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# The Experience of Countertransference for Music Therapists when Working with Children with Developmental Disabilities

Carly Caprioli

This research was completed as part of the degree requirements for the [Music Therapy](#) Department at Molloy College.

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THE EXPERIENCE OF COUNTERTRANSFERENCE FOR MUSIC THERAPISTS WHEN  
WORKING WITH CHILDREN WITH DEVELOPMENTAL DISABILITIES

A THESIS

Submitted in partial fulfillment of the requirements

For the degree of Master of Science

In Music Therapy

by

Carly Caprioli, MT-BC

Molloy College

Rockville Centre, NY

2016

MOLLOY COLLEGE

The Experience of Countertransference for Music Therapists When Working With  
Children With Developmental Disabilities

by

Carly Caprioli, MT-BC

A Master's Thesis Submitted to the Faculty of

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Thesis Committee:



Dr. Seung A. Kim  
Faculty Advisor

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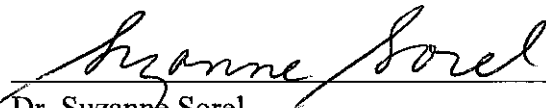
Date



Adenike Webb  
Committee Member

6/27/16

Date



Dr. Suzanne Sorel  
Director of Graduate Music Therapy

6-28-16

Date

**Abstract**

The purpose of this study was to explore how music therapists recognized, acknowledged, utilized, and managed countertransference when working with children with developmental disabilities. Three board-certified music therapists (MT-BC), who had experience working with this population and experienced strong countertransference reactions in their work, openly shared their experiences during 45-60 minute audio-recorded in-person or telephone interviews. Phenomenological design was employed in this study. Essential themes that emerged from the data were identified and presented. Common themes included feelings of attachment, re-experiencing the past, fulfilling needs in the therapist, and experiencing deep concern for the client. Overall, this study concludes that examining countertransference is a beneficial and valuable tool for music therapists working with children with developmental disabilities allowing them to increase their awareness and gain deeper insight into themselves, clients, and the therapeutic relationship.

*Keywords:* countertransference, music therapists, children, developmental disabilities

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The Experience of Countertransference for Music Therapists When Working with  
Children with Developmental Disabilities

My experience with countertransference has evolved throughout my educational career. I was initially introduced to the concept of countertransference as an undergraduate music therapy student. I was taught to perceive countertransference as a negative phenomenon that should be avoided in all therapy sessions. Throughout my practicum experience, I neither acknowledged my countertransference nor truly understood what countertransference meant. To me, it was interpreted as a “bad word,” meaning that it should be avoided at all costs. Furthermore, if countertransference should emerge in therapy, one would be considered a “bad” therapist. Despite this, I remember moments in my practicum work where I strongly reacted to some of my clients or music experiences. These strong emotional reactions often left me feeling guilty. At times, they even made me question my effectiveness and my clinical decisions as a practicum student.

My perceptions of countertransference began to evolve once I had begun my music therapy internship. I was working in an acute psychiatric outpatient facility that provides treatment to adults with mental illness and substance abuse. I was still experiencing strong reactions towards some of my clients and my music experiences, but did not understand why I was feeling this way. While receiving supervision, my supervisor introduced me to the benefits of countertransference. I then began to recognize how countertransference could be used within the therapeutic process to promote self-awareness and deeper insight into our clients’ experiences, as well as our own experiences as therapists. In addition, some of my colleagues have emphasized the importance of the benefits of countertransference and how it is often disregarded in processing our clinical work. My interest in countertransference began to grow.



Currently, as a graduate student, my education has provided me with more information regarding countertransference, including how to identify it, acknowledge, utilize, and manage it. My interpretation of countertransference is highly influenced by Mary Priestley (1994). In my opinion, Priestley's descriptions and explanations of this phenomenon are comprehensible and relatable. Thus, I have adapted her interpretations of countertransference to my work as a music therapist.

My experience with countertransference has carried over into my work with children who have developmental disabilities. However, I have recognized that it has become more challenging to identify countertransference in my work. I have often wondered, what do my clients experience in music therapy sessions? What do I experience in music therapy sessions? Why is it difficult for me to understand my client's experience? Do these feelings and thoughts belong to me, or my client? How would countertransference affect the therapy process? How do other music therapists experience countertransference when working with children? Many questions have sparked my interest to study this particular topic. Thus, my personal rationale for this study was to explore the importance of examining one's countertransference and how countertransference affects both the therapist's clinical experience as well as the client's therapeutic experience.

### **Need for Research**

Countertransference has been shown to be a powerful tool in deepening our understanding of both our clients' lives and therapeutic experiences as well as our own. Failure to examine countertransference could endanger clients, particularly vulnerable populations such as children with developmental disabilities (Dillard, 2006; Maroda, 2004; Priestley, 1994). Maroda (2004) clarifies, "if [the therapist] does not disclose her countertransference she may

well do more damage to the patient by influencing him covertly, never taking responsibility for this influence, and never giving herself and the patient the opportunity to ameliorate the negative consequence” (p. 105). Therefore, examining this phenomenon is important for the well-being of both client and therapist. In addition, the large gap in the literature suggests that this is a phenomenon neglected by music therapy researchers (Dillard, 2006; Paap, 2011).

Research on countertransference in music therapy is limited. A majority of the literature pertaining to countertransference or adaptations of countertransference is often based upon the author’s theoretical and personal perspectives (Dillard, 2006). Furthermore, most of the literature pertaining to countertransference is limited to a handful of writers (Bruscia, 1998; Hadley, 2003; Priestley, 1975; Scheiby, 1998). After searching the literature, a limited number of research studies were found discussing countertransference in music therapy, including qualitative studies (e.g., Dillard, 2006; Kim, 2008; Pedersen, 2007; Short, 2013; Wheeler, 1999) and master’s theses (e.g., Paap, 2011). However, most published studies do not deeply explore countertransference, but instead discuss how it impacted their study findings.

Published qualitative research provides interesting information regarding music therapists’ experience with countertransference. Dillard (2006) examined how music therapists with a psychodynamic orientation experience musical countertransference in their work. Pedersen (2007) examined how music therapists working in adult psychiatry experience countertransference. While both of these studies contributed to the music therapy literature, they were either exclusively conducted with adult populations or did not specify a population.

Paap’s (2011) master’s thesis was the only located research that explores music therapists’ experience of countertransference with a child with special needs. Paap utilized a first-person study that examined her awareness of countertransference and how it affected the

development of the therapeutic relationship with preschool children. The limited amount of literature on music therapists' experience of countertransference with children is an issue because music therapists working with children do not have enough literature that relates to their clinical work.

Despite this large gap, literature stresses the importance of identifying and examining countertransference (Bonovitz, 2009; Dillard, 2006; Hayes, Gelso, & Hummel, 2011; Paap, 2011; Scheiby, 2005) and addresses the problem of it being neglected in clinical work (Bonovitz, 2009; Dillard, 2006; Hayes et al., 2011; Pedersen, 2007). Neglecting to acknowledge countertransference is an issue that exists among many psychotherapeutic approaches. Diaz de Chumaceiro (1992) expressed how the diverse interpretation of countertransference among theoretical approaches causes this phenomenon to be ignored. Similarly, Dillard (2006) found that once countertransference is brought into consciousness, many therapists continue to deny the phenomenon as countertransference. Failure to identify and acknowledge these feelings and reactions could become detrimental to the client, the therapist, and the therapeutic relationship (Dillard, 2006).

The rationale for this study is to bridge the current gap in music therapy literature regarding countertransference in the population of children with developmental disabilities. The study explores the importance of examining one's countertransference and how countertransference affects the therapist's clinical experience as well as the therapeutic relationship, as perceived by therapists. This study will display how countertransference can benefit our clinical work, decision-making, and exploration of self.

### **Literature Review**

This literature review will discuss current theory and research on countertransference from fields of psychology and music therapy. Topics will include: (a) definitions, important concepts, and perspectives of countertransference; (b) how countertransference is utilized and perceived in psychotherapy; (c) how countertransference is utilized and perceived in music therapy; (d) music therapy treatment for individuals with developmental disabilities; and, (e) literature that provides evidence of countertransference when working with children, specifically children with developmental disabilities.

### **Transference**

In psychodynamic therapy, there are two main goals: to bring the client's unconscious material into his or her conscious awareness and to work through this material through the dynamics of transference and countertransference (Bruscia, 1998). In order to more fully understand countertransference, one must also understand the concept of transference. Transference is described as "a process by which a patient attempts to relive with her therapist the unfinished business from former important relationships in her life" (Priestley, 1975, p. 236). Through transference, the client re-experiences feelings, thoughts, or relationship patterns from his or her past in present situations (Bruscia, 1998). Sources of transference may include significant persons or objects from the client's past, such as parental figures, siblings, or objects from one's childhood (Bruscia, 1998).

Transference often emerges within the therapeutic relationship between the client and the therapist (Bruscia, 1998; Levy & Scala, 2012). Transference reactions vary from individual to individual and can be triggered by aspects of the individual, the therapist, or the therapeutic process (Levy & Scala, 2012). At times, clients often use transference as a form of resistance;

however, it could also be used as a means to overcome one's resistance, such as developing self-insight or gaining self-awareness (Bruscia, 1998). Bruscia (1998) states, "it is through the client's transference that a therapist gains an understanding of the client's problems and therapeutic needs; it is through the transference that the therapist becomes acutely aware of his own countertransference" (p. 44).

### **Countertransference**

The term, countertransference, was originally developed by Freud, who is celebrated as the father of psychotherapy. Freud (1910) defined this term as a feeling or reaction that "arises in the [therapist] as a result of the patient's influence on his unconscious feelings" (p. 144). Freud interpreted countertransference as a negative phenomenon. Freud believed it was triggered from unresolved conflicts that were originating from the therapist's past experiences or relationships. In addition, he considered it a threat to the overall therapeutic process (Bruscia, 1998). Maroda (2004) adds that classical psychologists believed that "'acting out' is likely to permanently bury an issue that needs to surface; that the traditional 'blank screen' is the appropriate analytic stance" (p. 9). Because of this, many psychoanalysts rejected this phenomenon from their practice leading it to be neglected for many decades (Hayes et al., 2011).

However, as time passed, many psychotherapists have found the benefits of examining countertransference (Hayes et al., 2011). It has become an essential tool in understanding the experiences of clients and therapists. The current view maintains that a therapist's exploration of countertransference "allows the therapist to pay attention to the client's behaviors that are affecting the therapist in particular ways and why this is the case" (p. 96). Thus, the definition and utilization of countertransference have grown and it has become an important key concept in understanding therapeutic process. Recently, three conceptions of countertransference appear to

hold precedence over therapist's understanding of the phenomenon; a totalistic perspective, an intersubjective perspective, and an intrasubjective perspective (Bruscia, 1998; Hayes et al., 2011).

A totalistic perspective of countertransference represents all of the therapist's reactions to the client (Hayes et al., 2011). Bruscia (1998) further explains that everything the therapist brings to the therapy process is considered countertransference. This includes the therapist's past and present experiences, personal beliefs, attitudes, thoughts, feelings, behaviors, physical reactions, and emotions (Bruscia, 1998; Maroda, 2004; Priestley, 1994). It is important to note, however, that these reactions are not separate from the client's transference reactions.

Intrasubjective countertransference refers to countertransference that originates from the therapist's self (Bruscia, 1998; Scheiby, 2005). In intrasubjective countertransference, all aspects of the therapist's identity and reaction to the client are shaped by his or her own personal and professional history. These aspects may shift in response to life events, personal relationships, specific clients, or clinical situations. Signs of intrasubjective countertransference may include: clinical specializations, theoretical orientation, work style, use of music, and/or interpersonal style.

On the other hand, intersubjective countertransference consists of the issues that emerge within the process of working with the client (Bruscia, 1998; Scheiby, 2005). These countertransference reactions may not easily come into one's awareness. However, these reactions may shift by interacting with the client and as the dynamics of the therapeutic relationship evolve. Signs of intersubjective countertransference may include: somatic reactions, polarized emotional reactions, unwarranted reactions, impulsive decision-making, drastic changes in the use of music, inappropriate roles and relationships, ruts and routines, and burnout.

**Five components of countertransference.** Countertransference is often activated and shaped by the interactions between the client and therapist (Bruscia, 1998). In order to clarify the process, Bruscia (1998) describes and dissects countertransference into five components: sources, activators, identifications, objects, and outcomes. The source of countertransference refers to its place of origin or the past experiences and relationships from the client as well as the therapist. Sources are developed through introjections, or the manifestations of adopting values or standards of others into one's own philosophy. An activator is made up of all of the experiences or encounters that trigger the therapist's countertransference reaction. Activators may include any event, feeling, or situation that causes the therapist to introject with the client's transference or the therapist's personal transference. These may occur during encounters with the client's transference and projective identifications, the therapist's past and present identifications, and environmental settings or contexts.

Identifications occur when the therapist identifies or places him - or herself within the relationship replicated in the therapeutic situation (Bruscia, 1998). The therapist may identify with the client, a significant other in the client's life, or a significant object in the therapist's own life. Identifications signify the formation of countertransference reactions towards the client or the object of countertransference. Objects of countertransference are defined as the object or person in which the therapist directs his or her countertransference response. Objects of countertransference could be directed towards the client, towards the therapist him- or herself, or towards the music. Lastly, the outcome of countertransference refers to "the extent to which the therapist uses countertransference to facilitate rather than obstruct therapy" (p. 53).

### **Countertransference in Child Psychotherapy**

Child psychologists encounter countertransference similarly to therapists who work with adult or adolescent populations. However, despite the importance of examining one's countertransference, there is a lack of literature addressing countertransference in child psychotherapy. Bonovitz (2009) supports, "there is a neglect of countertransference in the child field" (p. 236). This can be viewed as an indication of "countertransference problems" among therapists who work with children populations (p. 236). Furthermore, because countertransference cannot be measured, many psychologists have "dropped" it from their terminology and awareness (Newman, 1991, p. 132).

Countertransference occurs when therapists encounter memories and recollections of their own childhood in response to child clients (Bonovitz, 2009). Bonovitz (2009) explains that childhood recollections "bring with them an experience of ourselves as children, allowing us to revisit a self-state that may have been dormant until then and now is experienced within the relational context of a particular child patient" (p. 236). These experiences provide therapists with an effective resource for assisting and enhancing their clinical work (Bonovitz, 2009). Although some recollections may become a distraction from treatment, such as traumatic memories, they are typically used as a means of connecting with and understanding the child's point of view and can be viewed as countertransference.

### **Countertransference and children with developmental disabilities in psychotherapy.**

Psychologists who work with children who have physical or developmental disabilities are often faced with harsh and intense countertransference reactions that may be brought about by the client's disability (Gordon, Zaccario, Sachs, Ufberg, & Carlson, 2009; Hurley, Tomasulo, & Pfadt, 1998). These reactions may include "helplessness, hopelessness, rescue fantasies, fears of



their own mortality, and anxieties regarding body integrity, loss of control, and the random nature of catastrophic events” (Gordon et al., 2009, p. 113). In addition, psychologists are often faced with many challenges, since each patient requires individualized treatment and differs in levels of functioning (Gordon et al., 2009). Hurley et al. (1998) supports “working with this population challenges us to expand the depth of our own humanity by being open and available to people who have been devalued by society and not deemed capable of full participation in reciprocal human relationships” (p. 373).

Transference and countertransference reactions will most likely be present in therapy, even when working with individuals with disabilities. According to Hurley et al. (1998), these reactions are usually heightened and occur at a rapid rate compared to those experienced when working with typical clients. Thus, Hurley et al. (1998) stress the importance of defining and clarifying the therapeutic relationship in terms that the client is able to understand. This will help prevent the client from misinterpreting appropriate boundaries and can help decrease the intensity of these strong reactions.

Whitehouse, Lunsky, and Morin (2006) and Weiss, Tudway, Look, and Kroese (2010) emphasize how individuals with intellectual or developmental disabilities receive limited attention and access to psychotherapeutic treatment. Psychological needs of individuals with developmental disabilities are often unmet due to insufficiently trained psychologists (Weiss et al., 2010), dependency on behavior modification, and reliance on medication (Whitehouse et al., 2006). These factors may have a significant impact on the lack of literature and limited understanding of working with this population.

### **Music Therapy and Developmental Disabilities**

The American Music Therapy Association (AMTA, 2015c) defines music therapy as “the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program” (para. 1). Music therapy utilizes music to address the physical, cognitive, mental, developmental, emotional, and/or social needs of individuals among various populations. A significant amount of literature supports the effectiveness and benefits of music therapy for individuals with developmental disabilities (AMTA, 2015a, 2015b; Braithwaite & Sigafos, 1998; Geretsegger, Elefant, Mössler, & Gold, 2014; Whipple, 2012). Examples of how music therapy works with specific child populations will be discussed in detail below.

Music therapists have been working with individuals with developmental disabilities for many years. A developmental disability is defined as “a condition that is attributable to a mental, physical, or combination of these two types of impairments that manifests prior to age 22 and is likely to continue indefinitely” (Humpal, 2014, p. 266). Individuals with developmental disabilities experience delays and difficulties in one or more of the following areas: cognitive, physical, communicational, social or emotional, and adaptive skills. Music therapy has been considered an effective treatment modality among individuals with developmental disabilities (Hintz, 2013). In fact, clients with developmental disabilities are indicated as one of the highest populations served by music therapists nationwide (Silverman & Furman, 2014). Music therapists who work with this population often provide services in academic, day treatment, and community settings (Hintz, 2013). However, treatment can be provided in a variety of other settings, such as hospitals, rehabilitation centers, private homes, and private practices.

There are many specific populations that come under the broad definition of individuals with developmental disabilities. Music therapists commonly work with individuals with autism spectrum disorder (ASD), intellectual disabilities, emotional/behavioral disturbances, and learning disabilities. Descriptions of these four populations are discussed below and include a brief overview of the condition as well as specific goals and interventions that are addressed in music therapy treatment.

**Autism spectrum disorder.** Autism spectrum disorder is described as “a complex neurodevelopmental disorder that is defined and diagnosed behaviorally and usually manifests in early childhood persisting throughout life” (Geretsegger et al., 2014, p. 5). Individuals with ASD present impairments in social interaction, communication, and developing interpersonal relationships. They also demonstrate restricted or repetitive behavior, interests, or activities and experience sensitivity to sensory details (Hintz, 2013). Although individuals with ASD share distinguishing characteristics, severity of symptoms and manifestations of behavior vary from individual to individual (Hintz, 2013).

In music therapy with individuals with ASD, music is used as a means “to promote nonverbal expression and communication, socialization, self-awareness, sensory integration, and musical and interpersonal relatedness” (Hintz, 2013, p. 63). Other music therapy goals incorporate academic, behavioral, and speech/language interventions, as well. Music therapy interventions are created to encourage social interaction and the ability to relate to others. A range of music therapy methods can be used within this population; yet, improvisational and re-creative methods are the most popular.

**Intellectual disabilities.** Individuals with intellectual disabilities experience impairments in both cognitive and adaptive functioning ranging from mild to severe cases (Keith, 2013;

Weiss et al., 2010; Polen, 2013). Adaptive functioning involves everyday activities such as communication, self-care, social skills, functional academic skills, and activity of daily living (ADL) skills (Keith, 2013; Weiss et al., 2010). In addition, individuals with intellectual disabilities may experience deficits in speech/language skills, emotional skills, and motor skills and may have additional medical conditions (Keith, 2013; Polen, 2013). Specific populations that may exhibit signs of intellectual disability includes individuals with Down's syndrome, William syndrome, Tuberous Sclerosis, Klinefelter syndrome, Turner syndrome, or Phenylketonuria (Keith, 2013).

Music therapists working with individuals with intellectual disabilities often address goals pertaining to improvements in adaptive functioning (Keith, 2013). Treatment goals and music interventions may focus on improving gross/fine motor skills, communication skills, social skills, academic skills, and emotional/affective skills. Goals and interventions could also focus on developing ADL skills to promote feelings of normalization or to improve quality of life (Keith, 2013). In addition, some music therapy interventions may need to be adapted or modified to meet clients' individual needs.

**Emotional/behavioral disturbances.** Children with emotional and behavioral disturbances display impairments in mood, conduct, emotions, and difficulty relating appropriately to others (McCarrick, 2013). Children with emotional and behavioral disorders range in diagnoses and for some, are classified as mental illnesses, such as attention deficit/hyperactivity disorder, oppositional defiant disorder, mood disorders, and at times, eating disorders. Generally, children with emotional/behavioral disorders have difficulty socializing and relating to peers, struggle with sustaining attention, demonstrate aggressive or challenging behaviors, and display poor coping skills and problem-solving skills. Often, children with

emotional/behavioral disturbances may also have learning disabilities, affecting their cognitive and academic functioning.

Music therapists often serve this population within educational settings as a related service under the Individuals with Disabilities Education Act (IDEA; McCarrick, 2013). It is important to note that treatment varies from individual to individual; meaning music therapists should respect and recognize each child's individual differences. According to McCarrick (2013), children with emotional/behavioral disorders, however, work well within a structured, predictable, and consistent musical environment. In addition, trust plays a significant role in the therapeutic relationship. Therefore, music therapists are encouraged to provide a safe, creative, and nonjudgmental environment for successful therapeutic process to occur (McCarrick, 2013).

**Learning disabilities.** Learning disabilities are often comorbid with individuals who have intellectual or developmental disabilities. Learning disorders are described as deficits in cognitive processing that affect one's understanding of information or one's ability to retain information (Hintz, 2013). Many people may assume that learning disabilities only affect individuals within academic settings. However, the impact of learning disabilities affects individuals' daily living and quality of life. Impairments often include difficulties in academic skills and cognitive processing. Yet, other difficulties may arise in behavioral, social, and emotional situations.

Music therapy offers individuals with learning disabilities a structured and creative environment to practice and develop skills for their areas of need. Musical interventions may help in "increasing memory functions and auditory processing in learning, increasing attention span, serving as a contingent reinforcer, and increasing academic task performance" (Hintz,

2013, p. 173). In addition, musical experiences address underlying issues, such as behavioral, psychological, and social needs, that may be influencing the individual's quality of life.

### **Countertransference in Music Therapy**

Countertransference has become a significant concept in understanding the dynamics of the therapeutic relationship between the client and the therapist as well as the musical interaction that occurs within music therapy sessions. While the understanding and utilization of countertransference may differ according to background and theoretical orientation, its most salient feature of countertransference is described as “an unconscious or preconscious experience that becomes conscious overtime” (Dillard, 2006, p. 214).

Among the various music therapy models, countertransference is most commonly discussed within the context of music psychotherapy. Bruscia (1998) defines, “music psychotherapy is the use of music experiences to facilitate the interpersonal process of therapist and client as well as the therapeutic change process itself” (p. 2). Music psychotherapy utilizes a combination of facilitating music experiences with verbal discussion (Bruscia, 1998). However, compared to traditional, verbal psychotherapy, music is used as the primary method for communicating, building therapist-client rapport, and working towards goals. Verbal discussion is used as an additional tool to explore or process these experiences further. Music therapy models that incorporate music psychotherapy theories into their approach include: Analytical Music Therapy (AMT), Guided Imagery and Music (GIM), Nordoff-Robbins Music Therapy (NRMT), and Vocal Psychotherapy (Bruscia, 1998).

Mary Priestley (1994) identified three different forms of countertransference. The first definition of countertransference is similar to Freud's (1910) definition. This form of countertransference refers to the therapist's personal feelings and distortions in the relationship

with the client (Priestley, 1994). It is also important to consider both positive and negative countertransference; both allow therapists to examine all forms of countertransference that may impact the relationship with the client (Pedersen, 2007). The second form is called c-countertransference, or complementary identifications, which occur when the therapist identifies with the client's transference (Priestley, 1994). C-countertransference reactions refer to sound patterns, images, feelings, or thoughts that reflect unconscious or conscious repetitions of the therapist's past (Priestley, 1994). The third form, e-countertransference, is defined as repressed emotional or somatic reactions that arise in the therapist's consciousness (Priestley, 1994). Pedersen (2007) explains e-countertransference is parallel with empathy in that it involves feeling emotionally overwhelmed and using this information to understand the needs of the client.

**Musical countertransference.** Greatly influenced by Priestley's work, Scheiby (1998) discovered how countertransference could manifest in the music and music therapy experience. She developed the term musical countertransference, which is when the therapist's reactions towards the client are presented in the music and musical experience (Scheiby, 1998). Musical countertransference emphasizes the importance of being present during these experiences, which allow emotions and images to become conscious (Dillard, 2003). Scheiby (2005) further explains how it provides "a place where the client can listen to and connect with the unconscious as the music therapist is doing the same thing" (p. 9). Scheiby (1998) states:

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

transference. The medium through which these countertransferences are conveyed is the music played in the session. (p. 214)

Musical manifestations of transference and countertransference arise in form, structure, dynamics, articulation, rhythm, tone, timbre, emotional qualities, phrasing, and idioms (Scheiby, 1998).

Musical countertransference can be brought to the music therapist's awareness in a number of ways. Scheiby (1998) explains musical countertransference as: (a) music that does not fit the context of the client's music; (b) music that does not seem appropriate from the therapist's perspective; (c) musical expressions that take the therapist by surprise; (d) a sense of not knowing where the music is coming from; and, (e) musical expressions that do not feel authentic. These reactions occur during musical interventions, but they are the most recognizable when listening to recordings of music therapy sessions (Scheiby, 1998). Scheiby (1998) further explains that "when the therapist can maintain a constant focus on her musical response to the client's music, the therapist can self-monitor and self-adjust her musical response and use these reactions to guide subsequent interventions in the session" (p. 217).

In relation to Priestley's (1994) concepts of countertransference, Scheiby (1998) identified three main types of musical countertransference: classical musical countertransference, complementary musical countertransference, and emotional musical countertransference. Classical musical countertransference is made up of music that reflects the music therapist's unconscious distortions or projections onto the client. The client can trigger this musically or non-musically. Complementary musical countertransference refers to music that reflects the music therapist's past experiences, relationships, and personal identifications. Identifications could also be caused by the client's projections onto the therapist. Lastly, emotional musical



countertransference is defined as music that reflects the music therapist's emotional or somatic resonance with the client's feelings. Priestley (1994) describes this as the music therapist's emotional or somatic empathy to the client's repressed emotions.

Theoretical literature on musical countertransference is limited to Priestley (1975, 1994) and Scheiby's (1998, 2005) writings. Dillard (2003, 2006) was one of the first music therapists to conduct a qualitative study examining the experience of musical countertransference with psychodynamically-oriented music therapists. The purpose of this study was to examine how musical countertransference is experienced, how it is brought to one's consciousness, and how it is used by music therapists (Dillard, 2006). Overall, the four themes that emerged from this study included:

- (a) musical countertransference is a form of non-verbal communication within the therapeutic relationship, (b) signals to the experience, (c) differentiation between own reactions and reactions triggered within the therapeutic relationship, and, (d) utilization and/or response to awareness of musical countertransference. (p. 212)

When participants described their experience of musical countertransference as a form of non-verbal communication, many felt that there was "an association between the quality of the music and the interpersonal dynamics in the therapeutic relationship" (p. 212). Countertransference was often signaled by experiencing strong emotional or physical reactions, an urgency to respond, and confusion or feeling stuck (Dillard, 2006). Most of the participants found it difficult to differentiate their own reactions from reactions triggered by clients. The participants recognized that their own past experiences were the source of their countertransference experiences; supervision assisted many participants to become aware of these reactions. Lastly, the participants found that their awareness of musical countertransference was a valuable tool in

understanding their clients and an indicator for changes in treatment that meet the needs of their clients (Dillard, 2006).

### **Countertransference and Children with Developmental Disabilities in Music Therapy**

One study was located on music therapists' utilization of countertransference with children with developmental disabilities to support the purpose of this study. Paap (2011) examined her own countertransference when working with a preschool child with special needs in a first-person qualitative study. According to her findings, countertransference themes that emerged in her work included: a heightened sense of empathy and desire to help (nurturing mother), experiencing frustration and shifting to a directive presence (strong father), wanting to connect, a fear of abandonment, and feeling ineffective (Paap, 2011). Her countertransference reactions revealed important information about her therapeutic relationship with her client and indicate countertransference themes that are relevant to music therapists working with children.

In addition, anecdotal case studies have become a valuable resource in understanding how transference/countertransference as well as psychodynamic constructs are manifested in music therapy sessions. In Susan Hadley's book (2003), *Psychodynamic Music Therapy: Case Studies*, there are many case studies examining psychodynamic music therapists' experience with children with developmental disabilities. Some of the studies discussed children with ASD, emotional/behavioral disturbances, and speech/language disorders. In addition, most of these case studies include the authors' examination of transference and countertransference within the therapeutic relationship and how it influences the course of treatment.

Dvorkin and Erlund (2003) wrote a case study on a child with ASD receiving psychodynamic music therapy. They found that through the use of music, the child was able to communicate and advance in levels of functioning. Dvorkin and Erlund (2003) wrote,

“awareness of countertransference issues increased the therapist’s ability to understand what [the client] was communicating dynamically, i.e., it was an indicator of what was occurring between the therapist and the patient” (p. 275). The utilization of countertransference within this population has the potential to expose, work through, and resolve internal and external conflicts that may arise in therapy sessions.

**Countertransference, music therapy, and play.** Another common method that was used in many of the case studies was play therapy. Psychodynamic music therapists who work with children have incorporated play therapy techniques into their sessions (Kowski, 2003, 2007; Mahns, 2003; Tyler, 2003), an idea suggested by Mary Priestley (1994). Priestley (1994) writes:

Children are acting out their fantasies in their way all the time, working them through in play. It is only when they get trapped in them and cannot develop any further that their learning and behavior suffers and they need help. Therefore the analytical music therapist’s aim with a child-patient is to restore to her, or introduce to her, the ability to involve herself in the important “work” of self-healing play, together with the freedom to use her natural curiosity and creativity. (p. 275-276)

Winnicott (1971) explains that play is a universal phenomenon and helps in communication, building relationships, and developmental health. Due to children’s limited verbal and cognitive processing skills, the combination of music and play seems more appropriate and eases the child’s means of expression (Winnicott, 1971). Utilizing play in musical interventions could be incorporated in improvised music and songs, pre-composed songs, musical stories, and music to accompany the child’s play. Toys, instruments, movement/dancing, and art could also be used to symbolically depict characters, images, or emotions that relate to the client’s present or past life (Dvorkin & Erlund, 2003; Erkkila, 1997; Kowski, 2007). Overall, the therapist’s interpretation of

the child's play and music gives insight and access to the child's inner world and inner conflicts (Kowski, 2007).

Music therapy and play could be applied to typical children and even children with disabilities. Both populations present with vulnerabilities and particular challenges, however, children with disabilities may present with complicated challenges, such as difficulty in verbal skills, abstract thinking, spontaneous creativity, and imagination. Yet, this method could be modified to fit the client's needs.

### **Managing Countertransference: Techniques and Benefits**

Managing and examining one's countertransference has many benefits and can be a valuable tool in enhancing the personal and professional growth of music therapists. Scheiby (2005) explains that countertransference can be used as a "tool of insight" (p. 9) for the music therapist and the client. Awareness of countertransference and its connection to the client can help "translate unconscious processes manifested in music to conscious ones" (Scheiby, 2005, p. 9). In addition, other benefits include: increasing self-awareness, improving or developing a healthy relationship with the client, gaining deeper insight, decreasing stress and anxiety, and achieving meaning and fulfillment out of our work (Bruscia, 1998).

Within psychotherapy theory, Van Wagoner, Gelso, Hayes, and Diemer (1991) discussed five interrelated traits that assist therapists in managing countertransference: (a) self-insight (the extent to which the therapist is aware of his or her own feelings and understands them), (b) empathic ability (the ability to understand the perspective of the client's experiences), (c) self-integration (the ability to separate oneself from others' transference), (d) anxiety management (the extent to which the therapist is able to manage his or her own anxiety), and (d)

conceptualizing ability (the therapist's ability to interpret the client's dynamics within the therapeutic relationship and the client's past).

Particularly for music therapists, Bruscia (1998) introduced some techniques for coping with countertransference reactions in sessions as well as outside of sessions. During music therapy sessions, it is essential for the therapist to be present with the client. The following techniques could be used to help music therapists remain present with the client and prevent countertransference from interfering with the therapy.

Self-clearing is a technique that allows music therapists to take some time before a music therapy session to clear their heads (Bruscia, 1998). This allows music therapists to compose themselves and remain present before or after a session. Moving one's consciousness, or shifting perspectives, is another technique that may assist the therapist to interact with the client. Bruscia (1998) explains that there are three types of experiential spaces that music therapists can move between: the client's world (empathy), the therapist's personal world (self-awareness), and the therapist's world as a therapist (client-therapist relationship). This can be done through sensory, affective, reflective, and intuitive exploration. This technique helps the therapist determine if countertransference can be used in a beneficial way.

The technique of following procedural cycles ensures movement within the experience. This can help the therapist avoid feeling stuck or developing negative feelings. Bruscia (1998) suggested five procedures: (a) floating (freely allowing perceptions and reactions to happen naturally and in the moment); (b) checking in (being mindful of what is happening in the here-and-now and feeling grounded in the moment); (c) shifting (shifting perspectives from one world to another by trying to compare experiences); (d) reflecting (reflecting on what is happening

from the therapist's point of view); and, (d) action (taking what the therapist has learned and implementing it to benefit the therapy).

Another way of managing countertransference in a music therapy setting could be through creative art forms. Music plays a significant role in the music therapist's life. Therefore, utilizing music as a means of reflection and uncovering countertransference can help therapists cope with and understand their feelings. Bruscia (1998) describes that creating a musical portrait, or improvising, re-creating, or composing music that describes or depicts the client, elicits the therapist's insights and countertransference reactions. Mandalas are another method for exploring countertransference reactions through drawing or art. The interpretation of the shapes and colors chosen by the therapist can be a means of bringing countertransference reactions to ones' awareness. In addition, diaries or journals provide a place for therapists to write and reflect upon their experiences.

A majority of the literature stresses the benefits and the significance of receiving supervision (Bruscia, 1998; Dillard, 2006; Paap, 2011; Priestley, 1994; Scheiby, 2005). Bruscia (1998) describes supervision as the "most effective and efficient method for uncovering and working through countertransference" (p. 114). Priestley (1994) supports that supervision "can be a real help towards making a therapist take a long, hard look at his own work" (p. 305). Supervision allows a therapist to talk through and work through personal and professional issues by talking to another professional with experience. Supervision usually involves an examination of therapist feelings and reactions with regard to the clients. It examines the relationship that occurs between the therapist and the client and also examines processes that occur in the music and during sessions. Another suggestion is for music therapists to seek their own personal

therapy. This helps the therapist examine and understand their countertransference when being placed in the position of the client (Bruscia, 1998).

With the help of the techniques, an understanding of countertransference could deepen and enhance clinical experience. Thus, the investigation, identification, and utilization of countertransference allows for an effective and beneficial means of enhancing the client's therapeutic experience.

### **Summary**

Countertransference is a psychodynamic term used to describe the therapist's reactions that are projected or introjected onto the client or therapeutic situation. The examination of countertransference is beneficial and can be used as a valuable tool in enhancing therapists' personal and professional growth, informing clinical decisions, and understanding the dynamics of the therapeutic relationship. In the literature, child psychotherapists and music therapists have neglected examining countertransference reactions when working with children, specifically children with developmental disabilities. In particular, music therapy literature on countertransference with children with developmental disabilities is significantly limited. The neglect in acknowledging countertransference is an issue that will be addressed in this study.

### **Problem Statement**

The purpose of this study was to explore music therapists' experience with countertransference when working with children with developmental disabilities. The research questions were as follows:

1. How do music therapists experience countertransference while working with children with developmental disabilities?

2. How do music therapists recognize, acknowledge, utilize, and manage countertransference in their work?
3. What are common countertransference themes or experiences that occur when specifically working with this population?



## **Method**

### **Participants**

Twenty-two potential participants were contacted through purposeful sampling, which is described as a method of selection using recommendations to find participants for a study (Suri, 2011). Patton (2002) clarifies, “the logic and power of purposeful sampling lie in selecting information-rich cases for study in depth” (p. 230). Music therapy faculty recommended potential participants for the study. All potential participants needed to have the following inclusion criteria: (a) board certification as a music therapist (MT-BC); (b) experience with transference/countertransference in music therapy sessions; (c) experience working as a music therapist with children with developmental disabilities; and, (d) comfort with and openness to sharing countertransference reactions.

Once the study was approved by Molloy College’s Institutional Review Board (see Appendix A), an invitational e-mail was sent to potential participants with information regarding the purpose of the research (see Appendix B). Potential participants were reminded to respond to the email before the recruitment deadline (see Appendix C). When a potential participant expressed his or her interest in participating in the study, the consent form was sent via email to be completed (see Appendix D). The consent form included information about the purpose of the study, as well as information about confidentiality and securing data. An additional consent form for permission to audiotape was also provided (see Appendix E). Each potential participant was contacted and screened through e-mail. The study protocol was reviewed and each participant was asked if they had any questions or concerns regarding the study. The first three individuals to give consent were chosen as participants.

### **Study Design**

A phenomenological design (Colaizzi, 1978; Giorgi, 1975; Husserl, 1962; Moustakas, 1994; Van Kaam, 1959; Wertz, 2005) was used to collect and analyze data. Phenomenology is a qualitative method that enables a researcher to study and examine human experiences (Forinash & Grocke, 2005). Due to the complicated nature of countertransference, the phenomenological approach seemed well suited for the study. In addition, the utilization of a phenomenological design was employed in existing literature that examines countertransference in music therapy (Dillard, 2006; Pedersen, 2007). This study used broad, open-ended interview questions to ask participants about their experiences, and data were analyzed using inductive thematic analysis, which will be further discussed.

### **Epoché**

My interest to become a music therapist was greatly influenced by individuals with developmental disabilities. I have volunteered with children and adolescents with developmental disabilities in recreational activity centers and programs for many years. During this time, I developed a sentimental and nostalgic appreciation for individuals with developmental disabilities. My experience and involvement working with the special needs community has significantly influenced my personal philosophy and professional philosophy as a music therapist.

Although my clinical practice is theoretically integrative, my epistemology is strongly rooted in humanistic and existential philosophies. It has significant influence over how I view human nature and, more importantly, how I view each of my clients. I believe that every individual has a purpose in the world. Whether one is aware of it or not, an individual's existence has significant meaning to human nature as a community. In addition, each person has the

potential for success and the capacity to reach his or her fullest potential. If an individual has a disability or is experiencing a situation that is preventing him or her from reaching one's fullest potential, he or she has the strength and capacity to overcome all obstacles. I do not believe that one's disability or illness defines who one is as a person. Essentially, we are all the same. Thus, I firmly believe that every individual should be treated with respect. We should all aspire to treat others the way we would like to be treated.

I consider myself to be a new professional; I have been practicing as a music therapist for two years in addition to pursuing my graduate studies. My brain is like a sponge that is soaking up all of the information I am gathering along the way. My knowledge and understanding of music therapy is continuing to grow and flourish throughout my educational and clinical experience. Although my professional identity and theoretical orientation is not yet firmly established, I have become aware of my curiosity and bias, and how my philosophies might impact my analysis of data and the study's findings. In order to account for these biases, I incorporated qualitative techniques, such as bracketing, member checking, and triangulation, to increase trustworthiness and validity (Aigen, 2005).

Clinically, I consider myself an integrative music therapist, who adapts and incorporates concepts from various theoretical orientations that best fits my clients' needs. I believe that each theoretical orientation has techniques and key concepts that could benefit one's approach to treatment. In particular, I apply psychodynamic theories to my work, examining how unconscious material is made conscious and appreciating the dynamics of the therapeutic relationship (e.g. transference, countertransference, and resistance). Everything has a meaning, whether it is a behavior, memory, thought, emotion, or object. Thus, the utilization of psychodynamic theories in my clinical work helps me process what is occurring in my therapy

sessions, identify the immediate needs of my client, and most importantly, understand how my countertransference may affect my client's therapeutic experience.

I am aware of my personal and subjective bias to my study. I have identified the following assumptions: (a) the participants' educational and theoretical background will have significant influence over how he or she perceives and processes sessions; (b) some participants either have received supervision in the past or are currently receiving supervision; and, (c) some of the results of the study may be similar to countertransference themes from existing music therapy literature (Bruscia, 1998; Dillard, 2003; Paap, 2011; Pedersen, 2007; Scheiby, 1998). I believe that my study has addressed an important phenomenon that is often neglected within the music therapy community, especially with children. This study will also contribute to the large gap in literature regarding countertransference in music therapy.

### **Materials**

For this study, one digital tape recorder was used to record the interview. The researcher's personal computer was used to securely store all of the data.

### **Data Collection Procedure**

Once approval was received from the Molloy College Institutional Review Board (IRB), recruitment for potential participants began. After the first three participants gave informed consent, each participant set up an appointment for an interview. The purpose of the interview was to understand and examine the meaning and depth of the experience of countertransference. Location and type of interview (e.g., in person, telephone, or Skype) was determined based upon the participant's convenience. Two participants chose to meet in-person and the third participant chose to have the interview via telephone. All interviews took place in a quiet and private location, with minimal distractions and privacy.

Before the interviews, participants were asked to prepare or recall a specific event where countertransference was experienced when working with a child or a group of children with developmental disabilities. Interviews lasted between 45 and 60 minutes depending upon each participant's length of responses. Interviews were audio-recorded using a digital tape recorder device. All data was stored on the researcher's personal computer, which was secured and locked with a password. During in-person interviews, the researcher observed any noticeable non-verbal gestures, body language, or facial expressions and documented these observations after the interview (Kim, 2008).

The interview consisted of three sections (see Appendix F): (1) greeting/introduction, (2) main discussion, and (3) closure. The first part of the interview consisted of a brief introduction where participants shared demographic information with the researcher. Demographic information included the participant's gender, educational/professional background, years of clinical experience, and a personal definition of countertransference. This helped the researcher understand the participant's educational, cultural, theoretical, personal, and professional background, which may have influenced the data. The researcher then reviewed the purpose of the study and confidentiality procedures, and encouraged each participant to answer each question to the best of his or her ability.

The second part of the interview consisted of the following prompt:

Could you describe a specific experience in your clinical work where you experienced strong countertransference reactions when working with a specific child or with children with developmental disabilities?

The researcher incorporated verbal techniques such as amplification, redirection, probing, reflection, and summarization to gather more information from the participant (Comeau, 2004;

Kim, 2008). In the last section of the interview, the researcher asked the participant if there were any additional comments or questions. To end the interview, the researcher thanked the participant for her participation, reviewed any information that needed clarification, and reminded the participant of a follow-up session.

Approximately two weeks after the interview, the participants were contacted by e-mail for a follow-up conversation in order to clarify and confirm the data. Once corrections were made, the researcher began to analyze the data according to protocol. Member-checking was employed, where a summary of the results of the study were shared with the participants to verify whether the results of the study matched the participants' experiences.

### **Data Analysis**

The data was analyzed according to a phenomenological framework developed by Giorgi (1975) and Colaizzi (1978). The following steps are adapted from Grocke (1999) and modified according to this study:

1. Each interview was transcribed word-for-word.
2. The researcher followed-up with each participant to clarify and confirm the data.
3. Each transcript was read through several times to gain a sense of the overall experience.
4. The transcripts were read through again and significant statements were underlined or highlighted.
5. Significant statements were grouped together and placed into meaning units. Each unit received a heading.
6. Each meaning unit was transformed into a condensed description of the participant's experience.

7. A summary and condensed description of the interview were sent to each participant for verification. Each participant was asked if there was anything he or she would like to add or if there was anything missing from his or her transcript.
8. When participants returned the material, the researcher revised and made changes according to suggestions from participants.
9. When all three participants verified the overall description of their experience, the researcher compared each interview, identified common meaning units, and developed categories according to common themes.
10. New themes were reviewed several times until a synthesized description was created.
11. The distilled synthesized description was transformed into a final description of the experience of countertransference when working with children with developmental disabilities.

## Results

The purpose of this study was to examine music therapists' experience with countertransference when working with children with developmental disabilities. Three participants volunteered to participate in the study in interviews to understand and examine the meaning and depth of the experience of countertransference. During the interviews, each participant was asked to describe an experience in their clinical work where they experienced strong countertransference reactions when working with a specific child or group of children with developmental disabilities.

### Participants

Participants are referred to using the anonymous pseudonyms "Music Therapist A," "Music Therapist B," and "Music Therapist C." Music Therapist A's interview was conducted via telephone; the interviews with Music Therapist B and Music Therapist C were conducted in-person.

Music Therapist A is a Caucasian, female board certified music therapist who is in her mid-thirties. She received her master's degree in music therapy and currently holds a New York State License in Creative Arts Therapy. Music Therapist A has worked with individuals with developmental disabilities including individuals with ASD and children with multiple disabilities. She currently works full time as a music therapist and manages a team of creative arts therapists and child life specialists at a residential pediatric center for children with developmental disabilities. The nature of her clients' developmental disabilities is often caused by various neurological impairments, which require intensive medical attention. Music Therapist A describes this population as "medically fragile." Many of her clients are in vegetative or minimally conscious states and present with minimal, observable responses.



Music Therapist B is a Caucasian, female board certified music therapist who is in her late twenties. She has received her master's degree in music therapy. She is currently in the process of receiving her New York License in Creative Arts Therapy. In addition, she is currently receiving post-graduate training influenced by psychoanalytic theory. Music Therapist B utilizes an integral approach to her theoretical orientation; she follows a humanistic philosophy and incorporates behavioral and psychodynamic techniques into her work. Currently, she works at a residence for children with developmental disabilities and a day center for adults with developmental disabilities. A majority of her clients, who are diagnosed with ASD, are in the process of transitioning from "the child world into the adult world."

Music Therapist C is a Caucasian, female board certified music therapist who is in her early sixties. She has received her master's degree in music therapy and currently holds a New York State License in Creative Arts Therapy. Music Therapist C has been working at a school-based program specializing in early childhood. She continues to work with children ages birth to five years with varying diagnoses and populations, although majority of her clients are classified as Preschoolers with a Disability (PSWD). Specific populations with whom she has experience include children with autism spectrum disorder, behavioral disorders, learning disorders, cognitive impairments, and neurological impairments. Music Therapist C utilizes an integrative approach when working with her clients; she describes that she pulls from different theoretical concepts that meet her clients' most immediate needs. However, she identifies primarily as a humanistic practitioner and focuses her work around music-centered practice.

The results of the study are presented in four sections: (a) a summary of the case examples; (b) definition of countertransference; (c) individual case synopses; and, (d) essential themes resulting from the data analysis. Each section summarizes the significant material that

was discovered in the data analysis. The essential themes are separated into five categories: (a) experience of countertransference; (b) recognition of countertransference; (c) acknowledgment of countertransference; (d) utilization of countertransference; and, (e) management of countertransference. Excerpts from the participants have been placed under the essential themes to support the findings.

### **Summary of Case Examples**

**Music Therapist A.** Music Therapist A described her experience of countertransference when working with a male client diagnosed with arthrogryposis and bronchopulmonary dysplasia at the residential pediatric center. He had a tracheostomy and gastrostomy tube and required a wheelchair for mobility secondary to his multiple contractures. The child had received individual music therapy for five years. She began working with her client when he was four years old and ended sessions when he was nine years old. Music Therapist A considered herself to be a young music therapist during the time she was working with her particular client; she was between the ages of 24 to 28 years. Therefore, she stated, “I viewed the work quite differently.”

**Music Therapist B.** Music Therapist B described her experience of countertransference when working with a male client diagnosed with ASD at the children’s residential facility. Her client experienced some speech impairments, such as having difficulty enunciating words, and behavioral issues, such as exhibiting impulsive and violent behavior. The child had received group music therapy for one year. Music Therapist B worked with her client when he was ten years old. He was described to have a demanding and controlling presence in the group.

**Music Therapist C.** Music Therapist C described her personal experience of countertransference when working with a female client who was referred to as a “Preschooler with a Disability” (PSWD) at a school-based program for early childhood intervention. A

specific diagnosis for the child was not given for legal purposes. Her client came into the center when she was four years old. Before receiving services at the center, she had been receiving individualized services at home, which included special education, physical therapy, and speech therapy. Her family seemed reluctant to send her to the program because they felt that she did well within a one-to-one setting. The child was referred to music therapy and considered eligible for individual music therapy services by the school district without a formal assessment by a credentialed music therapist. Music Therapist C described that this created a sense of mistrust within the entire faculty and treatment team.

Music Therapist C described her client having one of the most “bizarre” manifestations of behavior that she has ever seen. Her client appeared to have functional physical and cognitive skills, but did not demonstrate an ability to verbalize or vocalize except through screaming and crying. Music Therapist C reported that her client screamed and cried every day throughout the entirety of the four-hour program. As a result, she was considered a challenging and difficult client and was often disliked by majority of the staff and some of her fellow classmates. Music Therapist C worked with his particular child over a span of six months. She reported that the child’s parents withdrew her client from the school, which abruptly ended music therapy treatment and prevented opportunities for closure. The countertransference experience described in the interview occurred near the end of treatment.

### **Definition of Countertransference**

The participants in the study were asked to provide their own definitions of countertransference. Each participant perceived countertransference differently, but with minor similarities. Two participants understood countertransference as any conscious or unconscious response that emerges when working with an individual in therapy sessions. Music Therapist A

expressed: “Whether I am aware of them or not aware of them, whether they are musical, physical, or emotional responses...they come from any type of response that I would have towards an individual that I am working with.” However, from a different perspective, Music Therapist B understood countertransference through examining one’s past relationships: “For me, it is past relationships that are coming into play in the present...It is about past relationships and interacting with them in your present, maybe not consciously.”

In contrast, Music Therapist C expressed that sometimes music therapists may misinterpret some physical or emotional reactions as countertransference: “Not every negative or positive reaction towards another human being is countertransference.” She expressed that it is important to “tease out” whether we are responding to something that is occurring in the moment or whether we are responding to something that is occurring within ourselves. She clarified:

When countertransference comes into play, it is when we, as the facilitator, the therapist, is responding not to the child, but to something within ourselves that the child has triggered that has nothing to do with that child...Countertransference comes in when it’s us not dealing with human beings, but with an image we hold within ourselves.

### **Individual Case Synopses**

**Music Therapist A.** Music Therapist A began working with her particular client when he was four years old. When working with this child, she experienced personal enjoyment. She physically experienced her breath rate increase. She felt that her sessions went by quickly, which led to maximizing her time with her client. She described their musical interactions as “major, upbeat, and affirming.” In the music, she felt that she was her “most creative, musical self” and found herself initiating and engaging in new musical ideas. Her music was described as being “overly supportive, overly structured, and overly validating.” She “developed an affinity”

towards this child. Being that she worked in a residential facility, she would find opportunities or “find a reason” to see the client more than just once a week. For instance, she would make sure to bring the client to special events or say goodbye to the client before she left for the day. Outside of her clinical setting, she noticed herself experiencing “consuming thoughts” about “different aspects of her work” with this child, such as reflecting upon her feelings of happiness in therapy sessions or imagining what it would be like if the child lived in her home. Also, if she was absent from work, due to sickness or vacation, she felt like it would be a “huge loss” for this child.

Music Therapist A’s awareness of her countertransference fluctuated over time: “I’m not sure that I was [aware] at first.” Clinical supervision helped her recognize and begin to process these reactions and discover where they were coming from. She was initially aware of her client’s significantly high needs and how she was meeting them in a specific way that nobody else was. This made her feel “very important.” She also felt like the staff was not giving her client enough attention or seeing the child’s unique and special qualities. She was then able to acknowledge that her countertransference was “fulfilling the need to be needed” and was experiencing an “inability to let others play a role for this child.” Her awareness of her countertransference enabled her to distance herself from the child, “refocus her attention,” and grow simultaneously as a professional.

Music Therapist A considers countertransference to be a valuable decision-making tool. Because many of her clients have minimal observable responses, A’s countertransference has helped her make decisions to either “move into a specific experience” or influence specific song choices. As she brings her countertransference to her “conscious mind,” she is able to acknowledge that they are coming from her and is able to gain insight into the source of her

countertransference. From there, she can recognize and “balance” what she is bringing into her music therapy sessions. She also mentioned that music therapists often view countertransference as “something negative or something we should eliminate.” Yet, countertransference has many positive qualities. She described it as one of the driving forces in therapy sessions: “it’s really what is driving the relationship-based nature of what we are doing.” The process of uncovering countertransference allows us to “engage with our responses in a meaningful way.”

**Music Therapist B.** Music Therapist B began working with her particular client when he was ten years old in a group music therapy setting. Her client had difficult behavioral issues and typically exhibited violent or aggressive behavior. When working with this child, she perceived him as a challenging client that “nobody wanted to work with” or liked. She often saw him as a “hopeless case” and felt bad for him. B’s understanding of her client made her think about her brother, who has a history with mental illness. In her past, there was a time where she viewed her brother as a “hopeless case.” She noticed certain characteristics or behavioral tendencies in her client that reminded her of her brother. In addition, these specific characteristics were also reflected in the client’s music. For example, the client’s music was described as “chaotic, frantic, and unbalanced.” As a result, B would often struggle to provide a “grounding solid basic beat.” She began to develop a “savior complex” towards her client and felt a need or “desire” to want to help him: “I was projecting that feeling of, ‘No, don’t give up on him.’”

Music Therapist B also experienced feelings of losing her sense of control in music therapy sessions: “I felt like I was losing my control a little bit because he wanted to control it.” Because her client had a strong and demanding presence, she noticed that she was giving him a lot of attention. She expressed that it was difficult to manage him in sessions and balance the group’s dynamic; “it may create jealousy and feelings of abandonment in the other children.” As

a result, she experienced some feelings of resentment towards her client. For instance, she felt angry or frustrated when her client attended sessions, disrupted sessions, or became violent towards group members. She felt like she needed to act authoritatively with him in order to have some sense of control and manage his problematic behaviors. On other occasions, she felt nervous around him during musical activities because she was not sure whether he would play with the instruments or use them as a weapon. Lastly, most of her energy was focused on keeping the music therapy groups orderly and safe. However, she still experienced a desire to help him: “There was this simultaneous wanting to help him while also being angry with him for hitting other people.”

Music Therapist B expressed that her busy schedule does not permit ample time to reflect on her sessions. She noticed that she often recognizes her countertransference during her drive home from work or while receiving personal therapy: “[recognition of countertransference] came more afterward with this particular child.” However, she was able to recognize the control issues with him during music therapy sessions. B’s wanting to “pray for some clients” is another countertransference reaction she has experienced in sessions. She considers it important to acknowledge any strong reaction that arises during a session.

Music Therapist B utilizes countertransference as a tool that informs her work. It “may affect the type of music I choose or feel that I’m getting with them.” For this particular client, countertransference helped her cope with his challenging behaviors and acknowledge whether her reactions were contributing to them: “For example, if I try too hard to control the session, I may create an unnecessary power struggle.” B also feels like countertransference reactions or our reactions to people are difficult to avoid: “You cannot help but have that affect your work because it’s always in the back of your head.”

**Music Therapist C.** Music Therapist C shared a specific moment in her clinical work that was still prominent and significant to her. C shared her countertransference experience when working with a four year-old girl who was classified with PSWD. Her client was considered a very challenging and difficult child to work with due to her “bizarre” behavior. C described, “This was a kid who had no adult, no child, no place where she felt like she belonged.” However, in individual music therapy sessions, C noticed that the child stopped crying when she began to improvise with her.

Music Therapist C described her improvisations to be “very primitive sounding.” She incorporated harsh dissonance, polyrhythmic patterns, grunting, and bold dynamics: “the more harsher our music, the more engaged she became.” C expressed that it was at this point where they developed a wonderful music therapy relationship: “I knew that this was a place where whatever message she wanted to send to the world, she was able to send.” She noticed that the child appeared to experience a “sense of completion” or a “sense of fulfillment” that she was able to express herself through music.

Music Therapist C described that as time passed, things became more difficult for the child and tension between the child’s family and the school began to rise. During one of their typical sessions, the child suddenly said a full-sentence that caught C by surprise: “You are so ugly!” C initially experienced shock and disbelief that the child spoke a full-sentence. Suddenly, she began to re-experience strong emotional feelings from a specific experience in her past: “This is where the countertransference came in like *that* [snaps].” C began to share her experience of being terribly bullied as a child in elementary school. She expressed: “As soon as this young woman said that, it all of a sudden opened these flood gates to being back there in 7<sup>th</sup> grade and just feeling this swirling of hate and misplacement and self-degradation that was



there.” C expressed how hard it was to reflect upon that experience and work through it. In response, she stopped her music and began to play familiar music from group music classes: “I just withdrew from everything else. All of that connected music we had just had, I went right back into, ‘Let us just do a song about animals and then we are done.’”

Music Therapist C expressed that this experience was one of her clearest examples of strong and unexpected countertransference. She mentioned how she was immediately able to recognize that her experience was a significant countertransference reaction: “There were those split seconds of experiencing it...It was within that session that I realized that this was not about her, this was about me.” After her experience, she described her ability to acknowledge her countertransference was through “self-process.”

Music Therapist C shared that she tries to keep countertransference separate from her clinical work in therapy sessions. C understands countertransference as a concept or tool that helps music therapists understand their own issues. She supports: “Countertransference is all about us and our ability to feel it, understand it, label it, and figure out where it is going to sit in your practice...I think we become better, more open vessels of music by recognizing that countertransference is something that does happen...The more we are able to examine ourselves that way, the more we are able to be open, flexible, and feeling human beings.” In addition, C emphasized the importance and value of examining transference: “I think the more aware we are of countertransference in the background, the more open we are to opening ourselves up to providing an opportunity for transference that our clients need in order to grow.”

**Essential Themes**

This section is organized into the following categories: (a) countertransference experiences; (b) recognition of countertransference; (c) acknowledgment of countertransference; (d) utilization of countertransference; and, (e) management of countertransference.

**Countertransference experiences.** This category is based upon each participant's overall description of their countertransference phenomenon, as described in the individual case synopses. The participants of this study experienced four major factors that influenced their particular experience. Based on their experiences, four predominant themes became apparent: (a) fulfilling needs in the therapist; (b) feeling attached; (c) the "superman complex;" and, (d) re-experiencing the past.

***Theme 1: Fulfilling needs in the therapist.*** Some participants experienced moments where their countertransference reactions were fulfilling a need within themselves. Music Therapist C reflected upon her experience when working with children with developmental disabilities for many years:

Our children come to us, they are very vulnerable, and they are very needing of our attention, our focus, and our love. They often want to connect with us and to be part of us. It's very appealing, in a countertransferential way, to feel so wanted and to feel so loved.

Music Therapist A's experience supported this in recognizing that working with her client was fulfilling a specific need to feel wanted: "Looking at what was fulfilling to me...in feeling like I needed to be needed."

***Theme 2: Feeling attached.*** This particular experience occurred in all of the participants' experiences. Music Therapist A and Music Therapist C developed a sense of attachment towards

their client because of their positive experience with their client. Music Therapist A stated: “I personally enjoyed the music and I also felt like I was my most creative and musical self. I think I developed an affinity towards this child.” Music Therapist C expressed: “After a while your visual focus as well as your musical focus tends to shrink and be aligned to that one child.” In Music Therapist B’s experience, her attachment towards her client was her connection to her sibling: “I was projecting that feeling of, ‘No, don’t give up on him.’...I actually tried to do a one-on-one session with him because I wanted so badly for him to have this experience. I wanted to help him.” Each participant’s affinity towards their client caused them to become overly invested and involved in their treatment. Music Therapist A expressed her need to see her client everyday: “I may have found a reason to see them...I would go and make sure that I found this child.” In music therapy sessions, the participants noticed they would focus most of their attention on these clients.

**Theme 3: “*Superman complex.*”** The participants experienced the feeling like they were responsible for helping their clients. As Music Therapist B described it, “The ‘superman complex’ is something that I resonated with...I have to be the one to help this kid. I have to be the one to swoop in and save this child. I am going to be the one.” In a similar way, Music Therapist A experienced a sense of importance while working with her client:

I am meeting their needs in a very specific way that nobody else is...Other people were cheating this child, they were not giving this child much attention or they didn’t see the special-ness or uniqueness, or that these very important things were happening in the music.

Issues with staff or colleagues seemed to influence each of the participants to develop this feeling of responsibility. B explained: “I had a supervisor who was burnt out and did not like

him. She would say, ‘Ugh, there is not a nice bone in his body.’ It always gets to me; you got to find good in everyone.” Music Therapist C shared that when tensions rose in her four year-old client’s life, she felt that being in music therapy was that one moment where her client could express herself and work through this difficult time in her life: “I was feeling like this was a breakthrough that maybe she could use to adjust.”

**Theme 4: Re-experiencing the past.** Some participants’ countertransference experiences triggered them to re-experience specific events or relationships in their past. Music Therapist C shared how her client’s statement triggered her to immediately place herself back in time to when she was bullied in school: “As soon as this young woman said that, it all of a sudden opened these flood gates to being back there in 7<sup>th</sup> grade.” She added that when she was re-experiencing her past, she was not present in the moment, but instead focused on her past. Music Therapist B re-experienced her past relationship with her brother when working with her particular client. There were specific characteristics about her client that reminded her of her brother and her own experience living and coping with a sibling who suffered from mental illness: “I felt like that as a child. Here is my brother with all these problems, and I’m like, ‘No, I have problems, too, and I need to act out.’”

**Recognition of countertransference.** This category describes how each participant was able to notice that they experienced countertransference reactions towards their client or clinical situation. It is summarized in three main themes: (a) the presence of emotional responses; (b) deep concern for the client; and, (c) the power of subtle reactions in the therapist.

**Theme 1: Presence of emotional responses.** The participants’ emotional feelings towards their clients indicated that they were experiencing countertransference. Music Therapist C was able to recognize her countertransference immediately in her session due to her strong emotional

response: “It all of a sudden opened these flood gates to being back there in 7<sup>th</sup> grade and just feeling this swirling of hate and misplacement and self-degradation.” Music Therapist B reported feelings of resentment towards her client when she felt like she was losing control of her sessions: “I would get angry when he would show up because we were having this nice session and then he comes into the room throwing everything.” Music Therapist A reported experiencing guilt, which allowed her to recognize her over-involvement in the client’s treatment: “This would be such a huge loss for this child.” In some cases, the participants’ feelings towards the clients prevented them from noticing other countertransference responses. Music Therapist A supported this concept: “My perception of some of these things may be clouded by my feelings toward this child.”

***Theme 2: Deep concern for the client.*** Some participants were able to notice a deep concern for their clients. This could have been due to the client’s severity of needs, the vulnerability of his or her condition, or his or her uncontrollable tendencies. Music Therapist A expressed her concern when she felt that other staff members were unable to meet her client’s needs: “This was a child who had really high needs...other people were cheating this child...They were not giving this child much attention or able to see the special-ness or uniqueness.” Similarly, Music Therapist C expressed concern for her client: “This was a kid who had no adult, no child, no place where she felt like she belonged.” Through another approach, Music Therapist B recognized her concern when she felt a need to pray for her client: “My wanting to pray for some clients...might be a clue if somebody has the inclination to feel that concerned about them; what is going on with them in that relationship?”

***Theme 3: The power of subtle reactions in the therapist.*** After reflecting on their experiences, some participants recognized the significance of small or subtle responses to their

clients. These subtle responses seemed to bring awareness to important countertransference material. Music Therapist A stated:

I would like to go back to the idea of how prevalent and sometimes loud the countertransference responses can be as factors in driving a session...I think it is something that we do not put all together, all of those more subtle pieces. I think that they are very important to consider.

To support, Music Therapist B reported: "Any strong reaction is something you need to think about." However, Music Therapist C brought to attention that not all subtle responses are considered countertransference:

Sometimes it is difficult for music therapists to understand that not every negative or positive reaction towards another human being is countertransference. Sometimes, when you work with young children, they are annoying...that happens to all of us as practitioners because we are real humans dealing with real humans.

**Acknowledgment of countertransference.** This category discusses how each participant was able to accept and understand components of and meaning behind their countertransference. The participants of the study were able to acknowledge their countertransference in different ways. Two themes were uncovered: (a) a delayed recognition; and, (b) assisted awareness.

***Theme 1: Delayed recognition.*** Some participants experienced difficulty in acknowledging countertransference reactions in the moment. Their countertransference reactions were either recognized after music therapy sessions or outside of their jobs. Music Therapist B did not acknowledge her countertransference until after she worked with her client:

I like to think I am *that* good to realize it in the moment...Sometimes this kind of stuff just comes to me when I am driving home...It came more afterward for this particular

child, but the reaction to the control thing was something that I think I noticed in the moment.

Music Therapist C expressed that she was able to acknowledge some of her countertransference reactions through years of clinical experience and reflection upon her colleagues' and music therapy students' countertransference experiences.

**Theme 2: Assisted awareness.** Some participants became aware of their countertransference reactions with the help of clinical supervision, personal therapy, or self-reflection. Music Therapist A reported that her clinical supervisor assisted her in recognizing and processing these feelings: "My clinical supervisor was the one who helped me to start processing where those things were coming from." Music Therapist B felt like she needed to make time to self-reflect and receive personal therapy or else she would have missed these countertransference experiences: "Being in therapy is important because sometimes I am not just talking about my personal life, I am mostly talking about my job." Working in a supportive environment, Music Therapist C was able to discuss and process her countertransference experience with the music therapists with whom she worked.

**Utilization of countertransference.** This category discusses how each participant incorporates their understanding of countertransference into their clinical work. The participants were able to utilize countertransference in a number of ways. Four themes emerged on using countertransference: (a) as a decision-making tool; (b) insight to the therapeutic relationship; and, (c) insight to self. In addition, one participant used this opportunity to address the importance of examining transference.

**Theme 1: Decision-making tool.** Some participants expressed how countertransference is considered a valuable tool in making clinical decisions and informing their work. Music

Therapist A stated: “As I bring various pieces of my countertransference to my conscious mind, I am able to make decisions within the sessions.” Participants used examples of how countertransference informs the direction of their musical experiences or musical intention. Music Therapist B reported: “It may affect maybe the type of music I choose or the type of feeling that I’m getting with them.”

***Theme 2: Insight to therapeutic relationship.*** Countertransference also served a purpose in understanding the therapist’s relationship with the client. Music Therapist A expressed:

It is really what is driving the relationship-based nature of what we are doing, which makes it different than giving someone medication or a listening assignment. It is really the process of bringing it into our awareness so that we can engage with our clients in a meaningful way.

Music Therapist B’s countertransference of her brother enabled her to gain greater insight into her relationship with her client:

This destructive tendency that he [her client] might have might be what my brother experienced when he was aggressive sometimes...I guess that is when my brother came up for that too, because it is tough when you have a tough case...feeling like the enigma. What can we do with this one? How do we solve this problem?

In addition to understanding the relationship, Music Therapist C addressed how accepting specific roles for the client could inform the therapeutic relationship. She expressed:

We as music therapists need to have that in ourselves to be willing to assume the role that your client needs you to assume in that moment...There are times when my little clients need me to be ‘mommy’ in all guises.



**Theme 3: Insight to self.** Music Therapist C expressed how she uses countertransference as a means of gaining awareness and insight to better understanding her self:

I think we become better more open vessels of music by recognizing that countertransference is something that does happen and being able to allow ourselves to feel it, recognize it, label it, and then put it somewhere to the side...then we could move this way towards the client. I think the more we are able to examine ourselves that way, the more we are able to be open, flexible, feeling human beings and just say, 'Whatever you got, I am here for you.'

**Theme 4: Importance of examining transference.** Music Therapist C emphasized how examining our clients' transference, in addition to countertransference, has valuable information that could inform our work as well as increase our awareness. She supported:

I do not think we focus a lot about the concept of transference and how vital and valuable it is for the client within music therapy practice, and particularly children with developmental disabilities and particularly with young ones...I think we need to be careful as professionals to not get caught up in ourselves and really spend more time thinking about what does that client need in the moment.

She stressed that transference may be equally as important as countertransference.

**Management of countertransference.** This category briefly mentions strategies each participants use to cope with countertransference in their clinical work or in their personal life. The participants briefly mentioned ways in which they are able to manage their countertransference experiences. There are two themes that emerged from the data analysis: (a) receiving supervision; and, (b) receiving personal therapy.

***Theme 1: Receiving supervision.*** Two participants mentioned the use of clinical supervision and peer supervision as a means to help process and become aware of countertransference responses. Music Therapist A expressed that receiving clinical supervision has significantly aided her awareness of her countertransference and enabled her to gain insight into the source of her countertransference: “My clinical supervisor was the one who helped me to start processing where those things were coming from...I would say that the largest piece was receiving clinical supervision.” Similarly, Music Therapist C reported that working in a supportive environment with other music therapists gives her the opportunity to share her experiences and process her countertransference through peer supervision: “We can really share our experiences and share openly about it. I think that aspect of it is really beneficial.”

***Theme 2: Receiving personal therapy.*** Music Therapist B briefly mentioned that one of her methods of managing her countertransference, along with self-care practices, is through receiving personal therapy. She shared that personal therapy has helped her gain awareness and insight to her countertransference reactions: “Being in therapy, I am not just talking about my personal life, I am mostly talking about my job.”

### **Essential Description**

Music therapists’ understanding of countertransference is significantly influenced by individual differences and/or educational and theoretical background. These differences affect the ability to recognize and acknowledge countertransference in one’s clinical work. When working with children with developmental disabilities, the interviewed music therapists experience countertransference reactions as physical or emotional responses ranging from subtle to strong. Countertransference can also be experienced as a deep concern for a client, especially in response to transference from the client.

The findings of this study demonstrated that the three music therapist participants experienced the following countertransference themes: (a) a fulfillment of needs in the therapist; (b) feelings of attachment towards the client; (c) a heightened sense of responsibility (“superman complex”); and, (d) the reliving of past experiences. Results showed that the acknowledgment of countertransference reactions can be difficult to recognize in the moment; however, some may be more easily recognizable depending upon one’s level of awareness. The utilization of supervision, personal therapy, and self-reflection assists music therapists in becoming aware of and developing greater insight in the source of their countertransference. Interestingly, this study found that countertransference can be an effective and beneficial tool in making musical and clinical decisions. In addition, it enables music therapists to develop a deeper understanding of the client’s transference, the client’s overall experience, and the therapist’s examination of self.

### Discussion

The thematic results were organized into five categories: (a) countertransference experiences; (b) recognition of countertransference; (c) acknowledgment of countertransference; (d) utilization of countertransference; and, (e) management of countertransference. Under the category of countertransference experiences, the following five themes were presented: (a) fulfilling needs in the therapist; (b) feeling attached; (c) “superman complex:” and, (d) re-experiencing the past. The category of recognition of countertransference identified the following three themes: (a) the presence of emotional responses; (b) deep concern for the client; and, (c) the power of subtle reactions in the therapist. Acknowledgment of countertransference identified two themes: (a) a delayed recognition; and (b) assisted awareness. The category of the utilization of countertransference identified four themes: (a) decision-making tool; (b) insight to therapeutic relationship; (c) insight to self; and, (d) importance of examining transference. Finally, the management of countertransference presented two themes: (a) receiving supervision; and, (b) receiving personal therapy.

The results of this study indicate that when working with children with developmental disabilities, each participant’s countertransference was influenced or activated by some aspects of their client’s particular condition, severity of needs, or vulnerability. The term, developmental disabilities, addresses a large array of specific populations that fit within this broad category. The number of areas of concern as well as the severity of needs varies from individual to individual. In addition, children with developmental disabilities experience delays and difficulties in cognitive, physical, communicational, social or emotional, and adaptive skills (Humpal, 2014). They often present with limited verbal and cognitive processing skills, which makes it difficult for them to express themselves or process what is happening around them. The vulnerability of

the population and the diverse areas of concern impacted the clients' transference that was projected onto the therapist. Thus, each participant's countertransference reaction was in response to her client's transference.

According to the results, all of the participants had a need to feel validated by their clients or satisfy a need in themselves. Some of these reactions included: developing an affinity towards the child, providing the child with a lot of attention, experiencing an abundance of enjoyment and pleasure when with the child, having a sense of control, and placing importance on their roles as the therapists. All of the participants were seeking validation from their clients. When the client was not validating the therapist, countertransference reactions were recognizable or noticeable by the participants. The incorporation of music could have also heightened these feelings in sessions because of the child's positive response to music and the music therapists' possible bias of the effects of music therapy compared to other treatment modalities.

In addition, each of the clients described in the interviews were children with developmental disabilities who were considered challenging cases or were not receiving enough attention from other clinicians. Music Therapist B and Music Therapist C described clients who were "disliked" by other staff. Additionally, both of the clients they discussed had an absent parental figure or caregiver who could not provide them with the love, attention, and acceptance they possibly needed. Similarly, Music Therapist A felt that her fellow staff members were not giving her client enough attention. This was yet another factor that could have influenced the music therapists to experience such strong countertransference reactions towards their clients and take on that caregiver responsibility.

In comparison to the literature, the results of this study differed from the countertransference reactions of psychologists who worked with children with developmental

disabilities. According to a study by Gordon et al. (2009), common countertransference reactions amongst psychologists working with children with developmental or physical disabilities included intense and harsh reactions, such as anxiety, helplessness, and fear of own mortality. The differences in countertransference reactions that emerged in psychologists may suggest that some therapists still continue to perceive countertransference as a negative phenomenon. As a result, this causes them to recognize negative countertransference reactions towards their clients. The findings of this study, however, indicate that all of the participants' perceptions of countertransference have incorporated an integrative approach to understanding their countertransference reactions. The descriptions of their experiences show that countertransference can contain both positive and negative qualities.

Only one music therapy study had some similar findings regarding music therapists' experience of countertransference when working with children with developmental disabilities. Paap (2011) explained her countertransference reactions taking on the role of the "nurturing mother," (p. 32), which parallels the results of this study. She described her experience of countertransference as "feeling very nurturing" towards her client, empathizing with her client, and an urge to "mother" her client (p. 32). Her abilities to empathize and nurture her client satisfied her need to mother the child.

### **Countertransference as a Subjective Experience**

The data demonstrated that the participants' descriptions of their countertransference experiences differed in many ways. In the literature, countertransference is regarded as a phenomenon that is greatly influenced by an individual's past and present experiences, personal philosophy, attitudes, thoughts, feelings, behaviors, physical reactions, and emotions (Bruscia, 1998; Hayes et al., 2011). The findings of the study showed that these individual differences

were present in the following ways: (a) participants' definitions of countertransference; and, (b) participants' intersubjective and intrasubjective experiences.

**Definition of countertransference.** When the participants were asked to define countertransference in their own words, each participant's definition of countertransference was very different. Yet, their definitions of countertransference influenced how they described and recognized their countertransference experiences. All of the participants' definitions of countertransference incorporated various elements of classical, totalistic, intersubjective, and intrasubjective perspectives (Bruscia, 1998; Hayes et al., 2011). Despite their differences, all participants understood countertransference as the therapist's unconscious reactions that are brought to one's consciousness by the client. Unconscious reactions were interpreted as either a physical or emotional reaction or a past image or experience. Differences in how they defined countertransference were shown through their choice of wording, their choice of musical examples, and overall perception of their experience. Individual differences are discussed below.

Music Therapist A defined countertransference as any conscious or unconscious response towards the client. Her description of her countertransference was predominantly explained through the ways she consciously or unconsciously responded to her client (e.g. affection, personal enjoyment, overly supportive and structured music). With the help of supervision, she was able to become consciously aware of her reactions towards her client, thus allowing her to recognize and acknowledge that the countertransference reactions she had toward the child were satisfying specific needs within herself.

Music Therapist B defined countertransference as past relationships consciously or unconsciously emerging in present relationships. In her countertransference description, she connected her relationship with her client to her past relationship with her brother. Her client

presented many similar characteristics and behaviors reminiscent of her brother (e.g. “hopeless case,” chaotic, aggressive, uncontrollable). This seemed to significantly impact her relationship and interaction with her client as it caused her to direct most of her attention towards him and develop a deep concern for him. In addition, it gave her an opportunity to unconsciously resolve or fix issues from her past relationship. Although it took her time to recognize her countertransference, she was finally able to realize that she was re-enacting and re-experiencing her relationship with her brother through her relationship with her client.

Music Therapist C defined countertransference as an experience where the therapist is responding to something in herself that is separate from the client. She described it as dealing with an “image” we hold in ourselves. In her experience, her client’s surprising statement triggered her to re-experience her past experience of being bullied as a child (e.g. recalled location, classmates, and feelings of hate and self-degradation). In that moment, she was not present with her client, but was instead consumed with her past image. She was immediately able to recognize her countertransference because of her strong emotional reaction.

**Intersubjective and intrasubjective experiences.** Bruscia (1998) separated manifestations of countertransference into two domains: intersubjective countertransference and intrasubjective countertransference. Intersubjective countertransference is countertransference that originates from the therapist’s self. This may include aspects of the therapist’s identity, personal history, and professional history. Intrasubjective countertransference is countertransference that originates from the interactions with the client. This may include physical or emotional reactions evoked by the client’s transferences or therapeutic relationship.

The participants’ definitions and descriptions of countertransference might have been greatly influenced by their intersubjective and intrasubjective experiences. Intersubjectively,



each participant's personal, educational, professional, and theoretical background played a significant role in how they understood the concept of countertransference, how they acknowledged it, and how they utilized it. For example, Music Therapist B utilized a psychodynamic approach to understanding her countertransference by relying on how the past influences present relationships. This could have been due to her current post-graduate training, which is greatly influenced by psychoanalytic theory.

Intrasubjectively, each of the participants' descriptions of their countertransference experiences was greatly impacted by their client's transference and the therapeutic relationships. All of the participants adopted a specific role that influenced their countertransference reactions toward their clients. For example, Music Therapist A felt like others were not meeting her client's needs the way she was able to meet them. This caused her to develop a sense of importance, thus adopting the role of "nurturing" or "overly involved" mother.

### **Types of Countertransference Experiences**

Mary Priestley (1994) introduced three types of countertransference: classical countertransference, c-countertransference and e-countertransference. Due to the complicated nature of countertransference, various elements of each type could be found in one's overall countertransference experience. Data analysis showed that each participant's experience captured elements of these types of countertransference experiences. However, the participants' c-countertransference and e-countertransference reactions most prominently emerged from the data.

C-countertransference, or complementary identifications, occurs when the therapist identifies with the client's transference (Priestley, 1994). It often appears when the client uses the therapist as his or her "internal or projected object," which causes the therapist to develop

identification towards that projected image (p. 86). All of the participants' countertransference experiences appeared to be influenced by their client's transference; each participant assumed a role that was meeting the needs of their client. Music Therapist A's client presented a transference that caused Music Therapist A to become a nurturing mother figure. Music Therapist B's client presented a transference that caused Music Therapist B to adopt a strong, authoritative figure to balance the power struggle. Music Therapist C's client presented a transference that was pushing Music Therapist C away, which could have caused her to react similarly as the client's mother figure.

Priestley (1994) describes e-countertransference as repressed emotional or somatic reactions that arise in the therapist's consciousness. E-countertransference is often the therapist's unconscious response to the client's emotions or feelings. Common e-countertransference reactions included feelings of pleasure, attachment, curiosity, guilt, frustration, anger, and shock. Music Therapist C's countertransference experience demonstrated how e-countertransference emerged in her work with her client. As her client triggered her reaction, all of the repressed thoughts, memories, feelings, and emotions were immediately brought back to her conscious awareness. Because of this overwhelming sensation, she was unable to respond to her client's needs or work through her countertransference in order to remain present with her client. In response, she stopped what she was doing and moved to something that could hide or repress her emotions from her client. These emotional reactions brought to awareness questions about why she was experiencing these feelings, but also, what was happening in her client.

**Musical countertransference.** Each of the participants were able to recall how their countertransference reactions emerged in their music. These manifestations of countertransference arose in structure, dynamics, articulation, rhythm, tone, timbre, emotional

qualities, and idioms (Scheiby, 1998). Scheiby's (1998) explanation of the manifestations of musical countertransference during musical interventions was recognized in participants' descriptions of their music. The majority of the participants' music did not fit the context of their client's music, took them by surprise, or did not feel authentic.

In relation to the participants' musical countertransference experiences in Dillard's (2006) study, participants in this study experienced some difficulty recognizing how their countertransference was reflected in the music. During the interviews, some of the participants did not focus their description on musical countertransference; rather, a majority of their focus was on the transference and countertransference dynamics that informed the therapeutic relationship. In addition, most of the participants utilized countertransference as a means of informing their musical decisions, such as deciding musical interventions to use or choosing musical elements that would meet their client's needs in the music. However, this could also imply that some participants might have been aware of and trained to recognize countertransference, but not musical countertransference.

### **Managing Countertransference**

The participants of the study briefly mentioned a few methods of managing countertransference reactions. The use of supervision and personal therapy appeared to be the most prominent means of uncovering, exploring, and managing countertransference. Additional methods that were mentioned included self-reflection, exercise, praying or meditation, and self-care practices (e.g. performing, playing music for self). Bruscia (1998) describes, in detail, many techniques and strategies music therapists could use in order to help manage countertransference reactions. Due to the nature of working with children with developmental disabilities, failure to examine countertransference could lead to dangerous implications (Dillard, 2006; Maroda, 2004;

Priestley, 1994). Therefore, incorporating strategies to cope with and work through countertransference could help one contribute to his or her personal and professional growth.

**Importance of supervision.** Supervision was cited as a valuable resource for assisting the participants in recognizing and acknowledging their countertransference at times when they were unaware. As some of the participants experienced difficulty in recognizing countertransference during sessions, supervision presented the opportunity to uncover, recognize, and process countertransference that was not yet brought to their consciousness. Both Music Therapist A and Music Therapist C considered supervision or peer supervision to be beneficial and supportive when some aspects of their countertransference experiences were not easily recognizable.

This finding has been widely discussed in the literature; the benefits of receiving supervision are found in many music therapy publications (Bruscia, 1998; Dillard, 2006; Paap, 2011; Priestley, 1994; Scheiby, 2005). Supervision has been found to help music therapists examine aspects of the therapeutic relationship between the client and therapist, as well as processes that occur in the music and therapy sessions. Furthermore, the use of supervision is highly recommended for music therapists working with children with developmental disabilities.

## **Conclusions**

### **Summary**

This was a phenomenological study exploring music therapists' experiences of countertransference when working with children with developmental disabilities. The study examined how music therapists experienced this particular phenomenon and were able to recognize, acknowledge, utilize, and manage their countertransference when working with this population. The participants of the study included three board-certified music therapists who openly shared their experiences of countertransference in an audio-recorded in-person or telephone interview. Data were collected and analyzed according to protocol employing phenomenological inquiry. Themes from the participants' experiences emerged and were extracted from the data. Finally, detailed descriptions of the findings of the study were presented. It is my hope that the findings of this study are able to begin bridging the current gap in music therapy literature regarding countertransference with children with developmental disabilities. In addition, I hope that this study influences other music therapy researchers to continue investigating how countertransference could benefit or affect our clinical intentions, our therapeutic relationships, and our self-explorations.

### **Personal Reflection**

I faced some challenges in adopting the role of the researcher and separating my personal bias and professional self from the interviews. However, similar to the interdependent qualities of transference and countertransference, I found that examining these reactions informed my research and have allowed me to gain a deeper understanding of my own countertransference experiences as a music therapist. In this section, I will share some of my personal reactions and observations I noticed during my research process.

During the interviews, there were moments where I felt very engaged in my participants' experiences. I noticed that my body language displayed my interest and full attention; I had a tendency to lean in toward my participants. I provided a significant amount of verbal nods or gestures. There were also some moments where I felt like I was able to relate their countertransference experiences to my own. This was prevalent when participants' descriptions of their clients matched characteristics of my own clients. As I was picturing their experience in my mind, I would often replace myself and my client into the phenomenon that was being described. As a result, I was able to connect more with my participants' experiences. Additionally, because of my interest, I was becoming emotionally connected and experiencing some of the emotional reactions that they were describing. I felt like I was able to place myself in the experience with them and empathize with how they felt. Once the interviews were over, I often felt emotionally drained or fatigued.

I found it more difficult to connect with my participant's experience when the interview was conducted by telephone. Although I was unable to observe non-verbal gestures, such as facial expression and body language, I was able to observe some subtle changes in the participant's tone of voice. When she was talking about her experience with her client, I noticed that her voice sounded more strained, soft, and vulnerable. Although I was able to gain some sort of understanding from the emotional quality from her voice, I felt that if I had the opportunity to observe facial expression or body language, I would have been able to feel more connected to her experience.

I thoroughly enjoyed the interview process and listening to each of my participants' individualized countertransference experience. Each interview brought new information into my awareness and expanded my understanding of countertransference. During one of my interviews,

a participant reminded me about transference. Because the aim of my study was to examine countertransference, I initially forgot to consider the importance of transference and its impact on understanding countertransference and the dynamic therapeutic relationship. However, this gap in research exposed an important discovery. I learned that one's understanding of transference greatly impacts one's understanding of countertransference. Sometimes, as clinicians, it is easy to focus our attention to our own personal reactions, responses, clinical decisions, and music over those of our clients. However, Bruscia (1998) reminds us, "It is through the transference that the therapist becomes acutely aware of his own countertransference" (p. 44). Therefore, being open to examining our client's transference in addition to our countertransference is important to consider.

### **Limitations of Study**

There are several limitations to this study. The first limitation is the demographics of the participants, who were all Caucasian female music therapists with master's level education. The homogenous sample could have limited the perspectives of the diverse community of music therapists who work with children with developmental disabilities.

Another limitation was the difficulty of recruiting participants, which resulted in a small sample that did not reach data saturation. Gathering participants for the study was a long and difficult process. Only a small number of music therapists responded to the invitational email and expressed their interest in participating in the study, while others were unable to participate at the time the study was being conducted. Other qualitative studies that examined countertransference had a small sample size of participants, as well, though it is unclear if the researchers reached data saturation (Dillard, 2006; Pedersen, 2007). Although the reasons for the small sample size were not addressed in previous studies, the following are possible factors that

could have impacted the amount of participants for this study: disinterest, unavailability, discomfort in recalling past experiences, feeling like they did not identify with the criteria, or denial in experiencing countertransference in their work.

The literature that addresses the possible neglect or denial of examining countertransference amongst therapists who work with children support these possible claims (Bonovitz, 2009; Dillard, 2006; Newman, 1991). Due to the complicated nature of countertransference and multiple ways countertransference could manifest, the process of identifying countertransference may be difficult for therapists to notice in sessions and outside of sessions. Additionally, working with children may bring up sensitive and personal material from the therapist's childhood that may become uncomfortable to experience in therapy, causing feelings of anxiety, guilt, resistance, and denial (Bonovitz, 2009).

A final limitation was the use of telephone interviews. As previously discussed, the researcher was unable to observe non-verbal cues, such as facial expression, emotional expression, or body expression in the telephone interview, which restricted the interpretation and description of the participant's experience. Future research would benefit from conducting interviews exclusively in-person or via Skype, so that body language and expression can be observed.

### **Implication for Music Therapy Practice**

The findings of the study reveal that countertransference exists when working with children with developmental disabilities. When brought to one's awareness, it could become an effective tool in deepening our understanding of our clients' lives and therapeutic experiences as well as our own. There is a significant lack of awareness and neglect in examining countertransference when working with children. Failure to examine countertransference could



place clients in a dangerous position. Additionally, awareness of musical countertransference could deepen one's understanding of how countertransference could musically manifest. Thus, it seems necessary to emphasize and focus the examination of countertransference and musical countertransference in music therapy education, supervision, training, and practice.

### **Implications for Future Research**

There is a great need for future research regarding countertransference with children, which is evident by the lack of research and limited music therapy literature. Future studies will be able to bridge the gap in the literature, promote awareness of examining countertransference in our clinical work, and expand music therapists' understanding and knowledge of the phenomenon of countertransference. Some suggestions for future research include: (a) replicating this study with psychodynamic/psychoanalytic music therapists; (b) replicating this study with music therapists of various theoretical orientations; (c) replicating this study with a larger sample size of music therapists, (d) replicating this study focusing on a specific population of developmental disability (e.g. children with autism spectrum disorder, children with emotional/behavioral disturbances); (e) examining countertransference in various clinical settings (e.g. medical setting, educational setting); and, (f) examining musical countertransference with children with developmental disabilities.

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Appendix A  
**IRB Approval Letter**



1000 Hempstead Avenue  
 Rockville Centre, NY 11571  
[www.molloy.edu](http://www.molloy.edu)

**Tel. 516.323.3801**  
**Tel. 516.323.3711**

**Date:** November 24, 2015  
**To:** Professor Seung-A Kim/Carly Caprioli  
**From:** Kathleen Maurer Smith, Ph.D.  
 Co-Chair, Molloy College Institutional Review Board  
 Patricia Eckardt, Ph.D., RN  
 Co-Chair, Molloy College Institutional Review Board

**SUBJECT: MOLLOY IRB REVIEW AND DETERMINATION OF EXPEDITED STATUS**  
**Study Title:** Music Therapists' Experiences of Countertransference When Working with Children with Developmental Disabilities: A Phenomenological Study  
**Approved:** **November 24, 2015**

Dear Professor Kim/Carly Caprioli:

The Institutional Review Board (IRB) of Molloy College has reviewed the above-mentioned research proposal and determined that this proposal is approved by the committee. It is considered an EXPEDITED review per the requirements of Department of Health and Human Services (DHHS) regulations for the protection of human subjects as defined in 45CFR46.101(b) and has met the conditions for conducting the research. Please note that as Principal Investigator (PI), it is your responsibility to be CITI Certified and submit the evidence in order to conduct your research.

You may proceed with your research. Please submit a report to the committee at the conclusion of your project.

Changes to the Research: It is the responsibility of the Principal Investigator to inform the Molloy College IRB of any changes to this research. A change in the research may change the project from EXPEDITED status that would require communication with the IRB.

Sincerely,

Kathleen Maurer Smith, Ph.D.

Patricia Eckardt, Ph.D., RN

**Appendix B**  
**Invitational E-mail**

Dear \_\_\_\_\_,

My name is Carly Caprioli, and I am a graduate music therapy student at Molloy College in New York. As part of the requirement for my program, I am conducting a research study titled, *The Experience of Countertransference for Music Therapists When Working with Children with Developmental Disabilities*. The purpose of my study is to examine the experience of countertransference when working with children with developmental disabilities.

You have been contacted and considered eligible for the study because you meet the following criteria:

- 1) You are a Board-Certified Music Therapist (MT-BC) who experiences transference/countertransference in music therapy sessions.
- 2) You have worked as a music therapist with children with developmental disabilities.
- 3) You may be comfortable and open to recalling and sharing countertransference reactions.

Participation in this study will entail a 45 to 60 minute in-person, telephone, or Skype interview, depending upon your preference. Interviews will include open-ended questions asking you to recall and reflect upon an experience of countertransference when working with children with developmental disabilities.

The interviews and all data will remain anonymous and confidential. We will use pseudonym identifiers rather than your name in our study records. Your name and other facts that may identify you will not appear when we present this study or publish its results. Data will be stored and secured with access only granted to the researcher.

Participation in this study is completely voluntary, and you may withdraw from the study at any time. If you would like to participate in this study, please respond to this email with a signed consent form. Please respond by     TBD     to participate in the study.

If you would not like to participate in this study, please disregard this email.

If you have any questions about the study, please feel free to contact me. You may also contact my faculty advisor, Dr. Seung-A Kim, with any questions regarding this study. All of our contact information is provided below.

Thank you for your consideration.

Best Regards,

Carly Caprioli, MT-BC  
Molloy College  
Tel: (516) 578-9842  
[ccaprioli1@lions.molloy.edu](mailto:ccaprioli1@lions.molloy.edu)

Faculty Advisor  
Seung-A Kim, PhD, AMT, LCAT, MT-BC  
Molloy College  
Tel: (516) 323- 3326  
[skim@molloy.edu](mailto:skim@molloy.edu)

Appendix C  
**Reminder E-mail**

Dear \_\_\_\_\_,

On \_\_\_\_\_, I sent my e-mail invitation to you regarding a research study I am doing on music therapists' experience of countertransference when working with children with developmental disabilities. If you are a Board Certified Music therapist who utilizes transference/countertransference in music therapy sessions, has worked as a music therapist with children with developmental disabilities, and may be comfortable sharing countertransference reactions, you are invited to participate in the present study. However, your participation is entirely voluntary and appreciated. If you have not yet responded to my invitational e-mail, I would greatly appreciate it if you could do so. The current study will provide significant new information, and it has been difficult getting a representative sample.

Thank you.

Best Regards,

Carly Caprioli, MT-BC

Appendix D  
**Letter of Informed Consent**

**Title:** The Experience of Countertransference for Music Therapists When Working With Children With Developmental Disabilities

**Student Researcher:**

Carly Caprioli, MT-BC  
Graduate Student, Music Therapy, Molloy College  
1000 Hempstead Avenue  
Rockville Centre, NY 11571  
[Ccaprioli1@lions.molloy.edu](mailto:Ccaprioli1@lions.molloy.edu)

**Advisor:**

Seung-A Kim, PhD, LCAT, MT-BC  
Analytical Music Therapist  
Associate Professor, Music Therapy  
Director, Undergraduate Music Therapy  
Molloy College  
Rockville Centre, NY 11571  
516-323-3326  
[skim@molloy.edu](mailto:skim@molloy.edu)

Dear \_\_\_\_\_,

I am Carly Caprioli, a graduate student of music therapy at Molloy College. I am currently conducting a study to explore music therapists' experiences of countertransference when working with children with developmental disabilities. This study is being conducted as part of my graduation requirement.

You have been invited to participate in this study because you meet the following criteria:

- 1) You are a Board Certified Music Therapist (MT-BC) who experiences transference/countertransference in music therapy sessions.
- 2) You have worked as a music therapist with children with developmental disabilities.
- 3) You may be comfortable and open to recalling and sharing countertransference reactions.

The interview session will involve a 45 to 60 minute in-person, telephone, or Skype interview, depending upon your preference. You will initially be interviewed about personal background information including your education and work experience. You will then be asked to recall and reflect upon an experience of countertransference when working with a child or children with developmental disabilities. The interview session will be audio recorded and transcribed. About two weeks after the interview, you will be asked to review the transcription to ensure its accuracy.

Your participation is entirely voluntary. You may decide at any point to stop participating in the study, at which time you may choose to withdraw with no negative consequences.

Your identity will be protected. This study is strictly confidential, and your name, facility and any other identifying factors will not be used to describe you in the study findings. Instead, you will be referred to with an anonymous pseudonym, for example, “Music Therapist A.” All audio recordings and transcriptions of the interviews will be locked in a secure place. You have the right to listen to the tapes of your own interview. The audio recordings will be destroyed after the study is completed. The transcriptions of the interviews may be used for future publications or presentations, but your identity will always be anonymous.

This study will not necessarily provide any benefits to you. Your participation in this study may lead you to gain a deeper understanding of your countertransference experiences, resulting in increased self-awareness and insight. The information may be beneficial to students, educators, and supervisors in music therapy. It may assist and inform the therapist to understand and recognize the benefits of examining one’s countertransference. In addition, it may lead to future research regarding music therapists’ examination of countertransference. However, your participation in this study may bring up unpleasant feelings, thoughts, or physical sensations. If you experience unpleasant feelings or feel uncomfortable during the interview or at any time during the study, emotional support will be offered. You are free to end the interview or your participation at any time, but you will also have the option to reschedule your interview.

Please contact the investigator at [ccaprioli1@lions.molloy.edu](mailto:ccaprioli1@lions.molloy.edu) for more information or with any concerns that may arise for you during the study. You may also contact the faculty advisor, Dr. Seung-A Kim, at [skim@molloy.edu](mailto:skim@molloy.edu), at any time. Questions about your rights as a study participant may be directed to the Molloy College Institutional Review Board at: [irb@molloy.edu](mailto:irb@molloy.edu) or 516-323-3000.

Check all statements you agree to:

I give permission to Carly Caprioli to audio record her interview sessions with me.

I give permission to Carly Caprioli to use these recordings for educational purposes related to this research study.

---

**Participant’s Signature**

---

**Date**

---

**Researcher’s Signature**

---

**Date**

*Molloy College***CONSENT FORM**

An explanation of the procedures to be employed in this study, in which I have voluntarily agreed to participate, has been offered to me. All my inquiries concerning the study have been answered to my satisfaction. I understand that the information collected will be held in confidence, and that my name will not in any way be identified. I understand that additional information about the study results will be provided at its conclusion upon my request. I know that I am free to withdraw from this study without negative consequences at any time. I understand I will receive a signed copy of this form.

Signing your name below indicates that you have read and understood the contents of this consent form and that you have voluntarily agreed to participate in this study. Please sign your name and send it back to the researcher by   TBD   at the following e-mail address: [ccaprioli1@lions.molloy.edu](mailto:ccaprioli1@lions.molloy.edu).

<b>Participant's Signature</b>	<b>Date</b>
<b>Researcher's Signature</b>	<b>Date</b>

**Complete the following if you wish to receive a summary of the results for this study:**

NAME: \_\_\_\_\_  
(Typed or printed)

E-MAIL ADDRESS: \_\_\_\_\_

ADDRESS (optional): \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip)

Appendix E  
**Permission to Audio Record**

**Student Researcher:**

Carly Caprioli, MT-BC  
 Graduate Student, Music Therapy, Molloy College  
 1000 Hempstead Avenue  
 Rockville Centre, NY 11571  
[Ccaprioli1@lions.molloy.edu](mailto:Ccaprioli1@lions.molloy.edu)

**Advisor:**

Seung-A Kim, PhD, LCAT, MT-BC  
 Analytical Music Therapist  
 Associate Professor, Music Therapy  
 Director, Undergraduate Music Therapy  
 Molloy College  
 Rockville Centre, NY 11571  
 516-323-3326  
[skim@molloy.edu](mailto:skim@molloy.edu)

I, \_\_\_\_\_, give Carly Caprioli permission to audio record my interview session. This audio recording will be used only for research purposes. I have already given written consent for my participation in this research project. At no time will my name, personal information, or contact information be used.

I understand that I will be audio recorded during my scheduled 45 to 60 minute interview with the researcher. I give permission for the recording to be used from December 2015 to August 2016.

I understand that I can withdraw my permission at any time. Upon my request, the audio recordings will be erased and removed immediately.

If I want more information about the audio recordings, or if I have questions or concerns at any time, I can contact the investigators at the top of this page.

I understand that my signature below indicates my voluntary consent to be audiotaped. I understand that I will be given a copy of this signed form.

Please send this form to the researcher by     TBD     at the following e-mail address:  
[ccaprioli1@lions.molloy.edu](mailto:ccaprioli1@lions.molloy.edu).

Thank you for your participation.

---

**Participant's Signature**

---

**Date**



Appendix F  
**Interview Questions**

Demographic Information:

1. Could you provide a brief description of yourself? (e.g. age, ethnicity, educational background, theoretical background, clinical background)
  - a. How many years have you been working as a music therapist?
  - b. Could you describe any populations you have worked with in the past?
  - c. Could you describe the population that you currently work with?
2. How do you define countertransference?

Interview Questions:

1. Could you describe a specific experience in your clinical work where you experienced strong countertransference reactions when working with a specific child or with children with developmental disabilities?
  - a. What were some specific reactions you experienced with this particular child?
  - b. How did you recognize your countertransference when working with this particular child?
  - c. How did your countertransference emerge in the music? What did it sound like?
  - d. As you reflect upon your experience, what is that like for you?
  - e. How did you acknowledge your countertransference when working with this particular child?
  - f. How did you utilize countertransference when working with this particular child?
  - g. Do you have any additional comments or questions you would like to ask?