to think highly of the client more readily when the client can avoid his self-critical behaviors and accept his wish to be liked or loved. It is a delicate balance that the therapist must find due to the client’s constant need to be reassured even when he feels that he is not worthy of praise. It is not only the client that may have grandiose fantasies, as the therapist may also have unrealistic expectations about what therapy will do for their clients, which may be counterproductive to the entire therapeutic process (Cooper, 2010).

McHenry (1994) examines countertransference issues in treating someone with borderline personality disorder. In some cases, the therapist may have issues that are similar or parallel to the client. Boundary issues may become blurred in the process, what McHenry calls the “boundariless relationship.” This could include the therapist being available at all times for the patient, as well meeting the patient other places other than the office. Sexually acting-out could also be another factor. The therapist could also spend time on the phone with the patient outside of their formal therapy sessions, leave his number for the client when going on vacation, or hold or sit too close to the patient. In this boundariless relationship, both the patient and the therapist may become increasingly desperate, which may cause the patient to discontinue treatment or the therapist to refuse to continue working with the client. A therapist who has to feel like he is perfect himself
may have difficulties because he is facing the same kind of issues as the Borderline patient, namely that he is either perfect or nothing. The patient may project a perfect self onto the therapist, causing the therapist to try to become the perfect therapist. This may cause a power struggle between the client and therapist, which may lead to the therapist refusing to continue treatment or the client quitting (and thinking that nobody can help him). If a therapist becomes unable to perform his duties because of the idolized role they have built up for themselves, they may be unable to form the necessary therapeutic alliance with the client. Furthermore, termination may not even be an option for the therapist because it would be viewed as a failure and proof that he is not perfect. The therapist may have countertransference reactions such as talking nonstop to the patient as a way to avoid emotional material that may be overwhelming for the therapist. The therapist also must deal with how he handles anger and hatred from his client. “When the therapist’s predictable or characterological countertransference issues are not acknowledged, understood, and worked through, the psychodynamics of the patient are perpetuated rather than changed, and the therapist helps recreate the past rather than alter it” (McHenry, 1994, p. 565). The therapist with narcissistic tendencies may have difficulty having his self-worth dependent on his client, who may verbally abuse him and try to break him down. The therapist must not be dependent on his client for his self-worth for this very reason. If a therapist is denying his countertransference responses, this could cause the client to sense the therapist’s issues and become anxious or mistrusting of him. Therefore, it is of utmost importance that the therapist in this situation is in therapy himself. Also, the therapist is recommended to engage in supervision or case consultation on a regular basis. (McHenry, 1994).

From another perspective, Connolly and Cain (2010) discuss the implications of positive countertransference when working with psychotic patients in psychotherapy. This experience can have an impact on the well-being of the therapist, as well as on the therapeutic alliance. Some of these positive countertransference examples could include experiencing deep empathy for the patient, a strong urge to nurture or protect, a feeling of wanting to rescue the patient, and displaying sympathy or compassion for the client’s
situation. Other examples could include things of a humorous nature, appreciation for the client’s level of attachment, and even a feeling of spiritual awakening when working with particular clients. These elements may enhance the relationship between client and therapist, providing a stronger working alliance. There are also sometimes problematic positive countertransference responses, such as the case of erotic or grandiose feelings towards the patient. Although humor may in some cases be appropriate as an intervention, the therapist must be sure not to make the interaction seem trivializing or showing a lack of empathy regarding the patient. It must be acknowledged that much of the “crazy” behavior of the clients in relating to the therapist may very well be in response to introjects, which could include the therapist or possibly other caregivers. In working with psychotic patients, the therapist must be self-aware enough to be able to not project their own issues onto those in their care (Connolly & Cain, 2010).

Relevance to Music Therapy

There are many examples in the literature concerning the implications of transference and countertransference in music therapy. In Mary Priestley’s Analytical Music Therapy method, transference issues could be addressed in a verbal manner, but could also be addressed in the course of musical improvisation. These emotions can be explored through the music. In some cases, the therapist can play the patient, while the patient can play the therapist’s role. Priestley also mentions that transferences are not unique to patient and therapist, but are observed in many other relationships as well. How the therapist decides to work with it (or in some cases ignore it) is up to the individual therapist (Priestley, 1994).

One example of an adapted application of psychology concepts into another field is the use of Ellis’ Rational Behavioral Therapy in music therapy practices. “This modality, which uses vocal music as a positive reinforcer, requires rewriting of the lyrics for the client’s specific need, with rational lyrics containing more than three of the five criteria determining rational thoughts” (Diaz de Chumaceiro, 1992, p. 22). The songs that the patient uses represent their transference to the music therapist. In addition, the client
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and the therapist both could have transference and countertransference reactions to the old and new versions of the songs.

Marom (2008) discusses the therapist’s countertransference reactions in working in hospice care. In most of these situations, a variety of interventions were used, including song choice, singing, song writing, and song improvisation. In the hospice setting, often a patient may reject the therapist or activity when they are trying to protect themselves from being emotionally overwhelmed. This could cause a power struggle between the client and therapist that could be detrimental to the therapy, so these issues need to be addressed. In working with dying patients, many times the therapist has to assess whether the client is occupied with tasks of living or tasks of dying, and then choose an appropriate intervention based on this. The therapist may be affected by a patient’s non-involvement, and may have an intrasubjective countertransference reaction to this. This could include all parts of the therapist’s background personally and professionally. The music therapist may feel that he/she have to save the client from hopelessness. Another aspect that the therapist must be aware of is the degree to which they have pre-conceived notions or expectations in regards to the therapy. He/she may want to elicit certain responses from the patient, which could even backfire and cause the patient to withdraw further. “If the therapist is not quick to adapt to reality, the therapist may experience a growing sense of failure, boredom, impotence, helplessness, or frustration and become passive aggressive” (Marom, 2008, p. 15). To counter this, the therapist has to be really attuned to exactly what the particular client needs from the therapeutic relationship. In the case of a dying person, countertransference feelings may be felt very strongly by the therapist due to the depression and will to live that may accompany this state. In addition to this, the therapist may project his own fear of the unknown onto his patient, who is already struggling with this issue. The therapist may also try to alleviate the patient’s depression by playing only happy songs, or playing music that is of a faster tempo or major key, rather than meeting the client in their present emotional state (the isoprinciple). A countertransference phenomenon that happens often in music therapy is the act of making the music harmonious and pleasing to counteract
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the ugliness or pain that is unbearable in the session. Filling the silences in music as well as in verbal discourse is a way for the therapist to deal with the awkwardness, and may help the therapist to deal with anxiety or confusion resulting from this. The therapist may also become unmotivated and cancel sessions or harbor negative feelings toward the patient. Another common countertransference reaction has to do with when a patient’s rejection of the therapy or therapist reminds the therapist of a rejection in his life in the past, whether it is personal or professional in nature, especially when the therapist has not dealt with these unresolved feelings or issues. Bruscia (1998) also claims that “competence is a rampant countertransference problem in music therapy” (Bruscia, 1998, p. 85). In hospice care, countertransference feelings may also be evoked by the family members of the patient. (Marom, 2008).

Statement of Purpose

In therapy, the relationship between the client and therapist is of extreme importance. In many ways, the relationship tends to have quite a great influence on the work that is done in the therapeutic setting. This can affect the work in both positive and negative ways. The dynamic may be further complicated when the therapist has a diagnosis of a psychiatric illness as well as the client. Literature posing the important question about how music therapists with psychiatric illnesses encounter these dynamics and what their actual experience is like is limited due to the fact that most people are not willing to talk openly about their issues due to the discrimination and stigma attached to mental illness. Countertransference issues have a great influence on the therapist’s reaction to the therapeutic process, as well as on the course of treatment. The purpose of this study, therefore, was to examine the experience of music therapists diagnosed with a psychiatric illness who are treating a client who also has a psychiatric diagnosis as well as the specific challenges of therapeutic dynamics (including countertransference). The examination includes how the countertransference is defined and handled by the therapist, as well as the specific role of the music and the impact on the therapeutic process. Information in the literature review raises important points about the experience of therapists with mental illness who are treating clients with similar diagnoses. This
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study examines this phenomenon in the form of a qualitative study utilizing phenomenology.
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**Method**

**Design**

Because the purpose of this study was to explore and understand the specific experiences of research participants on an in-depth level, this study employed a phenomenological method of data collection and analysis. This procedure focused on the participants' human experience or way of being in the world, as well as their interactions with clients in the music therapy setting. Interviews (Please see Appendix A for verbatim interviews) were structured in such a way so that the participants' experience will be viewed from various angles, enabling them to better understand these experiences, as well as deal with questions or issues that arise as a result of them. Information from each interview was culled, after which meaning units were extracted based on the relevance to the study. Common re-occurring themes were compared and analyzed, after which the meaning units were grouped in a way that led to a reconstructed narrative of each participant (Please see Appendix B for an example of the data transformation of participant B). This research can be viewed as following the tenet of emergent design, in that the “findings and structure of a given research project will unfold spontaneously as a result of the unique interaction between the researcher and the setting at a particular time. The knowledge gained as the research unfolds should be actively used by the researcher in guiding the emerging design of the study” (Aigen, 2005, p 356).

**Participants**

Prospective participants were music therapists diagnosed with a psychiatric illness. Following approval for the study from the IRB at Montclair State University, participants were invited to the study via various Listservs accessed by music therapists. The email (Please see Appendix C for recruitment email) invited those to the study who had a psychiatric diagnosis and were comfortable talking about the effects of this on their work with clients in music therapy. Potential participants that were involved in the study met these requirements:
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- Board certified music therapist
- 21 years or older
- Has had transference and countertransference issues related to their illness while working with patients
- Is in sound mental and physical health in that his/her mood is properly managed with or without medication, and thus is able to be involved in the study
- Has access to a mental health professional should the need arise at any time during the study, including during or after the interview

Those interested in participating in the study contacted the researcher, who followed up privately, via telephone and/or email. Participants were provided with informed consent documentation (Please see Appendix D for consent form) and, after consent was granted, arrangements for an interview place and time were made. There were initially to be four interviews, including the PI, who was interviewed first by the thesis sponsor. Because of the sensitive nature of the study, the PI was only able to get two others to agree to do the study, resulting in a total of three interviews. Participants were told if they were to be involved in the study it would entail:

- An audio recorded, live in-depth interview which would take approximately 45 minutes to an hour. During this interview, the participants would be asked questions regarding transference and countertransference related to their experience working with clients. The PI then transcribed the interviews and then subjected them to data analysis.
- A follow up phone interview after the verbatim interview was sent to each participant. This interview was to clarify that the participant’s experiences were portrayed accurately following the data analysis. The phone interview took place approximately 2 weeks after the audio recorded interview.
Data collection

Data collection consisted of one in-person, audio recorded interview, lasting for approximately 45 minutes to one hour. The interviewees were given the option of conducting the interview in the participant’s home or another location, based on the preferences and availability of each participant. The interview was primarily guided by principles of phenomenological inquiry, as it focused on the human experience or being in the world, as well as the participant’s interactions with others in the music therapy setting. Guerrero’s (2009) phenomenological study examining music therapy interns’ experiences with client resistance was used as a model, with her method being applied to the topic of transference and countertransference in therapy for this study. In the phenomenological approach, the experience is treated as a unified whole, rather than divided into smaller fragments to be studied. One of the important tenets of this approach is that human beings are complex, and so human experiences may also prove to be extremely complex (Forinash & Grocke, 2005). Therefore, the interview was designed to help participants elaborate upon the nature of their experiences through open-ended dialogue established by certain initial, guiding questions, but continuing according to the directions of the conversation itself. Examples of some initial, guiding questions include (not necessarily asked in this order):

- How did you experience transference and countertransference issues that emerged for you when working with a particular client or client group (whether or not the client[s] were diagnosed with a psychiatric illness)?
- How did these issues manifest specifically in the music, and what was the role of the music (if at all) in the management of these issues?
- Did you find your diagnosis affected your work differently when dealing with certain populations? In what way?
- In what ways do you experience the role of your own psychiatric illness with respect to these issues, when working with the client(s)?
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- How were you able to manage/deal with these issues in relation to your own psychiatric illness?
- What has been helpful in the process of working through these issues (e.g., supervision, therapy, etc.)?
- When working with a client who also has been diagnosed with a psychiatric illness, are there specific ways that you approached working with the client? Were you able to utilize the countertransference issues in a way that was helpful to the therapeutic process, and, if so, how?

At the beginning of the interview, the PI first asked about the participant’s main population of clients they have worked with, as well as the theoretical orientation and methods in music therapy used (this could include improvisation, songwriting, singing, etc.). The participant was then asked questions regarding their experiences with clients, including what happened moment to moment, as well as what the participant was feeling during the whole experience. This also included the reactions the therapist had, interactions between the client and therapist, the role of the music in the process, as well as any important events that followed as a result of these feelings or experiences.

Data Analysis The recorded interviews were transcribed verbatim (Please see Appendix A for the verbatim transcripts of interviews of participants A, B, and C). The recordings will be erased as soon as the interviews have been transcribed into a word document. The phenomenological approach used by Guerrero (2009) and Muller (2008) were employed regarding the use of the data collected in the participant’s interviews. The following steps were then performed in order to arrive at phenomenological constructions of the participant’s experiences:

1. After a review of the transcript, information or statements not relevant to the research question were edited and were not used for the study. These sections were culled out, resulting in a shorter transcript consisting of several pages.
2. A copy of the culled transcription was sent to the participants by mail so they could review it.
3. There was a follow up phone call, approximately 2 weeks following the interview, to review the transcriptions and to ensure that the information in the culled transcripts was accurate.

4. The culled transcripts were then divided into individual meaning units concerning the therapist’s experience of transference and countertransference when working with clients.

5. The meaning units were examined to identify any common themes or patterns that emerged, which resulted in different categories. Examples of the participant’s experiences were labeled or categorized in this manner. The labels served as codes which were then designated as meaning units. Examples were cited from each participant’s experience regarding the particular phenomenon.

6. The codes were then grouped according to the participant’s experiences with countertransference in the therapeutic setting. The ordering of the codes was structured as follows:
   - Background information, including population served, therapy setting, and diagnosis of the therapist (or possibly the client).
   - Transference and countertransference dimensions, including the therapist’s reactions to clients.
   - How the therapist felt during interactions with the client (angry, defensive, threatened, etc.).
   - Possible physiological responses to the clients during the experience.
   - How the therapist handled the situation when the client also had a psychiatric illness. Was the therapist able to not let their illness get in the way of the process?
   - Confidence about their own abilities as a therapist, as well as the management of their emotions in the midst of transference and countertransference.

7. Using the code sequence, the coded meaning units will be pasted together in order to produce narratives, reconstructed according to the meaning units.
8. The narratives may have to be edited slightly, but the text will not be altered much, as not to obscure the meaning.

9. The codes will be used in order to describe the phenomenon concerning the four participant's experiences (Please see Appendix B for an example of the data transformation process for participant B).

Analyzed data was presented in the Results section, with implications for music therapy practice and other areas of practice/inquiry, in the Discussion.

**Ethical Precautions**

Throughout this study, careful measures were implemented in order to protect the safety and confidentiality of participants. A linking code with participant identities was used to ensure confidentiality. The codes and data were locked and stored separately, and were only available to the PI. The recording of the interviews were erased once they had been transcribed into a word document. The protocol for this study, including consent procedures, was reviewed by the MSU Institutional Review Board (IRB), and no participant was invited to this study prior to approval by the IRB.
Results

The results of the data analysis in this study, as described in the method section of the thesis, consisted of several outcomes, including:

- The reconstructed narratives of the three participants involved
- Code or category descriptions including examples from each category which were extracted from the participant’s interviews
- A summary of the participant’s experience of transference and countertransference when the therapist has a psychiatric illness and is working with a client that might share the same or similar diagnosis.

Reconstructed Narratives

Narrative A:

Participant A and the client are both diagnosed with bipolar disorder.

Background Information:

I can talk about particular sessions, and I also was thinking in particular a client that I worked with in my internship. He was 56 years old with a diagnosis of bipolar disorder. That particular client - we worked one on one every week. Initially he told me that he really wanted to learn how to play guitar better and he wanted to be more involved in music and that this was very important to him - so I kind of set it up as a lesson, and he seemed really excited about it and he was almost in a manic state that day.

I guess I felt connected to him in a lot of ways, namely the bipolar diagnosis, but also because when we were singing we were singing together … we were kind of on the same page. I thought that these songs were great for therapy but I also had a personal connection to them. But that’s not always a good thing, because I had a real strong emotional reaction to the song, and here I am playing that song and singing it with another person who had been in a similar situation or predicament to my own.
I had been so concerned with making a personal and musical connection with him, and then it just happened. It felt as if we had made a connection through the music that was unspoken. There was an entirely different vibe in the room after the music was played.

But it was hard to talk to him about it when he would make comments like “you really don’t know what it’s like” and other similar comments. I knew that there was no way I was going to tell him about my experiences, but at times I wanted to. I just said I understand that you’re going through some hard times, and tried to talk to him about it. When he made comments like that, I wasn’t going to say it, but I was thinking “I really have been where you’ve been, and I understand it a lot more than you think.”

He was always questioning [in the session] why he had to do this, why he had to do that. It made me uncomfortable when he would question what we were doing in the session. I guess he just...it made me feel...first of all, maybe it made me feel like I’m doing the wrong thing. I thought maybe I’m doing this wrong. I’m still a student of music therapy and I don’t have a lot of experience, so maybe I should have approached it differently. I noticed that the client was very self-conscious, and I identified with this client in this manner. He would say things like, “I’m not really a singer, I love to sing but I’m not really a singer.” And I’ve played guitar for 25 years, and I just started to sing prior to studying music therapy. I found myself doubting my competence as a therapist, which I had already been insecure about.

I got a little nervous just from the experience of talking to him. I felt like I really didn’t know what I was doing or even what direction the session was heading in. I found the verbal processing part of the session to be very difficult for me. I started to sweat a little more, I felt a little bit on edge. It felt like he pressured me in this way, and—even if it was unconsciously...ultimately ended up making me feel the same way as him.

I think I felt in times of my life I’ve gone through some really difficult periods and I knew what it was like to feel that way. To feel like things are hopeless or that things are not going to get better. I really identified with him in that way. I have had
experiences that parallel this guy. It was a very difficult client to work with for me because there were so many similarities... I really felt that a lot of the things he had been through I've experienced. Many of the things he said- I remember saying the same kind of things. There was a lot of denial that I have this illness and questioning why am I here in the hospital. But I felt like it really hit home for me because it felt like...had my situation been different could I have been in his situation?

It felt like he almost treated me- the second week when I came back like an authority figure, a parental figure. That whole relationship felt very weird to me in a lot of different ways sometimes because I didn’t feel comfortable in that role, and I felt like...Here this guy is 56 years old and he’s treating me like I’m a parental figure. It just kind of felt awkward to me. I did feel bad for him at times because he really wanted the simplest...what most people consider to be the simplest things. I want my own apartment...I want a job...I would like to have a girlfriend and maybe one day marry. I guess most people kind of take those things for granted, but this guy never had any of those things. He never had any stability. There were a lot of transference and countertransference issues that were happening, just because of situations like that. He almost made me feel like it was my responsibility for him to be able to play the guitar. So I felt like I was helping him, and because of this it was one of the most rewarding experiences I've ever had. By reaching him...helping him become more aware of himself, able to be more comfortable with his voice, to express himself, and sing songs with me. Also to help him reminisce about different times in his life, and even talk about his experiences as well.

**Narrative B:**

Participant B is diagnosed with generalized anxiety disorder and depression, and her client is diagnosed with depression.

**Background Information:**

I'm thinking of a client that... he is in his mid to late 60's. He is Hispanic. His name is S. He has a diagnosis of depression. And he is living where I have been working.
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He has been living in a nursing home in a long term care setting and he suffered a stroke about 2 years ago and as a result of the stroke he’s paralyzed on the left side of his body. So he reports to have a history of using cocaine for 30 years. However, he denies that he was addicted to it. However, he was using coke at the time of his stroke, so there’s a correlation with that. However, he completely does not see that that could relate {to his stroke}.

{During one particular improvisation}, I felt very disconnected. And when he did play, we weren’t together. We weren’t musically in synch. I felt that he wasn’t listening to me, and he was kind of all over the place.

I was trying to just think of different ways to connect with him and let him know that I’m really hearing him. I didn’t get the impression that he thought I was hearing him, because he has a lot of abandonment stuff and constantly thinks I’m going to leave. And it was kind of a big risk to take {to disclose my own illness}. But I just felt that for him in our relationship and...where he’s at that it might be a bit of help to him. I think that I was afraid that he was going to probe, and that he was going to question and want to know more. That would have caused a lot more anxiety, but he didn’t actually. He didn’t even inquire, but he was very present when I said that. I hadn’t even planned to disclose it (my struggles with depression), but it just kind of happened in the moment.

There’s also been a lot of him testing the relationship and what the relationship is. In the sense of therapeutic relationship, friendship, romantic...so there’s been a lot of testing by him, and challenging me about that. That’s very uncomfortable. Especially more about the romantic comments because I had to be very clear with the boundaries, but once I did it’s been better. But he’s definitely...he’ll make comments about the way I look, or my hair...different things like that.

That’s when I remember him speaking and him interjecting and saying “What are we doing? I don’t know why we’re doing this” and just sort of questioning. I go in there with the blues idea and I feel it got shot down and that he didn’t latch onto it. And, again...this is all my stuff. This is all me feeling rejected. Especially -again, when
there's this whole verbal thing. He interjected, and at the end was questioning me. I felt very defensive. I felt like I had to explain myself and prove myself. And I caught myself. I was very aware that I was trying to defend it at first.

This client is extremely resistant and I get really frustrated working with clients that exhibit a lot of resistance. I was feeling frustrated during the music making because I was trying to provide an opportunity for him to really connect, but it wasn’t happening. At times I did change my rhythm. I tried to match him, and nothing was being effective in what I was trying to do.

{I was} anxious that you know... “What do I do? How do I do this?” And I began feeling anxious when he began speaking, because then I felt that he was kind of judging...not judging me but...questioning me. After the improvisation, he spoke in great detail. He shared his opinion very emphatically about...you know...I guess how he felt about it, though he was very passive aggressive about it. He immediately questioned why I brought this in, and wanted to know what I was expecting him to do. I remember having a lot of anxiety, and in general I have a lot of anxiety when he begins speaking. How to respond. Especially verbally. Because we’re trained musically and...you know...that’s a big anxiety for me is using verbal skills. I find for myself it’s more my anxiety issues really impacting on the way I run the session, the way I facilitate it. When I leave I feel anxious. I get a lot of somatic symptoms. My stomach gets upset, I get sweaty...

And it can be very draining. And like you said before, especially when it’s things that really hit home for you, and hit home for myself. In part I was thinking, “Well I understand it so it will be easier.” But actually, no. It’s that much harder. But moving forward with him, I’ve developed a lot more empathy for him. Which is generally not a hard thing for me, but with this particular client it’s been really hard to have an immense amount of empathy. I don’t know if I think a lot about him more because of the mental illness, but I’m sure that’s a part of it. I suffer from periods of depression and more so generalized anxiety. That’s been my longstanding thing that I’ve really struggled with. So that has really impacted my work with him to the point of me obviously perseverating
about it and replaying it {the session}. Yeah. It’s been a real challenge. The depression component of him being isolated and not getting out of bed. That I feel very related to, very connected to...and have an immense amount of empathy and understanding of that.

There’s a need for me- I guess to feel heard, and to feel validated. And it’s interesting because I think those are the same needs that he has never had met. I’m pretty aware of where this stuff comes from...with my mom, and that she kind of dismissed a lot of things growing up and there was a lot of pressure to succeed and to do really, really well academically. So I know that that’s pretty much the source of the countertransference. It’s probably related to my mom. So just feeling...yeah, trying to get validation from people. He {the client} projects a lot and there’s a lot of transference on his part. He sees me a very high figure, and you know—he thinks I don’t do anything wrong. Things like that. I feel very pressured as a result of that. That’s part of...I guess my countertransference in trying to please him.

Narrative C:

Participant C and the client are both diagnosed with bipolar disorder.

Background Information:

There was one {client that I worked with} who was bipolar. He was younger, and he would be very hyper and would never want to sit down. This one was maybe.....nine {years old} So they start to diagnose really young with that sometimes. So I would try to do that...meeting them where they are in the music, so I’d play a dance song and then try to calm him down. Maybe do a drum circle, but try to bring the beats slower. And they were also telling me that his mom wouldn’t give him his medication all the time. So you could tell the days he didn’t have his medication because he would be not only hyper but he would also be really angry and really...like intense and not calm at all. Sometimes we would dance. I’d do a few dances to really try to get his energy out. Or do a lot of drumming...something like that.
There were always other people in the classroom to help, and... Yeah, it got stressful sometimes. {This kid} could definitely be really difficult. I guess it’s hard, especially when there’s a whole class there too, but you try and stay calm when the class is getting out of control. A lot of the time, there is obviously more than one kid at a time that’s in a hyper mood. But especially when he was in a hyper agitated state... then the other kids would feed off of that. But then that was almost like countertransference. I’ve often thought that no matter what I do these kids are going to be upset... you know... and go off anyway.

If S. was going through episodes or something when he would come in, I would think that knowing that he was really high yesterday, like meaning mania... I would just feel kind of nervous checking in with him. I know when I would be manic the next day I might be depressed or something like that. So just kind of checking in with him. I was going to say I think it’s different because in a way he can’t help it because he’s manic. I felt worse saying things to him {to calm down} because I knew that his thoughts... that he couldn’t calm down.

I don’t know if it’s being nervous or just a little uncomfortable sometimes trying to talk. “Ok that’s enough now. Let’s calm down and...” ... you know... even though you want to encourage him to have fun. {In one instance} I was trying to match his energy, but then I felt kind of nervous that he was... I was worried about what was going on with him. Because he can be really energetic, but then when he has that agitated energy you kind of feel that he doesn’t know where to put all the energy. My stomach would tighten.

I guess there was a sense of powerlessness... you know... I didn’t really have much authority over the kids in that area. I felt I kind of understood what he was going through. That things would seem... no matter what people said it didn’t seem like it was going to get any better. When he was not having a good day and didn’t want to be there. But when you have that mania part that’s a different kind of feeling. I really recognize that. I think that that’s what... the last time I had a relapse that’s what I felt. I guess I don’t think about it until stuff like that comes up. Like when I see, “Oh, he is bipolar.” I
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see what he’s doing. It makes more sense now. But then sometimes I can spot it too. The fast talking...

Like where you’re talking about empathy...teachers are not supposed to have favorites but I really tried to...I don’t want to say paid more attention to him, but tried to always be like, “Where is S. today?” When he walked in...even though I kind of looked at all of them. I guess if I think about it I was always like...you know...worried about him. Yeah, I don’t know if I would say more {empathy}, but a different kind. A different perspective as someone who has had the diagnosis as opposed to just someone who has had good or bad days or has been sad sometimes. I just remember feeling like, “Oh, I remember being both of those” {manic and depressed}, you know what I mean?

So that is like dealing with the countertransference because I did feel like, you know...I could relate to him, I feel bad for him. A lot of people can say, “Oh, I know how he feels.” But you don’t really know how he feels if you haven’t had the diagnosis. I was going to say, I might almost be favoring him by not calming him down as much, as opposed to some of the other kids. You know what I mean...like letting him talk. Because I know he has to get the thoughts out. {I may have favored him} because I did know what he was going through. Yeah. But I never thought of it like it was so difficult because he had bipolar. And because I had it.

Then I guess I thought a lot that it’s got to be sad to be a kid and going through that. Because you don’t know what’s going on...you don’t understand. You have a condition. There’s a reason why you can’t sleep. And there’s a reason why you’re talking a mile a minute. It’s not just that you’re in a really fun mood. And sometimes I’d be tempted to say, “Yeah, he really should take his medication. I know because {of my experiences}.” I don’t know if that would help the mother... I felt like it was my duty to bring him in the middle somewhere. To try to get him grounded, or stabilized. It felt good {to have him look up to me like that}. He was a good kid.
Category descriptions with cited examples of the Participants’ Experiences

Category 1: Level of connectiveness

This involves the level of connection with a client experienced by participants. This refers to the concept of being connected through the music, or possibly something of a more personal manner, such as the diagnosis. The following is an example of both a connection through the music as well as the shared diagnosis:

Participant A: “I guess I felt connected to him in a lot of ways, namely the bipolar diagnosis, but also because when we were singing we were singing together...we were kind of on the same page.”

Participants expressed degrees of connectiveness through the music in the following ways:

Participant A: “I thought these songs were great for therapy but I also had a personal connection to them. But that’s not always a good thing, because I had a real strong emotional reaction to the song, and here I am playing that song, and singing it with another person who has been in a similar predicament to my own.”

Participant A: “I felt as if we had made a connection through the music that was unspoken. There was an entirely different vibe in the room after the music was played.”

From a different perspective, participant B had an experience of feeling disconnected from the client in the music:

Participant B: “And when we did play, we weren’t together. We weren’t musically in synch. I felt that he wasn’t listening to me, and he was kind of all over the place.”
Category 2: Struggle to connect with client.

Therapists had difficulty connecting with the client and at times had conflicting feelings concerning the level of disclosure concerning their own illness. The therapists strongly identified with the patient's problems, history, or current situation, but still had difficulties establishing a connection with the client. The following examples illustrate this struggle to connect:

Participant A: "But it was hard to talk to him about it when he would make comments like, "you really don't know what it's like" and other similar comments. I knew that there was no way I was going to tell him about my experiences, but at times I wanted to. I just said that I understood that he was going through some hard times, and tried to talk to him about it. When he said comments like that, I wasn't going to say it, but I was thinking "I really have been where you've been, and I understand it a lot more than you think."

Participant B: "And it was kind of a big risk to take. I was having a...I was trying to think of different ways to connect with him and let him know that I'm really hearing him. I didn't get the impression that he thought I was hearing him, because he has a lot of abandonment stuff and constantly thinks I'm going to leave."

Participant B: "But I just felt that for him in our relationship and...where he's at that it might be a bit of help to him. I think that I was afraid that he was going to probe, and that he was going to question and want to know more. That would have caused a lot more anxiety, but he didn't actually. He didn't even inquire, but he was very present when I said that. I hadn't even planned to disclose it {my struggles with depression}, but it just kind of happened in the moment."
Category 3: Feeling challenged by the client/Boundaries

In certain instances, the client questioned or challenged the actions or methods that the therapist used in the session, as in these examples:

Participant A: "He was always questioning why he had to do this, why he had to do that. It made me uncomfortable when he would question what we were doing in the session."

Participant B: That's when I remember him speaking and him interjecting and saying. "What are we doing? I don't know why we're doing this" and just sort of questioning.

This category also involves a testing of the boundaries between the client and therapist, where the lines may often times become blurred within the therapeutic relationship. The concept of setting boundaries by the therapist is illustrated in these two examples:

Participant B: "There's also been a lot of him testing the relationship and what the relationship is. In the sense of therapeutic relationship, friendship, romantic...so there's been a lot of testing by him, and challenging me about that."

Participant B: "That's very uncomfortable. Especially more about the romantic comments, because I had to be very clear with the boundaries, but once I did it's been better. But he's definitely...he'll make comments about the way I look, or my hair...different things like that."

Category 4: Feeling rejected by the client

The therapists dealt with the possibility of being rejected by the client. This rejection was sometimes personal in nature, but also concerned the actual
music or music experience itself. An example of the therapist being rejected musically by the client is:

Participant B: “I go in there with the blues idea and I feel it got shot down...that he didn’t latch onto it. And, again...this is all my stuff. This is all me feeling rejected.”

**Category 5: Feeling defensive**

As a result of being challenged by the client, the therapists became defensive and felt that he/she had to prove themselves musically or otherwise, as in these two examples:

Participant B: “And I caught myself. I was very aware that I was trying to defend it at first.”

Participant B: “Yeah. Very defiant. Especially again, when there’s this whole verbal thing. He interjected, and at the end was questioning me. I felt very defensive. I felt like I had to explain myself and prove myself.”

**Category 6: Feelings of frustration**

The therapists experienced feelings of frustration towards the client due to the resistance to the therapist’s interventions. An example is:

Participant B: “He’s extremely resistant and I get really frustrated working with clients that exhibit a lot of resistance.”

The therapists experienced frustration due to an inability to connect with the client musically or personally. The following are examples of this:

Participant B: “I was feeling frustrated during the music making because I was trying to provide an opportunity for him to try to really connect, but it wasn’t
Participant C: “There were other people in the classroom to help, and...Yeah, it got stressful sometimes. He could definitely be really difficult.”

Category 7: Feelings of self-doubt.

It is not uncommon for a beginning music therapist to be insecure concerning his/her musical abilities due to their lack of experience. Concerning this, one participant said:

Participant A: “I noticed that the client was very self-conscious, and I identified with the client in this manner. He would say things like: “I’m not really a singer. I love to sing but I’m really not a singer.” And I’ve played guitar for 25 years, and I just started to sing prior to studying music therapy.”

The self doubt could also be in reference to the participant’s general therapeutic presence or feelings of competency as a therapist. For example, these two quotes concern the therapist’s feelings of competency due to inexperience:

Participant A: “First of all, I thought maybe I’m doing this wrong. I’m still a student of music therapy. I don’t have a lot of experience, so maybe I should have approached it differently.”

Participant A: “I found myself doubting my competence as a therapist, which I had already been insecure about.”

Category 8: Concern about the client’s level of agitation.

The therapists identified with what the client was experiencing regarding their level of agitation. The following two examples illustrate this:
Participant C: “But then that was almost like countertransference. I’ve often thought that no matter what I do these kids are going to be upset...you know...and go off anyway.”

Participant C: “I was going to say I think that it’s different because he in a way can’t help it I think because he’s manic. I felt worse saying things to him {to calm down} because I knew that his thoughts...that he couldn’t calm down.”

**Category 9: Anxiety/Nervousness.**

Music therapists’ became extremely nervous or had anxiety while working with a patient. The therapists also had difficulty verbally processing the session due to the anxiety that they experienced. Examples of this phenomenon would be:

Participant C: “I don’t know if it’s just being nervous or just...a little uncomfortable sometimes trying to talk. “OK, that’s enough now. Let’s calm down and...” You know...even though you want to encourage him to have fun.”

Participant A: “I got a little nervous just from the experience of talking to him. I felt like I really didn’t know what I was doing or even in what direction the session was heading in. I found the verbal part of the session to be very difficult for me.”

Participant B: “And I began feeling anxious when he began speaking, because then I felt that he was kind of judging...not judging me but...questioning me. After the improvisation he spoke in great detail. He shared his opinion very emphatically about...you know...I guess how he felt about it, though he was very passive aggressive about it. He immediately questioned why I brought this in, you know...and wanted to know what I expected...what I was expecting him to do. I remember having a lot of anxiety, and in general I have a lot of anxiety when he begins speaking.”
Category 10: Somatic symptoms.

Common across all of the participant’s experiences were somatic symptoms in response to the stress, nervousness, anxiety, or uncertainty encountered in the session. Examples of these somatic reactions would be:

Participant C: “You mean like my actual...my stomach would tighten I guess....”

Participant B: “I find for myself it’s more the anxiety...my anxiety issues really impacting on the way I run the session, the way I facilitate it. When I leave I feel anxious. There’s a lot of...I get a lot of somatic symptoms. My stomach gets upset, I get sweaty...”

Participant A: “I started to sweat a little more. I felt a little bit on edge.”

Category 11: Energy shift.

Energy shift represents a change in the level of energy, such as when the therapist felt drained by the experience of working too closely with someone with a mental illness. One participant found it more difficult to work with another person with a similar diagnosis in this example:

Participant B: “And it can be very draining. And like you said before, especially when it's things that really hit home for you, and hit home for myself. In part I was thinking, “Well I understand it so it will be easier.” But actually...No, it's that much harder.”

Energy shift also has to do with matching the energy level of the client when the client may have an agitated or manic energy level, and the inherent difficulties that the therapist faces in this situation. For example:
Participant C: "I was trying to match his energy, but then I felt kind of nervous that he was...I was worried about what was going on with him. Because he can be really energetic, but then when he has that agitated energy you kind of feel that he doesn’t know where to put all the energy."

Category 12: Sense of powerlessness

Many times the therapists experienced an overwhelming sense of powerlessness, where events seemed out of the realm of the therapist’s control. These three quotes exemplify this feeling:

Participant A: “It felt like he pressured me in this way, and—even if it was unconsciously...ultimately made me feel the same way as him.”

Participant C: But yeah, I guess there was a sense of powerlessness of...you know...I didn’t really have much authority over the kids in that area.”

Participant C: “I guess it’s hard, especially when there’s a whole class there too, but you try and stay calm when the class is getting out of control. A lot of the time there is obviously more than one kid at a time that’s in a hyper mood. But especially when he was in that hyper agitated state...then the other kids would feed off of that.”

Category 13: Feelings of hopelessness

The therapists strongly identified with a client’s sense of hopelessness, drawing from their own background and personal experience with illness. Examples of this among the participants are:

Participant A: “I think I felt in times of my life I’ve gone through some really difficult periods and I knew what it was like to feel that way. To feel like things are hopeless or that things are not going to get better. I really identified with him in that way.”
Participant C: “I felt...I kind of understood what he was going through. That things would seem...no matter what people said it didn’t seem like it was going to get better. When he was not having a good day and didn’t want to be there.”

**Category 14: Having empathy for the client/resonating with client.**

Music therapists were able to demonstrate more empathy when working with clients who shared the same or similar diagnosis, even though at times this may be difficult. This sometimes presented a dichotomy, as it wasn’t always necessarily easier to work with the clients just because of the shared diagnosis:

Participant B: “The depression component of him being isolated and not getting out of bed. That I feel very related to, very connected to...and have an immense amount of empathy and understanding of that.”

Participant A: “But I have had experiences that parallel this guy. It was a very difficult client to work with for me because there were so many similarities....I really felt that a lot of the things he had been through I’ve experienced. Many of the things he said, I remember saying the same kinds of things. There was a lot of denial that I have this illness and questioning why am I here in the hospital.”

Participant B: “I don’t know if I think a lot about him more because of the mental illness, but I’m sure that’s part of it. I suffer from periods of depression and more so generalized anxiety. That’s been my longstanding thing that I’ve really struggled with. So that had obviously impacted my work with him, to the point of me obviously perseverating about it and replaying it (the session)). Yeah. It’s been a real challenge.”

Participant C: “Like where you’re talking about empathy...teachers are not supposed to have favorites...but I really like...but he was a good kid too, but I
really tried to...I don’t want to say paid more attention to him, but tried to always be like, “Where is S. today?” When he walked in...even though I kind of looked at all of them. I guess if I think about it I was always like...you know...worried about him.”

**Category 15: Identifying with client’s experience of mental illness.**

The therapist’s ability to identify with the client sometimes involved the therapist seeing aspects of their own life or experience in the client, as in the following examples:

Participant C: “But when you have that mania part, that’s a different kind of feeling. I really recognize that. I think that that’s what...the last time I had a relapse that’s what I felt.”

Participant C: “I just remember feeling like, “Oh, I remember being both of those” [manic and depressed], you know what I mean?”

Participant A: “But I felt like it really hit home for me because it felt like...had my situation been different could I have been in his situation?”

Identifying with the client also included favoring the client in some way, as demonstrated by this participant:

Participant C: “I may have favored him because I knew what he was going through.”

Participant C: “I was going to say, I might almost be favoring him by not calming him down as much, as opposed to some of the other kids. You know what I mean...like letting him talk. Because I know he has to get the thoughts out.”
Participants identified with the client’s experiences of mental illness, and felt empathy for the client in a different way because of this. This is illustrated in the following examples:

Participant C: “So that is like dealing with the countertransference because I did feel like, you know...I could relate to him, I feel bad for him. A lot of people can say, “Oh, I know how he feels.” But you don’t really know how he feels if you haven’t had this diagnosis.”

Participant C: “Yeah, I don’t know if I would say more {empathy}, but a different kind. A different perspective as someone who has had that diagnosis also, as opposed to someone who has had good and bad days or has been sad sometimes.

Category 16: Familial Identification.

Familial identification could be viewed from several angles, the first being the patient ascribing the role of the parental figure onto the therapist. The following is an example of this:

Participant A: “The whole relationship felt very weird to me in a lot of different ways sometimes because I didn’t feel comfortable in that role, and it felt like...Here this guy is 56 years old and he’s treating me like I’m a parental figure. It just kind of felt awkward to me.”

The therapists sometimes enacted a countertransference reaction towards the patient based on a previous relationship in the therapist’s life, as in this example:

Participant B: “I’m pretty aware of where this stuff comes from...with my mom, and that she kind of dismissed a lot of things growing up and there was a lot of pressure to succeed and do really really well academically. So I know that
that’s pretty much the source of the countertransference. It’s probably related to my mom. So just feeling...yeah, trying to get validation from people.”

Category 17: Sympathy for the client.

As well as being able to be empathic towards clients, therapists felt genuinely sympathetic towards their patients, often times because of the therapist’s sensitivity due to their own similar background and experiences. These two quotes are examples of the unique manner in which therapist’s felt sympathy towards their clients:

Participant A: “I did feel bad for him at times because he really wanted the simplest...what most people consider to be the simplest things. I want my own apartment...I want a job...I would like to have a girlfriend and maybe one day marry. I guess most people kind of take those things for granted, but this guy never had any of those things. He never had any stability. There were a lot of transference and countertransference issues that were happening, just because of situations like that.”

Participant C: “Then I guess I thought a lot that it’s got to be sad to be a kid, and going through that. Because you don’t know what’s going on...you don’t understand. You have a condition. There’s a reason why you can’t sleep. And there’s a reason why you’re talking a mile a minute. It’s not just that you’re in a really fun mood.”

Category 18: Inflated sense of responsibility for client

An inflated sense of responsibility for the client entailed the therapist taking on too much responsibility for the client, which stretched the boundaries of the client-therapist relationship. The therapists felt obligated to help the client by educating the client or family, as in this participant’s experience:
Participant C: “And sometimes I’d be tempted to say, “Yeah, he really should take his medication. I know because {of my experiences}.” I don’t know if that would help the mother…”

The therapist may felt responsible for providing a way to help ground the client and at times felt pressured in trying to please the client. The following are examples of this:

Participant C: “Like it was my duty to bring him in the middle somewhere. To try to get him grounded or stabilized.”

Participant B: “He projects a lot and there’s a lot of transference on his part. He sees me as a very high figure, and you know- he thinks I don’t do anything wrong. Things like that. I feel very pressured as a result of that. That’s part of...I guess my countertransference in trying to please him. I’m trying to appease him and figure out what it is that this person needs.”

Category 19: Feeling gratified as a helper.

Although the participants found it difficult to work with another person with a similar illness, they found that it was ultimately a rewarding experience to notice a positive change in a client due to their work done in music therapy. The following few examples describe what it is like to be in the role of the helper in the relationship:

Participant C: “It felt good {to have him look up to me like that}. He was a good kid.”

Participant A: “By reaching him...helping him become more aware of himself, able to be more comfortable with his voice, to express himself, and to be singing songs with me. Also, to help him reminisce about different times in his life and even talk about his experiences as well.”
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Participant A: "So I felt like I was helping him, and because of this it was one of the most rewarding experiences I've ever had."

Below on page fifty-six is a table illustrating the number of meaning units in nineteen categories across participants A, B and C.
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Table: Distribution of Meaning Units Within Categories, Across Participants

<table>
<thead>
<tr>
<th>Categories</th>
<th>Participant A- number of meaning units</th>
<th>Participant B- number of meaning units</th>
<th>Participant C- number of meaning units</th>
<th>Total number of meaning units</th>
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<tr>
<td>Level of connectiveness</td>
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<td>Feeling rejected by the client</td>
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<td>Feelings of hopelessness</td>
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<td>Feeling gratified as a helper</td>
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**Essential Description of the Phenomenon**

What follows is a descriptive summary of the music therapist’s clinical experiences working with clients in the event of a shared or similar diagnosis of mental illness. The therapists struggled to connect with the client on a musical or personal level and were sometimes challenged by their clients, and had to set clear boundaries within the relationship. Participants faced being rejected by the client musically or personally, and because of this had to contend at times with feelings of defensiveness, frustration, and self-doubt. The client’s level of agitation was also of concern to the therapist. Feelings of anxiety and nervousness were experienced by the therapist in response to the client, which often resulted in somatic symptoms. A shift in the energy level of the therapist was felt when working with a client with a similar diagnosis. Feelings of powerlessness and hopelessness were also experienced by the therapist in reaction to the client. Empathizing with or identifying with the client’s experience of mental illness was at times easier because of the common ground; for the very same reason, the therapists sometimes found it more difficult to work with the client, at times emotionally connecting too deeply with the client’s feelings, experiences, or situation. Familial identification also was a factor, with the therapist either rejecting the parental role ascribed to them by a client or identifying the source of the countertransference as coming from the therapists own relationship with a family member or parent. When the therapists were able to connect with the clients empathetically, their common experiences enabled them to feel sympathy for the client regarding their issues and situations. The therapists also tended to have an inflated sense of responsibility for the client, perhaps due to the shared diagnosis. Therapists were able to feel gratified as a helper by reaching another person musically and personally who has been in a similar predicament concerning mental illness.
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Discussion

The purpose of this qualitative study was to provide insight and information concerning situations when the music therapist (or helper in a relationship) shares a psychiatric diagnosis with a client. This includes the following research questions:

- What is the actual experience like for music therapists diagnosed with a psychiatric illness who work with others with the same or similar diagnosis?
- How does this affect the countertransference experiences of the therapist?
- In what ways might the therapists experience countertransference differently because of this unique situation?

In response to the first research question, there are three distinct accounts (interviews) or experiences that are included, where each participant was able to sum up their individual experiences concerning the phenomenon. From these personal accounts, 19 general categories were formed across all 3 participants’ interviews. Each category describes a particular experience or feeling that the therapist encountered in working with a client with a psychiatric diagnosis. Meaning units (68) were extracted from the participant interviews, after which they were put in a logical order according to category. The personal narratives were then edited slightly, with careful consideration taken not to alter the meaning of the words of the participants. This yields three distinct narratives or experiences concerning the challenges of therapists with psychiatric diagnosis in their work with others. In addition, an essential description, or descriptive summary of the phenomenon is included based on the 19 categories and across all 3 interviews.

An important aspect of these findings that should not be overlooked concerns what is distinct about the use of music in therapy as opposed to the more traditional avenue of verbal therapy. In his book *Music at the Edge* (1996), Colin Lee discusses his work in music therapy with a patient who is dying of AIDS. Of this experience, Lee claims that in the case of this client “words could not have expressed his most inward feelings with the same magnitude as his improvisations” (Lee, 1996, p.155), although Lee
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does not disregard the importance of the role of words in music therapy. The patient in Lee’s book made an extremely poignant statement that I believe to be relevant concerning these matters:

How far into feelings are you as the therapist willing to go? Obviously, when the client goes into feeling, how far does the therapist go, or does he remain on the edge of the field so to speak. Normally, one would not go with the client because it is not the therapist’s role. In music, however, I believe it’s different. What is one thing in verbal therapy, is different in music. If you are creating music then of course, if you hold back on your emotional participation, then you are going to fail. On the level of performance or productivity you say, “I’m going to put up a barrier, I’m not going to invade certain areas.” Therefore you are going to control the situation and the client is not going to enter certain areas, because he is restrained from doing so. (Lee, 1996, p. 87)

Reflections on findings

Major Themes

There were many key issues or themes within the literature as well as in statements contained within each participant’s interview regarding what the experience was like for the therapist which address the research question of this particular study. The category of familial identification came up for participant A and participant B. Participant B talks about the source of her countertransference possibly coming from her relationship with her mother, and how she was seeking to appease or seek validation from her client in a similar manner. Priestley (1994) states that in certain circumstances the therapist may have to determine if their unconscious is viewing the patient as someone else from their past. The therapist must learn to see clients as their own unique selves. Priestley talks about an example where she identified a client with her half-sister, thus disrupting the professional relationship between client and therapist.
Participant B expressed feelings of being frustrated both at the client’s level of resistance and in the actual process of making music with the client. Participant A and C both experienced feelings of powerlessness and hopelessness at times in response to the client. They were also able to empathize with the client’s despair due to their own personal experiences of feeling this way. Priestley (1994) states that “when a patient is battling seriously with a crisis in growth it is possible for the therapist to experience very testing levels of frustration, rage, despair and other difficult emotions” (Priestley, 1994, p67).

The issue of self-doubt on the part of the therapist is clearly evident in Participant A’s narrative. The therapist was uncomfortable with his musical skills, his voice in particular. Due to lack of experience, the therapist doubted his approach to the session in general. The participant also doubted his overall competence as a therapist. Bruscia (1998) explains that competence is a huge issue in music therapy for several reasons. For one, there is a tremendous amount of study and knowledge that goes into being a music therapist. Since one has to have a wide array of approaches, techniques, abilities and skills, not everyone can be competent in all aspects of the practice. Therapists must realistically work within the confines of their own unique set of skills and abilities. Since competence issues are so rampant and can be detrimental to the therapy, therapists may benefit by expanding their skills and knowledge and possibly seeking supervision. In addition, there may be an aspect of self-doubt due to the potential level of insecurity attached to the field of music therapy as a relatively new profession. (Bruscia, 1998).

Concerning an inflated sense of responsibility for the client, Participant C felt it was her responsibility to inform the mother that the child should take his medication regularly, as the therapist has had personal experiences of going off her medications and ending up in a manic phase. Participant C also felt like it was part of her responsibility as a therapist to help keep the child stable or grounded. Participant B may have had unrealistic expectations concerning her role in the client’s life by taking on the client’s belief that the therapist can do no wrong. In her countertransference reaction she feels
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pressured, trying to please the client and live up to his expectations. Bruscia (1998) states that “therapists have to be careful that they do not attach too much significance to their role or position within the client’s life” (Bruscia, 1998, p 84). The therapist may feel a need to have the client acknowledge the importance of the therapist’s role in their life, to the point of even entertaining notions or fantasies of rescuing the client, and may try to resolve the client’s problems by taking on the brunt of the responsibility for them (Bruscia, 1998).

Concern about the client’s level of agitation is another factor that the therapist deals with in working with a patient with a psychiatric illness. Participant C discusses her feeling of helplessness concerning the clients “going off” or getting upset, despite her best efforts to control this. She also felt bad telling one particular client to calm down, as she knew that he was in the middle of a manic episode and had no way of bringing him down from it. Perhaps because of her personal experiences with bipolar disorder and manic episodes, Participant C felt that she was unable to regulate the client’s extreme moods and level of agitation. Yalom (1983) discusses how therapists “must strive continually to avoid any situation in a group which would elevate anxiety, and to attempt to provide a group structure and a group climate that ameliorate anxiety.” (Yalom, 1983, p 280). Yalom also points out that physical exercises and muscle relaxation exercises may be used, as well as games that may engage clients and get them to take small risks in interacting with others in the group.

Somatic symptoms in response to the anxiety or nervousness that the therapists are experiencing are a common occurrence in music therapy. Concerning the participants of this study, participant A reported that he started to sweat more in response to being nervous when working with a client, and felt “on edge”, perhaps in reacting to the client’s mood. Participant C also said that her stomach would tighten when working closely with a client in response to the stress, and Participant B described her somatic symptoms similarly, as she would sweat more and get an upset stomach as well. Regarding somatic reactions, Bruscia (1998) discusses experiencing physical discomfort at times, as well
changes in body energy or tension. In these types of countertransference reactions, he describes how the body may begin to feel tired, relaxed, energetic, or tense in response to the client. Bruscia also describes bodily sensations or pain such as experiencing a backache or headache, and how this reaction may be a metaphor for the corresponding countertransference feeling in the therapist (Bruscia, 1998). Priestley (1994) states that “the therapist may find that either gradually or 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” (Priestley, 1994, p 87). Regarding this response to the client, Priestley compared this to the Russian echo effect, in which “the healer responds to the pain of the patient by feeling a corresponding discomfort in his own body” (Priestley, 1994, p 88).

**Challenges due to the shared diagnosis**

In the struggle to connect with the client, therapists may feel a tendency to self-disclose their own issues with mental illness, which may prove to be problematic. Participant A felt a strong urge to tell his client just how much he understood what the client was going through. The client would often state that the therapist couldn’t possibly understand what his experiences were like. In this case, Participant A chose not to self-disclose to the client, perhaps sensing that it was too personal and might endanger the therapist/client relationship. Participant B had a similar situation, but she did disclose to her client that she struggled herself with issues such as depression. In searching for a way of connecting with her client, Participant B made a judgment call and chose to share some personal information that she thought might benefit the therapeutic process and working relationship. Although she claimed the thought of him probing further was initially anxiety provoking, the client did not inquire further regarding the issue. In this situation, the disclosure was not planned but just happened spontaneously. Although self-disclosure may be beneficial, it must be in line with the primary goals of therapy. “Total therapist transparency is neither possible nor desirable. Therapists must disclose in a manner that provides patients with support, acceptance, and encouragement, and can do
so through selective self-disclosure" (Yalom, 1983, p 162). In discussing inpatient settings, Yalom (1983) claims that “the therapist’s self-disclosure greatly accelerates the work of the inpatient group.” (Yalom, 1983, p 162). A moderate level of self-disclosure by the therapist may model a certain type of openness and willingness to take risks on the part of the client. Furthermore, “patients will have more trust in a therapeutic procedure if they see that the therapist is willing to engage in the same procedure” (Yalom, 1983, p 165).

The concept of energy shift in the form of a change of body energy or tension in the therapist is also a common occurrence in music therapy. Participant B shared this feeling of being drained, but in her case regarding the difficulty in working with her client due to the shared history of mental illness, with the issue being that it was something that really “hit home.” Bruscia (1998) recounts a story wherein while improvising with a client he begins to feel totally drained, to the point where he was having trouble playing and even holding himself up in his chair (Bruscia, 1998).

Benefits due to the shared diagnosis

There were at times positive aspects due to the shared diagnosis of mental illness. Participant A felt a connection to the client because of the shared diagnosis, as well as through the act of singing a song together. Through the music, he was able to establish a connection that changed the “vibe” in the room. Participant A also felt gratified as a helper in that he was able to reach another person in a time of need and let him express himself, sing songs, become more aware of himself, reminisce about different times in his life, and re-live some positive experiences from the his past. Participant A described this experience as one of most rewarding things that he had ever done. Participant C expressed that she liked working with her client, and that it was nice to have him look up to her.

Because of the shared experiences between client and therapist, having sympathy for the client and his situation might have been experienced differently. There was
certainly an element of sadness at seeing another person in a similar situation. Participant C expressed this sadness concerning the issue of a 9 year old boy diagnosed with bipolar who was clearly struggling. The sadness also came from the fact that Participant C felt that the boy didn’t really understand what was going on with him. Participant A experienced sympathy for the client in a unique way because he felt that the client was not asking for much, just to be able to be independent, have a job, and marry one day. However, Participant A realized that the client may never achieve these goals, which made him feel guilty and contributed to the countertransference dynamic in the relationship.

One of the most important of the findings in this study revolves around the concept of feeling empathy or resonating with the client. Participant B discusses how the client’s level of isolation and depression were issues that she really connected with personally, and enabled her to have empathy for her client even though it was difficult at times. Participant A found that he connected personally with many of the statements that his client made, and shared many similar experiences, concerning medications, denial of the illness, and family difficulties. Participant C was able to really connect with the feeling of mania that manifested in her client, as evidenced by his agitation, fast talking, and impulsiveness. She also really connected with the polar opposites of the depression and manic spectrums. Participant B believed that it was challenging to work with her client, and that the mental illness factor played at least a small role in that dynamic between them. Participant C believed that she might have favored her client over others due to the shared diagnosis, and that she may have shown a different kind or level of empathy towards him because of this. Due to the similarity concerning the diagnosis and personal history, the therapists were able to often times connect with the client, show a new level of empathy for them, identify with their experience of mental illness, and have a greater understanding of what the client has been through and is currently struggling with.
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Clinical Implications

Value: Information Discovered

This study yielded some very interesting results as far as the information discovered across the three participants’ experiences and offered the participants an opportunity to openly discuss their work with clients in music therapy, as well as how their diagnoses may have played a factor in the therapeutic setting. Since there is scant literature in music therapy concerning this topic, this research is valuable and something that deserves to be pursued even further. While each participant had experiences that were uniquely their own, there were also commonalities as well. For instance, all three participants seemed to experience nervousness or anxiety in response to their clients, which sometimes manifested in the form of somatic symptoms. All three participants made comments regarding the level of empathy or compassion they had for their clients and how they felt that their experiences enabled them to be there for them in a different capacity. Table 1 in the appendix shows the number of meaning units for each participant, as well as the total number of statements from each category across all three subjects.

Implications for music therapy

The implications of this research can be applicable regarding therapists dealing with psychiatric patients of all ages in music therapy. In setting out to find out what the experience was like for the therapist, other questions continued to arise concerning the therapeutic relationship, transference and countertransference, and so on. These findings are important for those working with psychiatric patients, even if the therapist doesn’t have a mental illness. People can be more compassionate to others in need, rather than contributing to making a very vulnerable person feel even worse. It is our duty as therapists to provide this environment for clients. They deserve as much, as if you were in their position, you would expect someone to extend the same courtesy.
Findings from this study may enable music therapists, interns, students, and others to understand more completely the challenges that music therapists with psychiatric diagnoses may face when working with others with a similar illness. It may afford those in this position the opportunity to understand their countertransference reactions and utilize them to serve the best interest of the patient. These findings may also have relevance on a much larger scale than simply pertaining to the field of music therapy.

As it is clear that the therapist can have countertransference reactions that may negatively affect his/her work, monitoring this through supervision is essential. This can enable the therapist to see more clearly what is going on in the relationship, as well as examine the countertransference reactions and how they can be used effectively in therapy. Role playing in supervision may give the therapist the chance to be in the shoes of the patient, and understand the patient’s transference issues and the resulting countertransference experiences. Odell-Miller and Richards (2009) claim that “the business of supervision, in turn, is to restore and sustain the artist in the therapist, so that she can bring her imagination and originality to the encounter and become fully engaged in the mutual process of change” (Odell-Miller & Richards, 2009, p. 43). In my own case during my internship, supervision was essential in providing me an outlet to express my concerns about not letting my own history and illness interfere with my work with the clients, as I had very strong countertransference reactions to one patient in particular, and really had to work hard at trying to use this constructively in the therapy.

Reflection on method/limitations

Effectiveness of method

I found that in conducting this research study, there were certainly limitations and situations that I had not anticipated. I was interviewed first by my thesis sponsor, and I found parts of it to be very difficult for me considering the sensitive nature of the study. I found the interview process with both participants to be extremely enlightening, at times very serious and dark in subject matter, and even humorous at times.
This research requires the participants to be very open about their past, their illness, and the effects on their work as a music therapist. At times I felt under pressure during the interview, and found myself uncomfortable with answering certain questions. However, I felt that this was a good experience because it enabled me to see more clearly what the interviewees would be experiencing, as well as what my role would be as the interviewer. There were also times in all of the interviews where the participants had to sit with a question for a few minutes before they could answer. Since the subject was of such a personal nature I believe that this was natural.

In one of the interviews, the participant was surprised at the first few questions, which had to do with working with clients. The participant may have had preconceived notions concerning the nature of the study, believing it to be more about their personal experiences with their psychiatric illness. Although this was certainly a factor in the study, it was more focused on their experiences working with particular clients, the transference and countertransference issues, and how their diagnosis might factor into the equation.

An important point that came up during the process of this research study concerning the method was the sheer difficulty of finding participants willing to be interviewed and share this very personal information with me as the researcher. My initial intention was to conduct three interviews apart from my own, but I was only able to find two others willing to participate even though I posted a recruitment email on several list servs (and several times on each one). I received emails from others who recognized the value of the work, but were not interested in being interviewed for fear of a breach of confidentiality. I also received an email from a prominent music therapist in New York City who told me that she supervised several music therapists with bipolar disorder, but that they would not participate for fear of disclosing their illness (even in an anonymous study where precautions were taken to insure confidentiality). Therein lies the dichotomy that we are confronted with: How can therapists who are not willing to disclose their own illness expect others to disclose to them? Because of the shame that many with mental illness carry with them as well as what society imposes upon us,
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somehow it is unacceptable for someone in the role of the therapist to have a mental illness. This refers back to what the literature review discusses concerning the “us and them” mentality concerning psychiatric diagnoses. I believe that for this reason alone, this research is extremely important to the field of music therapy, and something that needs to be addressed on a much larger scale and in much more detail than the information gleaned from this study.

Implementation of method

Having no prior experience with phenomenological approaches proved to be difficult for several reasons. Although I had my own interview to learn from before the others, I had never conducted these kinds of interviews. It was very easy for the conversation to drift towards background information, types of interventions used, psychiatric history of the interviewee, or thoughts about what was effective or ineffective in regards to approaches in music therapy. I had to constantly try to bring it back to an experience: what something was like, how they felt, what they thought, and so on. Sometimes the interviewee would talk more generally about a client, or sometimes even switch from one client to another within one statement. It proved to be very challenging to redirect the question back to a specific client and a specific experience, event, or session. This was most certainly true in my interview with my thesis sponsor, and was evident at times during the other interviews. I also had trouble describing some of the feelings associated with my experiences. On hearing the recording interview played back I was surprised at how I couldn’t answer simple questions about what I was feeling when working with a particular client, as it proved to be difficult to process all of the emotions about the experience. On reflection, I was able to clarify these feelings that I couldn’t initially express in the narratives. The other interviewees also had the chance to clarify that the culled transcripts were accurate as far as content was concerned, and were able to omit or add material.

Even though I had read much on the phenomenological approach towards qualitative research, I found the process very difficult. This was especially true of the
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interview process. At times I was uncertain when to probe deeper regarding a statement or topic, especially if the subject matter seemed emotionally difficult for the participant. I also felt uncomfortable sometimes redirecting the interviewees, not wanting to interrupt their thought process. I felt at times that even though the conversation was going off topic I let it continue for longer than it should. I also found myself disclosing to the interviewee’s some of my history with mental illness just so that they didn’t feel that they were the only ones disclosing very personal information.

The actual transcribing and culling of the interviews was a very laborious undertaking. Though it was rather time consuming, I wanted to make sure that the interview was word for word. The interviews were all between 10-15 pages transcribed, after which they were each culled down to 2-3 pages of relevant information. I found the actual culling process to be sometimes difficult, because I had to focus only on the information relevant to my particular thesis question. The issue was basically that the information had to be related to an event or experience, with the focus on what one saw, felt, and experienced. At times background information and general impressions came up, which sometimes were important to the research question even though they didn’t focus on one event, per se. For this reason, it was at times difficult to cull down the interviews to an acceptable length so that the meaning units could be extracted from them.

It was initially difficult for me to decide on what would be designated a meaning unit in this project. Looking back at the data analysis and subsequent results derived from this, I believe that there may have been more meaning units (participant’s statements) that I may have overlooked that I could have extracted from the original interviews. It was a judgment call to decide at the time what I thought would be relevant related to my research project.

Establishing categories for the 68 meaning units also proved to be difficult. It was a process wherein there was a lot of trial and error, and I tried the categories in several different configurations before I finally felt comfortable how the meaning units fit into these groups. Initially I printed out and cut up the individual meaning units into strips of
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paper and physically put them into groups where they seemed to belong, without worrying about naming the categories yet. Even after they seemed to be grouped together in a logical manner, it was at times still challenging to figure out what to name the category according to the underlying themes. I went through several variations before they were named in a way that reflected the meaning units contained therein. Categories were combined where it seemed to make more sense, resulting in 19 categories for the 68 meaning units. The categories and the meaning units were cross-referenced, enabling me to easily find and identify them and their groupings. Some of the meaning units also belonged to multiple categories, further complicating the process. After the 19 categories were firmly established and the meaning units seemed to fall into their respective places I was able to establish an order to the categories that seemed to have a logical flow and would make sense for the reconstructed narratives.

This topic is certainly worthy of more research and deserves to be pursued in a rigorous manner. As with anything in life, I look back at my work and think that I could have done it better, I could have asked different questions, or pursued the interviewee’s direction in a way that would lead us more to their truths concerning their experiences. While I read much about the process of phenomenology before conducting my interviews, I would strongly encourage those wanting to pursue this topic to investigate it much more extensively and to be better prepared. However, this was the first time I had done interviews like this, and I did the best that I could have done at that time.

**Implications for further research**

I believe that this research shed some light on an often neglected aspect of music therapy (and even therapy in general) that has not been properly addressed in the literature, or even discussed considering the fact that it is likely more commonplace than people think. This seems ironic since Mary Priestley, the main proponent of Analytic Music Therapy, suffers from mental illness herself. While I understand the stigma and discrimination that those with mental illness face all too well, I believe that coming forward (or at least participating in an anonymous study) should be encouraged solely for
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the information and understanding that could be discovered from this kind of study. I am reminded of one of the issues included in my literature review: Why is there such stigma surrounding mental illness? If someone has cancer, heart disease, or diabetes, they take their medication, manage their symptoms, and seek guidance and support from those in the medical profession that are there for the very purpose of helping them. Apparently we as a society have a long road ahead of us in order to view mental illness the same way we view other physical illnesses in which the symptoms are much easier for people to see and comprehend. This research is something that is extremely important not only to the field of music therapy, but to the larger scope of therapy in general.

Participants' statements (meaning units) and content point the way towards future developments or research. It was discovered that on the whole participants with mental illness were able to have a particular kind of empathy for clients with similar issues that those without psychiatric diagnoses would not have. Participant A and Participant C, who were both diagnosed with bipolar disorder, made statements wherein they really seemed to identify with and relate to their client’s experience of mental illness. Notably, these two participants also made statements regarding a sense of powerlessness and hopelessness when working with their clients.

**Personal Reflections**

I sincerely hope that as a result of this research study, others may feel more comfortable with participating in anonymous studies and perhaps even be able to be more open about their struggles with mental illness. It has taken me years to come to terms with and manage my illness. It is also something that I will have to manage for the rest of my life. At the time of the writing of this thesis, I have been dealing with my bipolar disorder for the last 10 years of my life (as well as 10 years prior to this trying to manage bouts of severe depression). Sometimes I feel as though 20 years of my life were taken from me, but all I can do now is try to live in the present and have high hopes for the future. I can say with conviction that being more open about my own experiences has given me a sense of empowerment that I never thought would have been possible.
Having known so many musicians, artists, and therapists in my life that have suffered from mental illness, I believe that these stories need to be told in order to help those in need, to provide an understanding of mental illness that could inform the process for the therapist, to help those on the outside to better understand the issues that we face on a daily basis, and to lessen the stigma and discrimination that abound concerning mental illness.

I can honestly say that I came away from this project with a greater understanding of myself, my illness, the rigors of qualitative research, and, as well a confirmation of the belief in the power of music to heal. I also discovered that I was not alone in my struggles with bipolar, including the resulting chaos it has caused in my life. Too often those suffering from mental illness feel a great deal of powerlessness, depression, shame, loneliness, and isolation, and it is exactly for these reasons that these issues need to be addressed in order for progress to be made.

Although the entire process concerning this thesis took me almost a year to complete, it has provided me with invaluable information that will inform my future work in music therapy, has shown me how to follow through with a long, arduous process, and will perhaps inspire others to think about these issues concerning mental illness and to pursue this research to a further extent than I was able to.
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Conclusion

The purpose of this study has been to examine the unique experiences of music therapists with psychiatric illnesses treating others with similar problems. Being that there is so little literature available regarding this topic, this study should shed some light on a subject concerning music therapy that has not been examined in detail thus far. This qualitative study uncovered information regarding the experience of these therapists such as level of connection, professional boundaries, feelings of anxiety, responsibility, powerlessness, hopelessness, self-doubt, defensiveness, frustration, empathy, resonating too strongly with the client, and identifying with the client’s experience of mental illness. My hope is that these discoveries will carry implications beyond the scope of music therapy and into other realms of psychotherapy.
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References


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Appendix A

Original Interview Transcripts (De-Identified)

Original interview transcript-Participant A

TS: Thesis Sponsor

A: Participant A

TS: So let’s start with you thinking of a session with a client. It could be recently or it could be any time in the past with a client that really left an impact that you really remember well. You remember the session well, you remember the music, and how you felt, and you know- you have a good image of the client.

Participant A: I can talk about particular sessions, and I also was thinking in particular a client that I worked with in my internship. I actually did a case study on him for the internship. That particular client- we worked one on one every week. We had a 25 minute session, and we started with- initially he told me that he really wanted to learn how to play guitar better and he wanted to be more involved in music and that this was very important to him- so I kind of set it up as a lesson, and he seemed really excited about it and he was almost in a manic state that day. He was bipolar and he seemed really excited and he wanted to get going with it and we worked on some chords. I showed him a song that he wanted to learn, and we talked about different things we could do. So that was the initial format and with that- this client that I’m thinking of. The second meeting came around and I went back to see him and he was completely kind of withdrawn and he said, “I really don’t want to do this.” You know- “music is just for the professionals” and this and that- and he was kind of going through this thing where he was really...and by the way played guitar a little bit. He knew some basic chords and stuff already. He seemed really down on himself and “this is not for me”, whereas the other week he was talking about, you know... I want to do more with music, I want to get better. So I kind of had to rethink what I was doing. I also didn’t feel that comfortable with the start of the session...my sessions with him because it was...I have a lot of experience doing guitar lessons and I wasn’t really clear what I was going for with him yet, so I felt like I really didn’t know what the clinical intent was. I didn’t really know what I was doing yet. So in
that way it was kind of like I was kind of glad that we shifted directions and he said that he might want to do something else musically. And he also – I definitely felt there were some transference and countertransference issues going on right from the beginning though with him. It felt like he almost treated me- the second week when I came back like an authority figure, a parental figure. He definitely had a thing where he kind of felt guilty about not doing what I had showed him, or what I had assigned him to practice. So I remember going back to my supervisor and saying...he asked me how it went with the session and I said that I felt “put upon.” And I felt like he kind of didn’t want to commit to what we were doing because it was in some way related to his treatment plan, and this particular client was not very... He really didn’t adhere to the treatment plans. He was always questioning why he had to do this, why he had to do that.

TS: So let’s go to that session. The session where you felt put upon, and let’s describe... this is really the beginning of the interview here. I mean the context is helpful but we still haven’t gotten to the experience. So describe the setting and the context for this session. The one where you felt put upon. You were in the context of lessons and...as much detail as possible.

A: Like I said, it was an individual session. As far as how I was feeling?

TS: Well, all of it. Describe as if you were telling me the story of that day. In that session.

A: When I went in he was... like I said he was very withdrawn and he seemed like he was making any excuse why he couldn’t play the guitar, and he said “I really want to do this, but I’m not up to it.” I feel like music... he held music up to such a high regard that he couldn’t – live up to it I guess? Like he couldn’t actually play an instrument because he would want to be really good, and he didn’t really feel that he had it in him.

TS: So he said this to you? At the beginning?

A: Yeah. Oh yeah. He said part of that. Part of it was my interpretation of it. It just felt like he didn’t want to commit to it. He didn’t want to even try for it. And I hadn’t really
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worked with him too much. This was the first- the second one on one session. I f guess he just...it made me feel...first of all, maybe it made me feel like I’m doing the wrong thing. Maybe I should approach this differently, that was my first thought. There are plenty of other things we can do that I’ve learned about or done some in my Practicum settings. We could do different approaches, we could do singing, or we could do song discussion. So a lot of those things went through my head. It was interesting to me that my supervisor told me that it’s interesting that I felt put upon because apparently that’s kind of what this client is going through. It felt to me that the client felt like I expected too much from him.

TS: Give me an example of when you noticed that. In that first part of the session when you walked in. Describe the feeling of put upon in that context. How did it manifest?

A: First of all, I thought maybe I’m doing this wrong. I’m still a student of music therapy, and I don’t have a lot of experience, so maybe I should have approached it differently. It felt like he was...I guess my expectations for him were too much, so he kind of threw it back to me and said I can’t really do this. It got me thinking about what I was doing, and kind of thinking what else could I do differently to work more effectively with this client.

TS: What did he put upon you?

A: He almost made me feel like it was my responsibility for him to be able to play the guitar. It had to be something that I helped him do, but it was all kind of on me. The way he was treating me was very like, “I’m really sorry” and all apologetic. I didn’t mean to not practice...kind of putting me in an authority figure role. I wasn’t really comfortable with that, and he also said that it’s such an issue for me to get the guitar from the closet from someone that works here. It’s too difficult for me to do this, so I can’t do it. I felt like he was making excuse. “There’s not a free room for me to go to and be undisturbed. It takes too long for them to get the guitar, I don’t want to bother them because they’re doing a lot and I don’t want to get in their way.”

TS: And that put something upon you? That put responsibility upon you?
A: Yeah, kind of. That's just the way I felt. I don't know if he was really blaming....he was kind of blaming it on other factors at the hospital. So I had to switch directions and I had to try different things with him. Just to get out of that.

TS: What was the first direction where this was happening? What were you doing?

A: Intervention wise or what my plans were?

TS: What was happening when you first felt this feeling of being put upon, and he was making excuses...

A: Well he was kind of making excuses and being apologetic.

TS: You mean, just a conversation you were having at the beginning?

A: Yeah. And so I felt bad, I felt like he's in this situation where he feels...and I understand the situation in the hospital is such that it is hard to find a place to go and be undisturbed. There are so many people there. So I understood where he was coming from but, it just seemed like he kind of projected that onto me, like he felt put upon by me to do better on the guitar. Ok- this guy came in and showed me these things, I'm going to get them down and be back the next week and continue to work. Almost like I expected too much from him, so he just kind of gave up. That made me feel put upon because I felt that I'm not doing the right thing. I'm not approaching it the right way. There must be some other activities that we could do...

TS: But it was him that put that upon you?

A: Yeah. I felt like that.

TS: Can you describe that feeling? The moment that you felt it to the best that you can recall. What was that like? In your body, or is there an image that goes with it, that sense of him giving up, him making excuses and you feeling put upon and...How else besides the description of that dynamic did it actually feel to you?
A: I got a little nervous, just from the experience of talking to him. I felt like I really didn’t know what I was doing.

TS: How did you experience that nervousness, in your body, say?

A: I started to sweat a little more, I felt a little bit on edge. What do I do now?

TS: On edge?

A: Yeah. It was particularly hard with this client because he is bipolar and I have had issues with that in the past...I mean...I have it. I am on medication, which I have been on for 10 years. But I have had experiences that parallel this guy. It was a very difficult client to work with for me because there were so many similarities, I saw so many things I had done.....this is not necessarily in one session but over the course of working with him in many sessions. I really felt that a lot of the things he had been through I’ve experienced. Many of the things he said, I remember saying the same kind of things. There was a lot of denial that I have this illness, and why am I here. But the only difference was that this particular client was 56 years old, and he had first had problems with mental illness when he was probably 18 or 19. So he just seemed to be just stuck in this rut, like he had never fully grown up. There were times that I wanted to tell him that I had empathy for him, which I think I did successfully. It was hard to talk to him about it when he would make comments like, “you really don’t know what it’s like” and other similar comments. I knew that there was no way I was going to tell him about my experiences, but at times I wanted to. I just said I understand that you’re going through some hard times, and tried to talk to him about it. When he said comments like that, I wasn’t going to say it, but I was thinking, “I really have been where you’ve been, and I understand it a lot more than you think.”

TS: How did you feel the empathy in the actual session though? Did you experience what you may have called some kind of empathic reaction to what you believe he was feeling?
A: Yeah. I think it resonated, some of the things he said really rang true to me. I understood where he was coming from.

TS: At what stage?

A: When he said that he didn’t really have this illness…over the course of time he went through different phases but at some points he would say, “I’m not sick, I don’t have anything wrong with me. Everyone else here is sick, but I don’t have a problem.” I remember feeling like that myself when I first got diagnosed with bipolar, which I think is fairly common with those with this illness. People who get diagnosed with it tend to deny it at first and not really want to believe that they have a problem. I really don’t have a problem, this is just me. I’ve just gone through some difficult periods but I’m fine.

TS: What about when he was commenting on making excuses and not being able to do things? Like giving up? What were you feeling at that point?

A: When he was talking about giving up?

TS: Yes. You did say before that that’s when you felt put upon. That was sort of your reaction to that. I’m wondering too about…you think there was empathy at that moment too?

A: I think so. Yeah. I think I felt in times in my life I’ve gone through some really difficult periods and I knew what it was like to feel that way. To feel like things are hopeless or that things are not going to get better. That’s what it felt like to me. He was making comments in the session such as “I’m too old to do this”, or get better at music.

TS: So you experienced some of that hopelessness in that moment?

A: Yes. I think so.

TS: Can you talk about, in the midst of this, when you moved on then to making music? What did you notice in the music? Can you describe as best as you can? Describe the music making. What was the music that you made? What was it like?
A: When we transitioned from the initial guitar lesson format, he wanted to do certain songs, so I would learn a few new songs, as well as a songbook that I used for the internship. So we worked on singing and song discussion for some of the sessions. I noticed that the client was very self-conscious, and I identified with this client in this manner. He would say things like, “I’m not really a singer, I love to sing but I’m not really a singer.” And, I’ve played guitar for 25 years, and I just started to sing prior to studying music therapy. I had never really attempted to sing at all before this. If you grow up singing your whole life, that just seems normal to you. If you’ve taken lessons, played in groups, or in ensembles, and so on. But that wasn’t the case for me, so I kind of related to that when he talked about “I can’t really sing, I’d like to sing, and love particular songs.” He was very hesitant at first. I had the lyric sheets for the songs for him, and he would join in here and there. His voice was very low in volume in the beginning.

TS: Do you remember the song you did?

A: I did a couple. One of the ones was a Tom Waits song, called Ol’ 55. We did this song, which he really liked. He said that he had heard the song before. He actually said that the song was “about me.”

TS: What was it about him that you remember that the song connected with for him?

A: He said that it reminded him of different periods of his life, and that it reminded him of...part of the lyric has to do with driving a 55' car. He was talking about different cars he had. He identified with that. He identified with the aspect of the song...I guess there are certain parts of it where it talks about being on the road, watching the sun come up, and so on. There’s also a lyric in the song that goes, “It’s 6 in the morning gave me no warning I had to be on my way.” He related to that when he talked about memories of getting up in the morning to go to work.

TS: How about to you? For you? That song that you did....

A: Yeah, that song has a lot of meaning to me, as well as some of the other ones we did. But that one in particular...it’s just a song I’ve always loved since I heard it. I heard it
years ago, and I’ve always loved Tom Wait’s music- the vocals, the lyrics, the piano playing. And it was a song that I associated with different periods of my life too. Definitively, there was a time that I was in the hospital being treated and someone came in...he wasn’t a music therapist but he came in to play music for the patients. At the time I was uncommunicative and really out of it, I was basically not even talking to my friends and family. I was really in a bad place. This person came in and played that song. I actually asked him if he knew the song, not expecting him to know it. But he knew it and he played it, and that had a huge effect on me. That was kind of one of the things that led me to want to get into music therapy. That song, and the person playing the song could reach me when I was unreachable. Nothing else could really get through to me, but that did.

TS: And how do you feel there was reaching one another in that session in that song? How was it similar or different than what you experienced?

A: You mean just as far as between me and the client?

TS: Yes. You described the person reaching you in that music when you were in the hospital. How was there kind of a reaching one another in this context? How was it similar, different? How would you describe it in the music? As detailed as you can describe.

A: For one thing, in that song he was able to sing along with me. I felt like he really connected to the song’s lyrics, and he had heard the song before. He surprised me. He sang with not a bad sense of pitch or anything...he sounded good. He had heard the melody before, and he had heard me play it in one of the group sing-a-ongs a few weeks prior to this. I think he identified with the song and he really said that “this song is me.” And I could really relate to that. I felt like that song reached him in a certain way, and he seemed really appreciative of that. Which was nice. I felt good that that was the case.

TS: Did you feel like the song reached him...did you also feel that you reached him? What did you feel as far as your connection to him?
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A: I felt that that was probably more of a turning point in me working with him individually at that particular moment because he had gotten more comfortable with me, more comfortable with the setting we were in (the one on one), and he was more comfortable with the song as he had heard it before.

TS: Did you experience connectiveness with him in the music?

A: Yes, I did.

TS: Describe that.

A: I guess I felt connected to him in a lot of ways, namely the bipolar diagnosis, but also because when we were singing we were singing together...we were kind of on the same page. He really enjoyed the song. He enjoyed what it was saying and what it meant to him, and we talked about that meaning a little bit after the song. I didn’t go into detail with him about my own personal connection to the song, but we talked about the meaning according to him. He seemed very pleased with it. It was nice that he liked the way the song sounded, but it was great that he connected to it in a very personal way. This is why this song is important to me. So I felt connected to him. I felt that we ...it was a much better connection than we had established when we first started sessions doing a lesson type format.

TS: Better because?

A: Better because he was more involved and he seemed interested...he seemed....the second session when I went back he really didn’t seem like he wanted to be there, but when we started singing songs and with him throwing out ideas- “Do you know this song?” And if I didn’t know it I would learn it. It got him more involved in the process. He could basically say to me that I could figure out some songs that he liked, and we could play them together. Then we could do a song discussion after that.

TS: So maybe if you could focus in on a moment in that session when you were singing together. You mentioned that part of the reason was you were really on the same page,
you were singing together. Can you describe the feeling of that? The feeling with him in particular. What was it like for you to be singing together with him?

A: It was at times difficult because I didn’t think through some of my ideas for songs sometimes when I was working with people. It might have been initially chosen more for…I thought these songs were great for therapy but I also had a personal connection to them. But that’s not always a good thing, because I had a real strong emotional reaction to the song, and here I am playing that song, and singing it with another person who has been in a similar situation or predicament to my own.

TS: And in that moment?

A: Not only did I understand what it was like for him because I had been in that situation. It just seemed that not only was it helping him but it was helping me as well. It felt that way.

TS: In what way?

A: Just to be able to give something back as far as being able to help other people that are going through difficult times. I just feel that it’s a very positive thing for me to be able to do. Definitely- probably the main reason why I wanted to do music therapy as a profession was to…I believe that intrinsically that music is therapeutic, but I think there’s a lot more to learn about it as far as music therapy as more of a science…but ultimately the thing for me was to give something back and help people like people had helped me in times of crisis…when I was unreachable. So I felt like I was helping him.

TS: By reaching him?

A: Yeah. By reaching him…helping him become more aware of himself, able to be more comfortable with his voice, to express himself, and singing songs with me. Also to help him reminisce about different times in his life, and even talk about his experiences as well.
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TS: Part of this experience is to help to understand your countertransference to this client, and I...you’ve been describing a lot of analysis about what you think is good about it and what you believe in about it. I’m still interested in what it was like to reach this client in singing together. I don’t think I’ve heard that yet. Can you imagine...feel this description of what it was like. Maybe there’s an image, maybe there’s a sensation. Or maybe there wasn’t. Of what it was like for this powerful song for you. Connecting with him in that song.

A: I just felt that it was very rewarding for me. I felt like we ...

TS: Rewarding how?

A: It was rewarding in that I could see the positive impact that the music and song were having on him. He was opening up a little more...He was...

TS: Before the impact. Something happened and then there was the impact. What was it that was happening?

A: I guess we were just in the same space together, in the same place...

TS: Hang onto that for just a second. Being in the same space. And sit with that. And really imagine it. Right? Senses and memory. What was that like? Being in that same space?

A: It felt like that was the first time therapeutically with me and this client...that was the first time that we connected like that, whether in individual therapy or a larger group. I don’t think we connected until that particular song, that session.

TS: And what did the connection feel like?

A: It felt great.

TS: Stick with the feeling of the greatness of it. And maybe there’s a descriptor.
A: It’s kind of like what was talked about in the Yalom books about the here and now. It felt like that was the first time we were together in the same moment. Like I had said, on the same page...

TS: But people can feel differently when they are together. It could feel awkward, it could feel warm, it could feel close...there could be all kinds of ways of describing what that’s like, and that’s where the countertransference is and that was the question I’m posing. You’re answering about the analytics of the therapy, but I’m still interested in your experience. Not your reflections upon it or analysis before the experience.

TS: It did feel a certain way.

A: I felt more of a connection to another person, unspoken basically through the music. It was definitely different for me because this client didn’t know my history or anything like that, so ....Who knows? Maybe he didn’t feel that we were connected but it seemed to me that we had a lot to talk about concerning the song, and experiences brought up as a result of it. So in that moment we were just ...

TS: You don’t have to necessarily talk about the therapeutic benefit, or why you thought it was good. How did you feel it was good? What was the feel, or the sense, or the imagery? The quality of that? With this particular person? And that particular music?

A: I just got a sense that he was moved.

TS: Did you feel that too?

A: I felt that. Yeah.

TS: Was there a place in your body? The location of that? Feeling moved?

A: Truthfully, it kind of felt like a big release. In those moments it didn’t seem like it was so difficult. Like the beginning ones were. At that point it seemed like we’re both here together and this is working, and we both seemed to be enjoying the process. I also felt
relieved in a certain way, and I also felt a release...like this is where you want to get, this is the goal of therapy. It felt great. It really felt amazing.

TS: In that moment that felt good, and as the session was moving towards closure...could you describe the rest of that? What it did from there? How you parted that day, or how you ended that day?

A: I think that it's difficult because so many of the sessions seem to run together.

TS: To the best of your memory.

A: I think that was the last song we had done. We had talked about it, and we were kind of moving in another direction. It got to a point...as far as finishing that session, we just talked a lot about his experiences. He told me about me growing up, he told me about experiences that he had. He talked about times when he would get up and go to work in the morning...just simple things and stuff that he remembered and really held on to. He said the song reminded him of when he was younger. He had spent some time living in Arizona, so he was remembering different people from that time of his life. Memories and things that were coming back to him. We discussed that, and I ended up actually doing a fill-in-the-blank for that song. I felt like that was the next transition as far as the therapy went. We went from the singing and song discussion and then did fill-in-the-blank because he seemed so connected to that song. Already, he was saying that this song was about him. So I felt that I could really work with that. That's what we did later, and it went over really well. I don't think he had ever done anything like that ever before. It was pretty amazing. I just had certain parts of the song that I just left off at the end, or sometimes the first phrase of a line...He really took to it, and was able to come up with some things that rhymed well, and was able to come up with really personal statements within the context of the song. So I felt that that was kind of the next step that made it more personalized, a song that was already very personal to him that he kind of connected with.
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TS: So it was kind of like a personalizing process. Is there anything you could possibly say about how you felt relative to him in terms of roles? Did you feel like you had a particular role that would have mirrored some other role in his life, maybe a family member or some other significant person? Did you have the sense that you were...again try to think of this particular encounter...rather than generally. Were you aware of if you were feeling a particular role more than one?

A: I felt like I was more of a ...sometimes I felt that it was more of a parental role..

TS: You being his parent?

A: Yes. I felt like he was kind of looking up to me, and making weird...not weird comments but he would say things like sometimes “you really sound good on the guitar” and “I really like your voice” and stuff like that. But he got over that. He was able to later really be like “this is my voice and I’m going to sing and there’s nothing wrong with it.”

TS: So by this particular session, he was more in that independent place

A: Yeah, but he still seemed to be kind of looking up to me. That whole relationship felt very weird to me in a lot of different ways sometimes because I didn’t feel comfortable in that role, and I felt like...Here this guy is 56 years old and he’s treating me like I’m a parental figure. It just kind of felt awkward to me. And with that particular client, he had issues with his father who had died when the client was 16. His father was a Marine, and that’s why he went in the Marines- because his dad was in it and he wanted to live up to his dad’s expectations of him. But his dad was already dead by the time he enlisted. It was really difficult for me because I felt that he was a...I don’t know if there’s a term for this or anything but it really felt like he was 56 but he was really stuck in the place that he was when he first was 18 or 19 and he first had an illness, or psychiatric breakdown.

TS: Fixated, maybe?

A: I don’t even know if it was fixated, it just seemed like he was stuck in that same spot. And you would think that...you know this was a 56 year old person, but it didn’t feel like
that because his main...and I felt bad for him..I did feel bad for him at times because he really wanted the simplest ...what most people consider to be the simplest things. I want my own apartment...I want a job...I would like to have a girlfriend and maybe one day marry. I guess most people kind of take those things for granted, but this guy had never had any of those things. He never had any stability. There were a lot of transference and countertransference issues that were happening, just because of situations like that. Does that make sense?

TS: Sure. If that’s what you were experiencing. So there was an awkwardness to being in that role. And it sounds like...I wonder if there’s a relationship to what you said in the beginning. Of being put upon? And being put in the parental role. That was awkward. His father was gone. Not there for him.

A: It very much hit home for me because I feel like things like that as far as psychiatric illnesses go, for the people that deal with that...if they don’t have a support system...you know...it can go either way. You could end up like that 56 year old guy in the hospital that’s been dealing with this for his whole life...and he just didn’t have proper support. I mean, that’s not the only reason, he also made some poor choices. But I felt like it really hit home for me because it felt like...had my situation been different could I have been in his situation?

TS: And you now have a family of your own?

A: Yes, I’m married. I don’t have any kids yet but....

TS: And working on a Master’s degree. Yeah, that’s an interesting juxtaposition. Anything else to add about the experience that you think is important or significant, either in the music, or just as far as reactions to him?

A: I think that this particular session was the turning point, and he reacted very well to everything that was done in the session. I felt like this was when we started to build a good relationship in the individual sessions, and it made a difference in the group sessions that he came to as well. He was initially very hesitant to sit through them. He
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would go to a session, sit down, and just as the session started he would say that he couldn’t stay and walk out. He got better over the 6 months that I was there. He was able to play a percussion instrument without saying that he didn’t know what he was doing, or that he couldn’t “make anything happen” musically. So I think that he got a lot better over the course of the time that I was working with him, and I think it made him... because he had a good relationship with my supervisor and he also knew me, he would be more apt to come to the sessions... and in the beginning it wasn’t like that. He definitely... more times than not he would leave, and just not want to take part in it at all. So basically this was the real turning point.

TS: Through the connection in the song, and through the...

A: The verbal dialogue. The discussion that happened after it, and it led the way to the next couple sessions. A couple of things we would do differently and... had it been longer... I wished I could have been there a little longer, because I didn’t get a chance to do... after he had done the Waits song and the fill-in-the-blank activity, he surprised me. He said, “maybe I can write my own song.” But that was right at the end... or about a week before I was leaving. It would have been nice to do that. To get a recording... have him write a song, record it, and give the recording to him to keep. But the timing wasn’t right for that.

TS: You wished you could have been there longer?

A: Yeah. Yes I think so.

TS: Good. That sounds good to me.

TS: I hope that it was helpful especially when I was really being persistent and not letting go. The question of what it was like phenomenologically. Not just what you thought about it. This was a good moment because... no no but what was it like? Well it was important because... no... value judgments, reflections, analysis, those are fine, but what you really want to get at is... OK, what was it like? Images, metaphors, adjectives, adjective descriptors of what that quality of experience is.
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Original interview transcript-Participant B

PI- Principle Investigator

B- Participant B

PI: What I want to start with is just basically, if you have in mind any particular client or session that you remember that made an impact on you. If you could remember a little bit about the setting, and give a context for that just to start.

Participant B: Does it need to be a session where I am experiencing where I can recall a specific countertransference?

PI: It doesn’t have to be. It could be. That’s part of what I’m going to get to. Like maybe a particular client you worked with or maybe a little background about the age or diagnosis that they had just to kind of ...

B: Right. Sorry, I’m trying to think of a specific example..

PI: That’s fine. And it could be where you were feeling some countertransference..

B: Yeah. I’m thinking of a client that... he is in his mid to late 60’s. He is Hispanic. His name is S. And he is living where I have been working. He has been living in a nursing home in a long term care setting and he suffered a stroke about 2 years ago and as a result of the stroke he’s paralyzed on the left side of his body. Cognitively he’s intact. His main physical limitations are... you know feeling on the left side and the weakness. So I see him individually once a week and...

PI: Is this from a practicum setting or...

B: This is where I’ve been working. Yeah I’ve been working with him about a year and a half actually. And he sometimes comes to groups but the primary reason for working with him was that he isolates himself and he has a really hard time engaging with other people, especially with other people living there that are quite severely impaired.

PI: Right, so just socially in those settings he’s having trouble.
B: Right, And he also has a history of really having trouble relating to people, and just in any relationship. So for him to work with me and for me to work with him it's been a challenge. Especially for me. I don't know if he would say that but for me it's been a really big challenge. And the premise of our work is just allowing him to engage in music experiences. He's not someone that.. he has a lot of defenses so he's not someone that wants to talk about his feelings too much or.. explore it. But he is getting to a point now where he is starting to talk about stuff and he's starting to experience music and really work more collaboratively with me. But it's been a big struggle.

PI: And do you think that's just because.. one of the reasons is just in personally relating to each other?

B: Yeah, I think there's a lot of things that play. He's extremely resistant and I get really frustrated working with clients that exhibit a lot of resistance. He projects a lot and there's a lot of transference on his part. He sees me a very high figure, and you know—he thinks I don't do anything wrong. Things like that. I feel very pressured as a result of that. That's part of.. I guess my countertransference in trying to please him. I'm trying to appease him and figure out what it is that this person needs. So do you want me to think of a specific session?

PI: Yeah, a specific session and what was going on at that point for you.

B: Well, this is a... I don't know if it's a good example but I share it and if you want me to think of something else I have another thing in mind. But this is a recent session, so that's why it's kind of fresh. I decided to change things up a little bit working with him. In the past, we had done a lot of music listening, a lot of song listening, and some discussion. And then I had kind of over time try to invite him into making music together. And that's where a lot of resistance came into play. So I decided to try and take a little break from that because he was projecting like crazy and I was getting frustrated so I said let me..
PI: I just wanted to ask too...what was his...you said he was in a home, he was 60 or so, and he suffered from a stroke. Did he have any other...any psychiatric issues?

B: Yes. Sorry, let me give you more background information. So he reports to have a history of using cocaine for 30 years. However, he denies that he was addicted to it. However, he was using coke at the time of his stroke, so there’s a correlation with that. However, he’s completely does not see that that could relate to that. He has a diagnosis of depression. He actually stayed...and the depression was diagnosed I believe upon admission. Upon him being evaluated...

PI: After the stroke.

B: Right. And actually the past session...yeah the past session he said “I felt depressed yesterday” which was kind of..you know remarkable for him to even say that. And it manifests by him isolating himself, having confrontations with staff, and just things like that. That’s pretty much the only background other than...

PI: Yeah, I just wanted to ask about that. Could you think of a particular session where you felt the countertransference. If you can think of a particular session or just in general working with him how..a certain example of when you’re feeling a certain way countertransference wise and what that was like. You know..it could be metaphorically, it could be images you had, it could be reactions to things that he said or did.

B: OK. So a couple...maybe about a month ago or so when I was encouraging him to engage in live music, I came in with a structured musical idea of blues. He’s expressed interest in learning the keyboard. Needless to say, we’ve attempted and he gets frustrated and he’s very critical of himself. So anyway, I brought in...you know..the parameters of the musical structure of the blues, and I gave him a keyboard and he lays in bed and he props himself up. And we put the keyboard on one of those trays so he could reach it. And he only has use of the right hand. So I coded..I used color stickers just to outline the blues scale and I just..the only quote unquote rules I gave him was just you know..we were going to keep it in the blues. You can play any note that’s colored. You can play
them however you want, when you want them, kind of giving him a free range of that. He agreed, and I was on the guitar and I can’t remember who started first. I kept a very steady beat, structured..trying to keep the rhythmic structure so that he could feel invited to come in as he wishes. And when he did play, we weren’t together. We weren’t musically in synch. I felt that he wasn’t listening to me, and he was kind of all over the place. And he began playing outside of the blues scale..

PI: Outside the notes that you had set aside?

B: Yeah. So I let it go. You know, we kept going. However, as he..when I began ..I began humming or singing, but no words. That’s when I remember him speaking and him interjecting and saying “what are we doing? I don’t know why we’re doing this” and just sort of kind of questioning . I kept going and I said “just keep going.” He kept going, but to me it just felt like he was playing just to kind of appease me or just you know “OK, well whatever.”

PI: And he still was at that point just playing what he wanted to?

B: Yeah. I kind of felt like the whole improvisation that..for me I felt very disconnected from him and that he...possibly frustrated or you know...possibly now that I’m thinking back about it., anxious that you know “what do I do? How do I do this?”

PI: What is the next step? Where do I go from here?

B: Right. Exactly.

PI: So I mean..you said you felt disconnected from him. Were there any feelings going on with you as far as ..even like body wise...Were you feeling anxious?

B: Yeah, I definitely....I was feeling frustrated during the music making because I was trying to provide an opportunity for him to try to really connect, but it wasn’t happening. At times I did change my rhythm. I tried to match him, and nothing was being effective in what I was trying to do.
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PI: You feel like musically you just weren’t connecting at that point in the session?

B: Correct. And I began feeling anxious when he began speaking, because then I felt that he was kind of judging ..not judging me but...

PI: Questioning the whole..

B: Exactly, like questioning me. After the improvisation, he spoke in great detail. He shared his opinion very emphatically about ..you know..I guess how he felt about it, though he was very passive aggressive about it. He immediately questioned why I brought this in, you know…and wanted to know what I expected. ..what I was expecting him to do. I remember having a lot of anxiety, and in general I have a lot of anxiety when he begins speaking. Almost at me, that’s kind of how I perceive it. I don’t feel like he’s talking..

PI: To you...

B: Yeah, it’s kind of like an attack type of thing. The tone of his voice changes, and becomes a little harsh..

PI: So you felt a little bit defensive?

B : Yeah

PI: Kind of like..

B: Right, right. And I caught myself. I was very aware that I was trying to defend it at first. Well, you know..I came in here with this musical idea. I thought we could try it out and I thought I clearly explained quote unquote why I brought this in but he kept pushing..you know..But why? You know..he repeats himself. He has a habit of that. I guess when the answers not satisfying that he kind of perseverates on it. So he kept wanting to find out…I don’t really recall how this all ended, but I guess just staying with that moment I ..it’s just struggling. How to respond. Especially verbally. Because we’re trained musically and..you know..that’s a big anxiety for me is using verbal skills.
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PI: Sure. Because...A lot of times in this kind of field you make plans for something, but you can't make plans for what someone's going to say, and this could change the whole course of the conversation and the actual session, so..

B: Right.

PI: That makes sense

B: Yeah.

PI: When you felt disconnected from him in the session..when you were saying before...in some way, could you relate to him? About some of the things..his approaches to things , or not really? Were you kind of like...

B: You mean in that particular moment? I don't think so. And in part because I really wasn't sure what it is he was really experiencing. I guess a lot of it was my kind of transference and his transference and I guess trying to interpret and understand it. But moving forward with him, I've developed a lot more empathy for him. Which is generally not a hard thing for me, but with this particular client it's been really hard to have an immense amount of empathy. Because he's very defensive. So..you know...thinking about that session, I didn't really see it from his point of view..from his perspective. Again, he didn't state all this, just imagining what he could have been feeling. You know..he could have felt threatened, he could of felt exposed..you know..we hadn't really done a lot of music making and now I'm coming in with this invitation, which to me seems very structured. But on the other hand, maybe for him it was very frightening. So yeah, I don't think I was able to relate or really..you know..

PI: But you had empathy for him?

B: Later on I felt it. Yeah..in that particular moment I can't say that I really did. I think I was more caught up in trying to listen and get musically connected with him. And trying to keep adapting musically. To the rhythm, or timbre..different elements to try to connect with him.
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PI: And this client, it just felt more difficult to connect with him than some of your other clients?

B: Definitely.

PI: It wasn’t an easy process to work with him?

B: Yeah. He’s definitely a client that I think about when I’m not at work. Like not..you know ..but...The sessions kind of replay, so that ‘s why I think he’s a good example to share because it is someone I have a lot of countertransference towards. I find it exciting to work with him but also really really challenging.

PI: Do you think in his transference to you he treats you like you’re an authority figure or a parental figure? That kind of transference sometimes or not really?

B: Yeah. I thought about this and sometimes I felt that he treats me ..or sees me not as someone that he even can really relate to. That I’m almost.. I don’t want to say an object but someone who is kind of like an..

PI: An enigma, or something.

B: Yeah. Kind of. And there’s been other examples..things that he’s stated. A lot of projection about him idolizing me or putting me on a pedestal. So there could be some possible transference there. There’s also been a lot of him testing the relationship and what the relationship is. In the sense of therapeutic relationship, friendship, romantic...so there’s been a lot of testing by him, and challenging me about that.

PI: What did that feel like for you?

B: That’s very uncomfortable. Especially more about the romantic comments, because I had to be very clear with the boundaries, and once I did it’s been better. But he’s definitely...he’ll make comments about the way I look, or my hair...different things like that.
PI: I’m just curious- you don’t have to answer this if you don’t want to..I’m just curious..my own experience..I’m bipolar. I’ve lived with it for a long time. I had some very interesting experiences in my internship. I was working in a VA hospital where there were..I worked with a client that was bipolar one on one. So I’m just wondering..and you don’t have to say anything about your illness or anything you don’t want to say..I’m just wondering how you think ..with this guy having depression..if that had an influence on the way you worked with him and on the countertransference..and if so, in what way did that.....Because I found that really difficult. I had a lot of supervision time spent on this one client, because it was very close to home.

B: Yeah. Right when there’s somebody..I can understand that.

B: I don’t know if I think a lot about him more because of the mental illness, but I’m sure that’s a part of it. I suffer from periods of depression and more so generalized anxiety. That’s been my longstanding thing that I’ve really struggled with. So that has really impacted my work with him, to the point of me obviously persevering about it and replaying it (the session). Yeah. It’s been a real challenge. And I wonder if he kind of picks up on that now and if he sort of manipulates that in a way...by kind of going at me with all these questions and..

PI: Sometimes clients can almost be too perceptive sometimes ..If there’s one little thing they’ll hone in on it..

B: Right. They see something that kind of ticks you off, and they might keep going at it. The depression component..It’s interesting now that I’m talking about it. The depression component of him being isolated and not getting out of bed. That I feel very related to, very connected to..and have an immense amount of empathy and understanding of that. But I don’t find myself focusing..I find for myself it’s more the anxiety..my anxiety issues really impacting on the way I run the session, the way I facilitate it. When I leave I feel anxious. There’s a lot of..I get a lot of somatic symptoms. My stomach gets upset, I get sweaty...
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PI: So that could happen sometimes working with this client?

B: Oh, yeah. Again, especially when he’s talking. So there’s that specific element of him talking that gets me kind of stirred up. More than the music.

B: I was just thinking..The depression..I have a..I don’t know if it’s a habit or what..of picking up on people’s energy, and people’s mood....things like that. And I’m very sensitive to it. If I go into the room...first of all, every time I enter his room the lights are off, the curtains are drawn, and the covers are over his head. So you’re kind of walking into a ...

PI: A very depressed scene.

B: Right. So I need to be really mindful of how I’m feeling before I go in because if I’m OK and then I go in....and then in the middle of it I feel depressed then I know, “OK that’s...I’m picking up on his stuff.” But if I’m kind of going in feeling blah and feeling down...which has happened and it’s that much more challenging...of course you know..to be present and to have more energy...

PI: Sometimes a lot of the clients that are most difficult.. I can relate to that. I had clients that I dreaded. Walking into the room to be with them, it was like..I had to take a deep breath to get ready for this.

B: Yeah. I have another client that I feel like that about. With him it’s..I usually look forward to working with him, but I get..I used to get really ..I’d be OK, then once I got in I’d get anxious...And I go...where do I start? But now I think that since we’ve been working together for a while, I’m more relaxed about it. Because I know the environment I’m walking into...I can kind of anticipate it, and ..There’s been sessions where there’s just a lot of silence. And there’s no music, and no talking...and we sit in silence and..

PI: It could be really awkward.

B: It could be awkward and it could be hard
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PI: Maybe sometimes that’s what they need.

B: Yeah. I think it’s actually been very valuable for him. Just having somebody sit with you. Hopefully pretty helpful. Especially when you feel so alone. Just another human being being with you and they don’t want you to say anything

PI: That’s pretty powerfully to feel with a client.

B: Yeah. And also..I think being mindful ..and I’ve actually removed some of my schedule because I was seeing him....I was seeing 3 clients in the afternoon on Fridays and all of them have depression. All 3. So this is 3 hours of bam bam bam. And he was in the middle of them. ..in the middle of these two other clients so..

PI: This was the guy with the stroke...

B: Yeah. I moved the other two clients to another day because I felt just the heaviness of all this depression between all of them, and if I’m going in having a really bad week, or a really bad month. To kind of...protect myself in a way. You know- to take care of myself so that I could really be attuned to them. So that’s been helpful. Kind of reworking my schedule.

PI: To be a therapist, self care is really important.

B: Right. Definitely.

PI: And I think more so with anyone with any kind of psychiatric illness, or challenge..where maybe they’re dealing with more than the average person deals with.

B: Yeah. And it can be very draining. And like you said before, especially when it’s things that really hit home for you, and hit home for myself..In part I was thinking, “ well I understand it so it will be easier.” But actually no. It’s that much harder.

PI: But in a certain way, it gives you an advantage because ..as far as other people may not have the same level of empathy.
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B: Right. Yeah. There’s a certain level of understanding…and you just get it.

PI: You can say “I’ve been there, I understand what that’s like.” From a more personal perspective and not just..I read the DSM. You know?

B: Right. I’ve read about those things. And I’ve actually disclosed to him. Not in great detail, but just that I’ve had periods of feeling really low. I’ve found that to be really helpful for him kind of opening up a little more. And that’s been a recent..probably in the last couple of weeks

PI: So you felt that really helped the relationship?

B: I did. I really did. And it was kind of a big risk I thought to take. I was having a… I was trying to just think of different ways to connect with him and let him know that I’m really hearing him. I didn’t get the impression that he thought I was hearing him, because he has a lot of abandonment stuff and constantly thinks I’m going to leave. If I’m 10 minutes late or..He goes to the extreme, you know? But he’s defensive. Like, “Oh, that’s OK if you don’t come. But you usually come on Saturdays.” So there’s…

PI: Sometimes passive aggressive..

B: Right. Very passive aggressive.

PI: What was that experience like, though..not to go into great detail…but to disclose to a patient? Something so personal?

B: I actually…I felt pretty safe. I felt pretty comfortable. I can’t say I’ve done it a lot, or that I have made a habit of it. But I just felt that for him in our relationship and..where he’s at that it might be a bit of help to him. I think that I was afraid that he was going to probe, and that he was going to question and want to know more. That would have caused a lot more anxiety, but he didn’t actually. He didn’t even inquire, but he was very present when I said that. He was sitting up more. I hadn’t even planned to disclose it, but it just kind of happened in the moment. I had been talking about some superficial stuff before I disclosed that..like I had the guitar and I was telling him “This is my guitar, and
I learned this new chord..” Just kind of to get the session going, because it can get really tense. You know? In the beginning. He’s not the type of client that you walk in and he like immediately wants to engage. He waits for you to basically start it and to tell me what to do..so there’s a lot of..Again, there’s a lot of transference with him. And we just started having this conversation back and forth about the guitar and he was asking questions about the guitar..and then he said out of nowhere, “I felt depressed yesterday.” And we talked a little bit about that and I said, “ yeah, I sometimes have really low moments..you know..and that we all do and I just kind of generalized that it’s OK..

PI: Were you even surprised that he said that?

B: I was very surprised. He has..First of all, he has never used words “I feel “ or “I felt” so just that statement alone was kind of like astounding. I tried very hard not to get excited. It just was like, “that’s great!” Not great that you felt depressed, but great that you could state that. And he didn’t go into it, he just ...He didn’t elaborate, but he gave a little information about it..And then I said, “well do you feel depressed today” and he said no. So he was able to kind of distinguish a little bit I guess...his feelings and the severity of them.

PI: was there anything else about working with him, or that particular experience that you could talk about as far as certain feelings that came up for you, or again with the ..I mean..you’ve talked about some things already, with the countertransference and transference. Just what was the experience like. If there are any images that came to mind..If the session at times felt really heavy..

B: Yeah

PI: Like it was so dark that at certain times it was difficult to get through it. I’ve experienced that with some of my clients that I’ve worked with. Really difficult to be able to separate him and me. ..

B: Right.
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PI: It goes back to what you were talking about... before going into the session. Really checking in with yourself to know how you’re feeling...

B: Yes.

PI: ..before you go in because you’re coming into a situation where somebody is really depressed and it can immediately affect almost anyone.

B: Yeah...

PI: Because you notice..It’s just present sometimes when you just walk into someone’s room.

B: Definitely. And even the time of day. I tend to see him later in the day. So I’ve been kind of attuned to that. You’re more tired at the end of the day naturally..I see him at the end of the week. That’s part of the reason why I move some of the other clients around because after I see him, I have about another hour before I need to leave. So that hour could be interacting with other staff. There’s kind of a little environment before I go home..so I don’t know if I do it consciously I guess, but it helps. It helps kind of to leave what happened for there for there and when I go back next week we can revisit it....I think the whole..I go in there with the blues idea and I feel it got shot down...that he didn’t latch onto it..And, again..this is all my stuff. This is all me feeling rejected.

PI: So you felt like when he wasn’t following what you were telling him...you felt he was just saying “I’ll do what I want. I don’t want to listen to you.”

B: Yeah, very defiant. Especially again, when there’s this whole verbal thing. He interjected, and at the end was questioning me. I felt very defensive. I feel like I had to explain myself and prove myself. Instead of just...I think I even said to him, “It is what it is.” Why do we have to analyze it? But yeah..feeling really rejected that he didn’t see that...and again this is all my crap, but he didn’t see that I came up with this idea and..Just hearing myself say that it sounds kind of selfish but....I realize that it’s my own kind of transference and that that’s kicking up.
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PI: So there’s a need to feel appreciated by him? Or there’s a need to feel like you’re giving him a valid opportunity to explore in music...

B: Yeah. I think there’s a need to . . . It’s interesting. There’s a need for me—I guess to feel heard, and to feel validated. And it’s interesting because I think those are the same needs that he has never had met. So it’s really interesting. And, you know . . . I’ve been in therapy a long time and I’m pretty aware of where this stuff comes from . . . with my mom, and that she kind of dismissed a lot of things growing up and there was a lot of pressure to succeed and to do really really well academically. So I know that that’s pretty much the source of the countertransference. It’s probably related to my mom. So just feeling . . . yeah, trying to get validation from people..

PI: And, I’m just curious too . . . With him, you said he’s never had that. He has told you that, or just from basically some of the things that he said?

B: From things that he said and from . . . i guess my interpretation. He grew up in . . . he had a very unstable childhood. He was born in Puerto Rico, and his mom. . . . When he was 5, she sent him to his grandmother’s house in New York City. And then when his parents later came to New York, he went back to live with them. He was pre-teen, something like that. He describes his mother as crazy and his father as a drunk. He associates anger with violence. He reports to having a history of being physically abused, and he has said that he doesn’t . . . cause I remember talking about love one day, and how he doesn’t know what that is.

PI: That’s interesting, because I’m just wondering about . . . I had a very similar situation with a client. I’m kind of getting off topic, but just to . . . he was 56 years old and he had never had a girlfriend. He had been in the hospital since he was 18 or 19, off and on . . . never had a girlfriend. . . . to speak of. He couldn’t hold jobs, and he was in and out of the hospital and lived with his mom when he wasn’t in the hospital. It was very difficult because he always used to talk to me about “I want . . . you know, very simple things. I want to have my own apartment, I want to have a job, maybe meet someone I care for and marry. Just to have his own life. A lot of people tend to take that for granted. That
was difficult for me because I had been through very similar experiences to his. Dealing with medications and hospitals...going off medication.. all that stuff. So, I went through all that... but then I ended up going back to school. I'm finishing up my Masters, I'm doing my thesis..... I got married... So you're looking at someone else and this person is like... Also, he treated me like I was a parental figure and he's like 20 years older than me. So it was difficult for me to sometimes look at that, because here was this guy who didn't have anything... and I kind of looked at him through a different lens, and I was like... that could be me. He just didn't have any family support. I mean... he also made a lot of poor choices. For me, that was really difficult to look at and not think "that could have been me."

B: That could have been you... and knowing where you are now, which is so different.

PI: Sorry, I'm on a tangent...

B: No, that relates to S. in that he doesn't really have a lot of support. He has 3 children..

PI: His wife was not around?

B: She had passed away. He sometimes referred to her as his wife... and sometimes he said that we were never married so I'm really not sure of the whole story. He had a lot of remorse about her death, and he felt that he wasn't there because he was selling drugs, and doing all sorts of other things. He had stated that he wishes that she was here because he knows how it feels to be sick. To feel this useless way... because apparently she had been sick with cancer for years and years. He has the option to actually go to his house. However, he would need 24 hour care. He doesn't want to try to ask his son. That would be a heavy burden for the son. And there was that one session we talked about... and we were talking about our relationship and how we have to terminate. And what would that be like, and... he didn't really... he wasn't open to that, but I just thought I would put it out there. That that would be something that would have to happen. It's interesting to think about the layers of someone's life.

PI: Is there anything else that you want to add, any other thoughts, or...
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B: I can’t think of any. Do you have any other questions?

PI: No, I think that this is a lot of information to work with.

Original interview transcript-Participant C

PI- Principle Investigator
C- Participant C

PI: If you have something… anything in mind where you remember a certain client, if you remember the setting, what the population was, the music involved, how you felt during that session….it could be any client…

Participant C: I was thinking you were going to start talking about bipolar…

PI: We’ll let it unfold as the interview goes on..It could be related to..I’m bipolar and have had experiences working with bipolar clients, obviously in my internship. I’ve had a lot of experience because I was working in a VA hospital with adults- though there were older and younger clients that had bipolar disorder..so for me..that was my experience. But it doesn’t necessarily have to be an adult psych population, it could be a younger population but with a diagnosis or even without. It could be about how bipolar might have factored into the transference and countertransference that you experienced with a client. Does that make sense?

C: I’m trying to think…it was so long ago when I did. I haven’t worked in adult….I guess some of the kids were diagnosed with bipolar ..that I worked with.

PI: Was there something from that that you remember? Where you could remember the setting, or the particular client, age group..and how that was affected?

C: I guess I’m trying to think if.. are you looking for how..if I watched how they were acting..how I feel about it or something?

PI: That could be part of it. Sure.
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PI: It could be in general, just talking about a particular session...what you seem to remember from it.

C: I guess zeroing in on one client is what’s helpful.

PI: It’s difficult to zero in on one client?

C: Yeah, I guess.

PI: Could you think in general though? Working with the population...children with bipolar.

C: With behavior disorders in general?

PI: Yeah, you mentioned before that some of them were. As much as you can remember...it doesn’t have to be exactly...as long as you can get a picture in your mind of what...

C: Do they have to be bipolar though?

PI: No. They don’t have to be bipolar. They could have other diagnosis, or...it doesn’t have to be both you and the client having the same illness. It could be them having something else, or not even having a psychiatric illness at all. How was your work impacted from your personal experiences with mental illness?

C: I guess some of the kids with behavior disorders I think...cause they could get angry. That’s more of a oppositional defiant disorder...or some of the kids with autism..and they would act out for no apparent reason...and so you could always kind of think, “What did I do” or something. Was it something I did?

PI: That kind of set them off or made them act out.

C: Right. One of the kids...he had major anger issues where sometimes he would be really...what I thought seemed manic to me...like he’d be jumpy and laughing a lot and stuff. But he was definitely autistic also.
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PI: What was the other thing you said? Oppositional...

C: Defiant disorder. That's just a lot of anger, but they think it's because it's more about ... just say no to authority figures and it's like an antisocial disorder. Not wanting to obey authority... not wanting to do what's .. you know.. if you say black they say white. Just saying no just to say no. But then that was almost like countertransference. I've often thought that no matter what I do these kids are going to be upset.. you know.. and go off anyway.

PI: Did you find yourself thinking in cases like that maybe if you had done something differently that maybe they wouldn't have acted out?

C: Yeah, something like that.

PI: What was your reaction when they would act like that? What were you going through at that time? In a session if they would act out like that. What were you feeling? What kinds of things were going on?

C: Some of them could get violent. The one I keep thinking of would get... he had to be restrained and a lot of times he’d have... what's it called.. CPI... I can’t remember what the initials stand for. It’s where they’ll try to gently restrain him if he’s... like one time he threw a shoe at me. It wasn’t at me, but he just threw his shoe and I was trying to continue with the session. I guess it’s kind of like trying to remain calm or look like you’re remaining calm even if you’re scared that the kid is trying to go at you. Because he’s been known to hit people and he was a really big kid.

PI: So you felt a little bit threatened by their presence.. They were unpredictable and they were going to... you never knew what they were going to do.

C: Right.

PI: And you said that some of these kids were autistic and some of them had psychiatric... some of them were bipolar?
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C: Yeah, like it was more...There was another one who was bipolar and he was very...sometimes he would come in and be very hyper, and I would try to...that’s actually where I would try to use...this is a different kid I’m talking about. He was younger, and he would be very hyper and would never want to sit down.

PI: What age?

C: This one was maybe.....nine. So they start to diagnose really young with that sometimes. So I would try to do that..meeting them where they are in the music, so I’d play a dance song and then try to calm him down. Maybe do a drum circle, but try to bring the beats slower. And they were also telling me- his mom doesn’t..something about...I forget the reason she gave, but she wouldn’t give him his medication all the time. So you could tell the days he didn’t have his medication because he would be not only hyper but he would also be really angry and really..like intense and not calm at all. Sometimes we would dance. I’d do a few dances to really try to get his energy out. Or do a lot of drumming..something like that.

PI: When he was really angry and tense like that, were you..how did you react to that as far as...did you have any images that you had, or bodily sensations?

C: I guess he’s one of the one’s I thought of when ...A lot of the staff were trying to be active in getting the mother to give him his medication. Was because I thought...especially when you could have that agitated mania where you could have a lot of energy and maybe he wasn’t sleeping at night or something. So that could be why he would be..he would be kind of like a different kid. He’s usually very friendly and usually like “Oh, I love music. Let’s do a dance. I want to do this.” And sometimes his personality would be like more angry or snappy back at people instead of more calm. More like he’s kind of agitated, I guess is the word. And he would be depressed sometimes too. He would just say sad things about ..morbid kinds of things about..like “it’s not worth it to do that” or something that 9 year olds usually don’t say.

PI: And how did you react to that when he would say these negative things, or...
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C: Just like “Oh, that doesn’t sound like you” or “I hope you have a better day. You’re always great in music” or just positive things about him doing music. He’s a great dancer, and stuff like that.

PI: Now you’re kind of talking about how you would react to him..what things you would say back to him, but how did it feel?

C: I felt..I kind of understood what he was going through. That things would seem...no matter what people said it didn’t seem like it was going to get any better. When he was not having a good day and didn’t want to be there. And sometimes he would miss school a couple of days in a row, and a lot of times.. what I was thinking was..you know I wasn’t at his house, but it reminded me if..especially when the mania would turn to depression and you’re up for a couple of days..part of the reason you need to crash is because you need to sleep and then you’re depressed because you were just in bed or something. So maybe he was in bed and needed to stay home to sleep. They would mess around with the medication. And I always kind of struggled with..it’s funny I don’t know if I told you this but one of the times I relapsed I was in school . I had just started grad school, actually. That was in 2001, that was within the first year I started school. So I had to miss.. I can’t remember if it was a week, or two weeks of school. So I think when I applied for my internship...I can’t remember..you know when the forms say what medications you’re taking. I felt like I wasn’t sure if I should write that I was on lithium or whatever..You know, because some places might discriminate against hiring you if you are bipolar. I just think that’s funny....years ago I felt like that and I still don’t write that down, though. If they ask what medications you take, I don’t write it down. If people say it’s for heart medication...and I think it’s just if like...It’s not like it’s an emergency medication that someone will need to give to you if you have a heart condition or something like that. Anyway, I got off track. But there was a reason I was telling you this. Oh ...because I was thinking at school , the staff would talk about it. And sometimes I’d be tempted to say “Yeah, he really should take his medication. I know because..” You know, when I didn’t take my medication, in the months I got stabilized on my medication, it was 2001
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or something...was the last time I was unstable and I’ve been taking it ever since. I don’t know if that would help the mother..

PI: So you felt you wanted to..in a way, you thought it might help for you to disclose information, but at the same time you’re wanting to protect...you didn’t want to have to say “I know this because I have bipolar..

C: Right. And then it’s interesting..actually this is a good thing..I was thinking about this. It’s funny, you’d think that in working in a school where they deal with all this kind of stuff that wouldn’t be a big deal...but if they find out that one of their teachers is bipolar then you think that they might look at you differently.

PI: There is such a stigma attached to it, and if you feel if you are working with that population of clients, it’s almost like you want to have a separation between you and them. If you tell your employers that you have an illness, it just feels like there’s no separation between you and the client. It feels like they will kind of lump you into the same category. I actually disclosed to my practicum and supervisor for my internship. When I was working in adult psych...it was very real to me. It was a short term care facility for my practicum, and it really hit home because I could see myself in the people sitting across from me. I was in that situation...I was in hospitals...

C: See, it’s funny because I was trying to remember when I did my practicum. That was so many years ago. Maybe 2004. 2005? I remember..I don’t think that I disclosed it though, I don’t think I did..before my internship ..

C: Do you in general feel that..because I don’t tell people that easily, actually. You know what I mean? And then people who have known me for years..I’ll say “Did you ever know this?” And people will say, “No! Really? I never would have guessed that.”

PI: Yeah. I don’t really tell a lot of people. Recently for my practicum site and in my internship...I felt like it was necessary because it was really affecting my work with the clients. And I needed supervision time with my supervisor. Just to talk through it. It was difficult for me even in the thesis seminar class because of my thesis topic.
C: Well, some people that I’ve been in school with for years…It’s funny..because I think in one way it’s not such a big deal because a lot of people have it.

PI: But this is relevant to what we were talking about…we were talking about basically the importance of ..you were talking about feeling…I guess in a school setting..when you wanted to disclose but you felt like there’s a conflict of interest..

C: So that is like dealing with the countertransference because I did feel like, you know…I could relate to him, I feel bad for him. A lot of people can say, “Oh, I know how he feels.” But you don’t really know how he feels….

PI: If you haven’t been through it…

C: … if you haven’t had this diagnosis. Yeah, I have sad days, but…do you have said days if you know if you’re on the right medication you won’t have those sad days..is kind of..you know, I think there’s still a lot of people out there , like his mother, or there are certain people that think, “Oh, well he doesn’t need to take these pills every day, does he?” That’s what some people say.

PI: What do they think? That they can just medicate him randomly?

C: I don’t know. I don’t remember if they said something about the insurance or something like…they think it’s bad for his liver..you know..over years and years.

PI: So from my experience, when you’re going through these experiences you tend to have more empathy than the average person who doesn’t have these issues. Do you think that’s true? That you are able to have more empathy for them?

C: Yeah, I don’t know if I would say more, but a different kind. A different view…to be able to…a different view from someone who was just..say… From the actual perspective..that’s the word I was looking for…of someone who has had that diagnosis also, as opposed to just someone whose had good and bad days or has been sad. Because when he’s been coming in with all this..especially the mania part..I think because it’s kind of like that interesting part of the bipolar.. because the depression …a lot of people
have had just the depression, or just been really sad and down. But when you have that mania part, that’s a different kind of feeling. I really recognize that. I think that that’s what...the last time I had a relapse that’s what I felt. I kind of went to my mom right away and said “I don’t feel right. I feel like there’s something going on again. And she was like “what do you mean?” And we just watched it for a couple of days and on the third day I was in the hospital. The depression is almost not as...you know...you kind of think I can...

PI: Back to this client that you were working with. How did that feel? When you saw him in a manic phase, how did that affect you? In your work with him possibly? In the countertransference....

C: Well like I said...you mean...what did I do? My actual activities?

PI: You can go into what the activities were a little, but don’t get too hung up on them because it’s more about trying to get to the experience. What it was like for you personally? As opposed to just saying “well, this is the intervention I used.”

C: OK. Well, like I was saying....I was trying to match his energy, but then I felt kind of nervous that he was...I was worried about what was going on with him. Because he can be really energetic, but then when he has that agitated energy you kind of feel that he doesn’t know where to put all the energy. You might ask the aides, “What’s going on in his classes?” and they say he’s been like that all day, he can’t calm down. Then they talk about if the mother stopped giving him his meds and then the next day or two days later you see him depressed because that’s what’s coming. So you kind of know....Yeah..I kind of feel like.. I have that feeling like I know what’s coming. And then he’s out of school for two days after that because he’s probably not getting out of bed.

PI: I’m curious, do you think that manifested in the music in some way? What was going on in a session? Do you remember anything about the music that happened during those interactions?

C: You mean what was the difference between when he was manic or depressed?
PI: Yeah, what was going on in the music. Were you feeling any transference or countertransference?

C: Well the setting was in a group. It was a group class. I don’t know if I mentioned that. Yeah, this was in a class, so it wasn’t like I was able to focus just on him. But we would do a group dance and he would be very participatory obviously..he would participate a lot when he was hyper. He would often request certain songs. “Who let the dogs out.” Or whatever..He would request certain dance songs . Sometimes the aides were like, “he’s too hyper, don’t play this.” Because that would just make him go off the wall. You could kind of meet him at his level or you could go up here, where he’s gonna go..and you go a little under that…maybe some of the other kids liked. He won’t go “that’s my favorite song. Yah!!” And then go crazy…

PI: Do you think you’re more sensitive to that ….because of your own experiences? That you could look at him and gauge where he’s at certain times and then think of how you’re going to base your intervention on that? Based on what he says, or how he reacts, what his energy level is like?

C: Yeah, maybe. I would say. You mean I could kind of tell the difference between that kind of energy and just a kid in a good mood having regular energy? Yeah…

PI: There’s something about it …because it’s familiar to you…you can kind of objectively look at it in a different way, I guess.

C: Yeah. Objectively but also subjectively. At the same time. Does that make sense?

PI: Yeah.

C: Like where you’re talking about empathy…not to say..they always say teachers don’t..teachers are not supposed to have favorites..but I really like.. but he was a good kid too, but I really tried to…I don’t want to say paid more attention to him, but tried to always be like “where is S. at today?” When he walked in…even though I kind of looked at all of them..I guess if I think about it I was always like ..you know..worried about…
PI: So you felt more connected to this particular client? I think that’s pretty normal. I felt that way with certain clients. I don’t know if ..how much it had to do with..I think for some of them it was definitely that I saw myself in them. One of them had the same diagnosis..But I think that can help you identify, but at the same time it can be difficult to look at that because it may remind you of your own issues.

C: It’s funny because I don’t know if this is a common thing with other people, but I know a lot of the time ..especially ..actually even when I was depressed, but especially when I was manic..I’ll have a lot of blank spots, like my mom will talk to me about some story or something that happened and I’m like, “I don’t remember that at all. I don’t remember what you’re talking about.” You know..stuff that’s happened…it’s almost like your psyche turns off or..it’s not like a split personally thing or something like that. They might say that they vaguely remember something. It’s funny because I was thinking if you were going to ask me..because I never really was at school or at a practicum when I was sick..when I was going through..That’s why I thought it was kind of going to be hard to do this, but I guess ..that’s why when you said like does it remind me of when I was sick…a lot of the times when I was really sick I don’t remember, so it’s kind of..I remember when I was in the hospital getting better, talking about it, and …but when I was going through the actual episodes I think a lot of it was fuzzy, you know?

PI: Yeah, sure. Everything was just a blur. So what about…what did it feel like working with that particular client at times? In working with him were there any images that came to mind, or ..it could be images or metaphors ..I think I asked you this before, but I was going to get to physiological responses..if there were any bodily sensations you had at certain times when working with the client? When he was agitated, or when he was really hyper..were there any..you mentioned before that you got nervous..

C: You mean like my actual..my stomach would tighten I guess…

PI: Yeah. Reactions you had…so maybe an upset stomach
C: Yeah. I guess it's hard, especially when there's a whole class there too, but you try and stay calm when the class is getting out of control. A lot of the time, there is obviously more than one kid at a time that's in a hyper mood. But especially when he was in that hyper agitated state..then the other kids would feed off of that, and ..He was kind of like a leader because he was very friendly and hyper and outgoing. So kind of that personality and then add when he's manic to that. And he would talk a lot...kind of like trying to engage everyone so that everyone's like...Even though he's usually pretty polite to me or the other teachers..you try and like ..I don't know if it's being nervous or just..a little uncomfortable sometimes trying to talk.."OK that's enough now. Let's calm down and” ...you know..even though you want to encourage him to have fun...

PI: So that has to do with just setting boundaries.

C: Yeah.

PI: And how was that in that relationship? Setting boundaries. What are your thoughts on that?

C: I was going to say I think it's different because he in a way can't help it I think because he's manic. And the other kids, if you say “OK, let's sit down and go to the next thing” and then they'll know it's time. OK Let's sit down..say it to S. and he's like “but did you know that....and he'll have all these thoughts. I think he really was bipolar. A lot of kids are misdiagnosed with ADHD and sometimes it's diagnosed as that, and then later they figure out that they've got bipolar. Or kids with bipolar are misdiagnosed with ADHD. But sometimes it's just a kid being hyper...but I think they said he was bipolar with ADHD. But I don't think the both of those could really exist...that was him just being manic when he was ADHD..he was having thoughts come into his head. He was really focused. I said, “we're going to do something else now.” “I know I have the drum, but did you know that the cheetah is the best animal on earth? Or did you know” ...and he'll say all these things. OK. Calm your thoughts down. I felt worse saying things to him because I knew that his thoughts..that he couldn't calm down.
PI: Right. So you felt...again, that's related to how you've experienced these manic episodes..

C: Where you can't stop your thoughts.

PI: So you're seeing someone else in that state, and you didn't want to...

C: I was going to say, I might almost be favoring him by not calming him down as much, as opposed to some of the other kids. You know what I mean...like letting him talk. Because I know he has to get the thoughts out. And finally the aides would be like, "S! Quiet!" Which I hate. Or hold up the quiet sign. "You're going to get a token taken away." It's like, "let's take away his rewards because he's bipolar." Because it's hard. That happens with a lot of kids, I think. That they have a behavior disorder for a reason. But then I'll go off on why I hated working there. They all would do this reward system. "OK, you're getting tokens taken away." But I'm having a manic episode!

PI: Yes, that seems quite unfair.

C: But he's a good one to...I've been focusing on the same one. Because he definitely wasn't autistic. That was his main diagnosis...bipolar, actually.

PI: OK. I'm trying to get more at what the experience was like...any descriptors.. Maybe we could elaborate on any of the subjects you feel comfortable about. We talked about you having empathy, we talked about you sometimes feeling nervous when he's having a manic episode, or where he's kind of spiraling..I don't know if it was this particular client, but you talked about at times feeling threatened...

C: That was the other one. That was the older client. He was like 16 years old.

PI: So was there anything else about working with the younger client that you remember? Feelings that you remember...things that were going on in your head at the time....your reactions to him...and what that was really like...we're talking about this one client now that was diagnosed with bipolar, and you yourself had gone through that. Another thing you talked about a little was wanting to disclose. And then feeling like I
can’t really do that to the people I’m working for and ...what would they think of me if I were to do that?

C: Yes.

PI: How did these issues manifest specifically in the music and what was the role of the music, if at all in the management of the transference and countertransference issues?

C: I kind of was saying that about trying to meet him like...he loved dancing and I would take that as an assessment of what he liked to do. I mean it’s a little different because I’m talking about a group dynamic. In a group session. I would sometimes try to take..if he wasn’t too far gone I would take his request, but I know he liked all songs. If you would say, “Who let the dogs out” and the aides are going “no.” But I would do something else, like he likes the Backstreet Boys, or whatever. And I would be like, “that’s a little slower beat.” And then I would try and get him to sway. At least he’s not..because he comes in with his arms moving around and...At least I try to get him to sway back and forth, and do longer movements. And then I got him to sit, and at least if he’s still moving ...Let’s move out legs and arms with the drum, and then stomp our feet and just move our hands with the drums. And to just try and get him a little calmer. And when he’s depressed I just try and I’ll say, “ I know S. usually has a turn requesting a song. Maybe someone else can request a song.” Because he’ll say, “I don’t feel like dancing today.” Usually if he’s in a bad mood. Usually by the end of the song I’ll at least get him up. I’ll say something like, “I’ll be sad if I can’t see S. dance a little bit today, because he really helps us dance. He’s a good dancer.” Or something like that.

PI: Did you feel awkward in a sense being a parental figure to him within the session?

C: Did I start to kind of have motherly feelings, you mean?

PI: Did you feel there was a transference from him onto you regarding that? More like a parental figure?
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C: I feel like I...I guess I was saying...I don't want to say favored, but if he was...sometimes he was fine, whether or not he was on the meds, and I would do the whole group. But if he was up or down, I felt like I definitely had a music therapist goal. Like it was my duty to bring him in the middle somewhere. To try to get him grounded, or stabilized...and to try and...motherly?...I don't know. You care about the kids, I guess. I think he definitely looked up to me. He was a good kid and he looked forward to music, they always said. Especially on his sad days. He still wanted to come.

PI: And how did that feel to you? To have him look up to you like that?

C: Good. He was a good kid.

PI: I was going to ask- was supervision available to you, and if so, was it helpful?

C: We didn't really have supervision.

PI: That was alright? To not have supervision?

C: Oh, no. That might have been helpful. We had supervisors. But we didn't have supervision like the way we would have it if there was another music therapist. There would have to be another music therapist there to do supervision, right?

PI: Yeah.

C: Then no. They didn't have anything. They wouldn't talk about music things or maybe issues in the class about it. Or it wouldn't be private supervision.

PI: I feel like we covered a lot of stuff. One of the things...when we were talking about some of the experiences with this one client, the 9 year old that we were talking about. It's good to know sometimes what the intervention was, and sometimes you can have reflections upon that, or analysis of that. What you did. And that's kind of background information. You know...value judgments and that kind of thing. But the most important thing is getting to what that experience was like. So if there is anything else? Maybe...on any of the topics I was mentioning before...If there's anything else you
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You can talk freely about anything that you feel is relevant. And again, thinking of the experience and possible transference and countertransference and how that might have affected your work with him. And how, of course your own diagnosis might affect your work with that client.

C: I felt that that was kind of important...about... I 'd forgotten how often I was thinking, “ should I tell someone that I have it? Should we talk about....” Because there were so many...I 'm trying to think...I say there is so many, but he’s the only one that comes to mind that I can remember...with a definitive diagnosis. I think that other kid, the bigger kid had it too. I just thought that was interesting. But I don’t know. I guess in some ways it’s not such a big deal. I guess I don’t think about it until stuff like that comes up. Like when I see “Oh, he is bipolar.” I see what he is doing. It makes more sense now. But then sometimes I can spot it too. The fast talking....he’ll come in and..

PI: So there’s a recognition?

C: He could be talking a mile a minute...

PI: So there’s a recognition of what that is?

C: Yeah.

PI: I’ve been there. I know what that’s like. It always seems like it’s easier on the outside. When you’re going through that, you may tend to think that it’s normal. I mean..I thought it was normal when I was going through those phases, but..

C: Especially like hypomania. I was kind of hypomanic a lot. So I thought, “Oh, I have these great ideas, and I’m just going to be doing this, and I’m going to go out and...

PI: Right.

C: But then , the depression or when I stopped sleeping for a couple days at a time, or something. When I realized that there was something going wrong.
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PI: Right.

C: But kids...and then I guess I think I thought a lot that it’s got to be sad to be a kid, and going through that. Because you don’t know what’s going on...you don’t understand. Especially with him I was thinking, what was the mother ..the mother’s not only not giving him his medication but does she even explain to him what’s going on? You have a condition. There’s a reason why you can’t sleep. And there’s a reason why you’re talking a mile a minute. It’s not just that you’re in a really fun mood.

PI: So there’s a certain element of sadness looking at that from the outside?

C: Yeah.

PI: And seeing what he’s going through at such a young age. Is that...

C: Well that’s what I was thinking . Just I’m not sure if the mother understands. If she did, then she would be giving him his medication. She would understand that that’s what makes him stable every day. My doctor had explained to me when I first started taking medication that you have to take this every day, it’s like diabetes. It’s like taking your insulin shot. Once in a while if you forget to take a dose it’s not going to matter. But if you stop for a week, you’re going to start feeling the symptoms again. I remember the time that I relapsed. Half the people that were in there were there because they had stopped taking their medication. And I’m like, “Why do people do that?” I just don’t understand, you know?

PI: So do you think that knowledge of that on your own made you feel differently about looking at his situation...like you’re saying...You’re looking at him and saying, “What is his mother doing?” She’s not giving him his medication every day. She’s not informed enough to know....

C: Right. She’s not informed, and then it seems like he’s probably not informed. I wonder what is the school doing? It almost made me think..that’s the other thing..I felt like I as the music teacher..they hired me as a music therapist or whatever...They don’t
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let me go to the meetings, which is another reason why I hated it. I never get to go to any of the meetings for the kids because I'm always busy during the meetings. Because I had classes all the time. So I don't get a chance to say, "Well, one of us should talk to the mother. Hello?"

PI: Did you feel pressured? Did you feel like that was something that you had to do? Did you feel responsible...not responsible, but...

C: No, I think that teachers were probably either trying... I don't know if they were talking to the mother about it.....they probably said something and the mother was saying, "I'll think about it." I don't know. Either they weren't doing enough, or... I don't know. No. I didn't feel responsible because I knew I couldn't stick my nose in it. Because me and the gym teacher and the art teacher don't get to do that. We don't get to be involved in that. So even if we were to say something, it's like that's not your job, you know? It's just kind of sad, I guess.... exactly. You just hope that someone else does something, which I guess sounds kind of irresponsible. But I'm not the social worker..

PI: Well, it's not like you can go home with them and make sure they take their medication.

C: Yeah. I mean, I'm sure the social worker is telling the mother to give him his medication. He's supposed to take his medication in the day, you know?

PI: We're getting at some good points.

C: But yeah, I guess there was a sense of powerlessness of... you know... I didn't really have much authority over the kids in that area.

PI: So you didn't feel like you could... You could help them maybe within the music, but there wasn't a chance.... it's like you weren't even a part of the whole...

C: The IEP's or the meetings. Yeah.

PI: You just weren't a part of that?
C: Yeah.

PI: Was there ever a sense when working with this client of...I don’t know if I can do this. Or how do I do this? How do I work with a client who has this. Was there ever that kind of sense or...

C: Because I would feel weird or something?

PI: Yeah. Was there ever a sense of...

C: Did it bring up memories?

PI: That it might bring up memories or just...the fact that if the kid was really out of control, it would be hard to bring him back to that midpoint. Where he’s not too high or low.

C: Not that I couldn’t do it. There were always other people in the classroom to help, and ... Yeah, it got stressful sometimes. He could definitely be really difficult. Yeah- but I never thought of it like it was so difficult because he had bipolar. And because I had it.

PI: It was just something that was kind of a factor.

C: Yeah.

PI: I’ve never dealt with a client that was young that had bipolar. I think it was more difficult with me for the adults because of my experiences. Are there any other things that you want to add?

C: I can’t really think of anything...

PI: Mainly any other descriptors of what the experience was like. That’s really the whole point I’m trying to get at. The feelings...whatever pops in your mind.

C: I’m just trying to think back to my practicum a little bit. It’s so long ago. Because I remember relating to the feelings of some of the...that there would be one....because I knew a lot of them had bipolar in the group. I remember one guy just sitting like this and
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not saying anything...and totally depressed. And the girl next to him not shutting up. So I just thought that was interesting. I just remember feeling like “Oh, I remember being both of those”, you know what I mean? I remember we were doing some activity and she came up with all these ideas. And she was kind of speaking for the whole group because I think most of the people in there were either depressed or just spacing out. But I remember always kind of thinking that people who are manic are funny. You know what I mean? It’s kind of funny, even though it’s a little scary and weird. And there’s definitely something going on wrong. There’s something wrong with this person. But she was like, “What a cool idea.” It was like we were doing “Bridge over Troubled Water.” We were singing that song and we were drawing a bridge, and saying what are our troubles. Stuff like that.

PI: Is there something funny about manic behavior? With manic people, sometimes there’s no filter a lot of times. You can say wildly inappropriate things and...I suppose if you’re diagnosed you can say, “Well it’s because of that.”

C: Right. What’s funny, is even in the hospital people don’t say anything to you. Which is almost funny because they should be because you’re trying to get better and... they should have told you, “You know you shouldn’t be saying these things.” But we’re just kind of ignoring her..

PI: So there are times when it’s ..even when working with the kids with bipolar. There’s times when they can be....Where you find yourself catching yourself, a little bit? Wanting to laugh, but knowing you probably shouldn’t?

C: I think that what I’m trying to put together right now is what’s interesting..is that the adults are not called out on it in the group session. “We’re all saying what we want, and fuck this and fuck that.” But the kids...they can’t say that because it’s school . And if you’re manic and saying this it would be considered inappropriate. But maybe they wouldn’t be talking like that if they weren’t manic. But they’re going to get in trouble because it’s school. It’s kind of messed up. And I guess I never really put that together. I never really thought about it like that until right now. I remember this woman talking
about being manic. I remember she was cursing too. But I think everyone was allowed to curse. I think if it gets ridiculous. But you’re supposed to be able to talk however you want. But kids can’t. Even if they have Tourette’s. That’s another thing that is funny. There was a kid with Tourette’s in my class and once in a while he will curse. And they’ll tell him, “Stop it.” Doesn’t he have Tourette’s? Why are we yelling at him if he says a curse word every once and awhile? And they’re telling him he’s talking too much. That’s part of the diagnosis, people.

PI: I felt like at times in my internship I…people would say wildly inappropriate things where I really wanted to laugh, but I couldn’t.

C: Sure.

PI: So we’re getting to the end of the interview. Is there anything else that you want to add? Anything that pops into your mind?

C: No. I don’t think so.

C: I think….if I was going through episodes or something when S. would come in, I would think that..knowing that he was really high yesterday, like meaning mania….I would just kind of feel nervous checking in with him. I knew when I would be manic the next day I might be depressed or something like that. So just kind of checking in with him. So it wasn’t maybe almost more of a favoring….wanting to see how he was every day. That’s all.

PI: Over some of the other clients?

C: Yeah. Maybe. Yeah. Because I did know what he was going through, so…..And I guess in a way that’s an interesting dynamic because I never said that to him. You know…some clients and therapists obviously have that open communication. You have bipolar, I know you have bipolar. Even if I didn’t tell him that I did. I didn’t say to him, “How are you doing today? Are you feeling manic today?” He’s a child, and you don’t even know if he knows what you’re talking about. So a lot of people with their
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therapists….if I’m going through it, I’d walk into my doctor’s office. “How are you feeling today?” Are you still feeling manic? Or even on the phone… I used to call her to check in. “Are you still feeling hyper? Do you have racing thoughts?” She’d ask me the usual questions. “Did you get sleep?” If you’ve been depressed, do you feel like doing anything today? Why don’t you get up? But in my session, instead I’d say, “S., are you going to feel like dancing today? I think you should do some dancing.” That’s kind of more of my assessment and check in with him instead of, “Do you feel manic today?”

PI: Well, yeah.. with a 9 year old..

C: Yeah. I guess that’s good that you got a different perspective of a 9 year old. It’s crazy that they diagnose that early, but he definitely seemed to have signs like that, so….And I think in the DSM I thought they kind of had….I guess they don’t have a separate category yet but they definitely do…I thought maybe in the new one they’re going to do a DSM 5…a childhood bipolar I thought.

PI: Right. Well, thanks for taking the time to do this interview.
Appendix B

Example of Data Transformation: Participant B

Culled transcription: Participant B

And he also has a history of really having trouble relating to people, and just in any relationship. So for him to work with me and for me to work with him it’s been a challenge. Especially for me. I don’t know if he would say that but for me it’s been a really big challenge.

He’s not someone that..he has a lot of defenses so he’s not someone that wants to talk about his feelings too much or..explore it. But he is getting to a point now where he is starting to talk about stuff and he’s starting to experience music and really work more collaboratively with me. But it’s been a big struggle.

He’s extremely resistant and I get really frustrated working with clients that exhibit a lot of resistance. He projects a lot and there’s a lot of transference on his part. He sees me a very high figure, and you know—he thinks I don’t do anything wrong. Things like that. I feel very pressured as a result of that. That’s part of..I guess my countertransference in trying to please him. I’m trying to appease him and figure out what it is that this person needs.

And then I had kind of over time tried to invite him into making music together. And that’s where a lot of resistance came into play. So I decided to try and take a little break from that because he was projecting like crazy...

And when he did play, we weren’t together. We weren’t musically in synch. I felt that he wasn’t listening to me, and he was kind of all over the place.

That’s when I remember him speaking and him interjecting and saying “what are we doing? I don’t know why we’re doing this” and just sort of kind of questioning .

I kind of felt like the whole improvisation that..for me I felt very disconnected from him and that he…possibly frustrated or you know…possibly now that I’m thinking back about it., anxious that you know “what do I do? How do I do this?”

I was feeling frustrated during the music making because I was trying to provide an opportunity for him to try to really connect, but it wasn’t happening. At times I did change my rhythm. I tried to match him, and nothing was being effective in what I was trying to do.
And I began feeling anxious when he began speaking, because then I felt that he was kind of judging...not judging me but......questioning me. After the improvisation, he spoke in great detail. He shared his opinion very emphatically about..you know..I guess how he felt about it, though he was very passive aggressive about it. He immediately questioned why I brought this in, you know...and wanted to know what I expected..what I was expecting him to do. I remember having a lot of anxiety, and in general I have a lot of anxiety when he begins speaking.

I don’t feel like he’s talking to me, it’s kind of like an attack type of thing. The tone of his voice changes, and becomes a little harsh..

And I caught myself. I was very aware that I was trying to defend it at first. I don’t really recall how this all ended, but I guess just staying with that moment I..it’s just struggling. How to respond. Especially verbally. Because we’re trained musically and..you know..that’s a big anxiety for me is using verbal skills.

And in part because I really wasn’t sure what it is he was really experiencing. I guess a lot of it was my kind of transference and his transference and I guess trying to interpret and understand it. But moving forward with him, I’ve developed a lot more empathy for him. Which is generally not a hard thing for me, but with this particular client it’s been really hard to have an immense amount of empathy. Because he’s very defensive.

I think he’s a good example to share because it is someone I have a lot of countertransference towards. I find it exciting to work with him but also really really challenging.

A lot of projection about him idolizing me or putting me on a pedestal. So there could be some possible transference there. There’s also been a lot of him testing the relationship and what the relationship is. In the sense of therapeutic relationship, friendship, romantic...so there’s been a lot of testing by him, and challenging me about that.

That’s very uncomfortable. Especially more about the romantic comments, because I had to be very clear with the boundaries, and once I did it’s been better. But he’s definitely...he’ll make comments about the way I look, or my hair...different things like that.

I don’t know if I think a lot about him more because of the mental illness, but I’m sure that’s a part of it. I suffer from periods of depression and more so generalized anxiety. That’s been my longstanding thing that I’ve really struggled with. So that has really impacted my work with him, to the point of me obviously perserverting about it and
replaying it (the session). Yeah. It’s been a real challenge. And I wonder if he kind of picks up on that now and if he sort of manipulates that in a way…by kind of going at me with all these questions …

They see something that kind of ticks you off, and they might keep going at it. The depression component..It’s interesting now that I’m talking about it. The depression component of him being isolated and not getting out of bed. That I feel very related to, very connected to..and have an immense amount of empathy and understanding of that.

I find for myself it’s more the anxiety..my anxiety issues really impacting on the way I run the session, the way I facilitate it. When I leave I feel anxious. There’s a lot of..I get a lot of somatic symptoms. My stomach gets upset, I get sweaty...

So there’s that specific element of him talking that gets me kind of stirred up. More than the music.

The depression..I have a..I don’t know if it’s a habit or what..of picking up on people’s energy, and people’s mood….things like that. And I’m very sensitive to it. If I go into the room…first of all, every time I enter his room the lights are off, the curtains are drawn, and the covers are over his head. So you’re kind of walking into a very depressed scene.

So I need to be really mindful of how I’m feeling before I go in because if I’m OK and then I go in…and then in the middle of it I feel depressed then I know, “OK that’s…I’m picking up on his stuff.” But if I’m kind of going in feeling blah and feeling down…which has happened and it’s that much more challenging…of course you know..to be present and to have more energy...

But now I think that since we’ve been working together for a while, I’m more relaxed about it. Because I know the environment I’m walking into. I can kind of anticipate it…

There’s been sessions where there’s just a lot of silence. And there’s no music, and no talking..

I think it’s actually been very valuable for him. Just having somebody sit with you. Hopefully pretty helpful. Especially when you feel so alone. Just another human being being with you and they don’t want you to say anything.

And it can be very draining. And like you said before, especially when it’s things that really hit home for you, and hit home for myself. In part I was thinking, “ well I understand it so it will be easier.” But actually no. It’s that much harder.

There’s a certain level of understanding…and you just get it.
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And I've actually disclosed to him. Not in great detail, but just that I've had periods of feeling really low. I've found that to be really helpful for him kind of opening up a little more.

And it was kind of a big risk I thought to take. I was having a... I was trying to just think of different ways to connect with him and let him know that I'm really hearing him. I didn't get the impression that he thought I was hearing him, because he has a lot of abandonment stuff and constantly thinks I'm going to leave.

I felt pretty safe. I felt pretty comfortable. I can't say I've done it a lot, or that I have made a habit of it. But I just felt that for him in our relationship and... where he's at that it might be a bit of help to him. I think that I was afraid that he was going to probe, and that he was going to question and want to know more. That would have caused a lot more anxiety, but he didn't actually. He didn't even inquire, but he was very present when I said that. I hadn't even planned to disclose it, but it just kind of happened in the moment.

He said out of nowhere, “I felt depressed yesterday.” And we talked a little bit about that and I said, “yeah, I sometimes have really low moments.” And that we all do and I just kind of generalized that it’s OK...

I go in there with the blues idea and I feel it got shot down... that he didn’t latch onto it... And, again... this is all my stuff. This is all me feeling rejected.

Yeah, very defiant. Especially again, when there's this whole verbal thing. He interjected, and at the end was questioning me. I felt very defensive. I feel like I had to explain myself and prove myself.

There's a need for me-- I guess to feel heard, and to feel validated. And it's interesting because I think those are the same needs that he has never had met

Culled transcription: Participant B (with meaning units)

(B1, category 6) He’s extremely resistant and I get really frustrated working with clients that exhibit a lot of resistance.

(B2, category 18) He projects a lot and there’s a lot of transference on his part. He sees me a very high figure, and you know—he thinks I don’t do anything wrong. Things like that. I feel very pressured as a result of that. That’s part of... I guess my countertransference in trying to please him. I'm trying to appease him and figure out what it is that this person needs.
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(B3, category 1) And when he did play, we weren’t together. We weren’t musically in synch. I felt that he wasn’t listening to me, and he was kind of all over the place.

(B4, category 3) That’s when I remember him speaking and him interjecting and saying “what are we doing? I don’t know why we’re doing this” and just sort of kind of questioning.

(B5, category 1) I kind of felt like the whole improvisation that..for me I felt very disconnected.

(B6, categories 9 & 12) {I was} anxious that you know “what do I do? How do I do this?”

(B7, category 6) I was feeling frustrated during the music making because I was trying to provide an opportunity for him to try to really connect, but it wasn’t happening. At times I did change my rhythm. I tried to match him, and nothing was being effective in what I was trying to do.

(B8, categories 9 & 3) And I began feeling anxious when he began speaking, because then I felt that he was kind of judging..not judging me but…..questioning me. After the improvisation, he spoke in great detail. He shared his opinion very emphatically about ..you know..I guess how he felt about it, though he was very passive aggressive about it. He immediately questioned why I brought this in, you know… and wanted to know what I expected..what I was expecting him to do. I remember having a lot of anxiety, and in general I have a lot of anxiety when he begins speaking.

(B9, category 5) And I caught myself. I was very aware that I was trying to defend it at first.

(B10, category 9) How to respond. Especially verbally. Because we’re trained musically and..you know..that’s a big anxiety for me is using verbal skills.

(B11, categories 14 & 2) But moving forward with him, I’ve developed a lot more empathy for him. Which is generally not a hard thing for me, but with this particular client it’s been really hard to have an immense amount of empathy.

(B12, category 3) There’s also been a lot of him testing the relationship and what the relationship is. In the sense of therapeutic relationship, friendship, romantic…so there’s been a lot of testing by him, and challenging me about that.

(B13, category 3) That’s very uncomfortable. Especially more about the romantic comments, because I had to be very clear with the boundaries, and once I did it’s been
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better. But he’s definitely...he’ll make comments about the way I look, or my hair...different things like that.

(B14, categories 14 & 15) I don’t know if I think a lot about him more because of the mental illness, but I’m sure that’s a part of it. I suffer from periods of depression and more so generalized anxiety. That’s been my longstanding thing that I’ve really struggled with. So that has really impacted my work with him, to the point of me obviously perserverting about it and replaying it (the session). Yeah. It’s been a real challenge.

(B15, category 14) The depression component of him being isolated and not getting out of bed. That I feel very related to, very connected to...and have an immense amount of empathy and understanding of that.

(B16, categories 10 & 9) I find for myself it’s more the anxiety...my anxiety issues really impacting on the way I run the session, the way I facilitate it. When I leave I feel anxious. There’s a lot of...I get a lot of somatic symptoms. My stomach gets upset, I get sweaty...

(B17, category 11) And it can be very draining. And like you said before, especially when it’s things that really hit home for you, and hit home for myself. In part I was thinking, “well I understand it so it will be easier.” But actually no. It’s that much harder.

(B18, category 2) And it was kind of a big risk I thought to take. I was having a...I was trying to just think of different ways to connect with him and let him know that I’m really hearing him. I didn’t get the impression that he thought I was hearing him, because he has a lot of abandonment stuff and constantly thinks I’m going to leave.

(B19, category 2) But I just felt that for him in our relationship and...where he’s at that it might be a bit of help to him. I think that I was afraid that he was going to probe, and that he was going to question and want to know more. That would have caused a lot more anxiety, but he didn’t actually. He didn’t even inquire, but he was very present when I said that. I hadn’t even planned to disclose it, but it just kind of happened in the moment.

(B20, category 4) I go in there with the blues idea and I feel it got shot down...that he didn’t latch onto it...And, again...this is all my stuff. This is all me feeling rejected.

(B21, category 5) Yeah, very defiant. Especially again, when there’s this whole verbal thing. He interjected, and at the end was questioning me. I felt very defensive. I feel like I had to explain myself and prove myself.

(B22, category 15) There’s a need for me-I guess to feel heard, and to feel validated. And it’s interesting because I think those are the same needs that he has never had met.
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(B23, category 16) I’m pretty aware of where this stuff comes from...with my mom, and that she kind of dismissed a lot of things growing up and there was a lot of pressure to succeed and to do really really well academically. So I know that that’s pretty much the source of the countertransference. It’s probably related to my mom. So just feeling...yeah, trying to get validation from people.

Reconstructed Narrative: Participant B (with meaning units and categories)

(B5, category 1) I kind of felt like the whole improvisation that...for me I felt very disconnected. (B3, category 1) And when he did play, we weren’t together. We weren’t musically in synch. I felt that he wasn’t listening to me, and he was kind of all over the place. (B18, category 2) And it was kind of a big risk to take. I was having a...I was trying to just think of different ways to connect with him and let him know that I’m really hearing him. I didn’t get the impression that he thought I was hearing him, because he has a lot of abandonment stuff and constantly thinks I’m going to leave. (B19, category 2) But I just felt that for him in our relationship and...where he’s at that it might be a bit of help to him. I think that I was afraid that he was going to probe, and that he was going to question and want to know more. That would have caused a lot more anxiety, but he didn’t actually. He didn’t even inquire, but he was very present when I said that. I hadn’t even planned to disclose it, but it just kind of happened in the moment. (B12, category 3) There’s also been a lot of him testing the relationship and what the relationship is. In the sense of therapeutic relationship, friendship, romantic...so there’s been a lot of testing by him, and challenging me about that. (B13, category 3) That’s very uncomfortable. Especially more about the romantic comments, because I had to be very clear with the boundaries, and once I did it’s been better. But he’s definitely...he’ll make comments about the way I look, or my hair...different things like that. (B4, category 3) That’s when I remember him speaking and him interjecting and saying “What are we doing? I don’t know why we’re doing this” and just sort of questioning. (B20, category 4) I go in there with the blues idea and I feel it got shot down...that he didn’t latch onto it. And, again...this is all my stuff. This is all me feeling rejected. (B21, category 5) Yeah, very defiant. Especially again, when there’s this whole verbal thing. He interjected, and at the end was questioning me. I felt very defensive. I felt like I had to explain myself and
prove myself. (B9, category 5) And I caught myself. I was very aware that I was trying to defense it at first. (B1, category 6) He’s extremely resistant and I get really frustrated working with clients that exhibit a lot of resistance. (B7, category 6) I was feeling frustrated during the music making because I was trying to provide an opportunity for him to really connect, but it wasn’t happening. At times I did change my rhythm. I tried to match him, and nothing was being effective in what I was trying to do. (B6, categories 9 & 12) (I was) anxious that you know... “What do I do? How do I do this?” (B8, categories 9 & 3 ) And I began feeling anxious when he began speaking, because then I felt that he was kind of judging...not judging me but...questioning me. After the improvisation, he spoke in great detail. He shared his opinion very emphatically about...you know...I guess how he felt about it, though he was very passive aggressive about it. He immediately questioned why I brought this in, you know...and wanted to know what I expected...what I was expecting him to do. I remember having a lot of anxiety, and in general I have a lot of anxiety when he begins speaking. (B10, category 9) How to respond. Especially verbally. Because we’re trained musically and...you know...that’s a big anxiety for me is using verbal skills. (B16, categories 10 & 9) I find for myself it’s more the anxiety...my anxiety issues really impacting on the way I run the session, the way I facilitate it. When I leave I feel anxious. There’s a lot of...I get a lot of somatic symptoms. My stomach gets upset, I get sweaty...(B17, category 11) And it can be very draining. And like you said before, especially when it’s things that really hit home for you, and hit home for myself. In part I was thinking, “Well I understand it so it will be easier.” But actually, no. It’s that much harder. (B11, categories 14 & 2) But moving forward with him, I’ve developed a lot more empathy for him. Which is generally not a hard thing for me, but with this particular client it’s been really hard to have an immense amount of empathy. (B14, categories 14 & 15) I don’t know if I think a lot about him more because of the mental illness, but I’m sure that’s a part of it. I suffer from periods of depression and more so generalized anxiety. That’s been my longstanding thing that I’ve really struggled with. So that has really impacted my work with him, to the point of me obviously perseverating about it and replaying it (the session). Yeah. It’s been a real challenge. (B15, category 14) The depression component
of him being isolated and not getting out of bed. That I feel very related to, very connected to...and have an immense amount of empathy and understanding of that. (B22, category 15) There’s a need for me- I guess to feel heard, and to feel validated. And it’s interesting because I think those are the same needs that he has never had met. (B23, category 16) I’m pretty aware of where this stuff comes from...with my mom, and that she kind of dismissed a lot of things growing up and there was a lot of pressure to succeed and to do really, really well academically. So I know that that’s pretty much the source of the countertransference. It’s probably related to my mom. So just feeling...yeah, trying to get validation from people. (B2, category 18) He (the client) projects a lot and there’s a lot of transference on his part. He sees me a very high figure, and you know—he thinks I don’t do anything wrong. Things like that. I feel very pressured as a result of that. That’s part of...I guess my countertransference in trying to please him.

Final Narrative: Participant B (including background information)

Participant B is diagnosed with generalized anxiety disorder and depression, and her client is diagnosed with depression.

Background Information:

I’m thinking of a client that... he is in his mid to late 60’s. He is Hispanic. His name is S. And he is living where I have been working. He has been living in a nursing home in a long term care setting and he suffered a stroke about 2 years ago and as a result of the stroke he’s paralyzed on the left side of his body. So he reports to have a history of using cocaine for 30 years. However, he denies that he was addicted to it. However, he was using coke at the time of his stroke, so there’s a correlation with that. However, he’s completely ...does not see that that could relate to that. He has a diagnosis of depression.

I kind of felt that during the whole improvisation I felt very disconnected. And when he did play, we weren’t together. We weren’t musically in synch. I felt that he wasn’t listening to me, and he was kind of all over the place.
And it was kind of a big risk to take. I was having a... I was trying to just think of different ways to connect with him and let him know that I’m really hearing him. I didn’t get the impression that he thought I was hearing him, because he has a lot of abandonment stuff and constantly thinks I’m going to leave. But I just felt that for him in our relationship and... where he’s at that it might be a bit of help to him. I think that I was afraid that he was going to probe, and that he was going to question and want to know more. That would have caused a lot more anxiety, but he didn’t actually. He didn’t even inquire, but he was very present when I said that. I hadn’t even planned to disclose it (my struggles with depression), but it just kind of happened in the moment.

There’s also been a lot of him testing the relationship and what the relationship is. In the sense of therapeutic relationship, friendship, romantic... so there’s been a lot of testing by him, and challenging me about that. That’s very uncomfortable. Especially more about the romantic comments, because I had to be very clear with the boundaries, and once I did it’s been better. But he’s definitely... he’ll make comments about the way I look, or my hair... different things like that.

That’s when I remember him speaking and him interjecting and saying “What are we doing? I don’t know why we’re doing this” and just sort of questioning. I go in there with the blues idea and I feel it got shot down and that he didn’t latch onto it. And, again... this is all my stuff. This is all me feeling rejected. Especially - again, when there’s this whole verbal thing. He interjected, and at the end was questioning me. I felt very defensive. I felt like I had to explain myself and prove myself. And I caught myself. I was very aware that I was trying to defend it at first.

He’s extremely resistant and I get really frustrated working with clients that exhibit a lot of resistance. I was feeling frustrated during the music making because I was trying to provide an opportunity for him to really connect, but it wasn’t happening. At times I did change my rhythm. I tried to match him, and nothing was being effective in what I was trying to do.
I was anxious that you know... “What do I do? How do I do this?” And I began feeling anxious when he began speaking, because then I felt that he was kind of judging...not judging me but...questioning me. After the improvisation, he spoke in great detail. He shared his opinion very emphatically about...you know...I guess how he felt about it, though he was very passive aggressive about it. He immediately questioned why I brought this in, you know...and wanted to know what I was expecting him to do. I remember having a lot of anxiety, and in general I have a lot of anxiety when he begins speaking. How to respond. Especially verbally. Because we’re trained musically and...you know...that’s a big anxiety for me is using verbal skills. I find for myself it’s more my anxiety issues really impacting on the way I run the session, the way I facilitate it. When I leave I feel anxious. I get a lot of somatic symptoms. My stomach gets upset, I get sweaty...

And it can be very draining. And like you said before, especially when it’s things that really hit home for you, and hit home for myself. In part I was thinking, “Well I understand it so it will be easier.” But actually, no. It’s that much harder. But moving forward with him, I’ve developed a lot more empathy for him. Which is generally not a hard thing for me, but with this particular client it’s been really hard to have an immense amount of empathy. I don’t know if I think a lot about him more because of the mental illness, but I’m sure that’s a part of it. I suffer from periods of depression and more so generalized anxiety. That’s been my longstanding thing that I’ve really struggled with. So that has really impacted my work with him to the point of me obviously perseverating about it and replaying it (the session). Yeah. It’s been a real challenge. The depression component of him being isolated and not getting out of bed. That I feel very related to, very connected to...and have an immense amount of empathy and understanding of that.

There’s a need for me- I guess to feel heard, and to feel validated. And it’s interesting because I think those are the same needs that he has never had met. I’m pretty aware of where this stuff comes from...with my mom, and that she kind of dismissed a lot of things growing up and there was a lot of pressure to succeed and to do really, really well academically. So I know that that’s pretty much the source of the
countertransference. It’s probably related to my mom. So just feeling...yeah, trying to get validation from people. He (the client) projects a lot and there’s a lot of transference on his part. He sees me a very high figure, and you know—he thinks I don’t do anything wrong. Things like that. I feel very pressured as a result of that. That’s part of...I guess my countertransference in trying to please him.
Appendix C

Sample recruitment email:

Hello. I am a Montclair State University graduate music therapy major. I am conducting a study for my thesis work which involves music therapists who are diagnosed with a psychiatric illness, and how this may impact on their work with clients (who may or may not have psychiatric disorders as well). The study would focus on the transference and countertransference issues that the therapist deals with in this situation. This study has been approved by the IRB at Montclair State University. You may participate in this study if you:

- Are a board certified music therapist
- Have been diagnosed with a psychiatric illness
- Are 21 years of age or older
- Reside within a 50-mile radius of Montclair State University, Montclair, NJ;
- Have had transference and countertransference issues related to your illness while working with patients
- Are in sound mental and physical health in that your mood is properly managed with or without medication (thus enabling you to participate in this study).
- Have access to a mental health care professional should the need arise at any time during the study, including during or after the interview

The format for this would be one 45 minute to an hour long open ended interview which would take place in your own home or another location of your choosing. The interview will be recorded, transcribed, and the transcriptions would then be sent to you to insure that they are accurate. A follow up phone conversation would verify that the information from the interview was correct. The data would then be subject to phenomenological inquiry in order to understand the therapists experience regarding transference and countertransference in their work with clients.

Your information will be kept strictly confidential at all times during this study. You will not be mentioned by name in any papers or presentations. Pseudonyms or abbreviations will be used in documentation to prevent identification. The transcribed interviews will also be coded, with the codes stored securely in a separate location as the transcriptions (again to prevent identification). Only the principle investigator and possibly the thesis sponsor will know your identities.

This study may be beneficial because:
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- It may give you the opportunity to express thoughts and feelings, tell stories, and gain insights about challenging aspects of your work, as well as about your experiences as a therapist
- The knowledge that is gained from this study could support improvements in music therapy services by informing music therapists as well as music therapy students
- The quality of services offered by other mental health care professionals could benefit, including those who are diagnosed with psychiatric illnesses
- The public in general would be have an increased awareness and understanding regarding the challenges faced by music therapists (and therapists in general) with psychiatric illnesses
- There is very limited published literature in music therapy regarding this topic

Although careful precautions will be taken in order to protect your information at all stages of the study, there may be possible risks concerning a breach in confidentiality. You may also find it psychologically disturbing to talk about your own illness and how this relates to your work with clients. However, you do not have to disclose any information you don’t feel comfortable with, and you can choose not to answer any question asked. Furthermore, you are free to leave the study at any time. For your own well being, it is imperative that in participating in this study you have access to a mental health care professional should the need arise. My thesis sponsor, who is a board certified Music Therapist, will also be available by phone during the interview process if he needs to be reached for any reason, and will be a reasonable distance from the researcher at the time of the interview.

If you would like to participate in this project, you can send me a private message via email or call me and I will send you the consent form. You can reach me at:

adammakofsk@ yahoo.com

(201)916-3584

Thank you very much for your time and consideration.
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Appendix D

CONSENT FORM FOR ADULTS

Please read below with care. You can ask questions at any time, now or later. You can talk to other people before you sign this form.

Study’s Title: The challenges of transference and countertransference dynamics for music therapists with a psychiatric diagnosis.

Why is this study being done? This study will examine ways in which music therapists experience their work with clients, when the therapist is diagnosed with a mental illness. It will explore specific roles of the music and the overall impact of the illness on the therapy process.

What will happen while you are in the study? The researcher will interview you about your experiences working with clients. In the interview, the researcher will have a conversation with you, asking questions that help you share details about your experience. These questions will focus on whether and how your illness may have played a role in your work. The interview will be audio recorded. Later, the researcher will transcribe, edit, and send it to you. After this, the researcher will telephone you to make sure that the information in the transcript is correct. The researcher will then analyze and reorganize your information as part of the overall findings of the study, which the researcher may later present or submit for publication. At no time will your identity be linked with your personal information.

Time: This interview will take about 45 minutes to an hour. The follow-up telephone call will take about 20-30 minutes.

Risks: The researcher will take very careful measures to keep your information safe and to keep your identity disguised. He will use a false name, and will take everything out of your information that could identify you. However, there is always a remote chance of a breach, which could impact negatively upon your personal and professional well being. You may also find it disturbing to talk about your own illness and its effects on your work with clients- thus, you must have access to a mental health care professional in order to be in this study. You do not have to share any information, and you do not have to answer any questions you do not wish to answer. To help minimize risks, my thesis sponsor, who is a board certified Music Therapist, will also be available by phone if necessary during the time of the interview, and will be within a reasonable distance.
Benefits: This study may help you become more aware about challenging aspects of your work. You may find it helpful to be able to tell your story, and to express your thoughts and feelings. Knowledge gained in this study could help improve music therapy services by informing music therapists and music therapy students. Also, it could improve services provided by other mental health care professionals. In addition, it may increase the public's awareness of situations like those explored in the study. Because there is little published on this topic, it may also help add to the research literature in a useful way.

Who will know that you are in this study? Only the researcher and possibly the thesis sponsor will know who you are.

Do you have to be in the study?

You do not have to be in this study. You are a volunteer! You may stop participating in the study at any time. You do not have to answer any questions you do not want to answer.

Do you have any questions about this study?

Phone or email: (Principle Investigator) Thesis sponsor:
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Do you have any questions about your rights? Phone or email the IRB Chair, Dr. Debra Zellner (reviewboard@mail.montclair.edu or 973-655-4327).
The Experiences of Music Therapists with Mental Illness working with Clients with Similar Diagnoses

It is okay to audiotape me while I am in this study:

Please initial:  ______ Yes  ______ No

I have access to a mental health care professional should the need arise (required):

Please initial:  ______ Yes  ______ No

One copy of this consent form is for you to keep.

Statement of Consent

I have read this form and decided that I will participate in the project described above. Its general purposes, the particulars of involvement and possible risks and inconveniences have been explained to my satisfaction. I understand that I can withdraw at any time. My signature indicates that I have access to a mental health professional whom I can consult should the need arise in connection with this study. My signature also indicates that I have received a copy of this consent form. If you choose to be in this study, please print your name, sign, and enter the date in the lines below.

___________________________________________  _____________________________  ______
Print your name here  Sign your name here  Date

Adam Makofske

Name of Principle Investigator  Signature  Date

Brian Abrams

Name of Faculty Sponsor  Signature  Date
The Experiences of Music Therapists with Mental Illness working with Clients with Similar Diagnoses