

Master's Thesis

Meaning of countertransference in a music therapy student's clinical studies – towards a professional perspective

by

Tiinapriitta Savela

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**Department of Music
Faculty of Humanities
University of Jyväskylä
Finland**

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Tiivistelmä – Abstract <p>The concept of countertransference refers to the therapist's reactions to the client's inner world in therapy situation. Countertransference within therapy relationships can alternate from the therapist's obstructive reactions to positive experiences that may even guide the therapist towards purposeful interventions.</p> <p>In this research I study my own countertransference experience and my learning process of the meaning of countertransference. The methodology of the research is hermeneutic phenomenology and its structure follows the principles of the hermeneutic circle and of Gadamerian hermeneutic analysis. The data is composed of my self-reflections. I examine the self-reflections in the light of background theories that I have chosen to guide the analytical process. I analyze my reactions in therapy situation and the countertransference triggers that the situation contains, first by applying the countertransference theories of the psychodynamic frame of reference, then by considering the significance of music and musical interaction for my countertransference, and eventually by discussing the influence of my countertransference on the interaction within the therapy relationship. The content analysis proceeds as a dialog between the data and the literature, which eventually leads to a deeper understanding of the experience.</p> <p>Through this research process, I have learnt to observe the complex constructions of countertransference experiences in therapy relationships. I have also understood the importance of countertransference experiences in a student's personal growth and in the attainment of the goals set in music therapy training. As a result, I have formulated a tool for uncovering and processing countertransference. I now use this tool in my music therapy work and put the new understanding into practice.</p>	
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1 Introduction

The starting point for this research was my own countertransference experience that took place in clinical internship during my music therapy training. The experience was very intensive and chaotic, and the emotional loading of the situation was quite negative. In supervision I recognized some reasons for my experience; the material that my client brought to the therapy situation re-awoke traumatic memories from my own history and led me to experience intense countertransference. The uncontrollable nature of this experience made me choose the countertransference phenomenon as the topic of my thesis. The intensity of my own experience forced me to take a closer look at the subject; I wanted to understand better the reasons for my experience and the meaning of countertransference in therapy relationships.

The concept of countertransference refers to the therapist's reactions to the client's inner world in therapy situation. The activation of a therapist's trauma in therapy situation is a rather extreme example of the countertransference phenomenon. In general, countertransference within therapy relationships can alternate from the therapist's obstructive reactions to positive experiences that may even guide the therapist to make purposeful interventions. This research process started from a countertransference experience that was negatively oriented and obstructed my presence in interaction with my client. However, from this experience started a process through which I thoroughly studied the theories of countertransference and countertransference as a tool in therapy work. I have also learned to analyze my own reactions

within therapy relationships in a way that now enables me to use countertransference experiences for the benefit of my clients.

The next figure (figure 1) presents the research questions of this study. The main question is, *how does countertransference as a therapist's tool develop during clinical studies in music therapy training?* This question contains the idea that learning processes exist in music therapy training that are related to the understanding of countertransference.

Countertransference is a therapist's inner experience that activates when some aspect of the interaction within the therapy relationship touches the therapist's own areas of vulnerability. The influence of countertransference depends largely on the therapist's ability to observe, process and manage her own reactions; the countertransference management of a therapist determines her ability to act for the best of her clients. Countertransference can also be seen as one of the most important tools for a therapist. It may give clues about the meaning of interactional situations in therapy relationships. Through her own reactions, a therapist may attain new information about the inner world of a client and the ways that a client interacts with his environment in general. Therefore, countertransference management is a skill that considerably determines how well a therapist is able to support her clients and appropriately interact with them.

The main question of this research is an invitation to thoroughly investigate my own countertransference-related learning process. I start to approach this learning process by analyzing my countertransference experience, the construction of the experience and the influence it had on the interaction during therapy. Asking some subquestions will enable me to

answer the main question. First I ask, *what can I learn from analyzing my negative countertransference experience?* I answer this question by analyzing my reactions in therapy situation and the countertransference triggers that the situation contains, first by applying the countertransference theories of the psychodynamic frame of reference to the interactional situation, then by considering the significance of music and musical interaction for my countertransference, and eventually by discussing the influence of my countertransference on the interaction within the therapy relationship. This content analysis of the data is actually like a picture of my learning process towards a deeper understanding of the countertransference phenomenon. My intention is to present the transformation of my understanding, whereby an uncontrollable initial experience progressively structures itself during the course of the analysis.

In the second question, that takes me towards answering the main question of this research, I ask, *how can I apply this new knowledge to my music therapy work?* The active application of new understanding is an essential part of the model of hermeneutic analysis that I will soon present in more detail. The idea is that a researcher's ability to apply new knowledge in practice defines the depth of her understanding. I will answer this second subquestion by introducing a tool for uncovering and processing countertransference. This tool was developed to foster my ability to manage and process countertransference in my daily work. It also connects this learning process to my working life and continues the process of deeper understanding of countertransference.

This is a qualitative research that follows the principles of hermeneutic phenomenology. The

very nature of the research questions led me towards choosing a methodology that would allow a subjective viewpoint and enable the emergence of a researcher's learning process in a text. Obviously, the present research is extremely subjective, because the data is composed of my own self-reflections. Furthermore, the object of this research is my own learning process. This kind of effort to understand a lived experience and a developmental process of understanding – as modeled by the hermeneutic circle – is characteristic for hermeneutic phenomenology. One important aspect of this methodology is also the consideration of contextuality, in other words how the historicity of concepts and attitudes (i.e. the researcher's pre-understanding) influences the development of a new understanding.

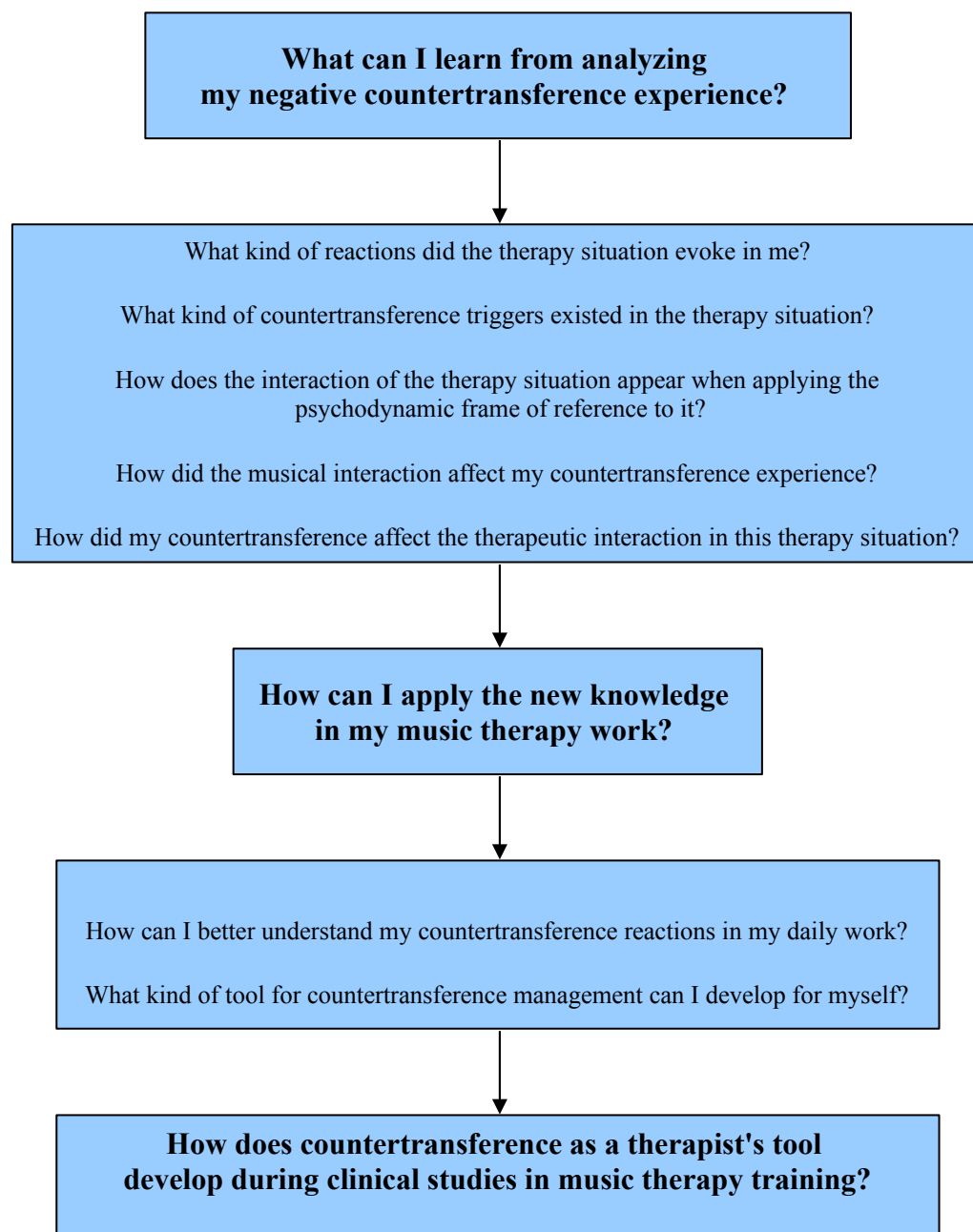
The structure of the research follows the model of hermeneutic analysis, as presented by Koski (1995) for research in Education. According to this model, the hermeneutic analysis has four steps: 1) the thematization of the researcher's pre-understanding, 2) the dialog between the researcher and her data, 3) the synthesis of the pre-understanding and the results of the data analysis, and 4) the active application of the new knowledge. Another important concept in relation to the structure of this research is called abductive approach. The abductive approach is characteristic of a research design where existing theories, in other words the pre-understanding of the researcher, guide the formation of a new theory. The abduction in my text appears as a dialog between the researcher and the data; the data analysis is conducted alternately by theories that I have chosen and ideas that arise from the data. This dialog stirs the research process into the appropriate direction and sketches an increasingly clear picture of the phenomenon under study. Moreover, because of the text's dialogical and abductive nature, the structure of this research differs from more traditional research in that much of the

literature review is embedded in the content analysis.

The aim of my research is not to find some truth about this interactional situation or to rigidly categorize my experience according to countertransference theories. Nevertheless, in the content analysis I analyze my reactions quite closely and apply background theories to my observations. The intention here is to obtain a better understanding of both, this singular experience and the countertransference phenomenon in general. The goals of this research are

- 1) to gain understanding of the formation of this particular countertransference experience,
- 2) to describe the learning process where I develop my understanding of countertransference as a phenomenon that impacts therapy relationships, and as an informative tool for the therapist,
- 3) to consider the significance of this kind of learning process for the attainment of goals in music therapy training.

Figure 1. Research questions



2 Methodology

This study, by its very nature, will be qualitative. Bruscia (2005) introduces the special characteristics of qualitative research. First, qualitative research is a personal process. Every study is rooted in the values and beliefs of the researcher. Despite that, it is always also an interpersonal process, where human beings study other human beings and the condition of human being. The third characteristic of qualitative research is to be a developmental process. It unfolds from moment to moment and proceeds unpredictably. The researcher experiments and interacts with her data until the purpose of the study has been achieved. For Bruscia, the process of qualitative research is not so much about doing as it is about being: the researcher must be a discoverer who is exploratory, observant, open, flexible, creative and committed to learning. (Bruscia, 2005.)

In this study these qualities of qualitative research are clearly present. The study is a personal process; it is rooted in my values that define why I find this research topic important and how I think this kind of subject could be studied as deeply and fully as possible. Despite the subjective nature of this study, it is also an interpersonal process: although I study my own experience and my own learning process in a very subjective way, I assume that my subjective experience can tell something about human experiences on a more general level. The nature of this research is also very much a developmental process: it proceeds step by step and the scenes that unfold in every step are unpredictable. Every time a new scene appears, it sets a new problem that should be discovered and resolved.

In the following sections I will introduce the methodological choices that I have made in order to find the answers to my research problems. First I will explore the principles of hermeneutic phenomenology and hermeneutic circle, then I will introduce the Gadamerian method for hermeneutic analysis that gives this research its structure. The principles of abductive reasoning and content analysis will also be discussed. At the end of this section, I will explain how I collected my data in practice.

2.1 Hermeneutic phenomenology

The methodology of this study is hermeneutic phenomenology. According to Lavery (2003), the use of the term “methodology” is supported rather than the term “method” to describe hermeneutic and phenomenological traditions. A methodology is more like a creative approach to understanding, not a correct method to follow. (Lavery, 2003.) Hermeneutic phenomenology is part of the wider hermeneutic tradition. The basis for this tradition is to be found in humanistic sciences, where the subject under study is the world as it is constructed by the human mind. These constructions can range for example from social constructions or ideologies to pieces of art. The common factor of these humanistic sciences is the interest in the meaning contents of the constructs. (Tuomi & Sarajärvi, 2009.) There are differences in the use of the terms hermeneutics and hermeneutic phenomenology. Different authors use these terms differently to describe the same or similar approaches (see for example Koski, 1995; Tuomi & Sarajärvi, 2009; Lavery, 2003). However, in practice it is also common to mix hermeneutic and phenomenological methodologies, for example by combining the

principles of phenomenology and the hermeneutic analysis of the subject (Koppa, 11.6.2013).

Phenomenology and hermeneutic phenomenology have shared beginnings and a common interest in lived experience. Phenomenology is essentially the study of human experience. In the phenomenological approach the focus is on understanding the meaning of an experience as it is lived, not the world or reality as something separate from the person, as it is in natural sciences. For Husserl, who was the father of the phenomenological approach, the main focus was the study of phenomena as they appeared through human consciousness. This consciousness was viewed as a co-constituted dialogue between a person and the world. Moreover, in hermeneutic phenomenology the goal is to create meaning and achieve a sense of understanding of the lived human experience. Heidegger, the developer of hermeneutic phenomenology, emphasized the situated meaning of a human in the world. Here rises the most important difference between these two traditions, because while Husserl believed that it is possible to bracket out the outer world and individual biases in order to achieve contact with the essence of an experience, Heidegger emphasized the historicity of understanding. Heidegger believed that a person's history, background and cultural context always have an impact on the way one understands the world and the experiences. (Lavery, 2003.)

In hermeneutic phenomenology all understanding is seen to be connected to a given set of fore-structures that can not be eliminated. This pre-understanding is the organization of a culture that is present in our understanding. An individual's background or historicity influences the interpretations of the phenomena. (Lavery, 2003.) Kenny, Jahn-Langenberg and Loewy (2005) describe this interpretation of a phenomenon as an intersubjective practice.

The intent of the researcher is to achieve understanding through dynamic interaction between texts, people and history. The researcher has to take into account her own historical context and look towards the past, present and future in the course of the research process. (Kenny et al., 2005).

According to Gadamer (1979), the aim of a hermeneutic analysis is to help a man to interpret and understand himself and his situational world of being, because these are the areas where all the interpretative phenomena manifest themselves. The goal of a hermeneutic process is to increase one's self-understanding (Gadamer, 1979). For Gadamer, the hermeneutic process is essentially clarifying further the conditions in which understanding takes place (Lavery, 2003). A researcher gets into a dynamic dialog with her own background, the historical context and the subject under study in order to deeply understand the meaning of a given experience.

In the interpretative process of hermeneutics the understanding and disclosure of phenomena are done through language. Language is the medium in which the understanding occurs (Lavery, 2003). So the understanding in hermeneutic analysis is tied to language, even if it can be used to interpret for example social processes or other subjects that are not written texts in their original form (Tuomi & Sarajärvi, 2009).

The goal of this research is to gain an understanding of my countertransference experience and the countertransference phenomenon in general. Countertransference is essentially a lived human experience; it is an experience that happens in interaction within a therapy relationship

and influences the interactional space of a therapy process. A therapist should strive to achieve a sense of understanding of her countertransference experiences in order to be able to use them for the best of her clients. The disclosures of countertransference experiences are related to an individual's background and historicity. Countertransference as such is a very multifaceted phenomenon and the attitudes towards it vary widely in the field of psychotherapy. It is important for a professional to clarify the conditions in which the understanding of countertransference takes place. In this research I have also tried to thematize the pre-understanding that influences my interpretations of the experience under scrutiny.

2.2 The hermeneutic circle

The hermeneutic analysis is a dialog between the past and the present. The understanding is shaped piece by piece in an interpretative process called the hermeneutic circle. According to Kenny et al. (2005), the hermeneutic circle is a way of thinking, it is a shape for a thinking process where one derives meaning from an experience. A single experience is contextualized within a whole, and the understanding of the whole is in turn influenced by knowledge of the single experience. (Kenny et al., 2005.) So the understanding of each part influences the understanding of the whole, and the view of the whole influences the understanding of the details.

Siljander (1988) has suggested three principles for the function of the hermeneutic circle. First, the process does not have a starting point as such, because the pre-understanding of the

interpreter influences her understanding. The pre-understanding is the basis for the interpretations, and when the interpretative process goes on, the pre-understanding changes and influences again the new interpretations that shape a new kind of understanding. (Siljander, 1988.) Kenny et al. (2005) write about entering the circle: when the researcher enters the hermeneutic process, she has to make a careful self-disclosure of her pre-understanding of the subject. This self-disclosure is similar to a self-hermeneutic process, where the researcher reveals not only her conscious biases but also their place in the historical context. (Kenny et al., 2005.)

The second principle is the dialog between the parts and the whole of a phenomenon. The better the understanding of the whole is, the better the understanding of the parts will be, and vice versa. The interpretative process starts with interpreting the details, but as the process goes on, the increasing understanding of the whole also changes or amplifies the meaning of single details. (Siljander, 1988.) Hermeneutic interpretation means that the researcher constantly works through her own translations of the subject. She resynthesizes uncovered and renamed insights and brings them back to the original source, the whole. (Kenny et al., 2005.) The hermeneutic analysis is a transformative process that goes towards a deeper understanding of the meaning. It is important that this process of transformation be visible also for a reader of the study. The description of a hermeneutic process has to show the thinking process in detail; the reader must be able to follow the transformative process through the language.

The third principle of the hermeneutic circle is the absence of ending of the interpretative

process, because of the continuous and endless nature of the circle (Siljander, 1988). Koski (1995) writes that for Gadamer, the model of the hermeneutic circle represents the continuous process of learning. Over and over again the limitation of our knowledge is uncovered and the prejudice of our thinking becomes visible. (Koski, 1995.) Kenny et al. (2005) also present the hermeneutic process as an unending circling, but they state that it is possible for the interpretations to reach some kind of stability during the process.

In the content analysis of this study I have tried to make visible the idea of hermeneutic circle. The single experience is contextualized as a whole, and the understanding of the whole is in turn influenced by the knowledge of the single experience. The analysis proceeds step by step from one scene to another, analyzing the details of one scene until a new construction is reached, and then analyzing the details of this new scene. This kind of learning process can not have a clear beginning or end, the understanding of the phenomenon just develops in the course of the analysis. Before the beginning there has been some pre-understanding of the subject, and after completing the research process, the development of one's understanding continues. This interpretative process where I explore the details of my experience and construct a new understanding on the basis of my analysis extends and deepens my understanding of the theoretical frameworks, of my countertransference experience, and of the countertransference phenomenon.

2.3 The four steps of the Gadamerian method for hermeneutic analysis

Gadamerian hermeneutics is a process of making interpretations and forming an understanding that contains an optimistic viewpoint as to the interpretation possibilities. An interpretation always has a creative element, a possibility to create something new. For Gadamer, the hermeneutic analysis is a creative discussion, where the horizons of the researcher and the subject under study might eventually be combined. (Koski, 1995.) This fusion of horizons means a dialectical interaction between the expectations of the interpreter and the meaning content of the text; these viewpoints can merge together and form a new kind of scenery of the topic. This co-creation occurs through a circle of readings, reflective writing and interpretations (Lavery, 2003).

Koski (1995) presents the four steps of the Gadamerian method for hermeneutic analysis:

- 1) Explicating the pre-understanding of the researcher
- 2) A hermeneutic dialog
- 3) Fusion of horizons
- 4) Active application of the new knowledge

First the pre-understanding of the researcher must be explicated. This means that the researcher tries to become conscious of the historical forces and attitudes that have an impact on her pre-understanding of the topic. The idea is not to try to achieve objectivity through this explication, but to thematize the pre-understanding as clearly as possible. (Koski, 1995.) I have tried to outline the historical forces and attitudes that had an impact on my pre-

understanding. This means thematizing my pre-understanding as clearly as possible. This also outlines the background theories I will be in dialog with in the following parts of the analysis. The themes that I have written about in section 3 are 1) psychodynamic music therapy and its view on transference and countertransference, 2) a historical review of countertransference and the historical weight of the concept, 3) the therapist's personal traumas and their relation to countertransference reactions in therapy situation, and 4) the learning processes in music therapy training; the goals of the training and the relationship between clinical experiences and the trainee's professional development.

The second step is the hermeneutic dialog. Here the researcher asks what the text tells about the subject. The dialog is based on reciprocal asking and answering: the researcher questions the text, while the text questions the researcher. This kind of dialog requires an active attitude of not knowing; the researcher is ready for letting the text challenge her pre-understanding. The idea is to ask genuine questions, which means that the researcher is also ready for accepting the answers that the text gives back, even if it would overturn her pre-understanding completely. Entering the hermeneutic dialog is somewhat risky for the researcher; one can never know in what direction it will take us. (Koski, 1995.) In the second step I analyze my research data. I ask questions and try to find answers for these questions from the content of my self-reflections. I analyze my texts, and then look at the findings in the light of background theories. The structure of this dialog follows the idea of the hermeneutic circle: I pose questions to the data and the answer I find leads me to the next question. Step by step this continuous and circular movement of asking and answering develops the understanding of the experience. This dialog is about finding words for my experience and formulating a

new, more advanced understanding of it.

The third step is the fusion of horizons, where the goal is to produce new knowledge by integrating the viewpoints of the researcher and the text. This integration is about the qualitative transformation of one's understanding, when the integrative interpretation rises above both the researcher's and the text's pre-understandings. After the integration, the original understandings are not significant anymore. This kind of dialog is a process that increases a human's self-understanding and mental development. (Koski, 1995.) In this research, the starting points for the dialog and for the fusion of horizons are overlapping because of the nature of my data; the data is my own text, the self-reflection of my experience in therapy situation. The process of analysis is a transformative process, where the actuality of my experience develops from an uncontrollable chaos to a more structured scene. When I introduce the results of the analysis, the new and deeper understanding of the data content becomes visible. This is when the fusion of horizons happens (i.e. the integrative interpretation of my countertransference experience).

The fourth step is the active application of the new knowledge. Here the researcher strives to apply the new knowledge in her life and work. For Gadamer, the applicability of knowledge is an indicator for the depth of the understanding. The researcher tests the meaningfulness of the knowledge in practice. (Koski, 1995.) In the part on active application, I discuss the applicability of my new understanding of countertransference experiences, and try to take this active application to a very concrete level by creating a tool that can be used in everyday music therapy work.

2.4 Abductive reasoning and content analysis

In qualitative analysis, the terms inductive and deductive are often used. Inductive reasoning means that the logic of the reasoning goes from single to general. There, a researcher tries to build a theory that is purely grounded in data, without any influence of theories that already exist. Deductive reasoning means that reasoning goes from general to particular; the researcher tries to prove that an existing theory is true by testing that theory. In addition, there is also abductive reasoning. According to abductive reasoning, the formation of a theory is possible when we have an idea that leads our thinking and the process of reasoning. In practice, abductive reasoning means that the thinking process is alternatively led by already existing theories and by ideas that are grounded in data. Pure inductive reasoning is a very challenging task to carry out, and the idea that our perceptions are grounded in existing theories is generally accepted. (Tuomi & Sarajärvi, 2009.) This principle can be compared to the idea of pre-understanding: the historicity and the context always guide our understanding of the topic.

In theory-guided analysis the theory or theories can aid the process of data analysis. The idea is not to test some existing theory, as it is in deductive reasoning, but the function of former knowledge is to guide the process of analysis. The existing theories give ideas or open doors for the thinking process. (Tuomi & Sarajärvi, 2009.) This door-opening can be compared to the idea of a dialog between the pre-understanding of the researcher and the data's horizon, as

Gadamer expresses it. The single findings that arise from the data are constantly compared to the whole.

According to Tuomi and Sarajärvi (2009), the themes that emerge from the data are always found by the researcher's own understanding. Besides a specific research method, this kind of working style also requires sensitivity and insight from the researcher. (Tuomi & Sarajärvi, 2009.) The researcher has to be sensitive when reading her data, examining her pre-understanding and choosing theories that can guide the process of analysis. This way it is possible to achieve meaningful constructions that give meaningful answers to the research problem. In this study the background theories that I have chosen guide the process of analysis and formation of new theories or knowledge. Much of the literature or the introduction of background theories is embedded in the content analysis; I discuss with the literature throughout the structure of this research.

The content analysis refers to the description of the data. The researcher collects the meaning structures from the data, presents and analyses them in her writing, and finally forms a synthesis of the analysis by evaluating the significance of the encountered meaning structures. So the content analysis is the analysis of the text; the aim is to find relevant contents from the text and arrange them in a compact and clear way without losing the meaning of the content. The stages of the content analysis are: 1) culling the raw data by coding the relevant information, 2) dividing the coded data in groups according to similarities and differences, and 3) constructing concepts that describe the meaning content of the data. The process

proceeds from the text's original phrases to theoretical concepts and conclusions. (Tuomi & Sarajärvi, 2009.) The text that I analyze in this study is the self-reflection of the feelings and thoughts that the therapy situation evoked in me. In the next part I will explain how the data collection was done and discuss the nature of self-reflections as research data.

2.5 Data collection

The main data of this research are my own texts, the self-reflections that I have written while watching the audiovisual material of the therapy sessions. The therapy process from which the data was collected was part of my music therapy training. I had written notes about all the sessions, and from reading my notes I chose two sessions where my countertransference issues were especially present.

All the sessions of the therapy process were filmed. The next step in collecting the data was to write self-reflections on the feelings and thoughts awoken in me by the interaction between me and my client. I watched the audiovisual material of two chosen sessions and observed the interaction. Every four minutes I stopped the video and wrote down everything that came to my mind, in a very free style. The goal was to produce a text where my own experience would be visible as authentically as possible, without any inhibition. In the text I marked the timeline, so it is possible to find the episode from the video to which the text is referring. After writing the self-reflections, I transcribed the discussions of these two sessions. In the transcribed text I also marked the timeline, so it is possible to see what the content of the

discussion was and judge it against my self-reflection.

Before writing these self-reflections I did some self-clearing. I wrote down feelings and thoughts that were in my mind at the time. The idea was to be able to separate the personal content of the two time layers: my personal thoughts that the interaction in the therapy sessions would awake, and the personal issues that were present at the time of writing the self-reflections (e.g. certain things that had happened on the day when I watched the videos).

The nature of self-reflections as research data is of course very subjective. I try to achieve an understanding of my own experience and texts, and of my own learning process. In qualitative research the subjectivity in approaching the research problem is quite typical, and especially so in hermeneutic phenomenology. However, it is important to remain aware of my motivation for this research throughout the research process, and also to be careful with my own personal biases and blind spots. Kenny et al. (2005) call this the self-hermeneutics of a researcher; to guarantee the validity of the research, the researcher must use methods of self-discovery to keep the integrity of the research in place. A researcher also has to report her biases accurately. (Kenny et al., 2005.)

The aim of this research is to produce information on the personal experience of a therapist, as well as to study a human experience with the all weaknesses and strengths that are related to it. The genuine and reflective attitude enables me to learn something new as a therapist and, on a more general level, to produce new information on the interaction of a therapist and a client in music therapy situation. Kenny et al. (2005) write about the double hermeneutics of

psychotherapy research: people are already interpreters of their experience of themselves, and they continue interpreting their experience in relation to certain contexts (Kenny et al, 2005). In this research the double hermeneutics is very visible. In my self-reflections I present my own interpretation of my inner experience, whereas in the content analysis, I interpret this experience in relation to the context (the interaction in therapy situation and the background theories).

3 Literature review – Thematizing my pre-understanding

In this section I will define the central concepts of this study. These definitions also form my pre-understanding; the basis or starting point for the process of analysis. The themes of my pre-understanding that I will define here are 1) countertransference in psychodynamic music therapy, 2) the history of the concept of countertransference, 3) the relation of the therapist's trauma and countertransference and 4) the learning processes in music therapy training. The analysis itself will be performed in the next section. Most of the literature review is actually embedded in the dialog of the next section, which is characteristic for the abductive approach.

Psychodynamic music therapy is the theoretical framework of my music therapy training. I will introduce the basic ideas of psychodynamics and their influence on therapy relationships in music therapy. Secondly I will take a look at the history of the concept of countertransference; the historical review draws a scene of the relativity of the concept, and its relation to the attitudes of the environment where it takes place. Then I will discuss the connection between a therapist's trauma and countertransference; I will investigate how traumatic experiences from our past can influence the formation of our experience in this moment, and how a therapist's own trauma may affect the countertransference in therapy relationships. Lastly I will discuss the learning processes in music therapy training. More specifically, I will reflect on the processes required for the development of the therapist's role, and on the relationship between these learning processes and countertransference experiences.

3.1 Countertransference in psychodynamic music therapy

Psychodynamic music therapy is a form of music therapy, where the therapist emphasizes the importance of the client's psychodynamic processes in the course of therapy (Ahonen-Eerikäinen, 1998). Psychodynamic music therapy is based on the psychodynamic theories of the mind. According to Bruscia (1998), the main aspects in the psychodynamic orientation are 1) the influence of past experiences on the present of an individual's life, 2) the existence of levels of consciousness and 3) the various operations of repression and defense mechanisms.

Individuals learn from everything they experience in their life, and generalize these experiences to present situations. Additionally to an individual's memories of the past, the unconscious layer also contains instincts of the species. This content of the unconscious has considerable influence over an individual's present life. The other levels of consciousness are the preconscious layer and the conscious layer. The conscious layer contains material that is in awareness. It also mitigates between the demands of the unconscious, the demands of reality, the need for personal safety and gratification, and standards of morality. The preconscious layer contains material that is out of awareness, but that could be in awareness. (Bruscia, 1998.) So the material of the preconscious layer can be brought into awareness if needed, whereas unconscious material needs special circumstances to become conscious. There is a difference in the quality of unconscious and conscious processes: conscious processes are rational and logical, whereas unconscious processes are irrational and illogical. These irrational contents of the unconscious may come up for example in dreams, psychotic thinking or the symbolism of art (Pervin, 2003).

Repression is the name for the mechanism whereby the psyche attempts to limit the influence of the unconscious realm. The psyche makes efforts to prevent unacceptable or threatening material in the unconscious from becoming conscious. Defense mechanisms are an individual's ways of coping in the situation where an experience threatens the balance between what is repressed and what is in awareness. In the therapeutic realm, typical defense mechanisms are resistance and transference. Resistance refers to the client's attempts to avoid the therapeutic process because of the fear that repressed material would be brought into awareness. Transference means reliving certain significant relationships from the client's past. (Bruscia, 1998.) According to Priestley (1994), transference means that the client repeats emotional behaviors he has used in his past relationships. She also describes the function of transference as a defense to prevent painful material from reaching to the conscious level of the mind. (Priestley, 1994.)

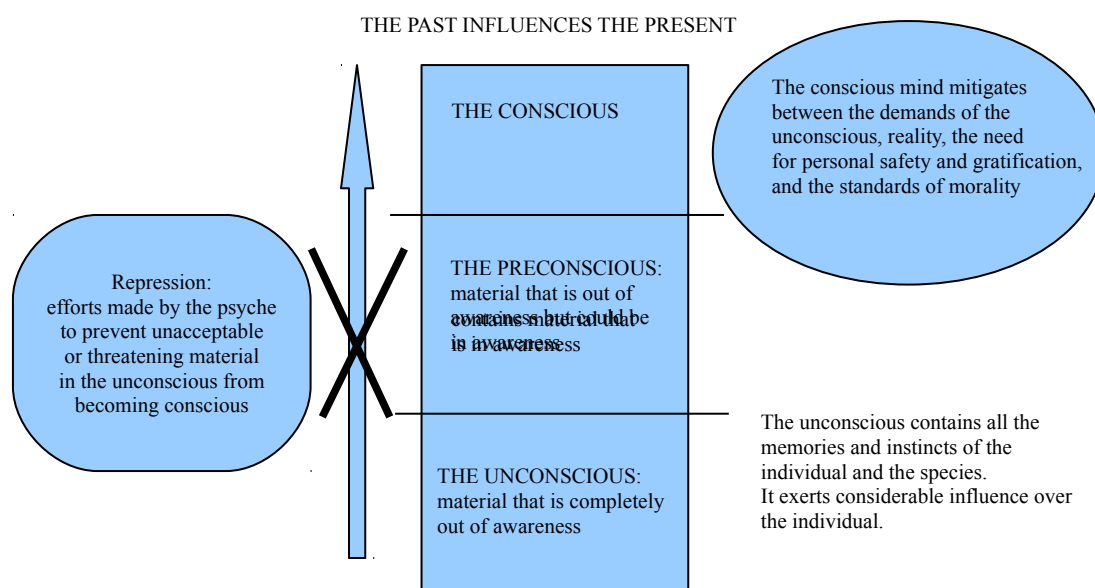


Figure 2. Psychodynamics of the mind

The corresponding dynamic to a client's transference is the countertransference enacted by the therapist. Although transference is defined as a defense mechanism, both transference and countertransference are actually central tools in psychodynamic therapy. According to Bruscia (1998), in psychodynamic therapy the primary goal is to bring repressed psychic material to the conscious level of the mind. In so doing, it is possible to solve the unconscious inner conflicts that cause misery in a client's life. These unconscious inner conflicts are usually seen as consequences from a person's early life and early relationships. In psychotherapy, the psychic material is worked through by using the transference and countertransference as tools to achieve more healthy and corrective emotional responses and experiences. These reconstructive experiences enable one's better coping in everyday life and in present relationships. (Bruscia, 1998.) The reconstructive function of transference and countertransference is based on how the therapist reacts in situations where a client relives his past relationships. The therapist does not react as the early object has reacted, but her response and interpretations help the client to liberate himself from repeating the defensive behavior. (Priestley, 1994.)

Bruscia (1998) defines transference and countertransference as follows:

A transference occurs whenever the client interacts within the ongoing therapy situation in ways that resemble relationship patterns previously established with significant persons or things in real-life situations from the past....The client reexperiences in the present the same or similar feelings, conflicts, impulses, drives, and fantasies as she did with significant persons or things in the past while also repeating the same or similar ways of handling and avoiding these feelings, persons, and situations. (Bruscia, 1998, p. 18)

Countertransference occurs whenever a therapist interacts with a client in ways that resemble relationship patterns in either the therapist's life or the client's life. Implicit is a replication in the present of relationships patterns in the past, a generalization of these patterns from one person to another and from real-life situations to the therapy situation, the casting of the client and/or therapist within the past relationship, and reexperiencing of the same or similar feelings, conflicts, impulses, drives, and fantasies through identification (Bruscia, 1998, p. 52).

Both transference and countertransference involve identificatory experiences in the context of a therapeutic relationship. Both concepts also contain the mechanisms of generalizing the past experiences to the present, casting the therapist or the client to the role of the past object, and reliving similar feelings in the present that have been lived in the past.

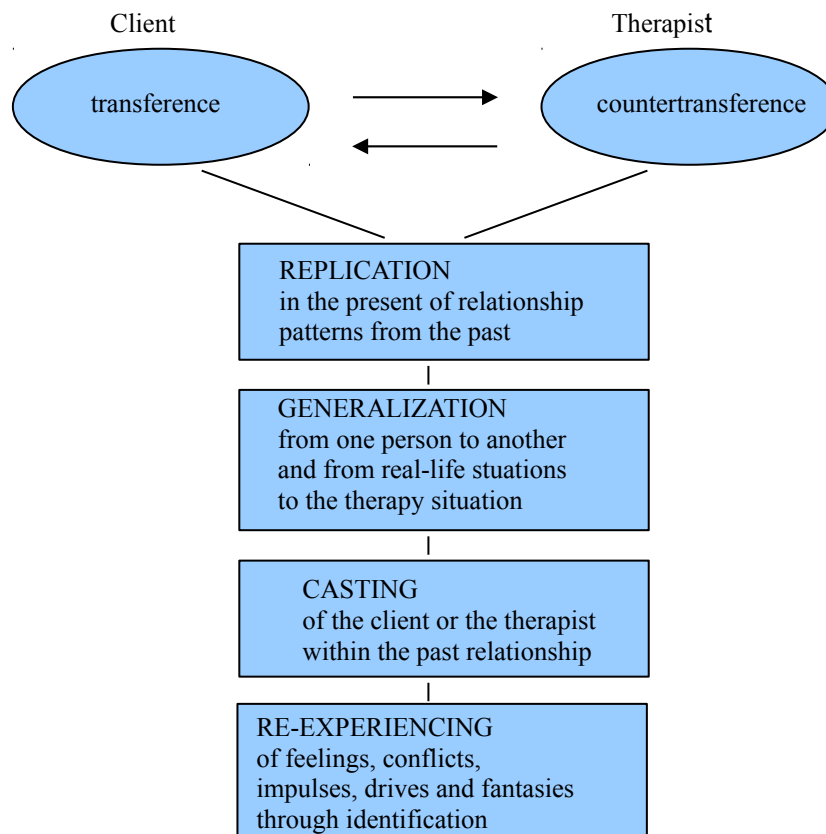


Figure 3. Transference and countertransference

In psychodynamic music therapy, music experiences are used to facilitate the interpersonal process between therapist and client. Music can be used in addition or in place of verbal discourse; the emphasis given to music can vary depending on the clinical situation and the therapist's orientation. (Bruscia, 1998.)

According to Erkkilä (2010), it is typical for the music psychotherapeutic approach to operate on different levels of consciousness; music can serve as a bridge between the conscious, preconscious and unconscious layers of the mind. Music awakes emotions, memories and images; it operates on the preconscious level. These preconscious visions are relevant especially because they give us a chance to search also the unconscious, non-verbal content of the mind. (Erkkilä, 2010.) The images, memories and emotions are seen as symbols that reflect the mind's unconscious tensions.

As we just saw, music and musical expression can be used as symbols that give a shape to issues that are difficult or even impossible to express verbally. Ahonen-Eerikäinen (1998) writes that a frequent goal of therapy is for example to use music to awake and work through emotions. Through musical expression it is possible to deal with difficult emotions from a symbolic distance. When an inner emotional state or conflict gets a musical shape, it may be easier to approach and understand it. (Ahonen-Eerikäinen, 1998.) Also Lehtonen (2010) discusses the symbolic processes in music therapy. He writes that music is a microcosmos, where it is possible to experience and express any material of our mind. One important aspect of music as a therapeutic tool is that through musical expression, it is possible to deal with actively dissociated material, thus making it easier to become conscious of it. (Lehtonen,

2010.)

One music therapy method that actively uses symbolic experiences as a tool for searching unconscious material is clinical improvisation. In clinical improvisation, the client shapes sounds into something meaningful for himself. Clinical improvisation is like free association in a musical shape; the client projects his internal introjects into the music he is playing.

(Bruscia, 1998.) Erkkilä (2004) compares clinical improvisation to early interaction between infant and mother. When mother and infant are communicating, they use pre-verbal levels of language. This means that they do not use words but other, musical qualities of the speech (e.g. rhythm, pitch and timbre). In musical expression we are able to use these same qualities; musical expression is shaped by the same qualities as the pre-verbal levels of speech.

(Erkkilä, 2004.) This experience of interacting on the pre-verbal level can give us easier access to deeper levels of consciousness and to repressed material.

3.2 Historical Review of Countertransference

According to Tansey and Burke (1989), Freud had a negative attitude towards the concept of countertransference. In the early phase of the development of psychoanalytic theory and practice there was an ideal of the therapist as a blank screen, against which the client can reflect his emotions and thoughts. Freud wrote in 1910, that a clinician should “overcome” his countertransference feelings. However, it is not completely clear what Freud meant by the word overcoming. Did he mean that the therapist should eliminate or avoid his feelings, or did

he mean that these feelings should be analyzed and understood in order to be able to work as a clinician? From Freud's statement followed four decades of silence in relation to the concept of countertransference. This neglect of countertransference is seen as a heritage from one generation to the next. The objective analyst was expected to be able to establish a sterile space for the patient, a space that would not contain any personal psychic material of the therapist. (Tansey & Burke, 1989.)

The theory of psychoanalysis developed and started to emphasize more the interpersonal experiences in the therapeutic relationship. The object relation theorists and the interpersonal psychoanalysis movement had a great impact on this progress. The widening application of the psychoanalysis to children and more disturbed adults gave additional pressure to develop the theory of countertransference further. Working with these populations demanded greater emotional responsiveness and more active participation from the therapist. (Tansey & Burke, 1989.)

In the 1950's, the countertransference theory polarized into two different camps. The classical view that originated with Freud classified countertransference just as largely unconscious and conflict-based reactions to a client's transference that may cause anti-therapeutic behaviors in the therapist and should therefore be eliminated. The totalistic view argued that the analytic situation is intrinsically based on a relationship between two persons. Hence, the countertransference should refer to all feelings that the therapist has for the patient, and all these feelings could be used to benefit the treatment if they are analyzed and understood, instead of being avoided. (Gelso & Hayes, 2007.)

The main differences between the classical and totalistic views are in their attitudes towards the therapist's intense responses in therapy situations. From the viewpoint of the classical camp, an intense response to a patient comes strictly from the therapist's own history and has nothing to do with the client, whereas the totalistic camp argue that if the therapist is able to examine the experience of even a strong response, something new about the client can be learnt. It can be said that the classicists may be too quick to judge countertransference as being just the therapist's private problem. On the other hand, the totalists may be at risk of muddling up the therapist's and client's unconscious material. (Tansey & Burke, 1989.)

According to Tansey and Burke (1989), during the 1970's and 1980's started the specifist movement, whose aim was to categorize the varieties of identificatory experiences in the countertransference. In the specifist movement, the theory of countertransference started to move towards a more complex structure. Theorists started to view countertransference as not such a black-or-white phenomenon, but more like a phenomenon with different varieties and different kinds of manifestation. (Tansey & Burke, 1989.)

Gelso and Hayes (2007) mention also the complementary and the relational view to countertransference. In the complementary view, countertransference is seen as an inseparable counterpart to the client's transference; therapist and client constantly induce both internal and external reactions in each other. The client pulls the therapist towards certain reactions by his way of relating, and these pulls make the therapist respond in a certain way, which again makes the client respond in a certain way. The complementary view captures the interpersonal

view of countertransference, but it may not take enough into account the therapist's own personal history and internal world as a causal factor. (Gelso & Hayes, 2007.)

The relational view overlaps with the complementary view, but it takes more into account the therapist's contribution to the interactive nature of countertransference. The relational view especially emphasizes a two-person psychology in contrast to the more traditional one-person psychology, where the focus is mainly on the client's problems. Here countertransference is also seen as a product of the inevitable interaction of the client's and therapist's dynamics. (Gelso & Hayes, 2007.) Bruscia (1998) names the intersubjective view, which is very much the same as the relational view. In the intersubjective theory, transference and countertransference are also seen as interdependent factors in the therapeutic relationship, where both client's and therapist's inner worlds impact each other. (Bruscia, 1998.)

The main differences between these various views in the course of history concern the origins of countertransference and the question of its position in psychotherapeutic relationships. Gelso and Hayes (2007) state that nowadays, the generally shared views are that countertransference is always a joint creation of the therapist and the client, and that it is not possible for the therapist to be anonymous or a neutral screen. The therapist must pay attention to her inner workings and at the same time respond to the client with her own personality. (Gelso & Hayes, 2007.)

Freud (1910): a clinician should overcome his countertransference in order to be able to help the clients (Tansey & Burke 1989)
The classical view: the countertransference is a largely unconscious and conflict-based reaction to the client's transference and should be eliminated (Tansey & Burke 1989)
The totalistic view: the countertransference should refer to all feelings that the therapist has for the patient, and all these feelings can be used to benefit the treatment (Tansey & Burke 1989)
The specifist movement: the aim is to categorize the varieties of identificatory experiences (Tansey & Burke 1989)
The complementary view: the countertransference is seen as an inseparable counterpart to the client's transference; the client pulls the therapist towards certain reactions (Gelso & Hayes 2007)
The relational view: the countertransference is a product of the dynamics of the client and the therapist (Gelso & Hayes 2007)

Figure 4. The different views on countertransference

3.3 The therapist's trauma and countertransference

Levine (1997) writes that trauma occurs when some stressful event creates an unresolved impact on an organism. Traumatized people are not able to overcome the anxiety of their experience, but are trapped in their trauma reactions by repeating them in their everyday life. The components of a traumatic reaction are usually hyper-arousal (increased heartbeat and breathing, agitation, tension etc.), constriction of the body and perceptions, dissociation, and freezing or immobilization associated with the feeling of helplessness. (Levine, 1997.)

Siegel (2010) presents the neurobiological basis for trauma reactions through the function of the amygdala. The amygdala monitors the incoming stream of perceptual input; if a person is sensitized by some past painful event, the amygdala detects similar conditions between a current event and a past trauma. If a match between event and past memory is found, the creation of the psychological state of fear will increase. Trauma impairs integration: the

person's perceptual interpretations, emotional responses, behavioral reflexes and sensory reactions are not integrated but influenced by past traumatic memories. So the unresolved trauma results in chaos and rigidity, making the mind incoherent. (Siegel, 2010.)

Porges (2004) has created the theory of neuroception. Through neuroception, we assess if situations or people are safe or dangerous for us. This assessment is unconscious and happens on the level of the autonomic nervous system. If we assess danger, a neurobiologically determined defensive behavior will be triggered. This primitive reaction to danger is the flight-fight-freeze response. On the other hand, if we assess the situation or person that we encounter as safe, we will inhibit the primitive defensive reaction and engage in a prosocial behavior instead. There is on-going evaluation of the significance of an event and its connections to similar events from the past. If danger is perceived, even if we are not cognitively aware of the threat, our body will start preparing us to react to the danger. (Porges, 2004.)

So the aftermath of trauma causes inability to integrate information. When a person experiences the burst of chaos that reliving the traumatic experience causes, the result is that she fails to integrate the information being perceived, and is not able to regulate her reactions awoken by the perceived material. Traumatized people get stuck in the particular actions that were evoked at the time of the original trauma and they also have a tendency to narrow their field of consciousness in maladaptive ways to the conditions that remind them of the traumatic event. (Ogden, Minton & Pain, 2006.)

The therapist's task in the therapeutic relationship is to be present for the client. According to Siegel (2010), this presence depends on the sense of safety. Unresolved traumas create states that impact how well we as therapists are able to openly assess various situations. A therapist should know her own tendencies of neuroceptive evaluation in order to create presence as a therapist, because when danger is being sensed, we can not socially engage with our clients. As a result, we as therapists are removed and paralyzed from our task. (Siegel, 2010.)

What is the connection between the therapist's traumas and countertransference? In their integrative conception of countertransference, Gelso and Hayes (2007) define countertransference as the therapist's internal or external reactions that are shaped by the therapist's past or present vulnerabilities. These conflicts and vulnerabilities create points to which the therapist has not found an internal solution, which in turn makes her vulnerable to particular patients. This kind of vulnerability can manifest itself for example in a situation where the client's material reminds the therapist of her unresolved traumatic experiences from her past. So the argument here is that there must be unresolved conflicts for countertransference to happen, especially when it is acted out during the treatment. There has to be a "soft spot" in the therapist that the client's affects stimulate. (Gelso & Hayes, 2007.)

The countertransference reaction originates from the therapist's conflicts and vulnerabilities, but the trigger for the reaction is usually some factor that resides outside the therapist. Most often this trigger is some behavior on the side of the client; the countertransference results from the interaction of a particular client trigger with a particular conflict or vulnerability originating in the therapist. The therapist's reactions to the countertransference triggers can

range from exclusively inner experiences to behavior that is acted out. Inner experiences include feelings, emotions, thoughts and bodily sensations, whereas external reactions include verbal or nonverbal behavior from the part of the therapist. (Gelso & Hayes, 2007.)

External countertransference can be very subtle and may not even be perceivable by the client, but it is still acting out the internal countertransference in one way or another.

Experiencing internal countertransference is bound to happen to every therapist at some point, because every person has personal issues, inner conflicts and vulnerabilities that have developed in the course of one's life history. The manifestation of countertransference depends largely on the extent to which the therapist is aware of her inner conflict or vulnerability that the patient's behavior triggers; the degree of awareness very often determines the ability to control countertransference reactions. (Gelso & Hayes, 2007.)

3.4 Learning processes in music therapy training

The structure of Finnish music therapy training is divided in theoretical and clinical studies. In the theoretical part of the training, students learn the theoretical bases of music therapy work, and in clinical studies theoretical knowledge is applied in practice. Important subjects in clinical studies are the self-experiential music therapy process and the supervision of clinical internships.

The self-experiential music therapy process is conducted as a group process. The length of the process is three years. The board of Finnish music therapy training, Sumuke, has defined the

goals of the group process in music therapy training. The primary goals are the development of the student's self-knowledge and the development of the personal competencies that are required in therapy work. Through the group process, a student learns about her personal ways to react in social and musical interaction. The aim is to improve the student's ability to work as a therapist and strengthen the qualities that help to maintain the therapist's own mental health while involved in demanding therapy work. One important aspect of the therapy process is also to deepen the student's personal relationship to music and gain an experience of music as a therapeutic vehicle. (Sumuke.)

The goal of supervision in music therapy training is to learn to study, assess and develop one's own work as a therapist. Students study the questions that arise from being in the role of the therapist, and analyze the experiences and emotions that the therapeutic relationships evoke. In supervision, the interaction during the therapy situations is analyzed from the perspective of both verbal and musical interaction. (Sumuke.)

In the clinical part of the training, the learning process is aiming at developing the student's personal competencies, in order to enhance her ability to work as a therapist. The learning processes where the students experience therapy relationships in practice help them develop their self-knowledge, their ability to reflect on the interaction in therapy situations, and their ability to analyze the emotions and experiences that arise in therapeutic interaction. It is important that students experience both sides of a therapy relationship; during the self-experiential music therapy process, they experience the client's role, and in clinical internships they experience the therapist's role.

The therapist's personal competencies and ability to build a therapy relationship are largely contributing to the outcome of therapy, independently from the specific type of treatment. Norcross and Wampold (2011) state that the therapy relationship accounts at least as much as the particular treatment method for why clients improve or do not improve. The elements that promote a facilitative therapy relationship are for example the alliance, the therapist's empathic abilities, and the therapist's ability to manage countertransference. (Norcross & Wampold, 2011.) Norcross and Wampold (2011) encourage education programs to provide competency-based training in the effective elements of the therapy relationship. In music therapy training, the therapist's personal competencies, their development in the self-experiential learning processes, and their contribution to the effectiveness of the therapy are all taken into account.

Lindvang (2010) has studied self-experiential learning and the development of music therapeutic competencies. She investigated 1) music therapy students and their experiences of self-experiential learning in music therapy training and 2) professional music therapists, their evaluation of their own competencies and their ideas of how they have been able to integrate the personal processes of music therapy training into their therapist identity. In Lindvang's research, self-experiential learning is corresponding to the self-experiential music therapy process of Finnish music therapy training. The results demonstrated that through self-experiential learning, students got to know themselves better, built up trust in what they felt in the moment, and developed the ability to contain complexity. They developed a high level of self-awareness, relational awareness and reflexivity. By using music in the self-experiential

process, students also learned how music can be a transformational vehicle. (Lindvang, 2010.)

Lindvang (2010) writes that students "developed self-awareness and self-confidence in relation to what they felt and sensed in the therapeutic process, corresponding to development of a complexity of consciousness" (Lindvang, 2010, p. 351). So the self-experiential learning of being in a client's role in therapeutic relationship made students more able to understand themselves in therapeutic interaction, and also more able to understand the complexity of the interaction in therapy relationships. In Lindvang's study, the professional music therapists found that self-experiential learning in music therapy training had helped them in many ways in their professional life. Self-experiential learning processes had made them understand the role of a music therapist and understand how to follow the personal needs and processes of their clients. They also pointed out that self-experiential learning had made them more able to handle and understand countertransference. (Lindvang, 2010.)

Hesser (2002) writes about the stages of development in the supervision of music therapy students. She introduces a model of two stages through which students have to go during supervision in their music therapy training. In the first stage, the focus is on practical matters: adjusting to a new clinical setting, learning the needs of particular clients, and learning to run music therapy groups and individual sessions. In the second stage, students begin to evolve a more personalized style of music therapy. They synthesize theoretical knowledge, clinical techniques and their own experiences of self-growth. This synthesis leads into a deeper level of music therapy practice. At this stage, the purpose of supervision is to help students to expand the awareness of themselves as therapists: how who they are affects the therapy, and

what personal issues they need to address in order to develop their clinical work. (Hesser, 2002.)

In music therapy training, the self-experiential learning plays an important role. Through personal processes, a student learns to analyze her own ways of reacting in interaction with others, and also to realize how her reactions are connected to her personal history. Through practical self-experiences of therapy relationships, student also learns to analyze the construction and the meanings of interactional situations. This kind of ability to conceptualize interactions is important, for example in understanding transference and countertransference in therapy relationships.

4 Content analysis - Analyzing my countertransference experience

This research process started in my clinical internship, which was part of my music therapy training. My client was a man whose problems and ways of interacting with me stirred up traumatic experiences from my own history. The situation reminded me of my ex-boyfriend, who got mentally ill and eventually committed suicide. As a therapist, when I now encountered this client with mental problems, who was of my age, and who possibly also had a tendency for suicidal behavior, my traumatic memories came up.

This experience in my internship was very intense and evoked strong emotions in me. I experienced the situation as threatening, and was not able to control my own reactions. I was also ashamed and felt guilty; I felt that I had failed in my task as a therapist because of my negative feelings in the situation. This episode made me think about what to do, and how to overcome the chaotic feelings connected to that experience. I also started to think about the meaning of this kind of difficult experiences as a part of music therapy training. How are this kind of intense and negative countertransference experiences related to the process of growing into the therapist's role?

In this section I strive to analyze my experience as directly as possible. Here I will do the content analysis of the data by following the principles of hermeneutic analysis that have been presented previously. The analysis progresses step by step: I will ask questions from the data, find answers by analyzing my self-reflections, and then look at these findings in the light of

the literature. The findings of each part will give birth to the next question.

4.1 Exploring my chaotic experience in the therapy situation

First question: What kind of reactions did the therapy situation evoke in me?

In this first part of the content analysis, my starting point is my own pre-understanding of the topic. Through my training, my own therapy, clinical experience and supervision, I have achieved an understanding of traumas and the way they impact human's behavior and experiences in stressful situations. When a therapist meets her traumatic memories in therapy situations, this kind of reaction is called countertransference, or therapist's transference. A trauma generated by a former stressful experience in the therapist's life affects her behavior in therapy situations and may make her experience the same kind of reaction again.

When I started to approach my experience here, I noticed that the content of my data still evoked strong confusion in me. The experience felt uncontrollable, inexplicable and offensive. Actually this chaotic feeling is the shape of my experience and the issue that I have to start studying more closely. What is the reason for the chaotic nature of the experience? What kind of details are there in this chaos?

Traumatic experiences may remain alive in a person's reactions and have an influence on one's experiences also later in life. Ogden, Minton and Pain (2006) write: "The complexity and variety of symptoms affecting both mind and body are perplexing to therapist and client

alike. Highlighting the role of dissociation in trauma symptoms, Pierre Janet (1889) emphasized that unresolved trauma results in profound deficits in the ability to integrate experiences. Processes that are normally unified, such as emotions, thoughts, identity, memory, and somatosensory elements, are separated” (p. 6). So the name for my chaotic experience is dissociation. A dissociated experience is not consistent, but it is fragmented in disjointed pieces.

This fragmentation has an impact on the emotional, cognitive and bodily content of an experience. Ogden et al. (2006) continue: “This integrative failure leads to an undue compartmentalization of experience: elements of trauma are not integrated into a unitary whole or an integrated sense of self” (p. 4). This means that the traumatic experience and its fragmented content are not organized in a way that a person would be able to process the experience as a part of her history or her self-image. Instead, the person's reactions in such a situation fluctuate between avoiding and alternatively violently reliving trauma material. “This biphasic pattern is the result of dissociation: traumatic events are distanced and dissociated from usual conscious awareness in the numbing phase, only to return in the intrusive phase” (Ogden et al., 2006, p. 4).

As we can see, chaotic dissociation is the nature of my experience. This experience’s inaccessibility marks my original traumatic experience, the reactivation of my trauma in the therapy situation, and also my feelings during this research process. I have recognized this kind of attempts to avoid feelings that are related to my trauma memories, and on the other hand the pervasive and uncontrollable way they can suddenly take over. At this point, it is

important to become conscious of the goal of this analysis; the goal is not to solve my trauma, but to examine the experience from the professional viewpoint of a therapist, and find solutions that may lead to professional development. Of course, the therapist's personal development and insights can not be separated from the professional development as such.

Next I will start to explore more closely the details of my experience. As a starting point for the analysis, I have taken the theory of levels of information processing. According to this theory, the experience of a human is divided into three levels that are integrated into each other. These levels are the sensorimotor, emotional and cognitive levels. Ogden et al. (2006) write about these experiential levels and their significance for information processing. They also connect these three levels to the theory of the triune brain, where the brain is divided in three parts: the reptilian brain, the limbic brain and the neocortex. These different parts have their own tasks in information processing and in organizing experiences. The reptilian brain governs arousal and relates to the sensorimotor level of information processing, the limbic brain correlates with emotional processing, and the neocortex enables cognitive information processing such as self-awareness and conscious thought. (Ogden et al., 2006.) Furthermore, Ogden et al. explain that according to this theory, the activity between these three parts of the brain is interactive: "These three levels are mutually dependent and intertwined, functioning as a cohesive whole, with the integration of each level of processing affecting the efficacy of other levels." And they continue: "In the aftermath of trauma the integration of information processing on cognitive, emotional, and sensorimotor levels is often compromised ... Dysregulated arousal may drive a traumatized person's emotional and cognitive processing, causing emotions to escalate, thoughts to spin and misinterpretations of present environmental

cues to as those of a past trauma” (Ogden et al., 2006, p. 7.) So the oldest part of the brain, the reptilian brain, automatically activates the increase of arousal when a person perceives objects seen as threatening. This increase of arousal has an influence on bodily feelings, emotions and thoughts, very often in a way that distorts reality.

What kind of reactions can I find from my data on these three levels of experience? I have analyzed my data and picked up phrases that tell something about 1) my emotional reactions, 2) my bodily reactions, and 3) the thoughts and images that the situation evoked in me. I have collected single expressions from the text, categorized them according to their degree of similarity, and given titles to the categories:

Categories of the expressions that describe my emotional reactions:	Categories of the expressions that describe my bodily reactions:	Categories of the expressions that describe my thoughts and images:
<ul style="list-style-type: none"> - hopelessness - helplessness - incapability - restlessness - anxiety - perplexity - fear - irritation - antipathy - frustration - guilt - shame - sadness - pity - concern - relief 	<ul style="list-style-type: none"> - bodily passivity and withdrawal - body expression is numb - inactivity of the voice and speech - feeling of detachment - feeling of irrelevant reactions in the situation - feeling of pronounced sexuality 	<ul style="list-style-type: none"> - absurd and frightening images - direct images of the person from my past - thoughts of my incapability and incompetence - images of despair and of sinking with the client - images of identifying with the client - images of the client's manipulation - images of closeness - images of the client's inner child that needs care

I will first analyze these categories separately and apply onto them the analytical model of Ogden, Minton, and Pain (2006), where the levels of experience are discussed one by one. Because the levels of experience are intertwined, for each experience on a certain level, its interaction with the other levels has to be taken into account.

Ogden et al. (2006) write that “the term cognitive processing refers to the capacity for conceptualizing, reasoning, meaning making, problem solving, and decision making” (p. 8). With the aid of cognitive processing we can observe and conceptualize information, and also plan our actions. This dominance of cognitive activity is called top-down processing in cognitive theory. (Ogden et al., 2006.) When I take a look at the categories that have been created from the thoughts and images of the data, it is clear that my thoughts have not proceeded in a way that is typical for professional observation and planning in therapy situation. Of course this was not my goal while writing my self-reflections: there my goal was to represent my subjective thoughts without any inhibition. Anyway, the thoughts and images that have arisen from the data are quite unprofessional. The data contains lots of images that are loaded with negative emotions (for example “at some point I got the feeling that he will lift his head and laugh in my face” or “I feel that the despair of this person is something I can not bear”). Ogden et al. (2006) write: “For the traumatized individual, the intensity of trauma-related emotions and sensorimotor reactions hinders the ability of top-down processing to dominate sub-cortical activity” (p. 9). This kind of connections between cognitive constructions and negative emotional reactions are visible in the data: images are loaded for example with fear (category “absurd and frightening images”), hopelessness (category “images of despair and sinking with the client”) and helplessness (category “thoughts of my

incapability and incompetence”).

Cognitive processing and bodily reactions are also inseparable. “Bodily feelings, or 'somatic markers' influence cognitive decision making, logic, speed, and context of thought” (Ogden et al., 2006, p. 9). For example, a person may know on the cognitive level that she is safe, but her body reacts to trauma triggers, which again impacts on the content of her thoughts. In my data there are points that may refer to this kind of connection between the sensorimotor and cognitive levels. For example, the experience of freezing (the category “bodily passivity and withdrawal”) may give a cue for the cognitive level to start reactivating trauma related memories (category “direct memories of the person from my past”).

Ogden et al. (2006) write about emotional processing: “Emotions add motivational coloring to cognitive processing and act as signals that direct us to notice and attend to particular cues” (p.11). Emotions direct our attention; they guide us to focus on the important things in our environment. However, a trauma can change this interaction between the emotional and cognitive levels. Ogden et al. (2006) write that it is usual for traumatized people to be detached from their emotions, or that they experience their emotions as urgent calls for action. When a trigger reminds a person of the trauma, the person may start to relive trauma-related emotions. This can lead to impulsive or irrational actions; in this kind of situation the traumatized person can lash out physically or verbally, and feel helpless, frozen and numb. She may take actions that are not adaptive responses to the present, but more likely adaptive responses to the original trauma. (Ogden et al., 2006.) So the emotions of a traumatized person can originate in a relived trauma. Trauma-related emotions may guide us towards

actions that are not appropriate in the current moment.

When I look at the expressions that describe my emotions, it is visible that they are strongly colored by negativity (categories “hopelessness”, “anxiety”, “fear”, “irritation”, “guilt”, “shame” etc.). The source of these negative feelings is not only in my own trauma memories, but also in the mirroring of the client's feelings and material in therapy situation. The emotions (“fear”, “hopelessness”, “helplessness”, “anxiety”) lead to freezing (“bodily passivity and withdrawal”, “inactivity of the voice and speech”), which again impacts on my ability to act appropriately as a therapist. Even if I had feelings of empathy towards the client (“pity”, “concern”), the trauma-related freezing emotions limited my ability to show empathy, or to plan appropriate interventions based on feelings of empathy.

The former already refers to the connection between the emotions and the body. Emotional and sensorimotor processing are inextricably connected to each other: “Emotions are matters of the body; of the heart, the stomach and intestines ... whether we are aware of these internal sensations or not, they both contribute to, and are result of, emotions” (Ogden et al., 2006, p. 12.). Ogden et al. (2006) write also about two kinds of manifestations of emotions: the inner manifestations, which are perceived through our bodily reactions, and the external manifestations, which are our behaviors that express our emotions for the outer world. So the emotions as such are actually bodily reactions, that manifest both inwardly and outwardly, and that we then name cognitively. When I consider this, it is interesting to analyze the connections between emotional and bodily expressions in the data. There are lots of expressions that refer to different kind of emotions, but quite few expressions that refer to

bodily feelings or reactions. This could mean that I do not recognize or observe my bodily feelings (emotions in my body) so well, but only give them names on the cognitive level.

Ogden et al. (2006) clarify the difference between emotional and sensorimotor processing: “Emotional processing pertains to experiencing, articulating, and integrating emotions, whereas sensorimotor processing refers to experiencing, articulating, and integrating physical/sensory perception, body sensation, physiological arousal and motor functioning” (p. 13). They continue by saying that the discrimination of these two is relevant, because inseparability can lead to intensification of both levels: “Clients often find themselves struggling with these effects of overwhelming emotions, with little awareness of how the body participates in creating and sustaining these emotions” (Ogden et al., 2006, p. 13).

This observation of overwhelming emotions and the reduction of bodily awareness may be an important issue for me. In the future I should learn how to be more conscious of my bodily reactions and their connections to my emotions and thoughts in therapy situations. This is also the core of sensorimotor therapy, which is the theme in the book of Ogden et al. (2006). It is possible to stop repeating the trauma reactions by becoming aware of our body, and learning new kinds of behaviors. “Client learns to observe and follow the sensorimotor reactions that were activated at the time of the trauma, as well as mindfully execute physical actions that interrupt maladaptive tendencies” (Ogden et al., 2006, p. 24).

Ogden et al. (2006) introduce the bottom-up processing. In bottom-up processing, which is the opposite to top-down processing, the physiological or sensorimotor reactions determine

the activity on higher levels. (Ogden et al., 2006.) So the hierarchy between levels is bidirectional: our cognitive constructions determine our emotional and sensorimotor reactions, but our bodily and emotional reactions also impact on what happens on the cognitive level. These two directions have a circular movement, where reactions on each level impact other levels as well. If a person is capable of integrating the stream of her experience, she can use this collaboration of the levels for her benefit. She can form a coherent whole from the information that has been observed, and use it for planning appropriate and useful actions in a given situation. For a therapist it is important to be able to plan actions based on the collaboration of these three levels of experience. A therapist has to be able to listen to her body, emotions and thoughts, because through them she observes her client, is in interaction with him and plans her interventions in therapy situation.

In my data I can see that I have not been able to integrate the experience appropriately. Rather, I simply reacted in a way that is typical for someone who is reliving trauma memories. I could say that the circular movement of the levels of experience has not worked in an integrative way, but more the opposite. The levels influenced each other and magnified both the negative experience and the experience of incoherence. Freezing and bodily helplessness caused the overwhelming and oppressive experiencing of inner emotions, which caused frightening images and the escalation of thoughts to the absurd, which in turn fed the fear and bodily freezing.

This kind of overwhelming cycle of experience can be viewed also through the “Window of Tolerance” theory. Ogden et al. (2006) write: “Unresolved survival-related action tendencies

include not only chronic postural and movement patterns related to defense, but also rapid mobilization of the autonomic nervous system in response to trauma related stimuli” (p. 26). The arousal level of a traumatized individual is often too high or too low, or typically alternates between two extremes. Both, hyperarousal (too high) and hypoarousal (too low) impact on the ability of cognitive processing: “In both cases, top-down regulation is compromised and meaning making becomes biased by the perceived danger signals” (Ogden et al., 2006, p. 26). In other words, when a person is hyper- or hypoaroused, she is not capable of integrating her experience appropriately. To be able to achieve such integration, one has to be in an optimal arousal zone: “In order to put the past in the past, clients must process traumatic experiences in an optimal arousal zone ... when clients are working within a window of tolerance, information received from both internal and external environments can be integrated” (Ogden et al., 2006, p. 27).

The window of tolerance is a zone where clients are able to process their trauma experiences. This is why therapists are helping clients to stay in that zone. Furthermore, it is also the zone where a therapist has to be in order to be able to separate her own traumas and conflicts from the client's material, and be able to help the client. My data indicates that in this therapy situation, I was not inside the window. My fluctuating arousal impaired my ability to act as a therapist and to make appropriate interventions. Later in this analysis I will come back to this theory, and consider how a therapist can widen her window of tolerance. However, I will now move on and start exploring the content of the therapy situation, as well as the factors that might have been at the origin of my experience.

4.2 Exploring the triggers of countertransference in therapy situation

Second question: What kind of triggers for countertransference were there in the therapy situation?

The situation in my clinical internship caused chaotic inner experiences in me. On the bodily level I experienced freezing and helplessness, in my emotions strong negative feelings, while my thoughts ran inappropriate routes. What reasons I can find for these reactions? As I wrote before, I experienced clearly that the therapy situation awoke my traumatic memories of my ex-boyfriend. In my therapy notes made after the session, I wrote: “Did I see something similar in my client as there was in X? Even if I was not aware of it in the situation, how did it influence my acts, my feelings, my thoughts... Helplessness, guilt, feeling of being helpless...” In this part of the analysis I try to find the factors from the data that link my experience in the therapy situation to the experiences in my history. What connective factors I can find between the therapy situation and my past experiences? Can I find some factors from the data that have served as trauma triggers? I also consider how the material that the client brought to the situation influenced my experience. Which of my reactions are more connected to the client's material than to my own history?

When I start to analyze the connection of my experience with my own history, I am of course in a very subjective area. No one else can have the knowledge of my experiences, neither the past experiences nor the present ones. However, I also find myself at the core of the therapist's work, because the therapist constantly has to analyze her subjective experience of the client

and apply the background theories of her work to this subjective knowledge. The result of this process should be a synthesis of the subjective experience and the objective knowledge that directs the therapist's interventions. The scientific reliability of this content analysis has to be measured against the nature of the therapist's work and its reliability in general.

Porges (2004) writes: "By processing information from the environment through the senses, the nervous system continually evaluates risks. I have coined the term neuroception to describe how neural circuits distinguish whether situations or people are safe, dangerous, or life threatening" (Porges, 2004, p. 19). Inside our nervous system is built a system that we constantly use to detect stimuli from the environment, and that tells us if we are safe or not. Also a therapist who meets her client uses this system and scans her client and the situation through neuroception. If there is something perceived as dangerous in a given situation that makes the therapist react, then the therapist's behavior will be defensive: "The detection of a person as a safe or dangerous triggers neurobiologically determined prosocial or defensive behavior. Even though we may not be aware of danger on a cognitive level, our body has already started a sequence of neural processes that would facilitate adaptive defense behaviors such as fight, flight or freeze" (Porges, 2004, pp. 19-20).

At the beginning of this chapter I summarized my chaotic experience like this: "On the bodily level I experienced freezing and helplessness, in my emotions strong negative feelings, while my thoughts ran inappropriate routes." So my experience tells about engaging in defensive behaviors. What were the triggers that activated my defenses? Here are the categories that I have formulated from the data; these categories describe my interpretations of the client's

behavior in the therapy situation:

Categories of my expressions that describe the client's behavior:

- client's sadness
- client's despair

- client's hostility
- client's arrogance

- sexual feelings of the client
- client needs attention from me and wants to please me

- defensive behavior of the client
- behavior that raises the client's self-esteem

These categories are quite broad, but they give an outline of the client's character and his behavior in the therapy situation. There were very contradictory and strong emotions in the client's behavior. I felt sadness and despair in his behavior, but also hostility and arrogance. I sensed also some sexual feelings that were present in the situation. The client showed that he needed attention and wanted to please me, but at the same time his behavior was quite defensive, as a polarity for the openness that he showed me by talking about very personal issues in a short time.

My experiences of the client's behavior are just my interpretations, but they tell that this behavior has been somehow boundless. I also felt that the client was quite good at manipulating the interaction in the situation. This observation is very subjective. The source for it is only my counter emotion of the situation, and my experience of the weakening of my own boundaries. My intention is not to give my client any diagnosis, but there are some elements that refer to some kind of personality pathology. For example Betan et al. (2005) have researched the countertransference phenomena and personality pathology in clinical

practice. They found that there were certain counter emotions of professionals that predicted patients' personality disorder diagnosis. The counter emotions are 1) overwhelmed/disorganized, 2) helpless/inadequate, 3) positive, 4) special/overinvolved, 5) sexualized, 6) disengaged, 7) parental/protective, and 8) criticized/mistreated. (Betan et al., 2005.) I can find connections in these counter emotions with my feelings in the therapy situation. I felt overwhelmed and disorganized, helpless, sexualized and criticized. For me it is helpful to understand that some of these feelings may have resulted from the client's pathology, and that clients who have difficult problems in general do provoke this kind of feelings in professionals. For me, an inexperienced trainee, this certain limitlessness of the client was challenging. As such, it already created the basis for the weakening of my own boundaries, for the activation of my trauma memories and for intensive countertransference.

When I read my self-reflection, there is a section in the text where I shifted from the client's emotion to my own trauma memories, and to the emotional space where the therapist's role was inaccessible for me. This section tells about my observations of the situation where the client starts to express his despair very strongly:

“Now, when the client starts to incite this despair, I realize that there rises restlessness and helplessness inside of me. I feel that the despair of this person is something I can not bear and carry, I can't cure it because I don't feel very hopeful myself either.”

“Here the client kind of drops emotionally, he starts to talk about the desperation of his destiny. He talks about his exhaustion and how he feels that everybody hates him. The sorrow rises, and he starts to plan how to shut himself away from the world. At this point I feel how I sink with him.”

“Now I can see the look on my face, I look somehow tensed, concerned and a little bit restless. The client talks

and talks non-stop and pushes himself lower and lower. I say nothing, I don't stop him, but just let myself sink with him.”

This text that I have written tells me how the client's despair was unbearable for me. When he talked about “shutting himself out of the world”, this in my mind turned into the possibility of suicidality, even though I do not know if it was what he meant. This made me “sink with him” and look tensed. Here the freezing reaction has happened, when I encounter the client's despair and interpret his words as potential suicidality. Freezing, the defensive reaction, is activated when I notice a trigger for danger in the client's emotional space. My self-reflection continues:

”Then suddenly the client falls into silence and looks like he will start to cry. It is silent, and when I look at the client, it seems like his posture and face would begin to become more shapeless, formless.”

This image of the client becoming more formless tells me of my trauma activation, and that my cognitions have started to become more absurd. In this vulnerable state of mind, the images that are colored with fear get to the surface and impact my experience in a way I have described in the first part of the content analysis. Freezing is a state where I am not able to do interventions that would create safety and hope for the client:

”The client has not got enough love, safety or acceptance, I can not give them to him either. The client starts to cry. I just stare at him and say nothing.”

In the situation I act like I was paralyzed in my mind. I feel helpless and in my mind, images flash that are colored by fear. These are the reactions that connect this experience to the

experience of my ex-boyfriend's suicide. For a moment I really feel frozen and incapable to show empathy.

There are many references to my emotions and thoughts in the data that can be connected to my past experiences. It is not possible to start analyzing all the emotions or thoughts separately to find the origin of each of them. I think that all the emotions and thoughts here are more or less a mixture of two time layers. However, on a more general level, it is important to try to find out which of my reactions are related more to the client's material than to my own history. The therapist has to be able to differentiate her feelings and reactions from the client's material, otherwise she will incorporate her own traumas and conflicts into the therapeutic relationship. This is the confusion that happened to me in this situation.

In the categories that describe the client's behavior, there are, in addition to sorrow and despair, also aggression or hostility, arrogance, sexual feelings and the need for attention and pleasing. The important issue that can not be avoided here is that the client had been mistreated in his childhood in many ways. He had experienced also sexual abuse, which also must be the origin for many of his problems. But how did these issues from the client's history impact my countertransference? I felt that at some point the client behaved quite aggressively towards me, and constantly tried to dominate me. I was confused by this manipulative behavior, it made me feel like I was forced into some role and not able to get out of it. This experience was quite tightly connected to our clinical improvisation. In my self-reflection I have described the experience as follows:

“The flirt begins here, I can see it from his face and the voice that is flattering. I somehow also answer to his behavior, I look like girlish and smile to him.”

”Flirting feels very uncomfortable to me here. I start the improvisation. The sound of my violin is fragile and warm, very feminine. Here I can see two musicians, a man and a woman, not a therapist and a client.”

”The sound of my violin is very strong and emotional, in my playing I clearly show myself as a musician, and I show my own voice that I have through my violin.”

”The client accelerates the tempo and the dynamics rises. The acceleration of the music continues for a while, the client makes the tempo go faster and faster. The client is very passionate, and kind of forces me into something.”

When I write about flirting and sexual tensions here, it has to be remembered that this is just my interpretation of the situation. From the text I get the image of a situation where an abused client places himself in the role of an abuser and forces the therapist into the role of the abused. At the same time I can see the influence of my own history on the situation, because I have experienced triggers that have made me relive my past experiences with my ex-boyfriend. The issue is not black-and-white, and also here it is not possible to directly address the origin of the experience. However, the feeling of being forced into something catches my attention, because I have not experienced such an abuse in my life. The feeling is confusing and unfamiliar. I can not explain why I go along with the situation. I just feel manipulated and ashamed.

In this second part of the content analysis, two sides of the experience came up that had an influence on my uncontrollable countertransference. On the one hand I met trauma triggers that stirred up painful memories from my past, on the other hand I got pulled into the

traumatic experiences from the client's past. In the next part of the content analysis I will explore more closely these two sides of the experience, and look at them using the countertransference theories of the psychodynamic framework.

4.3 The therapy situation in the light of the countertransference theory of the psychodynamic framework

Third question: How does the interaction in the therapy situation look like when I apply the countertransference theory of the psychodynamic frame of reference to it?

According to the psychodynamic theory, both transference and countertransference always contain experiences of identification in the therapeutic relationship. Transference means that a client relives in the therapeutic relationship significant relationships from his past.

Countertransference is a similar experience applied to a therapist: the therapist experiences the same kind of feelings as in other situations or relationships from her past. Next, I will apply the ideas of Bruscia (1998) to my experience, notably his description of the sources, activators, identifications and objects of countertransference.

Bruscia (1998) writes that countertransference originates from the past experiences of either the client or the therapist, and is activated in the present relationship. So the source of the countertransference can be the introjects of the client or the therapist. Introjects are internal representations in the person's intrapsychic structure. Every person carries gallery of introjects inside: self-introjects, that are representations of the self and have developed through

relational experiences, and object introjects, that are internalized models of other persons or things in the individual's past. (Bruscia, 1998.) In the therapeutic relationship, both client and therapist bring their personalities and also their personal inner galleries to the situation. These introjects have an impact on everything they do, including how they think and feel about their environment, others and themselves. And when a client and a therapist are in interaction, they both can activate these internal introjects in each other.

According to Bruscia (1998), countertransference can be activated by two kinds of client encounters: the client's transference or his projective identification. In transference the client tries to interact with his therapist as if the therapist were a significant person from his past. Usually this kind of casting leads to countertransference; the therapist at some level identifies with the client's object-introject. In projective identification, the client projects an unacceptable part of himself onto the therapist, manipulates the therapist so that she would identify herself with her client's self-introject, and then emphasizes this part of himself in the therapist. Experiencing projective identification can be very confusing for the therapist, because it involves a loss of ego boundaries and confusion between self and others. The client unconsciously manipulates the therapist's unconscious and makes her behave in a certain way. (Bruscia, 1998.)

Countertransference is always a matter of identificatory experience. When encountering the client's transference or projective identification, the therapist identifies with the client's self- or object-introjects. It is also possible that something in the therapy situation makes the therapist identify with her own self- or object-introjects, and so to relive her own life history.

This kind of countertransference is called the therapist's contamination; the therapist tangles with her own unconscious by bringing her own introjects to the relationship and identifying with them. Furthermore, if the client somehow resembles an object-introject of the therapist, the therapist can also develop transference toward the client. The therapist's contamination and transference reactions can be very dangerous for the client and the therapy process if they are not understood and managed fast enough. Acting out this kind of inner reactions can harm the treatment and is a sign that the therapist requires close supervision and further personal therapy. (Bruscia, 1998.) So the source of countertransference can be either the therapist's or the client's history. In her countertransference a therapist can identify either with the self-introjects or object introjects of a client, or her own self- or object introjects.

What do my countertransference experiences reveal if I analyze them in this way? Are the origins of my experiences in my history or in the client's history? What kind of client encounters (transference, projective identification) have activated my countertransference? What kind of identificatory experiences did I experience as a therapist (introjections of the therapist and the client)? The first scene I analyze is the situation where I shifted from my client's despair to my own trauma memories:

- the client shares his emotion of despair
- I start to feel restless and hopeless
- I feel that I can not bear the client's emotion
- I feel helpless myself
- the client's emotional state drops, he starts to talk about shutting himself out of the world
- I sink with the client and feel like frozen
- I am not able to react to the talk of the client
- my mind starts to produce images colored with fear

In this first scene the origin of my countertransference is quite clearly in my own history. I am sucked into the despair of the client, and I connect my feelings of the situation (hopelessness, anxiety, helplessness) to the feelings I have experienced in my past. The activator for my countertransference is the emotion that the client shares with me. In this situation the client probably identifies with his own self-introject, the mistreated child who feels despair. For me it is difficult to bear this intense feeling, because I connect it with my ex-boyfriend and his hopelessness. So I am identifying here with my own self-introjection, myself in the past situation, and give the role of my object introjection to my client, the role of my ex-boyfriend. So the name for this countertransference experience is therapist's contamination, because in the situation I as a therapist tangle with my own unconscious material by identifying with my own introjects. According to Bruscia, this can also be called therapist's transference, because I assign my client the role of my object introject.

The other scene is the situation where I sense some flirting on the client's side while I feel distressed and confused:

- the client flirts with me
- I feel that my femininity stands out in my behavior
- I feel the flirting as manipulative and uncomfortable
- I feel like drifting to reveal my personal self in our improvisation
- I feel that the client enjoys the improvisation that has sexual tension
- I feel like the client forces me into some role, and that I can not influence the situation

This second scene is more difficult to understand, but I try to analyze it by using my own intuition and emotions as a source. The origins of this experience can again be both the client's history and my own history. The client flirts with me, and the reason for this may of course be just that we have the same age, and that the roles in the therapy situation are not

clear enough. Anyway, I feel in this situation that I can not be myself, and I feel the manipulation and forcing from the client's side. If partial reliving of his traumatic experiences is present in the situation, the name for this experience is projective identification: the client projects on me the unbearable part of himself, his abused self-introject. My feelings of helplessness and of being forced would refer to my identification with the client's self-introject. The loss of ego boundaries, which is strongly part of projective identification, is also visible in the data. I experienced the situation as contradictory and did not feel like myself. It was also confusing that I felt like my femininity and sexuality stood out in the situation, even if I experienced the situation as very uncomfortable.

Pearlman and Saakvitne (1995) are concentrating in their book on countertransference experiences of therapists who work with clients that have experienced sexual abuse. According to Pearlman and Saakvitne (1995), these clients often experience intense transferences in the therapeutic relationship: "Inevitably, an incest survivor will struggle with powerful, intense, and often frightening transference reactions in psychotherapy ... for survivors of incest, transference responses and reenactments often include dissociated interpersonal aspects of traumatic memories" (Pearlman & Saakvitne, 1995, pp. 99-100). If a client has experienced sexual abuse, it is very typical that his transference reactions contain material from the sexual trauma. A client can give the therapist the role of the abuser, but he may also take the role of the abuser himself. In their book Pearlman and Saakvitne deal broadly with countertransference issues in this kind of situations. Sexual material in therapeutic relationship, and for example being an object for projective identification, may evoke difficult feelings in a therapist. For example shame, hate, confusion and guilt are

natural feelings when dealing with countertransference with such clients. (Pearlman & Saakvitne, 1995.) The client's sexual trauma is an important issue here, because it can partly explain my chaotic countertransference.

As it is analyzed before, my countertransference reactions are shaped by both the client's unconscious material and my own unconscious material. In the course of history of the concept of countertransference, there have been various definitions for it, changing from a therapist-centered viewpoint to a client-centered point of view. Nowadays it is generally accepted that countertransference is always the result of intersubjective interaction, and therefore contains material from both the client's and the therapist's inner world. For example Gelso and Hayes (2007) write: "...psychoanalytic theorists from diverse perspectives share the view that, at least to some extent, countertransference is always a joint creation of the therapist and the patient ... The same patient will evoke different reactions in different therapist, and the same therapist will respond differently to different patients. Both therapist and patient are part of the countertransference, although, it is important to appreciate the roots of countertransference as residing in the therapist, and his or her personality, anxiety and defenses" (p. 16.).

Gelso and Hayes (2007) emphasize the therapist's personality and personal inner world as a leading cause for countertransference, even if the experience of countertransference is a creation that is founded on the interaction between the therapist and the client: "Co-construction implies that both parties are involved in creating meanings and in the internal and external reactions of each to the other. Thus, although the therapist must have a hook

(indicative of unresolved conflict and vulnerability) for countertransference to occur, usually something expressed (verbally or nonverbally) by the patient serves as a precipitant. Such patient triggers touch the therapist in a sore area, and if the therapist is unable to understand or control consciously his or her reactions, countertransference is likely to be acted out.” (Gelso & Hayes, 2007, p. 131.)

From this perspective, the origin of my countertransference lay in my own areas of vulnerability. These were stimulated by my client's behavior and his way of interacting with me. This interaction led to the experience of intense countertransference. Also Bruscia (1998) describes countertransference as an intersubjective phenomenon that is constructed within the interaction between client and therapist: “In the ‘*intersubjective*’ point of view, countertransference and transference are inseparable, interdependent, and reciprocal aspects of the client-therapist relationship ... In this creation, the client and therapist form an intersubjective field wherein each individual co-creates a relationship and his/her position within it, on the basis of individual histories and the experiences both share in their work together”. (Bruscia, 1998, p. 52.) So the intersubjective interaction between client and therapist affects the therapeutic relationship and the creation of transference and countertransference.

4.4 Exploring the effect of musical expression and clinical improvisation on my countertransference experience

Fourth question: What kind of effect did the musical interaction have on my countertransference experience?

In the previous part of the content analysis, I described the scene where projective identification took place during clinical improvisation. How did the presence of music and the clinical improvisation affect that experience and the development of the situation? I have analyzed the part of my self-reflection that is related to the improvisation, and collected expressions from the text that are related to the following issues: 1) expressions that describe my behavior, 2) expressions that describe the behavior of the client, 3) expressions that describe the interaction between me and the client, and 4) expressions that describe the music. Inside these groups I have organized the expressions into categories according to their level of similarity. These categories show my impression of the situation and its dynamics:

Categories of the expressions that describe my behavior:	Categories of the expressions that describe the behavior of the client:	Categories of the expressions that describe the interaction between me and the client:	Categories that describe the music:
<ul style="list-style-type: none"> - I participate actively in the improvisation - I show myself as a musician - the nature of my playing is warm and strong, "feminine" - in my reflection I describe thoughts that are related to my personal world - I feel guilty of playing so strongly and showing my personal self in my playing - I try to end the improvisation, but I do not manage to do it - I feel manipulated 	<ul style="list-style-type: none"> - the client participates actively in the development of the music - the client plays passionately, I sense some sexual tension in his playing - the client will not end the playing, even if I try to find an ending for the long improvisation - the client enjoys playing with me 	<ul style="list-style-type: none"> - therapist and client play together as two musicians - therapist and client are in their own worlds and are avoiding open interaction 	<ul style="list-style-type: none"> - music alternates between fierce and mellow episodes - there is some deep seriousness in the music - the improvisation is long and repetitive

The client was a talented musician, and I think this factor influenced the nature of this improvisation. During the therapy process he had chosen to use his main instrument in clinical improvisations. My interpretation is that it was a defensive behavior; he wanted me to see how good he was in his playing, instead of moving towards expressing his inner world through the music. In this improvisation we both chose to play our main instruments.

The data tells that both my client and I were active in our playing, and that we both influenced the formation of it (categories “I participate actively in the improvisation” and “the client participates actively in the development of the music”). One thing that I notice here is that I showed myself more as a musician, not as a therapist (category “I show myself as a musician” and “therapist and client play together as two musicians”). I can use my intuition for analyzing this issue and see it from two viewpoints: hiding behind the musician’s role can be either a defensive behavior in an unstable situation, or it can be the result of me sinking into my own personal world instead of staying in the role of the therapist. This kind of drowning into my personal inner world is visible in the data (category “In my reflection I describe thoughts that are related to my personal world”).

According to the data, the client played very strongly and I felt some sexual tension in his playing. In the data I describe my playing as warm and sensitive, and I felt that my femininity stood out in my character (category “The nature of my playing is warm and strong, 'feminine'”). Showing my personal self and femininity was an issue that made me feel guilty (category “I feel guilty of playing so strongly and showing my personal self in my playing”). According to the data, the client seemed to enjoy playing together with me. In my self-

reflection it is apparent that I again and again tried to find an ending for the long improvisation (it lasted over 30 minutes), but the client refused to end his playing (categories “I would like to, and I try to end the improvisation, but I do not manage to do it” and “the client will not end the playing, even if I try to find an ending for the long improvisation”). This experience of not being able to affect the improvisation made me feel anxious and insecure (category “I feel manipulated”).

The defensive and avoiding nature of our interaction, despite the intensive nature of the improvisation, gave an exceptional tone to the situation (category “therapist and client are in their own worlds and are avoiding open interaction”). This observation supports the notion I have highlighted also before: we were both drowning in our own inner experiences. In my experience, my own traumatic memories were present, and also the traumatic experiences from the client's past may have affected his actions in the situation.

In my data I have described my images of the music: the corresponding categories are “the improvisation is long and repetitive”, “music alternates between fierce and mellow episodes”, and “there is some deep seriousness in the music”. Although I experienced some sexual tension and manipulation, the nature of the music was serious and profound. In my text I have described it for example with the words “melancholic”, “sinking”, “dark”, and “primitive”. This indicates that we both have been in a very deep state of experiencing music and in our own inner world. When the improvisation finally ended we were both confused, and I still did not get hold of my role as a therapist. I did not lead the conversation towards the improvisation, and did not ask the client to reflect on his experience.

Scheiby (1998) writes about how countertransference can manifest in music and musical expression. For example following experiences can be signs of countertransference: 1) music that seems out of context with the client's expression at that moment, 2) music that does not seem appropriate from the therapist's perspective, 3) musical expressions that the therapist makes and that take her by surprise, 4) a sense of not knowing where the music is coming from, and 5) musical expressions that the therapist feels pushed into producing (Scheiby, 1998, pp. 216-217). I can find some correspondence between these examples and my data. I experienced my musical expression as not appropriate for the therapy situation. I expressed my personal self too strongly by showing my own personal voice through my violin. On the other hand I felt like being manipulated and that the client pushed me towards a certain role and expression. I experienced the manipulation as oppressive, but was not able to resist it and break free from the role I got into.

Priestley (1994) introduces three basic types of musical countertransference: classical countertransference, complementary countertransference, and emotional countertransference. The classical countertransference appears in sound patterns that reflect the therapist's own unconscious transference distortions towards the client. Complementary countertransference means that the therapist identifies with the client's object introject in her music. In emotional countertransference the therapist identifies with the client's experiences through her own emotional and somatic awareness. Such experiences may very often show themselves particularly in musical expression and give the therapist the opportunity to get information about the client, including information that may not be accessible on the verbal level.

(Priestley, 1994.)

Scheiby (1998) adds still one subcategory to emotional countertransference, namely traumatic countertransference. In traumatic countertransference the therapist experiences the client's traumatic memories through emotional countertransference. In music therapy the first awareness of these experiences often happens through musical expression. This kind of experiences may be very intense, and increase the therapist's sensitivity for her own traumas. (Scheiby, 1998.) This means that through the musical interaction, a therapist can internalize the trauma-related emotions and bodily feelings of a client, even if these experiences are still not on the conscious level in the client's mind. Such intense experiences may be difficult to understand immediately. They may also make the therapist vulnerable to her own traumas and trauma-related emotions or bodily reactions.

When I look at my experiences during the improvisation and the signs of countertransference, I think it is impossible to give any specific name for the musical countertransference experience. Instead, it could be described as an interactional stream of experience, with an alternation between different identificatory experiences. However, I think that the most visible types are the classical and emotional countertransferences. In the situation my own self- and object introjects were present, which refers to classical countertransference. Already my instrument choice tells something: I chose the violin, which is the closest instrument for me. The violin is probably the instrument I can express myself the most freely with, but it may also be the instrument that makes it difficult for me to stay objective. The intensity of the improvisation also tells about my emotional state in the situation: in my playing I have

expressed characteristics of my personality that are probably only reserved for close people, not for clients in therapy situations. This aspect of my expression tells me that in my playing I was more likely discussing with my own object introjects than with my client. This is also a direct reference to classical countertransference.

The other type of musical countertransference – emotional countertransference or traumatic countertransference – is a phenomenon whose analysis is more complex to perform. My experience is connected to the same feeling of being forced into something, the feeling I have described in the previous part of the content analysis where I analyzed the possibility of projective identification. During the improvisation, at some points, I experienced the behavior of the client as aggressive and sexual, and felt myself helpless. I felt that I was the weaker part in this interaction, and felt guilty that the client saw me as a sexual person. The musical expression of the client forced me to express myself in a certain way, to express sides of myself that were not appropriate in that situation. Again, it is not possible to directly address these emotions, but if I analyze the situation through Priestley's emotional countertransference, it is possible that I partly experienced the client's unconscious shame and guilt for the abuse in his childhood. I could say that through our improvisation, the client let me feel and experience how it feels to be forced and abused sexually.

In his dissertation, Syvänen (2005) describes the formation of counter emotions in music therapy. I think this model describes well the stream of identificatory experiences in clinical improvisation. In music therapy, the presence of shared music impacts the transference and countertransference experiences. The music can serve as a mirror of the client's transference

and the therapist's countertransference. The model of the dynamics of counter emotion formation describes the phenomenon as a continuum with seven stages:

- 1) In his music the client expresses material that is related to his former significant relationships.
- 2) The therapist receives musical messages from the client, and experiences counter emotions evoked by the music: transference reactions towards the client, projective identification towards the client, complementary and concordant emotional reactions, and counter identifications for the client's transference. All counter emotions that the therapist experiences are projected onto the music she is playing.
- 3) The counter emotions of the therapist are composed – the therapist becomes conscious of her emotional reactions. These are a combination of the information the client has expressed and the countertransference of the therapist.
- 4) The therapist processes her counter emotions by comparing them with the material that the client has expressed in his music, and forms her own understanding of this interactional whole. The therapist formulates feedback about the information she has processed, and returns this more “ennobled” vision to the client in musical form.
- 5) The client receives the therapist's feedback that contains reconstructive and substitutive experiences.
- 6) The client internalizes the reconstructive experience. The experience shapes the client's psychic structure that was formed in his former relationships.
- 7) The client constructs a synthesis of the current conscious and unconscious object relations. The synthesis contains experiences from his former relationships and the experiences that he has experienced in the therapeutic relationship. (Syvänen, 2005.)

This model shows the circular movement that is related to therapeutic relationships. The client expresses his feelings, the therapist internalizes the feelings to process them, and returns them in a shape that enables the growth of the client. This movement is a continuous stream between therapist and client. The more capable the therapist is in her profession, the more effectively she can receive the client's material, process it, and return it back in a shape that enables development. In music therapy, and in the model of Syvänen, the presence of music lends a special quality to the interactional space. Syvänen (2005) writes that music has the ability to become a mirror for the interaction; both the client and the therapist can listen to their own emotional expression and then process it (Syvänen, 2005).

When I take a look at my data and compare it to Syvänen's model, it looks like during the improvisation, I was most of the time stuck in the second stage. I received the musical messages of the client, and experienced the counter emotions that the client's expression evoked: I experienced transference reactions, and also concordant emotional reactions when I identified with the client's self-introject. All my counter emotions are reflected in the music I play. Syvänen (2005) states that at the beginning of a musical episode, the feedback that the therapist gives her client is still mostly unconscious and unprocessed also for herself, and because of this it is also difficult to control it rationally. However, these emotional tensions are visible with honesty in the musical expression of the therapist. This way it is also possible for the client to reach and relive interactionally his past experiences during the improvisation, while the therapist's music is alternately the equivalent of her own past experiences and the emotional expressions of the client. Also the therapist's personal countertransference reactions

and her projective identifications that are useless for the client are present in the music of the second stage. (Syvänen, 2005.)

Both my inexperience as a therapist and the impact of my unresolved trauma resulted in my inability to proceed from the hold of my counter emotions towards the processing and returning of information during the improvisations. When the client and I played together, I unconsciously reacted to his messages, and was not able to control my expression rationally. This getting stuck in a certain stage continued for the whole improvisation, and even after the ending I did not consciously understand what the experienced phenomenon was. I just ended up being confused, when a professionally relevant intervention would have been to lead the conversation towards a reflection on the improvisation.

The presence of music in the therapeutic relationship provides an exceptional opportunity to experience and express transference and countertransference. Through musical expression it is possible to express tensions that are on the unconscious level of the mind and therefore not accessible on the verbal level. I feel that in this case, the music as a tool for expression highlighted unconscious processes that otherwise would not have become conscious at all. Through our shared musical expression, both my unconscious inner tensions and the inner tensions of the client became visible to me.

According to Syvänen (2005), it is typical that in the beginning of the therapy process the emotional tensions that reflect the problems of the client are strongly visible in the musical expression. Similarly, also the counter emotions of the therapist are usually more negative in

content. As the therapy process continues and progress is made in terms of issue processing, then also the music becomes more conscious and consistent in its content. This means that the pathological object relations of the client are not anymore projected so strongly to the music, which leads to the therapist's counter emotions having a more positive content. (Syvänen, 2005.) In this case we did not have the opportunity to discover what kind of progress could have been made, because of the shortness of the therapy process.

For a music therapist it is impossible to keep a completely neutral stance in therapeutic relationships, because her musical expression inevitably tells a lot about her personality. The music therapist uses her own personal expression as a tool in her work. Therefore, it is important to develop this tool continuously towards a more appropriate and functional direction; the therapist's own musical expression is a tool whose aim is to help the client in his process. Presumably, this kind of music therapist's musical expression develops through work experience and the increase of self-knowledge. On the other hand, the music therapist has to keep her relationship to music as genuine and living as possible, because only through genuine musical expression is it possible to create an interactional music space for the client.

Bruscia (1998) writes: "... music therapy is the meeting of musical selves, client with therapist. What makes the music such a powerful vehicle of therapy is that it is a two-way interaction between therapist and client: just as the therapist enters into the musical world of the client, the client also enters into the musical world of the therapist" (p. 177). This means that the music therapist has to share her musical world with the client. Furthermore, the music therapist probably has to share her personality and emotional world with the client more

openly than would be the case through verbal discourse only. In relation to countertransference issues, this creates both challenges and possibilities for the music therapist. On the one hand the countertransference reactions are more visible to the client, but on the other hand it may also be easier for the therapist to identify countertransference reactions in her own musical expression. The therapist has to learn how to control her expression and observe signs of countertransference, and at the same time keep her expression genuine and rich.

4.5 Analyzing the effect of countertransference on the therapeutic interaction in this therapy situation

Fifth question: How did my countertransference experience affect the therapeutic interaction in this therapy situation?

The previous part of the content analysis revealed that I got stuck in the experience of the counter emotions evoked in me by the client's expression. Bruscia (1998) introduces the model of the therapist's consciousness moving between three experiential spaces. Bruscia (1998) writes: "Navigating the steady stream of encounters in a session requires the therapist to continually expand, center, and shift his consciousness. While interacting with a client, a therapist can continually move into and out of three experiential spaces: the client's world, his own personal world, and his world as a therapist" (p. 95). When the therapist's consciousness is in the client's space, the therapist empathizes with the client's experiences in the present situation. When her consciousness is in her own personal world, she concentrates on

experiencing freely any personal feelings that the situation evokes in her. When she shifts her consciousness into the space of her professional world, she analyses the experiences of the client, her own experiences, and the meaning of common interactions from a professional perspective. (Bruscia, 1998.)

For the therapist, the main benefit of moving her consciousness between different interactional spaces is to be able to collect information about the client, her own inner state, and the connection between the two; she tries to understand the meaning of the interaction in order to understand something new in relation to the client's problems. This moving of one's consciousness is essential also in relation to uncovering countertransference. Bruscia (1998) writes: "Being able to move one's consciousness into the different spaces and layers is essential for being an effective therapist because ultimately, it will determine whether one can uncover and use one's countertransference to best advantage. In fact, I believe that by definition, countertransference is obstructive when the therapist gets stuck in one of these spaces or layers, and facilitative when the therapist can move from one to another with fluidity and purpose" (p. 96.). According to the information that emerged from the data, I could say that I got stuck somewhere between the client's world and my own personal world. This experience of getting stuck has prevented me from moving freely between the different worlds of the interactional space. That is why I was not able to collect any relevant information about the meaning of our interaction. This information would have been necessary in order to plan suitable interventions in the therapy situation.

Bruscia (1998) analyses the movement of consciousness even more precisely inside these

three experiential spaces. The therapist can also move her consciousness between four layers inside these three different worlds: "... experiences within each of these worlds can further move between four layers: sensory, affective, reflective, and intuitive" (Bruscia, 1998, p. 95). At the sensory layer, the therapist strives to experience the feelings from her body as fully as possible. At the affective layer she experiences her emotions as spontaneously and openly as possible. At the reflective layer, the therapist forms a meaningful whole from the experiences of the sensory and affective layers, and analyses them on the cognitive level. Eventually, the therapist also forms a synthesis of the information she has gotten from the previous phases. She uses this information to assist her intuition to find reasons for these experiences, and to understand how these experiences are related to the client's process. (Bruscia, 1998.)

In the therapy situations presented in my data, I was not able to reflect on the interactional information effectively. However, the model of moving one's consciousness between three worlds and four layers describes quite well the way I analyzed my data in this content analysis. I focused my consciousness alternately on the client's experience, and on my own experience and its different layers, and then analyzed them together from a professional perspective. Using this method, I formulated a professional viewpoint about my countertransference reactions and their relation to the interaction between me and my client. I strived to experience the situation at the sensory and affective layers, to understand the meanings of these experiences, and to analyze them on the cognitive level. I also used my intuition as a tool in this content analysis, for example when I tried to understand the meanings of my experiences in relation to the client's process, and also in relation to my own personal and professional processes of learning.

In his book *The Mindful Therapist*, Siegel (2010) discusses the same phenomenon as Bruscia, but through different concepts. He approaches the presence of the therapist from the perspective of interpersonal neurobiology. Siegel defines the word "mindful" as follows: "...being conscientious and intentional in what we do, being open and creative with possibilities, or being aware of the present moment without grasping onto judgments – being mindful is a state of awareness that enables us to be flexible and receptive and to have presence" (Siegel, 2010, p. 1). Siegel broadly discusses different concepts that represent the formation of the therapist's presence in therapy situations. The first concepts, and in my opinion the fundamental concepts in this construction, are "presence", "attunement", and "resonance".

One important point made by Siegel (2010) is that the ability to be present is dependent on the relative freedom from repeating certain reactions. Having *presence* means that we are not trapped in repeating certain behaviors that are for example resulting from our personality traits or our moods. Instead, we are really able to choose the way we react and create fresh approaches in problematic situations. Siegel refers to Porges's (2004) theory of neuroception and underlines that this kind of presence is dependent on the sense of safety. If we do not feel safe, we can not activate the social engagement system, which is a necessary precondition for a therapist who strives to be present for her clients. (Siegel, 2010.) Siegel (2010) writes: "Neuroceptive evaluation ... is shaped by ongoing appraisal of the significance of an event and the reference to historical events of this type from the past ... Our past experiences, especially of unresolved trauma, restrict our plateaus and create valenced states that bias how

we'll be able to openly assess various situations” (p. 21).

In the therapy situations that I have described in this study, my reactions were very colored by the influence of my trauma memories and their impact on my presence. I was not able to choose my reactions, or to estimate the situation with a present mind. Instead, I got caught up in repeating defensive reactions that were the result of my past experiences. Nevertheless, our inner reactions can also guide us towards a more creative interaction with our environment: “... the key is to be aware and flexible as we allow our own internal responses to inform us rather than entrap us” (Siegel, 2010, p. 23). However, profound knowledge of personal neuroceptive evaluation is required by the therapist in order to be able to use the internal responses to contribute positively to the therapy situation.

So presence is the foundation for the ability to accept interactional situations openly, and to be open for their possibilities. Siegel (2010) defines the second concept, *attunement*, as follows: “Attunement is how we focus our attention on others and take their essence into our own inner world” (Siegel, 2010, p. 34). This kind of interpersonal attunement requires the ability to go into the inner world of another individual, and the capability to let the other individual influence our own inner state. On the physical level, this happens by observing the behavioral signs that inform us about another person’s inner state, and by modifying our own being according to the other person's reality. However, there are again many kinds of factors that can influence our openness for the information that other individuals send us: “... attunement requires that our perceptual array be as open to incoming sensation as possible – rather than being markedly biased by similar experiences and our ensuing restrictive expectations that are

born from that earlier learning” (Siegel, 2010, p. 35).

Traumas and other learnt reaction models may restrict our ability to attune to the world of our clients. If the therapist's own reactions are too intense, she may not be able to collect the information of the therapy situation, and the result is obstructive countertransference. Siegel (2010) writes that in relation to attunement it is important for a therapist to know her own window of tolerance when encountering different situations and triggers: “We may have a wide window for some situations or feelings, yet a very narrow and easily ruptured window for other conditions” (Siegel, 2010, p. 50). In practice, the knowledge of one's own window of tolerance means that apart from being able to observe her own arousal and how the fluctuation of arousal affects her reactions, the therapist is also able to regulate her arousal in appropriate ways. Siegel (2010) continues: “Knowing our windows, and especially noting which ones are particularly narrow and restricting our ability to be present and attuned with other's emotions, is a vital aspect of attunement and being a mindful therapist” (p. 51). In this content analysis, I explored the reactions that the fluctuation of my arousal had caused, and the triggers that led to this uncontrollable experience. In this particular therapy situation, my window of tolerance was relatively narrow. When I encountered triggers that activated my trauma memories, I was not able to attune to the client's world appropriately.

Although I was not able to attune to the client's world appropriately, I probably went too intensively into his emotional space. On the other hand, the strong emotions and inner tensions of the client made me relive my own unresolved conflicts with great intensity. I can recognize that this type of reaction is somehow typical for me; I often attune too strongly to

emotions and inner states of other people. This kind of exaggerated attunement may cause a loss of my own boundaries and lead to unmanaged emotional experiences, for example when encountering difficult clients. If emotions are too intense, it may influence the free movement between the client's world, the therapist's personal world, and the therapist's professional world.

The third concept in Siegel's construction is *resonance*. Siegel writes about the concept of resonance as follows: "Resonance is the coupling of two autonomous entities into a functional whole. A and B are in resonance as each attunes to the other, and both are changed as they take the internal state of one another into themselves" (Siegel, 2010, p. 54). In this kind of state of resonance the interaction can lead to change; one can change because of what the other is. The client can experience transformation when the therapist creates propitious circumstances for it in the common space of resonance.

The space of resonance is probably the space where the therapist can move her consciousness freely between experiential spaces. And, in order to be able to move one's consciousness freely, circumstances have to be propitious for the creation of resonance. These circumstances are for sure the result of many different factors, but mostly they develop from the therapist's own inner space. Fear and other defensive reactions can bring the resonance down. According to Siegel (2010), the therapeutic space is the space where trust takes place: "Presence, attunement, and resonance are the way we clinically create the essential condition of trust" (Siegel, 2010, p. 75).

5 Results – Transformation of my understanding

In this section I will discuss the results of this study, especially how the understanding of my countertransference experience changed in the course of the analysis. First I will discuss the summary of the results of the content analysis; what I learnt about countertransference.

Secondly I will explain how I can apply this new knowledge to my music therapy work, by using a tool for uncovering and processing countertransference. At the end of this section, I will discuss the relation of countertransference experiences and learning processes in music therapy training.

5.1 The development of my understanding in the course of the analysis – what did I learn about countertransference?

In this section I will examine the previous process of analysis and formulate an answer to the question, “*what can I learn about countertransference by analyzing my own negative countertransference experience?*” This is the first step for a fusion of the horizons, where new knowledge is created through a qualitative transformation of understanding. When I started, I experienced my countertransference as totally negative and shameful. I was not able to understand why I had reacted the way I did. I thought that maybe I was not the right person for being a music therapist because of my difficult feelings in the therapy situation. I was confused because of the feeling of losing my empathic ability and of being manipulated by the client. I experienced the situation as chaotic and extremely uncomfortable. Here I will take a look at how my understanding of the initial experience changed during the analysis.

In the first step of the content analysis, I investigated the reactions that the therapy situation evoked in me. I recognized that the chaotic experience was related to the trauma memories from my history and started to analyze my own reactions in the therapy situation more closely. When I learned how trauma can affect our body, emotions, cognitions and the interaction of these different levels of information processing, I was better able to understand why I had reacted the way I did. I also got the first explanation on how my reactions affected my functioning in the interactional therapy situation. The new understanding of the reasons for my reactions helped me to go on with my analysis of the countertransference experience. In this first step *I learned to observe my own reactions in the therapy situation.*

In the second step I explored the countertransference triggers contained in the therapy situation. After examining the data, I recognized how the despair of my client activated a freezing reaction in me; how the client's emotion stirred up my defensive reactions. By learning about neuroception and defensive reactions, I understood that the reason for my reactions were in the interaction between me and my client; there were certain aspects in the client's behavior that served as trauma triggers and made to relive my trauma memories. I also recognized some reactions or feelings from my experience that may have been more related to the client's history than to my own. From this recognition I understood how my experience was a mixture of my own trauma memories and the client's trauma memories. Here *I learned to recognize the triggers of countertransference in the interaction of the therapy relationship.*

In the third step of the analysis, I asked how the interactions in the therapy situation appear

when I analyze them in the light of the psychodynamic countertransference theory. I observed the introjects that were present in this interactional situation. I also observed my own identifications and gave names to these identificatory experiences (therapist's transference, therapist's contamination, projective identification). Here I also considered the intersubjective nature of my countertransference and realized that the origin of my countertransference was in my own areas of vulnerability that were stimulated by the client's behavior. *I learned 1) to conceptualize the interaction in the therapy situation and 2) to see countertransference as an intersubjective phenomenon in the therapy relationship.*

In the fourth step of the analysis, I asked how the musical interaction affected my countertransference experience. I observed the manifestation of countertransference from the viewpoint of musical expression and interaction, what in the client's musical expression triggered my countertransference, and how I musically expressed my countertransference. I also gave names to the different aspects of the musical countertransference. Here I explained how musical expression can produce special information about the inner world and unconscious tensions of a client, and also serve as a trigger for countertransference. I understood the mirroring quality of musical interaction; how emotions and counter emotions are projected onto music in the therapy situation, and how the therapist can use musical interaction for receiving, processing and returning the client's psychological material through musical interaction. I realized how my countertransference in this therapy situation affected my musical expression by blocking my ability to process and return the client's material. I also understood that the musical expression and interaction in this therapy situation highlighted unconscious processes that may not have become visible otherwise. Here *I*

learned to see musical expression and interaction as a tool for uncovering and processing countertransference.

In the fifth step of the content analysis, I asked how my countertransference affected the therapeutic interaction in this therapy situation. I realized how I got stuck in the experience of counter emotions activated by the client's material, and I applied Bruscia's model of the three experiential spaces to this experience. I understood that my countertransference was obstructive because it hindered my ability to move flexibly between the different worlds of the interactional space; because of this obstructive countertransference, I was not able to collect information from the client's world and my own world, and then process this information in the professional world. I compared this freedom of moving one's consciousness to the concepts of presence, attunement and resonance, and understood how the therapist's unresolved traumas or other areas of vulnerability can hinder one's ability to be present and to build the conditions for trust within the therapy relationship. At this stage *I learned to observe the movement of consciousness between the three experiential worlds of the therapist during therapeutic interaction.*

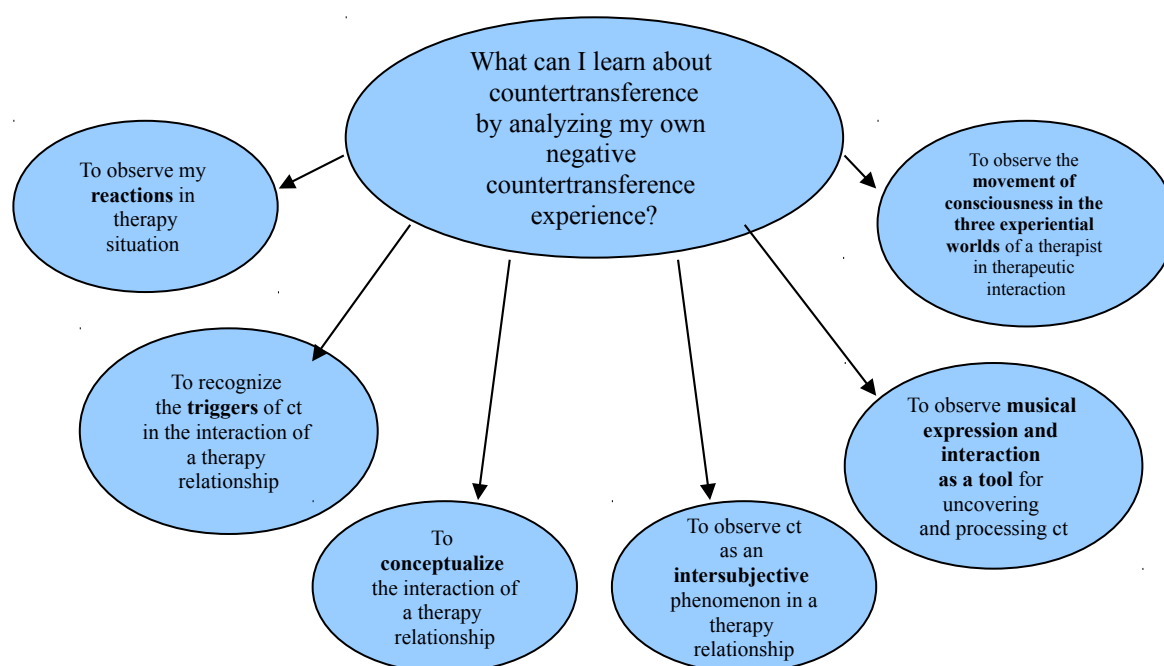


Figure 5. What I learnt from analyzing my countertransference experience

By analyzing my own countertransference experience, I have studied the principles of interaction and the principles of countertransference reactions in therapy relationships. The process of analysis has increased my self-knowledge, my understanding of the interaction in therapy relationships and my overall understanding of the concept of countertransference. At the beginning of the research process, my understanding of the experience was very subjective and constricted. It was colored by my negative emotions and uncontrollable inner reactions. This kind of understanding is of course restrictive for a therapist.

As a result of the process of analysis, I have learned how to observe, identify and understand my own reactions in the interaction of therapy relationships. For example, I see that the theory of information processing on three different levels is concretely applicable in everyday work.

As a result of this learning process I have more effectively started to observe my bodily and emotional reactions, the fluctuation of my arousal level, and the effect of these on my ability to think clearly.

It also has been important to understand the reasons why my experience was so uncontrollable. Experiencing trauma reactions can be very confusing and even frightening. However, if I encounter the same kind of experience in the future, I will be more ready to understand my reactions and the reasons for them. Another important aspect is that besides increasing my self-understanding, this learning process will also help me to observe and better identify similar reactions and experiences in my clients.

In the course of this research process I have understood how traumatic experiences of clients can activate also the therapist's trauma memories in therapeutic interaction. This activation happens through the mechanism of empathy, when the therapist identifies with the client's emotions. This is a very important aspect of the whole countertransference concept. It also highlights its intersubjective nature. We can empathize with another person's bodily expressions and emotions so strongly that it activates our own past experiences with similar aspects. If we as therapists are not conscious enough of our reactions and have not worked well enough our areas of vulnerability, we can start to react according to our past experiences in therapy relationships. In that case, the therapist can not be present here and now for the client. Instead, she reacts as she has learnt to react in her past. This kind of inner models of reacting can be very inflexible. On the other hand, if a therapist recognizes her own reactions and is able to manage them, she can use them as a source of information about the client's

inner world.

As a result of this process of analysis, I have understood what an essential tool countertransference is in therapy work. I have also started to see differently this specific countertransference experience. I no longer see it as a failure, but as the starting point for an important learning process. In therapy work, countertransference experiences are inevitable and a therapist has to learn how to manage and actively utilize them. I have also learnt that a phenomenon like countertransference can only be understood and its meaning internalized if it is experienced in practice.

5.2 Applying the findings to my work as a music therapist – creating a tool for uncovering and processing countertransference

In this section I strive to actively apply my new knowledge and understanding of countertransference to my music therapy work. Active application is the fourth step of the Gadamerian method for hermeneutic analysis. For Gadamer the applicability of knowledge is an indicator for depth of understanding; the meaningfulness of the knowledge is tested in practice.

The phenomenon of countertransference is continuously present in therapeutic interaction. A therapist has to be able to uncover her own countertransference reactions, manage them, and be also able to utilize them for the best of the therapy process. Countertransference can be seen as one of the most important tools of a therapist, if it is seen as a source of information

about the client's inner world, and the client's style to interact with his environment in general. With her own countertransference scanning and management, a therapist enables therapeutic interaction and the progress of the therapy process. This means that the therapist takes in the client's experience by empathizing with his inner world, observes it through her own experience, processes its meaning, and then returns it back to the client in a more constructive form.

The concept of countertransference management refers to managing countertransference reactions, or rather to the appropriate regulation of countertransference reactions. Gelso and Hayes (2007) define the concept as follows: “To the extent that something interferes with the process of therapy or the attainment of therapeutic goals, that thing – what ever it is – needs to be controlled or regulated as best as one is able. On the other hand, if something has the potential to facilitate the process and enhance the outcome of therapy, one should judiciously cultivate it and use it as an ally in one's clinical work” (Gelso & Hayes, 2007, p. 93).

According to these authors, managing countertransference does not mean that the therapist should eliminate her personal material from the therapeutic relationship. On the contrary, it means that the therapist continually strives to evaluate the relation between her own reactions and her interaction with the client. She also continually evaluates whether her own reactions could be facilitative in relation to the therapy process.

At this stage of the active application of my new understanding, I introduce a tool for countertransference management. The structure for this tool is derived from Bruscia's idea of the therapist moving her consciousness between three experiential worlds. I have constructed

this tool on the basis of the understanding that I have reached through the content analysis of this study, and its idea is to work as a practical instrument for processing my countertransference and utilize the results of this learning process in practice. This tool enables the therapist to scrutinize her own reactions as they occur within the therapy relationship, and to continuously assess how the obtained information can best be used to support the therapy process.

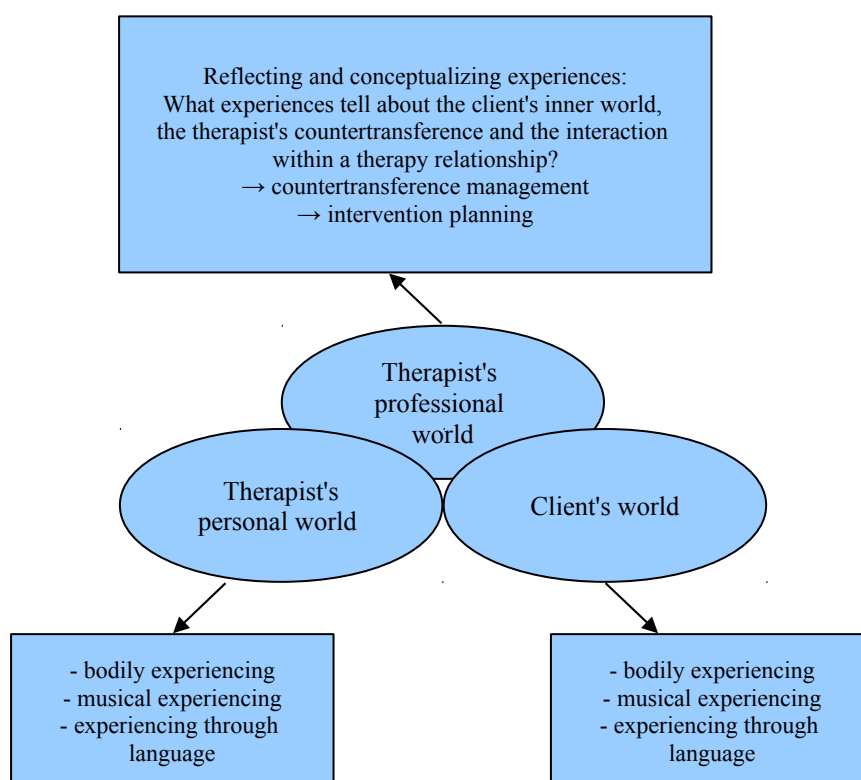


Figure 6. Tool for uncovering and processing countertransference.

This tool is meant especially for post-session processing. It contains three phases: experiencing the client's world, experiencing the therapist's personal world, and reflecting these experiences in the therapist's professional world. In the first phase I empathize with the client's world, for example with the client's state of mind in a certain interactional situation that has happened in a therapy session. I close my eyes and concentrate on experiencing the situation for a while. After empathizing with the situation, I move my consciousness into my body: its posture, sensations, arousal level and so on. After experiencing the client's state of being, I move on to do a musical improvisation while staying in the client's world. I produce music that is induced by experiencing the client's world. After this I shift to write about the experience; I write down 1) observations of my bodily experiences and 2) musical parameters, atmosphere, images and emotions that the musical improvisation contained.

In the second phase I act like in previous phase, but I concentrate on experiencing freely my personal world and my reactions in the same interactional situation. I observe the posture of my body, the sensations and my arousal level. After this I move on to do a musical improvisation by expressing the state of being that the interactional situation has evoked in me. After improvising I again write down my bodily observations, as well as the musical parameters, atmosphere, images and emotions that the musical improvisation contained.

In the third phase I move into the therapist's professional world. Before doing this, I strive to discharge the states that I have experienced in the previous phases by moving my body and breathing deeply, in other words by neutralizing my bodily state. In the professional world I start to reflect on the texts that I have written:

- First I explore what the experiences tell about the client's inner world. What do the experiences that I reached while empathizing with the client's world tell about the client's bodily reactions, emotional reactions and thinking? How are these reactions possibly related to the client's life and his history? What kind of inner introjects are possibly present on the client's side?
- Secondly I explore what the experiences tell about my countertransference. What do the experiences that I reached while empathizing with my own personal world tell about my bodily reactions, my emotional reactions and my thinking in this interactional situation? Is there some connection between these reactions and my own history or personal life at the moment? Are some of my own inner introjects present? Which reactions of mine are more related to answering and reacting to the client's world?
- Thirdly I explore what the experiences tell about the interaction in the therapy situation. What kind of messages does the client send me in our interaction? Do the previous experiences of the client's world and my own personal world tell for example about the client's transference or projective identification? What is the nature of my countertransference to the message that the client has sent? Do I identify for example with some of the client's introjects or with my own introjects?
- After exploring the experience of the client's world, the experience of my own personal world and the interaction of these two, I shift to analyze my countertransference. I try to find out whether special emphasis should be put on managing countertransference with this client. Is it for example possible that I start to

act in a way that is obstructive for my client and for the progress of therapy process?

In this phase I become conscious of my own negative reactions and think about how I should be able to manage them in the future.

- Finally I discuss what kind of new information I have reached about the client's world by using this countertransference tool. By empathizing with these different experiential worlds, what new information could be obtained about the client's problems, his inner world and his general way to interact with his environment? What kind of interventions can I plan on the basis of this new information? What kind of interaction does the client need from me as his therapist in order to proceed in his therapy process?

The use of this countertransference tool in my everyday work extends the learning process of this study. In that sense, it follows the model of the hermeneutic circle. Indeed, the study does not have an ending as such: the process is on-going, and my understanding of countertransference keeps developing further. This means that through the experience of therapy work, I achieved more extensive self-knowledge and became more conscious of my own areas of vulnerability what comes to countertransference. I learned to observe my own reactions and the client's reactions more delicately. I also learned to manage my countertransference reactions better and use the information obtained through them in intervention planning.

Hermeneutic phenomenology contains a positive idea about development through analysis. In this phase of active application of my new understanding, I take the process further than just

the construction of a new understanding of my countertransference experience. Through active application I connect the things I have learnt with my future work as a therapist.

5.3 The development of countertransference as a therapist's tool in the course of music therapy training – learning to observe therapy relationships through my own experience

In this section I answer the main question of this study: *how does countertransference as a therapist's tool develop during clinical studies in music therapy training?* I answer the question with the discussion of the results that have been presented in the previous sections. The focus is on what I learnt by analyzing my own countertransference experience and how I can apply this in my music therapy work. The key to answer this last question is to look at the research process in the light of the goals of music therapy training.

The answer to the first question illustrates how the thorough analysis of my countertransference experience and the application of background theories helped me understand my own reactions, the construction of interaction in therapy relationships, and the meaning of countertransference in therapy work. The answer to the second question exemplifies how I can use the new and more advanced understanding of countertransference in my music therapy work. As a summary I can state that through this research process, I have learnt to use my countertransference for reading the interactional situations and their meanings. I have also learnt to structure even the more complex reactions of mine, and to use the obtained information for the benefit of my clients and their therapy processes.

Can this personal, research-related learning process be compared with the learning processes of the music therapy training in general? The learning process that I have studied here started during the internship I did for the clinical part of my music therapy training. Such an intensive and profound analysis of a countertransference experience may be relatively rare. However, it gives an idea of the transformative process, and how the understanding of countertransference can develop during music therapy training from a subjective emotional chaos towards a more structured view.

Applying a more structured view to a subjective countertransference experience can be called the professional perspective. A professional therapist has to be constantly able to structure the chaotic views of interactional situations through this kind of processes. Of course with experience, the analysis of one's own reactions and of the interaction in therapy relationships becomes quicker and more natural.

According to Sumuke, the goals of clinical studies in music therapy training are to develop the students' self-knowledge, their ability to reflect on the interaction in therapy situations, and their ability to analyze the emotions and experiences that working with clients awakes. The results of Lindvang's (2010) dissertation showed that experiential learning in therapy training helped students to understand themselves better in therapeutic interaction and to understand the complexity of therapy relationships.

Countertransference experiences that happen in clinical training are closely related to other learning processes of therapy training programs, like the students' own therapy processes and

the processes of gaining theoretical knowledge. These processes progress and open themselves concurrently: a student connects her experiences of processing her own history and acting in a therapist's role, while at the same time gaining knowledge of the background theories behind the therapy work. Next I will introduce the idea of Gelso and Hayes (2007) about the characteristics that promote the countertransference management of a therapist. These characteristics are naturally stronger with some therapists than with others. On the other hand, they also develop through the learning processes of therapy training and work experience.

Gelso and Hayes (2007) introduce five therapist characteristics that promote the countertransference management: "...problematic countertransference reactions are less likely to occur when therapists possess more self-insight, conceptualizing skills, empathy, self-integration, and anxiety management skills" (Gelso & Hayes, 2007, p. 95). *Self-insight* is probably the central one of these characteristics, because through it we can understand the reasons and motivation for our reactions. Gelso and Hayes (2007) state that self-insight is a significant matter also because it defines our ability to understand the issues of other people (Gelso & Hayes, 2007). So the therapist has to seek a wider understanding of her mind's workings, because the wider is her understanding of her own inner tensions, the wider she can see the meanings of similar tensions in the lives of her clients. The attainment of this kind of self-understanding may also be painful. Gelso and Hayes (2007) write: "Discomfort... typically is required for self-insight. We need to be shaken up to be awakened, to see ourselves more accurately" (Gelso & Hayes, 2007, p. 96). To achieve broad enough self-insight one has to have the courage to look straight at her own inner world, even if it would

very often be easier to pass over the weak spots and just maintain the ideal self-portrait of oneself.

Conceptualizing skills refers to the therapist's ability to look at the interaction of therapeutic relationship in the light of theoretical knowledge: "... conceptualizing skills are likely to help prevent displays of negative countertransference reactions in that they provide an intellectual framework for understanding these reactions and perhaps how to contain them" (Gelso & Hayes, 2007, p. 98). When a therapist has a strong enough theoretical framework for her clinical work, it improves her ability to understand the reactions that her clients evoke in her. Through a theoretical framework, the therapist can also internalize the working models that guide her interventions. Theoretical knowledge can help a therapist distance herself from the situation, but it should not be used for defensive alienating. Gelso and Hayes (2007) write:

"...when taken to extreme, a therapist's use of conceptualizing ability to manage countertransference can assume the form of defensive intellectualization ...

Countertransference always results from some mix of therapist and client characteristics, and thus therapists' conceptualizations must involve themselves" (Gelso & Hayes, 2007, p. 98).

The conceptualizing ability is also connected to self-insight, because when a therapist uses theoretical ideas to interpret the therapy situation, she also has to have the courage to analyze her own reactions in agreement with these ideas. This viewpoint fits well into Bruscia's model of the therapist moving her consciousness: a therapist has to experience sincerely both her own feelings and the client's feelings, and then analyze these experiences on the professional level.

The third characteristic promoting a therapist's countertransference management is empathic ability. *Empathy* as a phenomenon in interaction is always a matter of identificatory experiences. So when a therapist feels empathy, she always identifies with the client on some level. Gelso and Hayes (2007) write: “Over- or underidentification can lead to, or result from, countertransference... Empathy helps to provide a middle-ground perspective. The therapist who is able to stay attuned to the patient's communications, feelings, experiences, and needs is less likely to put her or his own needs ahead the patient's” (Gelso & Hayes, 2007, p. 99). Gelso and Hayes use the same term as Siegel does, they talk about attuning to the client's world. Actually, here is again a parallel triad to Bruscia's model of moving one's consciousness between three worlds: self-insight helps the therapist to observe her own world, empathy helps her to observe the client's world, and the ability to conceptualize helps to understand the connections between these two.

The constructive use of empathy for gaining understanding of other people requires a characteristic that Gelso and Hayes call *self-integration*: “Self-integration refers to a therapist's having a relatively stable identity, being able to assess and, when necessary, alter the distance between themselves and a patient, and therapists who are better self-integrated will have an easier time with this difficult task” (Gelso & Hayes, 2007, p. 99). If I apply Bruscia's model to the concept of self-integration, it is a characteristic that enables the free movement between three worlds. A therapist who is self-integrated enough is not so much in danger of getting stuck in some of these worlds. She has the ability to empathize with the world of the client and then move back into her personal or professional world. Self-integration can be achieved by processing one's own inner conflicts: “As research has

demonstrated, countertransference that arises from areas of unresolved conflict can interfere with the psychotherapy process and outcome ... Therapists who have fewer conflicts, or whose conflicts are more resolved, are less likely to experience problematic countertransference” (Gelso & Hayes, 2007, p. 100).

The last one of the five characteristics that promote countertransference management is *anxiety management*. Gelso and Hayes (2007) write: “... anxiety is both an internal state that predicts external countertransference behavior and, in and of itself, it has been found to be an emotional marker of countertransference. It is plausible to assume, then, that therapists who are better able to manage their anxiety are less likely to experience countertransference behavior, and therapists who are less prone to anxiety will experience less of it when their conflicts or vulnerabilities are stimulated” (p. 100). Anxiety is a sign that tells a therapist about the activation of countertransference. Furthermore, anxiety is also a trait of personality that can, with different amounts of intensity, be part of an individual's inner structure. This regulation of anxiety is related to Porges' theory of neuroception; anxiety is a sign that tells about the activation of defenses, e.g. when a person observes some sign of danger in her environment. Different people have different amount of triggers that potentially cause the onset of defensive behavior; certain people are more prone than others to feel anxiety when interacting with other persons. If one knows her own tendencies of neuroceptive evaluation, or in other words the things that trigger her anxiety, this kind of self-knowledge also helps to manage the feeling of anxiety more effectively.

The above-mentioned characteristics that promote countertransference management may

develop during music therapy training. For the goals of the music therapy training to be achieved, the student's self-insight, conceptualizing ability, empathic ability, self-integration and anxiety management must be developed. These are the characteristics that help a therapist to understand the interaction in therapy relationships, her own reactions and their relation to the client's world.

As I wrote before, through this research process I have understood how the understanding or internalization of a phenomenon like countertransference can not be reached in any other ways but through self-experience. While the experiences in therapy training are not always easy, and although it is typical to move into areas of insecurity, this kind of experience may be the only possibility to understand something new and increase one's view on phenomena related to therapy work. The profession of a therapist can not be learnt in any other way but through experiential learning and by encountering one's own areas of vulnerability, because therapy work as such is also about encountering and experiencing together with clients.

I could say that the meaning of countertransference experiences for learning processes and the achievement of goals in music therapy training is the core result of this research.

Experiencing countertransference, and having open encounters with these experiences, can give new perspectives about oneself and the interaction in therapy relationships. The analysis of countertransference experiences can also foster a student's understanding of how a therapist can use herself as a tool in therapeutic interaction.

Because the understanding of a phenomenon like countertransference can not happen in any

other ways but by experiencing it in practice, I see that it would be very important to have the courage to go deep enough into the experience of a student during supervision, or during other modes of experiential learning offered by the music therapy training. In so doing, it would be possible to identify countertransference experiences and process them deeply enough. Of course, this kind of profound processing requires a safe environment and enough time for supervision.

6 Evaluation of the study

The structure of this research may be quite multifaceted or even complicated, but in its form I have tried to draw a picture of my learning process that developed from an incoherent experience towards a more structured view. In the study I first introduced the methodology to the reader, then thematized my pre-understanding of the subject, analyzed my countertransference experience according to the principles of the hermeneutic circle, and finally discussed the results of the content analysis. The results of this research are in the form of a discussion; in my opinion it is actually the only form in which the results of this kind of subjective learning process can be presented. These results are the point in the process that I have reached at the moment, but as I have written, the learning process continues and will hopefully allow me to reach new perspectives on the subject in the future while I get more experienced in my work.

The nature of this research is very subjective, but subjectivity was the starting point for the whole research process. I wanted to take a closer look at my own experience and achieve some understanding of it on a more general level; I wanted to understand myself better and be able to use this improved understanding in therapy work. During the process of analysis I have achieved also some new understanding of learning processes, in both the processes of professional development and the transformational processes of therapy relationships. These learning processes follow the idea of hermeneutic phenomenology and the hermeneutic circle; the understanding of a phenomenon is constructed piece by piece while the view of the whole

scenery gets more and more exact. The important features of this kind of learning process are the insights that always lead one's thinking to the next level. I could say that these insights make this kind of process worthwhile, although the process is not easy to go through.

Kenny et al. (2005) write that hermeneutics is sometimes criticized for being a method that leads nowhere; it just produces a circle that spins endlessly. The aim of hermeneutics is not to prove the existence of any phenomenon. It is an open-ended and circular process that increases levels of understanding. (Kenny et al., 2005.) This research has produced some new knowledge regarding my subjective experience and learning process. It should be possible to generalize this knowledge to the experiences and learning processes of other students and music therapists, even if such processes are always individually constructed.

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