## ARTICLE

# 'Self as instrument' – Safe and effective use of self in music psychotherapy: Canadian music therapists' perceptions

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## ABSTRACT

This article introduces the results of a pilot survey conducted with accredited Canadian music therapists investigating their perceptions of personal psychotherapy and the concept of *Safe and Effective Use of Self* (SEUS) in the music therapy relationship. An emailed survey questionnaire covered both closed and open-ended questions on SEUS-related topics. The open-ended questions were analysed using the qualitative data analysis software *Nvivo*. Simple percentages were calculated to analyse the results of the closed-ended questions. The results suggest that music therapists engaging in psychotherapy seem to work with similar client populations, use similar theoretical approaches and techniques, and hold very similar training to other music therapists. These music therapists appear to have an excellent sense of SEUS, whether or not they practice psychotherapy. Conversely, their training on both SEUS and verbal counselling skills is often seen as inadequate. It is suggested that music therapists who practice psychotherapy have completed their own psychotherapy and have ongoing music psychotherapy supervision. The results can be utilised as a discussion stimulus for the topic of SEUS in music therapy.

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## INTRODUCTION

Generally, music therapists emphasise the importance of the therapeutic relationship between music therapist, client, and their music. Thus, the concept of the music therapeutic relationship refers to verbal, non-verbal, and musical communication and emotional exchange on different levels including intra/interpersonal, and intra/intermusical (Bruscia, 1998a). Just as the music therapy process is much more than musicking together, the music therapist's use of self is more than their capacity to play musical instruments with their client. Certainly, they also use their self as an instrument in the therapeutic relationship. Containing their clients' emotions, music therapists equally use both music and their own person.

In my own experience as a music therapy educator, the term 'use of self' is sometimes confusing for music therapy students. It may be easier for some of them to explain how they use music as a tool of therapy. The term may also be easily misinterpreted as: "*It means that the therapist is personal and friendly with the client…*", "*…that the therapist does not hide his/her emotions from the client…*", "*…that the therapist discloses his/her personal (trauma and recovery) experiences with the client…*" "*…that the therapist is 'real' all the time, even when they've a bad day…*", or "*…that the therapist is happy and cheerful with the client…*"

In the Canadian province of Ontario, since the proclamation of *The College of Registered Psychotherapists of Ontario* (CRPO) on 1st April 2015,[1] only registered psychotherapists can use the title of 'psychotherapist' and practice in the scope of psychotherapy. Therefore, every music therapist working in Ontario must self-declare whether they practice music therapy or some form of music psychotherapy. Young's (2013) definition of music psychotherapy in *The International Dictionary of Music Therapy* has been used as a guideline to aid the Ontario music therapists' professional self-reflection.

> Music psychotherapy [is] the use of music experiences [active or receptive] to facilitate the interpersonal process of therapist and client as well as the therapeutic change process itself (Bruscia 1998b: 2). The use of music for this purpose varies according to the therapist's philosophy or approach (e.g. psychodynamic, humanistic, music-centred, transpersonal) and treatment goals deemed necessary by the therapist and/or client(s). Bruscia (1998a) outlined four levels of engagement used in music psychotherapy contexts, ranging from exclusively musical to exclusively verbal: 1) music as psychotherapy; 2) music-centred psychotherapy; 3) music in psychotherapy; and 4) verbal psychotherapy with music. Some well-known models of music psychotherapy include analytical music therapy (Priestley 1994), GIM (Bonny 2002), vocal psychotherapy (Austin 2009), and group analytical MT (Ahonen-Eerikaïnen 2007). Music psychotherapy can occur in both group and individual treatment contexts. It is generally considered to be an advanced form of MT practice requiring specialized training and/or certification. (Young, 2013, p. 82)

Many Ontario music therapists who self-declared that they practice in the scope of psychotherapy – either music as psychotherapy, music-centred psychotherapy, music in psychotherapy, or verbal psychotherapy with music (Bruscia, 1998a) – have already been approved by the CRPO as registered psychotherapists (RPs). However, many music therapists in Ontario continue practicing music therapy *without* needing to register at the College. This is because not all music therapists identify themselves as psychotherapists. Furthermore, not all music therapy (i.e., neurologic music therapy or community music therapy) fall within the scope of psychotherapy as defined by the Government of Ontario (2007):

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[1] The current CRPO members represent various psychotherapy approaches. The specialisations of individual psychotherapists include diverse practices such as family therapy, pastoral counselling, and arts therapies. See more: www.CRPO.ca

> The practice of psychotherapy is the assessment and treatment of cognitive, emotional or behavioural disturbances by psychotherapeutic means, delivered through a therapeutic relationship based primarily on verbal or non-verbal communication. (The Psychotherapy Act, Section 3, p. 1)

> In the course of engaging in the practice of psychotherapy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to treat, by means of psychotherapy technique delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning. (The Psychotherapy Act, Section 4, p. 1)

The Canadian Association of Music Therapists (CAMT) and the Music Therapy Association, Ontario (MTAO) have organised several workshops and panel discussions attempting to guide music therapists with their self-declaration process.[2]

According to the competencies articulated by the CRPO and CAMT, a music therapist engaged in the psychotherapeutic practice must meet the entry-level competencies. They must be able to independently practise complex and critical thinking, be able to assess the client's therapeutic needs, determine the appropriate therapeutic aims, and plan and evaluate the ongoing therapeutic process. They must also be able to use the appropriate music therapy/psychotherapy theories, approaches, techniques and interventions based on their clients' needs. Likewise, they need to be able to integrate their theoretical knowledge with their clinical and personal experience, and their personal and clinical experience with their theoretical knowledge. The competencies require that a successful candidate has not only mastered the various clinical (and musical skills) taught in music therapy training and internship, but have also mastered the integration of their clinical skills with their authentic selves. Music therapy trainings must therefore include evaluating students' competencies in academic, professional, clinical, and personal areas. Furthermore, the trainings must teach about Safe and Effective Use of Self (SEUS) in the therapeutic relationship as it is one of the major competencies of psychotherapy practice in Ontario.

The following CRPO definition of the SEUS acknowledges the diverse theoretical background of registered psychotherapists:

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[2] According to Rowlands (2014), the College acknowledges the difficulties and the 'fine lines' in distinctively differentiating between music therapy and music psychotherapy practices:

> Music therapists who do not become members of the College will not be in breach of the Psychotherapy Act, 2007, as long as they do not use the title, Psychotherapist (or any abbreviation of that title); claim to be qualified to practise psychotherapy; and practise the controlled act of psychotherapy, i.e. do not work with clients who have serious mental health disorders, using the techniques of psychotherapy. Music therapists will, however, be able to work with clients who have serious mental health disorders, using the techniques of music therapy (but not psychotherapy). Academics and senior practitioners in the field of music therapy, who are trained in both music therapy and psychotherapy, are best positioned to know where that line is drawn (it will always be a bit fuzzy). (Rowlands, 2014, p. 2)

After the window to be grandparented into the College closed in March of 2017, the music therapists of Ontario have been applying for membership via the route which assesses their psychotherapeutic learning and competencies. Newly graduated music therapists can apply to be accepted as *qualifying members* (RP qualifying) although they are also required to pass an examination testing their competencies to practice psychotherapy.

> One of the defining competencies of psychotherapy practice, Safe and Effective Use of Self refers to the therapist's learned capacity to understand his or her own subjective context and patterns of interaction as they inform his or her participation in the therapeutic relationship with the client. It also speaks to the therapist's self-reflective use of his or her personality, insights, perceptions, and judgments in order to optimize interactions with clients in the therapeutic process. Psychotherapeutic traditions and practices related to the development of a psychotherapist's safe and effective use of self in the therapeutic relationship are diverse. Some applicants will have developed this competency while engaging in their own personal psychotherapy. Others will have taken courses that address use of self; these may include, for example, personal family history and dynamics, anti-oppression and diversity, power dynamics, relational boundaries, experiential practice as client, or interpersonal relationship development. Others may have engaged in a guided and reflective Indigenous practice, such as the four directional ways. For some practitioners, this competency may also address in a particular form of clinical supervision. (CRPO, 2015, p. 1)

The purpose of this article is to introduce the concept of SEUS and explore what it means for music therapists. The literature review will first present the key concepts of the use of self. The survey results will then focus on Canadian music therapists' perceptions of it. Finally, the discussion will further consider the survey results in relation to current literature, highlighting the most important themes that emerged from the data.[3]

## USE OF SELF – LITERATURE REVIEW

The idea of SEUS has not yet been published in the music therapy literature, nevertheless there is current material addressing music therapists' self-care (e.g., Trondalen, 2016). There is various literature and research focusing on different aspects, such as the therapeutic musical relationship (e.g., De Backer & Van Kamp, 1999; Kenny, 2016; Pavlicevic, 1990, 1997, 2000; Procter, 2002; Trevarthen & Mallock, 2000), and psychodynamic concepts such as countertransference (e.g., Bruscia, 1998c, 1998d, 1998e, 1998f, 1998g, 1998h, 1998i, 1998j). Nevertheless, the concept of use of self has been extensively researched in the fields of psychotherapy and social work (e.g., Arredondo & Toporek, 2004; Chapman & Oppenheim, 2008; Cheon, 2007; Dewane, 2006; Ganzer, 2007; Heydt & Sherman, 2005; Kondrat, 1999; Lum, 2002; Reinkraut, Motulski & Richie, 2009; Reupert, 2007, 2008, 2009; Shadley, 2000; Ward, 2008).

Generally speaking, use of self refers to the basic foundations of any good and ethical clinical practice, emphasising the therapist's intentional use of their "personality, insights, perceptions, and judgments as part of the therapeutic process" (Punwar & Peloquin, 2000, p. 285). As Satir (2000, p. 25) states: "The person of the therapist is the center point around which successful therapy revolves." Likewise, Reinkraut (2008) underscores the importance of the therapist's moral awareness, pointing

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[3] For the purposes of the next sections, I will use the term 'music therapist' (not 'music psychotherapist'), and 'music therapy' (not 'music psychotherapy'). I believe all music therapists must practice SEUS in their therapeutic relationship.

out that many aspects impact a therapeutic relationship:

> With this in mind I propose that therapist's use of self be understood to mean the intentional use by the therapist of his or her abilities, experience, identity, relational skills, moral awareness, knowledge and wisdom in the service of the therapeutic benefit of the client. (Reinkraut, 2008, p. 15)

Furthermore, as stated by Knight (2012, p. 7): "the therapist's self is best framed as the medium through which she or he engages in clinical practice and as the most basic and primary of the tools that she or he has to bring about client change."

Psychotherapy related research has emphasised the role of the therapist's self in the therapeutic relationship as being a more important factor in the therapeutic outcome than any therapeutic approach or intervention (Lambert & Barley, 2001; Messer & Wampold, 2002). Clarkson (1996) even claims that any therapeutic change occurs within the context of a relationship. Conclusively, Peterson and Nisenholz (1999, pp. 12-14) introduce a list of features any therapist should be aware of when using their self as a tool of therapy. As therapists, we should be insightful and observe both verbal and nonverbal behaviour of the client, and be multiculturally sensitive, breaking out of "our own cultural capsules" (Peterson & Nisenholz, 1999, p. 12). We should be willing to enter into the subjective world of the client and foster an appropriate level of intimate therapeutic relationship, self-disclosure, and confrontation. We should also remain in a continuous process of our own personal growth. While contemplating these various aspects of use of self in therapy, we can argue that all of them are indeed aspects of good clinical practice.

The numerous use of self studies conducted amongst occupational therapists are thought-provoking for the similarities with music therapists' professional identity issues. Noteworthy to music therapy educators are the results in which the occupational therapists felt that they were inadequately trained in therapeutic relationship and use of self (Taylor, Lee, Kielhofner & Ketkar, 2009). These results support an earlier study which pointed out that occupational therapists' concerns over their professional recognition often led them to emphasise their professional knowledge, thus creating authority conflicts within therapeutic relationships. Interestingly, therapists with better personal and professional self-confidence were able to achieve better therapeutic relationships with their clients (Norrby & Bellner, 1995). Furthermore, according to Taylor, Lee, Kielhofner and Ketkar (2009) the more experienced occupational therapists viewed the therapeutic use of self through psychoanalytic concepts (see also Cole & McLean, 2003; Guidetti & Tham, 2002; Peloquin, 2005; Restall, Ripat & Stern, 2003; Sumsion, 2000, 2003). Interestingly for music therapists, a nationwide survey of occupational therapists' attitudes and experiences on use of self concludes that those therapists who valued it and had more training in it

> were more likely to report interpersonal difficulties and feelings of positive regard for clients and were more likely to report concerns about clients. The findings suggest that more attention needs to be paid to the therapeutic relationship and to the therapeutic use of self in education and in research. (Taylor, Lee, Kielhofner & Ketkar, 2009, p. 1)

I will next introduce the key-concepts often mentioned in the use of self literature: being a wounded healer, managing countertransference, and understanding vicarious traumatisation. These concepts will be further deliberated in the discussion section in relation to the themes that emerged from the survey data.

## Being a wounded healer

The use of self literature often mentions the concept of being a 'wounded healer' (e.g., Barnett, 2007; Barr, 2006; Bloomgarden & Mennuti, 2009; Dunne, 2000; Guggenbuhl-Craig, 1971; Kirmayer, 2003; Miller & Baldwin, 2000; Nouwen, 1972; Sedgwick, 1994; Sussman, 2007; White, 2000). According to Goethe, our own pain and suffering trains us to understand others' suffering (Groesbeck, 1975). Zorubavel and O'Dougherty Wright's review (2012) points out that the healing power emerges from the healer's ability to use their own woundedness. Furthermore, as stated by Gelso and Hayes (2007, p. 107): "Therapists who deny their own conflicts and vulnerabilities are at risk of projecting onto patients the persona of 'the wounded one' and seeing themselves as 'the one who is healed'." If we cannot access our own experiences of pain, we may have difficulty feeling empathy with the client. Though, essentially,

> being wounded in itself does not produce the potential to heal; rather, healing potential is generated through the process of recovery. Thus, the more healers can understand their own wounds and journey of recovery, the better position they are in to guide others through such a process, while recognizing that each person's journey is unique. (Zorubavel & O'Dougherty Wright, 2012, p. 482)

There is some music therapy literature on the topic. For example, Austin's (2002) wounded healer's perspective, Dunn's (2009) parallel journeys with his client, Salmon's (2014) reflections on music therapy in whole person care at the end of life, Ahonen-Eerikäinen's (2007) reflections of her case study, and Rinker's (1991) article about GIM and healing the wounded healer.

## Managing countertransference

The idea of managing is another main concept in the use of self in the therapeutic relationship. The concept was first defined by Freud (1910) as being a result of the client's influence on therapist's unconscious feelings. Currently, there are hundreds of more or less contra dictionary definitions of countertransference (e.g., Carveth, 2011; Fauth, 2006; Gorkin, 1987; Hayes, 2002; LaFarge, 2007; Maroda, 1991; Racker, 1982; Renik, 1993; Rosenberger & Hayes, 2002; Sandler & Rosenblatt, 1976; Searles, 1979; Smith, 2000). Racker's definition (1982) distinguishes between unobjectionable positive countertransference (which refers to caring and feeling affection for the client); complementary countertransference (in which the therapist's feelings complement the client's feelings), and concordant counter-transference (during which the therapist shares the client's feelings). An example of the last of these is when the therapist "thinks they are attending to the client's experience, but in fact they are replicating his or her own past. It is a kind of identification, but a false one drawing from

the therapist's own unresolved issues" (Clarkson, 1996, p. 92). The therapist's blindness to countertransference may also easily engage them "to play the omnipotent analyst" (Friedman, 2002, p. 63). Furthermore, as specified by Winnicott (1975) objective countertransference occurs when "the psychotherapist is reacting objectively to the client's projections, personality, and behavior in the therapeutic relationship" (Clarkson, 1996, pp. 89-90).

There is comprehensive literature available on music therapy and countertransference (e.g., Ahonen, 2014a, 2014b; Ahonen-Eerikäinen, 2003, 2007, 2014, 2016; Austin, 1998; Bruscia, 1998cdefghij; Diaz De Chumaceiro, 1992, 1998; Dillard, 2006; Dvorkin, 1998; Dvorkin & Erlund, 2003; Erkkilä, 1997; Eschen, 2002; Scheiby, 1998, 2005; Hadley, 1998; Isengerg-Grzeda, 1998; Kowski, 2007; Lecourt, 1998; Montello, 1998; Nolan, 1998; Pedersen, 2007; Pellitteri, 1998; Priestley, 1994; Salmon, 2008; Summer, 1998; Turry, 1998; Wilkerson & Dimaio, 2006). Musical countertransference as defined by Templeton (2013) in *The International Dictionary of Music Therapy* (2013) states:

> A relational energy exchange occurring between therapist and client in the context of MT, which is four-fold. The phenomenon encompasses: 1) the mt's unconscious musical reply to the client that is occurring in connection to the mts past relationship dynamics and can become conscious over time; 2) the therapist's unconscious musical reply to the client that occurs in connection to the client's past relationship dynamics; 3) a joining of both 1) and 2) occurring at the same time; and/or 4) an empathic musical response to a client's unconscious state associated with a strong identification to the client (Dillard 2006). (Templeton, 2013, p. 85)

Vegetative resonance (the therapist's somatic symptoms related to therapeutic relationship) are part of countertransference management and use of self in the therapeutic relationship. According to Berger (2001), vegetative resonance can reveal many things, such as the therapist's personal stress, the opening of our own wounds, or fears of not being enough, "unable to contain the horror or relieve the client's pain" (Berger, 2001, p. 193). Furthermore, a therapist may experience physical reactions during therapy sessions or even in anticipation of them. We may feel physical sickness, fear, anxiety, even "an overwhelming desire to get up, leave the session, or at the very least, move [...] Physical symptoms may be felt by the therapist before there is any indication of trauma material and can be an indication of some experience of trauma for the client that is undisclosed" (Berger, 2001, p. 193). These reactions can take place when the client describes disturbing material or even when anticipating that they soon will. Notably, "there is often an extraordinary synchronicity present in trauma counselling when the client works with a counsellor with similar personal issues" (Berger, 2001, p. 193). According to Ahonen's (2014a) clinical experiences as a music therapist:

> ...my sudden neck, stomach, or back pains during a session may be indicators of counter transference feelings. My somatic resonance may also mirror those feelings the client felt at the time of their original trauma. They can also reflect their fears around coming to the session or being in the session. I have also experienced that it is typical for me to experience somatic resonance when the client himself is dissociated from these feelings. (Ahonen, 2014a, p. 203)

## Understanding vicarious traumatisation

Vicarious traumatisation is another concept often associated with use of self. Vicarious trauma can take place anytime when working with traumatised individuals. It has also been called Secondary Traumatic Stress Disorder (STS) (Bride, 2007; Canfield, 2005; Figley, 1995, 2002; Jenkins & Baird, 2002; Kassam-Adams, 1995; Stamm, 1999), or indirect trauma (American Psychiatric Association, 2013; Knight, 2013). As a concept, it is very similar to compassion fatigue, a term often cited by the medical community to explain stress and fatigue in nurses when they compassionately try to do everything to lessen their patients' pain (Baranovsky, 2002; Conrad & Kellar-Gentry, 2002; Guenther, 2003; Killian, 2008; Mathieu, 2012; Racokzy, 2009; Rothchild, 2006). Fundamentally, for any therapist who is compassionate and empathetic, it is impossible to remain emotionally detached and non-responsive. Because therapists repeatedly listen to traumatic disclosures while having to control their reactions, they may become vicariously traumatised (Izzo & Carpel Miller, 2011). As stated by Pearlman (2014):

> All of the trauma work that we do, hour after hour, day after day, week after week… contributes to inner changes in the self of the therapist. It's an inevitable part of the work… because we're entering into a very dark world, and if we're open emotionally, in the way we need to be to be effective helpers, we're going to be impacted. (Pearlman, 2014, p. 1)

Dale (1999, p. 41), in his study of health care professionals working with adults abused as children, found that some degree of emotional strain was reported by most of these professionals, and that they felt disgust, powerlessness, identification with the victim, and anger with the perpetrator. Sometimes the vicarious traumatisation strikes the therapist in response to trauma stories within a group of peers or a therapy group. If the therapist does not address their symptoms, they may begin to act out with clients, become controlling, easily angered, or just simply stop listening (Klein & Schermer, 2000, p. 8).

Interestingly, "indirect exposure to aversive details of the trauma, usually in the course of professional duties" is referred to in the current DSM-V, criterion A (American Psychiatric Association, 2013), as being one of the stressors for the post-traumatic stress disorder (PTSD) diagnosis. The symptoms may include fatigue, helplessness, tearfulness, irritability, vulnerability to over stimulation, dissociative symptoms, nightmares, disturbing images, flashbacks of stories heard from trauma survivors, numbness, fear of future, self-blame, dampened meaning of life etc. Symptoms also include becoming cynical, fearful, or overprotective. As a result of vicarious traumatisation, we may begin to set up rigid boundaries in our personal relationships, but simultaneously experience lack of boundaries in our clinical work (Ahonen, 2014a, 2016). Furthermore, vicarious traumatisation may damage therapists' emotional and spiritual well-being, and destroy their self-image, world view, and belief system.[4] (If not properly addressed, vicarious traumatisation, compassion fatigue, and a long lasting

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[4] See also: Brady, Guy and Richardson (2001), Eidelson D'Alessio and Eidelson (2003), McKann and Pearlman (1990a, 1990b), Palm, Smith and Follette (2002), Pearlman and Maclan (1995), Pearlman and Saakvitne (1995a, 1995b), Saakvitne and Pearlman (1996), Sabin-Farrel and Turbin (2003), Schauben and Frazier (1995), and Van Dernoot Lipsky and Burke (2009).

emotional exhaustion can lead to burnout (Edelwich & Brodsky, 1980; Farber, 1983; Maslach, 2003; Wessells, Selder, Kutschr, Cherico & Clark, 1989).

The following section introduces the survey results that focus on Canadian music therapists' perceptions of SEUS and psychotherapy. Thereafter follows a discussion highlighting the most important themes that emerge from the data in relation to current literature.

## CANADIAN MUSIC THERAPISTS' PERCEPTIONS ON SEUS AND PSYCHOTHERAPY – PILOT SURVEY

The aim of this exploratory pilot survey was to gain insight into Canadian music therapists' reflections on personal psychotherapy and the concept of SEUS in the music therapy relationship, and to stimulate discussion on the topic. The study was approved by the Ethics Review Board of Wilfrid Laurier University.

### Method

An emailed survey questionnaire (in English and French) covered 42 closed and 11 open-ended questions on SEUS-related topics. The research participants were CAMT accredited music therapists (MTAs) who were identified by the CAMT accreditation list. To invite MTAs to complete the survey, each was emailed the introductory letter, informed consent, and a survey link. The survey was emailed to all CAMT registered MTAs (*n* = 609). 69 of these volunteered to participate in the study. Some participants also emailed the researcher their additional thoughts after they had completed the survey. The participants' average age was 39, and they were mostly females (86%). The open-ended questions were analysed using the qualitative data analysis software *Nvivo* and by creating descriptive categories. Descriptive statistics were used to analyse the results of the closed-ended questions.[5]

### Results

The results introduce the Canadian music therapists' engagement in the scope of psychotherapy and their reflections on SEUS and personal psychotherapy. The results also include suggestions for music therapy trainings to enhance SEUS competency. For readability, I will use acronyms for music therapy [MT], psychotherapy [PT], personal psychotherapy [PPT], music therapists [MTs], and music therapists engaged in the psychotherapy practice [MTPTs].

*Music therapists' engagement in the scope of psychotherapy – training, theoretical approaches, and techniques*

Almost half of the participating MTs (*n* = 31) indicated that they were engaged in the field of psychotherapy (PT) and therefore practiced music therapy (MT) in the scope of psychotherapy (PT).

Half of the participating MTs had bachelor degrees, whereas the other half also held a graduate level degree. However, most of the MTPTs (74%) had a master's degree. Interestingly, all MTs, whether or not they practised PT, seemed to work with a similar type of client population, children and adults, with diverse diagnosis. Additionally, MTPTs also worked with people with psychological trauma, PTSD, anxiety, depression, or other psychiatric disorders. 74% of MTPTs were engaged in full-time PT. Most of them practised individual therapy with over half practising group therapy as well.

Most of the MTs (95%), whether they practised PT or not, had some level of psychotherapeutic continuing education. For example, 76% had completed trauma therapy or crisis intervention trainings, and 34% had taken some level of GIM training. Likewise, out of the MTPTs, 39% hold some level of GIM training, yet only 10% were Fellows. Interestingly, 32% of MTPTs held some level of Nordoff-Robbins training. Similarly, 29% of them had taken a basic course in Neurologic MT. It appears that the training did not differ whether or not the MTs practised PT or not.

Furthermore, the theoretical orientations of MTPTs did not differ from other MTs either. Person-centred and humanistic existentialistic approaches seemed to be most common. The strongest influences for all MTs, whether or not they practised PT, were music-centred aesthetic MT (e.g., Lee, 2003), Nordoff-Robbins, GIM, and analytical MT.

### Music therapists' reflections on learning SEUS

In Ontario, a successful CRPO applicant must have completed a minimum of 30 hours of education and training related to SEUS in the psychotherapeutic relationship. SEUS-related entry-to-practice competencies required for registration with the CRPO include:

> 4.3 Ensure safe and effective use of self in the therapeutic relationship.
> 4.3.1 Demonstrate awareness of the impact of the therapist's subjective context.
> 4.3.2 Recognize the impact of power dynamics within the therapeutic relationship.
> 4.3.3 Protect client from imposition of the therapist's personal issues.
> 4.3.4 Employ effective and congruent verbal and non-verbal communication.
> 4.3.5 Use self-disclosure appropriately. (CRPO, 2015, p. 1)

According to the survey results, the most important source for learning SEUS was clearly the MTs' personal psychotherapy (PPT) (65%). Furthermore, 35% mentioned experiential courses during MT training, and workshops organised by the CAMT (29%). Most of the MTs also mentioned ongoing supervision. Other sources cited were internship in a psychotherapeutic setting, self-studies (reading literature), and GIM training. However, some comments clearly indicated that there had not been enough training on SEUS:

> This was not addressed in my training. There has not been to date a lot offered via SEUS.

> My guidance has come from mentors, reading, ethics training and self development.

According to the CRPO (2015, p. 1), one of the entry-level competencies required for registration is to be able to employ effective and congruent verbal and non-verbal communication in therapeutic relationships. Amongst survey respondents, song-writing, clinical improvisation, and GIM were the most commonly cited therapeutic techniques. Other techniques mentioned included receptive techniques such as music for relaxation and mindfulness, guided visualisation, or lyric analysis. Moreover, psychotherapeutic voice work and toning were utilised as well as creative arts therapy techniques such as drawing/writing/moving to music. Interestingly, almost half of the MTPTs also incorporated adapted music education and neurologic MT techniques. Many MTPTs also included community choir or bands as their therapeutic technique (23%). Although speculative, this could be rationalised as MTPTs practicing partly PT and partly other types of MT in order to meet their clients' therapeutic needs, or possibly as an additional source of income.

Interestingly, only 77% of the MTPTs incorporated verbal psychotherapeutic techniques (VPT), such as clarification, probing, active listening, and reflective questions with their clients. Furthermore, some indicated they used them only

> at the most basic level which I learned during internship and in master's training.

The main reasons cited for not utilising VPT were either not feeling qualified or because of the particular therapeutic needs of a certain client population:

> The [verbal] methods are not appropriate to the specific populations I'm currently working with.

Only 65% of the MTPTs had learned VPT during their graduate level MT training. Over half of this group had learned VPT during verbal psychotherapeutic training, and slightly less during GIM training. A mere 32% indicated they had learned VPT during their undergraduate MT training. A small number indicated they had not learned VPT at all.

### Music therapists' reflections on personal psychotherapy (PPT)

81% of the MTPTs specified that they had been engaged in PPT before, during or after their MT training. The most often cited reason was*:*

> I needed my personal therapy in order to use my self as a tool safely and effectively.

Techniques such as GIM, clinical improvisation, group analytic music therapy interventions, and various creative arts techniques which many music therapists experienced during their MT training experientials, were all considered beneficial. Analytic listening, especially working with transference, and mindfulness were also mentioned. Not surprisingly, many MTs described that they used music for their own therapy. However, only 45% of the MTPTs engaged in their PPT process had experienced at least a section of it in music psychotherapy, mainly in GIM. Other music psychotherapy experiences

included music and creative arts therapy, group analytic music therapy, and Nordoff-Robbins approaches. Those who had participated in GIM training found it extremely valuable, claiming:

> To date, GIM has been one of the most powerful and healing experiences of my life. The insights gained from my GIM sessions continue to stay with me. I most likely would not have become aware of my unconscious thoughts and feelings without experiencing GIM.

> It [GIM] was a very powerful therapy for me. I appreciated the way the music would allow me to bring up issues from my unconscious, so they could be looked at and processed verbally or in creative mediums afterwards.

The results suggested the main reasons why MTPTs had not been engaged in music psychotherapy were the small size of their communities, and concerns over potential dual relationships:

> I haven't found a music therapist who isn't a friend who practices with a worldview I would find useful in my own therapy.

> Small profession – wanting to remain colleagues in Canada rather than enter into a client/therapist relationship with colleagues and people whose work I respect.

> Small community, I prefer seeing someone I'm not acquainted with/don't know.

> If I wanted to have music psychotherapy I would not be able to find a practitioner who was sufficiently qualified and not in a dual relationship with me (our professional community is simply too small).

### Benefits of personal psychotherapy

Those MTPTs who had PPT experience described the many benefits they gained from it. The list includes gaining understanding of clients' experience, learning about SEUS, personal growth, working through past trauma, and self-care.

### Understanding client experience

The most often cited benefit of PPT was that it allowed music therapists to *"have the experience of being the client in therapy."* It allowed *"better understanding of client perspective as a participant in music…"* PPT also helped the MTs to gain understanding of their clients' experience in relation to various interventions. For example:

> Learning the effectiveness of musical and verbal interventions.

> I believe that personal therapy gives you a good perspective about what we ask
> of our clients but also an awareness to understand that the same technique is
> not going to work for everyone…

### Learning about SEUS

Many music therapists mentioned that their PPT taught them how to utilise SEUS, for example,

> better ability to engage in the safe and effective use of self.

> further understanding of the use of music as a psychotherapeutic tool.

> To work in any depth, personal therapy is essential. Unfortunately, even when
> music psychotherapy is available, most music therapists do not take advantage
> of it.

PPT experience also seemed to highlight the impact of the therapist's authenticity and transparency, guarding safe boundaries, and managing countertransference.

> …it taught me how important sense of safety and boundaries are in therapy.

> I learned how crucial it is that the therapist is authentic, and not fake. I also
> learned the impact of therapist's transparency (when it is not therapeutic).

> … learned how essential it is for the therapist to manage counter transference
> and not to treat the client based on their own assumptions.

> … I learned about somatic reactions, both mine and the therapists…

### Personal growth and working through past trauma

The benefits of PPT included aspects of personal growth such as increased self-esteem, increased self-awareness, greater clarity in decisions, and strengthened personal resources. Some mentioned processing trauma and grief, decreased anxiety, transforming negative patterns, and integrating life experiences.

> I cannot work with traumatized clients if I have not worked through my own
> personal trauma.

> Music making is connected to the body. It helps make connections or can be
> grounding when you're dissociating or unable to feel.

> Being able to explore and process personal issues.

> …deep processing of emotions that went beyond verbal awareness.

> …using the music to help tap the subconscious and get out of my head and my
> stories.

## Self-care

Self-Care was often mentioned as a benefit of PPT, because:

> …it is crucial [for an MT] to take care of their own therapeutic needs also…

> There is something very unique about being a care provider and having someone
> else provide that care to you.

Furthermore, a small number of MTPTs also disclosed that they had experienced vicarious traumatisation or burnout themselves.

> I did not truly understand its [SEUS's] importance until I burnt out and was very
> close to being an ineffective therapist, which when working with mental health
> patients, it is potentially quite dangerous.

> …there must be an ongoing clinical supervision during the training and after the
> training…

## Suggestions for music therapy training programs to enhance SEUS competency

Participating MTs applauded the regular clinical supervision during their clinical practicum and internship as a main forum for learning SEUS. They also complimented the teaching of musical resources as clinical interventions. Nevertheless, they also provided many valuable suggestions and ideas that could be incorporated into the MT curriculum to enhance the entry-level SEUS competency of graduates as defined by the CRPO (2015). The prevalent tone of the suggestions were that *"a healthy/safe/effective use of self should be a part of every training program, even undergraduate"*, and *"There needs to be a change in the way we teach the importance of the healthy and effective use of self in music therapy."* Music therapists reflecting on their own training suggested the following SEUS components be added to or enhanced in music therapy training.

### 1. Teach safe and effective use of self (SEUS) in the therapeutic relationship

MT trainings should incorporate more opportunities to explore and learn the importance of SEUS and its concepts in therapeutic relationship, such as countertransference, power dynamics, therapists' self-disclosures, and non-verbal communication. The concepts of vicarious traumatisation, compassion fatigue and burnout should also be explored during the training and at regular intervals during the clinical supervision. The training should assist students to understand the differences between their own therapeutic process and that of their clients, and, when working with diverse client populations, to protect clients from imposition of the therapist's personal issues.

> For a therapist who works with those who are non-verbal and have impaired functioning with behaviour issues, 'healthy and effective use of self' needs and approaches are different. There are similarities - but there are needs/approaches that are unique to working with this group.

> I feel strongly that music therapists should be well-trained as therapists - verbal and music, including significant psychotherapeutic training and personal therapy. I think we can only go as deeply with others as we have gone in ourselves, and that knowing how to process emotion verbally is essential for music therapists.

> Help students to understand that they are still at the beginning stages of learning when they complete their training. Many interns I have encountered are often over-confident and unable to truly see their areas of growth during the beginning months of the internship.

> We need to have more personal stories from those working in the field about the difficulty but importance of self-care as it pertains to the effective use of self. … As well as truly speaking to each student individually and having them understand the potential damaging effects it could have.

*1.1. Involve extensive music-making and improvisation beyond basic primary development of voice, guitar, and piano to enhance students' musical transparency and authenticity.* Students should *"explore the self in relation to the music,"* and *"include more hours of self clinical improvisations in peer groups as well as one on one basis."*

*1.2. Teach verbal psychotherapy techniques to meet the CRPO competency requirements.* It was suggested that:

> An introductory counselling course would be really helpful for music therapists in training. Learning and practicing basic active listening and interviewing skills (validation, open-ended questions, paraphrasing, etc.) is extremely important for music therapists, even when they aren't doing psychotherapy, and I don't feel that I learned those techniques adequately in my undergraduate degree.

> …there needs to be more discussion on how to use verbal psychotherapy before finishing the undergrad degree. Everything I learned in this area was from my internship supervisor.

## 2. Require personal psychotherapy for music therapy students

It was expressed that personal psychotherapy should be encouraged prior to entering the field and it should become a mandatory part of the education.

*2.1. Encourage personal psychotherapy prior to entering the field.* There should be better screening of candidates ensuring they have engaged in PPT, ideally music psychotherapy.

Music related psychotherapy counselling session as pre-requisite for completing the music therapy training.

I think it's important to stress that potential MT students have had their own personal therapy, in whatever modality is best suited to them.

I had already had years of therapy before becoming an MT student, and I still felt that I had a lot more personal work to do before I could be an effective therapist (interpersonal work, relational work).

*2.2. Require mandatory personal psychotherapy (verbal psychotherapy or music psychotherapy) during the MT training.*

Outlining the benefits of engaging in personal psychotherapy and inviting students to do so - role play, including verbal intervention as well as music psychotherapy technique.

Make attending personal psychotherapy a requirement of the program.

All students should be required to take the 'client' role in a period of personal therapy.

When I was in school it was recommended but not mandatory. I hope that as the profession continues to grow that it will be a standard in the education process for upcoming MT's.

In my opinion, on-going 'self' or 'therapeutic' work is critical in order to be a healthy, effective therapist. It's almost as important, if not more, than continuing education. Setting this standard, example and requirement during MT training would be beneficial for individuals as well as the profession.

## REFLECTIONS AND DISCUSSION

As the response rate of the survey was only 12%, the results cannot give a comprehensive picture of Canadian music therapists' views on SEUS. Furthermore, it is likely that responses were biased by the greater likelihood of inclusion of therapists who had a higher level of interest in SEUS. Despite its limitations, the results serve to stimulate a wider conversation about SEUS and related training needs amongst music therapists and music therapy educators.

According to the survey results, music therapists engaging in psychotherapy in Ontario seem to work with similar client populations as other music therapists do. They appear to use similar theoretical approaches and techniques, and hold very similar training.

The findings of the survey suggest that music therapists have an excellent sense of SEUS, whether or not they practice psychotherapy. They clearly value the SEUS and the benefits of their own personal therapy. However, at the same time, some portrayed their training on SEUS, including verbal

counselling skills, to be inadequate. This is important information for the music therapy educators to consider as the required CRPO SEUS-related entry-to-practice competencies include the therapist's capacity to employ effective and congruent verbal and non-verbal communication (CRPO, 2015). Furthermore, music therapy trainings are suggested both to teach verbal psychotherapy techniques to meet the CRPO competency requirements, and to involve extensive music-making and improvisation to enhance students' musical transparency and authenticity. The role of local music therapy associations could be to ensure proper continuing education, i.e., pre-conference workshops and intensives. It was also suggested that personal psychotherapy should be encouraged prior to entering the field, and should become a mandatory part of the education.

Those music therapists with some personal psychotherapy experience described the many benefits they garnered from it. The list included gaining understanding of clients' experience, encompassing the importance of authenticity, boundaries, and countertransference management; learning about SEUS; personal growth; working through past trauma, and self-care. The following discussion will further ponder these themes in relation to current knowledge in the field.

According to the survey results, one of the benefits of personal psychotherapy amongst music therapists was to gain understanding of clients' experiences during the therapy process. This included the importance of a therapist's authenticity and transparency, which directly references the CRPO SEUS-related entry-to-practice competency requirements for registration: "Use of self-disclosure appropriately" (CRPO, 2015, p. 1).

The impact of transparency and here-and-now disclosures have been widely researched for decades in psychotherapy-related literature (e.g., Barrett & Berman, 2001; Bloomgarden & Rabinor, 2000; Burkard, Knox, Green, Perez & Hess, 2006; Constantine & Kwan, 2003; Fisher, 2004; Ganzer & Ornstein, 2004; Goldstein, 1994; Hendrick, 1988, 1990; Henretty & Levitt, 2009; Knox, Hess, Petersen & Hill, 1997; Knox & Hill, 2003; Peca-Baker & Friedlander, 1989; Raines, 1996; Sweezy, 2005; Tantillo, 2004; Zur, 2009; Watkins, 1990). Remarkably, there-and-then disclosures are considered less therapeutic even though many therapists may equate them with use of self (Jeffrey & Austin, 2007; Kelly & Rodriguez, 2007). Any disclosures that communicate similarities between therapist and client are not as helpful as generally thought. Indeed, self-disclosures about our personal life, beliefs, values, world views etc. may even disturb the therapeutic relationship (Knight, 2013).

Rogers (1957), the pioneer of client-centred approaches, proclaims that the choices we make concerning the use of self in a therapeutic relationship should be based on two questions: What is authentic for ourselves? And what will meet the client's therapeutic needs? According to psychotherapy research, there are two types of self-disclosure: here-and-now disclosures and there-and-then disclosures (e.g., Baldwin, 2000; Edwards & Bess, 1998; Hanson, 2005; Kelly & Rodriguez, 2007; Peterson, 2002; Prilleltensky, 1997; Sugarman & Martin, 1995).

As music therapists, if our genuine here-and-now self-disclosure conveys our authentic reactions to the client's experiences or our thoughts about the client, the disclosure can be very therapeutic and enhance trust and the therapeutic alliance. However, there-and-then self-disclosures, information about the therapist, can also be helpful in developing the therapeutic relationship if they are controlled. For example, disclosures that expose our professional background, theoretical orientation, or cultural background may be helpful.

One of the most important aspects any music therapist brings into a music therapy practice is their musical authenticity, musical self (e.g., Aldridge, 1999; Bruscia, 2012; Chong, 2007; Hadley, 2006; Lee, 2012, 2016; Pavlicevic, 2000; Yehuda, 2002), and musical transparency. We listen to our own music and musical self while we improvise with a client in a musical, and therapeutic relationship. Moreover, we listen to our feelings in our own music in relationship with client's music (Arnason, 2002; Lee, 2000, 2003).

Most likely our musical authenticity during improvisations has more impact on our clients than our musical skills or theoretical orientation. According to Yehuda (2002, p. 1504), "Music is considered to be authentic when it sounds authentic or when you are feeling that it's real, when it has credibility, and it is perceived as unique." Moreover, the level of intimacy during improvisation can be much higher than in verbal dialogue and often demands even more awareness for the therapist.

According to the survey results, therapists' self-disclosures and their impact is not covered sufficiently during the music therapy trainings. As a music therapist, prior to disclosing information of past experiences it is prudent to ask oneself whether one is disclosing these items for the client or for oneself. What would be the therapeutic goal of these disclosures? How would this content serve a client's therapeutic process? It is imperative for music therapy trainings to stress the importance of therapists not imposing or unconsciously projecting their own values, worldviews, or beliefs upon clients.

As suggested by the participating music therapists, to gain an understanding of countertransference management, including the therapist's somatic reactions, it is crucial that music therapists who practice psychotherapy have completed their own psychotherapy and have ongoing music psychotherapy supervision. This directly reflects with the following CRPO SEUS-related entry-to-practice competencies: "Demonstrate awareness of the impact of the therapist's subjective context, and recognize the impact of power dynamics within the therapeutic relationship" (CRPO, 2015, p. 1).

Many psychotherapists agree that countertransference is "the key in helping the therapist to understand the transference" (Grotstein, 2009, p. 38). However, it can be both "a useful tool and a pitfall of treatment of trauma and traumatic loss" (Klein & Schermer, 2000, p. 7). Despite the fact that the countertransference concept entails the concepts of psychoanalytically and psychodynamically informed psychotherapies, regardless of our theoretical approach as music therapists it is critical that we are willing to do our best to separate our own personal material from our reactions to our client's trauma story and issues. In order to practise safely we must be aware of the subjective countertransference (what is taking place within our psyche), and the objective or realistic countertransference (how it is related to what is happening in therapy session right now) (Klein & Schermer, 2000, p. 28). Even if we do not agree with the psychoanalytic concept of countertransference, recognising its impact remains one of the main areas of SEUS.

Another topic music therapists gained greater understanding of during their personal psychotherapy was the importance of guarding safe boundaries in the therapeutic relationship. There is some literature about boundaries in music therapy. One example, Bunt and Hoskyns (2002), introduced physical and time-based, professional, ethical, and developmental aspects of boundaries. Compton Dickinson and Benn (2012) describe professional and therapeutic boundaries in music therapy in forensic settings. There is also a vivid discourse about boundaries in community music

therapy (Ansdell, 2002; Ansdell & Pavlicevic, 2004). Furthermore, both the CRPO and CAMT *Code of Ethics and Standards of Practice* highlight boundary issues, aiming to protect the public, monitor the welfare of clients, and ensure the therapist does not do harm.

As stated by Bruscia (1998h), if a therapist has boundary issues, two anti-therapeutic polarised reactions occur. If we over identify with the client, we stand to lose our emotional boundaries and may not differentiate between our own and our client's feelings and experiences. "When music-making is involved, the music of the therapist and client become so fused, structurally and emotionally, that the parts are indistinguishable and resistant to change" (Bruscia, 1998h pp. 81-82). The opposite anti-therapeutic reaction occurs when the therapist is trying to distance themselves from the client, building emotional barricades and protection in order to avoid emotions and a genuine therapeutic relationship. They may feel unconnected for long periods, or unable to empathise. "When music-making is involved, the parts of the client and therapist are so completely differentiated that the music sounds conflictual or incoherent and stays that way for long periods" (Bruscia, 1998h, p. 82). I believe the therapist's position to emotionally receive clients' material is sometimes difficult as the professional defence mechanisms simply may not be available. Furthermore, as a therapist, if I over-emphasise the professional distance, my client may not experience empathy and will not be truly helped.

As reported in the survey results, a number of music therapists had experienced burnout themselves. Some suggested a lack of boundaries as the main trigger. Thus, the importance of developing understanding of therapeutic boundaries during music therapy training, internship, and supervision cannot be overstated. Similarly, it would also be critical to teach music therapy students to learn to recognise the symptoms and warning signs associated with burnout, such as bringing clients' problems home, accusatory and martyr-like feelings, or detachment during which clients have become the 'caseload'.

Many participating music therapists mentioned the importance of self-care and finding ways to alleviate therapists' stress, both personal and work-related. Vicarious traumatisation was mentioned several times as something that music therapists wished they had learned about during their training. According to Ahonen:

> The sound of pain and hope does not leave any music therapist untouched and untransformed. Sometimes it follows us into our homes, into our relationships, even our dreams. It may even change our worldview, our values, and our attitudes. It may impact us to become vicariously traumatized. (Ahonen, 2014a, p. 201)

Several elements contribute to vicarious traumatisation, such as lack of psychological breaks and opportunities to ventilate feelings during the clinical work, or an unbalanced caseload. However, the most prevalent reason is inadequate training in the trauma and grief therapy processes, and a lack of supervision (Izzo & Carpen Miller, 2011). As suggested by the survey results, highlighting the importance of self-care and learning concepts such as vicarious traumatisation should be essential at undergraduate level training. Self-care is a crucial part of safe use of self. The survey results suggested that personal therapy should be mandatory in music therapy trainings, not only as an issue of ethical

concern, but also because it includes the self-care of the therapist. As therapists, practising safely means that we do not harm the client or ourselves. In order to keep the clients safe, the therapist must also remain safe. Cattanach puts it beautifully:

> The therapist must seek help and supervision, … know when to stop and rest. Have time away from the work, other things to do and enjoy. Find a safe place to stay contained; a place to travel towards in the imagination and in reality. (Cattanach, 1992, p. 196)

The survey participants' suggestion of making personal psychotherapy mandatory for music therapy students directly reflects the following CRPO SEUS-related entry-to-practice competency required for registration: "Protect client from imposition of the therapist's personal issues" (CRPO, 2015, p. 1). It also reflects the concept of being a wounded healer. Just as many psychotherapists are wounded healers (e.g., Miller, 1981), the survey results suggest many music therapists are also. It is important to reflect what this could mean in our clinical practice. How has our own pain trained us to understand others? How do we use our own woundedness in the service of healing, through empathy and countertransference? What do we have to be aware of during this very sensitive process? Do we agree with the following statement from Bruscia (1998c)?

> …not only that the music therapist should heal himself but also that they should take their own medicine. Any music therapist who has not, cannot, or will not experience music therapy as a client needs to change professions […] every music psychotherapist should do intense personal work over an extended period in whatever form of music psychotherapy he will be practicing. (Bruscia, 1998c, p. 116)

Interestingly, many use of self researchers emphasise that it is crucial to distinguish between the wounded healer and the impaired professional, whose personal trauma experiences harmfully impact their clinical work (e.g., Costin & Johnson, 2002; Gilroy, Carroll & Murra, 2001; Jackson, 2001; Rippere & Williams, 1985; Schoener, 2005; Sherman, 1996; Smith & Moss, 2009). It is generally recommended that therapists must be able to acknowledge their own traumatisation, seek help, and first heal themselves. Our own healing process must at least have started before we can begin to treat clients (e.g., Farber, Manevich, Metzger & Saypol, 2003; Norcross & Connor, 2005; Orlinsky, Schofield, Schroder & Kazantzis, 2011; Sawyer, 2011). Nonetheless, there has been little research into how a therapist's own recovery processes impact their clinical work, or how they determine they are adequately healed in order to be able to practise safely. Thus, "the ambiguity regarding the degree to which the therapists' own wounds have healed presents a dilemma for both the wounded healer and other professionals" (Zorubavel & O'Dougherty Wright, 2012, p. 482).

At the CRPO, it is the registered psychotherapist's gatekeeping responsibility to address and report any deficiencies in colleagues. Inherently, would this hinder open consultations with the colleagues, and authentic disclosures in clinical supervision "about how a colleague's or supervisee's wounds positively influence or interfere with their work?" (Zorubavel & O'Dougherty Wright, 2012, p. 482). Furthermore, according to Zorubavel and O'Dougherty Wright (2012, p. 482) there has been

silence on this topic: "The wounded healers' concerns often pertain to potential stigma if the nature of the wound is disclosed and judgment by colleagues regarding their competence to practice. These concerns can result in secrecy, self-stigma, and shame" (see also Knox, Burkard, Edwards, Smith & Schlosser, 2008; Yourman, 2003).

To summarise, 'safe' use of self in music therapy refers to the twofold idea of (1) not harming the client, and (2) not harming ourselves (self-care of the therapist). Generally, this means that a music therapist does not use their client to meet their own therapeutic (or other) needs, but rather protects them from their own personal issues by being aware of the impact of any power dynamics or their subjective context on the therapy process. Safe use of self also includes the therapist's self-care, i.e., being able to recognise vicarious trauma, compassion fatigue, or burnout signals, and having enough clinical supervision, personal therapy, and a balanced life rhythm.

'Effective' use of self refers to the skilful use of appropriate therapeutic interventions (musical and verbal) in order to meet the needs of a diverse clientele. It also refers to using our self as a tool and container to meet different individuals' needs. Effective use of self also means that the music therapist is able to reflect critically on any personal life philosophies and worldviews that could possibly impact on their clinical work. Without biases or conflicting interests, the therapist, again, by using their self, must be able to assess the client's individual therapeutic needs, plan and conduct a therapeutic treatment, evaluate the process, change the treatment plan if needed, apply appropriate theories and approaches, and at the same time integrate understandings of their own self into the therapeutic relationship. The CRPO SEUS-related entry-to-practice competencies include the following competencies: "to ensure safe and effective use of self in the therapeutic relationship and employ effective and congruent verbal and non-verbal communication" (CRPO, 2015, p. 1). Effective music therapy training should therefore include teaching both musical interventions and verbal interventions. In order to meet the needs of diverse clients, musical interventions should include multicultural musical resources.

Although not the focus of this article, along with the concept of use of self there also needs to be a critical discussion centred on the concept of safe and effective use of music (SEUM). This involves acknowledging the contraindications of using particular music with particular clientele. Similar to not utilising SEUS, not utilising SEUM may present real physical, neurological, and psychological dangers that could possibly harm the client.

Finally, a good music therapy training should encourage students' personal, musical, and professional growth, and equip them for self-care and work with diverse, multicultural client populations with a variety of therapeutic needs. This includes facilitating students' empathy, self-awareness and self-reflection skills by teaching SEUS, and encouraging them to develop their own musical self so that they might use music as their own, unique self-care as well.

In closing, according to Aponte and Winter (2000, p. 85), "At bottom, the single instrument each training model actually possesses is the 'person' of the therapist in a relationship with a client." The concept of use of self offers a framework for music therapists to understand more fully their responses with clients. In this framework we could argue that because we use our own person as a tool of therapy, many of the things we do as music therapists, including our musical interventions, could be considered as use of self. The music therapist's self-awareness, self-acceptance, self-regulation, and personal growth are crucial foundations for the use of self in the therapeutic process. In order to practise safely

and effectively, a recurrent critical reflection is indispensable.

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## Ελληνική περίληψη | Greek abstract

# 'Ο εαυτός ως εργαλείο' – Ασφαλής και αποτελεσματική χρήση του εαυτού στη μουσική ψυχοθεραπεία: Αντιλήψεις Καναδών μουσικοθεραπευτών

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## ΠΕΡΙΛΗΨΗ

Αυτό το άρθρο παρουσιάζει τα αποτελέσματα μιας πιλοτικής έρευνας που διεξήχθη με διαπιστευμένους Καναδούς μουσικοθεραπευτές διερευνώντας τις αντιλήψεις τους σχετικά με την προσωπική ψυχοθεραπεία και την έννοια της *Ασφαλούς και Αποτελεσματικής Χρήσης του Εαυτού* (ΑΑΧΕ) [Safe and Effective Use of Self, SEUS] στη μουσικοθεραπευτική σχέση. Ένα ερωτηματολόγιο μέσω ηλεκτρονικού ταχυδρομείου κάλυψε τόσο κλειστού όσο και ανοικτού τύπου ερωτήσεις για θέματα που σχετίζονται με την ΑΑΧΕ. Οι ανοικτές ερωτήσεις αναλύθηκαν με τη χρήση του λογισμικού ανάλυσης ποιοτικών δεδομένων *Nvivo*. Απλά ποσοστά υπολογίστηκαν για την ανάλυση των αποτελεσμάτων των ερωτήσεων κλειστού τύπου. Τα αποτελέσματα δείχνουν ότι οι μουσικοθεραπευτές που εμπλέκονται στην ψυχοθεραπεία φαίνεται να εργάζονται με παρόμοιους πληθυσμούς πελατών, να χρησιμοποιούν παρόμοιες θεωρητικές προσεγγίσεις και τεχνικές, και να κατέχουν παρόμοια εκπαίδευση με άλλους μουσικοθεραπευτές. Αυτοί οι μουσικοθεραπευτές φαίνεται να έχουν μια εξαιρετική αίσθηση της ΑΑΧΕ είτε ασκούν ψυχοθεραπεία είτε όχι. Αντιστρόφως, η κατάρτισή τους τόσο στην ΑΑΧΕ όσο και στις προφορικές συμβουλευτικές δεξιότητες θεωρείται συχνά ανεπαρκής. Οι μουσικοθεραπευτές που ασκούν ψυχοθεραπεία προτείνεται να έχουν ολοκληρώσει προσωπική ψυχοθεραπεία και να έχουν συνεχή εποπτεία μουσικής ψυχοθεραπείας. Τα αποτελέσματα μπορούν να δώσουν ώθηση για περαιτέρω συζήτηση σχετικά με το θέμα της ΑΑΧΕ στη μουσικοθεραπεία.

## ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

Ασφαλής και Αποτελεσματική Χρήση του Εαυτού (ΑΑΧΕ) [Safe and Effective Use of Self, SEUS], επάγγελμα μουσικοθεραπείας, μουσική ψυχοθεραπεία, προσωπική ψυχοθεραπεία