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Music Therapists' Insights Regarding a Shift in Practice Orientation:

A Clinical Retrospective Self-Study

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Abstract

This report details a clinical retrospective self-study that we undertook to gain insights into our experiences as an undergraduate practicum student and clinical supervisor. We studied our lived experiences of a shift in practice orientation that we implemented with a child with communication and behavioral challenges. Recognizing a few weeks into treatment that our initial outcome orientation and behavioral approach was not meeting the child's needs, we abruptly shifted to an experience orientation and music-centered approach, commensurate with Bruscia's (2014) Integral Thinking and Practice model. Curious as to whether our initial perceptions of this shift would hold up to investigative scrutiny, we undertook this retrospective study to answer the following questions: (1) What factors and circumstances may have precipitated (i.e., activated) the shift in orientation? (2) What factors and circumstances may have enabled (i.e., supported) a shift in orientation? and (3) What individual and collective insights might we gain about our lived experience of the shift relative to integral thinking and practice? Findings from thematic analysis of clinical artifacts inform recommendations aimed at helping music therapists to recognize theoretical influences and feel freedom and confidence to make shifts in practice as warranted. We advance reflexivity as a key strategy to improve clinical services and supervisory practices.

Keywords: retrospective self-study; reflexive phenomenology; theoretical orientation; music therapists' lived experiences

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Introduction

This report details a *clinical retrospective phenomenological self-study* that we undertook toward expanded understanding of and insights into our work as music therapists (Bruscia, 2005b; Hunt, 2016). All self-study research aims to "acquire firsthand, personal accounts of subjective experience with the phenomenon of interest as directly experienced by the self" (Hunt, 2016, p. 453).

Clinical retrospection may be undertaken for many different reasons. That said, all such inquiry aims to contribute to the researchers' expanded awareness of, comprehension of, and insight into some aspect of their subjective experience relative to their previous clinical work. Descriptions and interpretations of such subjective experiences represent "the unique understanding of the individual as opposed to some generalizable truth about the phenomenon" (Jackson, 2016, p. 441). Nevertheless, systematic clinical retrospection in music therapy may lead to the development of theoretical constructs and novel clinical techniques (Bruscia, 1998), as well as to expanded clinical expertise (O'Callahan et al., 2009), not only for those involved in the study, but also for those who encounter study findings through presentation and publication.

The specific phenomenon of interest to us was a shift in our practice orientation with Alex,[1] a seven-year-old child with communication and behavioral challenges. Treatment with this client occurred at our university music therapy clinic. At the time of treatment, Marie was a pre-internship (undergraduate) Student Music Therapist (SMT) assigned to a clinical practicum with Alex, and Susan acted as clinical supervisor (SUP).

In our university practicum program, based on an initial assessment of the clientele and in consultation with their supervisor (and, as indicated,[2] with the clientele), the SMT adopts a particular practice orientation. As Bruscia has posited in "Ways of Thinking in Music Therapy" (2011) and *Defining Music Therapy* (2014), in some cases, music therapists practice from an *outcome orientation*, viable when a client's needs suggest that treatment should target observable and measurable behaviors and responses. Here, music functions as a means to a predetermined and typically nonmusical end (e.g., decreasing verbal outbursts). Outcome-oriented strategies capitalize on music's potential to act as a stimulus or reward for a desired response, encourage specific skill development, and support treatment protocols with clearly defined and measurable objectives. Thus, this orientation is compatible with behavioral and cognitive-behavioral approaches, as well as with certain medical and rehabilitative protocols, such as when treating pain or remediating ambulatory function, for instance.

In other cases, music therapists practice from an *experience orientation*. In this orientation, music functions as a medium of experience for identification of a client's needs and exploration of their resources and opportunities. In this way of working, the therapist suspends their expectations of specific outcomes, focusing instead on "encouraging and supporting the client's optimal immersion in the music experience toward unearthing' whatever is relevant to them" (Gardstrom & Willenbrink-Conte, 2021, p. 67). Bruscia (2011) notes that this orientation is compatible with psychodynamic and humanistic practices.

Bruscia (2014) speaks against a single-mindedness, advancing instead the notion of *integral thinking and practice (ITP)*, in which the music therapist moves fluidly between practice orientations in response to the emergent and immediate needs of the clientele. The pre-internship students in our university training program are introduced to the concept of ITP in music therapy during their first year of study and, over the course of their training, come to understand the basic tenets of the two orientations that are adopted with clientele in the practicum sequence[3]— each one with its distinctive music strategies, characteristics, and therapist and client roles. However, the clinical acumen and fluidity required to practice in a truly integral fashion suggests that it occurs at an advanced rather

than entry level of practice. Thus, while the SMT may understand and be able to enact, if desired, the basic principles of outcome and experience orientations, they are not expected to possess the knowledge, skill, and confidence required to (1) discern a need for and (2) actualize a shift in their orientation from moment to moment as the necessities and desires of the clientele suggest.[4] Rather, they typically adhere to the adopted practice orientation for the entire 15-week semester.

Our work with Alex was a departure from program norms in that treatment took an unexpected turn five weeks into the semester. We shifted somewhat abruptly from an outcome to an experience orientation and made commensurate changes in location of treatment, methods, and techniques for the duration of the semester. After we had made the shift, during immediate session debriefings and lengthier supervision meetings, we not only discussed the client's treatment process, but also reflected on our own experiences of this new way of conceptualizing and enacting the process.

Then, a year after the practicum ended, the two of us reconnected to consider what might be learned about the shift and our experiences of it by engaging in retrospective inquiry. We embraced phenomenology, whose focus as a research methodology is on understanding and describing lived human experience (Jackson, 2014). One's *lived experience* comprises both their direct and personal encounters with a particular phenomenon of interest and the significance or meaning that is constituted through explicit remembrance of those encounters (Burch, 1990). As such, we designed a phenomenological self-study in which we undertook thematic analysis (Braun & Clarke, 2018) of multiple artifacts related to our prior clinical work to arrive at a deeper understanding of the nature of the shift and what we had experienced.

Research Questions

All interpretivist research "is an iterative process that begins with a general curiosity about a phenomenon or personal experience" (Darrow, 2016, p. 52). Our curiosity about the phenomenon of an unanticipated shift in practice orientation led us to systematically interrogate the professional literature on the topic, a process that began at the start of our investigation and continued up to the point of submission for publication submission. As we reviewed the literature, encountered and analyzed clinical artifacts, considered our findings, constructed the report (Aigen, 2012) – even as we re-constructed it in response to peer review – we arrived at our guiding questions: (1) What factors and circumstances may have precipitated (i.e., activated) the shift in orientation? (2) What factors and circumstances may have enabled (i.e., supported) a shift in orientation? and (3) What individual and collective insights might we gain about our lived experience of the shift relative to integral thinking and practice?

At present, we are unaware of any research that explores music therapists' experiences of and insights related to a shift in practice orientation, let alone within a supervised practicum at the pre-internship level of training.

Therapists' Positionality

As Jackson (2016) notes, in phenomenological research, "It is imperative that the location of the researcher in relation to the question(s) being asked be made clear" (p. 450) as one way of bracketing, or "consciously putting aside identified biases, assumptions, and so forth, in examining the data" (p. 442). This location or positionality, may encompass both the researcher's overarching worldview (i.e., epistemological assumptions and beliefs about human beings in the world) and the specific stance that they have adopted toward the research task or study (Sikes, 2020). In this section of the report, we reflect briefly on our epistemological stances and some of the life experiences and identities, values, and

biases that likely impacted how we approached the study. Henceforth, we use italics when writing individually in first-person narrative.

SMT (Marie)

I believe we come to know what we do about this world through our subjective experiences of it, and such experiences are formed and influenced by our beliefs, values, and upbringing. I agree with Hiller (2016) that "interpretive knowledge is also imbued with our values, local and political, and is thus not universal and not generalizable in the sense that it may readily apply to other agents in alternative situations" (p. 67). In other words, others may not be able to understand my experiences, as I will never be able to fully understand theirs. Yet, attempting to understand has merit in that it allows me to appreciate differing perspectives instead of disregarding them as untruthful. The present study appealed to me because it challenged me to analyze my own experiences, which could ultimately inspire readers and inform my current clinical work. Hunt (2016) also recognizes how gaining knowledge of therapists' experiences can lead to greater understanding of clients and how best to work with them.

While certainly invested in this project, I acknowledge that, as a new professional, I had yet to conduct research. As I faltered in my attempts to faithfully follow analytical procedures, my co-researcher was a valuable mentor and resource. Due to our past relationship as student and clinical supervisor, I found myself often reverting to a "student" role and quickly accepting her suggestions in the way a student regards her teacher as "always right." In other words, my tendency to revert toward her opinions left me biased against my own, likely clouding end results.

As someone who holds herself to particularly high professional standards, I noticed myself focusing on the errors and discrepancies in my clinical decisions throughout the semester. I carried feelings of fear, incompetence, and self-doubt into thematic analysis. While analyzing data, I made notes to myself about the "fear of confronting my own incompetence or dissatisfaction with clinical decision-making." Holmes (2020) speaks to the challenging and unique position one assumes when serving as both "insider" and "outsider" to participants under study. I found it challenging to be the very one studying myself in this research. Yet, this study marked an opportunity for me to gain greater comfort with self-reflective practices and to more deeply explore their clinical benefits.

SUP (Susan)

I hold that all knowledge is individually and socially constructed and, furthermore, that capturing and interpreting subjective human experience can enable more complete understanding of clinical processes. Thus, I was eager to engage in a clinical retrospective self-study as a way to improve my clinical work and supervision.

Essentially, this study represents my desire and commitment to learn more about ITP. In accordance with the developmental history of the profession in the United States, I was trained in undergraduate and graduate academic programs that focused almost exclusively on behavioral approaches to music therapy, with emphasis on the use of music as a stimulus or reinforcement for specific and predictable (and largely nonmusical) therapeutic outcomes. I am well-versed in outcome-oriented practices and confident in applying principles relevant to what is essentially a problem-oriented way of working. At the same time, once introduced to "Ways of Thinking in Music Therapy" (Bruscia, 2011) and related writings on ITP (Bruscia, 2014), I embraced new ways of conceptualizing clinical practice, pedagogy, and supervision. While I recognize the value of outcome-oriented strategies, I find greater meaning and personal satisfaction in experience-oriented clinical practice primarily because of (1) its emphasis on client agency in identifying their needs and how music might serve them; and (2) the use of music as an aesthetic form, medium of discovery, and health resource. I acknowledge that my bias toward a "here and now" way of working with an emphasis on musical rather than nonmusical processes likely impacts all

manner of my clinical and research endeavors. Indeed, the intensity and significance of my negative countertransference reactions toward a behavioral approach became evident through thematic analysis, a finding that will be more thoroughly discussed below.

I chose to co-investigate with Marie primarily because I perceived our supervisory relationship as having been characterized by positivity and candor, which are firm foundations for a collaborative scholarly endeavor. Marie and I were now professional colleagues, and yet we did not assume "equal roles and status as co-researchers" (Bruscia, 2005b). While many of my identities overlap with Marie's identities (white, female, cisgender, heterosexual, middle-class, non-physically disabled), I recognize that I hold additional privileges and power on account of my educational background and academic position. Additionally, I have prior research experience, whereas Marie was a newcomer to the enterprise of research. Thus, my tendency was to assume the role of mentor – recommending literature to read, explaining complex topics as I was able, re-structuring the report, etc. As such, I acknowledge that I undoubtedly imposed certain of my biases as a researcher and author and additionally may have erected barriers to my own awarenesses related to the phenomenon of interest.

Integrity

In designing and enacting this study, our attempts to enhance integrity (Bruscia, 1998b, 2005a) were supported primarily by (1) *personal authenticity* – taking consistent responsibility for all actions (e.g., recognizing and correcting errors in analytical processes, checking tendencies toward "impression management" during reporting [Vannini & Franzese, 2008]); (2) *prolonged and persistent observation* – engaging in recursive analytical processes wherein we repeatedly returned to the raw data to check our assumptions; (3) *reflexive practices* – keeping personal memos throughout the study to capture subjective material that arose through encounters with the data sets (i.e., emotions, insights, curiosities, autobiographical recollections [Blakey, 2009]), and reflecting via email and during video conferences on questions or concerns related to the research phenomenon and processes; and (4) *audit* – consulting periodically with two other professional colleagues with experience in phenomenological research to discuss methodological aspects, and submitting an earlier draft of this report for critical review by a music therapy colleague with expertise in first-person research.

As Aigen (2011) points out, dual relationships necessarily exist when researchers study their own work as therapists; these intimate relationships with the data are considered an asset in first-person research when such relationships lead to the development of meaningful insights regarding the subjective experiences around which phenomenological self-studies revolve (Hunt, 2016). Nonetheless, every researcher is beholden to standards of integrity for interpretivist research (Bruscia, 1998b). Consequently, we also engaged in (5) *bracketing* toward promoting rigor and managing any sensitive personal material (Tufford & Newman, 2010) that may have diminished the truthfulness of findings. Namely, in our reflexive memo-writing (see above), we aimed to externalize any emotions experienced during analysis that we sensed could have led to defensive posturing or inauthenticity in reporting (*e.g., I feel a bit of embarrassment as I watch what I did in this moment* and *I was reluctant to even begin the review process. Perhaps I was afraid of being unable to understand my own actions?*). For both of us, the lapse of time between our initial encounters with the data during the practicum semester and data analysis during the study period generally functioned as an assist to this aspect of bracketing, as some of the emotions we experienced "in the thick" of the clinical work had diminished in intensity with the passing of time.

Context for the Study: Orientations

Practice orientations and theoretical orientations[5] espoused by music therapists revolve around assumptions and beliefs about human beings, music, therapeutic relationships, and human change processes. Orientations help clinicians to organize clinical information in a coherent way, explain facts and phenomena, make informed and ethical decisions (Bruscia, 2005c, 2014a) and may "assist clients in the effective change of their behavior, cognitions, emotional functioning, and interpersonal relationships" (Strope, 2019, pp. 1-2). Orientations also provide markers by which to gauge treatment efficacy (Strope, 2019).

We hold that every music therapist's clinical practice evinces certain principles that can be linked to one or more practice orientations, whether or not the therapist is aware of and able to articulate the associated tenets (Reichert, 2018). Music therapists may draw from various theoretical sources in forming an overarching orientation, some *borrowed* from psychology and related behavioral and social science fields, such as behavioral/cognitive-behavioral, psychodynamic, and humanistic; some rooted in so-called *contemporary* perspectives such as resource-oriented music therapy (Rolvsjord, 2010) and feminist music therapy (Hadley, 2006); and some that could be considered *indigenous* to music therapy, such as music-centered music therapy (Aigen, 2005b). Therapists may speak of blending therapeutic strategies, methods, and techniques from multiple theoretical orientations in what have been called *integrated* and *eclectic* practices.

Although Bruscia (1998c) does note that the way one practices may be a function of their countertransference (a point that we will return to as we discuss our findings), in our review of the literature, we found just a handful of studies that report data on music therapists' intentional choice of orientation (Choi, 2008; Reichert, 2018; Weiss et al., 2017). Findings from Choi's 2008 survey of music therapists in the United States indicate that one's practice orientation is strongly correlated with the orientation espoused in one's training program. Reichert's (2018) more recent survey focused on therapists working with adults in psychiatric facilities in the United States, with findings showing a near-even split between cognitive-behavioral and humanistic orientations, but no mention of factors influencing these choices. Weiss et al. (2017), when discussing results of their survey of Israeli music therapists, speculate that not only training programs, but also the practice orientation of the clinical supervisor might wield a potent influence.

We were interested not only in how therapists choose a practice orientation, but if and how they come to alter their approach. However, we found no music therapy publications describing this phenomenon, at which point we broadened our search to include publications in counseling and clinical psychology. Studies in these fields evince that initial choice of orientation is thought to be influenced not only by training, but also by experience in the field, personality attributes and temperament, and personal values (Arthur, 2001; Norcross & Prochaska, 1983; Vasco & Dryden, 1994). Even *accidental* or *inadvertent* factors (e.g., initial clinical placements, unusual incidents) can play a role in the choice (Cummings & Lucchese, 1978). Research substantiates that one's orientation naturally shifts over time with increased personal and professional awareness and experience (Murdock et al., 1998; Plchová et al., 2016; Strope, 2019).

In contrast to the homogeneity of a singular orientation, the amalgam of numerous approaches (integrated, eclectic), or the evolution of one's orientation over the course of their career, Bruscia (2011, 2014) introduces us to ITP. A basis of Bruscia's integral practice in music therapy is that "it is not the therapist's way of thinking or preference that determines the focus of working with the client, but the client's needs as they shift from moment to moment and session to session" (p. 259). Integral practice thus both demands ongoing therapist reflexivity and grants "permission" for the therapist to move fluidly between practice orientations as immediate circumstances warrant. Without a doubt, not all music therapists think or practice in an integral way. In fact, it would seem

that most adopt a single, relatively static practice orientation, perhaps because one way of working is most familiar, comfortable, and suited to their personality (Choi, 2008) or because that orientation has customarily been applied to a particular clinical "population." From personal experience, we also know that some therapists feel pressured by caregivers, supervisors, and administrators to consistently practice in a certain way.

We now describe each of the orientations as we adopted them sequentially during the practicum semester.

Outcome Orientation: Treatment Stage I

At the start of the semester, during Stage I (weeks 1 – 4), we adopted an outcome orientation to treatment. Three factors contributed to the decision: (1) the parent's stated expectation for music therapy was that Alex would develop functional communication skills, social behaviors, and impulse control – all nonmusical outcomes believed to correlate with Alex's success in classroom and playground environments; (2) a behavioral approach was employed with Alex in school and had been linked to increased attention to task during music therapy services they had received three years prior; and (3) the SMT was at ease with a behavioral approach, having embraced behavioral principles and techniques in her previous practica with children with developmental challenges and while working in childcare.

Consistent with this orientation, Marie's primary emphasis during Stage I was on modifying the client's nonmusical behaviors by cueing and reinforcing participation in music activities and by setting limits by enforcing certain rules of behavior, as is customary in behavioral practices (Arthur, 2001). With the parent's input and following an initial assessment, the following treatment goals were established: (1) improve sustained attention during tasks; (2) improve impulse control; (3) increase frequency, volume, and clarity of spontaneous verbal communication; and (4) improve emotion regulation. Only because it was customary for practicum placements, Marie later added a musical goal: (5) expand upon expressive abilities when playing keyboard.

Sessions occurred in a two-person treatment room with a portable keyboard and a one-way window that divided this small room from another room from which the parent and SUP could observe and sessions could be filmed for subsequent review. For each session, Marie listed on a whiteboard a finite number of music activities from which the client was instructed to choose, such as highly-structured improvisation (i.e., responding to cues to start and stop spontaneous play on therapist-designated instruments), songwriting (i.e., verbalizing words and phrases to "fill in the blank" as prompted), and eurhythmic listening (i.e., responding to songs with movement directives).

Although the client had a choice of which activity to do and in what order, Marie took a directive approach by insisting that Alex verbally request to start or end each activity, the aim being to encourage functional verbal communication. Key to evaluation of treatment efficacy was Marie's determination of whether the client's participation could be considered socially "relevant" or "positive," and whether the client showed progress toward the established behavioral goals related to attention, communication, and emotion. Though one goal was musical in nature (5), it was still addressed in an outcome-oriented manner. For instance, the SMT instructed Alex in playing a song requiring finger independence. The sole intended outcome was for Alex to expand expressive abilities on keyboard to include playing with finger independence, regardless of whether he expanded expressive abilities in other ways by originating rhythms and melodies, playing tone clusters with a fist, or knocking percussively on the instrument.

After a brief "honeymoon period" of a few sessions characterized by compliance with the SMT's requests, Alex began exhibiting behaviors that were counterproductive to targeted treatment aims and incompatible with Marie's expectations: screaming,

tantruming, and disobeying safety rules. These behaviors escalated over time. Post-session processing during Stage I helped us to see that Alex's progress toward the established treatment goals had essentially halted. In fact, Alex had begun to regress, engaging in infantile behaviors such as flopping on the floor and mouthing instruments. This called upon us to think differently about what needs Alex's actions might have been communicating. We speculated that the client's behaviors might have been a plea for increased opportunities for unrestrained self-expression and the release of pent-up physical energy. We also acknowledged that some of Alex's health-related needs had yet to be discovered, and, having an understanding of ITP, agreed that an experience orientation might afford this discovery and lead to a more focused and fruitful therapeutic process.

Experience Orientation: Treatment Stage II

At the start of Stage II (weeks 5-15), in shifting to an experience orientation, we intentionally committed to humanistic tenets, most notably: (a) recognition of the client as a whole, autonomous, and capable being; (b) support of the client's right to exercise agency to act (as opposed to being acted upon) toward self-actualization; (c) respect for the client's choices and preferences, however expressed; and (d) value and support of the client's creative expressions (Abrams, 2014).

Commensurate with the change, we also decided to adopt certain core values of a music-centered approach. We shifted the focus away from expectations of the client's achievement of nonmusical goals and set our sights instead on the development of Alex's personal connection with music (i.e., intramusical relationships) (Aigen, 2005b). After all, Alex's love of music and dancing was why the family sought this particular treatment modality. We began capitalizing on opportunities to join with Alex in sustained musical interactions (i.e., intermusical relationships). Although we remained open to the use of all four music therapy methods and their variations (Bruscia, 2014), free instrumental improvisation was placed front-and-center, as we saw this method-variation as an essential medium for the client's self-expression and self-discovery.

Revised primary treatment goals were musical in nature and broad in scope so as to allow for nuanced alterations should our perceptions of Alex's needs change once more: (1) increase musical connections with others; and (2) expand ability to self-express through music. A secondary goal to improve impulse control was added, but this stemmed from an effort to ensure the client's safety so that they might maximally engage in and benefit from treatment; we were less concerned about whether Alex's nonmusical behaviors generalized to external contexts as we had been during Stage I, because the value of therapy was now gauged more in terms of how Alex used music as a personal and interpersonal resource toward greater health and well-being. With the revised goals in mind, we moved Alex's sessions to a large dance studio with an acoustic upright piano, a mirrored wall, and immediate access to a storage area with numerous instruments. Alex was still expected to adhere to a few safety rules (e.g., no kicking or throwing, ask permission before leaving the room), and upon receiving three "strikes" for having violated these rules, the session was immediately ended, with the parent's full support.

We agreed that it was clinically indicated for Susan to be directly involved in music-making at times, rather than acting exclusively as a removed observer in the classroom. We anticipated that this would afford Alex opportunities to musically relate with yet another person, contribute to an overall more relaxed and natural environment (versus one in which the client may have felt like they were the subject of observation and filming by an "other"), and enable Marie to have the modeling and guidance she desired while adjusting to a new approach and the use of clinical techniques within improvisation (Bruscia, 1987). We set up "music stations" around the classroom, designated by carpet squares on the floor upon which instruments were grouped. A podium held a small

amplifier and microphone for vocalizing and an iPhone and speaker for music playback. Alex had complete freedom to move from station to station and engage in music-making as desired. At times, we encouraged Alex's solo expressions, but more often we joined these, sometimes moving to Alex's chosen station and sometimes making music from a separate station.

We assumed a mostly nondirective approach: Alex led, and we took our cues from them, except when initiating musical facilitation techniques of redirection to introduce musical change and novelty (Bruscia, 1987) and when enforcing safety rules, as noted above. No longer was treatment efficacy gauged by whether or not Alex made verbal requests, sang, played, and moved in intentional response to the therapist's cues. With a shift from observing *if* Alex made music to *how* they made music, the value of treatment was re-defined as moments when Alex evidenced (a) intermusical connections: integrating with the therapists' pulse or playing in a back-and-forth manner while improvising; (b) joy: smiling, laughing, and playing with an energetic quality; and (c) creativity: originating rhythmic and melodic figures in improvisation, devising new playing techniques, and, toward the end of treatment, spontaneously creating rules for an original musical game.

Method

Ethical Considerations

In keeping with research ethics, before formally launching into data selection and analysis, we petitioned for Institutional Review Board (IRB) permission. Because the spotlight of this research was on our lived experiences, and because our intent was to examine artifacts deriving from the sessions, there was no need to involve Alex as a research participant. As such, this study underwent expedited review by our university's IRB and was approved as "Fast-Track Classroom Research - Exempt Human Subjects."

Data

In all, we had access to four types of data: a videotape from the first music therapy session during Stage II, electronically-stored clinical documents, the SUP's session feedback sheets, and slides from a conference case presentation that we gave in the semester immediately following the practicum semester (Gardstrom & Reddy, 2019).

Stage II Videotape. This videotape held particular significance, as it captured the first session in which we applied the principles of an experience orientation (week 5). Early on in the investigation, we independently reviewed this tape, taking notes on anything that stood out to us as important. We shared these notes with one another for the purpose of refining the research focus and questions (Braun & Clarke, 2006). (We returned to this tape later, each conducting a more thorough inductive analysis according to the processes outlined in Table 1.) We had hoped that a series of videotapes from the semester would serve as the primary source of data. As we embarked on this study, however, our access to all tapes except this one had expired in accordance with clinic policies.

Clinical Documents. Practicum students are required to assemble and maintain a clinical portfolio in which they store all documents related to their work, such as assessments, treatment plans, session plans and evaluations, reflexive journals, and treatment summaries.

Session Feedback Sheets. These were the SUP's written comments, questions, suggestions, and evaluative statements related to the sequential unfolding of Stage I sessions.

Presentation Slides. We were selected to present Alex's case at a music therapy conference in the semester following the practicum semester. For this, we developed 30

slides with an overview of Alex's treatment and a list of clinical moments that we each found to have been imbued with meaning, inspired change, and marked notable turning points in treatment.

Apart from the videotape, each of us analyzed different types of data, selecting the particular data sets and portions thereof that we believed would best help us to unearth our individual, subjective experiences and excavate insights related to our shift in orientation.

SMT's Data Selection

In addition to the videotape from Stage II, I analyzed reflexive journals, session plans, and session evaluations – all of which spanned both stages. I did not analyze conference presentation slides because, in analyzing the aforementioned documents, I had reached data saturation, that is, the point at which no new codes were unearthed.

I engaged in reflexive journaling after each session, writing about my feelings about the client, feelings about myself, and connections to music therapy theory. Reviewing journal entries provided me with a valuable window into my emotional state immediately following sessions, as well as my interpretations of the work as I underwent a drastic transformation in perspective.

Session plans in Stage I included a list of six to eight music activities with detailed procedural steps for each activity and a description of the goal areas addressed. In Stage II, as treatment was no longer outcome-oriented, plans consisted of a paragraph detailing optional music experiences, instruments, and techniques. Analyzing the session plans proved beneficial in highlighting how I viewed goal setting and the role of music in each stage.

In Stage I session evaluations, I wrote a few sentences describing how the client had behaved in each pre-planned activity. In Stage II, I listed the various instruments played by the client alongside summaries of how they had expressed and connected within the music. I chose to review session evaluations so as to learn how my understanding of the client's actions and treatment efficacy evolved as we moved from Stage I to Stage II

To determine data size, I first analyzed documents from the last session of Stage I and the first session of Stage II. I then analyzed documents pertaining to the sessions immediately before and after those two sessions, continuing to move away from the shift in both directions. This enabled me to reach data saturation and develop what I believed to be robust codes and themes related to the phenomenon of interest. Of 24 total sessions, I analyzed documents from a total of 10 sessions, five on either side of the shift.

SUP's Data Selection

In addition to the videotape, I analyzed the data sets in which my subjective voice was most appreciably represented: session feedback sheets from Stage I, Marie's journals from Stages I and II, and the presentation slides. I disregarded data in which my entries were more didactic and less subjective in tone (e.g., assessment and treatment plan).

I wrote the session feedback sheets while positioned in the observation room. I chose to analyze these sheets because they carried the potential for gleaning insight into my observations of and subjective responses to an outcome-oriented way of working with this particular client and the events that led up to the shift.

The journals included Marie's reflections as well as my narrative responses to these. I reviewed all eight of Marie's journal entries from Stage I and the first eight entries from Stage II, starting with the first and working forward in time, continuing beyond the shift until I reached data saturation. In the end, I analyzed more journal entries than Marie analyzed, mainly because my contributions to the journals – comments based on only certain of Marie's total reflections – amounted to less narrative data overall.

The slides represented a different level of data in that they contained summative and

interpretive statements based on Marie's and my processing of Alex's overall treatment process. I analyzed only those slides that both related directly to the shift and contained content unlike that represented in other data sets.

Data Analysis

For data analysis, we turned to Braun and Clarke's (2018) method of Reflexive Thematic Analysis (TA), a systematic yet flexible approach to developing patterns of meaning from qualitative data sets. We engaged in independent inductive analysis of all data sets with the plan to compare and contrast our individual themes and combine our findings into one report. Reflexive TA seemed particularly fitting for our project in that it can (a) be used for inductive or deductive analysis; (b) both reflect the explicit content of the data (semantic meanings) and report underlying assumptions and interpretations (latent meanings); and (c) be used across heterogeneous data sets. In TA, the researcher moves through the basic phases of taking notes, generating codes and initial themes, refining themes, and writing the detailed report.

Reflexive TA is more a group of methods rather than a hard-and fast-protocol for analysis; indeed, as shown in Table 1, we extended Braun and Clarke's general 6-step sequence of action steps to account for collaborative analytic processes and changes made to the report in response to peer review.

Table 1. Analytic Processes.

Step	SMT	SUP
1	Reviewed the data, highlighted phrases and sentences that seemed salient or piqued curiosity; jotted down initial notes.	Reviewed all data to re-familiarize; took notes to inform the coding process.
2	Re-visited the data; made a long list of potential codes before attaching codes to the raw data using an online commenting function.	Generated initial codes for each item in the set according to semantic content, using color-coding as befit the situation (i.e., for session feedback sheets).
3	Grouped all data by codes in a table; edited codes as necessary.	Collated the raw data according to initial codes; adjusted codes as necessary.
4	Grouped codes into themes.	Organized refined codes into distinctive and recurring themes, generating thematic labels to depict meaning; reviewed and adjusted these thematic groupings and altered labels to better fit the content.
5	Created thematic descriptions.	Created thematic descriptions.
6	Conferred verbally with one another to identify and notate overlapping themes, as well as discard those found extraneous to the research questions.	
7	Co-constructed the initial report, including an appendix listing both independent and overlapping themes.	
8	Examined and discussed peer reviewer feedback; amended research questions; co-constructed the revised report.	

Presentation of Findings and Discussion

As we address each of the three guiding questions below, we first list pertinent themes and subthemes followed by descriptions of these. (See Appendix for a complete listing.) To answer the first research question, we relied specifically on findings from data sets pertaining to treatment Stage I. For remaining questions, we drew upon all data sets as relevant.

Wherever included in the balance of this report, our individual reflections on the findings appear in italics following the author's initials. We view this as valuable contextual information as we aim to narrate a coherent story of our understandings and subjective experiences of the shift (Conway, 1996; Fivush & Graci, 2017).

Note: The sequence of presentation of findings for each question is not indicative of a hierarchy of importance.

Q1. What factors and circumstances may have precipitated (i.e., activated) the shift in orientation?

a. The SMT's authentic and timely disclosures about negative countertransference reactions.

Theme: **Countertransference** - *Expressing emotions that arose from interactions with the client and/or parent but that were not always understood on a conscious level until after self-reflection. (SMT)*

TA of Stage I journals brought to light the theme of *Countertransference,*[6] with incidents of negative emotional countertransference implicated in the decision to shift orientations.

As expected, many different emotions were triggered by and reflected in the SMT's work. The so-called "negative" emotions that she began to experience during Stage I were cause for concern and re-evaluation of orientation "goodness of fit." These emotions manifested in body language and tone of voice during sessions and post-session debriefings and were reflected in her journal entries. In particular, anger and frustration rose to the surface as Alex moved beyond the honeymoon period and began exhibiting what could be characterized as noncompliant behaviors. After one particularly challenging outcome-oriented session, Marie journaled: *Alex's inconsistency with listening and following directions can make me feel angry towards them*. Her emotions led to a brief instance of unintentional, excessive force when disciplining Alex just two sessions before the shift.

Marie: I often directed such emotions [of anger and frustration] at myself or Alex, unconsciously seeking to blame someone for the challenges I experienced in therapy.

Analysis of Stage I journals also revealed that the SMT had been owning a fair amount of responsibility for the client's acting out, which led to discouragement and a sense of defeat: *I never felt truly effective in my attempts to 'get to them'… in a way, I consider Alex's behavior to be a reflection of my inability to bring out the best in them.* Honorably, she believed that she must work harder in order to promote desired change and demonstrate clinical competence. Vasco and Dryden (1994) speak to Marie's lived experience in their observation that "When novices are faced with situations of therapeutic impasse or failure, they tend to blame these on their own inadequacies rather than on the limitations of the theoretical model they are using" (Changes in initial theoretical orientation section, para 1).

b. The SUP's (undisclosed) negative countertransference reactions.

Theme: **Dissonance/Conflict** - *A specific moment that sets in motion or is characterized by cognitive and/or emotional dissonance and results in the lived experience of imbalance or distress. (SUP)*

Theme: **The Centrality of Music** - *My calling attention to and asserting my perception of the value of music as a therapeutic agent and process. In some circumstances, I advance music as preeminent to other dynamic forces that may have been operative during the session or specific music activity. (SUP)*

Susan retrospectively recognized the full extent of her own emotional and physical countertransference reactions just prior to the shift, identifying the theme of *Dissonance/Conflict* through analysis of the presentation slides, which described two pivotal moments from Stage I:

Susan: The content of two slides was particularly revelatory: (a) I felt as though I was witnessing "interactions on a battlefield" as I watched Marie and Alex from the observation room; and (b) Marie's harsh disciplining of the client created great discomfort and was a signal that something was amiss. I experienced emotional dissonance as I witnessed interactions between the client and SMT. In retrospect, I was able to see that it was the combination of these two incidents that prompted me to reflect on a possible misfit and subsequently begin a conversation with Marie about making a shift in clinical orientation.

Indeed, Vasco and Dryden (1994) underscore that such emotional dissonance can function as "the motivational 'fuel' needed to promote change" (Dissonance and theoretical development section, para 3). Also relevant here are the SUP's recollections of physical signs of countertransference during Stage I, activated during review and analysis of feedback sheets:

Susan: Although I did not document this in any way during the semester, on at least two occasions during this time period, I recall feeling bored as I observed sessions, craving more musical activity. I also remember feeling physically and mentally worn-out at the end of multiple sessions during this stage. Granted, fatigue could have been related to the fact that sessions occurred in the late afternoon or that the observation room was darkened.

It is within the realm of possibility that the SUP was experiencing a concordant supervisory countertransference - that is, identifying and empathizing with Marie's feelings about her work with the client (Eyre, 2019) which, just before the shift, seemed to be characterized by frustration that depleted her energy and challenged her attempts to remain positive. Perhaps as a result of the decision to keep these countertransferential feelings to herself, the SUP was unaware during the semester of the significance of these reactions vis à vis the decision to shift orientations.

One's orientation to clinical practice ultimately may be viewed as a fundamental manifestation of countertransference (Bruscia, 1998). In this self-study, the SUP's bias toward working from an experience orientation with a strong emphasis on musical intersubjectivity and improvisational methods is indicative of this. This proclivity was made manifest in multiple Stage I data sets, leading to the theme of *The Centrality of* Music, and supported by comments such as: *Ignore some of this [acting out] and move on? Get to the music somehow. That's a general principle, it seems* and *[In my humble opinion], there is always therapeutic value in BEING IN MEANINGFUL MUSIC EXPERIENCES with another*.

Q2. What factors and circumstances may have enabled (i.e., supported) the shift in orientation?

To be sure, on a pragmatic level, the availability of a more accommodating treatment space made the shift achievable. The many benefits of access to a large, open classroom that allowed for set-up of the music stations and opportunities for unencumbered movement and dance (in front of a mirror, no less) were not lost on us. We viewed the shift to the new space as paralleling the shift to a less restrictive way of thinking about and practicing music therapy in that both allowed for an expansion of the container within which the client could explore and express self.

Systematic data analysis revealed other enabling factors.

a. The SMT's critical thinking about the client's actions and reactions.

Theme: **Critical Thinking About Treatment Events and Planning** - *Looking deeply into events of treatment to determine what occurred, why it occurred, and what the best steps might be moving forward with all the available information.*

Subthemes: **Reflection on the Client** - *Thinking deeply about what was going on for the client, including ways in which my own challenges and triumphs in therapy could inform my understanding of theirs;* **SMT Self-Reflection** - *Thinking deeply about my own experiences, understandings, and beliefs related to the work and identifying areas of potential growth. (SMT)*

Analysis of data from Stage I confirmed the SMT's consistent commitment to thorough consideration of the client's musical and interpersonal actions and interactions, what these might mean, and how they might inform the ongoing treatment process. She took thorough notes after each session, interpreting what needs the client may have been attempting to communicate. For instance, in one reflexive journal, she pondered: *As Alex shook the ocean drum violently, I wondered what they were trying to tell me. Was there turbulence in their friendships about which they need to express frustration? Did they simply enjoy the sensory feedback that the crashing sounds of the ocean drum provided?* The SMT chronicled stated and inferred preferences of the client, such as Alex's apparent interest in the Spanish language, their gravitation toward use of the microphone and fascination with pre-programmed beats on the electronic keyboard. She applied all of this information to future session planning. With this concerted focus on observing, interpreting, and attempting to address what the client required from music therapy at any given point in time (versus rigid adherence to her own session agenda), the SMT was already evincing a fundamental tenet of ITP and was thus well-positioned to embrace any shift in orientation to better meet the client's health-related needs.

b. The SMT's musical openness to more free and flexible play.

Theme: **Musical Openness** - *Assuming a willingness to fully engage in the music-making, freely accepting whatever happens, and flexing accordingly. (SMT)*

The SMT's preference for a less pre-planned and rigid style of music-making was depicted in excerpts within her documentation, leading to the theme *Musical Openness*. She reflected on this in her journal after the first experience-oriented session: *In my life, I like to always know what I am doing and be organized. However, there is something different about music that allows me to break out of the shell of structure, and I thrive off of it. For instance, I can never seem to play all of the exact notes on the page when I am playing a pre-composed piece on piano.*

I find it way more fulfilling to take what is written and incorporate it into my own improvised patterns and interpretations… I think my appreciation of flexibility while playing music translates into an appreciation for the flexibility of working in an experience-oriented approach.

Fortunately, along with her confidence and comfort with an improvisational performance style, Marie possessed certain knowledge and skills required to engage the client in therapeutically-focused improvisation. In the prior academic year, she had completed a course in clinical improvisation in which she was exposed to music-based clinical techniques commonly employed during dyadic and group improvisation (Bruscia, 1987) (imitation, incorporation, reflection, rhythmic grounding, making spaces, introducing change, etc.), and she had already demonstrated during Stage I her ability to recognize and respond profitably to the client's improvised sounds and music.

Concordant with her openness and ability to flex in music-making, the SMT was open to changing the very way she thought about music. She reflected: *Although I had never done anything like this before, I don't recall feeling highly skeptical; rather, I would say I was open to making changes and intrigued by the possibilities a shift might afford. I was well aware that what I was currently doing wasn't working, and I was desperate to try anything new that might help alleviate my frustrations and allow me to connect with Alex.* The SMT's negative emotions during Stage I, her critical thinking skills, and her musical capabilities and confidence all contributed to her ability to be receptive to change, which was essential for the shift in practice orientations.

c. The SUP's trust in the SMT's ability to respond in musically productive and meaningful ways.

Theme: **Trusting the SMT's Clinical Musicianship** - *My sense that I can depend on the SMT's musical decisions and output, emanating from her (1) timely and skillful use of musical facilitation techniques, and (2) contributions to/embellishments of the ongoing musical aesthetic. (SUP)*

From previous classroom experience, the SUP knew Marie's functional musical skills to be strong and recognized her musical passions. And, in fact, one of the SUP's themes derived from TA was *Trusting the SMT's Clinical Musicianship*, making it possible to envision the SMT working effectively in a more flexible and fluid manner. Videotape analysis further substantiated Susan's confidence in the Marie's musical competence, with statements such as: *[Marie] is poised for musical action and knows how to join the music-making in meaningful ways. [Marie] harmonizes on "we all have pain… sorrow"; she is "right there" and knows what to do musically.*

d. The SMT's prior exposure to ITP and various theoretical orientations.

Theme: **Orientation Influence** - *Writing with the language, thought processes, and beliefs that are unique to certain practice orientations.*

Subthemes: **Behaviorism Influence** - *Writing in a way that reveals the influence of behaviorism, including a focus on nonmusical goals (i.e., verbal communication skills), behavioral techniques, and targeting and changing specific behaviors;* **Humanism Influence** - *Writing in a way that reveals the influence of humanism, including a focus on supporting the client's ability to enact change and the importance of an authentic, respectful, collaborative client-therapist relationship;* **Music-Centered Influence** - *Writing in a way that reveals the influence of music-centered theory, including a focus on purely musical goals, the unique affordances of improvisation, and the detriments of unnecessary constraints on musicing. (SMT)*

The music therapy curriculum at our university includes a course in which students are exposed to a handful of theories that guide music therapy practice and the philosophical tenets that undergird them. This exploration of various perspectives on the nature of health, music, and therapy, as well as the roles and responsibilities of client and therapist, can be aimed at helping students to begin the process of determining theoretical "goodness of fit" for a given client, as well as for themselves as practitioners. Having learned about ITP and the theoretical orientations aligned with the two ITP practice orientations, the SMT was well-postured to shed "dichotomous, one-way thinking" and see differences in clinical approaches not as threats but as viable clinical alternatives (Bruscia, 2014, p. 251).

Marie: *Learning about behaviorism helped me to better understand my actions during Stage I, and exposure to humanism (Abrams, 2014) and music-centered music therapy (Aigen, 2005b) gave me both a critical framework of understanding and the confidence to act differently during Stage II.*

This conceptual understanding also supported the SMT's data analysis processes. With a grasp of the tenets and vocabulary unique to each of the three aforementioned orientations, she was readily able to identify evidence of their representation in the data.

Q3. What individual and collective insights might we gain about our lived experience of the shift relative to integral thinking and practice?

a. Ongoing personal and professional self-reflexivity is paramount to treatment integrity.

Theme: **Critical Thinking About Treatment Events and Planning** *(see thematic descriptions above) (SMT)*

Subtheme: **SMT Self-Reflection** *(see thematic descriptions above) (SMT)*

Theme: **Efforts to Stimulate SMT Reflexivity** - *Feedback designed to encourage the SMT's consideration of certain events that, as a somewhat detached observer, I determined had clinical significance. Underlying these efforts to support reflexive thinking is my assumption that thoughtful consideration of certain phenomena could positively impact the SMT's knowledge, skills, and therapeutic attitudes, thereby contributing to more effective, meaningful, and satisfying clinical practice during the semester and beyond. (SUP)*

Analysis pointed unequivocally to the importance of self-reflection, especially for us in bringing to our awareness incidents of negative countertransference that may impact treatment decisions and actions. Relevant self-reflexive strategies were self-observation/inquiry (journaling) and supervisory dialogue.

For Marie, self-reflexive measures prevented her anger and frustration from spiraling into countertransference reactions that may have negatively affected the therapeutic relationship in a multiplicity of ways, including explosive emotional reactions, harmful decision-making, constricting routines or ruts, and ultimate burnout (Bruscia, 1998c). In her reflexive journals, Marie frequently examined her challenges and what she was or ought to be doing about them. Not surprisingly, *SMT Self-Reflection* emerged as a noteworthy subtheme.

Self-reflexivity also helped Marie to process thoughts and feelings that, had they been left unexpressed, ultimately might have caused her to question her dedication and worth as a therapist. Fortunately, she was able to discern the true source of her feelings of defeat: an ill-fitting and, consequently, ineffective theoretical framework.

Marie: As I began working in a way that best met Alex's needs and allowed me to harness my

own potential as a therapist, I saw how the struggles Alex and I had faced during Stage I were a reflection of an ineffective way of working and not a reflection of our worth, abilities, or intentions. This is why continual self-reflection and exploration of multiple orientations is key… I believe it was particularly essential that I remained attuned to and processed my feelings of intense discouragement in Stage I in order to even be in a position to embrace the shift to Stage II. Perhaps we need to acknowledge and then release ourselves from fears of inadequacy in order to see the potential for success with a different approach.

If, in fact, Susan's unacknowledged countertransference was somehow implicated in suggesting a shift in orientation, this was only brought to her full awareness during the analytic process. She directed a fair amount of her supervisory efforts during both stages toward encouraging Marie's reflexivity, leading to the thematic label of *Efforts to Stimulate SMT Reflexivity*. This was evidenced by questions posed in the feedback sheets and journals, such as: *Would it be helpful to discuss this in lab with your peers? Food for thought: What is at the root of your anger? Considering parallel processes once again, I wonder if you've given thought to how you might work through your own feelings upon termination with A?* That being said, Susan certainly could have devoted more energy to consideration and articulation of her own subjective responses. Retrospective study enabled Susan to see once again the critical importance of taking full advantage of available self-reflective strategies when in a supervisory role:

Susan: *I began the semester with the honorable intention of consistently journaling about my experience as a way to inform the supervisory endeavor, but this strategy fell by the wayside as the semester unfolded and my overall workload increased. As a result, the quality of my supervision may have been compromised.*

It is unfortunate that Marie and Susan did not anticipate during the practicum semester that they would engage in a retrospective self-study, as a set of reflexive journals from the SUP's perspective could have been a valuable addition to the other data sets, potentially revealing additional insights about the shift.

b. Collective experiences of joy likely figured prominently into the decision to sustain an experience orientation throughout the semester.

Theme: **Therapist Success and Enjoyment** - *Remarking upon successful moments of therapeutic interaction initiated by the therapist(s) which contributed to overall joy and connection in sessions. (SMT)*

Theme: **Pleasure and Delight** - *Feelings of pleasure I derived from witnessing clinical events and actions*.

Subthemes: **Client Accomplishment** - *Feelings of pleasure from witnessing the client's musical accomplishment/mastery and/or the client's initiation of an interpersonal or intermusical connection with the SMT;* **SMT Accomplishment** - *Feelings of pleasure from witnessing the SMT's clinical musical accomplishment/mastery and/or actions of the SMT that are effectual in bringing about an interpersonal or intermusical connection with the client. (SUP)*

Both the SMT and the SUP found myriad references to their own experiences of joy, and this sentiment derived from multiple sources.

For the SMT, the presence of joy was revealed across multiple data sets, leading to the theme *Therapist Success and Enjoyment*. She wrote about how fun it was to harmonize and sing and commented repeatedly on the joyful sense of musical freedom during improvisational episodes. Of note here is that, while most references to joy appeared in Stage II data sets (videotape and journals), there were in fact references to joy during Stage

I. For instance, in Stage I, Marie documented: *Alex's amount of eye contact with the SMT during the [joint drumming] experience. They remained facing her, and their bright affect suggested enjoyment of the intermusical interaction.* Noteworthy about expressions from both stages is that joy emanated from collaborative music-making; that is, Marie experienced joy while singing and playing with others.

Another element of the SMT's experience of joy was the sense of satisfaction she derived from observing what she interpreted as joyful moments for the client. For example, in Stage II she documented: *I am starting to have a shift in my perspective as I consider how my own sense of freedom and joy in the music while improvising might be shared by Alex as they engage in the music without previous constraints.*

Through analysis, Marie identified experiencing joy in all forms as a vital motivating factor for her. Her observations align with those of Wheeler (1999), who also analyzed clinical artifacts and noted how experiencing pleasure or delight was important to her as a therapist and often resulted from connecting with clients and witnessing their own enjoyment.

As Susan coded the data and generated themes, her experiences of *Pleasure and Delight* came to the fore. Through analysis of the videotape, it became evident how much more attentive and alive she felt after the shift and how much more positively she viewed all clinical relationships: her relationship with the client and with Marie, Marie's relationship with the client, and Marie's relationship with music. While it would be inauthentic to deny that she experienced joy from her own music-making during Stage II, analysis pointed primarily to her having taken pleasure in her role as a witness to the "successes" of the SMT and client.

Susan: The intensity of delight that I re-experienced as I watched the videotape and witnessed the client's and SMT's small yet meaningful "triumphs" highlighted the central position that these various relationships held, not only in terms of clinical efficacy, but also in terms of my satisfaction. It also brought into sharper focus just how dysphoric I had been during Stage I.

It is important here to revisit the fact that, in committing to an experience orientation, we re-defined the value of therapy to include moments when the client evidenced joy ("smiling, laughing, and playing with an energetic quality"). That being said, we must acknowledge that our own lived experience of pleasure and motivational joy during Stage II – once again, our emotional countertransference – undoubtedly figured into our decision to sustain an experience orientation for the duration of the semester. In retrospect, it is neither possible to determine whether our ongoing evaluation of treatment efficacy during Stage II was conducted with an appropriate balance of our own subjective experiences of joy and our perceptions and interpretations of the clinical benefits of joy for the client. Likewise, we will never know if we would have made another shift in orientation should our own experiences of Stage II treatment have been any less personally pleasurable.

c. At times, both the SMT and SUP acted incompatibly with the established orientation.

Theme: **Orientation Influence** (*see thematic description above) (SMT)*

Subthemes: **Behaviorism Influence; Humanism Influence; Music-Centered Influence** *(see thematic descriptions above) (SMT)*

Theme: **Music as a Means** - *The therapist's planful or spontaneous introduction of any musical form or activity whose function is (a) as a stimulus to evoke a desired nonmusical response in the client, (b) to establish a condition or context within which the client can demonstrate a desired nonmusical response, and (c) to reinforce a desired nonmusical response. (SUP)*

Theme: **The Centrality of Music** (*see thematic description above) (SUP)*

Although the practice orientations adopted during each stage were consciously and collaboratively determined, neither the SMT nor the SUP had actually exemplified as "pure" a form of the orientations as they had recalled prior to engaging in TA. These inconsistencies became obvious in references to theoretical principles that did not seem to belong in the stages where they appeared.

During analysis of Stage I data sets, the SMT was surprised to learn that she had articulated her desire for a therapeutic relationship that, in our view, is more characteristic of humanistic than behavioral practices, writing self-directives in her session plans such as: *set example for what the nature of the therapist-client relationship will be (positive, non-hierarchical, collaborative)* (*Humanism Influence*). A *Music-Centered Influence* was noted in Stage I statements about the intentional use of improvisation toward the client's musical self-expression and connection with others: *encourage free play*; *utilize techniques to foster intermusical connection*. Marie's use of musical language during Stage I was seen in her references to dynamics, pitch, texture, rhythm, and other musical elements of the client's music-making.

Although the SUP was certain that her written feedback during Stage I would have clearly and consistently evidenced the behavioral orientation adopted during this stage, she found instead just a single comment in the feedback sheets relating to the use of music as a tool for achieving a predetermined, nonmusical objective: *What might you do to promote a verbal response? Mom is working on this at home, too* (*Music as a Means*). Many more excerpts and themes within this and other Stage I data sets referenced concepts that are considered by some music therapists as irrelevant to the practice of behavioral music therapy, yet paramount to an experience orientation and music-centered approach. Most specifically, the *Centrality of Music* was apparent in statements such as: *I appreciate what it takes to quell your words and work exclusively with sound/music. This seemed to be what Alex needed at that moment…Sometimes all you can do is continue to reach out to Alex with the music.…attempt to make those INTERMUSICAL connections that can bypass their INTERPERSONAL anxieties and deficits.*

The principle in interpretivist research that frequency of response does not determine or equate with value is generally taken to mean that more responses of a certain kind do not necessarily signify greater import. In actuality, the reverse may have held true in this case. The paucity of comments related to the function of music as means to a nonmusical end during Stage I spurred Susan to go beyond the obvious and speculate about deeper, latent meanings. Examining this discrepancy led to new insights about factors and motives that may have led her to catalyze the shift.

One identified factor was intuition surrounding the SMT's inclinations. Although the SMT had not explicitly expressed a desire to work in a more flexible and music-centered way, the SUP may have interpreted certain journal excerpts as "evidence" of this inclination or, at the least, of some ambivalence about enacting a behavioral approach. For instance, in the SMT's third journal entry, she penned: *Part of me wants to fully support [the client's] exploration, believing that curiosity and creativity are essential to childhood play and shouldn't be snuffed out. However, the other part of me wants to be more stern with them.* More specific to music, she wrote in another Stage I journal entry: *I think it will also be important to look for ways in which I can share emotional experiences with [Alex] through music. Then, music can contain and enhance our interactions,* and *I really appreciate our time improvising together and the connections we have been able to form.*

In a related way, in carrying out a behavioral approach (which manifested as de-emphasizing musical processes and relationships), the SUP may have perceived Marie as not accessing her full potential as a music therapist. As such, the SUP may have been unconsciously renouncing a behavioral approach based on her gut sense that Marie's musical skills and creative energies were somehow going to waste, or that she would quickly become disenchanted with the work. In other words, the SUP may have intuited

an orientation misfit.

An equally plausible interpretation of the fact that Susan never once during Stage I mentioned the role of music as a stimulus or reward as would be expected in an outcome orientation (Bruscia, 2011) is that she was exposing her unchecked bias and rigidity, harkening once again to the countertransference mentioned in response to the first research question. As noted in the positionality statement above, although trained in behavioral approaches to music therapy, this was not the SUP's preferred way of working:

Susan: Perhaps I had not earnestly committed to implementing an outcome orientation and behavioral approach from the very start? While I value and endorse Bruscia's (2011, 2014) model of ITP in music therapy, I am most comfortable with and view myself as most clinically effective when working within an experience orientation.

And, when a therapist seeks to fulfill their own musical needs during their work with a client, countertransference can again be presumed to be functioning (Bruscia, 1998c):

Susan: I may have been expressing an unconscious desire to assume a more active role in the treatment process—hoping perhaps that I might have an opportunity to engage in active music-making (rather than observe the process) and thus fill a creative void that I often experience when I am not practicing as a clinician, performing, or actively composing.

TA of Stage II data sets revealed additional orientation inconsistencies in the SMT's reference to behavioral thinking with comments about decreasing rule-breaking behavior and increasing "positive" and "relevant" behavior. Not surprisingly, in the context of the above discussion related to orientation bias, the SUP's analysis of data sets from Stage II revealed consistent faithfulness to an experience orientation.

Implications of Findings and Recommendation

Countertransference

To be candid, we were both surprised by the finding that our negative emotional countertransference during Stage I, both disclosed and undisclosed incidences, served as a key activator for the shift in orientation. Whether processed aloud at the time or not, these incidences ultimately pointed to clinically relevant phenomena.

In the SMT's case, the judicious disclosure of negative emotions (intrapersonal experience) led to exploration of the relational (interpersonal and intermusical) dynamics of the session. Her strong, unwanted emotions and their outward manifestations were a signal that something was amiss and catalyzed dialogue about the possibility that the client's behavior was a plea for a different kind of therapeutic experience.

We recommend that:

- students and clinical supervisors commit to strategies designed to unearth and process countertransference, particularly as pertains to decisions surrounding practice orientation.

During Stage I, the SUP was somewhat aware of, but chose not to disclose, negative countertransference, occurrences of which may have been implicated in her recommenddation to shift orientations. To be sure, the faculty supervisor can and does play an important role in guiding decisions about orientation. In fact, findings from early psychotherapy studies (Beutler & McNabb, 1981; Sundland, 1977) concur that trainees tend to take on the orientations of their assigned clinical supervisors. The extent to which this phenomenon occurs in music therapy is unknown due to a paucity of research on the topic. One might nonetheless surmise that the supervisor wittingly or unwittingly exerts some influence on the clinical decisions, values, and approach of the practicum student. Each supervisory relationship and context is unique in terms of whether and to what

degree a supervisor might consciously strive to influence the supervisee's thinking and practice. Certainly, reflexivity sits at the center of this ethical decision. Turry (2019) cautions:

> It can be important for supervisors to become aware of their own personal motivations and attitudes and how they affect the supervisory process. When a supervisor is not conscious of these attitudes or prejudices, it can be detrimental to the supervisory relationship and process. (p. 342)

In the United States, certified music therapists are expected to "seek and participate in supervision on a regular basis" (AMTA, 2015). While not explicitly stated, it can be inferred that music therapy supervisors in academic settings are held to this same standard, whether or not they are practicing clinically apart from their supervisory duties. Although Susan was confident in the decision to make a shift in orientation, it could have been helpful to discuss the rationale for and details of this change in professional or peer supervision.

We recommend that:

- clinical supervisors engage in regular self-reflexive strategies and, as available and affordable, take advantage of peer consultation and professional supervision to identify and work through issues pertaining to clinical practice and supervisory roles, relationships, and dilemmas.

Exposure to Orientations

Awareness of one's beliefs about the key components of music therapy relationships and processes is critical: Music therapists are obligated to make sound decisions and act in the best interest of the client; additionally, they must be able to justify these clinical decisions and actions by tethering them to established and/or emerging theoretical perspectives, both as they are called upon to self-advocate and as they have opportunities to launch new positions. Without at least a basic understanding of ITP, music therapists in training and professional practitioners may remain steadfast in their initial orientation regardless of how the client presents, simply out of a lack of awareness. A sudden move from an outcome to an experience orientation could be viewed as not only daunting but also as confusing, nonsensical, and even irresponsible or contraindicated without awareness of a way of thinking and practicing based on flexibility and fluidity in service to client needs. Familiarity with principles associated with ITP makes it possible for therapists to "consider various options for being responsive to the client" (Bruscia, 2014, p. 259). Moreover, the ability to flex, to implement ITP, is predicated in large measure on one's ability to articulate the tenets of varying borrowed and indigenous theoretical orientations and their influence on practice (Bruscia, 2011, 2014).

Music therapy practicum and internship supervisors are also implicated here. Not all therapists who supervise practica placements have a working knowledge of an integral approach, perhaps having trained in programs where a single theoretical orientation was advanced (Choi, 2008). As such, a supervisor may not know to nudge a supervisee toward a conscious shift in practice orientation, even if such a shift were indicated.

We recommend that:

- students be introduced to integral thinking and practice, and intentionally dialogue about practice orientations throughout the practicum sequence.
- students be exposed to fundamental principles of various theories that undergird their practice, as also recommended by Reichert (2018) and Weiss et al. (2014).
- clinical supervisors gain exposure to integral thinking and practice.

Clinical Musicianship

An understanding of ITP is necessary but perhaps not sufficient. That is to say, just because someone understands and accepts the validity and viability of multiple ways of working does not necessarily mean that they are willing to enact integral thinking and practice. Let's face it, changing one's orientation can be a "difficult and scary choice" (Strope, 2019, p. 26). In fact, there is evidence that even seasoned clinicians are reticent to shift their single, preferred orientation, even when it may be in the client's or their best interest to do so. Strupp (1981) writes about the "rigidity of adherence to one's theoretical orientation" that comes from extreme congruence between the therapist's personal beliefs and that theoretical orientation. Strupp's observation bears out in Delshadi's (1998) survey of psychologists and psychology students, who reported "being less open to using methods of other orientations than novice therapists" (p. iii).

Resistance to working in an integral fashion could be related to the music therapist's actual or self-perceived musical competence. We found that the SMT's overall strong clinical musicianship and the SUP's trust in this strength was a critical support to the orientation shift. A less competent musician may not have embraced and enacted the shift so readily.

In Alex's case, demonstrated interests and presumed needs indicated that improvisation be regularly offered as an option. However, an experience orientation, by definition, calls upon the therapist to be ready to engage the client in any and all four methods of music therapy (Bruscia, 2014) in order to address the priority health needs that are revealed in the course of the session. This means that the therapist must be competent in the design and implementation not only of clinical music improvisation, but also of receptive experiences, re-creation and performance of pre-composed musical forms, and composition.

We recommend that:

- education and training programs adopt a methods-based approach to pedagogy in order to thoroughly prepare students to make orientation shifts in accordance with client need, as also recommended by Gardstrom et al. (2021) and Gardstrom and Hiller (2022).

Incompatibilities

A surprising finding was that our recollections of the ways in which we had worked did not always align with the orientations we claimed to have adopted. Marie realized she was more music-centered and humanistic during Stage I and more behaviorally-oriented during Stage II than she had previously thought. Susan similarly realized she was more experience-oriented and music-centered during Stage I than she had thought. In trying to make sense of this unanticipated phenomenon, we turned to Bruscia's (2014) commentary on the fluidity that characterizes ITP. He writes:

> In common parlance, an integral practitioner is flexible rather than fixed and open-minded rather than single-minded, but in that flexibility it is possible to be fixed sometimes, and in that open-mindedness it is possible to be single-minded sometimes. Integral thinking and working is the opposite of one-way thinking and working, but includes them. (p. 260)

What we take from this is that, in contrast to what we previously may have thought (or perhaps hoped for), there likely is no "pure" form of either an outcome or experience orientation. Put another way, some permeability of attributes should be expected in daily practice. To take this a step further, although the present study was designed to neither confirm nor dispute this finding, such fluidity of ideology and action could even be construed as a sign that one is thinking and practicing in an integral fashion.

Reflexivity

The importance of critical thinking – one's ability to comprehend and synthesize, or decipher, their observations in order to form a judgment and act accordingly – was highlighted throughout this study. And, as evidenced by the thematic descriptions (see above), the SMT's critical thinking was inextricably intertwined with – in actuality, entirely dependent upon – the SMT's reflexive practices.

To be sure, analysis revealed the importance of conscious (intentional), immediate, and ongoing reflection on the *client* – their general actions, verbal communications, and music-making and what needs and preferences these might suggest. This kind of careful, consistent attention to the "other" is absolutely essential to ITP, as Bruscia (2014) outlines:

> An integral therapist…thinks the way the client needs him to think, not the way of thinking the therapist has already adopted; similarly, an integral therapist works the way the client needs him to work, not the way the therapist has already decided to work. (p. 260)

And yet, one's observations and judgments of a clinical context and situation can never be entirely objective; they are saturated with subjectivity, which is why reflection on the *self* is also imperative to ITP. Self-reflexive strategies can enable the therapist to distinguish what the client may prefer or need from what the therapist themself may inwardly prefer or need.

Considering our findings as a whole, we notice this common thread of reflexivity, conceptualized here as "the therapist's efforts to continually bring into awareness, evaluate, and when necessary, modify one's work with a client – before, during, and after each session, as well as at various stages of the therapy process" (Bruscia, 2014, p. 54). Bruscia (2014) makes it abundantly clear in his explication and description of ITP that reflexivity serves as a kind of gateway, enabling access to ongoing awareness of and shifts in locus (where the therapist is "coming from"), focus (the aspect of client and treatment requiring the therapist's attention), and perspective (macro and micro "frames").

Reflexivity from a micro perspective involves attending to "what transpires moment to moment during each session, such as a particular music experience or any of its segments, a specific client-therapist interaction, or each procedural phase or step of a model or method" (Bruscia, 2014, p. 257). Reflexivity at a macro level is concerned with "big picture" factors and decisions, such as what music therapy methods, models, and orientations are employed. In Alex's case, our reflections on micro-level issues, such as the participants' responses to specific method-variations and interactions, led to macro-level understandings and decisions, such as the recognition of affordances of free improvisation for the client and the ultimate movement from outcome- to experience-oriented work. Our shift in focus from the nonmusical to the musical enabled us to notice and nurture the client's uniquely musical strengths and creativity. From this new focal point, we were inclined to treat Alex's actions as communicative rather than as unruly and disruptive. In turn, this not only led to a more positive and relaxed clinical environment overall, but also seemed to improve the rapport between the SMT and the client. And so, self-reflexivity in the actual clinical moment, a requirement of integral practice, is a formidable challenge for all clinicians; we often fail in spite of our best efforts. Nonetheless, we assert that even retrospective self-reflexivity can be a useful practice toward managing countertransference reactions (both positive and negative) that hold the potential to impede future clinical interactions, relationships, and dynamics, such as boundary confusion and extreme emotional reactivity (Bruscia, 2014).

Journaling is just one of many ways that music therapists and trainees can use self-reflexive strategies to form connections between theory and practice (Barry & O'Callahan, 2009).

Marie: While I may have had a cerebral understanding of what the various theories involved (due to my concurrent enrollment in a theories course), I did not truly have a grasp on if or how my thinking and actions aligned with the tenets of those theories; hence, I learned the need for and value of ongoing reflexivity in successfully enacting integral thinking and practice.

We recommend that:

- students be introduced to and supported in use of multiple self-reflexive strategies (e.g., journaling, music listening, art-making, etc.) to access and process their subjective experiences during practica. Such subjective responses may include emotions that could interfere with their ability to think and act critically on the client's behalf, as well as those that could point to a need for change, including a change in practice orientation (e.g., frustration, discouragement, inadequacy).

Reflexivity in Evaluating the Shift

When writing about integral practice, Bruscia (2014) calls our attention to the ethical importance of establishing evaluative criteria and offers several relevant considerations. One such consideration is whether the evidence of change should be objective, subjective, or both (p. 264).

Reflecting on both objective and subjective measures, we found an experience orientation ultimately to be a better fit for Alex. Encouraging the client to engage with music however they desired and offering truly free instrumental improvisation experiences enabled them to express a greater range of emotions, access and showcase their musical creativity in unprecedented ways, and engage in unbridled and playful musical dialogue with session participants. It also appeared to us to have freed them from the demands and constraints of verbal communication, which was believed to have become a significant stressor, one that may have triggered Alex's behavioral outbursts during Stage I.

Incorporating free improvisation enabled us as therapists to remain in the "here and now" and to "drop concepts of how therapy should go," in turn allowing space for insights (Amir, 1993, p. 97) that informed our immediate and ongoing decision-making. Additionally, the pleasure that we derived from engaging with the client in an experience-oriented, music-centered way had implications related to the present discussion. In our case, it seemed that experiences of joy, derived both from collaborative music-making and witnessing others' pleasure and success, was identified as one motivating factor in the decision to sustain an experience orientation.

In the final analysis, however, had Alex not been able to remain safe in the less structured environment, use music-making as a resource for intrapersonal and interpersonal growth, and essentially direct their own treatment process (as we witnessed during Stage II), we would have been compelled to consult with one another and with the parent about the benefits of a return to a more structured environment and another shift in practice orientation.

Limitations, Challenges, and Benefits of Retrospective Study

All retrospective research involves reflecting on the past, whether immediate or distant. This report was crafted long after termination of treatment. Interestingly, the time that lapsed between data generation and analysis was a limitation, challenge, *and* benefit. On the one hand, we were subject to the human limitations of memory. It was a challenge to recall original intentions and feelings related to our work with Alex – actions and experiences that may have contributed to a more robust understanding of the phenomenon that was the focus of the study. On the other hand, the passing of time enabled us to better bracket preconceived notions and biases which may have encumbered our inquiry (Jackson, 2016).

For both of us, this was a first attempt at interpretivist research using Braun and Clarke's model of TA. As such, we felt significantly tested in regard to selecting which data sets to analyze, whether to do so in an inductive or deductive manner, and how and when to connect our findings to the extant literature. A chief pragmatic challenge was navigating the procedural steps; approaching each step with intention involved some "backtracking" (i.e., a re-analysis of complete sets). In retrospect, we acknowledge that it may have been helpful to connect more frequently with one another as we independently completed analyses in order to ensure that we were individually on track and, as warranted, aligned in our analytic processes. It also may have been useful to interrogate resources on TA more thoroughly before beginning the analytic phase. We unearthed a couple of articles and discovered a beneficial website by the authors (*Thematic Analysis: A Reflexive Approach,* Braun & Clark, n.d.) *after* we were well into the analytic process. With enhanced understanding of their model, we then felt compelled to engage in re-analysis of certain data sets, which prolonged the research process.

To be sure, there were missteps along the way; yet we view even these as advantageous in that they reminded us of the importance of humility in true reflexivity. The ability to say that one should have done things differently is a key step in making changes for the better, and it is this very same humility that we were called to adopt when making a shift in orientation during Alex's treatment.

In the end, investing in an intentional and detailed analytic process enabled us to trust that whatever we learned would be imbued with meaning. Engaging in this research gave Marie newfound and Susan renewed appreciation for both interpretivist research and an integral approach to treatment, both pursuits calling upon the clinician-researcher to flex in response to ever-evolving needs and findings rather than cling to rigid procedures and prescriptive steps toward targeted results.

Conclusion and Further Questions

In this report, we have detailed our findings related to a shift in practice orientation. We benefited from new and enlarged constructions of our clinical practice, insights that also might help others to: (a) better identify the true nature of their clinical work and the ways in which it is influenced by theoretical principles; (b) better recognize when a particular orientation is ill-suited to the client; (c) feel the freedom and confidence to make shifts that they deem through observation or intuition are warranted; and (d) rely more intentionally and consistently on preferred reflexive strategies as a way to improve clinical services and supervision.

As often occurs with research of any type, findings have stimulated additional questions. Vasco and Dryden (1994) call for therapist training programs to enable "a more informed process of selection of one's theoretical orientation" to avoid "mismatches between therapists and theories, which may be reflected negatively in personal well-being and therapeutic performance and efficacy" (Implications and suggestions section, para 2). With that, we wonder how we might balance the importance of "goodness of fit" for the student and professional therapist and their preferences, temperament, personality, etc. (Arthur, 2001) with "goodness of fit" for the client? Can we truly work effectively in integral fashion if our personal values are incongruous with a particular orientation (Strupp, 1981)? Is integral practice tenable if we as therapists find little pleasure and satisfaction in working within a particular orientation? Furthermore, we question how music therapists who are pressured or required by uncontrollable workplace factors to practice within a certain orientation can reconcile this pressure with their desire to practice integrally, selecting orientations that best address client needs.

Clinical retrospective self-study is just one of many viable avenues for music therapists to respond to these types of questions, continue their personal development, and support

growth of the field. It is our hope that this investigation will inspire other clinicians to engage in self-study, as well as in ongoing reflexivity, as pathways to more thoughtful practice and, ultimately, improved health and well-being for the clients whom we are privileged to encounter.

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Marie Reddy Ward is a board-certified music therapist based out of Kansas City, MO, USA. She graduated with a bachelor's degree in music therapy from the University of Dayton and completed her internship in hospice care. She has since worked in memory care and assisted living facilities, in addition to providing home-based music therapy services for adults and children with intellectual and developmental disabilities. Apart from music therapy, Marie is also passionate about music ministry and has worked and volunteered for many years as a musician in Catholic churches.

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[1] To protect the anonymity of the client and family, references to the client's actual name in raw data and in this report have been replaced with this pseudonym, and gender-neutral pronouns have been used.

[2] We are keenly aware of and strive to avoid the *epistemic injustices* that serve to disregard or silence, in particular, children's voices regarding treatment (Klyve, 2019). To be sure, many clients have the cognitive capacity to understand various orientations to practice and the communication skills to articulate their preferences to the music therapist. In the present case, we made the decision of which orientations to employ on Alex's behalf, relying primarily on input from the parent and our own observations and interpretations of Alex's actions and interactions, as will be further explained below.

[3] Bruscia (2014) also writes of an ecological orientation, which presently is not as commonly practiced among U.S. practitioners as the other orientations, and is less feasible to enact in a university practicum context.

[4] This is not to say that certain students could not demonstrate the ability to practice integrally.

[5] The terms *practice orientation* and *theoretical orientation* are used synonymously in the literature and, in that an orientation has been defined as a "direction of thought, inclination, or interest" (Merriam-Webster), this interchangeability is acceptable in our view. However, in this report, we intentionally and exclusively use the term music therapy practice *orientation* when discussing both general stances that inform treatment practice (e.g., outcome or experience orientations in ITP) and theoretical orientations that serve as specific, conceptual frameworks (e.g., behavioral or psychodynamic music therapy).

[6] From a totalist perspective, countertransference can be defined as all facets of the therapist's (or supervisor's) personhood that they import into the therapeutic space and process, including "beliefs, attitudes, thoughts, motivations, feelings, intuitions, behaviors, physical reactions, and so forth" (Bruscia, 1998c, pp. 51–52).

Appendix

Themes and Descriptions

Student Music Therapist

Themes	Subthemes	Data Sources (Stages)	Descriptions
1. Countertransference[1]		Journals (I)	Expressing emotions that arose from interactions with the client and/or parent and were not always understood on a conscious level until after self-reflection.
2. Critical Thinking About Treatment Events and Planning		Session Evaluations (I & II)	Looking deeply into events of treatment to determine what occurred, why it occurred, and what the best steps might be moving forward with all the available information.
	2.a. Reflection on the Client	Journals (I)	Thinking deeply about what was going on for the client, including ways in which my own challenges and triumphs in therapy could inform my understanding of theirs.
	2.b. SMT Self-Reflection	Journals (I)	Thinking deeply about my own experiences, understandings, and beliefs related to the work and identifying areas of potential growth.
3. Musical Openness		Journals (II) Session Plans (II) Video Analysis (II)	Assuming a willingness to fully engage in the music-making, freely accepting whatever happens, and flexing accordingly.
4. Orientation Influence		Session Plans (I & II) Session Evaluations (I & II)	Writing with the language, thought processes, and beliefs that are unique to certain practice orientations.
	4.a. Behaviorism Influence	Session Plans (I) Session Evaluations (I & II)	Writing in a way that reveals the influence of behaviorism, including a focus on nonmusical goals (i.e., communication skills), behavioral techniques, and targeting and changing specific behaviors.
	4.b. Humanism Influence	Session Plans (I & II) Session Evaluations (I & II)	Writing in a way that reveals the influence of humanism, including a focus on supporting the client's ability to enact change and the importance of an authentic, collaborative client-therapist relationship.
	4.c. Music-Centered Influence	Session Plans (I & II) Session Evaluations (I & II)	Writing in a way that reveals the influence of music-centered theory, including a focus on purely musical goals, the unique affordances of improvisation, and the detriments of unnecessary constraints on musicing.
5. Therapist Success and Enjoyment		Journals (I & II) Session Evaluations (I & II) Video Analysis (II)	Remarking upon successful moments of therapeutic interaction initiated by the SMT and SUP which contributed to overall joy and connection in sessions.

[1] Themes emerging from TA point to notable overlap in SMT's and SUP's emotional experiences, as characterized by distress and dissonance; the SUP further identified through autobiographical recollection the possibility of negative concordant countertransference during Stage I in the form of boredom and fatigue while observing outcome-oriented sessions.

Supervisor

Themes	Subthemes	Data Sources (Stages)	Definition
1. Dissonance/Conflict		Slides (I)	A specific moment that sets in motion or is characterized by cognitive and/or emotional dissonance and results in my lived experience of imbalance or distress.
2. The Centrality of Music		Feedback Sheets (I) Video Analysis (II)	My calling attention to and asserting my perception of the value of music as a therapeutic agent and process. In some circumstances, I advance music as preeminent to other dynamic forces that may have been operative during the session or specific music activity.
3. Trusting the SMT's Clinical Musicianship		Video Analysis (II)	My sense that I can depend on the SMT's musical decisions and output, emanating from (1) timely and skillful use of musical facilitation techniques, and (2) contributions to/embellishments of the ongoing musical aesthetic.
4. Efforts to Stimulate SMT Reflexivity		Feedback Sheets (I) Journal Comments (I)	Feedback designed to encourage the SMT's consideration of certain events that, as a somewhat detached observer, I determined had clinical significance. Underlying these efforts to support reflexive thinking is my assumption that thoughtful consideration of certain phenomena could positively impact the SMT's knowledge, skills, and therapeutic attitudes, thereby contributing to more effective, meaningful, and satisfying clinical practice during the semester and beyond.
5. Pleasure and Delight		Video Analysis (II)	Feelings of pleasure I derived from witnessing clinical events and actions.
	5.a. Client Accomplishment	Video Analysis (II)	Feelings of pleasure from witnessing the client's musical accomplishment/mastery and/or the client's initiation of an interpersonal or intermusical connection with the SMT.
	5.b. SMT Accomplishment	Video Analysis (II)	Feelings of pleasure from witnessing the SMT's clinical musical accomplishment/mastery and/or actions of the SMT that are effectual in bringing about an interpersonal or intermusical connection with the client.
6. Music as a Means		Feedback Sheets (I)	The SMT's planful or spontaneous introduction of any musical form or activity whose function is (a) as a stimulus to evoke a desired nonmusical response in the client, (b) to establish a condition or context within which the client can demonstrate a desired nonmusical response, and (c) to reinforce a desired nonmusical response.