Experiences of Personal Therapy as a Client: Perspectives of Asian Music Therapists during Their Training in the US

Hyejin So
Lesley University

Follow this and additional works at: https://digitalcommons.lesley.edu/expressive_dissertations

Part of the Social and Behavioral Sciences Commons

Recommended Citation
https://digitalcommons.lesley.edu/expressive_dissertations/63

This Dissertation is brought to you for free and open access by the Graduate School of Arts and Social Sciences (GSASS) at DigitalCommons@Lesley. It has been accepted for inclusion in Expressive Therapies Dissertations by an authorized administrator of DigitalCommons@Lesley. For more information, please contact digitalcommons@lesley.edu.
Experiences of Personal Therapy as a Client: Perspectives of Asian Music Therapists during Their Training in the US

A DISSERTATION

Hyejin So

In partial fulfillment of the requirements for the degree of Doctor of Philosophy

LESLEY UNIVERSITY
February 25, 2016
Lesley University
Graduate School of Arts & Social Sciences
Ph.D. in Expressive Therapies Program

DISSERTATION APPROVAL FORM

Student's Name: Hyejin So

Dissertation Title: Experiences of Personal Therapy as a Client: Perspectives of East Asian Music Therapists During Their Training in the US

Approvals

In the judgment of the following signatories, this Dissertation meets the academic standards that have been established for the Doctor of Philosophy degree.

Dissertation Committee Chairperson: [Signature] 1/28/16

Internal Committee Member: [Signature] 2/4/16

External Committee Member: [Signature] 2/10/16

Director of the Ph.D. Program/External Examiner: [Signature] 2/25/16

Final approval and acceptance of this dissertation is contingent upon the candidate's submission of the final copy of the dissertation to the Graduate School of Arts and Social Sciences.

I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

[Dissertation Director]

I hereby accept the recommendation of the Dissertation Committee and its Chairperson.

[Dean, Graduate School of Arts and Social Sciences]
STATEMENT BY AUTHOR

This dissertation has been submitted in partial fulfillment of requirements for an advanced degree at Lesley University and is deposited in the University Library to be made available to borrowers under rules of the Library.

Brief quotations from this dissertation are allowed without special permission, provided that accurate acknowledgment of sources is made. Requests for permission for extended quotation from or reproduction of this manuscript in whole or in part may be granted by the head of the major department or the Dean of the Graduate College when in his or her judgment the proposed use of the material is in the interests of scholarship. In all other instances, however, permission must be obtained from the author.

SIGNED: ____________________________
ACKNOWLEDGEMENTS

This dissertation is a collaborative work involving many people. I faced numerous challenges during my doctoral study that I could not have overcome without them. I would like to express my gratitude to each and every one.

I would like to thank Dr. Robyn F. Cruz, my chairperson, for her guidance, intelligence, and commitment in spite of her being away on sabbatical; Dr. Michele Forinash, of the internal committee for her inspiring classes and consistent support throughout the program; and Dr. Laura Beer, my former advisor and external committee, for her genuine encouragement and passion. All of you are my role models for teaching and researching.

I cannot thank my participants enough. They were willing to open up to me and share their life stories for this study. I admire their love for music therapy and ceaseless endeavors to learn, grow, and achieve.

I am very grateful to my Cohort 5 colleagues, Kyung Soon, Eunsil, Mimi, Lee Ann, Varda, Tim, Dana, and Hadas. Thank you for your support, intelligence, creative arts, and humor. You are my special multicultural family.

I am deeply thankful to my church members at New City Church for their support and care. With their prayers, I was able to stay strong and finish this dissertation.

I was blessed to work closely with several mentors, Dr. Dong Min Kim, Dr. Youngshin Kim, and Dr. Diane Austin. Thank you all for your willingness to share your knowledge and wisdom whenever I was in need. I am also thankful to Dr. Byung-Chuel Choi at Sook Myung Woman’s University, who introduced me to music therapy for the first time and gave me many professional opportunities. I would also like to thank Dr. Kyung-Sun Kang, who invited me to teach at Sung Shin Woman’s University and enabled me to grow as a music therapy educator.

I am very grateful to my former colleagues, Shauna Spear, Bonnie Kirk, and Dana Decolator, at the Family and Child Support department at HeartShare preschool in New York. Thank you for three years of love, support, and acceptance and for throwing me a farewell party each time I left the US to return to Korea. I miss you very much.

My parents, Dr. Jaehyun So and Mrs. Kyunghee Kim, deserve my biggest thanks. They showed me what selfless love is. Their sacrifice enabled me to be who I am now. My father is the best example of commitment to work and love for family. My mother shared her curiosity about the world and love for foreign languages with me. I thank my younger brothers, Joon and Sung, for their presence and encouragement. Special thanks go to my little nephew, Noah H. So, for giving me priceless smiles during the last phase of this dissertation.

To my LORD, thank you for your steadfast love. You have been with me every single moment, even when I was unaware. You have made all my accomplishments possible.
<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>8</td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>10</td>
</tr>
<tr>
<td>Statement of Problem</td>
<td>13</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>16</td>
</tr>
<tr>
<td>Research Questions</td>
<td>16</td>
</tr>
<tr>
<td>Nature of the Study</td>
<td>17</td>
</tr>
<tr>
<td>Implication of the Study</td>
<td>17</td>
</tr>
<tr>
<td>2. LITERATURE REVIEW</td>
<td>19</td>
</tr>
<tr>
<td>Personal Therapy for Therapists/Trainee Therapists</td>
<td>19</td>
</tr>
<tr>
<td>Freud’s Original Ideas</td>
<td>19</td>
</tr>
<tr>
<td>Impact of Personal Therapy for Therapists/Trainee Therapists</td>
<td>22</td>
</tr>
<tr>
<td>Requiring Personal Therapy in Educational Settings</td>
<td>28</td>
</tr>
<tr>
<td>Personal Therapy for Music Therapists/Student Music Therapists</td>
<td>32</td>
</tr>
<tr>
<td>Cultural Perceptions of Psychotherapy in East Asia</td>
<td>38</td>
</tr>
<tr>
<td>Cultural Values of East Asia</td>
<td>38</td>
</tr>
<tr>
<td>Perceptions of Mental Health Care in East Asia</td>
<td>40</td>
</tr>
<tr>
<td>Integrating Personal Therapy for Music Therapists in East Asia</td>
<td>48</td>
</tr>
<tr>
<td>The Field of Psychotherapy</td>
<td>48</td>
</tr>
<tr>
<td>The Field of Music Therapy</td>
<td>49</td>
</tr>
<tr>
<td>3. METHOD</td>
<td>52</td>
</tr>
<tr>
<td>Research Questions</td>
<td>53</td>
</tr>
<tr>
<td>Rationale for Research Design</td>
<td>53</td>
</tr>
<tr>
<td>Recruitment of Participants</td>
<td>54</td>
</tr>
<tr>
<td>Demographics of the Participants</td>
<td>55</td>
</tr>
<tr>
<td>Data Collection</td>
<td>57</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>58</td>
</tr>
<tr>
<td>Trustworthiness</td>
<td>61</td>
</tr>
<tr>
<td>Ethical Considerations</td>
<td>62</td>
</tr>
<tr>
<td>Researcher’s Reflexivity and Bias</td>
<td>63</td>
</tr>
<tr>
<td>4. RESULTS</td>
<td>65</td>
</tr>
<tr>
<td>Individual Textural Descriptions</td>
<td>65</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table 1, Descriptive Characteristics of Participants and their PT experiences ..................56
Table 2, Descriptive Characteristics of Participants’ Therapists ....................................56
Table 3, Examples of Thematic Data analysis: Data Extracts and Applied codes .................60
Table 4, Themes, Categories, and Subcategories Derived from Interview Transcripts ..........110
LIST OF FIGURES

Figure 1, A process of Data Collection and Data Analysis ..........................................................52
Figure 2, Visual Representation of the First theme .............................................................70
Figure 3, Visual Representation of the Second theme ....................................................80
Figure 4, Visual Representation of the Third theme .......................................................89
Figure 5, Visual Representation of the Fourth theme .....................................................105
ABSTRACT

This phenomenological research explored previous personal therapy (PT) experiences of East Asian music therapists during their training in the US. The study focused on examining the meaning of being therapy clients while they were music therapy students, and discovering the influence of PT on their personal, clinical, and musical development during and after the training. In addition, two different cultural influences on the therapeutic process were examined. Eight music therapists from Korea, Hong Kong, and Japan participated in this study. The length of their PT experiences ranged from six to 24 months. The participants’ therapists were Asians who immigrated to America European, who immigrated to America American, or Americans of non-Asian heritage. Participants completed basic questionnaires and then took part in in-depth interviews. The NVivo 10 computer program was employed to organize and analyze the interview data. Member checking and peer debriefing functioned to support the credibility of the data analysis. Throughout the coding process, 4 themes, 13 categories, and 20 subcategories emerged. The themes and categories were as follows: (a) Cultural experiences (Asian cultural experience, Western cultural experience, and cultural stigma attached to therapy) (b) Therapy experiences (therapy space, beginning stage, student therapists’ therapists, personal influences, clinical influences, academic influences, musical experience, and difficulties in therapy) (c) After therapy (therapeutic application, and need for personal therapy of therapy of student music therapists). The results of the study reported that PT was one of significant resources for music therapy students’ personal and professional development. The rationale for integrating PT in student music therapists’ training has implications for music therapy educators and related mental health practitioners in East Asia. It is suggested that student music therapists consider PT as a catalyst for both personal and professional growth.
CHAPTER 1

Introduction

The concept of personal therapy (PT) for psychotherapists was originated by Freud in the early 1900s. He claimed that analysts would benefit from undergoing analysis themselves (Rake & Paley, 2009). Since the inception of psychoanalytic training, it has thus been considered essential that psychotherapists undergo PT as part of their professional and personal development (Gold & Hilsenroth, 2009). The following types of mental health professions stressed the need for PT: training of psychoanalysts (Caligor, 1985), psychologists (Holzman, Seawright, & Hughes, 1996), family therapists (Forman, 1984; Patterson & Utesch, 1991), psychiatrists (Habl, Mintz, & Bailey, 2010), and music therapists (Hesser, 2001; 2013). Studies have reported that psychoanalytic/psychodynamic-oriented therapists are the most likely to seek PT (Norcross & Guy, 2005; Prochaska & Norcross, 1983; Garfield & Kurtz, 1976).

Many trainee psychotherapists in the West have engaged in PT as part of their education and certification processes (Geller, Norcross & Orlinsky, 2005). Most European countries mandate a certain number of hours of PT prior to the licensing of professional mental health practitioners. For example, in the United Kingdom (UK), a certain number of hours of PT is required in order to be certified as a mental health practitioner by the following associations: British Association for Counselling and Psychotherapy, United Kingdom Council for Psychotherapy, the Division of Counselling Psychology in the British Psychological Society (Grimmer & Tribe, 2001; Rizq; 2011). In the US, trainee analysis is mandatory only for psychoanalysts, while a few graduate programs integrate PT into their curricula (Coopersmith, 2010; Geller, Norcross, & Orlinsky, 2005).
In the developing stages of PT for trainee analysts, the sole focus was on didactic functions “to experience in [one’s] own mind the validity and force of the main findings” (Balint, 1954, p. 157). Over time, the dimensions of trainee analysis began to take on more of a therapeutic component. Therefore, personal analysis became one of the requirements for trainee analysts to explore their unconscious, which is a core theory of psychoanalysis (Balint, 1954).

As previously stated, Freud originally supported analysts undergoing analysis themselves because he assumed it would enable them to assess their own clinical work more objectively by separating personal issues from those of their clients (Freud, 1964; Fromm-Reichmann, 1950). He also believed that neutrality was necessary for a successful outcome in the therapeutic relationship (Lister-Ford, 2007). The value of PT for therapists/therapists in training has already been extensively addressed by numerous studies in the West (Buckley, Karasu, & Charles, 1981; Daw & Joseph, 2007; Hesser, 2001; Linley & Joseph, 2007; Lutz & Izarry, 2009; Macdevitt, 1987; Mackey & Mackey, 1994; Mahoney, 1997; Mohl, Lomas, Tasman, Chan, Seldge, Summergrad, & Notman, 1990; Murphy, 2005; Norcross, 2005; Oteiza, 2010; Rake & Paley, 2009).

Oteiza (2001) reported positive effects of PT for psychotherapists with psychoanalytic backgrounds in her descriptive phenomenological study. Her study showed that participants thought PT helped them to acquire self-awareness and objectivity, understand their own differences and challenges, and discover an avenue for guidance. Moreover, they shared that PT was helpful in understanding their clients’ therapeutic processes, and therefore enhanced their professional growth as well. Norcross (2005) also talked about the positive effect of PT with psychodynamically-oriented therapists and claimed that “Personal therapy is an emotionally vital, interpersonally dense, and professionally formative experience that should be central to the
development of health care psychologists” (p. 840). Guy and Liaboe (1986) claimed that PT is necessary for experienced therapists because there is a danger that they might feel “a sense of superiority, even omniscience” (p. 22). Furthermore, they imagined that arrogance and delusion might prevent some from acknowledging the need for personal therapy. Students in graduate training programs for psychotherapy in general can be educated about the positive side of undergoing personal therapy for improving their clinical skills and for the value of emotional steadiness. Macdevitt (1987) investigated the professional benefits of PT with doctoral-level psychologists. One hundred and eighty-five participants with an average of 16 years of clinical practice participated in a survey. Eighty-two percent of the participants acknowledged that it was beneficial to be aware of their countertransferential reaction and that it led to professional growth. In addition to professional and personal development, they mentioned that self-care was one of the positive outcomes for professional psychotherapists who experienced PT (Daw & Joseph, 2007; Mahoney, 1997). Grimmer and Tribe (2001) interviewed seven counseling psychology students and seven recent graduates on the effects of mandated personal therapy during professional training. The positive results included professional development, such as solidifying professional identity, “experiencing modeling” (p. 293), and “validation of therapy” (p. 293). PT functioned as a support for issues such as stress management and addressing personal difficulties for the participants. Likewise, undergoing PT provided positive experiences for therapists/student therapists in their personal and clinical development. Personal and professional growths are both complementary and interconnected (Norcross & Guy, 2005).

The field of music therapy in the West has also paid attention to the needs for PT for music therapists/student music therapists. As these therapists begin to understand the therapeutic strength of music, it is suggested that they undergo PT in order to develop the self-knowledge
necessary to engage in better clinical work and comprehend the complexity of dynamics in a
any type of music therapy would be a “transformative experience” (p. 54). Moreover, particular
advanced trainings such as Guided Imagery and Music (Abbott, 2014) and Analytical Music
Therapy mandate experiencing a certain period of PT (Priestley, 1994). Nordoff-Robbins music
therapy training also recommends PT or self-experience in making music (Sorel, 2014). Some
education programs implemented music therapy experience as a mandatory component of their
curriculum (Hesser, 2013; Wigram, Perdersen & Bonde; 2002) so that student music therapists
have therapeutic experience in music for their own personal growth, for the development of
clinical skills (Hesser, 2013), and in order to understand the therapeutic dynamic with clients
(Wigram, Perdersen, & Bonde; 2002).

Statement of the Problem

The importance of PT for therapists/student therapists has been discussed and studied in
the West. However, this tradition has not been integrated into the field of music therapy in East
Asian countries. There are two factors that explain why the necessity of PT for therapists/student
therapists has not been as well recognized in East Asian countries as it has in the West.

First, the concept of PT in general is still a new trend in East Asian countries as it only
became recognized in the late 20th century. In the 1980s, rapid industry changes occurred in
Korea as the Gross National Product (GNP) grew (Joo, 1998). Social development and transition
brought confusion and conflict, leading to an uptick in the divorce rate, suicide attempts, and
related issues, and people began to seek psychotherapy/counseling to address them (Joo, 2006).
In China, the recognition of concerns about mental illness arose in the 1970s (Qian, Smith, Chen,
& Xia, 2002). China accepted the notion of psychotherapy in the 1980s as it gained exposure to
Western cultures (Chang, Tong, Shi, & Zeng, 2005). Iwakabe (2008) also noted that the field of psychotherapy in Japan experienced growth in the late 1990s.

The field of music therapy has only been fairly recently introduced to East Asia as well. In China, music therapy programs were first implemented for psychiatric patients, and a training program was opened in the 1980s (Kim, 2015). Japan became interested in music therapy and renowned music therapists were invited to visit in 1967, which led to the development of the music therapy field (Haneishi, 2005). In Korea, music therapy techniques were partially utilized by psychiatrists around 1960. Formal music therapy training for degree programs began in 1991 (Chung, 2000).

Second, while the growth of Western influences paralleled exposure to the concept of therapy in East Asian countries, cultural discrepancies still provoke a variety of reactions in Asian therapeutic contexts due to the cultural unfamiliarity with certain mores and diverging values. In Western cultures, people appreciate “their own preferences, needs, rights and contracts” (Hamamura, 2012, p. 2). They prioritize their individual goals and reasonable inquiries regarding the benefits and losses in the group. Individual autonomy and independence are valued in Western societies where individualism is prevalent (Heine & Lehman, 1997). Individuals acknowledge their strengths and uniqueness. By contrast, group-oriented attitudes prevail in East Asian cultures (Hofstede, 1991). In particular, Confucianism is a strong influential value that focuses on the needs of groups rather than the individual (Kwon, 2009; Song, 1997). Because collective cultures focus primarily on group harmony and unity, individuals avoid cultivating a positive self-image or exploring feelings about the self. Asian people also endeavor to improve their weaknesses in order to gain the approval of others (Lee, 2004). Jing and Fu (2001)
characterized Asian culture by stating, “One must not be driven by emotions. Rather, one should think of the consequences before taking action” (p. 411).

In addition to the recent introduction of the concept of psychotherapy and cultural differences in a therapeutic context, Bae, Joo and Orlinsky (2003) discussed the difficulties of adapting the idea that therapists in East Asia should experience PT. While the values of Confucianism have likely been a key influence on their lives, Korean therapists have chosen a vocation that requires an individual-oriented perception. It is possible that those therapists “experience ambiguity and some conflict[s] through being collectivist by culture and individualist by career” (p. 314). In addition, the researchers reported that only 36% of the 538 Korean therapists in their quantitative study had experienced PT in the past. This figure is much lower than the 80% of psychotherapists in other countries who have had PT experience (Orlinsky, Rønnestad, Willutzki, Wiseman, & Botermans, 2005). The researchers explained that most of the participants were still novice therapists who had not had the opportunity for PT and additionally feared the cultural stigma of “dwelling on personal issues or seeking individually focused solutions to problems” (p. 309). It seems therefore inevitable that one should explore which bicultural components have been assimilated when ascertaining the significance of personal therapy experiences for East Asian music therapists/therapists in training.

In the field of music therapy in East Asian countries, only a few studies that targeted Koreans have addressed the need for PT among therapists/student therapists. Yi (2008) proposed that receiving PT might be one way to manage music therapists’ countertransferential reactions. Moon (2014) explored the experiences of short-term music psychotherapy on Korean music therapy students as an experiential component in the class. Bae (2011) provided two types of group music therapy for Korean participants in music therapy training. However, none of the
researchers specifically discussed cultural components in their research. Moreover, it was not possible to find other studies that focused predominantly on East Asian participants.

In sum, considering the relatively short history of psychotherapy and music therapy development in East Asia, there is a lack of research that directly addresses US-trained East Asian music therapists who formerly experienced PT as clients while enrolled in degree programs.

**Purpose of the Study**

The purpose of this phenomenological study was to explore previous experiences of PT by East Asian professional music therapists trained in the US. In particular, this research focused on their perspectives as clients during their formal music therapy education in the US. A central topic was to discover how their PT experiences influenced both their personal and professional development. Furthermore, this research examined how the participants perceived and integrated two dissimilar cultural experiences during their own PT.

**Research Questions**

This study proposed four research questions. These questions guided the exploration of East Asian music therapists’ personal therapy experiences during their training in the US in both their personal and professional development:

1. How did experiencing personal therapy influence Asian music therapists’ development during their training?

2. How might personal therapy have influenced the ways Asian music therapists use music clinically and personally during and after training?

3. How did specific Asian cultural perspectives influence Asian music therapists’ own therapeutic processes?
4. What cultural modifications to clinical practice have Asian music therapists made regarding Western concepts of therapy, and why?

**Nature of the Study**

A phenomenological approach was employed to discover the significance that PT had for eight East Asian music therapists who experienced it during their training in the US. All eight were individually interviewed in depth by the researcher. Each interview focused on obtaining vivid retrospective descriptions of their PT experiences and was transcribed verbatim by the researcher. Data were analyzed using Creswell’s modified version based on Moustakas’ data analysis techniques (Creswell, 2013). After listing significant statements, the researcher clustered significant statements into themes and presented them with both textural and structural descriptions. In addition to interview data, member checking and peer debriefing played a role in assuring the trustworthiness of this phenomenological study.

**Implication of the Study**

This phenomenological study aimed to provide information about the meaning of East Asian music therapists’ previous PT experiences from a client’s perspective. As much as music therapists value their clients’ therapeutic changes and developments, there is a need to focus on therapists’ own personal and professional growth. Furthermore, this research aimed to minimize cultural gaps for therapeutic applications and maximize the benefits of PT. To date, no research has investigated the PT experiences of East Asian music therapists during their training in the US, especially with a focus on their bicultural values.

Hence, it is hoped that this research will promote awareness of the impact of PT on students, educators, and clinicians in the field of East Asian music therapy. They will be able to profit from reading this research and consider undergoing PT themselves. They might then apply
what they have understood from this research discussion in their own settings and incorporate it in their training programs.
CHAPTER 2

Literature Review

The aim of this qualitative research is to explore East Asian music therapists’ former personal therapy (PT) experiences from a client’s point of view while they were being educated in the United States (US). This study focuses on the meaning of their personal and professional experiences over the course of PT. In addition, an examination of the cultural differences between the East and the West in a therapeutic context is provided.

This chapter comprises three parts. The first section will look into Freud’s initial idea of requiring PT for therapists/trainee therapists and why this is considered a significant component of their training. Relevant studies that discuss the impact of PT will be examined from both a positive and negative point of view. The implementation of this application to the field of music therapy will be introduced as well. In the second section, cultural elements and perceptions regarding psychotherapy will be explored. It is crucial to inspect different cultural attitudes toward mental health services between East Asians and Westerners because the focus on addressing mental health issues originated in the West. The last section addresses the integration of PT for music therapists/student music therapists in East Asia. The current situation and developments in the field will also be examined.

Personal Therapy for Therapists/Trainee Therapists

Freud’s Original Ideas

In the early stages of establishing his theory of psychoanalysis, Freud (1964) maintained that there was a risk of confusion between analysts’ and their clients’ psyches and that this might jeopardize a course of therapy. Thus, he believed that all the analysts should undergo personal analysis at least for five years on a regular basis in order to sustain “objective investigation”
Personal analysis, officially known as “training analysis” (Lasky, 2005, p. 15), is regarded as the most crucial element in training from an educational point of view, including teaching techniques and supervising during the initial period of developing the concept of personal analysis for the trainees. However, the didactic elements became separated from training analysis and came to be incorporated as part of training. In addition, Balint (1948) emphasized that the need for PT in “such an emotionally overcharged atmosphere is not conducive to the necessary freedom of thought; on the contrary, it leads to inhibited thinking” (p. 164).

**Countertransference.** Countertransference has often been discussed as an important phenomenon that should be addressed. Freud was concerned about analysts maintaining neutrality, and he believed that they needed to deal with countertransferential reactions by undergoing their own personal analysis (Reich, 1951). Countertransference means that multifaceted reactions of therapists are triggered on both conscious and unconscious levels through their work with clients (Bruscia, 1998) in exploring the unconscious during the therapeutic process (Mander, 2000). Those reactions involve all of the therapists’ emotions and attitudes toward their clients (Kahn, 1997). Reich (1951) maintained that countertransference should be monitored through the experience of PT. Otherwise, therapists’ unresolved unconscious involvement with their clients might cause emotional instability and distorted perceptions and eventually potential risk to clinical work. Therapists need to be sensitive to their “own feelings, impulses, fantasies and so on” (p. 69) to learn about their clients’ inner world in depth. Therefore, PT offers an effective way for therapists to focus on their clients’ needs in an objective way. The phenomenon of countertransference prompts therapists who follow psychodynamic/ psychoanalytic approaches to look into PT. McLoughlin (1995) stated that
psychodynamic work requires exploring the inner psyche and deals with dynamics of
transference and countertransference in the therapeutic alliance, notions that originated in
Freud’s psychoanalytic work. Also, countertransference engenders an element of risk for
therapists who do not engage in a sufficient amount of personal therapy. Reynolds (1995) stated
that those therapists who accept the concept of countertransference choose to go to PT in order to
deal with their potentially harmful reactions. Guy and Liaboe (1986) maintained that experienced
therapists in particular may find that their narcissistic sides, such as having a “sense of
superiority, even omniscience” (p. 22) interfere with the therapeutic process. This point was
supported by Wiseman and Shefler (2001). The researchers claimed that “it is also necessary to
reduce the grandiosity of those who come and think they already know what they are doing and
also to strengthen the weak points” (p. 133). They felt that this was especially risky for beginner
therapists. In addition, any stress from clinical work that therapists experience can be alleviated
through their own treatment. If therapists do not seek therapy to resolve stress, they might suffer
negative psychological consequences (Norman & Rosvall, 1994).

**Theoretical Orientation.** As previously stated, Freud initially facilitated the idea that
psychoanalysts/trainee analysts should experience PT. Several studies have indicated that
therapists who are theoretically oriented to a psychoanalytic/psychodynamic approach value PT
more highly than those who practice behavioral modification (Bike, Norcross, & Evans, 2009;
Deacon, Kirkpatrick, Wetcher, & Niedner, 1999; Garfield & Kurtz, 1976; Norcross, 1990;

Guy, Stark, and Poelstra (1998) stated that psychodynamically-oriented therapists remain
involved in PT for the longest period of the time both before and after becoming professionals.
Three types of motivations were found: “requirements of the training programs selected by these individuals, greater personal need, or general introspective tendencies” (p. 475).

On the other hand, therapists who practice Cognitive Behavioral Therapy (CBT) do not consider it important for therapists to undergo PT. The value of PT does not have a long history in the field of CBT. Only recently has the idea of incorporating PT gained momentum in Europe because the philosophy of CBT mainly targeted changes by encouraging clients to learn and apply practical skills as a treatment tool (Geller, Norcross, & Orlinsky, 2005). Alternative ways to support those in need included family and friends and developing enough strength to cope (Norcross, Bike, Evans, & Schatz, 2009). Linley and Joseph (2007) showed that therapists who used cognitive behavioral approaches reported experiencing fewer personal changes but more feelings of exhaustion.

**Impact of Personal Therapy for Therapists/Trainee Therapists**

**Motivation for Seeking Personal Therapy.** In general, studies have indicated that the pursuit of professional and personal growth was an important motivator for those electing to participate in PT. The requirement of PT as part of professional training was the main purpose in the quantitative research by Williams, Coyle, and Lyons (1999). Eighty-eight percent of 84 counseling psychologists in the UK reported that they had sought therapy because it was a mandatory part of their training and some maintained that there were even “more stringent requirements, such as having therapy before, during and beyond training” (p. 551). However, another quantitative study indicated contrasting motivations involved in the desire to seek therapy (Norcross, Strausser-Kirkland, & Missar, 1988). Psychologists ($n = 234$), psychiatrists ($n = 104$) and clinical social workers ($n = 171$) responded to a survey and 55% of them indicated that their primary motivation for engaging in PT was related to their personal issues. The pursuit
of PT as part of training requirements was only pertinent to 10% of the participants. They reported “marital conflict” (p. 40), “depression” (p. 40), and “anxiety” (p. 40) as their three greatest concerns. They also mentioned the desire to deal with family issues and increase self-knowledge. Bike, Norcross and Schatz (2009) found comparable results in their study of 727 mental health practitioners. The breakdown of reported personal problems was as follows: “marital–couple distress (20%), depression (13%), need for self-understanding (12%), and anxiety–stress (10%)” (p. 19).

In their quantitative study, Deacon, Kirkpatrick, Wetcher, and Niedner (1999) outlined the personal reasons that led marriage and family therapists to seek PT. One hundred and five therapists returned their survey and indicated the 10 most frequent issues that would potentially lead them to undergo PT. Those issues were “divorce, sexual assault, sexual abuse, substance abuse, physical abuse, posttraumatic stress disorder, depression, marital problems, obsessions, and problems concerning their children” (p. 76). The five highest ranked stressors were “marriage, depression, personal growth, relationships, and family of origin issues” (p. 77). Specific issues that the participants were currently working on in their PT included having experienced physical abuse, a sexual attack, psychosomatic symptoms, sexual abuse, and issues related to their own children. In another study cited by Daw and Joseph (2007), participants mentioned undergoing PT “to prevent burn-out” (p. 229).

Positive Impact. Numerous research projects have discussed positive contributions in both the professional and personal development of therapists and student therapists who experience PT. Oteiza (2010) indicated increasing self-awareness about “blind spots” (p. 226) and “unresolved issues” (p. 226) and a deeper understanding of clients. In addition, therapists felt enabled to provide a safe therapeutic space in a clinical work.
The studies repeatedly found that therapists and student therapists modeled their own therapists’ behaviors as they learned. “The style, attitude and manner” were characters that therapists wanted to imitate (Oteiza, 2010, p. 226). Desired characteristics were “warmth and concern” (Rake & Paley, 2009, p.283) and “empathy, acceptance, egalitarianism and active listening” (Norcross, Bike, & Evans, 2009, p. 40). It was helpful to observe how therapists demonstrated skills and approaches and how theoretical knowledge applied to the actual experience of PT (Rake & Paley, 2009).

Exploring therapeutic material in a PT experience brings personal changes that will link to professional changes. Zeddies (2000) explained that training analysis leads trainee analysts to explore their own unconscious, which is a core resource in psychoanalytic work and further facilitates deeper understanding of clients. Also they became more available emotionally. Therefore, there is a parallel process between analysts resolving their psychological conflicts and gaining a better understanding of patients.

Many studies reported that personal and professional developments are inseparable and interactively complement one another. Wiseman and Shefler (2001) interviewed five experienced therapists whose theoretical orientation is based on a psychoanalytic approach. A consensual qualitative coding technique was employed to analyze individual interview data. Six domains emerged: “(a) importance of personal therapy for therapists; (b) impacts on the professional self: identity; (c) impacts on one's being in the session: process; (d) experiences in previous and current therapy; (e) self in relation to the personal therapists; and (f) mutual and unique influences of didactic learning, supervision, and personal therapy” (p. 133). In the first domain, interviewees shared that their motivations for seeking therapy for training purposes and personal edification cannot be separated. In talking about the benefits of PT, one participant
declared that it “reduce[s] the grandiosity of those who come and think they already know what they are doing, and also […] strengthens the weak points” (p. 133). In the second domain, interviewees explained how they built their professional identity as a result of their therapists’ modeling, thus solidifying their professional identities, and increasing self-understanding. The third domain consisted of their experience as clients. Engaging in PT enhanced the participants’ capability to have empathy for their own clients and provided them the “freedom to be authentic and spontaneous” with their patients (p. 134). They described their therapy experiences as clients as being “meaningful” (p. 135). One of the therapists maintained that as a result of therapy, “his therapist-self and his analysand-self” are now inseparable. There is a parallel process between two identities. Another theme arose related to interviewees’ experiences as clients. One of roles of the therapists was to act as “a good mother” (p. 136). It is interesting that one participant rejected internalized techniques or approaches as modeled by his own therapists. This was provoked by his desire to create his own way of interacting with clients. The last domain discussed aspects of “didactic leaning, supervision, and personal therapy” (p. 136). One participant stated that all three components are essential for professional growth. Another thought there was reciprocal influence between supervision and the therapy experience. PT fostered the ability to have empathy for the clients while supervision prompted understanding. In fact, it was described as “experiential learning” (p. 137). One participant claimed that PT was the most influential element for both professional and personal change.

Interplay between the two developments was discussed in Daw and Joseph’s (2007) study as well. Forty-eight therapists in the UK responded to the survey including “closed and open questions” (p. 227). The demographic of the participants showed that 32 of them had gone to PT. The interpretative phenomenological analysis yielded four themes. The first theme addressed the
role of PT in both personal and professional care. Two therapists stated that PT was necessary for their own personal care, especially after dealing with their clients’ intense emotions such as their sexual distress or trauma. Therefore, PT became a space for self-care that helped them provide “safe and effective” (p. 230) therapeutic work for their own clients. The second theme “personal development” (p. 230) discussed how PT assisted positive personal changes and cultivated awareness about personal weak points and desires. This experience further led to “a better psychological understanding of [the] internal process” (p. 230). Therapists mentioned experiential learning as a third theme that emerged from the learning process through actual therapy experience. They found that PT was necessary to understand “the nature of their work” (p. 230). The last theme that participants mentioned involved their learning experiences by becoming clients. The therapists reported that they came to own “a deeper understanding of process issues, models, and techniques” (p. 230) through actual therapy experience rather than just studying theories.

Even though most of above-mentioned studies reported the worth of experiencing PT and the resulting positive changes, those positive experiences did not consistently bring pleasurable reactions. Some of the participants in Oteiza's (2001) study shared that “the emotional and experiential side [of PT] was not at all easy” (p. 227). All of the participants in the study by Stringer-Seibold (1998) stated that it was “scary, hard, painful, emotional, uncomfortable, challenging, draining, and tough” (p. 55). Interestingly, however, the participants repeatedly declared that “my best sessions were my worst sessions” or “the best sessions hurt the most” (p. 55).

**Negative Aspects.** The problematic sides of therapy also need to be noted. Sometimes financial pressures restrained therapists from continuing their own PT (Guy & Liaboe, 1986;
Mahoney, 1997). Cases of “harmful” (p. 304) experience resulted from therapy encompassed damages to marriage, exhibiting self-destructive behaviors, and creating excessive isolation (Buckley, Karasu, & Charles, 1981).

Being both a therapist and a patient sometimes provoked confusion about the two roles and interrupted the nature of helping work. One therapist shared the fear of being a PT patient at the same time he/she was working as a therapist and treating other people. Distorted perceptions may arise so that therapists may criticize themselves as “being crazy, losing control, and becoming a helpless, dependent infant” (Fleischer & Wissler, 1985, p. 590). Frequently, therapists will compare themselves to their own patients, particularly those who exhibit greater pathologies than they do. Wiseman and Shefler (2009) found similar results regarding confusion in the roles and mentioned that transitioning from being a patient to being a therapist was perplexing. This difficulty almost discouraged one therapist from continuing due to having a “desperate feeling” (p. 135) and s/he emotionally regressed as a result of the analysis.

Some therapists who were in PT recounted adverse encounters in their relationships with their own therapists, such as not liking them, finding them to be unskilled, feeling neglected, or experiencing a therapist’s death. Moreover, some therapists’ therapists attempted sexual advances or abuse (Deacon, Kirkpatrick, Wetcher, & Niedner, 1999). Some therapists worried about confidentiality, did not feel secure in their therapists’ professional identity, could not find a suitable therapist, or became conscious about what other people thought; they especially worried about their own clients’ opinions (Norman & Rosvall, 1994).

Grimmer and Tribe (2001) mentioned negative experiences concerning therapists’ personalities or methods of interaction. Examples included therapists who were uptight, excessively used “cliché[s]” (p. 292), were insensitive about their own nonverbal expression,
used palpable “frame[s] of reference” (p. 292), lacked egalitarianism, criticized the participants, made incorrect diagnoses, pressured them for emotional disclosure, presented suspicious attitudes, acted distant, lacked empathy, or were invasive.

**Requiring Personal Therapy in Educational Settings**

Letting graduate students know about the importance of therapy would help them cultivate their clinical skills, diminish the likelihood of later danger in their psychotherapeutic work, and foster emotional steadiness if the program is unable to implement PT as part of a curriculum (Guy & Liaboe, 1986).

The following two qualitative studies examined the responses of both current counseling students and recent graduates in the UK in order to investigate their experiences of 40 hours of mandated PT during their education (Grimmer & Tribe, 2001; Murphy, 2005). Both their professional and personal developments were impacted by their PT experiences. Participants felt that their personal development was enhanced by a sense of deepening empathy. Examples of reflexivity cited by the participants include admiring their therapists’ interventions, fantasies about being friends with the therapist, “not disclosing to the therapist affective experiences during therapy” (p. 292), and learning the importance of establishing therapeutic relationships within therapists’ ethical boundaries. Regarding the development of a professional identity, participants said that observing therapists’ work provided “modeling” (p. 293) such as learning interventions and different ways of interactions. “Validation” (p. 293) implied firming up beliefs about the efficacy of psychotherapy. Participants found the presence of therapists to be emotionally supportive and noted that PT functioned to manage the stress derived from their training. They noted the interconnection between professional and personal developments. The clearer their self-awareness became, the more accurate their boundaries with clients became. In
other words, PT enabled them to differentiate between issues of their own and those of their clients, such as countertransference reactions or overidentification. Even unsuccessful therapy experiences offered participants a lesson in dismissing particular interventions or modifying them for their own practices.

As noted above, Murphy (2005) also indicated similar findings regarding changes in personal areas paralleling the cultivation of clinical skills. The results of the study provide four phases: “reflexivity” (p. 29) as increasing awareness of personal issues triggered during training or clinical work, “growth” (p. 29) as increasing empathetic understanding of the clients, “authentication” (p. 30) as validating self as therapist and building positive values of psychotherapy, and lastly “prolongation” (p. 30) as students’ evaluated the need for more than 40 hours of PT for the sake of cultivating professional skills regardless of whether or not they were experiencing problems.

Gold and Hilsenroth (2009) provided an interesting viewpoint in their quantitative study. They investigated student therapists’ and clients’ evaluations of their therapeutic relationships. Thirty clients worked with 18 doctoral student therapists who had had PT experiences, while the other 30 clients worked with seven doctoral student therapists who had had no therapy experience. The clinic was located at a university counseling center. The graduate clinicians with therapy experience were engaged in “once-or-twice-a-week, insight-oriented, exploratory treatment” (p. 162). All of the doctoral graduate clinicians in the study had participated in Short Term Psychodynamic Psychotherapy (STPP), engaged in the same type of psychotherapy that they had trained for with the clients, and had experience conducting assessments. The study provided a “semi-structured diagnostic interview” (p. 164) to help establish empathic relationships and discover therapeutic goals for the clients. In addition, the participants engaged
in an “interview follow-up” (p.164). Lastly, the participants engaged in a “collaborative feedback session” (p. 165) to lead them to find “a new way of thinking and feeling about self and others” (p. 165). The Combined Alliance Short Form–Patient (Hather & Barends, 1996) and Combined Alliance Short Form–Therapist (Hatcher, 1999) measured therapeutic alliances from the perspectives of both the client and the clinician. Analysis of variance and Cohen’s d (Cohen, 1988) were employed to evaluate the therapeutic relationships and differences between the two groups. The statistical results are as follows: Clients reported that the relationship was positive regardless of their therapists’ therapy experience. However, significant differences were found between the therapists who had engaged in therapy and those who had not. Student therapists who had engaged in PT rated their therapeutic relationships more highly and felt more self-assured in helping and collaborating with their clients. In addition, the clients with therapists who had received PT remained in therapy for double the amount of time. They stated that the therapists who had engaged in PT did not seem to have conflicts in sharing the same therapy goals and they felt more self-assured. Their clients were also devoted and believed in the positive effects of therapy.

Ethical Issues in Educational Settings. Ethical issues have been a distinct concern when PT is required in educational settings. According to updated ethical codes, receiving any type of therapy should an option rather than a requirement for students (American Psychological Association, 2010). Having a dual relationship in which faculty members conduct a therapeutic treatment is prohibited so that it does not hinder their assessing students’ academic achievement objectively. Turkington (1984) stated that it is unfortunate the American Psychological Association (APA) failed to work out an agreement requiring PT as part of professional formation because of political disagreements and conflicting needs.
One of the most common concerns discussed by faculty was that students felt pressured to undergo PT (Wampler & Strupp, 1976). They indicated that most of the program directors in their research agreed with not requiring students to engage in PT. Some of them were concerned that active suggestions about the gains of PT may make students feel pressured or obligated to seek PT. This point is supported by McEwan and Duncan (1993). The researchers stated the students felt forced to engage in PT when it was mandated on top of other concerns about dual relationships and confidentiality. Safety issues were also linked to confidentiality concerns. Safety for trainees should be assured so that they can break out of their comfort zone to increase inter- and intra-awareness (Robson & Robson, 2008). Therefore, it is important to establish trust immediately.

**Negative experience for student therapists.** Along with ethical matters, Moller, Timms, and Alilovic (2009) revealed that clinical psychology students felt pressured about financial costs and suffered from emotional distress that had the potential to affect the course of their training. These difficulties were described by the participants as “opening a can of worms” (p. 378) and a “Pandora’s box” (p. 378). The researchers also noted that the participants were ambivalent about the requirement of engaging in PT because it may not be fully effective.

Holzman, Searight, and Hughes (1996) distributed a survey to graduate students (N = 1,018) in an American Psychological Association-approved clinical psychology program in order to learn about their PT experiences. Half of them responded to the survey. Seventy-four percent of the samples indicated having had a PT experience during graduate study and that the course of their therapy was either 75.1 weeks or 79.5 % sessions. Even though PT experience brought about growth in personal development, the researchers also reported reasons for participants not to seek PT. Seventy-five percent of those who returned the survey responded they had never
engaged in PT. The most prevalent reason (56%) given was not feeling the need for PT. Financial difficulties (53%) ranked second. Over 50% of the samples who listed negative aspects of PT mentioned that they had no plan to receive PT in the future.

Treating student therapists can evoke difficulties for the therapists as well (King, 2011). The researcher interviewed eight psychodynamic psychotherapists who had treated student therapists and discovered possible conflicts. Even though all the participants determined that PT was necessary, difficulties were encountered. The first “clinical dilemma” was related to the trainees resisting engagement in PT, and they were not fully committed to their own therapeutic work. Therapists’ personal dilemmas were shared as well. They included “pressure to model, sense of responsibility, therapeutic narcissism, countertransference reactions, over-use of self, and stressful involvement” (p. 186). Thus, it was found that requiring therapy may potentially cause worries to therapists who offer PT to their students.

**Personal Therapy for Music Therapists/Student Music Therapists**

The value of having a PT experience has received attention in the field of music therapy as well. Understanding various functions of music enhances both therapists’ clinical skills and personal growth. The use of music is a distinct component in the work of music therapy. The need to understand the transformative power of music and self-exploration for personal growth both while treating others with music therapy and while receiving PT is significant (Hesser, 2001). In addition, the experience of undergoing PT brings a deeper understanding of clinical work and changes in therapists’ musical relationships. Hesser believes that music must be deeply related to therapists’ personal histories and that exploring music throughout one’s lifetime should foster self-reflection, and musical sensitivity. Therefore, music is inseparable from the life of
music therapists, and a transformative experience in music will bring personal and professional growth.

In addition to exploring music that music therapy students can benefit from, music psychotherapists must also demonstrate psychological maturity and cognitive accuracy. Austin (2002; 2008) explained that increasing self-awareness is necessary in order to sustain accurate perceptions as professionals in utilizing “transference, countertransference and other unconscious dynamics” (p. 91). Also, self-knowledge is theorized to bring a better understanding of countertransference (2008). The discerning of a boundary between personal issues and client issues is one of impacts, and Austin (2008) shared that the music psychotherapists should recognize and identify their “own issues, feelings, strengths and vulnerabilities” (p. 92) through psychotherapy or supervision in order not to become confused in therapeutic work. She underlined the importance of PT for music therapists, especially when they work with clients who have similar issues. In particular, common experiences such as traumatic events in the past may blur the boundary and cause a negative countertransferential reaction.

Iliya (2014) investigated how a singing experience helped nine creative arts therapists in a grieving process for significant others who had passed way. Her mixed-method study reported that a one-time singing intervention prompted feelings of emotional support as well as “grief resolution” (p. 148). Furthermore, the participants were able to lessen their emotional distress after the session. Nevertheless, this research project did not include an explanation of how the singing intervention influenced the therapists’ professional work.

The following literature introduces the idea of implementing music therapy experiences as an integral part of the training course. PT is “one of the best ways to continue growing” (p. 184) for music therapy students because they can validate how therapy works through an actual
experience (Wheeler, Shultis, & Polen, 2005). Furthermore, it is important to find a therapist and a therapy model that is aligned with both students’ philosophies and needs. PT also offers both therapeutic and didactic experiences. Wheeler (2002) also reported on the benefits of experiential learning and explained that participating in a music therapy group (MTG) led students to increase their self-awareness and knowledge about music therapy at the same time. MTG provided a place for students to expand their capacity by trying new materials. Broadening their own perspectives about the self and being human was another contribution. As a result, students were able to transfer this realization in working with their clients, especially when making a clinical decision.

Specific examples of integrating required music therapy experiences have been found in the following two articles. Hesser (1985; 2001) explained how she implements therapeutic components in a graduate music therapy program at New York University. One part of her teaching philosophy is to provide the opportunity for self-expression throughout the courses in the program. All the students are assigned to a music therapy group (MTG) where they can enhance their personal and professional growth. Furthermore, they can learn about the strength of music therapy work. If the students have not had any first-hand experience prior to enrolling in the program, they may be urged to find extra support. In order for students to feel safe, this program makes an effort to create “a non-competitive” (p. 68) atmosphere. Frederick (1989) also supports Hesser’s idea that MTG is the most useful way for students to develop.

Aalborg University in Denmark has also provided Experiential Training in Music Therapy (ETMT) for 19 years in a program that includes individual and group music therapy (Wigram, Perdersen, & Bonde, 2002). The philosophy of this program lies in the belief that students should experience music therapy as clients and “musical self-experience… [for] the
The acquisition of therapeutically flexible musical skills” (p. 271). The Danish Ministry of Education approved mandating ETMT in the program, and ETMT became an integral part of the curriculum to show that it is an important part of developing skills. Ethical policies underlined the importance of protecting students’ confidentiality, audio recording or filming the session in case objective intervention is needed to document “serious problems” (p. 286), and mandating ETMT leaders to be under supervision. Intertherapy, which was developed by Mary Priestley, offers another format that students may follow. The term Intertherapy refers to how two students take turns in playing the part of therapist and client for two-hour sessions. This idea has been implemented as part of ETMT and Intertherapy takes place in the presence of a supervisor for both students.

The participation of music therapy students in music therapy was presented in the mixed method study by Amir and Bodner (2013). They conducted a music therapy group (MTG) for students. Students were informed about ethical issues regarding the purpose of the group and they were assured that there would be no adverse effects on their course evaluations. An informed consent form was given and private information was protected. Qualitative results indicated the students participated in MTG in four ways: “talking” (p. 256), “observing” (p. 256), “playing” (p. 256) and “vocal activity” (p. 256). Their styles in participation showed that they identified with other group members, participated in a moment of silence, took on leadership roles, and let themselves be nurtured by the group. Quantitative results showed that the most frequent form of participating in the group was talking. Observing and playing were ranked next. Vocal activity was the least frequent form of communication. The primary form of participation was “identification with one of the group members” (p. 260). The second common form was “being a silent participant” (p. 260). The last two were “being a leader” (p. 260) and being a
“child of the group” (p. 260). This research solely examined how music therapy students participated in MTG, noting forms, roles, or other ways. There was no specific discussion of any professional or personal implications for the participants afterwards.

Gardstrom and Jackson (2011) investigated the perceptions of 41 program coordinators regarding the requirement of PT. The researchers conducted a mixed method study by collecting information on the current trend of implementing PT for undergraduate music therapy students. Descriptive statistics were applied to analyze the generated data and used to interpret narrative statements with a phenomenological approach. Six of the 41 participants mandate PT for their students with the goal of increasing their learning and self-awareness. Many of the respondents do not mandate PT. A few of the most frequent reasons involved concerns about financial issues, lack of permission from universities to require PT due to legal issues, and ethical matters such as dual relationships. Thirty percent of the participants encourage students to undergo PT if they present personal problems and need to increase their insights about therapeutic work or if they need to improve their clinical skills. One participant believed that PT would not be effective if it was required. Rationales for not requiring and not encouraging were similar. The program coordinators who do not encourage PT commented that protecting students’ privacy and cultivating their skills are more important. The results of this study revealed several issues that music therapy educators should consider, such as possible legal and ethical issues, the need for financial support, the positive effects of PT for students, and PT as an appropriate experience for undergraduate level students. This research examined only the perspective of program coordinators about implementing PT as an integral part of an undergraduate level course.

Gardstrom & Jackson (2012) also shared the views of undergraduate music therapy students during and after their participation in group music therapy. The phenomenological
research was generated data from students’ reflection notes and an online survey. The emergent 16 themes are as follows: “exploration/insight into self, emotional safety/comfort, musical self-expression/creativity, client empathy, connection to others, clinical methods/techniques/structures, novelty, validation/acknowledgement, self-care, resistance/ambivalence, insight into others, musical interest/motivation, professional identity, low pressure learning environment, and personal imperative”. Likewise, the short-term music therapy group influenced students’ personal, professional, and musical experiences.

**Personal Therapy in Post Graduate Programs in Music Therapy.** There are a few post graduate music therapy training programs that require PT. Analytical Music Therapy (AMT), developed by Mary Priestley, mandates two types of music therapy for trainees. Undergoing individual therapy from AMT therapists focuses on both didactic and therapeutic experiences. Exploring the inner self through interactive music-sharing and words enhanced trainees’ beliefs in the strengths of AMT. Priestley maintained that this is the only way for the trainees to understand their own clients and increase accurate sensitivity in AMT. Intertherapy takes place in the second part of the training that pairs two trainees who assume therapist and client roles for each other. This process is observed by supervisors.

Guided Imagery and Music (GIM) is another approach that requires PT during the post training program to become a certified GIM therapist (Abbott, 2013). This training ensures that trainees engage in a certain number of sessions for each level. Moreover, they are required to receive only GIM therapy sessions for their personal and professional learning. Paik-Maier (2013) explained that GIM trainees are asked to receive personal GIM therapy sessions as a part of their supervision process as well. The goal of this experience is to increase self-awareness about trainees’ own countertransference toward clients. By contrast, PT is not mandated during training.
in Nordoff-Robbins (NR) music therapy training. Sorel (2013) explained that NR training is designed to enhance the trainee’s development through “a combination of supervision, classes, and clinical work” (para. 1), while other training models encourage this growth by requiring personal therapy. Even though PT was implemented at the NR training center in London, UK, it was no longer provided after 2003 due to financial issues. However, Sorel claimed that mandating PT should be included in the next generation of NR training.

**Cultural Perceptions of Psychotherapy in East Asia**

This section introduces cultural characteristics of East Asia and then looks at these cultural elements in a psychotherapeutic context. Furthermore, it examines how culture has shaped the East Asians’ view of undergoing PT.

**Cultural Values of East Asia**

Culture includes specific belief systems and norms that frame traditions for individuals and groups. It provides a sense of security and a feeling of inclusion as being part of an in-group (Sapir, 2011). Cultural beliefs are manifested in “practices, competencies, ideas, schemas, symbols, values, norms, institutions, goals, constitutive rules, artifacts, and modifications of the physical environment” (Fiske, 2002, p. 5).

In East Asian culture, Confucianism has been a strong influence (Kang, 2010) along with Taoism and Buddhism (Donllinger, 1988). The philosophy of Confucianism emphasizes family-oriented perceptions, mutually dependent relationships, faithfulness, sacrifice, a group-oriented attitude, hierarchy, and the preference for male offspring (Kwon, 2009; Song, 1997). Moreover, emotional expression in Korean culture is considered self-centered and not allowed (Kwon, 2009).
Agricultural and traditional backgrounds have come together in East Asia to create a group-oriented culture. This culture encourages a strong sense of responsibility and feelings of fellowship as a group member. Due to the emphasis on the needs of the group, family or relationships with others are considered more important than an individual’s motivation or capability (Lee, 2004). Therefore, “Collectivism as its [Individualism] opposite pertains to societies in which people from birth onwards are integrated into strong, cohesive ingroups, which throughout people’s lifetime continue to protect them in exchange for unquestioning loyalty” (Hofstede, 1991, p. 51).

**Socio-economical changes in East Asia.** Around the same time that East Asian countries showed rapid industrial development, they gained exposure to Western cultures and began to accept new mores. In the early 19th century, industry developed and lifestyles of the middle class improved, especially in urban areas. Both the US and Europe have had great influence over Japan since that time (Synodinos, 2001). By the mid-1990s, “western scientific technology and government structures” (Suzuki, Ito, Ishida, Nihei, & Maruyama, 2010, p. 517) brought modernization to Japan. Ishikawa (2007) reported that social leaders encouraged the Japanese to embrace the technology of the West and merged it with Japanese values.

China also modernized after the Opium War in 1853, which allowed its citizens to absorb Western cultural values (Debary, 1988). This modernization of China is largely due to changing individual and social values resulting from contact with Western cultures and the Chinese have created a bicultural self (Lu, Kao, Chang, Wu, & Jin, 2008).

Korea also exhibited a similar phenomenon. As the Gross National Product (GNP) grew in Korea during the 1980s, Koreans became involved in businesses worldwide and rapid industrial changes occurred. Exposure to Western cultures changed the country so that “Koreans
began experiencing weakened cultural identity, and to some extent, disintegration” (Joo, 2006, p. 104).

Socioeconomic growth brought new aspects to the traditional family-oriented system and raised a concern about emotional well-being. Interracial marriage, independence of women, and the rise of single parenthood have altered the family system even more. The rate of singles and divorced couples has increased because the Japanese people began to seek “self-actualization” (p. 513). Simultaneously, economic growth also prompted their quest for security and individualization (Suzuki, Ito, Ishida, Nihei, & Maruyama, 2010).

Social development and transitions in Korea resulted in confusion and conflicts such as “divorce, suicide and emerging problems related to youth and children” (Joo, 2006, p. 104). Yoo, Lee, and Yoo (2007) also stated that rapid development in Korea affected cultural values; marriage customs changed and nuclear families became common. At the same time, destruction of the family grew. Because Confucianism has not disappeared completely from Korean society, the “ideal of extreme We-ness” (p. 212) still creates conflicts and confusion in relationships. Reexamining the family relationship is necessary for the quality of family life, especially for needs such as emotional stability and mental well-being.

**Perceptions of Mental Health Care in East Asia**

Even though accepting Western culture enriched Asian people’s quality of life, it is undeniable that this transition is still confusing. The importance of addressing psychological issues paralleled the changes. According to Joo (1998), socioeconomic development in Korea “led many people who felt these changes most intensely to seek counseling or psychotherapy” (p. 17).
Psychotherapy is an interpersonal process that prompts cognitive, affective, and behavioral changes (Corsini, 2000). The psychotherapeutic experience is designed to help clients deal with emotional issues, promote self-expression, and gain insights. This experience also concerns spiritual development (Bruscia, 1998; Cautin, 2011). However, Asian culture emphasizes the importance of people relating to each other and values conformity, while American culture focuses mainly on people’s independence and the cultivation of the inner self (Markus & Kitayama, 1991). Sato (1998) also explained that collective cultures consider therapeutic transformation as “dissolving the self by merging with the environment” (p. 278) as opposed to immersing the self and owning the independent self in a therapeutic context. Therefore, Asian cultures can be understood to be resistant to the necessity of PT as it is stressed in Western countries.

Seeking Attitudes About Mental Health Services. Asian cultural values strongly influence negative perceptions toward seeking professional psychological health services (Hom, 1996; Yakunia & Weigold, 2011; Gim, Atkinson, & Whiteley, 1990). Atkinson and Gim (1989) reported that the more highly acculturated Asian Americans were, the more they recognized the need for professional mental health services. They exhibited greater tolerance of cultural stigma and a willingness to open their personal issues to mental health practitioners. On the other hand, Chinese students showed more accepting attitudes toward problematic behaviors and did not perceive the necessity for professional help (Mau & Jepsen, 1990). They sought help from friends rather than professional counseling (Chang, 2008). Korean undergraduate students with “higher level[s] of negative social network orientation and self-concealment” (Yoo, Goh, & Yoon, p. 274) revealed relatively more negative attitudes toward professional psychotherapy.
The following two research projects look at attitudes and cultural factors that influenced likelihood of Asian students to seek professional mental health services. Li, Wong, and Toth (2013) aimed to find correlations between their levels of academic stress and their willingness to seek therapy and/or previous encounters with counseling. Asian international students ($N = 177$) who attended university in the US participated in this mixed method study. Only 17.5% of the samples reported any previous experience in counseling. Three measurements were employed to generate quantitative data—Attitudes Toward Seeking Professional Psychological help (Fischer & Farina, 1995), Willingness to Seek Counseling for Academic Problems (Gim, Atkinson, & Whiteley, 1990), and The College Stress Inventory (Solberg et al., 1993). Data analyzed by hierarchical multiple regression showed that a predictor of willingness to seek counseling was related to attitudes toward mental health services and previous counseling experiences. Also, academic stress was a significant factor in forming attitudes toward seeking help through counseling. Six themes emerged from the qualitative results, showing both positive and negative perceptions of mental health services. The most common theme revealed that the participants thought counseling services were only for people with “serious mental illness” (p. 8). While 27 students believed that counseling is “helpful” (p. 8), 10 of the participants expressed negative views about “sharing their personal information with a stranger” (p. 9). They said that it would make them feel uncomfortable to talk about their personal matters. Another salient theme to emerge was that Asian international students perceived that counseling had practical roles, such as providing “help” (p. 8), “solving the problems” (p. 8), and “advice seeking” (p. 8). The researchers pointed that the participants’ perceptions toward counseling derived from cultural stigma that counseling is reserved for people with “severe mental health problems” (p. 10). This
cultural bias shows that seeking psychological help is considered shameful for the family in group-oriented Asian cultures.

Leong, Kim & Gupta (2011) found similar results about attitudes toward mental health services along with a correlation with acculturation among Asian American college students. Four scales were used to analyze participants’ attitudes and acculturation levels: Acculturation Attitude scales (Kim, 1988), Loss of Face Scale (Zane, 1991), Conception of Mental Health Scale (Nunnally, 1961), and Attitude Toward Seeking Professional Help Scale (Fischer & Turner, 1970). The researchers distributed questionnaires to 134 Asian American undergraduate students. The result of this quantitative research indicated that Asian American participants’ attitudes toward seeking professional psychological help were strongly linked to cultural aspects. The higher the acculturation level the participants manifested, the more positive attitudes \((r = .34)\) and conceptions toward mental health services they indicated. Loss of face was related to acculturation levels and acceptance of the need for professional mental health services. The samples who highly adhered to Asian cultural values showed no need for professional counseling, and “interpersonal openness regarding their problems” (p. 149), and indicated “high levels of shame or loss of face” about the idea of seeking psychological help (p. 149). Cultural aspects strongly influence Asians’ attitudes toward seeking professional mental health services.

**Relationships with therapists.** The family relationship is tight and influential on the formation of individuality in Asian cultures. Children develop their “ego structure and self-image” (Slote, 1998, p. 43) based on their family, from which their identity is inseparable. Psychological suppression results from being raised in an authoritative family. This atmosphere brings “fear, dependency, and hostility” (p. 46) and leads to emotional restriction. Children are not allowed to express their feelings, especially toward their parents (Slote, 1998). Thus, the role
of each family member can be projected in a therapeutic situation. Cheong (2001) maintained that “Sometimes clients would expect a therapist to be like a family member. Therapists would take an authoritative father role and family members would take a child role” (p. 9). Song (2005) pointed out that “the attitude of unconditional dependency of clients on the therapist, caused by upper and lower relationship patterns, should not be depicted as immature” (p. 28). Song’s statement is important to contemplate as it relates to cultural tendencies. At the same time, psychotherapists may need to be careful about making judgments about whether this closeness is related to cultural influences or has its roots in resistance to separating from the family and becoming an independent self.

Cultural aspects were evident in clients’ expectations about therapists whom the Chinese perceive to be authority figures and they expect therapists to provide “explicit directions in how they should conduct themselves, and [clients] will strictly follow the statements, observations, and recommendations of the therapist” (Qian, Smith, Chen & Xia, 2002, p. 53). However, these dynamics do not foster independence and may even interrupt the therapeutic process (Qian, Smith, Chen & Xia, 2002).

Failure to form a solid therapeutic relationship can occur when non-Asian psychotherapists do not understand Asian cultures. In their theoretical paper, Tsui and Schultz (1985) emphasized that Asian cultures are oriented to obeying authority, confining emotional expression, and focusing on family relationships. Asian clients who are less acculturated would be more dependent on therapists to provide them with guidance and structure. Therefore, it would be helpful for Asian clients to be familiar with the effects and processes of counseling because they might be unfamiliar with the purpose of receiving counseling (Cha, 2001; Tsui & Schultz, 1985).
It is noteworthy to examine how Korean therapists perceive themselves in therapeutic relationships. The following study by Joo (1998) provided the perspective of how Korean psychotherapists identify and experience psychotherapeutic relationships in comparison to Western psychotherapists. The researcher indicated that Korean therapists expressed themselves as more “formal” and less “invested.” Unlike Western therapists who described themselves as “directive,” Korean therapists perceived themselves as “superior.” Joo further explained that these findings were influenced by Korean cultural values, such as group cohesion and hierarchical relationships.

**Expressing Self.** The devaluing of emotional needs and expression is found in Asian culture as well. Kwon (2009) mentioned that her Korean clients repressed their emotions, experienced difficulty in self-expression, and had an unclear awareness of their thoughts and feelings because there was no opportunity for them to explore or express them. Zhou, Siu, and Xin (2009) stated that the bias exists that Asian Americans are “diligent and high achieving” (p. 290). Therefore, their emotional issues are easily overlooked. This fact may cause Asian clients to terminate treatment early. Shim (2012) also suggested that therapists need regular supervision to be more sensitive to their clients’ cultures in order to maximize therapeutic effects. Moreover, they should consider a spectrum of “normality/psychopathology from the cultural perspective” (p. 108).

Difficulties in self-disclosure are displayed in the following studies as well. Chen and Danish (2010) reported that acculturation levels and emotional disclosure are correlated in their quantitative research. Ninety-eight Asian students in the US were recruited. The researcher employed four scales: Asian Values Scale-Revised (Kim & Hong, 2004), Suinn-Lew Asian Self-Identity Acculturation Scale (Suinn et al., 1992), Distress Disclosure Index (Kahn & Hessling,
and Emotional Self-Disclosure Scale (Snell et al., 1988). The results indicated that the less acculturated Asian people are, the less distress they disclose. Only values-based acculturation is related to distress disclosure; behavior-based acculturation does not affect it. Regarding emotional disclosure, the researchers found that no matter how acculturated Asian participants may be, they were more willing to disclose their emotions to friends than to unrelated, reliable adults. Furthermore, behavioral acculturation was interrelated to emotional self-disclosure, and people with less behavior acculturation were more willing to open their emotions to unrelated, trusted older people. The researcher also explained that it is culturally common that Asian people seek advice or directions from seniors.

Self-disclosure can be still challenging for Asians in spite of the fact that it is a necessary element in successful counseling (Zane & Ku, 2014). Difference in self-disclosure was discovered between Asian international students and American students (Yoon & Jepsen, 2008). Asian students revealed themselves less, were less aware of their need for therapy, and showed greater distress and embarrassment about counseling. The researchers stated that this finding is linked to cultural stigmas about counseling and that Asian students choose to derive help from other support systems instead.

**Suggested Cultural Modification.** As stated in the aforementioned literature, cultural gaps have been found in the application of traditional modes of Western therapy. Leong and Lee (2006) maintained that it is imperative to employ cultural modifications pertinent to clients’ levels of cultural adjustment, self-concept, and communication styles in a cross-cultural context. Tseng (2004) also supported the notion that therapists should adapt their therapeutic approach, modify the foundation of psychopathology, and adjust the philosophical perspective of human beings in order to become culturally competent.
Directive counseling styles and formatted counseling were preferred by Asian international students (Li & Kim, 2004; Yoon & Jepsen, 2008). A quantitative study by Kang (1993) showed consistent results. As hypothesized, male Korean students who were less acculturated evaluated counselors who had a directive style more highly. However, male Korean students who were more acculturated greatly preferred a non-directive counseling style. The researcher suggested that when mental health practitioners work with Korean clients, they need to provide “a structured, rational, and directive style of intervention” (p. 165). Also, the participants preferred counselors who had similar cultural backgrounds. Because all of the participants in this study were male, there is the possibility that results might differ with female Korean students.

There has been an effort to eliminate the social stigma toward engaging in psychotherapy in Japan. Iwakabe (2008) stated that the Japanese people have repulsion toward “treatment” (p. 106). Therefore, mental health practitioners shifted their targets of population to educational settings, “working with schoolchildren, their family members, and teachers as their main client populations” (p. 107). Furthermore, they use a nonverbal medium such as art supplies because it eases their discomfort in personal sharing. These approaches can contain their “intuitive understand[ing] and sharing through the sensibilities” (p. 112).

There needs to be a change in public awareness as well. Li, Duan, Ding, Yue, and Beitman (1994) pointed out the social stigmas regarding psychotherapy as well as the lack of understanding, techniques, and professional training of psychotherapists in China. The authors maintained that “policy” (p. 281) and “organization” (p. 281) should be more grounded to make Western-based psychotherapy more accepted and solidify the knowledge of mental health practitioners. Hou and Zhang (2007) introduced the possibility of educating Chinese people by
using mass media to make them aware of the benefits of professional mental health services.

“The possible formats may be interviews with counseling professionals and educational programs about mental health issues, counselling, and how counselling services can be used in daily life” (p. 47).

**Integrating Personal Therapy for Music Therapists in East Asia**

**The Field of Psychotherapy**

Kang (1990) offered information regarding psychotherapy as an integral part of training for Korean therapists, which began in 1970. PT was not officially required for academic program for degrees. However, the number of psychotherapists who receive PT has increased as time has passed. “Counselors take therapy for their personal and professional growth that is called educational analysis in Korea (Yoo, Lee, & Jo, 2010). “Educational analyst is counselor’s counselor” (p. 1431). This unique concept of Educational Analysis was coined by Shim (1991). The educational analyst not only helps with increasing therapists’ self-awareness but also guides clinical work and plays the function of role model. However, researchers reported that there were very few research studies published regarding educational analysis in Korea, even though educational analysis or PT is significant for both personal and professional growth.

Shim (1991) indicated that educational analysis is not prevalent during training due to financial difficulties and the lack of students’ motivation as they undergo their academic training in Korean schools. However, there was no discussion found regarding cultural aspects in the above-mentioned studies. Joo, Bae, and Orlinsky (2003) support Shim’s (1991) research. They compared Korean participants’ professional and practice characteristics to Western therapists’ data from US ($n = 844$), Norway ($n = 804$), and Germany ($n = 1,059$). The outstanding difference in the results is that Korean therapists’ PT experiences were distinctively fewer than those of
Western therapists. Furthermore, even therapists whose practice is based on psychoanalytic approaches rarely underwent analysis, which raises concerns.

However, Sohn, Yoo, and Shin (2003) emphasized that as psychotherapy has become more widespread in Korea, self-reflection has grown to be an essential element for counselors’ professional development and proposed supervision is a way of enhancing self-reflection. Yoo, Lee, and Jo’s (2010) other research investigated the educational analysis experiences of Korean counselors or counselor students. This quantitative research analyzed the participants’ frequency, motivation, and reflection of educational analysis. In addition, the researchers examined the participants who had no educational analysis experience to understand their attitudes toward educational analysis. The results showed that the frequency of participating in educational analysis was 1.6. The motivations for participating in educational analysis were 43.9% to resolve personal issues, 38.3% to seek professional help, and 14.5% for both. A full 85.5% of participants reported that their educational analysis experience was effective or very effective. Personal development, self-awareness, and the understanding of personal issues were the most helpful areas. For professional development, awareness of counselors’ issues was most helpful. About quarter of the participants thought that educational analysis contributed to their professional development and 82.1% agreed with the educational analysis requirement for continuing professional growth. The congruent result was indicated in the research by Kim and Cho (2015) that educational analysis had positive influence on counselors’ professional development, such as counseling communication skills, knowledge about clinical cases, and ethical attitudes. Additionally, counselors with educational analysis showed emotional sensitivity and better planning skills for counseling sessions.

**The Field of Music Therapy**
Unfortunately, there is a lack of research concerning the impact of PT on therapists in the Asian music therapy field. Even though only a few studies have attempted to discuss personal and professional development, none of them provides information directly either about the impact of PT or cultural implications.

Korean researchers (Kim, Lim, & Choi, 2014) briefly mentioned that music therapy for beginning music therapists was one way to deal with their vocational difficulties. Countertransferential reaction was discussed as something to be dealt with during Korean music therapists’ therapeutic encounters. Kim (2012) indicated that Korean Music and Imagery (MI) therapists experience interactive growth during their own clinical work. The participants stated that this growth resulted from working actively on their countertransference. They used supervision to explore countertransferential reactions. Therefore, the therapists increased self-awareness and experienced self-acceptance throughout the process. Yi (2008) also examined Korean music therapists’ ability to deal with countertransference. The result of the survey showed that 54% of respondents believed that personal analysis or personal therapy can offer a way to manage countertransferential reactions.

The following two studies investigated therapy experiences for Korean music therapy students. Moon (2014) conducted a phenomenological study to discover the meanings of music psychotherapy experiences that took place in class. Korean music therapy students in this study reported both professional and personal developments. This opportunity led them to cultivate clinical skills and be involved in self-reflection. Bae (2011) investigated how music therapy groups influenced Korean music therapy students’ “anxiety, mood, job engagement, and perceived self-efficacy” (p. iii). The results indicated that the MI group related positive feelings about “job engagement, trait anxiety, total mood disturbance, and self-efficacy” (p. 59).
Even though all the studies above discussed therapeutic experiences of music therapists/student music therapists, none of them mentioned cultural perspectives or direct PT experiences.
CHAPTER 3

Method

The purpose of this phenomenological study was to explore the previous personal therapy experiences (PT) of East Asian professional music therapists from their perspectives as clients, while they pursued formal music therapy training in the US. In addition, the researcher examined cultural aspects of their experiences because the participants were originally from East Asian cultures but had engaged in Western models of therapy. The elements discussed in this chapter include (a) rationale for the research design, (b) sampling and information regarding the research participants, (c) outline of the research design, (d) process of data analysis, (e) ethical considerations, and (f) trustworthiness. The process of data collection and analysis is presented in Figure 1.

Figure 1. A process of data collection and data analysis.
Research Questions

In order to discover the meanings of East Asian participants’ therapy experiences in the US, the proposed research questions were as follows:

1. How did experiencing personal therapy influence Asian music therapists’ development during their training?

2. How might personal therapy have influenced the ways Asian music therapists use music clinically and personally during and after training?

3. How did specific Asian cultural perspectives influence Asian music therapists’ own therapeutic processes?

4. What cultural modifications to clinical practice have Asian music therapists made regarding Western concepts of therapy, and why?

Rationale for Research Design

This current study was viewed through the theoretical lens of phenomenology – a qualitative research method that explores participants’ previous PT experiences from the point of view of a client and two different cultural experiences.

A qualitative research study explores the meaning and quality of subjects’ responses rather than quantifying them (Denzin & Lincoln, 2007), finds “silenced voices” (Creswell, 2013, p. 48), and aims to discover “concept[s] or phenomen[a]” (p. 98). A qualitative research study is truly interested in understanding the meaning of human experiences (Aigen, 2005; Bruscia, 2005; Creswell, 2013; Denzin & Lincoln, 2007). Phenomenological research methods were developed by Giorgi, Colaizzi, Benner, van Manen, van Kaam, and Moustakas (Forinash & Grocke, 2005). Phenomenological researchers seek to discover the core experience stated by participants (Creswell, p. 13) and “common meaning for several individuals of their lived experience of a

**Recruitment of Participants**

Purposive sampling was employed to recruit participants who fit the criteria rather than randomly searching in order to find appropriate samples. This technique can provide an option to choose “individuals and sites for study because they can purposefully inform an understanding of the research problem and central phenomenon in the study” (Creswell, 2013, p. 156). In addition, it is applicable when the research generates data mainly from interviews (Vogt, Gardner, & Haefele, 2012). The intention is to acquire abundant information from the cases (Boehnke, Lietz, Schreier, & Wilhelm, 2010).

The criteria used to recruit appropriate participants follows: (a) identified as native East Asian music therapists, (b) completed formal music therapy training (or the equivalent) in the US, and (c) experienced any type of individual PT over at least three months during their training.

For this study, the researcher contacted potential participants who might have engaged in personal therapy during their training in the US. All of the possible candidates were directly contacted through the researcher’s personal connections. All the contacts took place in person or through emails. Various routes were used to obtain their email addresses. First, the researcher personally knew their contact information. Second, the researcher searched through the alumni directory of current university. Last, one of the researcher’s peers who attended a doctoral program introduced possible participants to her. Thirteen individuals were asked if they had experienced any type of personal therapy and if they would be interested in being interviewed for this research project. Two people responded they had never been in therapy. They explained that they had gone to one or two trial sessions and decided to not return. One other person had had
only 10 counseling sessions on campus, and this did not meet the criteria. The remaining eight Asian music therapists agreed to be interviewed for the research. Upon accepting the participants’ verbal agreement to take part in the study, the researcher distributed a recruitment letter (Appendix A) that included a detailed explanation of the study, an informed consent form (Appendix B), a basic questionnaire (Appendix D), interview guidelines (Appendix E) and interview questions (Appendix F). A copy of the signed informed consent form was scanned and returned to all the participants immediately.

**Demographics of the Participants**

One male and seven female music therapists participated in this research project. All of them identified themselves as native East Asians; they ranged in age from 31 to 41. The sample included music therapists from Korea, Japan, and Hong Kong. Their main purpose in moving to the US was to pursue formal education. Seven of the participants hold master’s degrees in music therapy in the US, and one participant was not in an academic program but had completed the equivalent training accredited by the American Music Therapy Association (AMTA). The participants’ clinical experience ranged from three to 14 years. All the participants continued post graduate training and specialized in particular approaches of music therapy. Their current careers were focused on practicing clinical work or teaching, either in their home countries or the US. The period of time over which the participants received personal therapy ranged from six to 24 months ($M = 15.1, SD = 6.35$). The rest of the information regarding participants’ therapy experience is summarized in Table 1.
Table 1.

*Descriptive Characteristics of Participants and their PT Experiences*

<table>
<thead>
<tr>
<th>Name</th>
<th>Format of PT</th>
<th>Type of PT</th>
<th>Period of PT (months)</th>
<th>Educational Status during PT</th>
<th>Graduated year</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Individual</td>
<td>Verbal</td>
<td>18</td>
<td>Master</td>
<td>2008</td>
</tr>
<tr>
<td>B</td>
<td>Individual</td>
<td>Music</td>
<td>11</td>
<td>Master</td>
<td>2008</td>
</tr>
<tr>
<td>C</td>
<td>Individual</td>
<td>Verbal</td>
<td>24</td>
<td>Doctoral Leave of absence</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Individual</td>
<td>Verbal</td>
<td>12</td>
<td>Master</td>
<td>2011</td>
</tr>
<tr>
<td>E</td>
<td>Individual</td>
<td>Music</td>
<td>12</td>
<td>Master</td>
<td>2005</td>
</tr>
<tr>
<td>F</td>
<td>Individual</td>
<td>Verbal</td>
<td>12</td>
<td>Master</td>
<td>2004</td>
</tr>
<tr>
<td>G</td>
<td>Individual</td>
<td>Music</td>
<td>12</td>
<td>Master</td>
<td>2004</td>
</tr>
<tr>
<td>H</td>
<td>Individual</td>
<td>Music</td>
<td>24</td>
<td>Master</td>
<td>2007</td>
</tr>
</tbody>
</table>

Table 2.

*Descriptive Characteristics of Participants’ Therapists*

<table>
<thead>
<tr>
<th>Theoretical orientation</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Analytic psychology</td>
</tr>
<tr>
<td>B</td>
<td>Humanistic/Psychodynamic</td>
</tr>
<tr>
<td>C</td>
<td>Analytic psychology</td>
</tr>
<tr>
<td>D</td>
<td>Humanistic</td>
</tr>
<tr>
<td>E</td>
<td>Psychoanalytic</td>
</tr>
<tr>
<td>F</td>
<td>Humanistic/Psychodynamic</td>
</tr>
<tr>
<td>G</td>
<td>Psychodynamic</td>
</tr>
<tr>
<td>H</td>
<td>Psychoanalytic</td>
</tr>
<tr>
<td></td>
<td>Asian immigrant</td>
</tr>
<tr>
<td></td>
<td>American</td>
</tr>
<tr>
<td></td>
<td>Asian immigrant</td>
</tr>
<tr>
<td></td>
<td>American</td>
</tr>
<tr>
<td></td>
<td>Asian immigrant</td>
</tr>
<tr>
<td></td>
<td>American</td>
</tr>
<tr>
<td></td>
<td>European immigrant</td>
</tr>
</tbody>
</table>
Data Collection

The Institutional Review Board of Lesley University officially approved the study on August 7, 2014 (APPENDIX C). The interview data were collected between August 11, 2014 and September 27, 2014. Prior to the interviews, participants received interview packages via email that included a basic demographic questionnaire, interview guidelines, and the list of interview questions.

**Basic Demographic Questionnaire.** The researcher created a basic questionnaire in order to obtain the participants’ personal information, such as personal and educational backgrounds and details of PT experiences, including types of PT, duration of PT, and basic information about their therapists. This questionnaire assisted selection of suitable research samples and provided necessary background information to refer to throughout the interviewing process and interview data analysis.

**Interview.** The primary data resource used to gather participants’ experience for this study was individual interviews. The researcher interviewed the four Korean participants in Korean, which is her native language. She interviewed the remaining participants in English; all of them were fluent in English. The interviews were considered in a semi-structured manner, as they consisted of “direct questions but with freedom for either the interviewer or interviewee to raise issues not previously anticipated or to dismiss questions deemed less relevant” (Hugh-Jones & Gibson, 2012, p. 104). The interview questions were divided into four categories: general, personal, professional, and cultural experiences.

After participants had returned a pre-survey and signed a consent form, they were individually interviewed by the researcher. Two samples were interviewed in person, either in the researcher’s work office or at the participant’s office. The rest of the participants were
interviewed via free call programs, such as Skype or VSee because all of them resided in various locations in the US, China, or Japan. Because this research project relies solely on the participants’ retrospective memories, the researcher emailed interview questions prior to the actual interview so that participants could review them and recall their therapy experiences as clients. Moreover, the researcher practiced the interview format with two colleagues ahead of time in order to help the interviewees feel comfortable enough to share their personal information. During the rehearsal, the researcher experienced her roles as both an interviewer and interviewee. The peers shared their honest feelings and impressions about the researcher’s attitude, manner of speaking, and emotional presence. The researcher did not want to sound too formal while interviewing participants because the research topic was highly private and sensitive and the participants needed to feel comfortable. Based on the feedback from colleagues and the doctoral committee, the order of interview questions was changed so as not to jump into asking private questions too soon.

In face-to-face interviews, the researcher recorded the dialogue with a Samsung Galaxy Note and a Sony recorder ICD-UX512. The iFree Skype recorder program was used to audiotape web interviews. The VSee program offered its own recording function for videotaping conversations. The length of the interviews ranged from one hour, 13 minutes, and nine seconds to two hours, eight minutes, and 24 seconds.

Each interview was transcribed verbatim by the researcher. The Express Scribe software program was used for transcribing. All the audio files, consent forms, and basic information were stored on the researcher’s personal computer. In order to protect the privacy of the participants, the password for this computer was set up so that only the researcher could access information.

Data Analysis
In order to capture and explore eight Asian music therapists’ previous therapy experiences as clients, this research project applied Moustakas’ (1994) and Creswell's (2013) ideas for data analysis in a flexible way. First, Creswell (2013) stated that Moustakas’ modified version of the Stevick-Colaizzi-Keen method is the most pragmatic, and he proposed a simplified procedure of data analysis based on that version. Therefore, the researcher used Creswell’s simplified data analysis. In addition, the NVivo 10 computer program was used to organize the interview data.

The procedure was as follows:

1. Describing the researcher’s personal experiences
2. Identifying and listing significant statements verbatim from transcriptions of each interview without judgment and interpretation.
3. Creating meaning units (coding), clustering them into categories, and developing them to correspond with each theme of participants’ common experiences.
4. Conducting peer-debriefing for coding to confirm its accuracy.
5. Working on a second coding process on NVivo10 after review and feedback by peers.
6. Repeating and highlighting significant statements as well as removing unclear codes and expanding more meaningful units by reviewing original interview transcriptions multiple times.
7. Grouping repeated patterns of common statements for categories and subcategories and developing these into themes.
8. Writing the textural descriptions of the experiences using verbatim examples.
9. Writing the structural descriptions of the experience with verbatim examples that included the elements of composite textural and structural description of the experiences.
Table 3

Examples of Thematic Data Analysis: Data Extracts and Applied Codes

<table>
<thead>
<tr>
<th>Data extract</th>
<th>Coded for</th>
</tr>
</thead>
<tbody>
<tr>
<td>“There are not many cases when typical people go to counseling in my country.” (Participant A)</td>
<td>Therapy is unusual in Asia</td>
</tr>
<tr>
<td>“My therapists addressed my needs as a mother would.” (Participant B)</td>
<td>therapist as a good enough mother</td>
</tr>
<tr>
<td>“I came to understand my clients’ emotions better and help them to identify and focus on their emotions as I experienced the same.” (Participant C)</td>
<td>Able to focus on clients’ emotions</td>
</tr>
<tr>
<td>“It is not easy to listen to somebody without judging. But watching my therapist, I also wanted to listen to [my clients] the way she did and came to think about how [my clients would feel] when I did the same.” (Participant D)</td>
<td>Learning a non-judgmental attitude</td>
</tr>
<tr>
<td>“I had to tell her everything and she was pretty…not aggressive, but—you know—pretty clear about what she wanted to know or what she wanted me to process.” (Participant E)</td>
<td>Therapist’s personality</td>
</tr>
<tr>
<td>“She had a great understanding in terms of how Asian families are so attached. Almost like over-attached, you know—especially my mom raising her children—it was the center of her life and so hard for her to let it go.” (Participant F)</td>
<td>Feeling understood by therapist about family being over attached</td>
</tr>
<tr>
<td>“Through therapy, I guess I learned to trust myself a little more. It is okay to say what I want to say or start to get in touch with myself and understand ‘oh! This is what I am thinking’ or ‘oh! This is feeling.’” (Participant G)</td>
<td>Trusting myself</td>
</tr>
<tr>
<td>“I loved my playing better. That was a unique experience, but I now feel that I like the instruments better. I like how I have a relationship with the instruments and how I play in the concert and stuff. The whole thing is much …I am not making…I myself am doing it.” (Participant H)</td>
<td>Accepting own music</td>
</tr>
</tbody>
</table>

There are several important points that need to be addressed in the process of data analysis for a phenomenological inquiry. In order to discover significant statements and
understand the phenomena as experienced by the participants (Creswell, 2013), the researcher treated all statements equally and only later eliminated those irrelevant to the topic (Moustakas, 1994).

In the case of this particular research study, the researcher read verbatim interview transcripts numerous times in order to highlight significant statements and group them into themes. After formulating meanings for each significant statement, the researcher noted themes that emerged and assembled common phenomena and experiences. Themes that were drawn were presented by applying textural and structural descriptions. While textural descriptions detailed what the participants experienced, structural descriptions attempted to show how they experienced the phenomena in “conditions, situations, or context” (Creswell, 2013, p. 80). Composite textural and structural descriptions were integrated, which showed “the essence of the phenomenon” (p. 82) and the “culminating aspect of a phenomenological study” (p. 142), including emotions. In general, composite descriptions consisted of a long paragraph. They showed what a given phenomenon was and how the participants experienced it (Creswell, 2013; Moustakas, 1994).

**Trustworthiness**

Trustworthiness is necessary for “accuracy of the findings” (Creswell, 2013, p. 249) in qualitative research. Trustworthiness also ensures that “the processes of the research are carried out fairly, [and] that the products represent as closely as possible the experiences of the people who are studied” (Ely, 1991, p. 93).

**Triangulation.** Triangulation aims to obtain “corroboration evidence” (Creswell, 2013, p. 251) from multiple data resources. The researcher used three types of data resources: interview
data, member checking, and peer debriefing. As explained above, the interview offered the most useful information about each participant’s experience.

Member checking was used to intensify the trustworthiness of the data analysis. A verbatim interview transcription was emailed to each participant for reviewing before beginning data analysis. Two participants returned the transcription with no corrections. The rest corrected misspelled words or provided additional explanations. There were no major corrections or requests to withdraw any statements from the initial interview. In addition, the researcher relied on consulting with committee members throughout the process and was engaged in a peer debriefing.

Peer debriefing was also a significant component “to enhance the accuracy of the account” (Creswell, 2009, p. 192). A colleague who was a Ph.D. candidate in a creative arts therapies program in the US was involved in overseeing the collecting of data from the beginning to the final thematic analysis. She was a native East Asian with PT experience both in the US and in her home country. The peer provided feedback in each of the following steps:

1. Reviewing each of verbatim individual interviews that included coding lists of significant statements in Microsoft Word file format.
2. Providing both written and verbal feedback about repetitious or unclear codes.
3. Checking the accuracy of naming themes, categories, and subcategories.

**Ethical Considerations**

Prior to conducting individual interviews, the researcher presented details of research and informed consent forms for approval by the Lesley University Institutional Review Board. A description of the research and a list of participants’ rights were provided in a written document.
In the written consent form, the researcher informed participants that their confidentiality was guaranteed and their right to withdraw from the study was assured.

**Researcher’s Reflexivity and Bias**

The researcher’s initial impetus to study the current research topic stemmed from her own PT experience during her graduate study in the US. The researcher was mandated to participate in two years of a music therapy group and also volunteered to receive individual therapy as a client. Those experiences were invaluable and still influence her both personally and professionally. Returning to her home country and teaching Korean music therapy students, the researcher realized that they had need for PT, especially after she conducted the pilot study in 2012 on Korean music therapy students’ experiences of music therapy group that led to this current research topic. The pilot study indicated that Korean music therapy students benefited greatly both professionally and personally. However, the Korean participants repeatedly commented on the cultural distance they noticed. Therefore, the researcher decided to explore East Asian music therapists who had received PT during their training. In addition, she examined how cultural elements and their bicultural experiences influenced their therapeutic course and relationship with their therapists.

It is undeniable that the researcher’s personal experience was deeply related to the participants’ sharing in this research project. The researcher kept a reflexive bracketing process throughout the research process. The reflexive process consisted of keeping a personal journal and continuous communication with peer reviewers. They provided the researcher with an outlet for her personal feelings. This process is called Epoche and is a significant element in a phenomenological study. By writing out personal experiences related to a particular topic before beginning a data analysis, researchers strive to avoid overlapping or confusion between their
participants’ and their own previous experiences. Husserl maintained that phenomenologists must make an effort to prevent data from being biased by their personal values and previous experiences (Moran, 2000). Moustakas (1994) also supported the idea that a researcher needs to put aside personal preconceptions. He further explained that putting aside personal preconceptions allows researchers to perceive a phenomenon in a fresh and unbiased way. Furthermore, it helps them to be more accepting of participants’ various experiences (Forinash & Grocke, 2005, p. 324).
CHAPTER 4

Results

The purpose of this qualitative research project was to examine the personal therapy (PT) experiences of eight East Asian music therapists, from a client’s perspective. The research focused on investigating these music therapists’ previous therapy experiences while they were in formal music therapy training in the US. The research was intended to not only discover the meaning of their own therapeutic work but also included their cultural experiences from both Asian and Western points of view as they worked throughout their courses of therapy.

This chapter will present simple individual descriptions of participants regarding their education, cultural backgrounds, and their motivation to seek therapy and will include information about their therapists. 4 emergent themes with 13 categories and 20 subcategories will then be described, and fleshed out with in-depth descriptions of the participants’ experiences and direct quotes from interview transcripts.

Individual Textural Descriptions

In order to protect participants’ personal data, all names and identifiable information have been disguised.

Participant A worked as a music therapist in her home country after having completed her Master’s degree in Music Therapy in the US. She had previous experience living and studying both in Europe and in the US. In one of her classes, her professor asked if everyone was in PT and she noticed that she was one of only two who were not. This incident led her to seek PT. Following her professor’s suggestion, she chose to work with an Asian American therapist who was familiar with her culture. The therapist’s work was psychoanalytically oriented and consisted of a type of verbal therapy. Participant A felt that the first session was the most
meaningful. She commented: “Looking back, I remember the first session the most. I cried in the first session.” She stayed with her therapist for one and a half years and continued receiving PT after returning to her home country with a different therapist.

Participant B was involved both in educating music therapy students and in practicing music therapy in his home country. He received a master’s degree in the US and was in PT for approximately one year. He sought PT because he found that living and studying abroad was greatly stressful. He had one therapist and then switched to another therapist for one year in the US. Both were Caucasian females whose theoretical foundations were centered on psychoanalytic perspectives. He chose his therapists based on his interests in particular music therapy approaches. He described his relationship with the second therapist as follows: “Things became very comfortable. I was able to explore because I trusted my therapist.” After he went back to his home country, he continued post graduate training programs that included therapeutic experiences.

Participant C immigrated to the US after she completed her training and was hired as a full-time music therapist. During her training in the US, she was self-motivated to receive PT as a trainee music therapist because experiential learning through PT was suggested. In addition to that, she found living in a Western culture confusing, and that led her to seek therapy. Participant C wanted to experience analytic verbal therapy. Her friend recommended a particular therapist who was Asian American. Participant C reported that she discovered a new meaning of life through personal therapy. “All of the links. In other words, I used to think the events that had happened in my life were all separated. But when I felt everything was tied like a connecting link when I found the common place in various issues… It felt special.” She was not continuing PT at the time of the study.
Participant D, a native Korean moved to another Asian country in order to accept a faculty position after she studied music therapy and worked as a music therapist in the US. Her fieldwork supervisor suggested going to PT when she noticed participant D’s personal issues manifesting in her clinical work. Stressful situations regarding her studies and visa status were secondary reasons to find a therapist. She had no option to choose a therapist at the university counseling center, and both of her counselors were Caucasian females. She developed a deep trust toward the second therapist: “I really loved her [therapist]. Her name was [Kathy]. She was empathetic and encouraging.” She discontinued counseling after she graduated but continued post-graduate training for a certification that encompassed therapeutic components.

Participant E worked in her own private practice in her home country. She earned her Masters’ degree in Music Therapy in the US. She was then hired as a music therapist in another state in the US. When her professor encouraged everyone in the class to go to PT, she grew interested in becoming an actual client in order to learn more about music therapy. Her therapist was American and focused on analytical approaches in music therapy. Participant E expressed her therapy experience as follows: “It felt like opening my secret boxes in me. I discovered so many things about me in my therapy. I was always smiling after therapy.” Feeling full of new discoveries always made her feel “amazing.” She remained in therapy in the US for a year, but does not currently see a therapist in her home country.

Participant F has a Master’s degree in Music Therapy and currently works as a music therapist in the US. Her formal internship supervisor recommended that she engage in PT because supervision was not sufficient for her to deal with her personal issues. He also suggested a particular Asian-American therapist. This therapist offered verbal therapy and functioned as a support figure throughout her education in the US. Participant F described her overall therapy
experience: “I felt I was transformed; I felt more changes in my life.” She currently sees a music therapist who uses an analytical approach.

Participant G earned both Bachelor’s and Master’s degrees in the US. Since completing her Master’s degree in Music Therapy, she worked as a full-time music therapist and has remained in the US. The primary reasons that she wanted to go to PT were “to be a good student” to learn about music therapy. Along with this motivation, emotional struggles emerged. Prior to entering the field of music therapy, she had already read some articles that her therapist wrote that were intriguing to her. Therefore, she wished to become a client. Her therapist was a Caucasian female. Through PT, Participant G gained a new perspective on significant relationships in her life: “Once I understood where it came from, I could stop seeking a solution in my relationships. Right. It changed my whole perspective about how I react with people around me; my parents were able to understand that and change our relationships from there.” Participant G is still working with the same therapist.

Participant H returned to her home country after 10 years of living in the US. She mainly works as a music therapist and functions as a clinical supervisor and an educator. She studied both in undergraduate and graduate programs in two different states in the US. She decided to contact a music therapist when countertransferential reactions began to interfere with her clinical work. Her music therapist was an European American. Participant H summarized her therapy experience in the following sentence: “It was tough. It was very interesting and a lot of learning and tough. Those three words I guess.” She continued her PT until she left the US.

The Results of Interview Data Analysis

This section will introduce the results of the data analysis of eight individual interviews. The NVivo computer program served as the main tool to organize and analyze the generated
interview data. The eight individual interviews gave rise to 797 codes. However, after going through repeating coding numerous times, the researcher settled on 357 codes, which made up 4 themes, 13 categories, and 20 subcategories.

This inductive approach for data analysis revealed three main themes: (a) Cultural experience, (b) Therapy experiences; and (c) After therapy. Themes and categories are presented in the following figure 3. Subcategories will be introduced in the descriptions of each theme.

**Theme 1. Cultural experiences**

The first theme mainly captured participants’ Asian and Western cultural experiences. During individual interview, all of eight participants in this study talked about their cultural experiences in the details. This first theme contains 3 categories and 6 subcategories: (1) Asian cultural experiences (a. a tight relationship with family, b. group-oriented culture, c. expressing oneself); (2) Western cultural experiences (a. being different, b. classroom culture, c. culture oriented towards the individual) (3) Cultural stigma attached to therapy. It provides an important angle of how participants’ bicultural experience might have influenced their therapeutic process. The following figure presents a composition of theme 1.
Figure 2. Visual representation of the first theme with 3 categories and 6 subcategories. Numeral indicate numbers and percentage of codes.

**Category 1: Asian cultural experiences.**

*A tight relationship with family.* Four participants (B, D, F, and G) reported that their families have been involved in their lives. Participant F summed up this relationship in a few words: “In our culture, we are so interdependent on each other” and she explained that family is
a priority in Asian culture. Likewise, Participants B, D, and G shared that relationships with family members created emotional difficulties and ambivalent feelings.

In making a career decision to be a music therapist, Participant B, who is male, hesitated at first because he was unsure if this vocation could provide enough financial support for his own family, as he was the primary breadwinner in his household.

Participant D described how her family’s preference for a son was hurtful. Her mother unconsciously discriminated in favor of Participant D’s older brother. Her mother’s preference for the mother’s son was ingrained in her way of talking to or treating the two of them.

Participant D described how her mother enacted Korean cultural value of preference for a son:

Korean women have a tendency to do that [son preference]. She was unaware of it, but her way of talking or treating us was different in spite that she was a woman herself. I was very sensitive to her attitude.

Participant D continued to explain that this atmosphere in the household had created “very low self-esteem and an inferiority complex.” in Participant D. Additionally, her mother’s preference for Participant D’s older brother affected the formation of her personality. She explained, “I pretended to be overly animated and loud. But I was not that way originally. It was because I wanted other people to pay attention to me. I exhibited attention-seeking behaviors”. While growing up, she had felt “furious, heartily sorry, and resentful.”

Both Participants F and G talked about how the child-parent relationship in particular was deeply merged. Participant F provided an example from her witnessing of how the parents of her Asian clients had high expectations of their children. Japanese mothers would pressure their children by saying “Oh! Why are you not playing?” They also expressed their disappointment verbally by asking, “Why are the other kids beating the drum but not my children?” Participant F
attributed this to the fact that Japanese fathers work extremely long hours, and this leads Japanese mothers to become overprotective of their children. She described familial relationships as “so difficult for them [Japanese mother] to separate.”

Participant G shared the details of a complicated and ambivalent relationship with her father and described how it influenced her throughout much of her life. Her father was educated in the US and wanted her to become independent as she grew up: “He taught me to be independent. He wanted me to do my own things. Let me do a lot of thinking by myself.” From a positive perspective, Participant G was able to manage herself independently in the US partially due to her upbringing. However, she shared her ambivalent feelings toward her father. Even though she enjoyed being independent, it was difficult for her to do things all by herself. Sometimes, she would wonder, “Why am I doing it by myself?” She realized that it was “part of [her father’s] expectation.” He would say, “I don’t care that you are a girl. You’ve got to learn to take care of yourself.” She stated: “I have the mental capability to fulfill his goals, as I am always first or second in the class.” She acted to make her father proud of her. Therefore, his attitude “really changed how I think and how I see things.”

**Group-oriented culture.** In addition to family relationships, four participants (C, D, G, and H) mentioned that needs of other types of group were prioritized more than individuals in Asian countries. They shared how collective cultures were manifested in school, the work place, and business relationships. Participant D, a native Korean who also had lived in China for five and a half years, stated that both Korea and China are group-oriented culture: “In China, the Communist party is important. In some way, Korea is like that. The individual is not considered as important. Individual differences are not accepted. Community is more important.” She emphasized that individuals’ differences are not accepted in group-oriented cultures.
Similar to participant D, participant C described how her individuality was not accepted in Asian culture: “I cannot live for who I am. I live for who my mother wants and who society wants. In order to make oneself vanish and harmonize with other people, a group-oriented culture is enforced in Korea.” Therefore, participant C felt that “there was no space for me to think about myself, my voice, what I like and what I want to do. Instead, I catch what other people want very quickly.”

Participant D and G indicated that following certain group norms was significant in Asian cultures. Participant D stated that she was conscious of other people: “Other people are more important in Korea. How I look to other people is more important.” Another example of pursuing the same goal as others was shared by participant D. She explained that education is one of main focuses in Asian culture and shared the emotional influences that this value on her. Korean and Chinese people grow up in a very judgmental culture. She asserted, “Korean culture is about right or wrong. Things must be either be right or wrong. We have no grey.” Because education is a main focus, people generally feel discouraged when they do poorly in school. Therefore, she felt that she had not been good enough when growing up, and it was hard to discover what she was good at, even though she now knows that each person has different strengths. Participant G also stated that everyone tries to meet the expectations in society by “following the same path, doing the same thing.” She further explained that people feel they “should” do this. For example, people think they should follow the same footsteps that everyone else does: “When you graduate from high school, you have to go to college. You have to get on with your career. You have to buy a car. You have to buy a house. You have to get married. You have to have kids.”

Participant H shared that the group-oriented culture is prevalent in the work place. She felt that it was difficult to adjust because there is no clear boundary between personal and
professional relationships. She felt that cultivating business relationships in her country takes a lot of energy and time. She also mentioned that people preferred to become closer by sharing details about their personal lives. She reported that this culture seemed necessary in order to “make business flow easier.” However, she added, “Sometimes I feel that when I am too busy, I want to just skip that part.”

Participant C pointed out in group-oriented cultures—if only “we” is emphasized, “I” will disappear, and this is not a happy thing.

**Inhibition in expressing oneself.** Four participants (D, E, G, and F) indicated that verbal or emotional expression was restrained in different type of relationships such as school and family in Asian cultures. Participant E described Japanese people as polite and not too expressive about themselves. In conversation, they were “more likely to be listening to the person and following you,” “pretty passive in terms of learning,” and “not…very assertive.” She explained that there was an absence of direct verbal communication in Japanese culture: “We kind of know feelings and sense and we share common senses like that stuff. So I don’t have to tell everything.” Regarding different ways of interaction in the classroom, participant F was “shocked” by the classroom culture in US because students do not express themselves in Japan: “Just receiving information. We were not allowed to express our feelings or opinions. There was no interaction, you know. And we always needed to respect the teacher.”

The family was not a safe place for participants D, F, and G to express their feelings or personal opinions. Participant G stated that growing up in her family, she did not feel that she was allowed to cry. Her mother did not have empathy for her crying and she herself did not cry. When participant G cried, her mother would become critical of her and comment, “You cry easily.” This type of reaction from her mother would make her feel bad. She explained that “I
guess it had been really rare in my life that I was told something like, ‘You need to cry. You can cry. It is okay to cry.’” Participants D and F talked about how they felt when communicating verbally to their parents. Participants D repeatedly said, “I rarely talked to my parents. […] I hardly talked to them. Hardly. Talking to them in itself was just hard. Even if something happened, I could not discuss it with them. Sitting and talking was awkward.” Participant F also shared her difficulty in talking about intimate topics such as sex. “I have never even talked to my parents about those things [sex]. It was like ‘Am I allowed to?’ It was difficult to share those things.”

**Category 2. Western cultural experience.**

*Being different.* Five interviewees (A, E, F, G, and H) talked about their experiences of being different in Western cultures. In the US, each local culture had a different perspective on being different. This realization elicited reactions from both ends among those participants.

Participants C and G talked about the difficulty of being Asian in a Western culture. Being different implied not only having different ethnicities but also not having common cultural experiences such as music and movies. Participant C briefly mentioned that “there are a lot of conflicts between my cultural background and the [American cultural background].” Participant G shared an example: “I still struggle when I hang out with friends. We talk about cultural stuff like movies or like music. As much as I have been exposed to Western culture, [it] still could be difficult.” Therefore, she did not feel culturally assimilated: “There is not a lot of common foundation in that sense.” This situation made her feel “inadequate.”

Unlike participants C and G, being in a different culture provided positive experiences for participants A, F, and H, who attended graduate schools in a metropolitan area on the East Coast.
Participant A, who had previously experienced racism in Europe, had the opposite experience in the US:

There are many immigrants and different races in America. I was very impressed that differences were accepted naturally. They made fun of me in Europe. I was called “monkey” because I was an Asian. However, when I moved to America, it did not matter if I spoke English well or not because there are many different ethnicities.

Participant F, who was half Korean and half Japanese, came to embrace her multiculturalism and rebuild her cultural identity because she was able to connect with many Asians from different countries:

I felt like identified myself as Asian more than anything else. I don’t necessarily have to say I am only Japanese because there are so many Korean people and other people from Asia in the US, so if I say, “Oh, I am also half Korean,” we right away become like friends.

It was noteworthy, though, that participant H had two contrasting experiences when living in two different areas in the US. When she enrolled in a graduate program in an urban area, she felt accepted because “Everyone [various ethnicities] is there,” “no one cares where they are from,” and “that was normal.” On the other hand, she had an opposite experience in the other city, located in the South, where she originally arrived for her undergraduate study. She witnessed racism between black and white people in that area. Even though it was an indirect experience, she asserted that it was “the most shocking experience” among her cultural experiences. In her home country, everyone has same skin and hair color. She had never imagined beforehand in Japan that people might discriminate due to skin color. She stated that it was real that racism was
happening in front of her and commented, “This was not something written in the book. This was a real thing.”

**Classroom culture.** Studying in the US was one way for Participants A, and F to experience Western culture directly. Participant A mentioned that teachers and students collaborate with each other in the US. Even though she found some flaws in her teacher, she thought of the teacher as somebody who collaborated with students and “it was more like a natural human relationship.” Even though both participants E and F were impressed by the classroom culture, participating in group activities was challenging. Participant E felt “amazed” by the classroom culture but noted that it was “challenging” to participate in classroom discussions. Participant F said that she had to make an effort to adjust to this interactive classroom culture. She even “forced” herself to speak but “it was really difficult.” It was a new experience to see teachers ask students about what they feel and think.

**Culture oriented towards the individual.** Five participants (A, B, C, D, and E) shared their experiences in individual oriented culture. Participant E characterized American culture as “people are very frank and straight but nice. And so you get to have your own opinion. And you have to be very honest and open to anything for discussion and stuff.” Another quality of this culture was reported by participant B from his clinical experience with African Americans: “A boundary was very important for them. […] Before I took an action, I always asked if I could do it. I learned about keeping a distance.”

The beneficial parts of individual oriented culture in the US were reported by Participants D and A. Participant D emphasized being accepted as a unique individual in the US saying, “My personality was accepted rather than being fixed.” She continued, “I learned to admit that I was important. I was encouraged a lot.” She described American culture as being an “encouraging”
culture and she was able to make a lot of changes. She said, “I gained some confidence. I think my self-esteem became higher.” She began to acknowledge: “I am important. What I feel is more important than what other people think.” A similar notion was shared by participant A, who studied in the US at both the undergraduate and graduate level. She said that teachers “acknowledge what students did well.” However, participants C noted both benefits and difficulties in adjusting to this cultural aspect:

In America, speaking my voice was more valuable. [American culture] enabled me to explore and learn about myself. But it was very challenging for me to adjust at the beginning because my way of thinking was about being forced. I was confused because I did not know who I was.

However, participant C eloquently stated that “when Western culture regards the individual as being too important, [people can become] childish. It is essential to know and express one’s self. However, if only I is emphasized, it cannot become We because there is no sacrifice.”

**Category 3. Cultural stigma attached to therapy.**

In this section, four interviewees (A, C, F, and H) shared cultural misconceptions regarding receiving PT in Asian countries. They stated that negative preconceptions led Asians including themselves to avoid seeking PT. Participant H said that “people are not used to going to therapy” in Japan. Participant A also shared a similar perception in Korea: “There are not many cases of typical people going to counseling. Even though there are some people who study psychology, they go only for educational analysis [not for personal therapy solely].” She added there is a lack of understanding that people need to pay money for psychotherapy as well.

Participant F described how the decision to go for PT in the US was a “big step.” She hid information about receiving and paying for PT from her family. Even though the perception
about therapy is changing in Japan, the stigma still exists. Japanese people are likely to judge people in therapy by saying something like, “Oh! There is something wrong with you.” Koreans are likely to view therapy in the same way. Participant C stated that others would stigmatize them as being somebody with a mental disorder. She had known no one who went to therapy when she lived in Korea.

Participants C and H reported that America was a comfortable place for receiving PT because it was not unusual there. Participant C stated, “When I came to the US, I found that PT was very common. Especially in urban areas, there were many good therapists.” Participant H also thought it was “a better opportunity” to go to PT in the big city where she lived than in other locations in the US. She found that the “environment made it easier for me to go.” This particular city made her feel safe to seek PT.

**Theme 2. Experience during the Course of Therapy**

The second theme describes how the experience of PT was perceived. Connections with therapists in the therapeutic dynamics were explored as well. This theme encompasses 4 categories and 4 subcategories: (1) Therapy space; (2) Beginning stage; (3) Therapists’ therapist (a. attitude/character b. role); (d) Difficulties in therapy (a. confusion b. conflict with therapists). The following figure presents composition of theme 2.
Figure 3. Visual representation of the second theme with 4 categories and 4 subcategories.

Numeral indicate numbers and percentage of codes.

**Category 1. Therapy space.**

Five participants (A, C, D, F and G) addressed how their therapists’ therapy office had personal meaning for them. Their therapists’ office was not limited to being just a physical space, but also involved a symbolic and psychological meaning for the participants.
An intimate and personal space for participants A and D was created especially by the presence of their therapists. Interestingly, they used the same words to describe their therapists’ offices—a “narrow space.” But this “narrow space” became a place where they could share their emotions and life stories. Participant A talked about her life for the first time with her therapist:

I was sitting in that narrow space. In the very first session, [my therapist asked me] “How have you lived your life so far?” I didn’t know this person [the therapist] well. But in that moment when this stranger asked me if I could tell her how I have lived my life, [I asked myself] ‘How have I lived my life?’ I did not cry at that moment, but it was a refreshing shock.

Participant D described her therapist’s office and initial experience:

The therapy room was very small. There was only one desk, a small couch, and that was it. Everything was huddled against other things. But I just loved going there. Even though I was not crying all the time, I just loved being there. Whenever I talked, somebody always listened to my anger. It was my own space that I felt safe in.

Participant D did not feel lonely anymore at her therapist’s office.

For participant C, a therapy space functions to nurture and provide self-care. She said, “I just loved that therapy space. The therapist’s job is always to help other people. But in [that] therapy space, that person [her therapist] is always there for me for those 45 minutes. She is there only for me.”

Participant F, who had a Japanese-American therapist, described the therapy office as being “so oriental” and a “Zen room.” The Asian decorative cultural elements made her feel “so comfortable, [like] being home.” For participant G, the therapist’s office had a symbolic meaning in that she was able to cry in a therapy space: “I needed to cry so much [in my life]. That was the
place where I could do that [crying] I just went crying for weeks and weeks and weeks and weeks…for years actually, for the first couple years.” She described the experience as being “very new and relieving.”

**Category 2. Beginning stage.**

Five participants (A, B, E, G, and H) had strong reactions regarding the beginning stage of the course of PT. Participant E described the beginning phase as being like “fireworks” because she processed many issues with her therapist in a short period of time. Participant A reported that the first session remained the most memorable because she cried and felt truly understood:

I was surprised that I started crying. I came to understand why people cry in therapy…

[When the therapist asked] “How has your life been so far?”… [I told her that] I heard a lot people saying, “You are lucky because you studied abroad.” But to be honest, it was so difficult for me. But people had never said, “It must be difficult for you”. […] even my mother said the same thing [as other people]. I was having a really hard time.

She continued: “I had never talked about my feelings before. [So when the therapist asked that question], I came to remember those times. That was why I cried.” Even though it was the first session, with only one penetrating question from the therapist, participant A was able to open up and talk about her past life struggles, showing her pain from these sources of distress.

Conversely, the beginning stage was doubtful, resistive, and uncertain for two participants (B, and H). Participant B talked about his disappointment at an early stage of the therapy course due to his therapist’s simple interventions, such as selecting and writing songs, because he had expected more advanced techniques than that:
I was not sure if I should continue [therapy], paying a lot of money. I felt forced to trust the therapist. Also I thought the session fee was too expensive for those activities. I tried hard to believe there had to be reasons for that.

Participant B stated that his needs were not met during the beginning phase: “The beginning phase was difficult. I knew so much about song choices and song writing. […] I tried to be patient. I would have stopped if I had not been a music therapy student.” Participant H also shared a similar experience to participant B. She expressed the feeling that “the difficult part was the beginning. Honestly I was doubtful.” This doubt was caused because she had no idea where the course of therapy was headed and was uncertain about how effective therapy would be. Also, she observed no obvious changes afterwards. Therefore, she felt even more skeptical that it was the right time for her to be in therapy. She stated: “I was questioning the whole work, so that was maybe a difficult time.”

**Category 3. Student Therapist’s Therapist.**

**Therapists’ attitudes and personalities.** Four participants (D, E, F and H) talked about their observations of their therapists’ personalities and attitudes. They portrayed various sides of their therapists’ personalities.

Participant D felt her therapist was empathetic about her emotions as both a clinician and a foreign student. Participant D shared an example of how her therapist was being empathetic with her: “We are a pot. The pot can be filled up. We [as a therapist] need to empty the pot. That is why we need to go on vacation and get some rest.” Participant D added that “she [my therapist] did not give me that much direction. Instead [my therapist said] when we merge with and have empathy for other people’s feelings, we need to practice how to empty ourselves.” In addition to addressing her need for self-care, her therapist showed empathy for participant D’s language
difficulties and their implications for her studies. However, her therapist observed, “It must be
difficult for you”, and “I cannot imagine myself studying in your language.” For participant D,
her therapist’s empathy consisted of active listening, and accepting her feelings about her
difficulties.

Participants E, F, and H reported two contrasting qualities in their therapists. They found
their therapists nurturing but at the same time challenging. Their therapists challenged them to
work outside their comfort zone. However, this challenging side of the therapists was helpful and
led the participants to grow.

Participant E described her relationship with her therapist: “I had to tell her everything
and she was pretty … not aggressive, but you know pretty clear about what she wanted to know
or what she wanted me to process.”

Participant F described her therapist’s presence, and attitude as “so strong and helpful”
and “caring.” First, she shared a deep trust toward her therapist and described her as follows:
“She was the coolest Japanese therapist I have ever met. Yes, so I think she became my role
model as a therapist and also as a person living in [the US].”

In regard to challenging aspects of her therapist, participant F said that she was shocked
by her therapist’s recommendation and questions. For example, one of her therapist’s questions
was, “Okay, how is your love life?” She said that her therapist’s blunt questions guided her to
“expand [her] limitations or preconceptions.”

Participant H felt comfortable with her therapist, who had “a good understanding of
Asian culture” and “Asian minds.” She added that “She [the therapist] liked meditation. She
liked the way East Asians think.” When something happened, her therapist would say, “Just let it
go.” Also, she emphasized that she felt connected and “if she hadn’t have that influence from
East Asian thinking, it might have been difficult for me to work with her, but because she was interested in Asian culture, she was trying to learn a lot [about Asians].” Participant H also shared other aspects of her therapist’s personality. She had a lot of energy and encouraged participant H to make new attempts, taking action and trying to find answers. Participant H stated, “She was aggressive about taking action […]. She was tall and she had this strong power. People would get encouraged by her, but she was also tricky because her personality was so strong.”

**Therapists’ Roles.** The participants’ therapists played various roles. Five participants (B, C, D, E, and H) shared how their therapists’ roles led them to change. Mostly, their therapists guided them to see what they had not been aware of in the past. Participant H’s therapist would find themes that participant H needed to work on by uncovering significant “key words” in their verbal discussions. Participant E’s therapist discovered her repeated patterns in communication. Her therapist pointed out “bother” as a key word in therapy sessions. She expressed this experience as “eye opening.”

By asking questions, participant C’s therapist assisted her in realizing sides of herself that she had avoided confronting: “[There] were all these experiences that were emotionally blocked or were covered up so I would not confront them. [My therapist] led me to see them by saying, ‘Oh! There is something. What is that?’ Then I opened it to see by myself.” She emphasized, “I think my therapist fostered my strength to see [deeper sides of myself]. She did not give me correct answers but asked questions instead. Her questions hit the mark and were very objective.”

Participant B described his therapist as an “anchor” who supported him to understand more about his family dynamics. He used a metaphor to explain how his therapist played this role:
I was able to see a big picture of my relationship with my mother. I was supported [by my therapist] and able to dive into the situation. [My therapist] blew the air into the hose of my diving suit from the top of the ship. It was always safe. [My therapist said] “Go deeper.” I held that anchor tightly and looked at what was going on under the sea. There were difficult moments [under the sea]. There was lava flowing. But there were delicious seaweed and fish as well. Those fish were swimming comfortably. I had used to focus on my relationship with my mother, but I came to see all the related dynamics around me. Therefore, participant B trusted his therapist and felt that it was safe to explore what he had not been able to accept about family relationships. He figured out that there were different but positive sides in his newly discovered dynamics of his family relationship.

**Category 4. Difficulties in therapy**

*Confusion.* While the benefits of therapy were discussed throughout the interviews, both participants B and C shared their confusion during the course of their therapy as well. Participant B shared a simple example, namely, that delving into his personal issues was difficult while he was in his graduate program. He noted that working on himself in therapy interfered with his work with clients.

Participant C reported that she was too self-absorbed to focus on her clients. “Because I was too engrossed in exploring myself, countertransference reactions occurred a lot when I was working as a therapist. […] I was too excited [about self-exploration] and too focused on myself.” She added: “To be honest, my PT really impeded my therapy work as a therapist.” She felt “confused and unstable as a therapist.” Therapy was rather confusing at times “as if muddy water had been stirred.”
Conflict with therapists. Four Participants (A, C, E, and H) talked about conflicts with their therapists for various reasons. Some of them had different ideas and could not come to an agreement with the therapists on certain topics.

Participant E and her therapist expressed discordant ideas on terminating the course of therapy. Participant E had no more issues to discuss with her therapist after about a half a year of therapy. Even though in the psychoanalytic perspective of her therapist, she was still “hiding a lot of big things behind,” she felt that she “really did not have anything” to bring up. At that time, she felt “cleaned,” “plain,” and “white.” Also, she believed that she had experienced enough of a psychoanalytical approach “at that point.” Her therapist strongly suggested returning to therapy if she changed her mind.

Participant A experienced two types of conflicts with her therapist. Since her therapist was an immigrant with the same ethnicity, participant A perceived their relationship as hierarchical and her cultural perception of the relationship interrupted the therapy process. It was hard for her to “define their relationship until the course of therapy ended.” Moreover, participant A experienced conflict in using a certain language with her therapist. Her therapist was fluent in English and seemed to use English when the contents of discussion became deeper. She explained that she found it confusing when her therapist mixed both languages randomly. However, participant A found it uncomfortable to confront her therapist about this issue, and she only finally talked about it toward the end of course of the therapy, which was extremely hard for her. It became an obstacle in her understanding of the therapy process, and she felt “disconnected” when her therapist used two languages at random.

Participant H had difficulty accepting her therapist’s specific interventions. She was conflicted about “how deep” she had to go in, and she felt “pushed to go in a certain direction.”
She felt that her therapist probed too deeply and was too close and intimate, but she was not ready to explore the “dark side” with “certain topics,” such as her father’s death. When her therapist suggested exploring her father’s death, she hesitated to reopen the subject because she felt fine with it. Even though her therapist understood, participant H felt that her intervention was “so sharp.” Participant H shared that “strong interventions can be effective, but they make people struggle more than is necessary.” She acknowledged that her perspective on exploring her father’s death might not jibe with her therapist’s psychodynamic/psychoanalytic approach.

Participant C mentioned religious conflicts arose because her therapist was not a Christian. She gave as an example an episode with her therapist that showed their disagreement. When the participant C saw a couple at her church being physically affectionate inside the church building, she thought it was wrong. However, her therapist did not understand participant C’s point of view and said, “Look, how beautiful and honest they were with each other.” This conflict led her to terminate the course of the therapy because it called into question her religious priorities. She articulated that her goal was to learn and grow but not to change her religious values:

In therapy, this might be viewed as resistance. However, I preferred to own my resistance. My belief system is drawn from my religion. I cannot abandon the Bible and my Christianity. I wanted to gain strength to think on my own but did not want to change my thinking paradigm.

**Theme 3. The influences on personal and professional levels.**

The fourth theme underlines how PT experiences influenced participants’ various developments on personal and professional levels. This theme consists of 4 categories and 7 subcategories: (1) personal influence (a. acceptance b. changes in thinking paradigm); (2)

![Figure 4. Visual representation of the third theme with 4 categories and 8 subcategories. Numeral indicate numbers and percentage of codes.](image-url)
Category 1. Personal influence.

Acceptance. PT played a role in helping participants to accept their pain, difficulties, and themselves in general. Four participants (A, C, D, and H) shared how they came to accept their lives and what they discovered was meaningful for themselves.

Accepting her past struggles led participant A to discover what she wanted to do in her life. She explained that “I came to see who I am. In other words, I was able to face myself.” She provided the details of her experience in accepting her past distressing time. “It [living in Europe as an Asian] was really difficult [for me]. People told me I was lucky. But it was really difficult for me. I gained a lot, but I lost a lot, too.” She did not have anybody who could really listen to and understand her empathetically. However, after her therapy sessions, she came to accept that living abroad was difficult and racism was hurtful. Finally, she came to the conclusion that she wanted to return to her home country.

Participant H shared her traumatic experience of losing her father at the age of 17 and the process of accepting this experience emotionally in therapy. The grieving process took four years and it was too painful for her to think about his death. She stated, “I cannot forget it, but I cannot think too much about it.” However, the issue related to her father’s absence was repeated in a romantic relationship. She explained that “I had a fear of being left and that was kind of the main issue through my therapy.” Working through this issue, participant H felt “the weight became lighter. […] Something lifted me up and I felt lighter.” She talked about how accepting her difficulties began to influence her life: “I became accepting of many things. This is not to say I became more easygoing or anything, but in dealing with a tough situation, I would be better able to handle it.” The acceptance of her father’s death and changes in other relationships were reflected in her dreams as well. At the end of one particular dream, she received a letter saying
that she was not alone anymore. She talked about her dream and experienced it “fully” with the sounds and words in her music therapy sessions. Her healing experience was described as follows: “Everything made sense after that. I became less nervous and I could really feel there was a good bye and there is a hello and there are many people’s meetings and departures. I guess I could really accept that.”

Participants C, and D both talked about acknowledging dark sides in themselves through therapy, and they believed that facing those issues brought them changes. Participant D explained that psychotherapy was a way of reflecting the self. She shared how change can be made: “Healing can be made when [I] accept myself for who I am. I was able to see my weaknesses and rough edges parts in me. [Therapy] helped me to see those things.”

Participant C came to accept diversities in life and acknowledge that it was not always perfect and right. She expressed her observation that it was meaningful to “stir up and confirm impurities [in her] in therapy sessions.” She explained:

There would not be any growth if let the mud sink and lie there. Now I can see that I was very unstable, and it was painful, but it was meaningful for my growth. It does not necessarily mean I enjoyed that process. Facing myself was difficult.

On top of accepting her dark side, participant C also came to admit that there are always changes in life in general. She portrayed this acceptance artistically using a metaphor of four seasons and a tree bearing fruits:

I found a cycle. As there are four seasons in nature, it was meaningful to discover that there are four seasons in my life too. Now I can remember that particular session. There are buds in the spring and they grow thick in summer. As times goes by, they turn red and leaves fall. In the winter, there are only skinny branches left. There is a cycle of four
seasons in my life. If I only desired grown trees full of leaves and if I could not own them,
I would feel very empty and depressed.

When she discovered it she felt like “crying.”

Through their PT experiences, both participants C, and D stated that they found that their self-esteem increased. Participant C offered: “This is related to my self-esteem. I am worthy of being treated specially. I learned to love myself and how to do it.”

Participant D voiced a similar observation: “I came to learn about loving myself through therapy.” She explained: “I found that it could be possible to accept negative feelings. [Feeling negative emotions] does not mean that I am a failure. I became less fearful of failure.”

**Changes in thinking paradigms.** PT experiences brought changes in thinking paradigms for three participants (C, E, and G). Participants E, and G shared an example about changes in their thinking patterns that were related to their family histories. They realized that they projected their thinking patterns onto romantic relationships or friends.

Participant E had often thought she might become a burden to other people. That was why she could not take the initiative in relationships in general. This thinking pattern was reflected in her communication style as well. She processed this issue with her therapist and changed her way of thinking. Participant G found that her old thinking pattern regarding romantic relationship was deeply related to her family issues. She expressed the change she experienced through therapy: “It totally changed my mindset that my parents couldn’t love me.” She realized that her parents could not love her in the way that she wanted. She had always felt “unloved.” However, before entering the course of PT, she transferred this attitude to her romantic relationship rather than facing this fact. She often wondered, “Why doesn’t he love me? What did I do wrong?” and believed that she “could fix this.” She figured out later that her
thinking was related to how she had felt with her parents. However, she held onto the illusion that “Oh, I had a happy family. We are middle class and everything is fine.” It was painful for her to admit that her parents “weren’t capable of loving me and that was really hard concept.” Breaking that illusion in therapy was “a very shocking but very meaningful moment” for her. She explained that “I understand where it came from and then I could stop seeking a solution in my [other] relationships now. Right. It changed my whole perspective.”

Participant C discovered a repeated pattern of thinking and came to wonder why she had this pattern. “After all, I had made changes to my way of my thinking. [These can be applied to] my cultural background, too. [I confirmed] cultural biases. Therapy led me to broaden my perspective.” She found that PT experience had fostered “an ability to think analytically.” She further stated that “through my personal therapy, changes were made in my thinking patterns, not behavioral changes. These must have influenced my way of understanding and approaching my clients.”

Overall, changes in thinking paradigms by facing reality and finding the root of unconscious projection brought practical changes in these participants’ lives and relationships and provided them with new perspectives.

**Category 2. Clinical influences.**

*Client-centered work.* Four participants (C, D, F, and G) talked about how their PT experiences linked to their clinical work with clients. A parallel process was exhibited between their PT experiences and working with their clients. As they experienced changes and benefits from working with their therapists, participants came to understand their clients better and have more empathy for them. Their own PT experiences as clients offered an aspect of experiential learning and the participants’ perspectives became more client-centered in their clinical work.
Developing an ability to have empathy was repeatedly discussed by the participants. Participant E explained the importance from her point of view: “Knowing how you feel as a client is really important for therapists and it helped me a lot. I often imagine how my client might be feeling at a particular moment and that was a valuable thing.” Participant C experienced empathy in her therapy and learned how powerful it can be. “You can understand intellectually what empathy is. However, you can only experience empathy from therapists who have had professional training. It is significant to actually feel what you learn from your textbook. When my therapist empathized with me, I really grasped how powerful that was.”

Participant D shared how she developed in her ability to accept clients and actively listen to them. She reported that she had not known how to respond and interact with them before experiencing PT herself from the point of view of a client. However, her relationship with her therapist brought changes to her clinical work. “As I continued to be accepted and acknowledged by somebody [her therapist], I was able to accept my own clients as well.” Her clinical attitudes became more client-centered as she realized the importance of accepting clients. She stressed an importance of an element of active listening to engage with her clients. She claimed that “we need to become good listeners. We need to listen to, cry with, and encourage our clients.”

Participant G found that positive countertransference helped her to be emotionally present for a child client, as she began to understand how her own childhood experiences led her to repress her feelings. She became attached to one of her individual clients during her internship. She described this client’s emotional state as “angry” and stated that he “[did] not want to reach out to the world.” She admitted that she shared a common experience with this client and the dynamics triggered strong countertransference. As she worked on herself in PT, her understanding, and acceptance became intensified. She described their parallel process:
He could let go and be the kid he was supposed to be and those were [the] very best moments during that year, I guess. I mean of course it was helpful to me as well. I wanted to give what I didn’t have to this kid. I wanted him to have this place where he could feel he was accepted and he could be whatever he wanted to be. And that was completely parallel to what I was going through at that point, I guess.

Participants C, and F also talked about having more empathy for their clients by experiencing PT. Participant F came to acknowledge that transforming one’s self can involve pain in PT work. She detailed her clients’ experiences of:

Finding their own voice or something. You know, working on their issues is not an easy process for them. Because I know that being in my own therapy process it is not easy for me to face my own issues and kind of try to have different perspectives on them, so I think it is not easy to make changes in your life.

Participants C and G shared that they became more sensitive to their clients’ emotions in clinical work. Participant C stated that the Western concept of therapy led her to think more about emotions and feelings. She noted that:

When I observe my clients’ feelings, I allow them to express these feelings. [If I had not had my own therapy], my range of containing I would not be able to accept fully because I would not know how to express feelings. I had not had chances to figure them [my feelings] out in my home country.

Participant G addressed the importance of tears as a therapeutic medium because she had experienced this in her own therapy.
I value a lot peoples’ tears now because I understand what they are. Even [their] parents’ tears … and that is such a powerful tool. Tears can mean so many things; I have learned that it is strength to show how vulnerable you are.”

**Boundary.** When working as intern music therapists, three participants (A, F, and H) noticed unclear emotional boundaries with their clients, and felt that they needed to work on this area in the course of PT.

Working with cancer patients triggered emotional intensity in participant A. This happened especially with children who were undergoing chemotherapy. Interning at a hospital was extremely hard on her emotionally because she witnessed her clients’ suffering and death. PT was necessary at this point because the internship supervision was not sufficient to explore her deep feelings and emotional reactions to those clients. She explained:

Internship was the most difficult time, I think. […] I had had no one in my family who had passed away from cancer. Everything was new and related to death. Death is the heaviest and most difficult thing to process. It was very tough for me to witness their deaths.

When faced with adolescent clients with cancer, she started thinking about why these young people—even newborn babies—had to die and why they had to suffer. “In most adult cases of cancer, illness results from eating habits or smoking. But the only reason for pediatric cancers was genetics. Some infants were actually born with cancer. I started to question why these little children had to suffer. This thought was painful and I talked about this in my therapy.”

Participant F began to notice that her vague boundary with the clients was eroding. She described her confusion: “I was having a hard time defining what my issue was sometimes and what the actual clinical issue was.” This confusion manifested as “transference and
countertransference” as well. It was hard for her to make clinical decisions about where to stop helping her clients. She felt that this difficulty came about because “I was not mature enough and did not know what it was to be a professional.”

She finally understood this unclear boundary and related the needs of her clients to her own childhood needs. This issue finally came up in the therapy session and she worked on it with her therapist. PT was beneficial for her to gain awareness about the dangers of unclear boundaries in clinical work. “If I were not aware, then I might take a risk with client in the clinical process without knowing what was happening with me.”

Participant F provided the details of her countertransference in working with her clients at her internship site. She became perplexed when she felt “sexual attraction and tension” in her clinical sessions. This dynamic affected her style of playing music as well. She felt the urgency of talking about this topic, especially when working with a male client who was paralyzed and required a wheel chair. While they were playing music together, he said “I love you” to participant F. This male client who felt like he had no physical control over his life experienced sexual attraction to her as a result of co-creating music. She felt it was understandable to do that because “we use music that brings up all the senses of being alive in people.” She felt sympathy for him and explained: “He felt that he had regained a sense of being alive and falling in love with someone. I mean it didn’t have to be me, but he just projected his feelings onto me and learned about those projections.” She said that was really helpful for her to have emotional and sexual boundaries in her clinical work. The second area that she worked on in PT was attachment issues to her clients. She explained that “it was so difficult for me to say goodbye to clients when they were discharged [from the hospital] because I had so much of an attachment issue and then I felt so sad when they were leaving.” Her therapist helped her to see that this attachment was
related to her relationship with her own family and reflects the “Japanese family system.” With the therapist’s empathy about this cultural value, she realized how her mother had been devoted to raising participant F and her siblings, and how they became the “center of her [my mother] life.” Participant F realized that it was “hard for her [my mother] to let it go” and her relationship with her mother was projected onto her relationship with clients.

**Modeling.** Observing therapists’ work and ways of interacting with the participants became a great experiential learning experience and a model for participants’ clinical work. Three participants (C, D, and H) learned from their therapists’ techniques and imitated their attitudes or ways of building up a therapeutic relationship.

Participant C learned about ways of asking questions and the importance of the therapist’s presence. She borrowed her therapist’s way of asking questions because it guided her to discover who she was independently. Furthermore, she learned how important the therapist’s presence was and shared:

I learned the therapist’s role from my own therapist. It gave me a greater feeling that this person is with me rather than just her skills. She was with me in that space and time. I learned to be fully present from her.

The rest of the participants (D, and H) talked about modeling their therapists’ embracing attitudes. Participant F described her therapist:

She was attuned to and actively listened to her client. I kind of tried to embody her sometimes after those personal therapy experiences. […] I think it definitely shaped my current clinical work as a professional.

Participant D learned about the importance of having a non-judgmental attitude from her therapist and this made her feel accepted:
I needed therapy. I was too busy talking about myself but [my therapist] accepted me unconditionally 100% for who I am. I learned about that a lot. It is not easy to listen to somebody without judging. But watching my therapist, I also wanted to listen to [my clients] the way she did and came to think about how [my clients would feel] when I do the same […] I learned to be accepting and tried to put myself in their shoes.

Participant H’s therapist’s trusting intuition was one area that she wished to emulate. It was hard for her to trust her own intuition because she felt it was “risky.” However, she was amazed by her therapist’s using intuition and achieving great results. Therefore, participant H said that it “was great having her as a model and as a therapist.”

**Category 3. Academic influence.**

Undergoing PT had positive influences on academic performance for five participants (A, B, C, F, and G). The following examples show how PT assisted participants’ academic performance both directly and indirectly. First, PT functioned as an outlet to release participants’ academic stress. Participant A stated that “I received empathy as a student there. It [studying] was stressful, but it [PT] enabled me to release my stress by talking about it on a weekly basis.” She talked about how stressful she felt the class was. “I was concerned about if I would do well [in the class].” Her therapist had empathy for her concerns about class presentations, even though she did not teach her how to do presentations. Participant F also talked about a similar experience that PT helped her deal with. She felt that she had become healthier and that PT enabled her to release her emotional intensity from school work. A detailed example of another indirect link to academic work was reported by participant B. He shared how the presence of his therapist eased his stress about his school performance. Because he was able to project his mother issue onto his therapist, who was female, he did not necessarily have to expect that his
female professor would take on a motherly role. As a result of PT, he explained, “I was able to separate this [unconscious expectation for mothering] from my professor and transfer my academic stress to my therapist.” He found that this emotional separation intensified their professional relationship and he was able to focus on learning from his professor.

Other participant examples showed that PT had a direct link on school performance, such as participating in class discussion and writing papers. Participant C shared how her changes in thinking through PT carried through to how she wrote papers and stimulated her intellectual curiosity:

All of your thoughts are revealed in your writing. Before therapy, it was hard for me to express my creative thoughts [in writing] because I had not known what I was even thinking. However, after receiving personal therapy, I identified my own ideas and feelings; they were reflected in the papers.

Participant G found that her class participation increased. Before PT, speaking in class was challenging because she did not know what to say. She also felt “intimidated” most of the time, and was afraid of sounding “stupid” in class. On a deeper level, this reaction was related to her not feeling confident about her own thoughts and feelings. However, she described the changes in her class discussion participation:

Through PT I guess I learned to trust myself a little more. It is okay to say what I want to say or start to get in touch with myself and understand “oh! This is what I am thinking” or “oh! This is feeling.”

**Category 4. Musical influence.**

**Toward transformative experiences in music.** Four participants (A, D, G, and H) had negative associations with previous personal musical experiences. They had felt anxious,
vulnerable, or critical of themselves in music. Negative associations with self-image emerged as well. As they experienced changes through PT, they found that changes in their music took place simultaneously. Their transformative experience was reflected in their perceptions, playing, or, attitudes. Participant A, who attended a music college, shared a simple example. She used to feel very stressed about practicing her instruments. When she entered the music therapy field, she completely stopped playing her main instruments and rationalized this by saying that she just had no time to practice due to her music therapy studies. Through her own therapy work, she discovered and faced this anxiety that had been provoked by her music college. She was able to take a step further and finally found the courage to bring her instruments to the music therapy group that she was participated in.

Participant D had felt that playing piano was very stressful. “I used to hate playing the piano.” When she was a child, she had felt pressured to play accurately and beautifully. Now, her music has changed and when she plays her music for herself, she can admit, “I am not good. My fingers do not move fast enough, but I do not feel so much stress.”

Improvising music in therapy was very challenging for participant G. She was critical of her piano playing. First, she did not know “how to improvise” and could not identify herself as a pianist, even though the piano was her main instrument. Improvising on the piano was painful for her. She frankly stated that “I didn’t like what I was able to do. I wasn’t good enough basically. That was the big thing.” A deeper explanation for her struggle in improvising was that improvising in music touched her feelings, but she was not ready to face them yet. Instead of playing the piano, she found her musical identity as a singer through her music therapy experience. She felt more connected when using her voice. “I don’t have as much as judgment about my singing. I feel like I am more in control or I am able to do more when I sing.”
Participant B knew that he had some affinity for singing. However, through exploring his voice in music therapy sessions, he came to redefine his musical identity as a singer for the first time.

Participant H shared a profound experience about changes in music on different levels. She detailed her deep connection in music, speaking mainly about how her personal and musical changes were interconnected as “a parallel process” and found that the distance between herself and music became narrower. In improvising music, at first she felt she was “nothing.” It was hard for her to “take away pressure” and become herself. She mentioned that she was “stuck in one mode” and that it was very difficult to be flexible in music. Her therapist encouraged her “not to think about making beautiful music,” but to instead feel her emotions and reflect them into music. With her therapist’s support, she noticed that her playing sounded very different. Changes began to emerge. She began to accept her mistakes, such as missing notes, and the fact that “the quality of music may be not the greatest.”

Clinical use of music. Five participants (B, C, D, E, and H) noted changes in the viewing, improvising, and adapting of music for clinical uses. Participant H changed her opinions about the use of improvised music in clinical work. She noted that her musical interactions became more client-centered work and that her use of music in sessions shifted from that of “performer” to “therapist.” This new perception emerged as her personal development through PT narrowed the distance between her and her music in music-making. She also became flexible in improvising music, and she endeavored to convey the following nonverbal message to her clients: “This is what I want to do with you and this is how I want to help you.” This manifested as “there is less I” in improvising music. She shifted her mind to focus on her clients’ musical needs.
By experiencing verbal therapy, participant D learned the strength of music therapy as a means for a non-verbal expression. She talked about the difference between regular counseling and music therapy:

We can scream, act, and beat the drum. It does not have to be music. We can use voice and scream. However, there is nothing like that in counseling. I had to talk from the beginning to the end. Sometimes, there was anger that I could not verbalize. I cried but I could not express that.

She further explained that verbal therapy was not sufficient in terms of letting her feelings out and verbal therapy could not allow her to satisfy her needs for expression fully. She articulated the power of music as a therapeutic tool when she declared, “Music therapy is powerful. It touches people’s emotions and feelings more than any other type of therapy.”

Because participant E had a lot of experience being asked to play her feelings in music, she felt that she had more musical choices and felt comfortable offering her clients the same. She learned the technique of musical role playing and uses it now. She provided an example of theme-driven improvisation when she suggested, “Let’s play your feelings of autumn or memories of your hometown.”

Participant B began to use his voice more in his clinical work after he received music therapy where he mainly used his voice. He explained that he had modified his musical experience in his own therapy and applied it to his current work. He carefully uses his voice because he experienced just “how powerful the voice can be.” For example, for one client who has a mother issue he doubled his voice by humming on top of a viola playing a lullaby on an audio CD. This was very therapeutic and soothing for his client.
Participant C provided a music-centered description of distinct changes in her music. Following the clarification of her thoughts and feelings in PT, she achieved concrete changes in music as well. In the past, it had been hard for her to create a melody in improvisation. She confessed that her music in the past had been like “background music,” with “no theme”; she felt that her music was “blurry” and reminiscent of a “grey zone.” However, Participant C noted that this change occurred as her vague thoughts became clear and she began to know herself better over the course of her PT. Also, she became immersed in making music and was able to create musical themes more quickly than before. She had been once uncertain about what kind of music to play; now, she noticed that the time she needs to come up with a musical theme in her improvisation has shortened. Also, she became more focused on her clients’ music as she made musical connections with them.

**Theme 4. After therapy**

The fourth theme concerns how the participants have integrated the Western style of therapy into their clinical work with Asian clients and addresses the participants’ recommendations for future Asian music therapists. This theme includes 2 categories and 4 subcategories as follows: (1) Therapeutic application (a. providing structure b. communication c. different words for therapy d. no need for modification) (2) students’ need for therapy. The following figure presents composition of theme 4.
Figure 5. Visual representation of the fourth theme with 2 categories and 5 subcategories. Numeral indicate numbers and percentage of codes.

**Category 1. Therapeutic application**

**Providing structure.** Five participants (A, B, D, E, and G) talked about how they have modified a Western model of therapy into their own clinical work. Common modifications consisted of how they should provide structure for their clients. They felt that this should consist of framing a way to ask questions, setting limits in personal work, and providing practical tips for their Asian clients.

Participants A, B, D, and G felt that asking an open question can be overwhelming to Asian clients. Participant A talked about how her Korean client who suffered from anxiety had a difficult time in bringing up his personal issues when she asked broad questions, such as “How have you been?” Or “What do you want to talk about today?” Participant G believed that one solution was to offer more suggestions in the questions. For example, she would ask, “Does this [specific topic] make you feel this way [specific feeling] or that?” This wording might guide
clients to “think rather than just leave [the conversation] completely open.” Participant D, who works at the university counseling center, also narrows her questions. For example, she might ask, “How are your studies going?” Or “How are you getting along with your roommates?” based on the information that she has gathered from previous therapy sessions. She shares many of the characteristics of Asian clients in therapy sessions and notes that Asian clients can feel pressure to talk about themselves openly and therefore they remain in silence. They also expect therapists to ask questions first. Sometimes they become confused about what to answer and this may make them feel hesitant to return to therapy sessions.

Narrowing down therapy goals for Asian clients was preferable to providing total freedom in the session. Participant B elucidated the need to create containment in clients’ therapy. In the beginning of the course of therapy, he offers a direction of what he and his client are going to work on in a “curriculum” fashion. This functions to provide “safe boundaries” for clients.

These modifications were necessary because there are certain cultural elements with which Asian clients are more familiar, such as learning by rote (participant B) and preferring to answer questions rather than initiating them (participant D). Therefore, it is better for certain clients if therapists take the initiative in leadership and are specific in their clinical work. Participant D expressed this clearly when she said, “It sometimes is necessary to lead them like a teacher.”

Different words for therapy. Three participants (E, F, and H) reported that they use different words instead of “therapy” because there is still a cultural bias about receiving therapy in Asian countries. Participant E said, “I can’t say that my program is therapy.” Participant F also explained, “If we call it therapy, they don’t come.” In order to recruit more people, she calls her
group a “Musicing group” so that her clients will not hesitate to come. However, she actually uses “the concept of music therapy principles” in her work. Participant H also changed her program title to “supervision session” in working with music therapy students or mental health practitioners. She explained that “supervision is easier to step into,” but it includes therapeutic components because she knows that her clients need therapy but have never experienced it before. Her modifications help them benefit and open up to the therapeutic experience.

No need for modification. Three participants (A, B, and D) shared information about their partial integration of Western modes of therapy without modifications. They all try to create equal relationships with their clients rather than being authoritative. Participant A stated that she wants to create a “horizontal relationship” and “therapeutic alliance” with her adult clients.

Participant D shared that she did not want to change any of the therapy techniques that she learned from PT. She pointed out some Asian cultural elements and explained that sometimes Asian philosophy does not work in the therapy process because it is group-oriented culture.” She learned how to accept clients through having experienced Western models of therapy and she also understands why Asian clients have a hard time in Asian cultures. As she accepted and encouraged her clients, she noted that their responses became very positive. One client exclaimed, “Oh! She listens to and accepts me!” She stated that many of her clients cried because they had never had anyone who listened to them in the way she did.

Participant B had a positive experience when his American therapist respected his wishes by asking what he wanted to talk about or what direction he wanted the session to take. In addition, he learned the importance of respect when he worked with African-Americans. Therefore, he applies this approach to his own clients in order to respect their autonomy and personal space.
Category 2. Student therapists’ need for personal therapy

All eight interviewees stated that they strongly recommend that prospective music therapists receive PT as clients. In particular, five participants (A, D, F, G, and H) elucidated the importance of increasing self-awareness through PT. Participant F borrowed the term “wounded healer” and explained that mental health practitioners need to admit that they have “wounds” and need to heal them. Participant G shared a similar notion that people who are drawn to the mental health field choose their vocation because it is related to a desire to heal themselves. Therefore, it is necessary to discover who they are in therapy. Participant H also noticed that many Japanese music therapy students have personal issues that lead them to decide to study music therapy. Regarding family issues, participant G pointed out the need to face reality and uncover their delusion in order to admit their wounds. It “doesn’t matter how happy you were as a child. There is no perfect family.” Participant D explained that “people who believe that they were raised in a loving family should really go to therapy. This means they do not perceive their problems accurately.”

Participants also talked about how unresolved personal issues can jeopardize their clinical work. Participant F explained that music therapy work involves “the process of building relationships.” The dynamics in therapeutic work “bring up lots of emotions and memories and sensations that are related to your own issues.” Participants F and G mentioned that negative countertransference can happen without one’s being aware of personal issues and that therapists have a tendency to satisfy unmet needs or unresolved feelings from their clients. Participant G further stated that the therapy session is the “wrong place to fulfill our needs.” Participant A cautioned that distorted perceptions are greatly dangerous to clients and they will hinder the therapist’s ability to help them. Participant D explained that it is significant for therapists to
accept their blind spots; otherwise, they cannot see other peoples’ issues. They need to admit they can be imperfect through therapy, go through hardships, and feel. Then they can expand their realizations into empathetic acceptance of their clients. However, “countertransference 100%” will take place and it will hurt both parties in the therapeutic relationship unless they receive help from therapists. She suggested that music therapy students inevitably need to empty themselves out in order to listen to other people. Participant D stated that Korean students, in particular, need somebody who can listen to them fully with a non-judgmental attitude because Korean culture is more about disciplining than listening. Regarding a similar cultural aspect, participant F and H also sustained that Japanese music therapy students should receive PT despite cultural misconceptions about going to PT because many of them have had no opportunity to deal with their issues.

Participants stressed that personal therapeutic work will enable student music therapists to become “wounded healers” (participant F) and “better equipped therapists” (participant G) who are “more flexible, more accepting, and more versatile” (participant G).
### Table 4

*Themes, categories, and subcategories derived from interview transcripts*

<table>
<thead>
<tr>
<th>Theme (4)</th>
<th>Categories (13)</th>
<th>Subcategories (20)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Cultural experiences</strong></td>
<td>Asian cultural experience</td>
<td>A tight relationship with family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group-oriented culture</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inhibition in expressing oneself</td>
</tr>
<tr>
<td></td>
<td>Western cultural experience</td>
<td>Being different</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Classroom culture</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Culture oriented towards the individual</td>
</tr>
<tr>
<td></td>
<td>Cultural stigma</td>
<td>attached to therapy</td>
</tr>
<tr>
<td><strong>2. Experiences during course of therapy</strong></td>
<td>Therapy space</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Beginning stage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student Therapist’s Therapist</td>
<td>Therapist’ attitudes and personalities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Therapist’s roles</td>
</tr>
<tr>
<td></td>
<td>Difficulties in therapy</td>
<td>Confusion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Conflict with therapists</td>
</tr>
<tr>
<td><strong>3. The influences on personal and professional levels</strong></td>
<td>Personal influence</td>
<td>Acceptance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Changes in thinking paradigms</td>
</tr>
<tr>
<td></td>
<td>Clinical influences.</td>
<td>Client-centered work</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Boundary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Modeling</td>
</tr>
<tr>
<td></td>
<td>Academic influence</td>
<td>Toward transformative experiences in music</td>
</tr>
<tr>
<td></td>
<td>Musical experience</td>
<td>Clinical use of music</td>
</tr>
<tr>
<td><strong>4. After therapy</strong></td>
<td>Therapeutic application</td>
<td>Providing structure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Different words for therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No need for modification</td>
</tr>
<tr>
<td></td>
<td>Student therapists’ need for therapy</td>
<td></td>
</tr>
</tbody>
</table>

---

*Example quotes:

1. Cultural experiences
   - There was no space for me to think about myself, my voice, what I liked and what I wanted to do. Instead, I caught what other people wanted very quickly." (C)
   - Asian cultural experience
   - A tight relationship with family
   - Group-oriented culture
   - Inhibition in expressing oneself

2. Experiences during course of therapy
   - I had never talked about my feelings before. [So when the therapist asked that question, I came to remember those times. That was why I cried.’’ (A)
   - Therapy space
   - Beginning stage
   - Student Therapist’s Therapist
   - Therapist’ attitudes and personalities
   - Therapist’s roles
   - Difficulties in therapy
   - Confusion
   - Conflict with therapists

3. The influences on personal and professional levels
   - Healing can be made when [I] accept myself for who I am. When I accepted my issues and talked about them, I was able to see my weaknesses and rough edges parts in me. [Therapy] helped me to see those things.” (D)
   - Personal influence
   - Acceptance
   - Changes in thinking paradigms
   - Clinical influences.
   - Client-centered work
   - Boundary
   - Modeling
   - Academic influence
   - Musical experience
   - Toward transformative experiences in music
   - Clinical use of music

4. After therapy
   - “It sometimes is necessary to lead them like a teacher.” (D)
   - “Bring up lots of emotions and memories and sensations that are related to your own issues.” (F)
   - Therapeutic application
   - Providing structure
   - Different words for therapy
   - No need for modification
   - Student therapists’ need for therapy
Summary of Results

After careful analysis, this phenomenological research resulted in 4 themes, 13 categories and 20 subcategories. The four overarching themes are Cultural experiences, Experiences during course of therapy, Influences on personal and professional levels, and After Therapy.

The first theme, Cultural experience was split into three categories and six subcategories as follows: (1) Asian cultural experiences (a. a tight relationship with family, b. group-oriented culture, c. expressing oneself); (2) Western cultural experiences (a. being different, b. classroom culture, c. culture oriented toward the individual) (3) Cultural stigma attached to therapy. This theme discussed the participants’ common experiences, such as influences, conflicts, benefits, and discoveries in both Asian and Western cultures. All of the participants reported cultural biases toward undergoing psychotherapy in Asian cultures.

The second theme, Experiences during course of therapy, consisted of 4 categories and 4 subcategories as follows: (1) Therapy space; (2) Beginning stages; (3) Student therapists’ therapists (a. therapist’s attitudes and personalities b. therapist’s role); (d) Difficulties in therapy (a. confusion, b. conflict with therapists). This theme focused on the participants’ perceptions of their own PT, such as symbolic meanings of the therapy space and relationships with their therapists.

The third theme, Influences on personal and professional levels, was overarching. It included 4 categories and 7 subcategories as follows: (1) Personal influences (a. acceptance, b. changes in thinking paradigms, c. adjusting to the US); (2) Clinical influences (a. client-centered work, b. boundary c. modeling). (3) Academic influences (4) Musical influences (a. toward transformative experiences in music, b. clinical use of music). This theme chronicled personal and professional influences in the participants’ development.
The fourth theme, After therapy, examined participants’ practical adaptations in a clinical setting. This theme included 2 categories and 3 subcategories as follows: (1) Therapeutic applications (a. providing structure, b. different terms for therapy, d. no need for modifications) (2) students’ needs for therapy. The participants carefully discussed how they reflected on and reshaped their PT experiences in order to be able to provide culturally-tailored therapies for their Asian clients.
CHAPTER 5

Discussion

This phenomenological study examined the previous therapy experiences of eight East Asian music therapists who were trained in the US. In addition, the participants’ Asian cultural values were explored to examine influences on their therapeutic processes of therapy. The participants were interviewed individually by the researcher. The interview focused solely on details of their previous therapeutic experiences and depended on their retrospective memories. The researcher transcribed each individual interview verbatim. Through an inductive data analysis, 4 themes, 13 categories and 23 subcategories were identified. This chapter will examine the findings based on the research questions and interpret them based on the relevant literature.

Research question 1. How did experiencing personal therapy influence Asian music therapists’ development during their training?

Personal Development.

Uncovering and understanding the past as part of the process of personal development.

The participants in this study reported that one of positive effects of PT was that they faced, and eventually accepted, their difficult pasts. Specifically, the participants worked on emotional suppression, dealt with significant relationships, deepened their understanding of past experiences, and learned how these experiences linked to their present lives. Furthermore, their personal work brought positive changes into their lives. These findings are congruent with a study by Daw and Joseph (2007) that reported that PT functioned to discover “personal vulnerabilities and drives” (p. 230) that prompt personal growth. Participant A, who had had no one to listen her difficulties, was able to talk for the first time about her hurtful memories of living in Europe to her therapist. Finally, she realized that she missed her home country and
decided to move back. Participant H gained strength to face her father’s traumatic death in her therapy. She made a connection between a feeling of abandonment in her romantic relationships and her father’s absence. Furthermore, PT assisted her to “be better able to handle it [her father’s death].” She explained this change as follows: “Everything made sense after that. I became less nervous and I could really feel there are many meetings and departures in people’s lives.”

Both participants C, and D stated that accepting their dark sides in PT resulted in personal changes. Participant D who had been fearful of making mistakes stated that “healing can be made when [I] accept myself for who I am.” Finally, she was able to talk about and accept her vulnerabilities. Participant B also explored “deeper” sides of his family issues with his therapists. It was not easy for him, but eventually he was able to see the “big picture” of family dynamics, and not focus solely on his relationship with his mother.

Corey (2012) claimed that PT is necessary for therapists to explore their “unexplored blocks related to loneliness, power, death, sexuality, our parents, and other life challenges” (p. 21) because it will have an impact on both personal and professional development.

**Giving meaning to the present life (Insight).** Seven participants indicated that they received either psychodynamic or psychoanalytic therapy. The psychodynamic approach to psychotherapy focuses on deepening self-reflecting and self-understanding of “own actions and experience” (p. 52). (Leiper & Maltby, 2004, p. 52).

Participants in this study also reported that they discovered a meaning in life and this resulted in their increasing self-esteem. Participant C found that PT had the effect of “stirring up and confirming impurities,” which was meaningful. She stated that as a result, she was able to accept that life cannot be perfect all the time. She learned that it is normal that life has ups and downs. Furthermore, she claimed that this insight about life increased her self-esteem and that
she came to love herself and feel that she is worthy. Participants C, and D both grew to love themselves. Participant C explained, “This is related to my self-esteem. I am worthy of being treated in a special way. I learned to love myself” and Participant D asserted, “I came to learn about loving myself through therapy.”

Leiper and Maltby (2004) explained that PT in general prompts “the discovery of new understanding [and] is regarded as making…a crucial contribution to the process of personal change” (p. 64) and includes “a re-organized sense of who we are” (p. 64).

**Therapy as a place for self-care.** The therapy space functioned as a place of self-care for the participants in this study. They found that going to their therapists’ offices provided a space for them to be nurtured. The office environment reassured the participants that they were seen, heard, and accepted. Participants A, C, and D addressed the therapy space as part and parcel of self-care. Interestingly, both participants A and D described their therapists’ offices as “narrow spaces”; however, they felt intimate and safe in this place. Participant D remarked, “I just loved going there. Even though I was not crying all the time, I just loved being there. Whenever I talked, somebody always listened to my anger. It was my own space that I felt safe in.” Being in their therapist’s office allowed them to share their personal history. Furthermore, Participant D’s therapist guided her to learn the importance of self-care as a clinician: “[My therapist said] when we merge with and have empathy for other people’s feelings, we need to practice how to empty ourselves.” Participant C also shared how therapy nurtured her and explained the benefits of becoming a client: “I just loved that therapy space. The therapist’s job is always to help other people. But in [that] therapy space, that person [her therapist] is always there for me for those 45 minutes. She is there only for me.” In other words, a therapist also needs help. Daw and Joseph (2007) supported the finding that the therapy space itself is pertinent to self-care. They asserted
that PT offers a way of taking care of therapists on professional and personal levels “through helping to contain, work through, or off-load work-related [issues]” (p. 229). Moreover, sitting in the therapists’ office gives time “to process and reflect upon the impact of their clients’ stories, emotions, and behaviors” (p. 230), which is differentiated from receiving supervision.

**Professional Development.**

Wigg, Cushway, and Neal (2011) stated that the PT experience contributes to therapists/students’ professional development by enhancing “the development of empathy, greater self-awareness within sessions, socialization to the profession and validation of benefits of therapy” (p. 353) with the result that they are then “more skillful and accurate” (p. 353) clinicians. Moreover, becoming a client provides an opportunity to directly experience “a deeper understanding of process issues, models, and techniques” (Daw & Joseph, 2007, p. 230). The participants in this current study also reflected on the aspect of experiential learning by undergoing actual therapy.

**Increasing empathy for clients.** Rogers’ (1980) described empathy as “the therapist’s sensitive ability and willingness to understand the client’s thoughts, feelings and struggles from the client’s point of view. [It is] this ability to see completely through the client’s eyes, to adopt his frame of reference” (p. 85). In a clinical context, empathy involves “communicating” what a therapist senses of a client’s “world” with a nonjudgmental attitude. Empathy plays a role in gathering “psychological data” to help in interpreting or making a clinical judgment (Clark, 2007, p.5). In addition, empathy enabled the therapeutic process “to go further or deeper” (Raskin & Rogers, 2000, p. 135).

Studies have emphasized the importance of empathy in PT (Haenisch, 2011; Macaskill & Macaskill, 1992). The development of empathy toward clients correlates with the development
of clinical skills in this study as well. The actual therapy experience was a parallel process that enabled the participants to understand how their own future clients might feel in therapy sessions with them. The participants emphasized the aspect of feeling in empathy. Participant E explained that “knowing how you feel as a client is really important for therapists and it helped me a lot.” Participant C stated that “you can only experience empathy from therapists who have had professional training. It is significant to actually feel what you learn from your text book. When my therapist empathized with me, I really grasped how powerful that was.” Participant G was able to understand her clients better after she worked on her repressed feelings, which involved “the projective use of personal experiencing” (Clark, 2007, p. 16). Her PT experienced deepened her empathy and ability to act as an emotional container for her clients. She described having empathy for one particular client as feeling “his pain and frustration.”

On top of allowing the participants to feel what their clients feel, they reported that PT provided them with the opportunity to understand that becoming a client can be emotionally challenging (Moller, Timms, & Alilovic, 2009). Participant F came to learn that being in a client’s position can be challenging in and of itself and it helped to her understand the point of view of a client. The PT experience contributes to therapists’ understanding of the difficulties encountered that provoke “anxieties and feelings of vulnerability” (Kumari, 2011, p. 221) and “ambivalence” (Ivey & Waldeck, 2014, p. 91).

However, Peebles (1980) indicated that the number of hours one spends in PT may proportionately impact the development of empathy in student therapists. This finding may bolster the rationale for training programs to suggest PT as a significant option for developing clinical skills.
**Working on countertransference.** Countertransference is the therapists’ emotional reaction triggered by clients (Racker, 1957). Countertransferential reactions have the potential to confuse and endanger the therapeutic process and need “objective investigation” (Freud, 1964, p. 249) through regular personal analysis. McLoughlin (1995) also emphasized that therapist’s countertransference needs “interpretative enquiry” (p. 70) in order to be a useful tool for the client. PT for therapists can function to decrease the risk of countertransferential reactions (Kumari, 2011) and bring self-awareness of therapists’ personal issues (MacDevitt, 1987).

In this phenomenological study, the participants worked on their countertransferential issues with the therapists because they found that their emotional merging with their clients interfered with the clinical process. Participant F mentioned that she sometimes had a “hard time defining what my issues were and what the actual clinical issue was.” Through her own therapy, she discovered that her countertransferential reaction originated from emotional needs in her childhood. By talking to a therapist, she was able to establish a clear boundary between herself and her clients’ issues. Participant F also learned that her countertransference was related to her attachment issues. In particular, she found that terminating the course of therapy was challenging and that she became emotional. Her therapist helped her to see that this emotional overlap was connected to her own mother who had had a hard time separating from her children. Participant F pointed out that issues of family separation are prevalent in Asian cultures. She also shared an intense reaction to one of the clients at her internship site. One of her male clients exhibited sexual transference toward her. Even though she felt “sympathy” toward him, it was only through talking about this difficult topic with her therapist that she was able to maintain a clear emotional boundary.

Ivey and Waldeck (2014) addressed the concern of dealing with countertransference in
PT. They pointed out that PT has the potential to make the therapists feel self-absorbed during clinical work rather than focusing on the client. This occurs especially when the therapist and the clients are dealing with similar issues; the therapist’s personal issues can be abruptly exposed during clinical sessions. Participant C shared that she became self-absorbed during the course of PT and that this triggered a countertransference relationship in her clinical work with clients. She began to become “obsessed” with this and focused on her issues when she was with clients. She described this experience as confusing and unsettling.

Learning how to do therapy. Daw and Joseph (2007) indicated that actual therapy experience is a necessity for therapists as they learn by observing their therapists’ clinical skills and modeling them. The participants’ therapists were good models for them in their clinical work. Participant C patterned her behavior on how her therapist asked questions and interacted with her (Grimmer & Tribe, 2001). Participants F and D were impressed by their therapists’ attitudes. Participant F modeled her therapist’s sincere attitude through active listening. She stated that her therapist’s attitude helped form her professional self as a therapist (Gardstrom & Jackson, 2012). The non-judgmental attitude of participant D’s therapist led her to feel unconditionally accepted. Therefore, she now does the same for her clients as this helps her to understand them fully. Participant H had been afraid of taking risks but was surprised to see this brought positive a outcome. Thereafter, she modeled her approach to mirror that of her therapist.

Research question 2. How might personal therapy have influenced the ways Asian music therapists use music clinically and personally during and after training?

Negative associations with music. Playing music during the PT experience provoked participants’ negative memories of musical experiences they had encountered before entering the field of music therapy. For participant A, playing her main instrument had been stressful and
anxiety-provoking because she had felt pressure to perform perfectly. A perfect performance does not allow for any mistakes and requires investing a lot of time in practicing. After beginning to study music therapy, participant A stopped playing her main instrument. Participant D had had a similar previous experience about music. She asserted, “I used to hate playing the piano” because it requires playing perfectly. Participant G shared how improvising music in PT reflected the critical aspect of her personality. Improvising at the piano was challenging and she felt that she did not know “how to improvise.” Therefore, she undervalued her playing and was not content with what she played. Moreover, she felt that improvising was challenging because music touched her emotions when she was not ready.

Chong (2007) mentioned that student music therapists’ free playing in music is often constrained due to their past musical history and that their personal experience of music is directly linked to its clinical use. Therefore, it is essential for them to explore and embrace their own musical selves. She also pointed out that their educators need to help them search for their musical identity. Similarly, Hesser (2013) explained that though music therapy group, students can identify “their creative and expressive blocks and the judgments and critical thinking they bring to music making from their own musical pasts. Any difficulties and obstacles in using music for self-expression and relationships with others become clear.” (para. 6)

Establishing a new musical relationship with the self. This discussion is an extension of participants’ negative associations with music. It examines how experiencing PT enabled the participants to develop their new musical identity and to establish a positive relationship with music after facing their past distressful experiences.

Participants B and G solidified their musical identities as singers. Participant B spoke of exploring his voice in personal music therapy, reaffirming his love for singing and he found
himself using his voice more often. Participant G had had difficulty in improvising at the piano, but then realized that she felt more connected to singing and became less critical of herself when she used her voice. Participant D came to enjoy playing the piano, especially classical pieces. After having experienced positive psychological changes through PT, she realized that she does not have to be perfect in playing music. This realization allowed her to note that even though her piano technique is not excellent, she came to enjoy playing the piano. As she accepted her imperfections, she found that her musical changes were followed by psychological changes; this parallel process allowed her to stop idealizing her therapist and realize that she was not perfect either.

Camilleri (2001) stated that it is crucial that a music therapist be genuine because this quality is also reflected in music with clients. Participant H had struggled from feelings of pressure and trying to be flexible in improvising. However, her therapist encouraged her “not to think” and focus on her emotions instead. She then accepted her musical imperfections and realized that she is allowed to make mistakes, even if “the quality of the music may be not the greatest.” When musical connections were made, participant H felt her music was authentic and “natural.” She explained, “I am not lying when I play music.” In other words, music became an authentic way to communicate. By helping her realize this, the therapists’ role gained importance. Psychological changes were also reflected in music-making. Furthermore, her personal musical changes were definitely reflected in her clinical work with clients. Participant H noted that she became more interactive with her clients in co-creating music. She explained that her view of music changed from being “performance”-oriented to “therapeutic.” She became more client-centered in the session when she realized that “there is less ‘I’ in improvising music.” Similar changes occurred with participant C. Participant C provided a vivid description of her
music-centered work. As she integrated her thoughts and feelings, her music moved to the foreground and replaced the “background music” of her past. For example, she became able to create a melody quickly, whereas in the past, her music had contained “no theme.” She described her music pre-breakthrough as being “blurry” and in a “grey zone.” This musical change definitely influenced her co-creating of music with her clients. Turry (1998) explained that a therapist’s musicality is deeply related to the clinical use of music. “There is a parallel process between the therapist and client of gaining increasing degrees of musical freedom as therapy progresses” (p.167). Musical interaction assists music therapists both in assessing their clients’ inner worlds and in using countertransference in a clinical way.

**Strength of music in therapy.** Music helps people’s humanness “to emerge and to be observed...[more] often [than] seen through ordinary verbal communication” (Hesser, 2013, para. 7). Even though participant D had undergone regular verbal therapy, she was able to compare experiences of using words and music in therapy sessions. Sometimes she felt limited in her ability to verbally express her emotions and realized that music can give access to feelings that cannot be expressed through words. She articulated the clinical strength of music as follows: “It [music] touches people’s emotions and feelings more than any other type of therapy. I came to believe that it touches people’s emotions and feelings in a way that words cannot touch.”

Participant B, who found his affinity for singing in his PT, learned how powerful the human voice can be in clinical work as well. Thereafter, he came to use his voice more often for clients. Streeter’s (2002) research supports Participant B’s finding his voice after PT. He described the connection between therapists’ self-expression and their clinical work: “Once they have experienced something for themselves which has felt meaningful and expressive, then they seem more able to work confidently with their own client group” (p. 268).
Hesser (2001) maintained that music therapists/student music therapists need to be in music therapy in order to experience first-hand the “healing power” (p. 53) of music. Furthermore, she examined the link between their musical changes and their clinical use of music in their practice, noting that “Experiencing music in this way deepens our understanding of our clinical work and changes our relationship to music permanently” (p. 53).

**Research question 3. How did specific Asian cultural perspectives influence Asian music therapists’ own therapeutic processes?**

Discussion of the third research question consists solely of examining the participants’ different cultural experiences and the relationship between their bicultural backgrounds and their influence on their therapeutic process.

**Asian culture prioritizes needs of groups.** Confucianism is a common cultural value that has a strong influence on East Asian countries such as China, Korea, and Japan (Chang, 2013). Confucianism values the “well-regulated family” (p. 61), which is a root of “social and world peace” (p. 32). Yao (2000) explained that the characteristics of Confucianism include emphasizing family relationships and responsibilities. The group-oriented attitude was prevalent in the lives of the participants in this present study. For example, participant F described Asian people as being “so interdependent on each other.” The philosophy of Confucianism considers harmony with other people as an important value (Tien & Olson, 2003).

Four participants stated that the cultural emphasis on group orientation affected society’s ability to meet individuals’ needs and honor their personal space as individuals’ needs are secondary to those of family and groups (Bae, Joo, & Orlinsky, 2003). Participant D stated, “The individual is not considered as important. Individual differences are not accepted.” Participant C offered, “I cannot live for who I am. I live for whom my mother wants and whom society wants.
In order to make oneself vanish and harmonize with other people, a group-oriented culture is enforced in Korea.” Participant C pointed out a weakness of Asian culture in that “there is no space for me to think about myself, my voice, what I like, and what I want to do. Instead, I catch what other people want very quickly.” Participants G and D talked about Asian culture having certain mandatory standards. Participant G mentioned that Asian people follow “the same path, doing the same thing.” And that people feel that they “should” do this. Participant D said, “Korean culture is about right or wrong. Things must be either right or wrong. We have no grey.” Furthermore, participant D stated that she felt that she had not been good enough when growing up, and it was hard to discover what she was good at. Yoo, Lee, and Yoo (2007) reported that “coexistence and we-ness” (p. 195) are important in groups, especially in the family. However, the prioritizing group may present “obstacles to the adjustment of Korean people to changing norms in a rapidly individualizing society today.” (p. 195).

Family relationships in Asian cultures show a clear emphasis on valuing the group over the individual. Park and Chesla (2007) explained that “in the Confucian tradition, the family is the irreducible unit rather than the individual, and members are expected to be involved with other family member’s lives” (p. 306). Participants B and G explained how they felt obligated to satisfy the needs of their families. Participant G shared that she became a person of high achievement because her father expected her to be independent. She focused on her father’s expectation more than her needs. Even though she had the “mental capability to fulfill his goals,” she often left with questions such as, “Why am I doing it by myself?” Participant G also mentioned how hard it was for her to share her feelings with her mother as she felt disconnected from her. She confessed that she does not cry in front of her mother because her mother can be critical of her. Her relationship with her parents led her to feel “unloved.” Slote (1998) explained
that emotional repression comes about when there is no proper way of releasing emotions in the family, which appears “harmonious on the surface” (p. 44) but in which “intrapsychic conflicts” (p. 44) exist. Participant D rarely has conversations with her parents because it feels awkward. Participant F never talked about intimate topics such as sex because she does not feel allowed to do so. The participants’ relationships with their parents are aligned with the findings of study by Saw and Okazaki (2010) that Asian Americans experience “parental messages to inhibit, repress, or suppress emotions” (p. 87) while White Americans’ families allowed the free expression of emotions. In addition, there was “less family talk about feelings” (p. 87) in Asian Americans. Moreover, a significant connection was found between Asian Americans who learned not to express their negative emotions and the degree of social anxiety they exhibit.

**Western culture and the development of the individual self.** In contrast to Asian cultures, Western society views each individual as a separate being (Park & Chesla, 2007). Participants A, and H said that they did not feel marginalized as Asians in the US because there were many other immigrants. Participant H mentioned that “no one cares where they are from” and “that is normal.” She felt “comfortable.” Participant F, who was half Korean and half Japanese, embraced her two different races. When dealing with feeling of being the same or different from others around them, the participants seemed to enjoy accepting their uniqueness. The participants in this research seemed to prefer individualistic cultures, were able to view themselves as unique, and maintained a personal space for themselves. Some participants shared a deeper level of the process of individuation. Participant D felt that she had solidified her individuality through the course of the Western model of therapy: “My personality was accepted rather than being fixed.” Furthermore, she became more assertive and learned to accept negative feelings. Eventually, this change led her to love herself. She reported that this was due to the
positive side of individualism in Western culture. She expressed American culture as “encouraging.” She stated, “I am important. What I feel is more important than what other people think.” A similar aspect was shared by participant A. She talked about the classroom culture in the US and stated that teachers focus on students’ strengths and that they “acknowledge what students did well.” Participant D’s positive experience is deeply connected to the qualities of Western culture which prioritize individuals’ “own preferences, needs, rights and contracts” (Hamamura, 2012, p. 2) and potential and unique qualities (Hofstede, 1991). Similar reflections on Western culture were shared by participant B, who said that he learned through his clinical work with African Americans at the hospital not to invade someone’s personal space. He shared, “A boundary was very important. Before I took action, I always asked if I could do so. I learned about keeping a respectful distance.”

However, participant C pointed out one weakness of individualistic cultures in that “when the individual is regarded as being too important, [people can become] childish. It is essential to know and express one’s self. However, if only I is emphasized, it cannot become We because there is no sacrifice.”

**Therapist as an authority figure.** It is important that there be a therapeutic alliance in the course of therapy. Clients’ positive perception of the relationship with the therapist is a positive predictor of an outcome of treatment (Pinsof, Zinbarg, & Knobloch-Fedders, 2008; Slone & Owne, 2015). Ideally, the therapist should demonstrate empathy, respect, and acceptance of the clients (Rogers, 1961). A well-developed relationship with a therapist enables clients to openly talk about themselves (Kelly & Yuan, 2009). However, the participants in the study perceived their therapists as being authority figures rather than viewing their relationships as being horizontal. Qian, Smith, Chen and Xia (2002) reported that Chinese clients showed a
great respect for therapists as authority figures and tend to be submissive to them. This perspective interfered with their “developing [their] own resources” (p. 53) and manifested as resistance. Zane and Ku (2014) reported that the successful outcome of counseling is contingent on clients’ self-disclosure, which can be a challenge for Asian clients. For example, even though participant B felt skeptical and resisted his therapist’s interventions at the beginning stage of PT, he “forced” himself to believe that therapist was right rather than express his frustration or ask questions. Therefore, it was difficult for the participants to confront or ask questions openly, even though they felt that they were not understood or disagreed with the therapists’ therapeutic interventions. Participant A also experienced conflict with her therapist—who was Asian—but she felt unable to share her particular struggles with her therapist until the end of the course of therapy. Her therapist’s seemingly random choice of speaking English and Korean interrupted participant A’s understanding of the therapy process. Due to feeling “disconnected” from her therapist, she had a hard time expressing her difficulty understanding what the therapist talked about.

Research question 4. What cultural modifications to clinical practice have Asian music therapists made regarding Western concepts of therapy, and why?

The participants shared their ways of modifying therapeutic interventions based on their own experiences in Asian cultures so that their Asian clients would willingly participate in the therapeutic process. They chose to ask questions in a concrete and specific manner. According to Yoon and Jepsen (2008), Asian international students exhibited a greater preference for “directive styles” (p. 124) and “structured counseling formats” (p. 124) than US students, due to their respect for authority figures and their newness to Western concepts of counseling. Based on their own therapeutic work with Western/Westernized therapists, four participants reported that
when working with Asian clients, they felt the manner of asking questions should be different. For example, asking, “How have you been?” or “What do you want to talk about today?” might confuse Asian clients. Therefore, participant G provides narrower options by asking questions such as, “Does this [specific topic] make you feel this way [specific feeling] or that?” Participant D also used the same strategy when asking questions as follows: “How are your studies going?” Or “How are you getting along with your roommates?” She added that she often noticed her Asian clients were unwilling to talk openly and kept silent. It is imperative to note that the therapist’s way of asking questions is important to ensure that Asian clients feel safe and continue their course of therapy.

Participant E went so far as to say that she does not refer to her clinical practice as therapy. The cultural stigma regarding receiving therapy/counseling is prevalent and prevents Asian people from receiving mental health services. (Miville & Constantine, 2007; Ng, 1997; Yoon & Jepsen, 2008; Zhang, 1998). The participants indicated this type of cultural bias in their clinical practice as well. Participants F and H changed the title of their therapy groups respectively to “Musicing group” and “clinical supervision.” Of course, they still employ therapeutic elements in their work. In this way, more clients feel comfortable with participating. Iwakabe (2008) reported that Japanese psychologists do not use the word therapy because it implies that they are medical doctors who treat patients and supply diagnoses.

However, three participants (A, B, and D) claimed that certain Asian clients could benefit from the Western concept of therapy without therapeutic modifications. Asian international students’ acculturation levels are positively related to their willingness to seek mental health services (Hom, 1996; Yakunina & Weigold, 2001). Asian students with more acculturated attitudes preferred “an Anglo American counselor” (p. iv) to an Asian American one. Similarly,
more individualistic Asian international students preferred a more individualistic type of counseling (Park, 1992). Even though this study did not include quantitative data measuring participants’ acculturation levels, the participants all expressed their favor of Western concepts of therapy. Presumably, this influence was linked to their clinical practice. Participant A addressed the need of having a “horizontal relationship” and “therapeutic alliance.” Participant D explained that the Western tradition of psychotherapy is beneficial for Asian clients because it provides them the opportunity to discover their potentials and an appreciation of what makes them unique outside of their collective culture, which prioritizes group cohesion. Furthermore, this type of PT provides safe place for Asian clients to disclose themselves more openly.

Participant B shared that he liked the way his American therapist let him have his own autonomy and respect his personal space. Therefore, he modeled his therapist’s way of interacting with him.

**Summary of Discussion**

The first research question discussed both personal and professional development. First, the participants in this study reported that their PT experiences brought about positive influences on their personal growth. The participants reported that their self-esteem increased, they came to find their unique selves, and they were able to accept the unchangeable and painful elements in their pasts, such as the death of a father or an unsatisfactory relationship with their parents. The process of PT provided the participants the opportunity to discover meaning in their lives.

Furthermore, the participants’ therapists played a role in nurturing them on an emotional level. On a professional level, the participants were able not only to cultivate clinical skills but also to mature as therapists in their own right. Participants reported that one of the most important outcomes of their PT experiences was their ability to develop empathy. They also said that countertransference was an important motivation. Their countertransference blurred clinical
boundary lines between their own psychological issues and their clients’ issues. The participants reported that PT enabled them to see how their countertransference originated in their past experiences and how much they needed to be able to help their own clients clinically. They also found that it was important to see their therapists as role models. The participants imitated their therapists’ techniques and attitudes because they themselves found them beneficial.

The second research question examined the musical experiences of the participants through the course of their PT. The participants recalled negative musical experiences from the past and were able to build new relationships with music. For example, one participant discovered an affinity for voice, and another began to enjoy playing music after abandoning the compulsion to be perfect. The therapeutic process also facilitated the participants’ beliefs that music is a powerful medium for clinical use for themselves and their clients.

The third research question illuminated the participants’ bicultural experiences and their influences on the therapeutic process. The participants perceived Asian cultures as being mainly group-oriented, especially within the family. The emphasis on group unity and harmony made it difficult for them to separate from the family and become independent. In Western cultures, which stress individual-oriented perspectives, the participants were able to obtain their own space and to find their own voice. Some participants found that their Asian cultural backgrounds interfered with the therapeutic process of Western models because they perceived their therapists to be authority figures rather than allies in a therapeutic context.

The fourth research question captured the influences of PT on the participants’ clinical work with Asian clients. Cultural modifications were inevitable due to cultural discrepancies. For example, the participants used a “directive style” (Yoon & Jepsen, 2008) rather than asking open questions so as to not overwhelm Asian clients. Moreover, because of negative attitudes toward
mental health care in Asian cultures, the participants did not label their work as therapy but substituted names such as “Musicing group” or “supervision session.” However, some of the participants reported that the Western model of therapy without modifications was beneficial for Asian clients because it creates “horizontal relationships” and “therapeutic alliances.”

Limitations of the Study

This phenomenological study has several limitations. The first was language issues: Even though four participants from Japan and Hong Kong spoke fluent English, this might not have been an optimal language choice for them to express themselves compared to their native language. In interviewing the Korean participants in Korean, the researcher acknowledges that there might have been misinterpretations in the process of translating written descriptions into English. Second, online interviewing was necessary because six participants resided in other countries. However, an online format might have limited the sharing of personal stories and experiences due to the physical distance and the less intimate nature of a conversation over the Internet. Third, this research project relied solely on the participants’ retrospective reports. As some of the participants had continued PT after graduation, their recall might have been distorted or mixed with later experiences. Furthermore, the retrospective accounts that the participants shared as positive experiences gained from their personal therapy might also have occurred naturally by their being in a learning environment such as a classroom or clinical practicum site.

Implications

For future study. There are several suggestions for future research. This phenomenological study included only the participants’ individual therapy experiences in order to explore their common personal experiences. However, since Asian cultures have been influenced by the philosophy of Confucianism, which stresses group-oriented values, including
the format of Asian participants’ group therapy experiences may help to investigate cultural components more intensively.

Also, it would be interesting to examine why some Asian music therapy students chose not to seek or drop out from PT. In the process of sampling appropriate participants who met the criteria, the researcher learned that two people who were not selected for this study withdrew from PT after one or two trial sessions. Another had had only 10 sessions of short term counseling and discontinued. Their decisions might have been related to cultural biases, and investigating their perceptions might help other Asian music therapy students feel less risk in seeking and gaining benefits from PT.

Additionally, the research can be expanded to explore and differentiate the experiences between undergraduate and graduate students. This current study only included participants with master’s or doctoral degrees. The American Music Therapy Association (2016) differentiates mandated competences of undergraduate and graduate levels in educational programs. An entry level requires foundational knowledge and skills relevant to music and clinical areas. A graduate program requires achieving the same knowledge and skills at a much deeper level, including the competence to conduct inquiries. Therefore, it would be significant to differentiate between the two levels and explore how the experience of personal therapy may be applied and influence participants both personally and professionally.

Lastly, this phenomenological research was open to participants who had engaged in either verbal or music therapy. However, it would be interesting for a future study to focus only on participants with music therapy experience. Music is a pivotal experience of music therapy work and that is what makes it distinguishable from other types of therapy. Investigating musical experience on a deeper level and analyzing details of musical experiences, such as playing,
improvising, and using voice would strengthen the role and impact of music and inter/intrapersonal perspectives in music.

**For music therapy educators.** This research implies that experiencing personal therapy during training can be viewed as an adjunctive music therapy educational experience. Different philosophies of music therapy programs can apply the findings of this research for educational goals and training.

First, for music therapy educators in psychodynamically-oriented programs, PT can function as an opportunity for experiential learning that is directly linked to students’ clinical practice and personal maturity. Several participants in this study reported positive outcomes of dealing with their countertransference, developing therapeutic relationships, and accepting clients’ emotional responses, all of which are essential components in psychodynamic work. The learning experience that they gained from their own personal therapy experiences contributed not only to prompting professional development, but also to enhancing their understanding of therapy work more effectively than relying on reading books and studying theories.

Second, music therapy educators with different philosophies such as behavioral or neurological approaches can consider their personal therapy experience as a way to support their students’ academic work. The participants in this study affirmed that personal therapy was helpful to releasing stress during training, clarifying their thoughts, and being able to explain them in writing. In addition, they were able to acquire clinical skills by modeling their own therapists.

Third, this researcher hopes to convey and deepen understandings of cultural rifts and academic challenges for those music therapy educators in the US who train students from East Asia. Professors might be one of the most accessible resources for East Asian students when they
seek an appropriate therapist during training. With a better understanding of East Asian students, music therapy educators can provide optimal information and help them address their needs.
REFERENCES


Psychotherapist’s own psychotherapy: Patient and clinician perspectives (pp. 345-364).
New York, NY: Oxford University Press.


APPENDIX A
RECRUITMENT LETTERS

Dear Colleague,

My name is Hyejin So, Ph.D. student in Expressive Therapies at Lesley University. I am currently conducting a doctoral research and seeking participants. My research focus is to explore personal therapy experiences of Asian professional music therapists from a client’s point of view. More specifically I would like to learn about the professional, personal, and cultural influences of their experiences.

The criteria for choosing the participants follows:

1. Asian professional music therapists are native East Asians and have completed their formal music therapy education in the West.
2. Asian professional music therapists have experienced any type of personal therapy as clients for more than three months during their music therapy education.
3. Asian professional music therapists received any type of personal therapy from Western music therapists or psychotherapists who completed their training in the West.

First, participants will be invited to fill out a brief questionnaire. Then, I am going to interview each participant for 60 to 90 minutes and the interview will be either audiotaped or videotaped. All of the data and information will be completely confidential and kept in a secure environment.

If you are interested in participating in the study or know someone who may be a suitable participant, please feel free to contact me at hso@lesley.edu. Also, you are always welcome to contact me for further questions and information.

Thank you very much for taking your time to read this message!

Hyejin So
Hyejin So, MA, MT-BC, LCAT, NRMT
Ph.D. student, Expressive Therapies, Lesley University
APPENDIX B

INFORMED CONSENT FORM

Study of “Lived Experiences of Personal Therapy as Clients: Perspectives of Asian Professional Music Therapists”

Principal Investigator: Hyejin So, Ph.D. student in Expressive Therapies, Lesley University

Faculty Supervisor: Robyn F. Cruz, Professor in Expressive Therapies, Lesley University

You are being asked to volunteer in this study to assist my doctoral research on “Lived Experiences of Personal Therapy as Clients: Perspectives of Asian Professional Music Therapists.” The purpose of this qualitative study is to explore the lived experiences of Asian professional music therapists who completed their formal music therapy education in the West and experienced music therapy as clients during their education. Furthermore, this phenomenological study will investigate how their experiences influenced or failed to influence their personal and professional development, and how the concept of personal therapy in the West is or is not integrated into Asian culture and Asian professional music therapists’ experiences.

You will be interviewed about your personal therapy experience as a client when you were a student. This interview will include your personal, professional, and cultural experiences related to your personal therapy experiences. This individual interview will take approximately 60 - 90 minutes and will be either audiotaped or videotaped.

You will be personally interacting only with me as the principal researcher. This research project is anticipated to be finished by approximately March, 2015.

I, ____________________________, consent to participate in the doctoral research project “Lived Experiences of Personal Therapy as Clients: Perspectives of Asian Professional Music Therapists.”

I understand that:

- I am volunteering for an individual interview that will last approximately 60 – 90 minutes.

- The interview will include my sharing of personal, professional, and cultural experiences in relation to my personal therapy experience.

- The interview will be either videotaped or audiotaped.

- My identity will be protected.
• I might be contacted by the researcher for follow up to clarify facts or statements and to ask for further information after the interview.

• The interview transcripts and personal information will be kept confidential and only be used anonymously for the purposes of supervision, presentation, and/or publication.

• The interview may bring up feelings, thoughts, memories, and physical sensations. Therefore, possible emotional reactions are to be expected. However, I am free to end the interview at any time. If I find that I suffer severe distress, I will be provided with resources and referrals to assist me, and will not lose any benefits that I might otherwise gain by staying in the study.

• This study will not necessarily provide any benefit to me. However, I may experience increased self-knowledge and other personal insights that I may be able to use in my daily life. The results of the study may also help to increase public and professional awareness of the importance of experiencing personal therapy from a client’s point of view for Asian professional music therapists or Asian music therapy students.

• The video or audio recordings and transcripts will be kept in a locked file cabinet in the investigator’s possession for possible future use. However, this information will not be used in any future study without my written consent.

• I may choose to withdraw from the study at any time with no negative consequences.

Confidentiality, Privacy and Anonymity:
You have the right to remain anonymous. If you elect to remain anonymous, we will keep your records private and confidential to the extent allowed by law. We will use pseudonym identifiers rather than your name on study records. Your name and other facts that might identify you will not appear when we present this study or publish its results.

If for some reason you do not wish to remain anonymous, you may specifically authorize the use of material that would identify you as a subject in the experiment. You can contact my advisor Dr. Robyn F. Cruz at 412.401.1274 or rcruz@lesley.edu with any additional questions. You may also contact the Lesley University Human Subjects Committee Co-Chairs (see below)

You will be given a copy of this consent form to keep.

a) Investigator's Signature:

_________________________  ___________________________  ___________________________
Date  Investigator's Signature  Print Name

b) Subject's Signature:
I am 18 years of age or older. The nature and purpose of this research have been satisfactorily explained to me and I agree to become a participant in the study as
described above. I understand that I am free to discontinue participation at any time if I so choose and that the investigator will gladly answer any questions that arise during the course of the research.

Date          Subject's Signature          Print Name

There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee Co-Chairs Drs. Terry Keeney or Robyn Cruz (rcruz@lesley.edu) at Lesley University, 29 Everett Street, Cambridge Massachusetts, 02138.
To: Hyejin So

From: Robyn Cruz and Terrence Keeney, Co-chairs, Lesley IRB

RE: Application for IRB Review: Lived Experiences of Personal Therapy as Clients: Perspectives of Asian Professional Music Therapists

IRB Number: 13-062

This memo is written on behalf of the Lesley University IRB to inform you that your application for approval has been granted following a review by the full board. Your project poses no more than minimal risk to participants.

If at any point you decide to amend your project, e.g., modification in design or in the selection of subjects, you will need to file an amendment with the IRB and suspend further data collection until approval is renewed.

If you experience any unexpected “adverse events” during your project you must inform the IRB as soon as possible, and suspend the project until the matter is resolved.

Date of IRB Approval: August 7th, 2014
Thank you for your volunteering to participate in my doctoral research project. This survey is to obtain basic information about you. Your name and other identifying information will be protected – Hyejin So, Ph.D. Student, Lesley University, Email: hso@lesley.edu

A. Basic Information

1. Name:
2. Gender:
3. Age:
4. Ethnicity:
5. Country where you were born:
6. Please list your credentials:
7. Years of clinical experience:

B. Educational Background

1. Music Therapy Degree

1) Bachelor’s degree  2) Master’s degree  3) Certification program
4) Doctoral student  5) Doctoral degree  5) Other

2. In what year did you complete your music therapy training?

3. Where did you complete your training?
   Country:  State:  City:

C. Personal Therapy Experiences

1. How was your therapy structured?

1) Individual therapy  2) Group therapy  3) Other
2. What type of therapy were you in?
   1) Music therapy 2) Creative arts therapies 3) Verbal therapy 4) Other:

3. What was your therapist’s approach?
   1) Behavioral 2) Cognitive behavioral 3) Humanistic 4) Psychodynamic
   5) Psychoanalysis 6) Other:

4. What was your therapist’s gender?
   1) Female 2) Male

5. What was your therapist’s ethnicity?

6. How long were you in personal therapy when you were a student?

7. Did you continue your personal therapy after you graduated?
APPENDIX E

INTERVIEW GUIDELINES

Dear Colleague,

Here is an interview guideline. I am going to ask questions based on the followings. I would appreciate if you can take time to read them and think about your past experiences prior to the interview. Thank you!

1. General questions
   a. Cultural background
   b. Motivation to go to therapy
   c. Approach of personal therapy

2. Personal development
   a. Personal therapy experience
   b. Meaningful moments
   c. Difficult moments
   d. Personal growth

3. Professional development
   a. Meaningful experiences as a student?
   b. Influence on clinical work
   c. Influence on academic work?
   d. Influence on current professional work?

4. Music
   a. Influence on the use of music both in personal life and in professional development

5. Culture
   a. Cultural influence on therapeutic process
   b. Western concept of personal therapy and your clinical work
   c. Have you modified your personal therapy experiences culturally? Why?

6. Other
   a. Would you recommend that other music therapy students undergo personal therapy? If so, why? If not, why not?
APPENDIX F

INTERVIEW QUESTIONS

1. Cultural Experiences
   1. Can you introduce yourself?
   2. How would you describe your cultural background?
   3. How did your own culture influence your own therapeutic process?
   4. How did your experiencing the Western concept of personal therapy influence your clinical work?
   5. Have you modified your personal therapy experiences culturally? Why?

2. General Questions
   A. What motivated you to go into personal therapy?
   B. How did you choose your therapist?
   C. What made you choose a specific approach for your personal therapy?

3. Personal Development
   1. How would you describe your personal therapy experience?
   2. What were the most meaningful moments in your personal therapy?
   3. What were the most difficult experiences in your personal therapy?
   4. How did your personal therapy influence your personal development?

4. Professional Development
   1. What were your most meaningful experiences as a music therapy student/trainee?
   2. How did your personal therapy influence your clinical work?
   3. How did your personal therapy influence your academic work?
   4. How does your personal therapy influence your current professional life?
5. **Music**

1. How did your personal therapy influence the use of music (or musical experience) in your personal life?

   (How did your personal therapy experience effect experience with music afterwards?)

2. How did your personal therapy influence the use of music in professional development?

   (How did your personal therapy experience influence the use of music as a music therapist or music therapy students?)

6. **Other**

1. Would you recommend that other music therapy students undergo personal therapy? If so, why? If not, why not?

2. Do you have anything you would like to add?