Musical Intimacy and the Negotiation of Boundary Challenges in Contemporary Music Therapy Practice

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Abstract

This thesis details a grounded theory study that examined the new concept of musical intimacy. This research began with an initial interest in therapeutic boundaries, exploring how they interact with music in music therapy practice. Through a critical interpretive synthesis, examining the prevalence and presentation of traditional boundary ideas, musical intimacy emerged as a new boundary theme. Musical intimacy was an interesting concept that seemed to capture the complexities of musical experiences, and their unique interaction with therapeutic boundaries. It was the discovery of this concept that led me to explore it in more detail.

A grounded theory study was conducted, interviewing 20 music therapists from locations in Australia, the USA, Canada, the UK, Denmark and Norway. I used intensive interviewing to explore the music therapists’ experiences and understandings of what musical intimacy could be. Through this, I was also keen to examine how the music therapists were managing musical intimacy, and if they had experienced any boundary challenges within that context. The interviews were conducted in person across a three month period.

A grounded theory analysis, influenced by both Charmaz’s constructivist grounded theory (2014) and analytic strategies from Corbin and Strauss (2008), was applied to the interview transcriptions. The analysis process included: 1) data collection and initial analysis, 2) initial coding, 3) focussed coding, and 4) synthesizing to form the theoretical framework. Throughout the analysis process, the grounded theory technique of ‘memoing’ was used, as well as many reflexive strategies to reveal my influence on the emerging findings. This analysis allowed me to move back and forth between data and analysis, involving many streams of analysis, where I returned to the data to expand, confirm or challenge my initial ideas and themes. Through this process, a theoretical framework of musical intimacy and boundaries has emerged.

The grounded essence of the musically intimate experience emerged as the core defining feature of musical intimacy. The grounded essence is: the therapist experiences a powerful moment of connection in and around the music that triggers an acute sense of vulnerability and reveals the need for boundaries to keep things safe.
There were two main themes that emerged, which contributed to the musically intimate experience for these participants. These were: the ‘interpersonal experiences’ and the ‘intrinsic components of music’. The music therapists described a spectrum of experiences, which were a complex web of powerful moments of connection and challenging experiences. They also described their ‘ways of being and responding’ to the musically intimate experiences, which detailed how they managed boundaries in these moments.

The most interesting aspect of this research is the emergence and definition of musical intimacy. Musical intimacy captures a complex aspect of music therapy that was experienced by all 20 of the music therapists involved in this study. Musical intimacy provides a way for music therapists to conceptualise boundaries in their practice. It alludes to powerful moments of connection we can experience, and how there can be challenging moments in and around the music in music therapy. The ‘ways of being and responding’ are the beginnings of developing a new understanding of boundaries in music therapy practice. It is my belief that through this theoretical framework of musical intimacy and boundaries, we can begin to understand the complex nature of music and boundaries in a contemporary approach to music therapy practice.
Declaration

This is to certify that:

i. This thesis comprises my own original work towards the degree of Doctor of Philosophy except where indicated in the Preface,

ii. Due acknowledgement has been made in the text to all other material used,

iii. The thesis is fewer than 100 000 words in length, exclusive of tables, maps, bibliographies and appendices.

Signed: ________________________________

Name: Laura Medcalf

Date: 25/
Preface

This thesis includes one published article. Authorship of this article has been determined in discussion with the primary supervisor.

Paper 1 in Chapter 2


This co-authored article presents the method and findings from a critical interpretive synthesis of case studies in music therapy. It has been accepted by the British journal of music therapy and was published in April 2016.
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Chapter 1
Reflexive introduction and part one of literature review

The motivation for this study

During my training as a music therapist I was challenged by the complex, multilayered and intimate components of music therapy practice. Within these workings, the idea of boundaries seemed like an elusive, unspoken and intricate element that ran through most aspects of music therapy work. These ideas interested me because I felt unsure about my own boundaries and didn't have the confidence or knowledge in how to handle or approach them. I was also curious about the influence of music. I experienced different aspects of ‘musicking’ (Small, 1998) with people that lead me to believe that boundaries were somehow connected. There were emotional reactions and connections with music and people. I often felt the social aspect when making music with people. Additionally, there was the physicality of being closer to people when we played music together. These were all experiences that led me to consider the relationship between boundaries and music. These feelings left me questioning how boundaries are understood and implemented in and around the use of music in music therapy.

Time spent on clinical placements provided me with opportunities for great learning through the sometimes difficult and emotionally charged musical and interpersonal experiences. Working with medically fragile infants proved to be an exciting time to experience how music in this context could support the infants and their families. The playful musical interactions that occurred between the infant, the mother and myself were encouraging and seemed to provide a simple yet powerful experience in a challenging environment. The personal challenge for me was being faced with the reality of death, which was especially difficult with young infants. This led me to question therapeutic boundaries and consider what kind of relationship was healthy, both for the people I was working with and for myself. In addition, this was further confronted by my understanding of what I perceived a professional relationship to be, which seemed to be incongruent with the way I intuitively wanted to approach this work. I was left pondering how to navigate a professional relationship in this context while using a medium that I felt was naturally personal,
emotional and social.

This reflexive introduction and literature chapter will serve to locate my experience and assumptions about therapeutic boundaries while providing a landscape of the relevant literature. I will outline some of the therapeutic boundary theories currently used in music therapy practice and highlight some of the influences from related disciplines. Finally, I will provide a rationale for undertaking a critical interpretive synthesis of music therapy case studies, which is presented in journal article format in chapter two, and has been published in the British Journal of Music Therapy (Medcalf & Mcferran, 2016).

**Overview of the thesis content**

This thesis is being submitted with publication as one chapter contains a published paper (chapter 2). This paper was a separate critical analysis of music therapy case studies, which led this research to focus on the new concept of musical intimacy. The first chapter is a reflexive introduction that has been integrated with relevant literature. The second chapter presents the critical interpretive synthesis. Chapter three is also reflexive in nature and serves to outline further literature related to musical intimacy. These three chapters function as the literature review section in this thesis.

Following the literature chapters, I will outline the methodology of this research. This will include background information on grounded theory and the design of this research. It will also detail information about the participants, the interview and the analysis process. Next, the findings will be presented where I will detail the theoretical framework of musical intimacy that has emerged from this research. Following this, I will present the discussion outlining the main points of interest that have developed from this research. Finally, I will conclude with a summary of this research, the main implications of the findings and recommendations for further research.

Throughout this thesis I have used a reflexive writing style. Reflexivity has been embedded throughout this research process from design to analysis. As such I have sought a writing style that conveys my position and relationship with the literature, findings and discussion. In this way I hope to reveal how my interpretations and assumptions have influenced this research.
Identifying my own assumptions about boundaries

As a music therapist in the Australian context, boundaries felt like an area that had been hardly been examined or researched. When discussing this topic with music therapy colleagues they would recount stories about situations that were challenging for them. These discussions resonated with my own sense of not knowing. Was I doing the right thing? Was it ethical? What should I be doing? These questions echoed in my mind during training and practice yet the literature on boundaries did not seem to capture the complexities I experienced, nor did they provide enough guidance about how to approach this area of practice.

Through this next section I will outline some of the areas that I had reflected on before undertaking this research. They are: 1) reflection on self-awareness and boundaries, 2) reflection on the therapeutic relationship and boundaries, 3) reflection on context and boundaries, 4) reflection on theoretical approach and boundaries, 5) reflection on culture and boundaries, and 6) reflection on music and boundaries.

Reflection on self-awareness and boundaries.

I understood boundaries to be a multilayered and complex process. This included a level of self-awareness that prompted me to be mindful of how the intimate processes in therapy have the potential to cause harm to both parties in the therapeutic relationship. When discussing self-awareness as an essential tool for music therapists, Camilleri (2001) states, "through increased sense of self-awareness, we are able to determine what we are feeling, and what our limits are" (p. 82). Through self-awareness we can be more authentic and allow interpersonal relationships to unfold in a safe and potentially valuable way. Furthermore, this foundation of self-awareness could allow us to be conscious of who we are, what our values include and how this may influence our interpersonal experiences with the people we work with. Consequently influencing our understanding and implementation of therapeutic boundaries.

A number of music therapy authors have described how our values influence music therapy practice. Dileo (2000) suggests, "values are deeply imbedded and both the therapist and client bring values they have accumulated throughout their lives into
every therapy session” (p. 57). Interestingly she has highlighted the subtle ways that views and values influence every therapy session. I believe the embedded nature of views and values extends to how we enact our boundaries, as boundaries are played out through the interpersonal experiences in therapy. Similarly Brown (2001) states,

Being an effective and ethical therapist requires constant vigilance and growth in the area of personal awareness. It calls for sensitivity to one's own worldview and a willingness to be open to others. (p. 82-83)

She asserts that being aware of your worldview would allow a greater sense of the personal limitations when working therapeutically with people. Through identifying our values, we can reflect on our attitudes and assumptions that impact our approach to therapy. In this way we can see how boundaries are embedded within our individual approach to music therapy practice, which has grown out of the ingrained nature of our personal worldview.

One interesting idea has been outlined by Shoemark (2009). She has detailed an approach to practice that extends Gold's (2008) pyramid of theory, practice and research. Shoemark has added a fourth lens, the self, as she states; "as unique individuals, we influence the interpersonal process each and every time we engage with clients" (p. 34). Here, Shoemark has emphasized our individual influence on the interpersonal processes in therapy. This sense of self could also extend to the theories and types of research we believe in. Through our beliefs in theory, research and practice we embed our understandings, assumptions and beliefs. This in turn influences the interpersonal processes in therapy and how we enact and understand therapeutic boundaries.

In Bruscia’s (2014) latest edition of ‘Defining music therapy’, he has added reflexive practices to his working definition of music therapy. He states, “the therapist… maintains an awareness of his professional boundaries, responsibilities, power, emotions, and sociocultural differences from the client” (p. 36). He asserts that this reflexive practice should be brought into every aspect of the therapy process, and suggests that this is achieved through “self-observation, self-inquiry, collaboration with the client, consultation with others, and supervision” (p. 55). This, I believe, is a welcome addition to this definition of music therapy. It highlights the importance of being aware of ourselves, our clients and the interactions that we have through music, so that we may act in a way that is potentially helpful for our clients.
Reflections on the therapeutic relationship and boundaries.

Personally, my boundaries have evolved throughout my experiences as a music therapist. Working in the hospital environment required more sharing on a personal level with the people I was working with. How much shared was regulated by my own intuition or 'gut' feelings. It felt foreign to be very 'clinical' or 'distant' with the people I was working with, however I felt a need to align with some of the conventional understandings of therapy. Gary Ansdell (2002) described the term the ‘consensus model’ to define and categorize traditional approaches to music therapy practice. He states, “a separation of client/therapist roles is maintained by clear personal boundaries – assuming the engagement remains professional and avoiding social relationships developing” (p. 24-25). The separation in the relationship and having clearly defined roles, underpins many conventional approaches to music therapy practice.

I felt that this conventional therapeutic relationship was not relevant to the way that I practiced music therapy. This is similar to Forsblom and Ala-Ruona’s (2012) emergent findings. They interviewed six music therapists about their experience of post-stroke rehabilitation work in hospital and health care units, using a modified grounded theory approach. Interestingly, the personal interaction with patients emerged as essential theme in providing adequate patient care. Furthermore, they suggested that being too objective about patients and their problems can actually hinder the therapeutic process whereas being more personal with clients might actually improve their engagement with therapy. These ideas resonated with my experience and instinctive approach in music therapy where I felt the need to share more with the people I was working with. This seemed to be in conflict with the conventional approaches to the therapeutic relationship, and how therapeutic boundaries were perceived within that.

My experiences were more pertinent in a community setting, where traditional understandings of power dynamics in the client-therapist relationship felt more out of place. Somehow, being in the context of a client’s home encouraged me to share more or interact on a more regular social level. This led me to question where this 'need' came from. Perhaps I felt uneasy going into someone’s home as a 'professional' and the inherent power imbalances imbedded within that framework. Issues of power
in music therapy have come into focus more recently through newer theoretical models and conceptualisations about music therapy practice. Through her development of resource orientated music therapy (Rolvsjord, 2004, 2006, 2010), Randi Rolvsjord questioned the inherent power imbalances that are present in a medically based approach to therapy. She has presented a model that aims for equal therapeutic relationships, fostering a sense of empowerment through a mutual and collaborative process. These ideas resonated with my experience and aligned with my emerging beliefs about the therapeutic relationship. The traditional form of the therapeutic relationship seemed to encourage strict boundary theories that did not align with my perception of what was helpful in therapy.

Another perspective that has questioned the power dynamics in therapy is feminist theory. Refreshingly, feminist perspectives have been brought into music therapy thinking by some scholars (Curtis, 2013; Edwards & Hadley, 2007; Hadley, 2006; Rolvsjord & Halstead, 2013). These music therapy scholars have begun to question the inherit power imbalances that are present in patriarchal models (such as the medical model), where power to men is favoured and instinctively promoted. Hadley and Edwards (2007) were some of the first music therapy scholars to consider the need to articulate and highlight feminist perspectives for music therapy practice. They outlined the three waves of feminism and stress the need for music therapy scholars to consider their position and influences.

Feminist music therapy discourse moves away from an individualized approach, where the individual is seen as separate from their culture and history. Instead, feminist music therapy brings our awareness to the way that needs and issues may be deeply embedded within the societal structures and attitudes. Similarly, in his presentation on culture centred music therapy, Stige (2002) notes:

… sometimes we work with clients whose problems may be deeply interwoven with material and economic structure of society, or whose problems are shaped more by their attitudes and reflections, as well as attitudes of others, rather than their individual or objective biological constitution. (p. 19)

For my continuing reflection on therapeutic boundaries, feminist discourse spurred deeper reflection on how conventional therapeutic relationships are an embedded part of societal frameworks. These perspectives offer another viewpoint that questions the power imbalances inherent in a traditional approach to therapy.
Another welcome addition to music therapy discourse, is the questioning of inherent power imbalances through the notion of anti-oppressive practice (Baines, 2013; Baines & Edwards, 2015). Baines (2013) explains how “anti-oppressive practice asserts power imbalances that are based on age, class, ethnicity, gender identity, health, ability, race, sexual identity and income” (p. 2). Furthermore, she asserts that these are linked to surrounding oppressive structures (p. 2). When aligning with more traditional approaches to therapy, I experienced power imbalances that left me questioning the boundaries imbedded within that approach. The anti-oppressive practice concept illuminated some of the power imbalances that were present in the structures of the contexts I was working in.

I perceived boundaries to stem from specific theoretical approaches found in the music therapy profession. These different theoretical frameworks contain guidelines of what music therapy is and how to practice it. Furthermore, they often provide a framework for how boundaries should be understood and implemented. Looking at boundaries, I questioned how the theoretical approaches that I ascribed to, influenced my understanding of boundaries. Did the theoretical approach I used determine the boundaries in my practice? How did this reflect the boundaries between myself and the people I worked with? I was left pondering what my individual approach to music therapy was and how boundaries were interconnected with this. As many conventional approaches to music therapy used similar boundary theories and newer models of music therapy had not deeply examined boundaries in their context, there was little literature that addressed boundaries in different theoretical approaches.

The development of resource orientated music therapy, the inclusion of feminist perspectives and the addition of anti-oppressive practice, helped me to re-define some assumptions that I held about the conventional approaches to music therapy work. These perspectives assisted me to move away from a traditional approach to music therapy practice, and to further question the boundary theories we seemed to be relying on as a profession. Traditional frameworks of music therapy seemed to be in inextricably linked with the conventional boundary theories that I had begun to question.

**Reflections on context and boundaries.**
In addition to the above perspectives, I also felt that the ‘context’ we work in has different boundaries embedded within. During my first year working as a music therapist, I was working across multiple locations including a palliative care ward, community palliative care, aged care and special education. Through these differing contexts I encountered subtle variations on boundaries. In the hospital the physical distance between the patients and staff was very regulated. This stemmed from an infection control perspective, but also reflected how the medical model was embedded into all interactions with a patient. I was the staff member there to assess and provide treatment for the patient. In contrast, the school saw me much physically closer to the children, with both valuable and challenging outcomes. There were many instances of close connections with the students, which were encouraged by the culture in the school of a more ‘hands on’ approach with the children. It also saw me being hit, scratched and having my hair pulled, all of which can be common in that context. These differing settings heavily influenced my understandings of boundaries. In addition, there were certain policies and procedures tied up in each context that influenced how I practiced and determined what I could or could not do.

The idea of context is complex in itself as it encompasses a variety of meanings and considerations. Context in music therapy has been brought into consideration in recent times with the emergence of newer theoretical models. Community music therapy (Ansdell, 2002; Pavlicevic & Ansdell, 2004; Stige, 2011) provided a pivotal leap in the contextualisation of music therapy work in the community. In this approach, the context of music therapy has been expanded to the community and considers wider contextual influences. Music therapists in this approach also consider how these contextual influences are interactional in nature (Rolvsjord & Stige, 2015), with some including the context of therapy, the cultural context and the context of music. Within each of these interacting contexts are subtle and illusive boundaries that are seen on the macro and micro level (Stige, 2015).

Music therapists adopting a resource orientated approach (Rolvsjord, 2006, 2010), would consider it essential to contemplate the contextual influences on the individual and the processes in music therapy. Resource orientated music therapy rejects the medical model stating that this framework serves to dis-empower the individual through the inherent power imbalances of the expert illness ideology (Randi Rolvsjord, 2010). In addition, feminist perspectives (Curtis, 2013; Edwards & Hadley, 2007; Hadley, 2006; Rolvsjord & Halstead, 2013) and anti-oppressive
practice (Baines, 2013; Baines & Edwards, 2015) have seen a focus on the wider political context, including questioning of the inherent power imbalances in a male-dominated system of healthcare. How we sit within the political context is reflected in the way we practice and justify our work. These theoretical models and frameworks have highlighted how considerations of context, is central in the implementation of a contemporary music therapy approach. Furthermore, the notion of context is more poignant in some of these theoretical models, given their expanding music therapy settings, such as community work.

However, Rolvsjord and Stige (2013) state that these developments do not share a common understanding of context (p. 45). They discuss that these models offer “varying references to context including cultural, health-care, musical, theoretical, community, clinical, everyday, personal and political contexts” (p. 44). They suggest that the use of the word ‘context’ across music therapy approaches includes: 1) music therapy in context, 2) music therapy as context, and 3) music therapy as interacting contexts. Furthermore, they state:

Our awareness of context is crucial to the stories we tell about therapy; how we perceive the people we work with, how we understand health and illness, how we conceptualise therapy and change, and how we design research.

(Rolvsjord & Stige, 2013, p. 59)

In this discussion on boundaries, context is used to illuminate the relative factors that may influence the conceptualisations and implementations of boundaries. In my understanding these could include: 1) policies and procedures of the setting; 2) the culture or environment of the workplace; 3) the type or physicality of the setting (for example a hospital, community centre or home); 4) the culture of the interactions with the individuals you work with; and 5) your role in this setting. In my experience, the interacting contexts influence how to approach boundaries and may influence the theoretical paradigms that we align with. However from my literature search, I had not come across much research that had explored these complexities in any great detail.

**Reflections on culture and boundaries.**

I also sensed subtler boundaries in and around culture, as I felt that there were elusive boundaries embedded in culture that came into play in music therapy work.
The importance of culture in music therapy has been explored more recently (Brown, 2001; Gonzalez, 2011; Morris, 2010; Ruud, 1998; Stige, 2002). As Stige (Stige, 2002) states:

Music therapy grows out of and interacts with culture. Music therapy is different in different places and at different times, not just because science moves forward, but because therapy is embedded in culture. (p. 121)

There was the culture of the workplace, my own culture, the cultural context and the culture of the people I was working with. In addition, there were the musical cultures that were embedded in the use, value and meaning of music. I remember working with an elderly man who identified as Jewish. Many of his family members would be present during the sessions. They would suggest songs, sing along, play instruments, dance and be heavily involved in the music making in a lively and loving manner. I sensed that I was tapping into their musical culture that reflected their identities, their culture and spirituality. This musical culture seemed to also contradict the conventional ideas on boundaries, as these interactions reflected a deep connection to family and culture.

Similarly, Papadopoulou (2012) investigated the impact of culture on therapeutic boundaries by interviewing three music therapists from Greece, two of whom were trained in the UK. Themes that emerged included; 1) boundaries, which included; protection, responsibility, physical and internal boundaries, 2) cultural influences, 3) training influences, 4) flexibility in relationship, and 5) difficulties in relation to boundaries. One participant, who had trained in England, wrote about the importance of learning to use boundaries within the culture of the client. This was highlighted, when returning to work in Greece after training in the UK, because this required adjustments. They stated:

I believe the way we learn about personal and physical boundaries in the course is based on the British culture. Then we have to change all this to the Greek version. (p. 28)

They had to adjust to their way of using boundaries to suit the client’s culture. Interestingly, all interviewees believed that their culture influenced the use of boundaries in their clinical work. Another participant reflected on the change they had to make when they began practicing in Greece. They stated:

… the patient comes in, walks straight to the piano, sits very close to me, claps my back and says what are we going to sing today? I nearly fainted. Working
in the UK I found myself totally unready to face this when it happened… it took me some time to get back to Greece – not physically – but culturally. (p. 30)

The interaction of culture and therapeutic boundaries is complex, yet still requires reflection in music therapy practice. The cultural influence was another area that led me to question the conventional therapeutic boundary theories we were referring to, and how these might be influenced by culture.

**Reflections on spirituality and boundaries.**

As Abrams (2013) states, “this growing focus on the role of religion in healthcare, in general, has also raised concerns specific to the profession of music therapy” (para. 2). These concerns have been centred on how a client’s and therapist’s religious orientations may or may not impact upon how music, health, change, helping, and other components of music therapy are understood and integrated into the therapy work (para. 2). These concerns for music therapy could include the impact of spirituality or religion on boundaries. This is a complex idea, but given the central role of music in both religion and music therapy, this is an area that requires more exploration.

Marom (2004) investigated spiritual aspects to music therapy. She described treating spirituality issues like ‘hot potatoes’ stating: “I would avoid them, change the subject, and doom myself to behave unethically whether I addressed them or not” (p. 37). Treating the spiritual ‘problems’ like ‘hot potatoes’ highlights the need to consider spirituality within therapeutic boundaries. This author appeared to need guidance on these issues, which seemed to be challenging for her. Spirituality in music therapy could pose boundary challenges for music therapists. Similarly to context and culture, music therapists may need to have an awareness, be flexible and reflexive when spirituality is concerned. If boundaries are implemented appropriately for the context, then this may help with addressing the ‘hot potato moments’ of spirituality issues in music therapy.

In another example Pek (2010) explored the influence and prevalence of spirituality for 73 Australian music therapists, through a web-based survey using a both quantitative and qualitative questions. One of the participants described:

…one client had committed crimes which are against my Christian beliefs… I
found it challenging to put aside my personal views and relate to that client as an equal to the other group members. (p. 47)

This is a strong example of how our personal beliefs may influence our music therapy practice. For this participant perhaps a greater awareness of their personal boundaries around spirituality could have helped her to work with this client. Another participant in this study commented:

The social worker started a monthly church service, and the clients were getting very anxious and some getting violent. The music being used was evangelical music, which I felt was working up the congregation, and generally don’t feel comfortable when music is used this way. The social worker appeared personally offended when I suggested the music as the cause of the anxiety and aggression. (p. 48-49)

This example speaks to a challenging situation for the music therapist in and around the use of music. From this description it seems as though the musical experience was spurring on strong emotions from the clients, which left the music therapist feeling uneasy. Another participant commented, “we should follow the clients prompting, but I believe we are spiritual beings, and music has a real way of tapping into this, making a real difference” (p. 75). This participant described the way that using music has the potential to access spirituality within music therapy. This again highlights the way that spirituality is mixed with therapeutic boundaries.

The participants in this study (Pek, 2010) indicated a level of self-awareness that demonstrated their knowledge of the potential ethical considerations of spirituality in music therapy practice. However, Pek noted, “one participant indicated that client selection was based on clients religious beliefs, as priority would be taken with clients who held similar beliefs to the therapist” (p. 86). This particularly strong and un-ethical stance on client selection is (I hope) uncommon in music therapy practice. This study has been particularly useful as it contained many instances where spirituality experiences appeared to be mixed with therapeutic boundaries. Given the relatively large number of participants in this study, this may suggest that many music therapists are influenced by spirituality in their practice. What also seems to have emerged from this data is that spirituality presents some challenges in music therapy, which may also be linked with how we implement and understand therapeutic boundaries.
Reflection of music and boundaries.

Whilst culture, context and spirituality seem to play an important role in the negotiation of boundaries, I was also interested in the influence of music. At the earliest stages of my research I did not have the language to describe this topic. However, I was interested in how the intimate experiences with music could affect boundaries or change the nature of the therapeutic relationship. This stemmed from the many instances of connection through music that I had experienced. One such time was with a couple where the husband was dying of cancer. His wife was the main carer and had high levels of anxiety and carer stress. I vividly remember the look in her eye when I was singing a favourite song at their request. She was relaxed, leaning back in her seat and smiling at me. This moment of connection through the music left me to ponder the nature of the therapeutic relationship and the role of music within that.

In addition to intimate moments of connection, I also experienced social aspects of making music with people. I identified with Smalls idea of ‘musicking’ (Small, 1998) as an ecological model of musical activity; involving activity, relationships and context. In addition, this included viewing music as an active process, rather than an object, that can be accessed by all. I experienced social interactions through the use of music and wondered how this aspect of making music could influence boundaries in music therapy. Did the people I worked with trust me quicker because we were using music? Did they reveal personal information to me sooner because of the relationship that had developed through the use of music? My thoughts around music and boundaries were at this stage varied, uncontained and lacking clarity.

Underpinning all of these ideas was uneasiness. I didn't feel that I had enough understanding or 'tools' to tackle the boundary issues that I was facing. There seemed to be many layers of complexities with boundaries that had not been considered in the literature that I had explored. There were subtleties around the therapeutic relationship, the context, culture and intricacies in and around the music itself. I was left questioning the boundary theories we were using and whether they were representing contemporary music therapy practice. I wondered how I could practice in a way that was ethical while still building relationships and helping people to strive to improve their health and well-being through the use of music.
Current understandings of boundaries

In order to explore boundaries in music therapy, it is important to understand what the current theories are. Understandings of therapeutic boundaries have been discussed and researched in other related fields for the past 20-30 years (Fronek, et al. 2009; Gutheil, 2008; 2008; Gutheil & Gabbard, 1993, 1998; Kendall, 2011; Milton, 2008; Pope & Keith-Spiegel, 2008; Reamer, 2013). Music therapy literature has adopted theories largely from psychotherapy to guide boundary theory and practice. This literature is located in more traditional approaches to music therapy, which some have labelled the medical model or consensus model (Ansdell, 2002). These traditional models of music therapy have emerged from or been melded into the medical context and, as such, have seen fit to adopt theories from other medically focused therapies such as psychotherapy (Bruscia et al., 2014; Davis, Gfeller, & Thaut, 2008; Dileo, 2000; Dileo & Bradt, 2005; Standley, 2005; Wheeler, 2014).

In psychotherapy, Langs (1979, 1978) has written most extensively about the ideal therapeutic frame for therapy and how to construct boundaries within this framework. He describes the therapeutic frame as “providing safety, care and holding for the clients in psychotherapy work” (Langs 1998, p. 8). In addition, he describes the specific ground rules of the boundaries in psychotherapy to include the ideal office environment, session, time, fees, privacy and confidentiality. His perspective may be useful to some however it presents the notion that there is one correct way to approach and manage boundaries in psychotherapy work. This can be seen as limiting or directive, which does not allow for the multitude of influences in and around boundary challenges. Furthermore, these rules of psychotherapy place much power and control on the therapist, leaving the client disempowered through the process of therapy.

In the music therapy literature, Wheeler (2014) details the importance of developing ethical thinking for the individual music therapist. Ethical thinking is the developing of awareness around potential boundary issues, which requires skills in reflection, responsibility and critical questioning (Pope et al. 2008). Dileo (2000) outlined some further principles that include; enacting care and compassion, adhering to veracity (honesty) and fidelity (honouring commitments), striving for excellence and acknowledge your accountability (p. 7-8). Ethics and boundaries share
similarities and are sometimes discussed together. In her chapter on ethics, Wheeler (2014) outlines multiple relationships and gifts as part of potential ethical dilemmas in music therapy practice. She discusses boundaries within this and details an overview of boundary crossings and violations. The crossover between ethics and boundaries is murky and hard to define.

Aligning with the boundary theories from psychotherapy, Dileo (2000) has provided a detailed text examining therapeutic boundaries in relation to music therapy practice. Although focused on ethics in music therapy, she has devoted a whole chapter to describe boundaries in music therapy. She aligns with the boundary theories created in psychotherapy and suggests that music therapists follow similar guidelines. One of the major components of boundary theories that she refers to is dual relationship, where a therapist and client have more than one relationship such as a friendship and a therapeutic one. She advocates for dual relationships to be avoided, stating that they lead the therapeutic relationship to include many boundary crossings and potentially to boundary violations.

Dileo’s position, although a useful starting point, appears to miss many of the complexities that are present in music therapy practice. By advocating for no dual relationships, it seems to miss one of the fundamental aspects of music therapy, namely the musical relationship. Although not every approach in music therapy focuses strongly on the musical relationship, I feel that it is an integral part of the process that is present across music therapy approaches. Dileo’s presentation of boundaries aligns with the ideals of Langs (1979, 1998) and the concepts developed by Guthiel and Gabbard (1993, 1998) where boundaries are seen as standards for guiding correct therapeutic practice.

**Boundary crossings and violations.**

One of the key ideas presented in psychotherapy boundary theories is the idea of boundary violations and boundary crossings (Gutheil & Gabbard, 1993). Boundary crossings are described as minor deviations from traditional psychotherapy that neither harm nor exploit the patient and may advance the therapy process (Gutheil, 2008b). Similar to Langs (1998) ideas, they relate to aspects of the therapeutic process such as; self-disclosure, gifts, touch, space/setting, time, clothing and the therapeutic relationship (Gutheil & Gabbard, 1993). Similarly, Wheeler (2014) states
that "boundary crossings are behaviours, practices or decisions that are clearly different from usual therapeutic practice" (p. 70). These ideas refer to ‘usual therapeutic practice’, which align with traditional models in music therapy. Interestingly, these ideas from psychotherapy literature have been applied across some music therapy literature (Bruscia et al., 2014; Davis et al., 2008; Dileo, 2000; Dileo & Bradt, 2005; Standley, 2005; Wheeler, 2014). However, they may not be relevant for the different and varied theoretical approaches, contexts or settings where music therapy takes place.

Interestingly, other related fields have begun to question the rigidity of these boundary theories (Coe, 2008; Kroll, 2001; Lazarus, 2013; Martinez, 2000; Pope & Keith-Spiegel, 2008). Even Gutheil (2008a), who originally presented these ideas, questions the obsessive preoccupation with boundaries that took hold in psychotherapy in the 90's stating; "a therapist who is too fixated on boundary violations may be risking liability for other forms of substandard or unethical practice" (p. 8). In addition, Kendall et al. (2011) note that “although much is written about appropriate boundaries, there is little research that informs policies, practices, discipline-specific and inter professional education” (p. 510).

Boundaries in some music therapy contexts appear to be relying heavily on these traditional theories. They seem to not have considered the evolving discussions on boundaries in other related fields (O'Leary, Tsui, & Ruch, 2013). In addition, the evolving nature of music therapy practice to include newer theoretical models makes it timely to question and explore these boundary theories from a contemporary perspective. Furthermore, they do not take into consideration the influence of music, which is interesting given its prominent role within music therapy practice. I will now examine particular aspects of traditional boundaries and use examples form current music therapy literature to highlight the incongruences present.

**Dual relationships.**

As mentioned above, one aspect of traditional boundaries is the idea of a dual relationship. A dual relationship exists when a counsellor has other connections with a client in addition or in succession to the counsellor-client relationship (Moleski & Kiselica, 2005). For the conventional perspective, Reamer (2013) discusses that a boundary crossing occurs when a social worker is involved in a dual relationship (p.
173). For Reamer (2013), any dual relationship is considered a boundary crossing and therefore something to be avoided. The fear here is that creating other relationships will diminish the therapy process and potentially lead the therapist and client down the slippery slope to boundary violations (Coe, 2008). Similarly, Dileo (Dileo) states:

> What is important to consider is the potential for these activities to change the nature of the therapeutic relationship itself by creating a conflicting or competing relationship with the client. (p. 128-129)

Differently, Bolger (2012) has described a cross-cultural music therapy project in Bangladesh within an international development program. This music therapy project took place in a refuge for women and children in rural Bangladesh, with the music therapist living and working in the community. As Bolger describes in this work it is clear that aspects of therapy, like the time of the session, the space, clothing and language, were all flexible and adaptive processes that differ from conventional methods described above. This flexible and intuition directed work, challenges traditional ideas on therapeutic work as it is situated in a community music therapy context. Consequently, it also challenges traditional notions on the way boundaries are constructed and practiced; however, it is evident through her descriptions that it is a valuable and relevant approach. Within the therapeutic process, the balance of personal and professional life appeared to be challenged. As Bolger states; “I reflect yet again on how my personal and professional lives are so unavoidably entwined here’ (Bolger, 2012, p. 34). It seems that some sort of dual relationships were inevitable in this context and, critically, these relationships served to help develop the therapeutic alliance. Perhaps in music therapy work rather than strict avoidance of dual relationships, a more flexible and context specific approach should be adopted.

There is little research in music therapy that has directly addressed the complexities of boundaries in music therapy practice (Foster, 2007; Papadopoulou, 2012). Foster (2007) explored the notion of friendship in the therapeutic relationship. This small scale study interviewed three music therapists from a range of clinical contexts who all practice in creative music therapy. The main themes that emerged from the analysis included; 1) boundaries, ethics and therapist fears, 2) balancing personal and professional, and 3) facilitating relationships. In the theme of ‘boundaries, ethics and therapist fears’, there was an emphasis on the need for boundaries to be flexible and adaptable. Interestingly, the results stressed the need for
flexibility based on the unique context of every situation, rather than rigid adherence to a set of rules. Following this, the participants also discussed anxieties about right and wrong and how this can inhibit the therapist’s trust in their own instincts (p. 17). For the participants in this study, worrying about what to do in the tricky situations led to more anxiety and fear about being an ethical therapist.

With ‘balancing the personal and professional’ theme, the data indicated that overlaps between friendships and professional relationships are quite common. One participant discussed having dinner at a client’s home, and suggested that this can often be therapeutically appropriate, as long as professional boundaries continue to apply. These ideas suggest that dual relationships with clients may be common and can sometimes be therapeutically appropriate within certain contexts. In these new approaches, the therapeutic relationship in music therapy has evolved. With this change, critical reflection and research is needed in regards to boundary issues. This will aid the development of contemporary music therapy practice.

**Touch and boundaries.**

Another area often discussed in boundary theories is touch. Physical and personal boundaries are of course to be maintained for the safety and security of both client and therapist. Guthiel and Gabbard (1998) discuss that the concern about professional boundaries has grown out of a wish to prevent sexual misconduct. Therefore, the use of touch in therapy is naturally an area of concern. Differently, Schneider and Patterson (2010) consider the value in using touch in early childhood services. They suggest that appropriateness of touch is influenced by culture, religion, gender, age, familiarity and social standing (p. 19). In addition, they question the rigidity of some institutions making it policy not to touch children at all. Like other boundary issues, it is something that may require reflexivity, rather than set boundaries that are too loose or rigid and will ultimately cause harm (Coe, 2008). However, we should also not assume that it is all right to use touch with certain populations (children, elderly). Consequently, this is a boundary issue that requires more research, especially given the intimate nature of music therapy work.

**Self-disclosure and boundaries.**
Self-disclosure refers to behaviours that reveal personal information about the therapists to their clients (Constantine & Kwan, 2003). Like other boundary issues, the use of self-disclosure is debated in the literature (Gutheil & Gabbard, 1998). Hill and Knox (2001) conducted a literature review on self-disclosure in psychotherapy and found 18 analogue studies that investigated non-clients perceptions of self-disclosure. Of the 18 studies, 14 reported positive perceptions of therapist self-disclosure. They argue that the use of self-disclosure may help build the therapeutic relationship and help the therapist to appear more personal.

Similarly, Audet (2011) explored client perceptions of the impact of therapist disclosure on therapeutic boundaries. The author states:

On the one hand, therapist disclosure is viewed as a boundary violation that deviates from the ‘normal’ therapeutic stance. On the other hand, it is accepted as a viable therapeutic technique that loosens client–therapist boundaries and significantly humanizes the therapist to the client’s level. (p. 88)

In this study, nine clients were interviewed about their experience of disclosure from their therapist. Interestingly, five participants described their therapist, prior to receiving self-disclosure, as formal, rigid, impersonal, authoritative or clinical. Not knowing anything personal about their therapist appeared to make them feel more like a client. Another interesting finding was that all participants felt that therapist disclosure added a human dimension to therapy. However, two participants had experiences with their therapist that appeared to severely compromise therapeutic boundaries. For one participant, their therapist shared something with them and the participant couldn’t understand how they could do it. This sharing diminished the participant’s view of their therapist and left them questioning whether to continue with therapy or not. This example suggests that self-disclosure could be beneficial to developing the therapeutic relationship. However, it should always be considered in the context of the person, their culture and their views and values.

**Contemporary approaches to boundaries.**

Although there is strong advocacy for traditional approaches to boundary issues, there has been some development towards a more contemporary, holistic approach to boundary management. Feminist therapists have written about how
boundaries may be constructed and understood within a feminist lens (Brown, 1994; Root & Brown, 2014; Shonfeld-Ringel, 2001). Feminist therapy developed out of feminist movements but has been difficult to define. Feminist therapy theory has often uses theories that are political and sociological, and has resulted in a “myriad of feminist therapies that share certain core concepts but vary widely” (Brown, 1994, p. 13). Brown (1994) asserts:

> Appropriate boundaries in therapy are a reflection of race, class, culture, setting, and most importantly the specific and unique relational matrix among and between the human beings in the therapy room. (p. 31)

She proposes that the way to address boundary issues and reduce the risk of violations, is not in rules for boundaries, but rather in how we understand the intricate, complex and sometimes subtle ways in which boundary violations can occur in therapy (p. 32). She further states:

> A way to reduce the risks for boundary violations does not lie in the identification of concrete rules regarding boundaries. Rather is rests in our ability to understand the characteristics of boundary violation and then to learn to ask if those characteristics are, or are highly likely to be present in a particular instance. (p. 5)

From my perspective, the idea of boundary crossings and violations sits firmly within the medical model, where the health worker is placed in the centre of the relationship, given power and authority over the client (Kane, 1982). This does not seem appropriate for other theoretical models in music therapy, where there has been a questioning of the traditional power dynamic in the therapeutic relationship. In addition, the use of music in music therapy appears to create complexities with boundaries that have not yet been considered. With the development of relatively new approaches to music therapy, such as community music therapy (Ansdell, 2002; Pavlicevic & Ansdell, 2004; Stige, 2011) resource orientated music therapy (Rolvsjord, 2006, 2010), culture-centred music therapy (Stige, 2002) and music centred music therapy (Aigen, 2005), adopting conventional boundaries would be seen to be detrimental to the therapeutic process, and potentially negatively influence the music therapy work.

In community music therapy, O’Grady and Mcferran (2007) question the value of traditional boundaries and consider whether these boundaries are actually helpful in ‘community’ or ‘well-being’ work (p. 23). They question how boundary
theories that stem from psychotherapy, would ever be relevant for work with such a
different philosophical underpinning. Similarly, Ansdell and Pavlicevic (2004)
discuss that music therapists are re-thinking their identities, roles, boundaries and
attitudes and assumptions in their community music therapy work. If our approach to
music therapy is changing, then our approaches and theories on boundaries also need
to evolve. Additionally, if we are striving for equal therapeutic relationships
(Rolvsjord, 2006, 2010) and ideas of empowerment and ownership (Proctor, 2001),
then the ideals of boundaries from a medical framework need to be reflexive to these
new practices.

In critiquing traditional boundary theories in social work, O’leary et al. (2013)
asserts, “the social work relationship has adopted restrictive artificial barriers that are
not in keeping with the profession’s values and come of the realities of practice” (p.
136). O’leary et al. (2013) propose an alternative framework for guiding boundary
issues in a way that aligns with contemporary values in social work. In this model
they promote connection between the social worker and client, rather than separation
and professional distance (p. 143). They state:

It (the model) emphasises the dynamic nature of boundary setting that reflects
changes within the professional relationship over time and acknowledges the
interplay of both visible dimensions of the relationship and the less visible,
unconscious dynamics that are recognised through practitioner’s reflective
processes. (p. 143)

This model seems to foster a more inclusive and respective approach, which
encourages equal relationships and values the input of the client. For music therapy,
the development of a model of boundaries that considers the developing nature of our
practice is also needed.

**Motivations for a critical interpretive synthesis of case studies**

The next chapter details a deep examination of some music therapy literature,
using a critical interpretative synthesis method. The motivation for the critical
interpretive synthesis was driven by the need to find music therapy literature that
specifically explored boundaries. Where was the literature on boundaries in music
therapy? The literature I could find was limited to textbooks that referenced
traditional theories on boundaries, or some newer models where they discussed the
need for boundary theories to be developed. I widened my search and found some articles that had boundaries as a finding from research looking into another area. These were interesting but they did not go into enough detail about the complexities of boundaries. There was other literature that alluded to boundaries but it was either not discussed in enough depth or it lacked some clarity.

As mentioned above, other allied health fields have been researching and discussing this area for around 20-30 years (Fronek, 2009; Gutheil, 2008a, 2008b; Gutheil & Gabbard, 1993; Kendall et al., 2011; Milton, 2008; Pope & Keith-Speigel, 2008; Reamer, 2013). There was a need to explore boundaries in music therapy. I felt that boundaries required ongoing reflection and discussion within the music therapy community, so it was a surprise to find so little literature on the topic in music therapy. As there was little literature on boundaries, I decided to critically examine some case studies to explore boundaries that were implicit and assumed.

A critical interpretive synthesis felt like a good approach to literature analysis, as it would allow me to critically examine some music therapy literature using a traditional boundary lens. As described above, traditional boundary theories include boundary crossings that describe situations where someone or something steps outside of a traditional approach to therapy (Gutheil & Gabbard, 1993). These conventional ideas felt rigid, constraining and foreign to the way that I practiced music therapy. In addition they felt incongruent with newer developments in music therapy practice. I believed that instances of traditional boundaries would be described in these case studies and was eager to see how they were presented. Did the music therapists talk about boundaries at all and what did they look like? Furthermore, were there other boundary challenges that had not identified in the music therapy literature.

The critical interpretive synthesis method allowed me to use descriptive analytic strategies to critically interrogate the literature. This included extracting data from the case studies, like theoretical approach, age, context diagnosis and boundary theme, then compiling them together to get an overall picture from the case studies. This data was then used for further analysis into individual themes and examining what theoretical approaches, ages, or contexts were present in each boundary theme.

I liked this approach because I wanted to be able to explore the literature in great detail. Through this method I could extract data from the literature and use that to explore alternative perspectives. This was an interesting and exciting way of tackling literature as it allowed me to view the literature in a new light and to step
outside of my own pre-assumptions about boundaries. With the application of the critical interpretive synthesis method, I decided to use case studies as I felt they would provide a unique way to explore contemporary music therapy practice. Given my interest in boundaries, it was fascinating for me to take a sample of case studies and use a boundary lens to begin see what was happening in music therapy practice. By applying the critical interpretive synthesis method to case studies I, felt that I could access the individual experiences of music therapy and begin to formulate ideas about what boundaries mean in music therapy practice. The next chapter will detail the critical interpretive synthesis.
References


A critical interpretive synthesis of music therapy case studies: Examining therapeutic boundary themes in the context of contemporary practice

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Abstract
This article presents the results from a critical interpretive synthesis that examined the prevalence and presentation of therapeutic boundary themes in music therapy case studies. Conventional boundary theories are often defined as the parameters of practice that encourage the clinician to perform boundary processes in a certain way. These theories pertain to practical and interpersonal elements when negotiating the therapeutic relationship and include features such as boundary crossings and boundary violations. A carefully selected set of case studies were examined and interrogated to determine the presence and type of boundary themes. These were analysed by distilling narrative descriptions from the case studies and comparing them with information about population, age of clients, theoretical approach and cultural setting. Musical intimacy emerged from the analysis as a concept that contained a myriad of boundary challenges, which often appeared to contrast conventional ideas on boundaries. The results of this critical interpretive synthesis are discussed along with recommendations for music therapy practice.

Keywords
boundaries, case studies, critical interpretive synthesis, music therapy, musical intimacy

Rationale
Therapeutic boundaries are a complex and multifaceted concept in music therapy that includes both practical and interpersonal considerations. This study describes how music has the potential to make them more elusive, personal and complicated. The combination of music and therapy creates a type of musical intimacy, which can create experiences where music elevates, highlights or reveals the underlying and authentic elements of the therapeutic process. Musically intimate experiences can trigger emotional responses, build stronger connections and create powerful moments within the therapeutic alliance. This dynamic has the potential to test therapeutic boundary processes in music therapy work. Traditionally, music therapists have largely adopted the conventional notions of therapeutic boundaries that are relevant in fields such as psychotherapy, social work and counselling. The phenomenon of musical intimacy challenges these. Music creates unique conditions that can allow people to reach across boundaries and borders. However, there is little discussion in the literature of the way that music impacts, changes or challenges therapeutic boundaries or, more importantly, on how music therapists negotiate these boundary challenges.

Although boundaries have been considered an important part of therapeutic approaches for some time, they received a surge of attention in the past 20–30 years in related fields such as psychotherapy and counselling (Gutheil and Gabbard, 1993; Pope and Keith-Spiegel, 2008; Reamer, 2003). With a growing interest in research and literature, boundaries are recognised as an essential element in therapy and have been adopted by other related professions such as music therapy. Therapeutic boundaries serve to protect the client and therapist from harm, and as Gutheil (2008) states, ‘a boundary is the edge of appropriate behaviour at a given moment in the relationship between a patient and therapist, as governed by the therapeutic context and contract’ (p. 18). They are there to guide the therapist for the ‘in-the-moment’ ethical decisions and to avoid harm for the client or legal action against the therapist. Additionally, pushing boundaries or treating them with flexibility may serve to aid the therapeutic process and help achieve goals set out in therapy.

Boundary crossings and boundary violations are a common concept among allied health professions (Fronek et al., 2009; Gutheil and Gabbard, 1993; Pope and Keith-Spiegel, 2008; Reamer, 2003). In the psychotherapy literature, boundary crossings are described as benign departures from conventional therapeutic practice, whereas boundary violations
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are instances that cause harm (Gutheil and Gabbard, 1993). Boundary crossings relate to components of therapy such as role, time, place and space, money, gifts, services, clothing, language, self-disclosure and physical contact (Gutheil and Gabbard, 1993: 639). Each of these boundary crossings may help meet the clinical goals of the therapy, contribute to interpersonal interactions and form an important aspect to the work. As such, these boundary crossings are all considered within the context and approach to the therapy work. As we will demonstrate in this critical analysis, there is ample evidence that many music therapy sessions contain boundary crossings of some kind.

Some authors suggest that boundary crossings can easily lead to boundary violations and argue for therapists to be cautious when considering any form of boundary crossing (Coe, 2008). The fear is that ‘we may fail to consider a boundary crossing’s potential future complications, unexpected developments, and unintended consequences’ (Pope and Keith-Spiegel, 2008: 647). These ideas suggest that boundary crossings have great potential to lead to boundary violations and should be exercised with caution. These ideas are situated in psychodynamic or medially oriented practices where clear boundaries are in line with the conceptual approach. In these approaches, the therapeutic frame is essential to provide stability, predictability and a sense of safety for the client (Wheeler, 2014). In this way, boundaries serve to support the therapeutic frame through expectation, predictability and safety. However, there is danger of becoming too rigid in a way that negatively impacts the therapeutic process. Allen (2010) questions ‘how we might strike a balance between boundaries so rigid that treatment is restricted and patients are ultimately harmed, and boundaries so loose that treatment is uncontainable and patients are ultimately harmed’ (p. 20).

Conventional theories about boundaries potentially contradict the theoretical positions underpinning music therapy practices such humanistic, creative music therapy and other newer music therapy practices. As an example in community music therapy (CoMT), the music therapist often becomes more involved in the community they are working with and are included in other non-music therapy activities to build the therapeutic alliance. The aim is to achieve a therapeutic alliance that is as equal as possible, with shared control of the therapeutic process.

Using CoMT as an example, we suggest that this approach challenges the boundary theories that we refer to as a profession. This may also apply to other models in music therapy that adopt a more flexible approach to boundaries in their work, such as creative or humanistic music therapy. We suggest that this sense of reliance on conventional boundary ideas may be incongruous with the trends and approaches to contemporary music therapy work. Ansdell (2002) states that ‘there seems to be a deepening mismatch between what many music therapists practice, and the over arching theoretical model which claims to guide and legitimate their work’ (p. 139). This could suggest that what is occurring in practice might be quite different from the ideals, theories or models that are commonly used to explain or guide boundary issues.

O’Grady and McFerran (2007) explicitly question the rigidity of conventional boundaries and ask whether they are actually useful in the community. These Australian music therapy scholars discuss how music therapists working in community contexts may need to individually negotiate appropriate boundaries with each participant, rather than work from a predefined set of rules (p. 23). They argue for a flexible approach to boundaries that is context-responsive to allow for the intricacies of music therapy to play out.

Similarly, Rolvsjord (2010) discusses this kind of shift away from the expert-therapist model as essential to the theory of resource-oriented music therapy (RoMT). Her emphasis on empowerment includes a focus on nurturing and developing strengths within a mutual and collaborative relationship (Rolvsjord, 2010: 10), which can be seen as quite distinct from the conventional power dynamics of psychotherapy. In conventional psychotherapy, roles are clearly defined, and this helps to clarify the boundaries of the therapeutic relationship. RoMT theory challenges how therapeutic boundaries should be managed in the therapeutic alliance, which brings into question how the boundaries of this new therapeutic alliance should be negotiated.

Emerging theories about music therapy make it timely to challenge assumptions about therapeutic boundaries in order to continue to develop understandings that underpin the music therapy profession. In order to analyse these assumptions from a critical viewpoint, we chose to begin by investigating the literature on boundaries in music therapy and case studies were selected as a reflection of contemporary music therapy practice. Our aim was to examine the prevalence and presentation of boundary crossings and themes as a first step and then to interview music therapists about the results of the analysis in future research. The following research question was developed to guide this initial investigation – What boundary crossings and themes are present in case studies in music therapy practice?

**Design and methodology**

A critical interpretive synthesis is a fresh approach for tackling diverse and complex literature. The method aims to critically analyse data from varied sources, including both quantitative and qualitative studies, for the purpose of theory development (Dixon-Woods et al., 2006). It is the critical nature of the analysis that distinguishes it from other literature review methods (McFerran et al., 2014), and the process is characterised as iterative, interactive, dynamic and recursive rather than following a set of fixed procedures and predefined sequences (Annandale et al., 2007: 445).

The critical interpretive synthesis presented in this article differs from previous investigations in that the literature was limited to case studies. We chose to use case studies as we were aiming to capture quality, expertise and a variety of representations of music therapy practice. We chose to use descriptions of ‘boundary crossings’ within music therapy
case studies as a lens to focus the analysis. This focus allowed us to identify the assumptions underpinning contemporary practice, from which position we could highlight what was congruent and incongruent with traditional theories. We were also open to the emergence of unanticipated boundary themes through the analysis.

**Literature inclusion**

A total of 86 chapters were examined from four music therapy textbooks describing case studies in music therapy practice (see Appendix 1). The textbooks were (1) *Developments in Music Therapy Practice: Case Study Perspectives* (Meadows, 2011), (2) *Where Music Helps: Community Music Therapy in Action and Reflection* (Stige et al., 2010), (3) *Inside Music Therapy: Client Perspectives* (Hibben, 1999) and (4) *Psychodynamic Music Therapy: Case Studies* (Hadley, chapters 1–14, 2003). This study began with the analysis of Meadows (2011) that had been recently published and included diverse contexts, theoretical approaches and types of clients, as well as a systematic approach to chapter formulation. We thought that this would provide a good overview of music therapy practice to begin our investigation.

As 18 of the 34 chapters contained boundary themes (52%), we felt that it served as a useful vehicle to pilot the use of a critical interpretive approach. Theoretical sampling (Strauss, 1987) along with maximum variation sampling (Patton, 1990) was used to guide the case study selection process. Theoretical sampling involved purposeful selection/sampling of case studies, with selection being guided by the demands of the emerging theory (Draucker et al., 2007; Schwandt, 2001). From the initial analysis of case studies (Meadows, 2011), there was a sense that the boundary themes that were emerging may be similar according to which theoretical approach or with which population they identified. We felt it was important to explore different theoretical approaches and populations to look at what boundary themes were occurring within these. As such, the second text was based on CoMT to explore this approach in more detail.

Maximum variation sampling (Patton, 1990) involved capturing central themes while ensuring diversity. To ensure diversity, we aimed to use books that were very different from the previous texts. In light of this, the second text was based on CoMT and the third book focused on client experiences in music therapy. We felt that this would provide an interesting alternative to the previous two texts. Finally, the fourth text was located in psychodynamic music therapy. The application of these principles meant that music therapy case study texts were selected for their potential to provide diversity in data and to complement or expand the emergent themes. This is congruent with the critical interpretive synthesis approach where data are gathered through an organic process that fits with the emergent and exploratory nature of the review questions (Dixon-Woods et al., 2006: 3). The literature included was intended to capture a *selection* of case studies in music therapy practice. As such, the authors acknowledge that there are other notable case study texts in music therapy that would also have added insight to this critical interpretive synthesis.

**Definition of key concepts: boundary crossings**

The following boundary crossing definitions were used as a lens to view the case studies and examine the presence and presentation of boundary themes. These were identified through descriptions from the authors in each case study, although the authors did not explicitly describe them as boundary crossings. We also remained open for other boundary themes to emerge. This was done through a reflexive process where we would let boundary themes emerge from the case studies. In this way, the case studies were treated like qualitative data and analysed in a similar way. These boundary themes are the interpretations of the authors, based on their understandings of boundary themes. Further clarification was not sought from the authors and as such these findings are to be taken in the context of the authors own assumptions and ideas about boundaries. The following definitions represent what we identified as boundary crossings.

**Dual relationships.** A dual relationship exists when a therapist has other connections with a client in addition or in succession to the therapist–client relationship (Moleski and Kiselica, 2005: 3). This can involve a friendship or taking on other roles within or around the therapy process.

**Self-disclosure.** Self-disclosure refers to behaviours that reveal personal information about the therapists to their clients (Constantine and Kwan, 2003). It is when the therapist discusses personal information with the client.

**Touch.** Dileo (2000) states that the use of touch in therapy is a controversial topic, as it can be associated with the loss of therapeutic boundaries, dual relationships and sexual exploitation (p. 135). Guthiel and Gabbard (1998) discuss that the concern about professional boundaries has grown out of a wish to prevent sexual misconduct. Therefore, the use of touch in therapy is naturally an area of concern and is considered a boundary crossing.

**Time and place.** In conventional approaches to therapy, strict adherence to time and place is observed to provide structure and predictability for the client (Guthiel and Gabbard, 1993). Therapy would take place in a professional setting and ideally at a set time decided by the therapist and client.
The analysis of each chapter took elements from the synthesis method described by Flemming (2010) and also utilised some ideas from Dixon-Woods et al. (2006). The process was as follows:

1. **Understanding the paper in relation to itself.** Reading through the chapters to develop an understanding of its context and identifying potential boundary crossings and themes (Flemming, 2010).
2. **Translating the chapters into one another.** The descriptions, themes and ideas used by the authors were identified and placed into boundary theme categories (Flemming, 2010).
3. **Categorical data collection.** Descriptive data were collected into an excel spread sheet and translated into numbers in order to be used for descriptive statistical analysis. These data included title, author, source, year, type of article, setting/context, theoretical approach, diagnosis or issue, gender, age of client, level of experience of therapist, culture and boundary crossing/theme.
4. **Distillation of narrative descriptions.** Each theme was distilled to capture the essence of what was described in the case studies. This involved first reading through the extracts and identifying key words or sentences, then compiling and further distilling the essential information to capture the essence of the theme.
5. **Statistical analysis of trends in relation to boundary themes.** Descriptive statistical analysis was undertaken with results being presented as tables and charts in order to identify trends within themes and statistical data categories.
6. **Form a synthesising argument.** Distilled narrative descriptions and statistical data were compared and merged to form a synthesising argument. Global themes were created by gathering similar boundary themes together. This integrated the data from across the studies into a coherent theoretical framework comprising a network of constructs and the relationship between them (Dixon-Woods et al., 2006: 5).

**Results**

This critical interpretive synthesis analysed 86 chapters selected from four music therapy textbooks, which focussed on case studies in music therapy practice (see Appendix 1). **Boundary crossings** included known understandings of therapeutic boundaries, and **boundary themes** were emergent ideas on therapeutic boundaries. These were combined to form the boundary themes from the analysis. The authors identified boundary themes in 41 of the chapters analysed, making a total of 78 boundary themes, often chapters included more than one boundary theme (see Figure 1).

Of all the chapters analysed, 23% were music psychotherapy or psychodynamic music therapy and 23% of approaches were CoMT. Most notable diagnoses included mental health issues (20%) and early intervention (18%). Chapters written by authors from the United States were most likely to contain boundary themes (27%) followed by UK authors (17%). The authors identified 12 boundary themes in the 41 chapters (see Figure 2) and formed them into three global themes.
Occurrence of boundary themes

<table>
<thead>
<tr>
<th>Boundary themes</th>
<th>Number of chapters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Touch</td>
<td>8</td>
</tr>
<tr>
<td>Therapeutic relationship</td>
<td>11</td>
</tr>
<tr>
<td>Musical alliance</td>
<td>9</td>
</tr>
<tr>
<td>Cultural boundary</td>
<td>10</td>
</tr>
<tr>
<td>Roles and power dynamics</td>
<td>2</td>
</tr>
<tr>
<td>Self-disclosure</td>
<td>6</td>
</tr>
<tr>
<td>Dual relationships and safety</td>
<td>2</td>
</tr>
<tr>
<td>Gifts</td>
<td>11</td>
</tr>
<tr>
<td>Implementing boundaries</td>
<td>9</td>
</tr>
<tr>
<td>Ethical considerations</td>
<td>5</td>
</tr>
<tr>
<td>Transference and countertransference</td>
<td>2</td>
</tr>
</tbody>
</table>

**Figure 2.** Occurrence of boundary themes in chapters.

**Global themes**

The authors grouped together similar boundary themes to create three global themes. These are (1) therapeutic relationship, (2) intimacy and (3) therapeutic frame (see Figure 3). In the following sections, these will be discussed with the support of illustrative examples and excerpts from the narrative descriptions to provide additional depth to the descriptive statistics that are offered.

**Global theme 1: therapeutic relationship**

The occurrence of dual relationships, self-disclosure or gifts is often considered a boundary crossing. These boundary crossings all relate to different aspects in the therapeutic relationship and appeared to serve the development of therapeutic process in these case studies. Although they can be considered as boundary crossings, each of the case studies illuminated how they can benefit the therapeutic process.

**Dual relationships.** One example took place in a centre for music and medicine where musicians and performing artists who have other health concerns are treated. The authors identified their approach as music psychotherapy, in which clinical improvisation was a vital element. There appeared to be elements of friendship as well as the therapeutic relationship present. The music therapist reflected that their client ‘seemed to want a personal connection with them’ (Loewy and Quentzel, 2011: 310), which appeared to indicate a certain level of a dual relationship. This was more highlighted through the musical relationship that developed, illustrated in the following excerpt:

We distinctly recall approaching Paula in the hallway … she was screaming, complaining of pain and refusing to move … I grabbed my guitar and met Paula with music outside the hall … I worked myself into ‘I can’t give you anything but love’ improvisation with lyrics of ‘soon we’ll go in the music room Paula’. This delighted Paula and she sang back to me as we waited for the medics. (Loewy and Quentzel, 2011: 302)

Through these descriptions, we sensed a musical friendship that developed alongside the therapeutic one, and we suggest that this served to enhance the therapeutic process.

Another music therapist described feeling a void due to the absence of their client (Nirensztein, 2003: 235). This work took place at a boarding school for maladjusted teenagers using a psychodynamic music therapy approach. The music therapist stated,
I was pained and confused. I felt void due to his absence and I realized that there was a message here for me also – the changes that Eli had confronted in therapy also threatened his relationship with external reality. If I wanted to give him a sign of the existing relationship in spite of his absence, and this was the only way I had to help him, I had to go outside of the setting and call him at home. (p. 235)

The author stated that they went through moments of pessimism, bordering on a sense of guilt and had detailed fantasies of adoption. This music therapist concluded there was a need to give up a future of therapy with this client due to their own countertransference experience (Nirensztein, 2003). Through these descriptions there appeared be another level of relationship developing that may not serve (or be helpful to) the therapeutic process.

**Self-disclosure.** One description categorised as self-disclosure was one music therapist who had the same cultural background as her client and disclosed much about herself to the client (Bruggen-Rufi and Vink, 2011). The authors stated, ‘she began telling stories about her youth, and I was able to tell her that my parents were also from Indonesia, so that I had some understanding of her experiences and struggles’ (p. 575). This work took place in a nursing home and the authors identified as using culture-centred music therapy. The author also stated, ‘these conversations added a level of intimacy to our work that allowed her to be even more expressive, giving her the feeling that she could talk to me about everything’ (p. 578). Through these accounts we felt that the self-disclosure aided the development of the therapeutic relationship.

**Gifts.** Two chapters mentioned receiving gifts, one from a client to a music therapist and one from a music therapist to a client (Bruggen-Rufi and Vink, 2011). Another music therapist was invited to a family home for a farewell dinner. They were then invited to come and stay in one of their apartments in Turkey (Mahns, 2003). Gifts are also considered as boundary crossings, but here in these descriptions there was no sense that they compromised the work.

In this global theme of therapeutic relationship, the most common theoretical approach was psychodynamic music therapy (see Figure 4).

**Global theme 2: intimacy**

Within a psychodynamic approach intimacy can be considered to give added strength to the work. Through these descriptions in the case studies, many of the examples identifying as psychodynamic described intimacy through music, emotional connections and using touch. As such, eight of the chapters in this theme identified with a psychodynamic approach (see Figure 5).

**Touch.** Touch was described in nine chapters and was categorised under the global theme of intimacy. Touch predominantly appeared in chapters written by authors from the United States (50%) with Israeli and Norwegian authors comprising the remainder. In the chapters analysed, children sat on music therapist’s laps (Elefant, 2011; Schwartz, 2011), fell asleep on them (Crowe, 2011), held hands (Stige, 2010), were held by the music therapist (Elefant, 2011) and one music therapist applied light pressure to a client’s leg (Crowe, 2011). One music therapist touched an elderly client’s hand, which appeared to settle her for a brief moment (Forinash and McKnight, 1999).

<table>
<thead>
<tr>
<th>Global theme</th>
<th>Boundary themes</th>
<th>Chapters</th>
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<tbody>
<tr>
<td>Therapeutic relation</td>
<td>Self disclosure</td>
<td>2</td>
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<tr>
<td></td>
<td>Dual relationships</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Gifts</td>
<td>2</td>
</tr>
<tr>
<td>Intimacy</td>
<td>Musical intimacy</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Emotional connection</td>
<td>5</td>
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<tr>
<td></td>
<td>Transference and countertransference</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Touch</td>
<td>8</td>
</tr>
<tr>
<td>Therapeutic frame</td>
<td>Roles and power dynamics</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Therapeutic setting</td>
<td>11</td>
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<tr>
<td></td>
<td>Personal boundaries and safety</td>
<td>11</td>
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<td></td>
<td>Cultural boundary</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Implementing boundaries</td>
<td>8</td>
</tr>
</tbody>
</table>

**Figure 3.** Global themes, boundary themes and the number of chapters.
Musical intimacy. Musical intimacy also emerged as a sub-theme of the global theme of intimacy. The majority of the descriptions involved practice with adults (78%). One music therapist described magic moments in the music. They discussed a sense of flow that they described as a ‘socio-musicing space’ that led to a transformation in the music, leading to the project becoming like a musical ritual (Ansdell, 2010). One of the clients in this music therapy project elaborated stating, ‘then something else happens, a transformation occurs. And it’s often in music you hear it first … it’s instantaneous, you experience this transformation …’ (p. 156).

Other clients reflected on musical intimacy in the case studies on client perspectives (Hibben, 1999). One client stated,

when you sing with me, I feel like you’re reaching inside me, past all the things I can do for people, past how I look and how smart I am – to just me. This feels very new, to be contacted in this way. (Austin, 1999: 127)

Another client stated,

he played music that was exactly in tune with me, and I felt my sadness more intensely. Alan and I build on each other’s music, and at the end, the music brings me to a compassionate place of sanity. (Logis and Turry, 1999: 109)

In these descriptions, there was a sense of intimacy created or enhanced by the music and musical processes described by the authors.

Emotional connection. Descriptions of emotional connection appeared in five chapters, including authors whose approaches were either psychodynamic (60%) or analytical music therapy (40%). The authors identified these approaches with little description; as such, deductions about the differences between these similar theoretical approaches cannot be made. One music therapist described, ‘I was left having to hold and process Matthew’s unmanageable feelings and I felt irrationally annoyed that he had skipped out of the room so lightly after playing’ (Sweeney, 2003). This music therapist was working in a hospice for children and identified as working within a psychodynamic framework. Through the author’s descriptions there appeared to be an emotional connection, which was interpreted as a traditional boundary crossing. However, there was no sense that this had a negative impact on the therapeutic process.

Another music therapist commented that sessions with their client generated feelings of being on an emotional roller coaster (Rogers, 2003: 133). This music therapist identified as using psychodynamic music therapy working with children and adolescents who had suffered from abuse of some kind. The author discussed her countertransference reflecting,

My countertransference response was to feel shocked, powerless, abused, controlled, and my task was to reflect on and contain these feelings, recognizing that Jenny appeared to be inviting further abuse and pushing onto me some of the shock and outrage she had experienced. (p. 130)

This emotional connection seemed to serve the therapeutic process in helping the client to communicate her experiences and for the music therapist to help her work through them.
Global theme 3: therapeutic frame

This global theme included the boundary themes: roles and power dynamics, therapeutic setting, personal boundaries and safety, implementing boundaries and cultural boundaries. The themes all relate to descriptions about the therapeutic frame in music therapy. In this global theme of therapeutic frame, CoMT was the most common theoretical approach (see Figure 6).

The settings were spread across a variety of countries (see Figure 7).

Roles and power dynamics. One emergent theme that occurred in analysing the descriptions of boundary themes was roles and power dynamics. This theme included descriptions of the changing and flexible roles taken by music therapists as well as discussion of power dynamics within the therapeutic relationship. These were identified as boundary crossings when they differed from the roles and power dynamics expected in the conventional therapeutic relationship.

One music therapist observed the music therapist’s flow in and out of an ‘overtly’ therapeutic role, switching between being therapist, director, co-musician, facilitator and collaborator at the same time (Pavlicevic, 2010a). This was CoMT work, which took place in a community setting with children. As this work involved performance and becoming involved in the community itself, the music therapist’s roles were often switching.

Another music therapist reflected, ‘my role was to facilitate the process, be a back up person, prompt her [the client] to use her musical cues should she have problems generating words’ (Baker, 2011: 292). This work was in a neurological rehabilitation setting primarily using melodic intonation therapy. As part of the process, the music therapy sessions would take place in the community to help facilitate recovery. This called for the music therapist to be adaptable in their roles to provide the support needed in this context.

Therapeutic setting. Descriptions included in this theme related to instances when music therapy took place in a non-traditional setting. This can be seen as a boundary crossing because it takes place outside the traditional parameters of conventional therapy. The music therapists conducted their practice in places outside traditional therapeutic settings, which included the following: a music therapist’s office (Nöcker-Ribaupierre, 2011), a bathroom (Edwards and Kennelly, 2011), community (Baker, 2011; Pavlicevic, 2010a), a community festival for adults with disabilities (Stige, 2010) and a scrap yard (Ansdell, 2010).

Personal boundaries and safety. We grouped together descriptions that involved either the music therapist or the client’s personal boundaries, or safety being challenged. One music therapist experienced instances that ‘felt intense and difficult’ (Edwards and Kennelly, 2011). This work took place in a paediatric hospital on a burns unit. They state, ‘These sessions were often quite long, commencing in Beni’s individual hospital room, moving to the bathroom for his debridement bath, to the table in the bathroom for his dressings to be changed and finally back to his room’ (p. 159). Music therapy in this context was used to provide distraction and relaxation to assist pain management during procedures. We placed it as a boundary crossing because the location of the bathroom was outside a regular space for therapy. However, the benefit of providing music therapy in this space was therapeutically appropriate and served the client’s needs.

Another author reporting on a CoMT project stated, ‘as I turn off the rail bridge and into the narrower dirt road, my senses are on high alert’ (Pavlicevic, 2010a). This work was in a community setting and the music therapists are involved in the neighbourhood, knowing the local police station staff and the local gangs that the children or adolescents belong to (p. 226). One of the music therapist states,
Figure 6. Occurrence of theoretical approach in global theme, therapeutic frame.

Figure 7. Therapeutic frame and cultural setting.

I am aware at times that I’m a middle aged white woman going into a context that’s very different from my own and therefore being very careful about not wanting to impose an agenda which may come from my background. (p. 227)

Another music therapist commented that a client was showing aggressive and demanding behaviour, taking place in a hospice for children (Sweeney, 2003). They stated, ‘He was testing the boundaries of his new environment, pinching bottoms of new people that he met and showing some aggressive and demanding behaviour’ (p. 28). Another music therapist commented that a client lit matches in a session (Mahns, 2003). They stated, He lit one match after another and let them fly around the room like rockets. Because of this, I moved the following session outside, where we lit a small bonfire. With this significant action he showed me how much fire he had inside, the desire for a warm centre, for a mother that would understand his feelings. (p. 62)

Discussion

Boundary crossings were described in a number of the chapters reflecting on music therapy practice (47%), and just under half of the chapters analysed were considered to contain boundary themes. We consider this a relatively high amount given that the chapters were not written with the intention to present boundary themes. We propose that this frequency suggests the need for further examination of boundaries in music therapy practice.

Musical Intimacy

Boundary crossings and themes were found across the case studies regardless of theoretical orientation, setting or diagnosis. However, the most interesting theme to emerge was labelled as musical intimacy, which involved boundary crossings that occurred in and around the music. We believe that the prominence of this theme suggests that music and musical intimacy may affect boundary processes and have a myriad of unique ethical implications for music therapy practice. This is an important finding as it highlights the potential impact that the music can have on boundary processes and how music therapists may need to deepen their understanding of boundary management.
Descriptions of musical intimacy included emotional connections in the music, magic moments in the music and moments of intimate musical communication. Of great interest were the emotional connections or the emotional reactions that some authors described as passing through the music. In the chapters analysed, one music therapist eloquently stated that ‘music offers a medium for expressing unsounded feelings and thoughts’ (Tyler, 2003: 40) and another music therapist reflected, ‘emotional reactions between therapist and client, can pass through the music’ (Mahns, 2003: 75). These established ideas present music as something that can carry and express emotions between client and therapist. For many music therapists, the dynamic interrelations that can occur in the therapeutic process in music therapy are central to the work. If music acts as a vehicle for expressing emotions, this is likely to create a closer connection between the client and therapist. Engaging in a medium that is so emotionally charged may create a context with many more potential boundary issues around maintaining a healthy relationship.

Garred (2001) discusses music therapy as a triangle where the therapist, client and the music are interconnected and a dynamic relation between each is made (p. 40). Although not a new idea, it is striking as it places music on equalFootings with the client and therapist. What music therapists may need to consider is that the client’s emotional experiences may be changed or developed by music used in the context of therapy. Furthermore, how do these experiences impact the clients or themselves as clinicians? Does the client view the music therapist as a ‘music buddy’ and feel more connected to the therapist because of the normative social aspect of music-making together? How music therapists negotiate the nuanced elements of friendship and the therapeutic alliance is potentially made harder by the presence of music and our multiple relationships with it. It is hoped that music therapists, especially through practices such as supervision, are already considering these issues.

The emotional, social, cultural and personal qualities of music pose a myriad of complexities on the therapeutic process and potentially the boundaries constructed within that context. We need to understand what happens through, around and as a result of using music in therapy and the impact on therapeutic boundaries. This would enable us to create a more holistic approach to boundaries that is specific to music therapy practice.

**Touch and musical intimacy**

Touch can be considered part of an intimate relationship, and it is often described in the music therapy case study literature, especially with children and elderly populations. A large proportion of the descriptions of touch found in the chapters were with children often involving sitting in the therapist’s lap while doing musical activities, holding hands or have pressure applied to them for sensory needs. This would all happen in and around the music. Dileo (2000) describes touch as a controversial topic because it can be associated with the loss of therapeutic boundaries, the promotion of dual relationships and sexual exploitation (p. 135). We believe that this level of uncertainty and fear is not to be undervalued given the intimate nature of therapy and the vulnerability sometimes experienced by the people we work with.

In contrast, Schneider and Patterson (2010) debate the value in using touch in early childhood services and suggest that appropriate touch can be influenced by culture, religion, gender, age, familiarity and social standing (p. 19). They discuss the potentially unhelpful rigidity driving some institutions where policy states not to touch children at all. It is hoped that the validity of using touch in therapy, like other boundary issues, is being considered with sensitivity by many music therapists. However, we suggest it may be something that requires reflexivity, rather than set boundaries that are either too loose or rigid and will ultimately cause harm (Coe, 2008). We also believe that it is necessary to consider touch with other age groups and question with what populations is touch appropriate. This requires more research, especially given the intimate nature of music therapy work that often incorporates the use of touch.

**Self-disclosure**

Self-disclosure is a notion that is commonly addressed in literature from other allied health fields that rely more heavily on verbal encounters. This literature frequently considers how contextual influences impact self-disclosure and addresses the assumption that too much self-disclosure will change or negatively impact the therapeutic relationship and potentially cause harm to the client (Dileo, 2000). Music therapists talking completely openly about themselves could potentially move the focus onto themselves and lead the client to take on the problems of the therapist. However, there is also danger of being too ‘clinical’ and therefore not being able to build the therapeutic alliance accordingly.

In this critical interpretive synthesis, we found only two chapters that contained descriptions of self-disclosure. Perhaps music therapists may not feel comfortable discussing self-disclosure and have uncertainties about what is ethical. This relates to the findings of Foster (2007), who explored the idea of friendship within the therapeutic relationship. He suggested that anxieties about right and wrong may inhibit the therapist’s trust in their own instinct (p. 17) and that his data indicated overlaps between friendships and professional relationships are quite common (p. 19).

In a fresh and contemporary approach to practice in a developing country, Bolger (2012) reflects how her work in Bangladesh often involved her personal and professional lives being intertwined (p. 34). The crossover was heavily influenced by the context and the approach to the music therapy work. As CoMT approaches become more common, these types of crossovers may also be more common and may even be considered a strength. Similarly, Forsblom and
 Ala-Ruona (2012) found in their study on music therapy with adults with an acquired brain injury that being more personal with their clients helps the therapeutic process. This was a major influence on the clients’ experience and how much they were engaged in their therapy process. We suggest that it is important to continue to reflect on how we approach self-disclosure within contemporary approaches to music therapy practice, especially in and around the use of music.

Theoretical approaches

A variety of theoretical approaches were represented under each of the boundary themes; however, a closer look at the differences between CoMT and psychodynamic music therapy identified some interesting distinctions. The most common themes represented in the CoMT literature were ‘roles and power dynamics’ and ‘therapeutic setting’. When the authors adopted a CoMT approach, it was more likely to take place in the community outside traditional therapeutic settings and a more equal relationship was sought between the therapist and client. Community music therapy theory intentionally moves away from pre-existing understandings of music therapy and towards contextualised and negotiated approaches to establishing boundaries. We suggest that strict adherence to psychodynamic theories about boundaries may not be so relevant and could potentially damage the therapeutic process, especially in theoretical approaches such as CoMT.

When authors identified with psychodynamic approaches to music therapy, themes surrounding the therapeutic relationship were most prominent (musical intimacy, personal boundaries and dual relationships). There was a sense of intimacy created in and through the therapeutic relationship that stood out as diverging from conventional therapy. The intimacy created in a psychodynamic framework can contain boundary issues, but they are often an essential part of the therapeutic journey. Allen (2010), a psychotherapist stated, ‘what are clinicians to do with the intimacy that they strive to create? Who and what defines the limits or boundaries of that intimacy’ (p. 20). Similarly, one of the chapters analysed stated, ‘we need different terminology in which it is possible to show a close connection with a psychodynamic framework, while maintaining a comfortable distance’ (Mahns, 2003: 75). We suggest that how music therapists handle and navigate this intimacy is another boundary issue that warrants more exploration than is possible within this research.

In summary, music therapists have an additional layer of intimacy that is created through, around or as a result of music. This manifests as a unique quality as a profession, yet it has the potential to change, alter and develop the therapy in ways not common to other allied health professions. This left us considering questions of how we maintain appropriate therapeutic boundaries when the context of music therapy creates conditions that have emotion, culture, history, identity, social and innate communicative qualities embedded within it.

Limitations

The first limitation is that case studies are from the viewpoint of the author, who may only wish to portray the best parts of the therapy. There is little opportunity to ask questions and gain a full understanding of the meaning of what they have described. These case studies were also never written with the primary intention of describing boundaries, so there may be misunderstandings of the representations. We have tried to present the findings as clearly as possible to distinguish our interpretations.

In terms of the methodology of this critical interpretive synthesis, the inclusion of literature was an emergent process that did not aim to gather an equal amount of case studies. The literature included is a representative sample of case studies in music therapy and as such does not provide a comprehensive sample of case studies that might reflect more variations in practice. Nonetheless, in the process of reading and extracting data from the initial 83 chapters, a point of saturation was felt to be achieved. Saturation is defined in the grounded theory literature as a point where no additional data are forthcoming, and this point is reached by joint collection and analysis of data (Glaser and Strauss, 1967). In this case, no new ideas were felt to be emerging through the analysis, and continued reading seemed to be reinforcing what had already been perceived.

This type of research is grounded in the subjective impressions formed by the researchers about the data being analysed. We have adopted an interpretivist orientation to this process, with an epistemological stance that values knowledge constructed through the perspective of individuals, rather than privileging objective processes that would require verification and agreement about truth. There was no verification of the analysis. However, our existing experience and interest in this subject was seen as providing valuable and unique perspectives to inform the analysis.

Conclusion and recommendations

Therapeutic boundaries are scarcely addressed in the music therapy literature. There is little research or discussion on boundary themes and the possible ethical implications specific to music therapy practice. Music creates unique conditions for therapy and is considered to comprise one-third of the therapeutic alliance (Garred, 2001). Music is personal, social, emotional, communicative, historical, part of our identities and an integral part of our cultures. Furthermore, musical experiences have the capacity to foster change, alter or develop the therapeutic process and therefore create different boundary challenges for music therapists.
The results from this critical interpretive synthesis suggest that boundary crossings and themes are present across a variety of contexts, settings, theoretical approaches, cultural settings or populations. Some of the issues presented in this article, such as self-disclosure, intimacy, touch and therapeutic relationships, have been considered in other articles but have perhaps not been conceptualised in terms of boundaries. We suggest that music therapists may benefit from more particular guidance and understanding of boundary management given the multilayered aspects involved when combining music with therapy. Theories from allied fields may provide a good beginning. However, they may not address the complexities of practice, nor are they particularly relevant for contemporary music therapy approaches. Therapeutic boundaries overlap, creating a complex web of boundary issues in music therapy practice that require more research for the continued development of an ethical and professional music therapy practice.

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**References**


## Appendix 1

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Chapter 3
Reflection post-critical interpretive synthesis and additional literature

Introduction

The amount of traditional boundary crossings present in the case studies, in the critical interpretive synthesis surprised me. Interestingly, music therapists described many instances of traditional boundary crossings, including using touch, exchanging gifts, self-disclosing about themselves to their clients and conducting music therapy outside a 'regular' space for therapy. As discussed in the first chapter, boundary crossings, as a concept stem from traditional theories located in a psychotherapeutic, medical or behavioural type approach to therapy (Gutheil & Gabbard, 1993). The number of boundary crossings presented in these case studies could suggest that the boundary theories we are ascribing to may not align with what is occurring in practice.

The case studies presented diverse and fascinating illustrations of music therapy work and often the boundary crossings appeared to support the therapeutic process. The use of self-disclosure in one case study appeared to help develop the therapeutic relationship (Bruggen-Rufi & Vink, 2011), using touch in another appeared to help soothe a client and help the therapeutic process (McKnight & Forinash, 1999), and when conducting music therapy sessions outside a rehabilitation facility, one music therapist was able to help facilitate a woman’s recovery back into the community (Baker, 2011). As such, the presence of the boundary crossings did not appear to compromise the work, and through the author’s descriptions, the process appeared to benefit the people they were working with.

What was also intriguing was how the boundary crossings happened in and around the music. The emergence of musical intimacy as a boundary theme both surprised and confirmed my thoughts. The authors discussed sharing intimate moments through music, which was demonstrated through a) the use of touch (Elefant, 2011; McKnight & Forinash, 1999; Schwartz, 2011), b) the descriptions of meaningful communicating, and c) the 'magic' moments of connection (Ansdell, 2010; Pavlicevic, 2010). Musical intimacy seemed to capture an aspect to music therapy that had not been addressed in the boundary literature. The discovery of this
theme felt right, in that it matched my own experiences of working in music therapy. This naturally led to the need to discover more about musical intimacy and to explore how music therapists negotiated boundaries within this musically intimate context.

The development of musical intimacy from the critical interpretive synthesis triggered the need to re-examine some literature. Through this chapter, I will reflect on the emergence of musical intimacy by contextualising music’s role in the different theoretical approaches in music therapy, while also exploring different theories on the use of music in music therapy. I will continue to identify my assumptions that have shaped this research, situating the research by highlighting my theoretical influences. Through this discussion, I will further reveal the need to examine therapeutic boundaries in and around the music in music therapy. Musical intimacy may be the key element to understand the complexities of boundaries in music therapy practice.

**Music and musical meaning in music therapy**

How do we define and contextualise music in music therapy practice? Music is inherently hard to define due to the many different interpretations and understandings of it. Bruscia, McShane and Burnett (2014) state, “music is product and process, material and experience, real and imaginable, personal, interpersonal, sociocultural and transpersonal” (p. 119). This broad statement describes some of the multilayered aspects in music, which are some ways that music therapists conceptualised it in music therapy. Music is a complex interaction of different elements related to aspects such as culture, spirituality, identity, our personal history and emotion. In a similar statement, Aigen (2005) describes the mechanism in music therapy as “musical forces, musical experiences, musical processes, and structures of music” (p. 51).

Some other music therapists have used theories from related areas to help support and explain our understanding of music in music therapy. One prominent concept is found in Small’s idea of ‘musicking’. Small (1998) provided a seminal leap in broadening our understanding of music’s role in everyday life. He developed the term ‘musicking’ stating: “music is not a thing at all but an activity, something people do” (p. 2). Here, he challenged the conventional understandings of how music was understood, namely of how music was often understood within a Western idealisation of a piece of classical music or product. He further states; “to music is to
take part, in any capacity, in a musical performance, whether by performing, or listening, by rehearsing or practicing, by providing material for performance” (p. 9). This broad definition of the act of ‘musicking’ covers a range of musical experiences that are participated in by individuals in everyday life.

This concept has been particularly influential in the development of culture centred music therapy (Stige, 2002). Drawing on Small’s initial notion, Stige (2002) conceptualised ‘health musicking’, which he described as the “collaboration between the therapist and client that includes ‘musicking’ in relation to health concerns” (p. 210). He further elaborated and defined ‘health musicking’ to include the “appraisal and appropriation of health affordances or arena, agents, activities, and artefacts of a music practice” (p. 211). The ‘arena’ relates to the location or area where health musicking can take place. ‘Agents’ relates to goals or issues that are the focus of the ‘musicking’ and it is through the participation and collaboration of ‘agents’ that afford health possibilities through ‘musicking’. The collaboration between therapist and client for health related goals through the act of ‘musicking’, is how the concept has been integrated into a culturally centred approach. This concept may also be relevant to other music therapy approaches as a way of framing the therapeutic processes.

Tia DeNora has extended Small’s ideas of musicking into concepts of musical identity. She stresses the influence of context and asserts that it is through the interaction of music and a particular context that gives it meaning for individuals. In addition, she describes that it is in the way that music can ‘afford’ us health benefits which contributes to our identity construction. She explains how individuals can see the potential health benefits of particular music and that we will naturally seek out this music. This process helps us to construct our identities through the affordances and appropriations of our individual music. DeNora’s work has expanded Small’s idea of musicking, and as such has been adopted in some music therapy approaches, such as community music therapy. Similarly to these ideas, Frith (2013) asserts that music and identity is a dynamic experience, where music allows a way of shaping identity through the reflection of our views and values. In addition, he explains that this is an evolving process where our musical memories can connect to our emotions and personal history of people and place. This is a construction of our personal identity through the musical memories that contribute to our “imagined cultural narrative” (Frith, 1996). These ideas help us to understand the multilayered
components of how we interact with music and what influence this has on our identity construction. These ideas may also help to understand the complexities of musical intimacy.

Gary Ansdell (2003) has outlined conceptualisations of music in musicology that he believes are relevant to music therapy practice. He describes that music; 1) is not an object but embedded in sociocultural process, 2) is a cultural phenomenon, 3) is socially and culturally constructed in a way that forms its meaning, 4) enacts real emotion, 5) is largely experienced as social participation, and 6) can allow the performance of the self (p. 155-156). These understandings are relevant to music therapy as they detail some of the multifaceted meanings within the music experience. Thinking about music as a multilayered concept could contribute to the development of musical intimacy. Because music is experienced socially, emotionally and is embedded in culture, it may contribute to the intimate interactions that occur in music therapy practice. Through these different theories we can begin to explore the concept of musical intimacy.

Small (1998), De Nora (2000) and Ansdell (2003) have outlined important theories that are used by music therapists to explain and underpin their approaches to music therapy practice. However, there are vast differences in how music is understood and implemented across the different theoretical approaches in music therapy practice. These differences reflect our beliefs in music and the role of music therapy in helping people with their health and well-being. These diverse perspectives and ways of using music may offer different understandings for this new concept of musical intimacy.

**Conceptualisations of music across theoretical approaches.**

The different understandings of music in music therapy influence how we practice and frame our practice. Bruscia et al. (2014) state, “music therapy is not merely the use of music but the use of music experiences” (p. 119). The inclusion of the word experiences is important because it stipulates how music is implemented to involve the individual, process, product and context and the dynamic interactions between them (Bruscia et al., 2014). Furthermore, Bruscia et al. (2014) note that “what makes music therapy unique is the reliance upon music experience as the primary aim, process and outcome of therapy” (p. 120). Therefore the music
experience can be seen as a key element in music therapy practice. This is similar to
the notion of ‘health musicking’ described above by Stige (2002), as the music
experiences in music therapy are guided by health needs, which are worked through
in the therapeutic relationship.

Music experiences in music therapy have been summarised by Bruscia (2014)
to include; “improvising, recreating, composing, and listening to music” (p. 127).
These are common ways in which music is utilised and implemented to support the
therapeutic process and the specific theoretical approach in music therapy practice.
Although they are present in many music therapy frameworks, the way they are
individually conceptualised is often very different. Using improvisation in a
behavioural approach would see improvisation implemented in a measured way to
clearly meet a desired goal set by the therapist. In contrast, in a community music
therapy approach, improvisation may arise more organically through a mutual and
collaborative therapeutic relationship.

The way we define music in music therapy links to our understanding and
belief of how it can be used to help promote health and well-being. As Rolsvjord
(2010) states; “the role of music in music therapy is inevitably related to our
understandings of music” (p. 60). In this way we promote our understanding of music
through the theoretical approaches and methods that we use in our practice.
Furthermore, Ruud (2010) asserts that our ontologies of music, how we
fundamentally conceptualise music, are “constructed and articulated differently within
different music therapy traditions” (p. 54).

Music is conceptualised in a variety of ways across the different theoretical
orientations in music therapy. The use of music in a behavioural approach is tailored
towards the clinical goal, determined by the music therapist and measured over time
to effect change. Music is used “to access emotions and memories, structure
behaviour, and provide social experiences in order to address clinical goals”
(Wheeler, 2014). Bunt and Stige (2014) discuss behavioural music therapy as;
“reductive and predictive, with causal relationships being set up between behaviour,
intervention and therapeutic outcomes” (p. 89). For example, if a client can
consistently hit the drum five times then they are addressing a goal of improving their
fine motor skills. This can be assessed, implemented and evaluated by the music
therapist, who holds the power as the professional helping the individual. Admittedly
these are basic understandings of a behavioural approach to music therapy.
Nevertheless, they highlight the assumptions that these theoretical models place on the value of music as a tool to effect change.

To slightly challenge the behavioural model, Potvin, Bradt and Kesslick (2015) explored symptom care and the experiences of patients with the role of music therapy in palliative care. They state that music therapy research, in cancer care, has mostly focussed on "unidirectional flow from the music intervention to symptom management outcome" (p. 137), summarising a behavioural approach in this context. However, the researchers assert that music is an innately human experience that interacts across human experience and vertically into the depths of the individual experience (p. 138). They suggest that there is much more to the experience of music therapy than the conventional approach allows for. These researchers conducted a randomised controlled trial examining the effect of music therapy verses music medicine on symptom control in cancer care. They separately applied a thematic analysis to interviews that were part of a mixed methods study. The therapeutic relationship emerged as a main theme, including empathy/support, shared experience, interpersonal connectivity and individualised experiences. One participant stated; "not only did I feel the music but I felt the camaraderie between me and her" (p. 152). Another stated "the session with her (music therapist), it was camaraderie! We were singing, we were laughing, it was the interchange but sometimes it would lift your spirits also" (p. 153). These findings may suggest the presence of musical intimacy within the conventional framework of a behavioural model. These researchers have explored the possibilities that surround a behavioural approach by incorporating a holistic perspective that considers the effects of the relationship and human experience.

An alternative view of the way music is used in music therapy is found in psychodynamic music therapy. Psychodynamic music therapy has variations within itself and is understood in different ways. A European approach to psychodynamic music therapy is informed by psychotherapeutic approaches, with a “focus on musical, form-giving exchange between therapist and patient, undertaken during musical improvisation or via listening to music” (De Backer & Sutton, 2014). This is very different from behavioural music therapy, as this model ascribes to the idea that music can express the unconscious or conscious elements of the psyche. In this way, the client’s issues can be worked through and expressed musically between the therapist and client. The model ascribes to psychodynamic thinking, including
psychoanalytic phenomena such as transference, countertransference, holding, containments, projective identification, free floating attention and reverie (De Backer & Sutton, 2014). Many psychodynamic music therapists will use music improvisation to engage the client through dynamic musical interactions, where “experience is felt, and from where thinking begins” (De Backer & Sutton, 2014). Furthermore, Ekkila (2011) states, “music is thought to reflect abstract mental contents in a symbolic way. In particular, emotions, images, associations and memories the music evokes are central” (p. 261).

An example of a European approach to psychodynamic music therapy is found in Campo and Matin’s (2014) presentation of their work with a 13-year-old boy with autism. Here, they assert that musical improvisation is an intermediate area, where the client and therapist creatively interact, through sound and silence. The authors describe the case of Juan, who they described as having fixation and obsessions with certain subjects, one of which was music. They state their goals as; “aiming to convert music into a vehicle for communication and relation instead of something that isolated Juan” (p. 159). They describe the music therapy process with improvisation, as involving mirroring, matching and transitioning from isolation to dialogue and conversation in music. In this example, musical improvisation was used as a space to help Juan process some of his obsessions and move towards communication through music, rather than isolation.

The distinction between behavioural and psychodynamic approaches to music therapy lies in the conceptualisation and beliefs about music. The music experience in behavioural music therapy is viewed as a goal orientated process where music is the means to achieve a non-musical goal. Music is more of an external force that allows greater engagement, helping to achieve health and wellness outcomes. In some psychodynamic music therapy approaches, the therapeutic work happens in and through the dynamic interactions in the music. The ‘needs’ or issues of the individual are expressed and processed within the music space, and in some instances, music is seen as a way of accessing or expressing the inner psyche. Although different in their applications and understandings, these approaches share one similarity; namely, that they both use music (in some way) to achieve non-musical goals. Music is somewhat viewed as a tool that can effect change, whether it is to change behaviour or reflect and work through psychological issues.

Differently, music therapists aligning with music-centred ideals (Aigen, 2005)
emphasise that music making is the main goal in music therapy. When articulating music-centred music therapy, Aigen (2005) states; "the mechanisms of music therapy processes are located in the forces, experiences, processes, and the structures of music" (p. 51). Music-centred music therapy differs from the previous models, the model emphasises the inherent clinical value of musical experiences and honours the client’s experience and motivation to make music, rather than achieve a non-musical goal (Aigen, 2005, p. 55). Placing music-making as the goal sets this approach apart from previously discussed music therapy approaches. Whereas the previous models used music in some way to achieve non-musical goals, music centred music therapy focuses on the music-making as central to the process. Furthermore, Aigen (2005) states; “it is not just that music is the primary response mode of the client, but that musical expression and experience are the actual domains the therapist seeks to act on rather than through (p. 49). Here, Aigen (2005) has described how music centred music therapy, has shifted focus from using music to achieve non-musical goals, to making music experiences as the primary goal and motivation for the client. Health and well-being improvements are thought to be an added benefit to the music-making experience.

A different approach in music therapy is seen in community music therapy. In community music therapy, music is seen as a way to bring communities together, empowering them to improve their health and well-being. Pavlicevic and Ansdell (2004) state, “(community music therapy) tells stories of music as building identities, as a means to empower and install agency (p. 12). This more holistic approach views music as a resource where individuals can use their musical experiences as a form of empowerment and community building. Stige (2010) states; “the participants interest in and love of music is essential, but the shared music-making also relates to concerns for health, human development and equity” (p. 5). Central to this approach is the idea of a mutual and collaborative relationship. Community music therapy moves away from a medical model where the therapist is the expert who holds the power in the therapeutic relationship.

Pavlicevic (2010) discussed a community music therapy project in South Africa. The use of music in this project served to bring communities together through various ‘collaborative musicing experiences’ (Ansdell & Pavlicevic, 2005; Pavlicevic & Ansdell, 2004). Pavlicevic (2010), wishing to portray the power of music, selected ‘magic moments’ that she observed with music during this project. She states;
“overall the magic moments I had a sense of their feeling the flow, sensing the musicking’s energy” (p. 109). These moments appeared organically and involved contributions from the individuals in the project and some support from the music therapists. Through her descriptions, Pavlicevic described the collaborative musicking processes that are present in a community music therapy approach. Here, music is a resource, for the individual and for communities, that may help their health and well-being.

Similarly, to community music therapy, resource orientated music therapy (ROMT) uses music as a resource to empower individuals, thus helping with their health and well-being. Influenced by feminist perspectives and empowerment theories, resource orientated music therapy involves nurturing of strengths, resources and potentials through a collaborative process where music is seen as a health resource (Rolvsjord, 2010). ROMT shares similarities with community music therapy in that it seeks a mutual therapeutic relationship where empowerment through shared musicking is a focus. In addition, ROMT strongly rejects the illness pathology that is prevalent in healthcare settings, noting the way that this disempowers the individuals that we work with.

Through these diverse music therapy models, we can see distinctions in how each one conceptualises music. These concepts of music determine the implementation, the use, and the belief in what value music has for individuals or communities in their health and well-being. It is interesting to reflect on these distinctions, especially given the focus of this research on the new term of musical intimacy.

**Research design**

The emergence of musical intimacy set in motion the focus for this research. This felt right to me, as I had always sensed that there was something about music and boundaries in music therapy. At the beginning of this process, I did not have the language to describe what this was. Through the process of doing the CIS, I was able to identify an area of music therapy practice that influences boundaries in a myriad of ways. This discovery allowed me to focus the research on an area that is unique to music therapy, yet also creates complexities with boundaries. This focus felt fitting for where music therapy is, where it is going and my own influences on this research.
Research question.

The critical interpretive synthesis led me to develop the following research question. “How do music therapists negotiate the boundary challenges that can occur in the musically intimate context of practice?” I used the word ‘negotiate’ as I was interested to see what actions and processes music therapists were using to manage the boundary challenges in and around music in their work. I used the term ‘boundary challenges’ as I believed, informed by the CIS, that musical intimacy contained challenges for music therapists. This was an assumption, that I held in the initial stages of the research, which informed some of the questions during the data collection stage. In addition, I was keenly interested in exploring the concept of musical intimacy. Did this concept resonate with music therapists and could they relate to it, using examples from their practice? This research question allowed me to focus on musical intimacy and the therapeutic boundaries that may surround that.

Conclusion

This chapter has detailed my reflections on the critical interpretive synthesis. Through this, I have explored more literature around the concept of musical intimacy, which has included different theories on music and discussion on the way that music is viewed in different theoretical orientations. The critical interpretive synthesis led me to focus this research on the topic of musical intimacy and the boundary challenges that can occur around that. The next chapter will detail my methodological choices for this research, as well as details about the participants and analysis process.
References


Chapter 4
Method chapter

In this chapter I will outline the methodological choices and philosophical underpinnings that have informed this research. I will discuss my choice of research methods, detail the participants involved in this study and describe the analysis process. Through each of these components, I will highlight my assumptions and beliefs about research in order to be transparent about the way this research was constructed and how this influenced the findings presented in later chapters.

My own beliefs about research

My philosophy of research underpins this research, which includes values and beliefs about how knowledge is gathered, analysed, consumed and valued (Ruud, 2010). In the context of this study, my values place me in a qualitative paradigm aligning with subjective and interpretative understandings of research. Merriam (2014) states, “qualitative researchers are interested in understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences” (p. 6). Correspondingly, I value the individual experience, believe in multiple truths and seek to let the ideas emerge from data.

Within the philosophy of research are my ontological and epistemological assumptions. Ontology refers to each person’s understanding of reality and epistemology refers to the nature of knowledge (Merriam, 2014). Building on these ideas, Holden and Lynch (2004) state:

The researcher’s view of ontology effects their epistemological persuasion which, in turn, effects their view of human nature; consequently, choice of methodology logically follows the assumptions the researcher has already made. (p. 398)

This statement illustrates how our ontological and epistemological views influence each step in the research process, culminating in the particular style of research and methods used. I endeavoured to highlight my own ontological and epistemological assumptions in the introduction chapter of this thesis.
These underpinnings have led to a unique interpretation of the literature and construction of the experiences gathered in this research. Rather than bracketing my assumptions as some traditions of qualitative research suggest (Husserl, 1973), I have used them as a resource to extend and enhance the process, and expand the understandings of the findings in this research (Charmaz, 2014). This is consistent with qualitative thinking, as Holden and Lynch (2004) state, “the involvement of the researcher should be actively encouraged” (p. 12).

**Why grounded theory?**

I selected a grounded theory design to enable a deeper exploration and interrogation into the music therapist’s experience, aiming to build a new theory of musical intimacy and boundaries. The intricacies of music, musical intimacy and boundaries are grounded in the understandings and constructed realities of individuals and therefore align well with a constructivist grounded theory approach (Charmaz, 2014). As the concept of musical intimacy and boundaries had not been explored, I felt an open-ended yet directive approach that is shaped by emergent themes was appropriate. This would allow the subjective actions and processes around musical intimacy and boundaries to be examined in detail.

Other qualitative methodologies were considered for this research, including phenomenology. Phenomenology is the study of the lived experience, which aims to capture the essence through a distillation of the participant’s data (Heidegger & Dahlstrom, 2005; Husserl, 1973). Phenomenology allows a deep exploration into the lived experience of a phenomenon. Phenomenology would have allowed for an interesting exploration into the concept of musical intimacy and boundaries, as the participants experience would emerge and reveal some stimulating insights. Additionally, it would have provided a detailed essence of the music therapist’s experience, thus helping to define and reveal musical intimacy. However, I felt that a more interrogative and directive approach was needed to really uncover the intricacies and implicit assumptions surrounding music intimacy and boundaries. Grounded theory provided a methodology that allows questioning and probing strategies to reveal the underlying workings of these concepts.

The need to develop, with these concepts, an indigenous music therapy theory was important and aligned with a grounded theory approach. The need for indigenous
music therapy theory has been discussed by some music therapy scholars (Aigen, 1991, 2013; Bruscia, 2014a). Three of the most common indigenous music therapy theories were developed primarily as clinical approaches; Nordoff-Robbins music therapy (Nordoff, Robbins, & Marcus, 2007), analytical music therapy (Eschen, 2002) and guided imagery and music (Bruscia & Grocke, 2002). These approaches were developed experientially and were some of the most detailed clinical approaches available. However, they lacked an overarching theory to detail common procedures and protocols. Aigen (2013) notes more recently that music therapy theories have been developed to explain practice rather than dictate it (p. 219).

According to Strauss and Corbin (1998), the word “theory” is used to determine relationships that exist among concepts coming from the data. A theory supports the different understandings of the social world by revealing concepts and categories, and how they interact with each other. Similarly, El Hussein et al. (2014) asserts that a theory, is a statement regarding possible relationships among categories about a phenomenon that facilitates the comprehension of a social world (El Hussein et al., 2014, p. 8). Grounded theory methodology provided an approach to this research that would allow a greater exploration, while aiming to create an indigenous music therapy theory that begins to explain the intricacies of musical intimacy and boundaries.

**Grounded theory beginnings and current understandings**

Grounded theory is a research design where researchers create theory from data using interrogative and iterative analysis processes. It is a research method that has been widely adopted across different paradigms. Two sociologists Glaser and Strauss (1967) introduced the concepts of grounded theory. Their publication (Glaser & Strauss, 1967) grew out of their criticism of both quantitative and qualitative research methods, where they noted an embarrassing gap between theory and empirical research. In this text, they pioneered the basis for what we understand grounded theory to include today by describing how data collection and analysis could occur alongside each other, creating a process where emerging themes inform the subsequent data collection. They proposed processes such as theoretical sampling, coding, constant comparison between data and analysis, saturation and memo writing (Glaser & Strauss, 1967), which have become synonymous with the
broad understanding of grounded theory today.

One of the defining features of a grounded theory approach is the interaction between data and analysis (Glaser & Strauss, 1967). Researchers engage in iterative processes where data is gathered and analysed, which then informs the subsequent data collection. Alongside the interaction between data and analysis is the process of theoretical sampling. Theoretical sampling is a grounded theory technique that is widely adopted for grounded theory studies. It is the process of gathering new data according to the developing theory needs (Strauss & Corbin, 1998). If data is gathered through interviews, then theoretical sampling involves selecting participants who either expand or develop the emerging theory. Through the process of theoretical sampling, the notion of saturation is achieved. Saturation is the concept where no new themes emerge from the data (Strauss & Corbin, 1998). By exploring different perspectives and expanding on the emerging theory through theoretical sampling, the grounded theory researchers reach a point where there are no new concepts emerging from the data. It is at this point where grounded theorists will stop gathering more data and focus on developing the emergent findings into a theory.

In the early developments of grounded theory, Glaser and Strauss proposed that a high quality grounded theory study should have a close fit with the data, durability over time, be useful, and have explanatory power (Glaser & Strauss, 1967). Through these concepts, they were challenging ideas that qualitative research was fundamentally unreliable as a scientific method of inquiry. They provided one of the first approaches to qualitative research that included systematic and rigorous procedures. Glaser and Strauss (1967) urged grounded theorists to refrain from engaging in any literature but rather that they should let new ideas emerge from the data.

The development of grounded theory came at a critical point in the history of qualitative methodologies. Charmaz states; “by the mid 1960’s, the long tradition of qualitative research in sociology waned as sophisticated quantitative methods gained dominance in the US” (p. 41). Within this quantitative context, the introduction of grounded theory did not initially make waves. It was not until some years later that it began to gain popularity and some researchers became convinced of the value and credibility of qualitative approaches. Although seen as essentially qualitative, Glaser and Strauss’s (1967) classic grounded theory is actually post-positivistic in its approach. Higginbottom and Lauridsen (2014) state:
Grounded theory’s alignment with post-positivist ideals, including the belief in the existence of one reality and in researcher objectivity is echoed throughout the writings of Glaser and Strauss (1967) and Glaser (1978). (p. 9).

This suggests that the original Glaser and Strauss (1967) approach to grounded theory is one of the most ‘quantitative’ styles of qualitative research, which has left it open to criticism from those situated in a qualitative paradigm.

Following the introduction of grounded theory, Glaser and Strauss began to differ in their opinions of what grounded theory is and should be. Kenny and Fourie (2014) state, “as Glaser and Strauss continued to mature grounded theory, their progression precipitated professional and methodological divergence” (p. 4). Glaser remained loyal to his training and aligned with a quantitative positivist paradigm, whereas Strauss began to more strongly embrace a qualitative interpretive paradigm (Annells, 1997). One of their fundamental debates was around the notion of verification. Verification is the process whereby the emergent theory is verified with participants or external sources. Strauss (1987) believed that induction, deduction and verification were essential, whereas Glaser (Glaser) continued to assert that grounded theory is inductive only through an objective stance to the data (Cooney, 2010).

Through these differing approaches Glaser developed his own text ‘Doing grounded theory: issues and discussions’ (Glaser, 1998), and Strauss teamed up with Juliet Corbin to produce ‘Basics of qualitative research: techniques and procedures for developing grounded theory’ (Strauss & Corbin).

Strauss and Corbin’s (Corbin & Strauss, 2008; Strauss & Corbin, 1990) writings provided a seminal leap in the grounded theory story proposing alternative concepts about how grounded theory can be implemented. They challenged the notion of refraining from literature until after analysis, developed a methodical and rigorous coding process and stated that theory should be discovered by the researcher rather than let to emerge naturally (Strauss & Corbin, 1990). They received scathing responses from Glaser (1998) criticizing their work describing it as a forced, full, conceptual description. They have since published a 2nd and 3rd edition (Annells, 1997 2008) where they describe their approach as suggested techniques and guidelines that is more flexible (Corbin & Strauss, 2008). Their approach is often called Straussian grounded theory, while Glaser remains firmly in his original beliefs and is known as Classic or Glaserian grounded theory (Kenny & Fourie, 2014;
In Corbin and Strauss’s most recent edition (2008), they have incorporated some current theories on research and grounded theory, namely, from Kathy Charmaz’s work on constructivist grounded theory (Charmaz, 2014). The movement towards constructivist grounded theory shares similarities with developments in phenomenological research. One of the major shifts in thinking for grounded theory is that research is constructed rather than discovered. In a phenomenological approach, researchers aim to explore the lived experience for their participants (Heidegger & Dahlstrom, 2005). Similar to grounded theory, phenomenology has distinct schools of thought, descriptive and interpretative (Tuohy, Cooney, Dowling, Murphy, & Sixsmith, 2013). Descriptive phenomenology is most associated with the works of Edmund Hursell (1973). This methodology aims to describe the lived experience as it appears in conscious thought (Moran, 2000). Differently, interpretative phenomenological analysis (IPA) acknowledges that an experience cannot be simply extracted from an individual, but “that it involves processes of engagement and interpretation on the part of the researcher” (Smith & Shinebourne, 2012, p. 73). IPA and constructivist grounded theory share similarities in the inclusion and understanding of the role of the researcher in constructing and interpreting the experience of the participant.

Constructivist grounded theory is the latest development in the grounded theory story. Charmaz (2014) states:

If we start with the assumption that social reality is multiple, processual, and constructed, then we must take the researcher’s position, privileges, perspective, and interactions into account as an inherent part of the research reality. (p. 32)

Constructivist grounded theory delves into the participants multiple perspectives and interrogates them, aiming to create a theory. Additionally, researchers in this type of research assume that the observer’s values, priorities, positions and actions affect their views throughout the research process (Charmaz, 2014). Therefore, constructivist grounded theory allows the researcher to learn and interpret nuances of meaning and action, to construct an interpretive rendering of the realities we study rather than an external reporting of events and statements (Charmaz, 2014, p. 645).

Reflexivity is embedded within grounded theory, which is heightened in a constructivist approach. Reflexivity as a process, has developed into an essential
Reflexivity is the process that asks, “How does who I am, who I have been, who I think I am, and how I feel affect data collection and analysis” (Pillow, 2003, p. 176). Reflexivity has evolved through many phases and is often defined differently by its use and implementation in qualitative research. Some argue that a structured approach to reflexivity, which affirms the validity of the research, is seen as a step back towards positivist ideals (Linda, 2002; Pillow, 2003). Others argue that being too descriptive can make reflexivity a cathartic indulgence by the researcher which does not ultimately improve the research (Lynch, 2000). I believe that being reflexive provides insight into how knowledge is produced, making the link between research, data, analysis and the emergent findings clear (Pillow, 2003).

Glasserian (Glaser and Strauss, 1967; Glaser, 1978), Straussian (Strauss and Corbin, 1990, 1998; Corbin and Strauss, 2008) and Constructivist grounded theory (Charmaz, 2006, 2014) are the three main paradigms in grounded theory. In describing the different approaches to grounded theory Charmaz (2014) states:

We may have different standpoints and conceptual agendas yet we all begin with inductive logic, subject our data to rigorous comparative analysis, aim to develop theoretical analyses, and value grounded theory studies for informing policy and practice. (p. 55)

In this research, I have combined elements from both a Straussian approach and constructivist grounded theory. I have incorporated foundations in constructivist grounded theory approach, as I believe in the constructed nature of qualitative research and have actively used and reflected on my influence on the process (Charmaz, 2014).

The belief in constructivist grounded theory that our participants are constructing their reality and in turn we are also constructing our interpretations, is an important concept in this research (Charmaz, 2014). Glaser’s notion of an objectivist stance in grounded theory (Glaser and Strauss, 1967; Glaser, 1978) aligns too closely with positivist ideals about research. As discussed above, my philosophy of research is aligned with qualitative methodologies, valuing the individual experience and believing in multiple realities. Here it is evident how my ontological and epistemological positions have informed the research method, in choosing to align with a constructivist grounded theory approach.

I will demonstrate, through this discussion of the procedures and analysis, how
this grounded theory study is fundamentally constructivist, but has used strategies from Straussian approaches, as methods for analysing and looking at the data from another perspective. At times, I stepped outside the data to gain new perspectives, and, at other times, I dived in to examine the nuance elements of the data. In this way, I was able to see how the participants and myself as researcher, were both constructing these experiences.

Participants and interviews

In this next section I will detail the processes used for gathering participants. I will also present the style of interviewing that was used throughout the data collection process. Following this, the participants’ demographics and narrative stories will be presented.

Sampling of participants, participant criteria and recruitment process.

In grounded theory discourse theoretical sampling is a common process. Theoretical sampling is the process where participants are selected according to the emergent themes and ideas in initial analysis (Charmaz, 2014; Strauss & Corbin, 1998). This process allows the researcher to gather new data from participants who will add to the emerging theory by reaffirming emergent themes or contrasting with new undiscovered areas. This also allows the researcher to look for data that will challenge the emerging theories or fill in areas that are lacking, by looking for specific participants to match these needs. Through this process the research reaches a point of saturation where no new data is emerging and the researcher can stop collection and begin the next stages of analysis (Charmaz, 2014).

In this study, theoretical sampling as it is understood in grounded theory was not implemented in the traditional way. The main way that it differed was that the participants were mostly recruited at the start of the interview process. As the participants were from diverse locations around the world, there were logistical reasons for gathering the participants during the planning stages of the intended research trip. In order to successfully reach the different countries and gather the interviews, I needed to know where the participants were and how many participants were in each location. Unfortunately, this did not allow for an emergent process of
selecting participants that matched or challenged the emerging theories.

Participants included 20 music therapists from a range of international locations. This involved locations in the USA, Canada, Europe and Australia. The criteria for each music therapist were for them to have been practicing for at least five years and be currently working. This meant that participants would have a range of experience and work in a variety of areas. These criteria were chosen to gather a wide range of experience on this topic, as the concepts appeared multilayered and complex. I felt that gathering a range of international and theoretical perspectives would enable a greater understanding of musical intimacy and boundaries.

Participants were recruited through contacts of the primary supervisor of this project. The supervisor’s contacts were sent an email asking them to assist in the recruitment process in their local area. If they agreed, they were asked to send information about this study to their music therapy contacts in their local area. This included the plain language statement and information about how to contact the student researcher if they were interested in participating (Appendix E, Appendix F). For some contacts, this included sending to specific music therapists that they thought would be interested in participating in the study. For others it was a case of sending to the whole network of music therapists in their area. I then received emails from interested participants and was able to set up times in each location to conduct the interviews. Before contacting any potential recruiters, this research gained ethics approval from the University of Melbourne (Appendix D).

**Interviews.**

*Approach to interviews.*

Interviews were selected as the method of data collection for this study. As Kvale (2009) states, “interviews attempt to understand the world from the subjects point of view, to unfold the meanings of their experiences, to uncover their lived world prior to scientific explanations” (p. 1). The interview process is a popular qualitative method of gathering data, as it has the potential to gather rich data that can be used in many qualitative methods. Intensive interviews were used to collect data in this study. Intensive interviews allow an in-depth examination of a specific phenomenon and are “open but directed, shaped yet emergent, and paced yet
unrestricted, which makes it an ideal fit for grounded theory” (Charmaz, 2014, p. 187). Intensive interviews were felt to match the constructivist grounded theory approach due to their open yet interrogative nature.

**Interview guide and process.**

An interview guide was used at the beginning of the data collection process (Appendix G). Each interview began with asking questions about the participant’s background and their experience of working as a music therapist. This was necessary to build the relationship and to understand more about each participant. The participant was given the option to reflect on why they had chosen to take part in the interview. This was to give them the opportunity to speak openly about the topic or to uncover any experiences or thoughts that they had had prior to the interview.

The participants were not given much information about the topic before the interview. This was intentional, as I wanted to let their experiences emerge through a more organic process that was grounded in their experience. The questions focussed on their experiences of musical intimacy and what that might look like in their experience. I asked for examples and details about these experiences. This naturally led to questions around boundaries and musical intimacy, and some questions about challenging experiences with musical intimacy. Some participants started with questions around boundaries, as this was what drew them to participate in the research. The interviews were flexible yet directive to go along with ideas presented by the participant but also answer the research question.

In addition, Wilber’s (2007) quadrant thinking map was used to guide the interview process. This was a way to structure the interview questions to allow the participant to view their responses from different perspectives. The quadrant thinking has four areas that include, the self and consciousness, behavioural, cultural and worldview and the social perspective. These four areas are also examined from the ‘inside’ and the ‘outside’ perspective. As this is such a complex topic, this provided the opportunity for the participants to view their experience from another viewpoint. The quadrant thinking provided a way for the participants to un-pack their experiences and therefore deepen the understanding of musical intimacy and therapeutic boundaries. As fitting with the constructivist grounded theory approach, this research is focussed on un-packing the actions and processes that underpin these
concepts. In this way, the process “lets the data reveal what lies beneath the surface of the experience by helping the participant to view it from different angles” (Charmaz, 2006, p. 19).

**Reflexivity and initial analysis during the interviews.**

During the interview process I felt that it was important to be reflexive to continually reveal my influence on the data collection process. The interviews were conducted in person in the town or city where the participant worked. Reflexivity and initial analysis was conducted during the data collection period of three months. This included, 1) ‘memoing’ about the interview questions and the participants’ responses after each interview, 2) reflecting about the interview dynamics and the process, and 3) mapping of emerging themes to reflect on what was emerging and what could be further explored. Through these processes, I was aiming to explore my own impressions and assumptions that may be influencing the research, using the researcher as a helpful addition to the process.

The reflexive grounded theory technique of ‘memoing’ was used throughout data collection, analysis and the writing up of this research. Charmaz (2014) describes how memo writing “provides space to become actively engaged in your materials, to develop your own ideas, fine tune subsequent data-gathering, and to engage in critical reflexivity” (p. 324). Memoing serves as an essential link between data and theory generation (Charmaz, 2014). Additionally, it provides one useful method for incorporating reflexivity into the research. During the interview process, memoing helped me to reflect on, 1) my impressions of the participants, 2) the interview process and questions, 3) the initial analysis process, and 4) the construction of theory. More of the reflexive strategies will be outlined in the following sections in this chapter.

Here is an example of a memo documenting my initial impressions of one participant.

She saw things not in a linear way. They merged and maybe that's why I was having trouble really following her. In other interviews it felt much easier to follow and hear the key ideas to follow up on and pick up on how the participant was responding to the questions and me. Maybe she had a lot of protective barriers? She felt a little
guarded at times and I wondered, given that she is a lecturer, whether she saw me more as a student? I definitely felt like a student with her. Maybe that speaks to the nature of this topic being very complicated and personal at times. Maybe she felt she couldn’t share as much with me.

Through this example, it is evident how I struggled with the process and the relationship dynamics in this interview. Through this reflexive memoing, I was able to explore my own feelings during the interview and examine how this may influence the later analysis. It also made me aware of the barriers that I felt and begin to explore what they might mean.

In this next example I was reflecting on the themes that were coming up in the interviews.

This music therapist was very analytical and she had thought about the topic a lot. She had asked for the questions beforehand and had made some notes on all of them. I found myself saying in her interview that other music therapists had talked about what she was talking about. The ideas she was saying were starting to sound very familiar. Except she had a great way of describing the 'moments' in music therapy that I believe was linked to musical intimacy. She described that they are when the clock stops and you are completely there in the moment with the client.

This was participant thirteen and it is clear that I was beginning to hear repetitions of experiences from the participants. Here, I was able to identify that themes were starting to repeat themselves. This allowed me to reflect on what those themes were and to focus the following interviews on some different areas. Through this process, I was able to identify this but also note the new ideas that she presented.

**Demographic information.**

The following is a list of the demographic information of the participants. To minimise the chance of recognition, each participant’s demographic information is grouped together. This should provide an overview of the information needed to give an understanding of the types of participants involved in this study.

1. Participants were located in Australia (3), USA (5), Canada (2), UK (3), Denmark (3) and Norway (4).
2. The range of experience was from 6 to 34 years.

3. The main theoretical orientations described by the participants included; psychodynamic (12 participants), humanistic (13 participants), creative music therapy (5 participants), community music therapy (2 participants), resource orientated music therapy (1 participant), developmental (1 participant) and neurological music therapy (1 participant). All except one music therapist identified as using two or more theoretical approaches in combination.

4. Settings that the participants worked in included; early childhood (6 participants), mental health (9 participants), palliative care (2 participants), aged care (2 participants), adults in prison (1 participant), adolescents (2 participants), forensic psychiatry (2 participants), stroke rehabilitation (2 participants), and special education (4 participants). All except one music therapist identified as working in two or more areas.

This demographic information will not be linked with narrative stories to protect participant identities.

**Narrative stories from participants.**

To give more depth and understanding about the participants in this study, I am including the narrative stories from each participant here. Although these were part of the analysis and form part of the findings, they also serve to provide valuable information about the participants and their own individual experiences. These are presented in no particular order and any information that may make the participant known has been removed. These vary in length as some participants shared more about their story as a music therapist than others. The analysis process for these narrative stories will be explained later in this chapter, when I detail all of the analysis processes.

**Participant one.**

Mike has been working as a music therapist for 14 years. When he studied music therapy his course was just beginning, so there was a lot of collaboration involved. He was trained to work from his intuition and still works that way now. He describes his approach as eclectic including psychodynamic,
humanistic and existential elements. He works a lot in private practice. He feels that music provides a great emotional outlet where no one gets hurt. He believes that you can have vicious fights in the music, but no one gets hurt. He believes this is one of the powers of music.

*Participant two.*

Sharon has been working as a music therapist for 15 years. She has worked mainly in forensic psychiatry and with people with mental health issues. She feels there are two main aspects to musical intimacy, which are emotional intimacy and physical intimacy. For Sharon, music can trigger emotion, create close connections and deepen the therapeutic relationship. She has seen musically induced anger, where something in the music triggers an angry response. She feels that her patients relate to her more easily because she is a musician. She feels that there is a great power in music and that music therapists need to be aware of this. She tries to have an unconditional positive regard for her patients and tries to be more human and authentic with them. She will address issues in the moment and she will use reflection and supervision afterwards. She also needs to be very aware of her boundaries and what is ok and not ok for her personally.

*Participant three.*

Sarah has been working as a music therapist for 16 years. She has worked in a NICU in a children’s hospital and now works in the community with young children and their families. She feels that her approach and philosophy to practice is much more aligned with her current work in the community. In the hospital she never felt completely comfortable with how her approach aligned with the hospital environment. She feels that connecting through music can be powerful and it is a human interaction. In the NICU she tried to be authentic and human to create the connections. In the community she had to rethink her boundaries. She is closer to the mothers in her group because she is part of the same community. She also feels that when they sign up to her groups they are not just wanting the group but they want to know her as well. She has found no
problem with this approach and finds that it aligns more with her own philosophy and practice.

*Participant four.*

Jessica has been working as a music therapist for 13 years. Most of her work has been with people who have suffered abuse or trauma. She works a lot with improvisation and is trained as a psychodynamic music therapist. She feels musical intimacy can be a very multisensory experience and can include moments where you feel like you’re in an altered state. For her, it's moments when you feel like something magical or transformative is happening. She creates safety in the musical structures, being careful not to go too deep too quickly. She had a strong experience in her training where she felt a client dissociated in the music and went too deep too quick. She learnt from this and it informs her pedagogy in teaching music therapy students. She will constantly check in musically and verbally and gets a lot of information about someone from how they are interacting in the music.

*Participant five.*

Emily has been a music therapist for 6 years. She has mainly worked in special education and some private practice work. For her, making music is intimate and can lead to a musical being togetherness that is hard to describe. She encourages these moments and feels that they deepen the therapeutic relationship.

*Participant six.*

Tom has been a music therapist for 8 years. He has worked mainly in an aged care facility. For him, music can be highly personal, especially when choosing music that is meaningful for his clients. He has seen strong emotional responses to music and will always check in verbally with the client to make sure they are all right.
**Participant seven.**

Maria has been a music therapist for 34 years. She works from a psychodynamic approach and uses a lot of improvisation. She finds it very easy to create intimacy when using music. For her, music can open up things for her clients a lot quicker than verbal psychotherapy. Music can promote feelings of love and she remembers one client who fell in love with her. She addressed this and helped that client to direct that love towards himself. She uses parameters in the music to create safety and predictability. She will record sessions to later analyse and uses supervision if there are any issues that she needs to address. She operates with the phenomenon of musical transference, where things are passed and picked up on in the music. She will bring this up with her client if she feels it will serve the therapeutic process.

**Participant eight.**

Amanda has been working as a music therapist for 8 years. She works mainly with children and infants with special needs, and in aged care. Her approach to music therapy has changed over her career. She was trained in creative music therapy and was challenged when she couldn’t replicate this approach in practice. She now uses an eclectic style of music therapy that uses elements from humanistic and psychodynamic approaches. For Amanda, musical intimacy is those times when time stands still and is the truest point of connection. She feels that these moments can deepen the therapeutic relationship. She uses her intuition to guide her and she tries to be authentic with her clients. She will reflect on what is happening with her clients and uses supervision to address any other issues.

**Participant nine.**

Andrew has been working as a music therapist for 16 years. He has worked with people in prison and, also, once they have left prison. He uses a community music therapy approach and he has also been involved in an action research project with ex-inmates. He has thought a lot about intimacy in this
context as he often works in the participant’s homes or in their local community. He feels they are very close and has had experiences when they are very connected in the music. They have a band community and he described some very strong performance experiences where the band was really connecting with the audience. In this context, Andrew has to be very reflective about the process.

_Participant 10._

Shawn has been working as a music therapist for 13 years. He has been working in the mental health area and has had to develop his own approach, as music therapy wasn't traditionally practiced in this area.

_Participant 11._

Lisa has been working a music therapist for 6 years. Her first role was in a school in an environment that she found challenging. She found the staff attitude towards the students and herself was very unsupportive, which made her want to connect and provide more support for the students. She found herself in a 'band community" with some of the students, which lead to some boundary issues. She had to leave the job because she felt unsupported and unsafe in that work environment. At a new school, she felt very well supported and was able to work in a way that suited her. She found it to be such a relief that she was working with people who had the same approach to the students as she did. She has reflected a lot about her first experience and feels happy that she is now working in a supportive environment.

_Participant 12._

Cheryl has been working as a music therapist for 27 years and at her current role for 26 of them. She works in a facility for adults with intellectual disabilities. Over the years she has had to deal with a lot at her work and has developed strategies to protect herself and her clients. She has a strong sense of where her boundaries are, but is flexible and strives to create a connection with her clients.
Participant 13.

Hannah has been working as a music therapist for 25 years. She used to be quite strict with her boundaries when she first began but now she follows her intuition a lot more. It is important for her to know what her own boundaries are and she will tell this to music therapy students. She uses everything she can to get in touch with her clients as they often only have very small signals. She feels music therapy is about creating a close connection with her clients.

Participant 14.

Michele has been a music therapist for 28 years and currently works in a setting that provides support for children, adolescents and adults with intellectual disabilities, learning disabilities, autism, mental health issues, trauma and dementia. With children, she will set up the session as being quite structured but is happy to follow her gut and change the direction to follow the client. She feels that the music therapy room provides a safe container for her clients to express themselves without judgement. She used to say that everything in that room was between her and her client but she had a couple of experiences where she had to change that. She reflects a lot about her work and this helps her to keep defined what she is working on. Sometimes, if things feel like they are going in a different direction, she will step back and reassess what her goals are.

Participant 15.

Dianne has been a music therapist for 33 years. She has worked with people with a variety of issues. She feels that music is a way to become intimate very quickly and she is careful to respect that. In the moments of making music with her clients she is doing a lot. She is checking in, both musically and verbally, she is rolling out the red carpet of choice, she constantly assessing to see if they are ok and thinking where should they go next. She will address any issues that come up straight away. She gets a lot of information from how someone is reacting to her and the music. She feels that music is a very profound way to
connect.

**Participant 16.**

Roy has been a music therapist for 28 years. He currently works in an outreach facility for adults with mental health problems but has worked with most populations that music therapists can work with. He loves his job because he feels he is doing great work. His groups have a great reputation in the community and people will try to come to this facility just so they can be a part of it. He feels the groups run themselves because the members really care about it. When he first started as a music therapist he stuck very much to what he had learnt in his training. He felt he wasn't doing such great work and he didn't have so much confidence. He got to the point where he almost left music therapy and started a new career in IT. When he came back he started trying things in his own way. Gradually his confidence built and he remembers one client in particular. He was working with a child with autism and he got great feedback from the social worker and his mother saying that the child has turned into a ‘different kid’. After this he began taking all kinds of work and his confidence was building and building. He also started developing his own approach and starting to write it down into the format of a book. He now feels comfortable to share things with his clients, talk about topics such as religion and to really connect with his clients while playing music. He trusts his intuition and he has not had a problem with it at all.

**Participant 17.**

Ruth has been a music therapist for 22 years and is currently working in palliative care. She feels that her boundaries are pretty straightforward as they are clear in the context that she works in and she is supported by her workplace. She has experienced people having strong emotional reactions to music so she will introduce the music slowly. In some ways she feels that music has no boundaries. She can be working with a client playing or writing a song and then hear it later on when she is in the supermarket. For her this is a positive thing that adds to the life of the music.
Participant 18.

Mary has been a music therapist for 7 years. She currently works in forensic psychiatry and with children with developmental needs. Within her work, forensic psychiatry, she finds it helpful that there are boundaries set in place by the facility. Sometimes the intimacy created through the musical experiences can be surprising for her and her clients. She remembers one group where they spontaneously created a song where the group members sang about personal experiences in their life. This felt intimate in the room and she felt that if someone else had come into the room at that point, it would have been very intrusive. She finds that with her work with children, sometimes they are testing her. She has three rules with children, don't hurt yourself, don't hurt me and don't hurt the instruments. She had one boy who broke an instrument and then thought that he could have it. She said no and he became very angry, but she felt that this was a test of their relationship to see if she could handle his anger. She is glad of the support from the organisation where she works. She has agreements with her clients, which she has found helpful sometimes when some of her boundaries have been challenged.

Participant 19.

Graham has been a music therapist for 17 years and was originally trained in the Nordoff Robbins approach. He has worked a lot with children with intellectual disabilities as he found he had some special skills in this area. He finds that he can really connect with the children through music. He also works in aged care and likes to have fun with the residents. He will bring out all of the old songs, which will sometimes bring up very real experiences for his clients. He likes to joke with them and finds that a lot of the intimacy can happen with humour. He had a personal experience where he had an accident and had to re learn many things. This seems to have impacted his approach and he talks about one client who suffered a similar accident. He worked with this person for a long time and still remains friends with the family.
Participant 20.

Rachael has been working as a music therapist for 13 years. She currently works in a facility with people who have dementia, ABI and intellectual disabilities. She has been at her current workplace for over ten years. She feels well set up in this workplace by the staff and the facility. She has a music therapy room which she feels has a great impact on the therapeutic process. She feels that her clients can really relax in this room because it is away from the rest of the facility. She feels that her work on the palliative ward can be very intimate because she is in their personal space and using music within that. She feels that those patients can be more vulnerable as there isn't really the same safety there for them. She thinks carefully about which songs she will play in that space because even something as simple as 'you are my sunshine’ can be very intense emotionally for people.

Analysis process

The analysis was an evolving and interactive process that moved back and forth between data and the emerging themes, which is consistent with the grounded theory approach. It was heavily influenced by processes aligning with constructivist grounded theory (Charmaz, 2014), however, some of the analytic strategies implemented stem from the Straussarian approach to grounded theory (Corbin & Strauss, 2008; Strauss & Corbin, 1998). These strategies were used to view the data from another perspective and to examine trends or themes that may have been blocked or shaded through my own assumptions and beliefs about this research. In addition, a phenomenological approach was used to create the grounded essence of the musical intimacy experience.

The analysis included the following steps; 1) initial analysis conducted alongside data collection, 2) line by line coding, 3) initial coding and focussed coding using descriptive statistics, 4) musical intimacy distillations, 5) conditional matrix, 6) narrative stories, 7) formation of grounded essence of musical intimacy experience, 8) theoretical coding, and 9) synthesizing to form theoretical framework (see Figure 4.0). It is important to stress that these processes were not conducted in order, I often moved back fourth between different analysis stages, as is incongruent with a
grounded theory approach. Figure 4.0 demonstrates the iterative and cyclic process that occurred during the analysis. Data collection and initial analysis occurred alongside each other. Following this were the analysis processes of initial coding, focussed coding and different analytic strategies. Underpinning all of these processes was the grounded theory technique of ‘memoing’, and also other reflexive strategies. Finally all of these analysis processes were synthesized to form the theoretical framework. I will now outline each of these processes, using examples of how the analysis process was applied to the data.

**Initial analysis conducted alongside interviews.**

Some initial analysis was conducted alongside the interviews, as mentioned in the above section detailing the interview process. This analysis process served as the starting point for further analysis, some key themes were identified and set aside for further exploration. To reiterate, the following processes were undertaken during this stage, they included; 1) ‘memoing’ about the interview questions and the participants’ responses after each interview, 2) reflecting about the interview dynamics and the process, 3) mapping of emerging themes to reflect on what was emerging and what could be further explored. As these were explained previously in this chapter; I will now detail the remaining analysis processes.
Initial coding - line by line coding.

Line by line coding is a process where each line of data is examined for potential emergent ideas (Glaser, 1978). This process allows the researcher to see nuances in the data and prompts you to remain open to concepts that may otherwise have not been seen (Charmaz, 2014). Charmaz (2014) explains that this process can allow you to “break up the data, define the actions, look for assumptions, examine explicit actions and meanings and identify gaps in the data” (p. 260).

Each interview was coded using line by line coding, after all the interviews were completed and transcribed. Through this process and the analysis that was conducted alongside the interviews, key themes and ideas began to emerge. Furthermore, this process allowed me to reveal the actions and processes that each participant was describing. In one example, I highlighted the following line, “You support what you hear and create that intimate space umm, and reinforce that” (participant five). Within this one line I was able to pull out different processes relating to the intimate space in this participants practice. The action was the ‘intimate space’ and the participant’s processes included ‘support’, ‘create’ and ‘reinforce’. These were all illuminated through the process of line by line coding.

The initial codes gave me possible directions to take the analysis. Deciding which one to take was informed by reflexive practices described in the section at the beginning of this chapter. Initially I focussed on the codes that I felt had been most prominent in the interviews. These emerging themes allowed me to move forward to focussed coding, while still moving back and forth between the data and the emergent themes.

Focused coding and analytic strategies.

Following line by line coding, key themes were identified and further explored using focussed coding (Charmaz, 2014). This is the second major phase of coding and has been described in different ways. Glaser (1978) described this part in the process as ‘selective coding’ where core variables are grouped together to generate fixed codes. Differently, Strauss and Corbin (1990, 1998) describe this process as ‘axial coding’ where data is analysed for connections between categories, using procedures that pulls the data back together. Focussed coding (Charmaz, 2014) is a
set of processes that allow you to sort and categorise the initial codes, looking for themes that advance the theoretical direction of the analysis. Charmaz (2014) states that “focussed coding condenses and sharpens what you have already done because it highlights what you find to be important in your emerging analysis” (p. 283). This stage of the analysis was more conceptual where codes were interrogated, synthesized and examined to focus on the emerging themes.

To further develop these codes, I used descriptive statistics and different analytic strategies to analyse trends and relationships between codes. Descriptive statistics were used to examine patterns of language across the participant’s data. This can be viewed as an objectivist stance where the researcher aims to remove themselves from the data by looking at it in numerical terms, which is more in line with a Glassarian (Glaser, 1992) approach to grounded theory. However, my intention was not to stand outside or be removed from the data. It was an exercise to try to highlight some of my assumptions that were potentially influencing the analysis of this data. One example is the exploration of the language the music therapists were using to describe music as powerful. I examined each interview and extracted the language they were using. I compiled these into an excel spreadsheet to see patterns of words across the interviews (see Figure 4.1). I then grouped together similar words to create themes around 'music and power'. Following this stage, I was able to go back into the interviews to see how these new themes around music and power fitted into the interviews as a whole.

Figure 4.1 Example of language used for ‘Music is Powerful’ theme

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Musical intimacy was a central focus of this research question, yet this is a new term that has not been well defined. Due to this, I felt the need to capture the participant’s experience of musical intimacy. This naturally led to some phenomenological processes of distillation (Heidegger & Dahlstrom, 2005; Husserl, 1973, 2012). Distillation is the process where the experience is gradually distilled down until you have the essence of the experience (Husserl, 2012; Moustakas, 1994). This involved examining each interview and extracting anything related to musical intimacy. The processes of sifting, sorting and condensing the participants experience was applied and finally distilled to an essence of each participant’s experience. This distillation was used in further analysis to look at the musically intimate context. In addition to the individual essences, I compiled all of the participants’ distilled essences of musical intimacy into one. This allowed me to again look at musical intimacy across all of the participants to see the main themes and experiences that were emerging.

The conditional matrix was an analytic strategy that was applied to further scrutinise the emerging themes. A conditional matrix is an analytic technique developed by Strauss and Corbin (Strauss & Corbin, 1990, 1998). It is a way to look at a particular phenomenon from different perspectives. The conditional matrix included placing data and themes into several categories (see Figure 4.2 and Appendix B). These were placed into the following categories; 1) conditions (intimate musical context), 2) phenomenon (control/power dynamics), 3) context (co-created relationship), 4) strategies (what do music therapists do in response), 5) consequences (Small), 6) intervening conditions, the individual response (therapist and client factors), and 7) conditional matrix (theoretical approach, institutional context). Through this process I was able to step back and examine the emerging themes. Additionally, each of the categories represented another stream of analysis that had been carried out during the focussed coding part of the analysis.
Narrative stories.

The narrative stories were an analytic summary of the participant’s experience of being a music therapist. The participant’s individual stories appeared to be influencing their experience of musical intimacy and how they negotiated the boundaries. I felt that this stream of analysis helped to clarify more their construction of their experience. This process involved me going through each participant’s interview and extracting any data related to their experience as a music therapist. From here, I was able to compile all the information and condense down into a narrative story of their experience. These narrative stories varied depending upon how their experience as a music therapist had impacted their sense of musical intimacy and the boundary challenges around that. For some this was very important and they discussed how much their approach to music therapy, boundaries and the methods they used had changed over the years.

Grounded essence of the musical intimacy experience.

The grounded essence of the musically intimate experience emerged during the final stages of analysis. This is the distilled experience of musical intimacy that is grounded in the analysis from the data. This emerged through synthesising the combined distilled essence of musical intimacy with other emergent themes. Through a reflexive, creative and iterative process, I was able to distil the key ideas from the analysis, to form one concise summary that captured core experience of what musical intimacy is about. This grounded essence formed part of the theoretical framework that emerged from the analysis.


*Synthesizing to form theoretical framework.*

The final stage of analysis was to synthesize all of the findings from the previous analysis points. This was the longest part of the analysis and involved many different creative and analytic strategies. I used a technique of mapping all of the main emergent themes repeatedly, in order to work through the process and refine the theoretical framework. I undertook many discussions with my supervisor who helped me to flesh out and explore what these findings really meant. I again went back to the data to refresh and make sure that what I had ended up with was representing the participant’s experience.

At this stage of the analysis, I also sought feedback from the participants. Feedback or verification, as it is called by some (Strauss & Corbin, 1998) is when participants are sent parts of their analysis to validate or comment on the findings. All the participants were sent their narrative description, their individual musical intimacy distillation and a summary of the emergent explanatory theory. I encouraged the participants to send me feedback or to participate in a follow up interview. I received written feedback from five of the participants and conducted three follow up interviews. These discussion and notes from the participants have been included in the final emergent theory explained in the next chapter.

The final synthesising of the emergent explanatory theory occurred, in some part, during the write up in the following chapter. Through this process, I was able to expand and write about the details of the emergent explanatory theory. I also included my reflexive voice throughout this write up to continue to include this aspect of the research. The next chapter is the theoretical framework in its entirety.

**Summary**

This chapter has outlined the methodological choices that have informed this research. I have outlined the process of grounded theory from data collection to analysis. Descriptions of the participants have been included to give the reader the sense of who the participants are. The next chapter will detail the emergent theoretical framework of musical intimacy and the ‘ways of being ad responding’.
References


Chapter 5
Findings chapter

Introduction

In this chapter I will present the theoretical framework that has emerged from this grounded theory study. The theoretical framework addresses the research question: how are music therapists negotiating the boundary challenges that can occur in the musically intimate context of practice? This theoretical framework relates to the two main elements of the research question; musical intimacy and the negotiation of boundaries within that context. The core concepts in this theoretical framework are; 1) the interpersonal experiences in and around music, 2) the intrinsic components of music, 3) the spectrum of experiences that are influenced by the grounded essence, and 4) the ways of being and responding to musical intimacy. I will detail the main themes that have contributed to these concepts. Additionally, the music therapists’ ‘ways of being and responding’ will be outlined, demonstrating how these music therapists described negotiating the boundary challenges in and around musical intimacy. Through this presentation, I will outline how these multiple perspectives have been critically examined through rigorous analysis, questioning and critique. Furthermore, reflexivity will be described as it has played a vital role in working towards making my implicit assumptions explicit, thus clarifying my influence on these findings.

Throughout this chapter, I will present examples from the participants to ground the interpretations in the data gathered. Additionally, my interpretations and assumptions will be presented to make the process of constructing these findings transparent. To further lift these findings to a theoretical level and align them with the perspectives offered by both the participants and myself, I will sometimes refer to the findings by using the pronoun ‘we’. The word ‘we’ will be used to highlight my agreement with the interpretations of the experiences described by my international colleagues, the other music therapists who were the participants in this study. At other times, I will use the phrase ‘some of us’ or ‘many of us’ to indicate when the interpretations align with my perspective but not all of the participants in the study.
When the interpretations or descriptions do not align with my own perceptions I will use ‘they’ or ‘many of the participants in the study’ to indicate this. By embedding my relationship with the data through the use of personal pronouns in this revealing way, I hope to emphasise the constructed nature of the findings and to remind the reader of whose positions are being represented in a way that is stimulating and engaging. This is an intentional strategy for reflexively conveying my beliefs about the ways that researchers construct findings, and to transparently describe my processes as a qualitative researcher. Since the participants are professionals in my own field, I am choosing to honour the collegiality that I have experienced in listening to their descriptions and reducing any sense of objectivity or hierarchy in the presentation of results. Nonetheless, I acknowledge that this strategy is novel and that not all readers will agree with this strategy as an appropriate expression of reflexivity.

Many of the findings will be presented in the form of quotes from the music therapists, and then integrated with an explanation as to why they contribute to a particular theme. In addition, some descriptive statistics have been used to determine the frequency of particular themes across the participants, which I found interesting but not dominant in considering the value of various ideas. The numerical data in this study was used as a strategy to reflexively examine the data from different perspectives. This allowed me to gain a sense of patterns of themes or language that were used across the interviews. Furthermore, this strategy highlighted my assumptions and how they influenced the initial understandings. The constructed nature of the interpretations was influenced by a constructivist grounded theory approach (Charmaz, 2014), while the numerical data reflects the strategies from a ‘Straussarian’ approach to grounded theory (Corbin & Strauss, 2008; Strauss & Corbin, 1990, 1998).

Figure 5.0 provides an overview of the theoretical framework and how each of the themes relate to each other. Firstly, the musical intimacy distillation served to influence the construction of the theoretical framework. Within musical intimacy, the two main characteristics are the interpersonal experiences and the intrinsic components of music. It is the combination of these concepts that contributes to musical intimacy experience. In the centre of this theoretical framework is the grounded essence of the musically intimate experience. This is where the therapist experiences a powerful moment of connection in and around the music that triggers an acute sense of vulnerability and reveals the need for boundaries to keep things safe.
From these powerful moments of connection, music therapists have different ways of being and responding to musical intimacy. These are reflexive and intuitive processes that are influenced by our personal foundations and assumptions.
Figure 5.0. Theoretical Framework of Musical Intimacy and the ‘Ways of Being and Responding’
Overview of theoretical framework of musical intimacy

The core concepts of this theoretical framework are:
1) The interpersonal experiences in and around music
2) The intrinsic components of music
3) The spectrum of experiences that are influenced by the grounded essence
4) The ways of being and responding to musical intimacy

Influencing these concepts are the musical intimacy distillation and the grounded essence of the experience. This chapter will detail the theoretical framework. I will begin with the musical intimacy distillation and the grounded essence of the experience. This will be followed by the core concepts of the theoretical framework, in the order listed above. The chapter will conclude with a final summary of the theoretical framework of musical intimacy.

Musical intimacy overview

My beliefs and assumptions were influential in this understanding of musical intimacy, highlighted by my choice to focus on this term. My initial interest for this research was in therapeutic boundaries, looking at how they were understood and implemented in music therapy practice. I also sensed that there was something about the music in music therapy that influenced boundaries. This was grounded in my own experiences where I sometimes found the intimate nature of the musical interactions to be complex and multilayered. Through the critical interpretive synthesis (Medcalf & Mcferran, 2016), musical intimacy solidified as a key construct. In the case studies I discovered many instances where boundary challenges happened in and around the music and I was keen to discover if this concept resonated with other music therapists. I went into this data collection process with the assumption that musical intimacy is implicitly understood and a common experience in music therapy practice.

My interpretations of the participant’s descriptions have been combined to form this theoretical framework. Through this process, my beliefs about musical intimacy were scrutinised using many reflexive strategies. One strategy was ‘memoing’ which is a common tool in a grounded theory approach (Charmaz, 2014; Corbin & Strauss, 2008; Strauss & Corbin, 1990, 1998). I used this strategy in all aspects of this research including during the interview process, initial analysis, further
analysis and when synthesising the emergent explanatory theory. As I reflected through ‘memoing’, I was able to flesh out my thoughts, opinions and impressions about each aspect of the process. For example, when reflecting on the interviews, I would recount how I felt during the interview, how I perceived the interviewee, and how I thought they were responding to the questions. I also paid particular attention to my bodily responses; when did I feel there was something more, or when was there something that made me feel uncomfortable. Through these processes, I was able to dig deeper to reveal my assumptions and explore the data from different perspectives.

The participant’s experiences of musical intimacy were intuitive, emotive, multilayered, powerful and challenging. This next section will detail the musical intimacy distillation and the grounded essence of the experience. These two areas form the core descriptions of what the experience of musical intimacy was for the participants. The grounded essence is the underlying defining feature that highlights the essential characteristics of musical intimacy.

**Musical intimacy distillation.**

Influenced by phenomenology (Heidegger & Dahlstrom, 2005; Moustakas, 1994), distillation was a process of analysis that allowed me to refine and condense the participants experience to try to discover the essence of their experience. The process involved immersing myself in the transcripts to extract data related to musical intimacy, highlighting poignant phrases and themes, and then synthesising them to form the essence of the experience. As musical intimacy emerged from the critical interpretive synthesis as a new construct, I felt that it was important to capture the essence of the experience, by distilling the various descriptions into a concise and explanatory narrative. In this way, I was able to delve into the individual experiences of musical intimacy, which contributed to the construction of the emergent explanatory theory.

The distillation below is intended to capture both the diverse and similar experiences of musical intimacy described by the participants. Because of this diversity, there are some contradictions within the distillation. However, in qualitative research, it is important to include the multiple experiences of the one phenomenon. Therefore, the purpose of this distillation is to situate the reader in the musical intimacy experiences as a whole, to begin to convey the multiple layers and
complexities that were revealed in the descriptions of musical intimacy.

This distillation of musical intimacy influenced the analysis process to identify and confirm the main concepts in musical intimacy. This distillation includes different elements and experiences that make up the musically intimate moments for the music therapists in this study. These descriptions vary and relate to different components of our work. As we all work in different contexts, this distillation provides a landscape of the potential complexities and experiences we have in musical intimacy. Here, I will use the different pronouns to identify my association with the statements, as explained in the introduction to this chapter.

We feel that music can create connections and intimacy very quickly. The music itself is inviting or personal and there may be different levels of intimacy and closeness in music. We believe that with music you can connect in a fun but also intense way. Music can be social and a means of communicating on different levels. We feel that music has inherent powers that need to be recognised; it may bypass defences or trigger emotion. Some of us feel that you can get manipulated or seduced in the music. For some music therapists, music and its rhythms, have the ability to express love, sensuality and have a strong power for the client to ‘fall in love’ with their therapist. For others, the relationship in music may be similar to a parent-child, partner or sibling relationship. We feel that there are boundaries in music. There also may be no boundaries with music, because music is everywhere. Many of us get a lot of rich information from the music. We believe that who we are in the world manifests in the music and that the meaning of music is different for everybody. Musical intimacy is a bodily experience, where there is a sense of vulnerability and a potential for powerful connections or challenges with the people we work with.

Grounded essence of the musical intimacy experience.
Following the musical intimacy distillation was the development of the grounded essence of the experience (see Figure 5.1). The grounded essence of the experience is a statement that captures the core meaning of musical intimacy. The grounded essence of the experience is:

The therapist experiences a powerful moment of connection, in and around the music that triggers an acute sense of vulnerability and reveals the need for boundaries to keep things safe.

This will now be explained in more detail by explaining each section. These sections are: 1) the therapist experiences, 2) a powerful moment of connection, 3) the music, 4) vulnerability, and 5) boundaries.

**The therapist experiences.**

This exploration into musical intimacy and boundary challenges was explored through interviewing music therapists about their experiences. Through this process, I have interpreted their descriptions and lifted them to formulate this theoretical framework. Through the music therapists’ descriptions, I became acutely aware of how the experiences had influenced them as individuals. Furthermore, this theoretical framework has been constructed from their perspective and has not examined these experiences from the client’s viewpoint. The music therapists experienced musical intimacy with their clients in a multitude of ways in their music therapy practice. Therefore, this grounded essence is fundamentally about the music therapists’ experiences of musical intimacy with their clients.
A powerful moment of connection.

Powerful moments of connection had a strong presence in the interviews. During the initial stages of analysis, while reflecting on the interviews, the notion of ‘music as powerful’ began to emerge. I was struck by how the music therapists were describing music as naturally powerful or as doing something to their clients and the therapeutic process. This led to a stream of analysis looking at the language the music therapists were using and how they were using it. From this emerged the theme of ‘the intrinsic powers of music’, which will be detailed later in this chapter. This finding, along with the musical intimacy distillation, lead to the idea that the music therapists were experiencing powerful moments of connection within musical intimacy. Furthermore, these powerful moments of connection appeared to be a defining feature of the musically intimate experience.

In and around the music.

Musical intimacy happens in and around the music in music therapy. The music therapists described experiences of what they perceived musical intimacy to include. This included descriptions of interactions in the moment of music making, moments that happened before or after making music, and also the influence that the music making experienced had on the therapeutic process and relationship. One of the core defining features of musical intimacy is that it happens in and around the music.

That triggers an acute sense of vulnerability.

Vulnerability was present in the reflections from the music therapists. They perceived vulnerability in their clients, which was linked to how they described the intrinsic powers of music. Some would describe the power of music to illicit emotion in their clients, which they perceived could make them feel vulnerable. Similarly, some described the power of music in breaking down barriers in their clients and revealing inner vulnerabilities. In addition, I sensed vulnerability in the music therapists themselves. In these powerful moments of connection, they described being on the same level as their clients, feeling connected to them and sharing in a
moment that was meaningful. This vulnerability was a felt experience that was shown through the music therapist’s body responses, their tone of voice and their facial expression when describing these situations. This sense of vulnerability was felt throughout the descriptions of musical intimacy.

Reveals the need for boundaries to keep things safe.

Through these powerful experiences of musical intimacy, that triggered vulnerability, a need for boundaries was revealed. The music therapists described how they managed these powerful moments of connection. These powerful moments of connection were experienced with a mixture of positive and challenging aspects. It was after these peak experiences that the need for boundaries was most present. In the more positive ‘magic moments’ there was a need to manage how they would influence the therapeutic relationship and process. For some, there was a sense of coming down from the powerful moments and working out where they would go to next. Differently, in the more challenging situations, boundaries became important for keeping the musical interactions and music therapy safe. For some, this was about exploring the emotions that had come up and checking that their client was all right. For others, it was about using the music in a way that was safe, proving a structure for the intense experience. In these moments the therapists were challenged, yet they were able to articulate how they emerged from these situations. Boundaries in these moments were flexible, adaptive and responsive to the needs of the individual situation.

Core concept one - Interpersonal experiences
The music therapists all described interpersonal experiences in and around musical intimacy in a number of ways (see Figure 5.2). These experiences happened across music therapy sessions taking place before, during and after the musical interactions. Some of the music therapists described how the intimate musical experiences influenced the development of the therapeutic relationship. Others described conversations about music and the meaning or history of particular music to their clients. Some described interpersonal interactions that happened within the music making experience as communication through music. The participants also described the experiences that happened after the music making. This would sometimes be about processing what happened in the music, what the music brought up and where the music making experience would lead them next.

The interpersonal experiences are one of the core concepts in musical intimacy. They can be personal; include communication of some kind and lead to connections between the music therapist and the person they are working with. For some of the music therapists, the interpersonal experiences in musical intimacy influenced the therapeutic relationship as a whole. In addition, many of the music therapists felt that these experiences formed a big part of the therapeutic relationship. The interactional nature of music is central to musical intimacy as it highlights how both the client and the music therapist contribute to the concept. One music therapist described how the interpersonal aspects in musical intimacy are part of the process in the therapeutic relationship. She comments:

I don't know how musical intimacy can be different to personal intimacy. It's when there is strong rapport and the relationships are rich. They're reciprocal.
It's not just giving to the client; they're often giving me a lot as well. It's just flow and that's what makes the relationship work. (Participant 17)

The interpersonal experiences included five main themes, which are: 1) emotional responses and interactions, 2) social interactions and implications, 3) personal and revealing aspects with music, 4) physicality of musical interactions and 5) communicative aspects (both verbal and nonverbal). These will now be discussed in detail, highlighting how these concepts were developed through the analytic process.

**Emotional interactions.**

Through the interview process and later analysis, I became aware that all the music therapists were describing emotional experiences for themselves in and around the music. In addition, they also perceived emotional experiences for their clients in and around the music. Interestingly, the music therapists own emotional experiences were often in response to their client’s reaction to particular music or musical experience. Some of the music therapists described outward expressions of emotion from their clients. They then described how they responded to this and what their own emotional reactions were. Through the music therapists’ reflections, I could sense the strong emotional impact of these experiences. These emotional responses and interactions formed part of the musical intimacy experience.

Through their reflections the music therapists described how they move through emotions when playing music with people. Moving through these emotional states in music appeared to influence their interactions with their clients. The influence of the emotional experience on the interpersonal interactions emerged throughout different aspects of the analysis process. Some of these included the musical intimacy distillations, analysing the language used with power and music, and analysing the different strategies used to manage the musical intimacy experiences.

One music therapist commented, "certainly there are emotional states (as) we're moving through music, so it's a very being together in time experience" (participant 17). This music therapist described experiences with her clients where they were connected to different emotional feelings, while simultaneously communicating and interacting with her. Listening to the idea, of being together in time, gave me the sense that this music therapist felt in the same emotional space as her clients while
making music. Through her further descriptions, I sensed that this level of emotional connection influenced how she interacted with her clients. This was again revealed to me through the process of distilling this participant’s experience of musical intimacy. She described watching her client’s body language and emotional responses to the music, as she tried to match the music to the client’s mood. Her interactions through music entered the emotional space, which influenced how she interacted musically with her clients. She described these as contributing to her musically intimate experience in her practice.

Similarly, another music therapist commented:

It's a bit more intimate when there's just music and nothing for us to hide behind. It's not the cognitive brain, it's in the emotional place that the music is really happening. If the music is coming from inside you, it’s coming from your heart and we're both vulnerable. So definitely there's intimacy there.

(Participant 20)

This music therapist felt that the interactions in music happen in the emotional place. She further described the musical interactions as a ‘heart to heart’ connection. Listening to this description, again lead me to reflect on the influence of the emotional responses on the musically intimate interactions. I was beginning to see similarities in the ways that the music therapists would describe these emotional interactions through music.

Some of the music therapists described how the emotional musical interactions could influence the actions of their clients. One music therapist commented:

Playing together is a special kind of language that opens up the feelings. Very often playing together you just get a kiss or hug, or people want to tell you a lot of things from their world. (Participant 14)

This music therapist had experienced their clients opening up more and treating them in a more social way, resulting in a hug or a kiss. They described that through the emotional musical interactions, their clients sometimes responded with a kiss or hug. For this music therapist, it demonstrated to them that the therapeutic relationship had developed because their clients were responding in a positive way. Through the music therapist’s descriptions, I could see how this music therapist perceived these emotional interactions through music to be helpful to the therapeutic work. For me, it also spoke to the intimate nature of the musical experiences, and how this emotional connection contributed to the concept of musical intimacy.
Similarly, another music therapist discussed:

If I'm performing a piece of music and that has a strong impact that to me, is an intimate moment. It’s an emotional connection between the patient and myself where we share an experience. Because we have those intimate encounters through music it deepens the relationship. (Participant two)

For some of the music therapists, the emotional musical interactions helped to deepen the therapeutic relationship, as is reflected in this example. For other music therapists, this lead to interactions, which could potentially blur the boundaries between friendship and professional relationship.

Some music therapists discussed how their work impacted them emotionally and how the musical interactions played a role in this. One music therapist commented:

I remember going to see her when she was dying and I was so sad. We had never had a meaningful conversation but all of our connections happened in music. I felt, whenever my residents in that area are dying, a profound sadness because it's that heart to heart connection. With those clients, any connection we've had has been in the music. I feel it more but it's very hard to describe.

( Participant 20)

This participant described working with palliative clients as an emotional experience. Interestingly, she described that most of the communications and connections happened through music. From her descriptions, I sensed that these would often have a profound impact on the music therapist personally. This is considered in the context of palliative care, but, in her descriptions, the emotional musical interactions played an important role in how intense the emotional experience was for her. This led her to later reflect about the potential impact of these emotional experiences.

Another aspect to the interpersonal experiences was how they could create deep connections between the music therapist and the person they were working with. One music therapist described the following experience when discussing musical intimacy:

After every improvisation she would just have this joy on her face. In those moments you do realise that something very intimate has happened because we connected in ways that she didn't connect with other people at that time.

( Participant 20)

This participant was describing her work with adults with progressive neurological conditions. The participant believed that the interpersonal interactions with this client
was important as it allowed her to connect in a way that she couldn't in everyday life, due to the limitations of her condition. In this music therapist’s experience, the musical interactions allowed her and her client to connect in an intimate way that helped her client feel joy in that particular moment. This highlighted for me the often no-verbal nature of the interactions in musical intimacy that occurred between the music therapists and the people they were working with.

Through the music therapists’ descriptions and my interpretations, we feel that musical interactions in music therapy can be highly emotional. These emotions are played out in the interpersonal interactions that occur in and around musical intimacy. Some of the music therapists have experienced moving through emotional states and being together in time with their clients. Some of them have experienced deeper therapeutic connections with their clients, which in part we feel are due to the emotional musical interactions. Others of us have experienced emotional impacts personally, which has contributed to the connections we feel for our clients. We feel that these emotional musical interactions form an essential part of musical intimacy as they are uniquely intimate, happen through playing music with our clients and are an interpersonal process. We feel that our clients experience emotional responses and experiences to the music making, which influences our responses to them and also the interpersonal interactions that continue to develop. We believe this can impact the process of music therapy and will influence the therapist and client in different ways.

**Social aspects in the interpersonal experience.**

Through the music therapists’ reflections, I began to realise that they were often describing social aspects of making music with their clients. This led me to explore further, the social interactions in and around music. This became an important theme, which spurred on further analysis during the focussed coding stage. Here I was able to examine each transcript with their emergent themes, looking for descriptions of social characteristics in musical intimacy. As 16 of the participants described the social aspect as part of musical intimacy it became part of the larger core concept of interpersonal experiences in musical intimacy.

Many of the music therapists believed that playing music with their clients contains natural social elements (16 participants). Some of them described how their clients don’t think of music therapy as ‘therapy’, with one describing how his patients
sometimes call him their drummer friend (participant 10). Others described how the natural processes of playing music with people can lead their clients to feel that there is more to the therapeutic relationship than intended (12 participants). Others described the natural social aspect to playing music with groups of people (nine participants). All of these different social elements described in and around music led me to reflect more deeply on how they contributed to musical intimacy.

As I listened to the transcriptions, it seemed that some of the music therapists described playing music as a natural social activity. One music therapist particularly highlighted this. He reflected:

Music therapy is not just treatment and it's not just an activity. The clients never say they are going to music therapy; it’s always to play music. One of my clients asked if he could bring some of his friends down to music therapy because he wanted them to play in a concert. He wanted me to be his drummer also. (Participant 10)

This music therapist felt a level of social collaboration through the musical interactions with this client. As I listened to his descriptions, I got a strong sense of the social bond that had formed between the music therapist and this particular client through their natural band-like rehearsals. This music therapist stressed the positive aspects to this. It appeared that these musical experiences led this client to be interested in social activities and participate in life in a way that he had not done for some time. For this music therapist, the musical interactions contained social elements that had encouraged positive steps in the therapeutic process. This example, along with others, led to the inclusion of the social aspects in the interpersonal experiences in musical intimacy.

More of the music therapists’ descriptions further confirmed the inclusion of social aspects in the interpersonal experiences in musical intimacy. One music therapist commented:

It's the campfire feeling. If it's dark and you’re camping and you’ve got a group of people sitting around a fire. It makes us more wistful or reflective, so we're all in that emotional space. It's safe and people are sitting around singing, there's the campfire feeling. (Participant 20)

For this music therapist, playing music with a group of people creates the emotional feeling of being with friends sitting around a campfire. Through her descriptions, I got the strong sense of the social aspect to making music. She described the musical
experiences as a shared social activity that can bring a group together. Similarly, another music therapist described a song writing experience in a group. She explained:

I usually take the lead and play guitar. We call it ‘soup song writing’ where everyone adds some ingredients. I play a chord progression and everyone adds in words or phrases. It's a very intimate situation for both the facilitators and patients. The first time it happened spontaneously and there was a sense of 'what just happened?' It developed and became a special thing for this group. For someone to open the door on that would feel very intrusive. There was a real sense of vulnerability and that what we were building there was delicate. (Participant 18)

In this example, the music therapist described how the whole group contributed and began to share personal things about themselves through the spontaneous song writing exercise. During later analysis, this intimate social interaction had a strong impact on me. This example felt like musical intimacy, as it was in an intimate social sharing environment in music that this experience took place. As she described the example, I became aware that it was a vulnerable experience for herself and that she perceived her clients to feel the same way. I sensed this vulnerability through her body language, the tone in her voice and the language that she used to describe this situation. These social aspects are part of the interpersonal experiences in musical intimacy.

**Personal and revealing musical interactions.**

There was a strong sense of how the interpersonal experiences were personal and revealing. Through the music therapists’ descriptions, it seemed that the personal nature of music allowed the interactions to become more intimate. Some of the music therapists described personal space when playing together. Others discussed how music would often reveal personal aspects about the people they were working with. The personal and revealing aspects in the musical interactions also contributed to their therapeutic relationships, which in turn contributed to the concept of musical intimacy.

One music therapist described personal interactions they have experienced through making music with their clients. They reflected about a personal and intimate
moment with a client. This music therapist reflected:

I had one gentleman who wrote a song about his life and he ended up choosing to only share it with one person. I was there in the room when he shared this with his friend, and wow to witness that in itself. He really needed her to hear that song before he died and I got to sit there while that happened, which was incredibly emotional. And you could just tell how honoured she was that he chose her as the person to hear that song. (Participant 20)

For this music therapist, helping her client to write a song about personal aspects of his life was an intimate experience. She described how it became much more revealing and personal when they shared the song with the client’s friend. As I listened to this example, I could sense that it was a very personal and intimate experience. This music therapist felt that she witnessed a very emotional and intimate moment between her client and his friend. This then influenced the therapeutic relationship and the work that they did following this. Interestingly, it appeared to be the combination of writing and performing the song in that context that made the experience so personal.

Other music therapists commented on the close nature of making music with people. One music therapist described it as “being together in time” (participant 8). Another commented that she felt “on the same level as her clients” (participant 4) during the musical intimate experiences. The close nature of playing music appeared to lead to more personal and intimate interactions. One music therapist commented:

There is something about this closeness, being close together. You share things. There is body language when we are playing, very small things. We're getting to know each other very close, so there's an understanding. (Participant 9)

For this music therapist, playing together in a band created close connections. Their body language and non-verbal language helped them to understand the people they were working with, which lead to a closer relationship. Through his descriptions, I sensed the strong and personal relationship that had developed with the band members. This music therapist described how the musical interactions, being personal in themselves, helped to build the therapeutic relationship with the people he was working with.

Many of the music therapists also reflected how music could reveal personal aspects about their clients. This music therapist describes her interactions with an
eight-year-old boy:

He was dancing one day and he said ‘you know I just knew, when I was five or six years old and it hit me right here (he was pointing to his chest) right in the heart’ and I said what did you know, and he said ‘music, I just knew I needed to dance and I knew I needed some music’. I was really touched by that… he had his own personal relationship with music and I kinda felt like he was letting me into that in order to have this relationship. (Participant 18)

This music therapist discussed how this child let her into his own personal relationship with music. She reflected that over the period of time they worked together, the boy gradually shared more of himself, which happened through their interaction in music. Through her description, I felt that this boy had revealed an important part of himself to this music therapist. With further focussed coding looking at the revealing aspects of music, I was able to explore this example. I became to feel that their musical interactions provided a platform for the relationship to grow. The sharing and revealing nature of their musical interactions contributed to the musically intimate experience.

Some of the music therapists commented on the personal nature of music and how this influenced our interpersonal interactions. One music therapist noted, “patients tend to be more familiar with me quite quickly. I think that's because our society puts musicians up on a pedestal” (participant two). This music therapist felt that because musicians are held in high regard, this helped her to establish relationships with her clients much quicker. She discussed further that this helped her clients to open up quicker and share more personal aspects about themselves with her.

Differently, another music therapist reflected on the use of voice and explained, “there was something about the use of voice, something about me and the nurturing thing that happens when you sing for someone” (participant 20). This music therapist felt that the voice in itself is very intimate and, when she sings with her clients, the interactions are already personal and revealing because she is using her voice. Similarly, another music therapist commented: “sharing music that's meaningful in a very personal context can be intimate and somewhat intense too” (participant 17). This music therapist highlighted how sharing meaningful music in a personal context can influence the interactions. They felt that in these situations, where their clients are vulnerable, music could often trigger responses, which then influence the interpersonal interactions.
One of the music therapists described how, with music, you can be on many
different levels of intimacy at the same time. She explained:

There’s always those moments where you get to these very profound musical
moments or decisions on where to go and what to offer. I feel like, in playing
music, I’m on different levels of intimacy. I’m sometimes with people and
joined with them, other times I’m supporting them and providing a ground.
Another time I might be highlighting things and saying ‘do you want to go
(here)’ and bringing this up a little bit. (Participant 15)

We feel that these personal and revealing aspects in music influence the musical
interactions that happen in our practice. The personal nature of music can create
environments that are revealing, close, intense and meaningful. We feel the personal
and revealing nature of our musical interactions forms a big part of musical intimacy.

**Physicality and musical environment.**

As the music therapists described their musical interactions in musical intimacy
many of them spoke about the physical closeness that they had when playing music
with their clients. They discussed the physical closeness of playing instruments with
children. They described the musical environment and how this created a safe space
for the musical intimacy to happen. The physical closeness that often occurs when
playing music with our clients appeared to contribute to the concept of musical
intimacy.

During the focussed coding stage of the analysis, I became aware of how many
of the music therapists described the physicality of the intimate music space (16
participants). When playing music with their clients, many of the participants talked
about the physicality of their musical interactions. One participant discussed:

So we would play together and we were in very close proximity. He didn’t like
holding instruments; he didn’t like the sort of sensation of them, piano was his
thing. We would have like ten-minute-long improvisations, which were great,
and we’d have that moment at the end of stillness and silence, I’d be kind of a
bit lost in. (Participant 8)

The musical environment and interactions created a space where this music therapist
and their client were physically close. She described how he would sit close to her on
the piano and they would play together for a long time. This music therapist felt that
the closeness and intimacy of the musical environment helped to create the musically intimate environment. She also discussed how this was a big part of the work and how it seemed to help develop the therapeutic relationship. When describing the physical environment another music therapist commented:

When I work with children who have small signals, I have to be very close to them. I have to be there and it's very concrete intimacy. I cannot be afraid of using my body, voice or everything. (Participant 13)

This music therapist felt that she had to use everything in her body to get in touch with the children she was working with. She described this process and how it helped her to create musical intimacy, but also to monitor how her clients were coping with the intimacy. The intimacy created with the physical proximity was something she felt could enhance the therapeutic process.

For another participant the physicality of being in someone’s intimate space and bringing music into that context contributed to their idea of musical intimacy. When describing musical intimacy, she commented, "the intimacy of often being in the room while someone's in bed and then using your voice in that very intimate space" (participant 20). She described how the patient’s room is a very intimate space. Her clients are often in bed and she felt that bringing music into this space contributed to the idea of musical intimacy. She felt that the voice is especially intimate and, when used in that space, created very musically intimate moments with her clients.

Another music therapist described how the intimate space could create complexities with boundaries. She discussed:

One time I was playing and a gentleman sat very close to me and put his hand on my leg. So (with) physical intimacy, people with mental illness don't have a great deal of understanding of their actions. That was a very intimate gesture and I had to deal with that quite quickly and strongly. (Participant two)

For this music therapist, she discussed that often the intense musical interactions can sometimes lead the patient to feel that the relationship is closer than it actually is.

One other aspect is the idea that when using music, the physical distance doesn’t need to be very close in order for the interaction to be intimate. This music therapist notes:

Music can be intimate even if you’re sitting five meters apart. If you are sitting physically twenty centimetres apart that would be very close to one another. But music might have the same intensity, even if you’re sitting far
away from each other. (Participant one)

For this music therapist, he can feel the physical intimacy with a client even if they are sitting on the other side of the room. For him this demonstrated the personal nature of making music with clients.

These experiences led me to question how the physicality of the musical interactions also contributed to the concept of musical intimacy. Through the participants’ reflections they described being closer physically, sometimes sharing instruments or being in an individual’s personal space. It appears that the emotional, social and personal aspects are perhaps highlighted because we often work in close proximity with our clients. For these participants, the musical interactions created an environment where the client and themselves were often physically closer because they were playing music together. Through further analysis, I was able to explore how the physicality of making music contributed to musical intimacy within the core concept of interpersonal experiences.

**Communicative interactions.**

Communication in the musical interactions were discussed by many of the participants. They discussed different levels of communication, how the musical interactions would communicate something to them about their clients and how they could reach individuals through a type of dialogue in music. This participant states:

> Eventually we started having these musical dialogs where we’d have this improvisation. I’d play the guitar in free improvisation, he’d start singing about his life, about the trials and the predicament that he was in. He’d sing about those and make it into a song and I was able to support him, or underpin that musically. (Participant six)

This example presents a musical interaction that explored musical dialogues through both musical and verbal interactions. Similarly, another music therapist noted:

> For one girl, we tried to refrain from stressful or heavy music. Sometimes it would start there and you'd bring it back down to the piano. One of the excellent ways of talking to her was not talking. We'd play the big bass drum, that's how we talked. (Participant 19)

Another participant stated; "the magical indescribable thing when you realise you are actually communicating through music" (participant 20). This music therapist
described experiences of how, in some magic moments with music, she felt that she was communicating with her clients through the music.

Other music therapists reflected how the different levels of communication through music could be quite intimate. One music therapist described the interactions she had with some of her clients. She reflects; “not high functioning, but students who don't have language, but talk from their heart or another place. Going into that sphere with music is quite intimate” (participant 14). She describes how working with students who don’t have language can be very intimate as you go into a more personal space with them. She explained that this somehow accessed parts of the individual that make the interaction more intimate and personal.

Some of the music therapists described the non-verbal communications that can happen through the musical interactions. One music therapist commented:

One example is a musical interaction. I often get my clients to play drums. One client was playing the drums and me on bass, there's always a lot of smiling. I like to give her a response to let her know when it's really happening and playing well. It's also about being there in the moment. (Participant 10)

This music therapist reflected a lot about the non-verbal communications that happen in the moment of improvising with his patients. These interactions would help to reassure the client or communicate with them that he felt the improvisation was going well. Sometimes, this music therapist would make verbal comments during the improvisations. He would yell out ‘yeah’, or ‘that’s great’. For him, he felt that this provided more encouragement for the client to express themselves, and to feel that he was also enjoying the musical interaction. In this way the music therapist seemed to be confirming that the musical interaction was a two-way process, where they were equal levels interacting through music.

Some of the interpersonal interactions happened through the music without any language. One example is from a music therapist who was working in a school setting for children with intellectual disabilities, autism or other behavioural issues. The particular client she is describing was non-verbal, which she described as very hard to engage. She describes the process that unfolded:

I had one girl who was multi handicapped. She was so closed down, in her body as well, all curled up. You couldn't get eye contact with her. I knew she was in there and I was just playing and singing with her. Gradually she took her hands down and on good days she could give me eye contact. It got better and
better and I would play and sing to her and she would answer with her voice. Then seeing her come alive was very touching. I wouldn't say that I loved her, but I did professionally, her story really touched me. (Participant 14)

In this example, the interpersonal interactions were very minimal to begin with. Through the music therapist’s use of music to encourage interpersonal experiences, the client was able to interact more and more as the sessions progressed. The music therapist described it as seeing her come alive and that she “loved this client in a professional way”. For me as the researcher, it felt like an intimate experience, which was reinforced by the music therapists’ descriptions of how the client interacted with her. These intimate interactions allowed the client room to grow and interact on her level with the music therapist. These descriptions led me to the understanding that the multiple communications through music, were intimate in nature and allowed a certain musical intimacy to develop. We can never know if it was an intimate experience for the client, but the descriptions from the music therapist suggest a certain level of intimacy as experienced by the music therapist. This example also illustrates the multiple levels of communication that can be experienced in musical intimacy.

We believe that music therapists and their clients communicate on many different levels through music. We communicate emotions, we socialise through music and we share personal information through the music making experience. The communication that happens through and around music is multilayered and contributes to the concept of musical intimacy.

Core concept two - intrinsic components of music
So far I have detailed the multiple perspectives of interpersonal interactions that have contributed to this understanding of musical intimacy. This discussion has revolved around how these experiences are interactional in nature and include processes and input from both the music therapist and the person they are working with. Where the above themes were about the interpersonal experiences in musical intimacy, the following themes detail the intrinsic components of music. The intrinsic components of music are the descriptions of how music has natural capabilities that influence musical intimacy, the therapeutic relationship and the therapeutic process.

Through the participants’ descriptions I got a strong sense of how they perceived music to have a ‘power’ within musical intimacy and in the process of music therapy practice. With further analysis of the language used to describe music (Appendix B), I was able to examine the music therapist’s perception of music. In this analysis, I returned to the data and examined it by looking at how the music therapists were describing the music in their practice. The following table 5.0 lists the language that the music therapists were using to describe music, which I have categorised into ‘connection’ and ‘power’. This also lists how many music therapists used this language to describe music.

Following the analysis of the language, two main concepts emerged that made up the intrinsic components of music. The two central themes to emerge within the intrinsic powers of music are: 1) music is powerful, and 2) music can easily create connections that deepen the therapeutic relationship. Table 5.0 also illustrates the
language that contributed to each theme. Both of these themes have sub-themes, which describe different aspects of the perceived power of music within musical intimacy. These will now be detailed, grounding the themes in examples from the participants while also revealing my interpretations through the analysis process.

Table 5.0
List of Language used to Describe Music

<table>
<thead>
<tr>
<th>Connection</th>
<th>Participants</th>
<th>Power</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connection</td>
<td>10</td>
<td>Trigger</td>
<td>10</td>
</tr>
<tr>
<td>Intimate</td>
<td>8</td>
<td>Opens</td>
<td>10</td>
</tr>
<tr>
<td>Emotion</td>
<td>7</td>
<td>Power</td>
<td>8</td>
</tr>
<tr>
<td>Communication</td>
<td>6</td>
<td>Information</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Closer</td>
<td></td>
<td>Quickly evolves</td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td>4</td>
<td>Seduce</td>
<td>2</td>
</tr>
<tr>
<td>Personal</td>
<td>3</td>
<td>Directing</td>
<td>2</td>
</tr>
<tr>
<td>Deepening</td>
<td>3</td>
<td>Manipulate</td>
<td>1</td>
</tr>
<tr>
<td>Human</td>
<td>2</td>
<td>Inviting</td>
<td>1</td>
</tr>
<tr>
<td>Nurturing</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Central theme one - Music is powerful.**

In this theme of music is powerful, 18 music therapists described music as intrinsically powerful in some way. This idea first emerged during data collection where I became aware of the language that the participants were using to describe the influence of music. Through my initial analysis and reflections, I noted how the music therapists were continually describing music as ‘doing’ something to their clients, the process or the therapeutic relationship. The language that the music therapists used is shown in table 5.1, which lists the number of participants and the number of times that this language was used.

This language highlighted the strong notion that music is powerful. I explored different ways that this could be interpreted; however, I kept returning to the notion that the music therapists perceived music as naturally powerful. This was shown to
me firstly through their use of language. They described music as opening people up, as being able to manipulate people, and as triggering responses in their clients that was out of their control. It was the music itself that had spurred on these responses.

I again returned to the data through the focussed coding stage where I specifically explored the notion of music as powerful. Here, I examined the context in which these statements were being made. In what situations were the music therapists describing music as powerful? How did they perceive this power and what influence did it seem to have on the therapeutic process? After this further analysis, ‘music is powerful’ had emerged as one of the central themes in the intrinsic components of music. The main themes within this were; 1) music can trigger emotion, 2) music can reveal information and bypass defences, and 3) music is powerful. These themes all relate to the idea that the music itself is doing something to the person you are working with. I will now outline each of these sub-themes of music is powerful.

Table 5.1

Language used that Contributed to Music is Powerful theme

<table>
<thead>
<tr>
<th>Power</th>
<th>Number of times used</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manipulate</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Opens</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>Seduce</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Power</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Directing</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Inviting</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Quickly evolves</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Trigger</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Information</td>
<td>16</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>76</td>
<td>18</td>
</tr>
</tbody>
</table>

*Music can trigger emotion.*

Music acting as a trigger was described by ten music therapists; in addition to
these ten, a further three discussed how music can ‘open’ people up. They discussed a variety of emotions they had experienced from joy, hope, love, anger, fear and sadness. One music therapist commented; “the therapy space is eliciting feelings that can be intimate. Love, rage, anger, fear can be elicited in that space” (participant seven). Music as a trigger was seen as both a positive and challenging aspect to musical intimacy.

Many of the music therapists described experiences where music seemed to elicit an outpouring of emotion. One music therapist noted; “I looked up certain Hungarian songs, and when he listens there’s an absolute outpour of emotion” (participant six). Through his descriptions, I became aware of the way he was describing specific music to trigger emotion. This music therapist explained how this became a boundary challenge as he needed to check if their client was all right and whether this was a good process for them. Similarly, another music therapist described her work in palliative care:

   Music can trigger more emotion so I don't want to introduce too many variables. Some people are quite at home with being quite emotional. Some people are feeling quite undone and vulnerable. So I see how comfortable they are.

   (Participant 17)

This music therapist spoke about how she has learnt to not introduce music too quickly due to the strong emotional reactions she has witnessed in the past. Her descriptions of music triggering emotion were similar to other music therapists’ experiences and helped me to further build on the idea of music triggering emotion.

Another music therapist talked about musically induced anger. She commented; “musically induced anger (is) when someone’s very angry about a particular thing and the music sets them off or reminds them, (there’s) some kind of trigger there” (participant two). For this music therapist, the trigger was in the music and they have experienced their clients responding with anger to particular music. This example again illustrated the idea of music as an emotional trigger. Through this description, the music therapist seemed to be distancing herself from the angry emotion felt by her clients. Through further focussed coding, this revealed to me how she perceived music to be a trigger in itself.

   Music as a trigger formed part of the intrinsic components of music. These intrinsic components of music are a part of musical intimacy because these perceptions of music as powerful contribute to the musically intimate experiences of
the music therapists. The way that the participants were describing this aspect made it feel as though it is a prominent experience in musical intimacy.

**Music can reveal information and bypass defences.**

I believe that when you move into music you go through some defences, you bypass some defences a little bit faster, a little bit quicker than if you have verbal psychotherapy and it’s both a strength, but also can be a risk.

( Participant seven)

While listening to and analysing the transcriptions, I became aware of the music therapists descriptions of music. They would describe music as a force that could open people up (ten participants), reveal information (five participants) or bypass defences (two participants) with the people they were working with. Through their reflections and my interpretations, I came to view this aspect as part of the intrinsic components of music.

Many of the participants described getting information about their clients through the music. For these music therapists, this served to direct the therapeutic process and help monitor how the individual was coping with the musical interaction. This information included personal elements, ideas about how they were responding to the music therapist and the therapeutic process. One of the music therapists described how she often gets a second opinion within the musical interaction. She commented, “but in the music it’s like it’s clearer. It’s like, “ahhhhh”. It emerges. You know the conscious things emerge” (participant four). Through this process, she feels that this helps her to build the therapeutic relationship and help develop the therapeutic process. She also mentioned that this revealing information could help the therapeutic process and lead to the magic moments in musical intimacy.

Some of the music therapists described how the information they gathered in the musical interactions helped to direct and lead the therapeutic process. One music therapist described his approach to this. He explained;

If the client is giving me this (musical idea) and taking me on this journey, whether it’s conscious or unconscious, they’re doing it you know. So if that’s what they want, that’s what I’m going to give them, I’m going to go with that, and I’ve found there’s no problem with it. (Participant 16)

Listening to this music therapist, it was clear that his approach included really
following his clients during the musical interactions. Through his descriptions, I could feel his sense of wanting to explore his clients’ experiences through these musical interactions. In addition he seemed to feel closer to his clients as he described them being as one during the musical interactions. He would follow the information that he was getting in the music, which lead to moments of connection in the musically intimate experience.

The information that the music therapists described was often personal and intimate, which contributed to the therapeutic process and the experience of musical intimacy. Other information that the music therapists gained from the musical interactions can lead the experience in different ways and help to develop the therapeutic relationship. For these music therapists, the music itself seemed to reveal information about their clients. I included this theme in the central theme of music as powerful, because the information was often gathered without the participants deciding to share it. The music naturally revealed information about the clients to the music therapists.

**Music is powerful.**

Although music is powerful is one of the two central themes, there was enough data to warrant a sub-theme in itself. The idea that music is powerful echoed across the interview transcriptions with the music therapists using this language in their interviews intertwined with their descriptions of musical intimacy. The above sub-themes refer to ways in which music affects the client in some way. This theme deals directly with the idea that music is powerful, which eight of the music therapists described. Some explained the innate power of music to elicit response or experiences in their clients. Others described differences in the power of music, such as its ability to create intimacy.

One music therapist described how he perceived his clients’ view of music. He explains:

The main message from the band is that the power lies in the music. If there was one thing that got them out of criminality, they would say "it's the music". There has to be something extremely powerful there. There is something in that togetherness in the music. (Participant 9)

This music therapist discussed what he perceived the impact of music to be, on the
individuals he was working with. The way he described it made it seem that he also believed that music had a power in itself. He commented that “there was something in the music” that helped with the therapeutic process.

Differently, another music therapist described the power of music relating to its ability to create intimacy. One music therapist explained; “there's a level of intimacy in music that's amazingly intense... It's really profound and I think that's why music's so powerful” (participant 15). For this music therapist, music’s ability to create intimacy between herself and her clients was one of the essential aspects to musical intimacy, and to her music therapy practice. In a similar way, another music therapist described how music created connections that were powerful. She described:

Working with the well child, you can bypass everything else and you’re in your own little world and you’re just really connecting, in a really fun but still kind of intense way. You’re doing it through music and it’s really quite powerful. (Participant three)

This music therapist described the connection through music as powerful. Similarly, another music therapist described how music in combination with eye contact can create powerful situations in the context of her practice. She explains; “Maybe you're making eye contact and singing together and it's pretty powerful and intense. There are some clients who absolutely would not be able to handle that” (participant 20).

The idea of music as powerful aligned with some of my own experiences in practice. I have also felt the ‘power’ of music in triggering emotions, bypassing some defences and creating meaningful connections with the people I was working with. By acknowledging music as powerful, we get a sense of how musical intimacy was experienced by the music therapists. The music therapists described how music used in therapy has unique powers that contribute to the idea of musical intimacy. These ideas were varied and encompassed many different aspects to music therapy practice.

**Central theme two - Music can easily create deep connections.**

The second central theme to emerge within musical intimacy was the idea that music creates connections very easily. These connections serve to deepen the therapeutic relationship and aid the therapeutic process. This could also be seen as a ‘power’ in itself, however, I felt that these connections needed to be explored individually, as they spoke to other qualities of music that the music therapists
experienced. Additionally, the strong presence of these ideas solidified it as a central theme within the intrinsic components of music, which in turn contributes to the concept of musical intimacy.

My choice to explore the notion of musical intimacy brought ideas of connection and intimacy to the forefront. During the interviews, I questioned the participants about musical intimacy, which led to discussions on how music is naturally intimate. Through these interviews and later analysis, I was careful to explore my own influence on the emergence of this theme through different reflexive practices. I questioned my influence through language analysis, examining how the music therapists were using language and in what context they were using it.

The language that the music therapists used is listed in Table 5.2. The number of themes refers to how many times this language appeared and the participants refers to how many participants. The total is the number of themes overall and the number of music therapists that contributed to this theme. A total of 17 music therapists contributed to the theme of connections and music. This was closely followed by descriptions of music as intimate (8 participants), music enables communication (6 participants) and that music makes us closer (6 participants).

Within this central theme three sub-themes emerged around connection with music. These are; 1) music is personal and intimate, 2) music enables closer connections, and 3) music is naturally communicative on different levels. These themes will now be detailed through the participants’ descriptions and my interpretations of them.
### Table 5.2

*Language used that Contributed to ‘Music can Easily Create Deep Connections’ theme*

<table>
<thead>
<tr>
<th>Connection</th>
<th>Number of times used</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connection</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td>Closer</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Deepening</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Communication</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Personal</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Intimate</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td>Social</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>65</td>
<td>17</td>
</tr>
</tbody>
</table>

*Music is naturally personal and intimate.*

The focus on music and intimacy was central to this research, yet it also emerged as a theme that contributed to the wider concept of musical intimacy. The music therapists appeared to relate to the idea of intimacy and music very easily. Many of the music therapists described this aspect early on in their interview and they would often state that ‘music is intimate’ in a matter of fact tone. One commented, ‘my instinct is to say that music making is intimate’ (participant five). Similarly, when describing their music psychotherapy approach, one music therapist stated; “the method I practice has intimacy in it all the time” (participant seven). Nine music therapists described music as naturally personal and intimate and it seemed to be something that they experienced frequently in their practice. Some of them discussed how music creates connections very easily, which allows deeper connections to evolve. Many of these music therapists also described how music can make connections happen very quickly, leading to a deeper level of intimacy.

When describing her work one music therapist commented:

I feel that music is a way to become intimate very quickly. I’ve learnt to respect it. I feel that music is a way of sharing, relating and it’s a very profound way to connect. (Participant 15)
Through listening to her experiences, I was strongly aware that she felt music was a way to connect easily. She emphasised this point throughout her interview and, through her reflections, I felt that this was a big part of her work. For this music therapist, music has innate qualities that allow you to become intimate very quickly. Her descriptions formed part of further analysis where I was able to re-examine her descriptions of music in the wider context of her experience of musical intimacy.

Another music therapist believed that their connections were stronger when they happened through music. In this example, there was no verbal language between the music therapists and the people she was working with. She commented:

It's a bit more intimate when there's just music and nothing for us to hide behind. It's not the cognitive brain; it's in that emotional place that the music is really happening. (Participant 20)

She felt that because there was no verbal language the interactions were more like ‘heart to heart’ connections, reaching a more intimate part of the individual. This music therapist continued to reflect on how she has experienced music to be naturally intimate. She commented on her work in palliative care noting:

In palliative, I'm usually singing songs but I don’t have that safety. That might be why singing something as simple as "You are my sunshine" can be an incredibly intimate experience. You don't have as much safety there. Some of these people I'm meeting are in the most vulnerable time in their life, so that's why singing something simple can feel so intimate cause the safety is not where we would love it to be. (Participant 20)

She described that, in the context of palliative care, she is working with very vulnerable people. She comments that music in this setting can be so intimate because of the situation that her clients are going through. Through her descriptions, I got a strong sense of intimacy. She described the intimacy of essentially being in someone’s bedroom and bringing music into that space. This intimate space was demonstrated to me through the music therapist’s facial expressions and tone of voice when describing her work. In this context, she feels that music is very intimate and has the ability to access emotions that perhaps people are not ready to deal with.

*Music enables closer connections.*

When listening to the music therapists’ narratives of musical intimacy, I was
struck by the way they described closer connections in and around music. They commented that, in making music with their clients, they created closer connections. One participant commented; “we’re closer because we make music together” (participant one). Another reflected on a “musical being togetherness” (participant four). 14 music therapists commented on ways that music naturally creates connections. They described music as easily creating connections (10 participants), music as making the connections closer (six participants) and that music can deepen the relationship (four participants). One music therapist reflected on the connection she has felt when singing with her clients. She explains:

Especially if you’re singing harmony with someone, because that’s part of you, your voice is you. You’re not hiding behind an instrument. So if your voice is connecting and blending with someone else’s voice, that’s the deep down part of you connecting with someone else’s deep down part.

(Participant 20)

These descriptions highlight how this music therapist believed singing to be a deep connecting experience. This was further echoed in other participants’ interviews and emerged as a theme nearer the end of the analysis. Another music therapist commented:

She’s more aware of me and we can meet in music. Even if it’s just a very simple thing, like me just kind of holding a drum, but we’re in that shared space. Then she’ll say, ‘oh that was wonderful’.

(Participant eight)

Following the language analysis of further focussed coding and the musical intimacy distillation, the idea of closer connections in music solidified. This emerged when synthesising the findings to form the theoretical framework. Examining the intrinsic components of music as a whole helped to define how the participants believed music enabled stronger connections.

**Music can allow communication on different levels.**

Many of the music therapists described music as naturally able to communicate on different levels. Eight music therapists contributed to this theme describing music as communicative (six participants) and music as naturally social (four participants). Many of these music therapists felt that music itself can allow communication that sometimes their clients are not aware of. One commented;
“there’s that sort of magical indescribable thing that happens when you realise you are actually communicating through the music” (participant 20). Another noted; “I found that music was almost a means of communicating on different level” (participant six). This kind of communication contributed to the intrinsic components of music as it was described something that the music itself could create.

**Core concept three – A spectrum of experiences in musical intimacy**

![Figure 5.4 A Spectrum of Experiences in Musical Intimacy](image)

Through the music therapist’s reflections on musical intimacy, a number of different experiences emerged. One of the defining features of musical intimacy was that it created both powerful moments of connection and challenging experiences for the music therapists. What was intriguing was how the challenging experiences could be positive and the powerful moments of connections could create further challenges for the music therapists. What seemed to emerge was an intricate web of experiences that called for the music therapists to be flexible and intuitive in their approach to boundaries. Two central experiences emerged from the analysis: 1) powerful moments of connection, and 2) challenging experiences. These will now be presented in detail.

**Powerful moments of connection.**

A musical togetherness or ‘magic moments’ were described in some way by all of the music therapists. I first became aware of these ideas during the interviews. These powerful moments of connection stood out in the music therapists’ descriptions
and responses to my questions on musical intimacy. As they were describing these situations, I felt like I could visualise and understand these experiences. This was partly due to the way that some of them resonated with my own experiences, which had led me to explore this topic initially. It was also due to the sincerity I felt from the music therapists. This was demonstrated through their facial expressions, their body language and in the language they were using to describe these situations. These examples left me wanting to explore more, which led to a stream of focussed coding specifically examining these powerful moments of connection.

These powerful moments of connection were when the music therapist felt really connected to their client. They described feeling on the same level and experiencing “a feeling that something magical had just happened” (participant seven). One music therapist described; “when patients do get into it, I have noticed really profound connections between patients and sometimes with me. Sometimes that can feel scary for both the patients and myself” (participant 18). This music therapist described observing and feeling moments of connection between her clients and herself. She highlights how this was scary for both parties in that it created vulnerability through these profound connections. This highlighted an interesting idea that these moments of connection could be potentially helpful or harmful to the therapeutic process.

Similarly, another music therapist described:

There are times when I just get taken away. I become at one with it and all the things of music therapy are just taken away. When I tried to stop myself, I felt like I wasn't being honest with the patient. It was actually destructive to the client’s therapy. If the client is taking me on this journey, then that's what they want. I've found there's no problem with it. I could describe these moments as musical intimacy. (Participant 16)

This music therapist felt that, if they blocked these connections, it would hinder the therapeutic process. What struck me about this example was the idea of honesty in music and really following the client during these moments. Many of the music therapists talked about letting go, not thinking about music therapy processes and really connecting in that space with the person they were working with. From these experiences, it seems that these connections serve to help us as music therapists to connect with our clients in a very real way.

Another music therapist described:
There's something about coming to a good groove. We've all experienced being there together and it's good music. You just want to be there and you can be there for a very long time. (Participant nine)

Listening to this example again spoke to the idea of powerful moments of connection. It was interesting that this experience was from a music therapist working in the community with a band. This context contrasts with the other music therapists in this study yet it shares similarities in the way he described these moments of connection. The music therapists in this study worked in different contexts yet their experiences of these moments were similar. The descriptions of these experiences suggested to me that they could be experienced across a range of music therapy contexts. One therapist commented:

I remember a woman with moderate stage dementia who only had a few words. I would bring her to the music room and give her a drum. I would play the piano and we would be back and forth and we were absolutely able to connect. Her face would light up and she would be feeling absolute joy. When the music stopped, I knew she was trying to tell me that that was a magical experience for her and she felt this connection. (Participant 20)

This music therapist described the importance of musical interactions for people who have difficulties expressing themselves due to illness deterioration. This is the interpretation of this music therapist, as we can’t really know what the experience was for the individual. The interesting idea here is that the music therapist felt a connection with her client through the musical interaction that occurred. This relates to the aspect of musical intimacy, which is about interpersonal experiences that are contributed to by both the music therapist and the person they are working with. Intimacy in itself suggests a two-way process and these moments of connection between the music therapist and their client seemed to reflect this.

Through analysing the transcriptions, many of the powerful moments of connection appeared to be positive. Many of the music therapists stressed that these moments where a valued part of their work. During this stream of analysis, I was careful to be aware of my own experiences and assumptions surrounding these powerful moments of connection. I have also experienced these moments in my clinical practice and feel that they are an important part of my work. To challenge my assumptions, I re-examined the data looking specifically for these moments and in what context they appeared. I examined these situations and also searched for
examples that challenged the positive experiences. What I found was a number of challenging situations that all but one music therapist had described. This led to another stream of analysis examining the challenging experiences in and around musical intimacy.

**Challenging experiences in musical intimacy.**

The participants described a myriad of situations within musical intimacy that created unique complexities. On the one hand, musical intimacy was experienced as a source of magical connections that may help or empower the people we are working with. Alternatively, musical intimacy was described as creating experiences that can be personally challenging with the potential for both the client and therapist to be harmed. These contradictory views highlight some of the complexities of musical intimacy, where it can create conditions that may be helpful and/or harmful to the client, the music therapist and the therapeutic process.

My use of the word ‘intimacy’ is specific in referring to the interpersonal interactions that happen in and around the music in music therapy. The word intimacy alludes to a vulnerability in music and how this can be a delicate place to be. I also view this as a two-way process that may be influenced by both music therapist and client, yet I acknowledge that I have only explored the experiences of music therapists, therefore, any deductions made about the client’s experience are limited and ungrounded. In addition, I am not referring to aspects of intimacy where there are abuses of power or the intimacy that is felt in one’s own personal relationships.

The term intimacy appeared to be well received by most of the music therapists in this study. However, one music therapist noted that he was not comfortable with the term and preferred to use ‘musical interactions’ to describe his experiences. Although he was not comfortable with the term ‘intimacy’, many of his descriptions of his experiences appeared to be intimate and he did say that; “music is highly personal”. Despite many people being willing to use the word, the idea that intimacy can create challenges was common, with 19 participants describing challenging aspects in and around musical intimacy.

Acknowledging these challenges seems critical in providing a rich description of musical intimacy and the following paragraphs detail the challenging situations described by the nineteen music therapists. Naturally, the experiences varied greatly
since each music therapist worked using a different approach, with a different group of people and in a different context. They included experiences with intense emotion, feelings of loss within the music, challenges around boundaries and sometimes feeling unsafe in the environment. It is important to note that these experiences were described by the music therapists, who discussed their interpretations of their clients’ perspectives, but do not account for the experiences of clients themselves. It seems important to re-state that these findings only present half of the story and the complete context for the study is in the experiences of music therapists. Additionally, I have analysed the music therapists’ experiences adding another layer of interpretation.

**Intense emotion.**

One of the challenging aspects of musical intimacy was the intense emotion experienced by the music therapists. Some music therapists observed intense emotion during or after a musical experience. This included intense crying or anger that appeared to be triggered by the musical exchange. Some music therapists experienced strong emotions in the interactions with their clients. Others had their clients describe strong emotional reactions after the music therapy sessions, which they attributed to the music. For example, one music therapist who worked in palliative care stated:

> There was one lady that I worked with who had strong emotions after the session; I didn't even notice it so much in the session. Then I was told, don't come back. So I'm very conscious. I think, ‘let’s go slowly’, verbally first before I even introduce the music. (Participant 18)

This music therapist believed it was the music that had triggered strong emotions in her client and that these emotions were strong enough for the family to request that she did not return. It is impossible to tell what this experience was like for this client and there may have been other reasons for the music therapist being asked not to return. However, I could only learn from and interpret what this participant described and what they believed to be the cause. When listening and analysing this interview, it seemed like this experience led the music therapist to tread more carefully when using music. This was connected with other participants’ experiences leading to another theme about music triggering emotion, described above in the intrinsic components of music. Many of the music therapists felt that the use of music needs to
be treated with care, especially when working with vulnerable people. The experiences of many of the participants in this study is that musical intimacy may be harmful or helpful. What has emerged is the importance of being aware of this multilayered challenge to create safe conditions for therapy. In addition, being able to reflect on why the complex dynamic emerged appeared to be useful for these music therapists.

**Vulnerability in musical intimacy.**

Another theme closely related, is the notion that musical experiences can make people feel vulnerable. One participant commented; “when I can see them open up and they let me in, I find that very intimate. I have to be very careful and protective when that happens” (participant 14). I felt that this music therapist was consciously protective and careful because they perceive music experiences to be potentially vulnerable for their clients. Many music therapists in this study experienced similar situations where I sensed their belief in the potential for harm because of this vulnerability.

Some music therapists highlighted the potential vulnerability for their clients. However, I also sensed vulnerability in the music therapists themselves. Some described very intense experiences in and around musical intimacy, where they appeared to have been strongly affected by the experience. When describing these experiences, I noted their change in body language, rate of speech and pitch of their voice. I could sense in their expressions and body language how these particular experiences had affected them. Some of the interviews felt like a therapy session where the music therapist was able to de-brief and work through their challenging experiences. When analysing later, I was again reminded of this feeling. The following example illustrates the type of experience. One music therapist was working with a client who had suffered abuse and multiple traumas in her early life. When describing this situation that unfolded during a first session, she highlights the potential vulnerability for herself together with this client:

All of a sudden we’re improvising and it felt like she dissociated in the music. It was like deep sea diving where it’s dark and very visual. It was a very multi-sensory experience. I felt like I was not sure what to do. I felt like I was not merged with her, but in the same space and losing my sense of
identity in the music. I remember the only thing I could think of was like octaves, just repeating octaves. Just do that, just do that. And using my voice and picturing that we went really deep and thinking now I’ve got to get us both back. It had become an unsafe environment. It was too intimate, too intense. It was too much too soon. (Participant four)

This music therapist felt merged with the client, that she lost her sense of identity and that she was re-experiencing her client’s traumas in the moment of improvising. She described that after returning from the improvisation she had to check in with herself to make sure that she was all right to continue. The music therapist described that, after the improvisation, the woman who she was working with emotionally broke down and told her whole story to this music therapist. She described this as deep sea diving, where she found it hard to know how to get out. I feel that this is an example where the experience of musical intimacy has the potential to do harm as this music therapist described that she felt unsafe and vulnerable within herself. She felt that they had tapped into some issues that the client was not ready to confront and was surprised by the direction that the improvisation had taken them. This example highlights how musical intimacy could be potentially harmful for the music therapist. I sensed that this music therapist was very impacted personally by this interaction. Her use of ‘I’, also indicates the extent of the impact upon herself. This experience of music opening or being a trigger appeared to hinder the therapeutic process creating a challenging experience for the music therapist in musical intimacy.

The description of a different music therapist, working on another continent and with a distinct client group provides another illustration of the phenomenon of potential harm resulting from musical intimacy. The clients are 15 and 16-year-old male students with behavioural and learning disabilities in a school setting.

I came into the music room and they were like ‘no I don’t want music that’s so childish’. I said, ‘oh I thought we were going to make a band?’, ‘Ahh band’, then they changed their attitude. They were like ‘we’re going to have a name, an image’, and they had these suits that they wore to every music session. So we were a band, we created a band identity. Two of the boys started getting physical with me. They wanted to sit on my lap, have hugs but I didn’t feel that this was right. They were big boys and there were eight of them, it was kind of threatening actually. One boy, who had autism, wanted me to go to the cinema with him. He was really angry with me when I couldn’t join him. I felt like
when we were making music together, it was not a classic teacher student relationship; we were in a band and at the same level. (Participant 11)

The close nature of the relationships that developed through this process seemed to create challenges for this music therapist. As I listened to the description of the setting, I became aware of some of the complexities. She described some staff members asking her why she was bothering to try with the students, commenting that the students wouldn’t be able to achieve anything so it was a waste of time. Throughout her interview, I could sense her frustration and the personally challenging nature of the work. This was shown to me through her way of describing this situation. This interview at times felt like a therapy session, where I was supporting her to tell her story. This context appeared to contribute to the way that this music therapist approached her work. On the one hand, she tried to create a musical environment that empowered these students to take part and own their own experience of playing music together. In this way they could draw on their resources to engage in a music making experience that was meaningful for them. On the other hand, it presented the music therapist with challenges. This included keeping a physical distance that she was comfortable with and negotiating how to explain to the student that she couldn’t go to the cinema with him. It appeared that the music therapist felt that the ‘band identity’ seemed to encourage the students to think that they were friends with her. She discussed how hard this was for her and, when I sent parts of her analysis to her, she stressed again how challenging this situation was for her. The complexity of this context along with the close relationships developed through the musically intimate interactions seemed to make challenges for this music therapist.

Feelings of Love.

Some participants (11), discussed challenges around music as evoking feelings of love from their clients. This included perceptions of ‘feelings’ from their clients, having clients express that they had feelings for them and that the music may have evoked sexual undertones or reactions. One music therapist commented; “we were playing and then he came down, sat next to me and put his hand on my knee” (participant two). This music therapist felt that because they had had intimate interactions through music, her client felt that they were closer than they actually
were. She discussed how she had to negotiate with this client who she felt he had gained so much in the group, but this behaviour made her very uncomfortable.

Similarly, another music therapist stated:

When you play music it can have a sensuality, and maybe rhythmically speak to sexual undertones. When I worked with a psychotic young man, the music that we made actually evoked that he wanted to masturbate. (Participant seven)

This music therapist had to manage the challenging situation of their clients becoming sexually aroused in the musical interactions. She discussed that she had to stop the music and discuss with them that it was not appropriate behaviour. Similar to these ideas, one participant described an experience with one of her clients:

I worked with a man with middle stage dementia. When we played together he was very touched. He was crying and hugging and it was growing to something that was out of hand. I thought, ‘this can't be good for him’, because I'm not somebody who he can fall in love with, but the music seduced us to that state. So I had to be very careful. I think that's a boundary for both him and me.

(Participant 14)

As I listened to this participant describe this particular situation, I had a strong sense that she was working hard to negotiate boundaries with her client, and she conveyed a sense of exhaustion whilst describing it. As I worked with the data later, I re-experienced this sense of exhaustion in my own body and reflected that to negotiate the boundaries with this client was a delicate and challenging situation. She described that she could feel how lonely he was and that she was conflicted in what she was providing for him. This situation was confronting for her, it appeared to be a challenging experience that led her to question how she approached her music therapy practice. She discussed how she has learnt from this experience and keeps it in mind when working with similar clients.

Another music therapist described their experiences with music and how it can create an environment with feelings of ‘love’. He discussed:

The music goes where it needs to go. It's ok to seduce or manipulate as long as you know what's going on. I sometimes have experiences where something more is happening. The music has a strong power for the client to ‘fall in love with the therapist’. It's bound to happen because of that special relationship you have, verbally and musically. (Participant one)

When listening to this music therapist, I became aware of his sense that, because of
the musically intimate environment there is a natural tendency for these feelings to develop. Through later reflection and analysis, I became aware of the subtle challenges faced with this example. This music therapist also described a situation where a client at the end of a session had given him a red rose. This was a surprise to him and he felt that the client had developed certain feelings for him. These situations led me to reflect on the potentially challenging nature of the musically intimate experiences.

Seven of the music therapists interviewed described an experience where they felt a client had developed strong feelings for them. Sometimes the client had expressly told them about more intimate feelings and at other times the music therapist had interpreted their clients’ actions. My sense was that the musical interactions were implicated in this increased intimacy, more than in the therapeutic relationship itself and that somehow, by making music together, potentially led their clients to feel there was more to the relationship than the music therapist intended.

The challenges discussed here present complex situations that appeared to be negotiated with the clients. The word negotiation originally came from the research question and my initial ideas about boundaries in music therapy. The participants’ descriptions of these challenging situations revealed a type of negotiation between the music therapists and their clients. There was a strong sense that the music therapists were trying to balance the needs of their clients and the needs of themselves. With later analysis, I re-examined these challenging experiences and found a strong sense of negotiation with the clients.

These music therapists’ descriptions suggest that musical intimacy may present an array of challenges. These may include vulnerability, triggering of emotions for clients, boundaries around friendships with clients and the idea that music may evoke feelings of love and sensuality. These challenges were handled in a number of ways, which formed another stream of analysis examining how the music therapists responded to these situations. This revealed a new way of being and responding to the complex situations present in and around musical intimacy.

Core concept four - Ways of being and responding to musical intimacy
Through the analysis of the music therapist’s transcriptions, musical intimacy has been defined. The interpersonal experiences and the intrinsic components of music are the two core concepts that contributed to each music therapist’s experience of musical intimacy. From these ideas, the music therapists in this study experienced a spectrum of experiences, from powerful moments of connection to challenging experiences. The analysis and reflection on musical intimacy revealed a need to examine how music therapists were managing this.

I applied a conditional matrix (Strauss & Corbin, 1998) to the phenomenon of musical intimacy (Appendix A). The conditional matrix was a tool that allowed me to explore the concept of musical intimacy and its surrounding conditions, context, strategies and consequences. During this process, I became aware that one of the interesting aspects was exploring what strategies the music therapists were using to manage musical intimacy. This spurred a new stream of analysis where I re-examined the data. The ways of being and responding to musical intimacy emerged from this analysis.

The ways of being and responding illustrate the ways the music therapists managed musical intimacy in their clinical work. This included many approaches, strategies and processes that the music therapists used with musical intimacy. These ideas describe how the music therapists negotiated the boundary challenges that sometimes occurred within the realm of musical intimacy. The four central themes to
emerge are; 1) processes during the musical interaction, 2) initial responses after the musical interaction, 3) later reflections, and 4) pre-determined factors. Figure 5.6 below shows the number of participants who contributed to each theme, and how many times these ideas were referenced. Looking at this graph, it is clear to see that processes during the musical interaction was one of the strongest areas to emerge. All of these themes were made up of smaller strategies and include all the processes described by the music therapists. These will not all be presented in detail, but are included in Appendix C, to give the reader an overview of all the themes that emerged in this area.

![Figure 5.6 Strategies for Managing Musical Intimacy](image)

**Processes during musical intimacy.**

Processes the music therapists used, during the moment of musical intimacy, emerged as an important idea (17 participants). The music therapists commented on varying ideas describing what they were doing in the moment of making music. Through this, some common themes emerged. Initially, I was keenly interested to discover how music therapists were managing musical intimacy in their practice. After re-examining the data, I was surprised by the amount of processes described during the moment of making music. These processes illuminated the many and varied strategies that music therapists may use during the moment of ‘musicking’ (Small, 1998) with people.

Some music therapists described using musical elements to maintain safety
while others discussed being flexible and following their intuition. Some of the common themes to emerge were: 1) being authentic with yourself and your client, 2) analysing at the same time as playing, 3) working from intuition, 4) using musical parameters to manage intimacy, 5) monitoring level of musical input to manage intimacy, 6) being flexible, 7) having a heightened awareness, and 8) using musical check in. These themes are listed below in Table 5.3, including how many times they were referenced and how many music therapists contributed to that theme. I will now outline these themes in detail using examples from the participants.

Table 5.3

<table>
<thead>
<tr>
<th>Processes During Musical Intimacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the moment</td>
</tr>
<tr>
<td>Be authentic</td>
</tr>
<tr>
<td>Analyse at the same time as playing</td>
</tr>
<tr>
<td>Working from intuition</td>
</tr>
<tr>
<td>Using musical parameters as a strategy</td>
</tr>
<tr>
<td>Monitoring the level of musical input to negotiate the intimacy when playing music</td>
</tr>
<tr>
<td>Being flexible</td>
</tr>
<tr>
<td>Awareness</td>
</tr>
<tr>
<td>Information from music</td>
</tr>
<tr>
<td>Relax and wait</td>
</tr>
<tr>
<td>Sometime letting go in the music</td>
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</table>

*Be authentic with yourself and your client.*

Many of the music therapists described how they aimed to be authentic in their
musical interactions with their clients (eight participants). There was a sense that, if they were authentic within the musical interactions, this would support their clients and allow room for them to have meaningful musical experiences. This feeling of authenticity emanated through the participants’ descriptions of how they approached the musical intimacy experiences. One music therapist described being authentic as being comfortable within themselves while making music with their clients. They state; “so when I take into consideration what I’m comfortable with, I have to take into consideration the patients level of comfort” (participant two). This also illustrates how this process invokes both the music therapist and the person they are working with.

Another music therapist explains how authenticity is embedded with their approach to music therapy. He explains:

Part of my tradition is about being much more authentic. I try to be an authentic musician. Of course, I'm a therapist and I’m thinking about what am I doing. Is this ok? But at the same time I'm kinda enjoying myself and being authentic with my playing so I can support her. (Participant 10)

This music therapist described how being an authentic musician is important because it communicates to his clients that their interactions are valid. Through this music therapist’s descriptions, I became aware of the importance of authenticity for him. Being authentic meant playing music in a way that enabled a powerful connecting experience through musicking (Small, 1998). This is embedded in his approach to be authentic with his clients so that he can build the therapeutic relationship.

For another music therapist, they talked about the need to be authentic within themselves and acknowledge that being a musician is a part of their identity. She described:

I think that you have to work in a way so that you can be authentic. I’m a person before I became a music therapist, I did a lot of music and I have done a lot of music. I’ve been singing in choirs and singing in bands and I love music.

(Participant 14)

In a similar way to the previous music therapists, this music therapist was describing being an authentic musician within herself. This seemed to mix with her idea of being an authentic person in her approach to music therapy work. When re-examining the data later during focussed coding, I noticed how being authentic was a strategy to manage the musical interactions. Through the music therapists’
descriptions of being authentic, I sensed that it was a way of managing the musical interactions so that their clients would feel safe and supported. One music therapists commented:

I think the way I approach it, for me, is finding the most appropriate way of conveying like honesty with clients, with parents and with carers, and again kind of thinking about what feels right and what doesn’t. (Participant 8)

This kind of honesty and authenticity seemed to help the music therapist in the moment of making music. For these music therapists, being authentic was a way of conveying their intentions and helping to provide opportunities for meaningful experiences.

**Analyse at the same time as playing.**

The theme of ‘analysing while playing’ emerged from seven participants. When I first coded this theme, I felt that this was a concept that most music therapists could relate to. In my experience, analysing while interacting through music is one of the fundamental skills that we have as music therapists. For some music therapists, this was about balancing playing, responding, thinking about what the client might need, supporting and interpreting, all in the moment of making music. One music therapist described how she feels:

During the session it fluctuates between me totally letting go in the music and playing music, being with the client. It’s like being at many levels at the same time. I have a kind of inner supervisor that is checking with me ‘is that alright?’ ‘when should I stop?’ ‘Ohh, I heard something there’. So I need to have an inner supervisor, internalised supervisor that’s present in the sessions (participant seven)

These strategies appear to help keep the interactions safe and supported in the moment of musical intimacy. Another music therapist reflected this:

I will assess where someone is comfortable and what do they seem to need me for. It doesn’t mean that I will always choose to do that but I will look at what’s comfortable. I will look at who they are now in the music, so that can give me information. (Participant 15)

This music therapist placed great emphasis on assessing how comfortable her clients were in the moment of making music. The idea of analysing while playing was
a process that helped the music therapists to manage the intimacy. For me this theme highlighted an implicit understanding in music therapy practice, which is highlighted by the concept of musical intimacy.

**Working from intuition.**

Working from intuition was an interesting theme that emerged from seven participants. This theme emerged from the initial analysis and reflections during the data collection stage. I was struck by the music therapists’ descriptions of following their intuition or gut feeling. Later while exploring the individual narrative stories of each music therapist this theme was prominent. Finally, while specifically exploring the different strategies to manage musical intimacy, this theme solidified.

One music therapist commented; “My intuition tells me that even though the client might want me to back off, I think we have some work to do. So I might confront or explore” (participant one). Interestingly, this music therapist will follow his intuition even though he may feel resistance from his client. This reliance of intuition suggests a strong belief in this approach.

Many of the music therapists described how the sense of following their intuition has grown over the years of practice. One music therapist described following her gut in regards to song choice and how this reflected projective identification. She commented; “I guess because I’ve been a music therapist for so long I usually trust my gut. And so, if a song comes up, so many times it’s been spot on that I usually will err on the side of playing it” (participant 12).

Another music therapist commented; “I think it’s very much an intuitive thing. I love theory but I also go from gut first so” (participant three). Following our intuition is perhaps one of our implicit understandings about what makes music therapy work, especially when we are involved with intimacy and music. Similarly, another music therapist discussed; “Just think about following your gut and just kind of listening to that inner voice” (participant eight). Through following their intuition these music therapists were able to be flexible and adaptive to the intimate musical experiences.

**Using musical parameters to manage the intimacy.**
Using musical parameters emerged as a strategy to help manage musical intimacy (six participants). This theme included using particular musical components, such as repeating octaves or providing a strong chord ground, to help manage the intimacy in the music making experience. This theme first emerged during the analysis of participant four. She described a challenging experience where she felt the improvisation moved into an unsafe environment. She described using musical parameters to return the improvisation back to safety. It was interesting hearing this music therapist describe using music in this way and I found this reflected in other participants’ experiences. Some music therapists set up the instruments so that the individual can manage how close they are physically and provide a physical barrier if they need too. Others used safe and predictable chord structures for their clients to play and express themselves over the top.

One music therapist described her use of musical parameters:

As a music therapist you can create boundaries within the music through different parameters. For instance, if you want to create a holding structure, you can repeat a certain progression, or rhythm, or melody or certain theme. You create a boundary for a person that needs boundaries and needs to be held very firmly. So music is a wonderful tool to do that. (Participant 7)

Using musical parameters was an interesting theme that highlighted the musical ways that some of the music therapists used to manage musical intimacy. This reveals another intrinsic understanding about the ways that music therapists naturally use music in music therapy. Music can create these intimate experiences, yet through its structures and elements, music therapists can also use music to create safety.

*Monitoring the level of musical input to manage the level of intimacy.*

Managing the level of their musical input to manage the level of intimacy emerged from six music therapists. These music therapists felt that sometimes music could be too strong for their clients. They described monitoring how much music and what kind of musical experiences they would introduce to manage the intimacy and safety in the moment of making music. One music therapist described:

When is it too much, when are you merging with the client, when should you not merge with the client, when should you stop playing, when should you pull back.
(Participant seven)

Similarly, another music therapist commented; “so I think it’s important for me to work near and more far away, so I can help them to regulate, because they have no choice in being intimate” (participant 13). Another music therapist commented; “When trying to match their mood and energy with music, I’m seeing what their response is, asking them and watching their body language as that changes with music” (participant 17). These experiences all reflected the music therapist’s belief in monitoring their musical input to maintain safety for their clients.

**Being flexible.**

Some of the music therapists also described the need to be flexible in the moments of making music with people (five participants). They saw flexibility as essential in managing musical intimacy because of the myriad of directions making music with someone can take you. They stressed flexibility in their approach, methods and responses to the individuals they were working with. One music therapist commented:

> It can’t only be structured, but perhaps it can’t only be improvisation. I think there’s structure in improvisations too. There has to be room for changing structures I think, if the child wants to and if it feels right. That is together we’re being here and now. (Participant 13)

For this music therapist, it was important to her to have some kind of structure within her approach, which also included a lot of improvisation. However, she also knew that her structures could be completely changed depending on how the children were responding and what she felt their needs where. Her flexible approach was embedded within her language.

Another music therapist described:

> I feel like I’m constantly rolling out the red carpet to say ‘do you want to go here and there’, and I have to responsibly be very careful that I’m not going into my own aesthetic or my own emotional needs. Either for the music or for the relationship. So I think this is what fascinates with this process. (Participant 15)

This music therapist was very flexible in her approach, constantly throwing out new ideas to see what her client would respond to. She also described how she monitored
herself in the process and was careful not to go into her own needs. This highlights how with flexibility we also need the heightened awareness, not only of our clients but also of ourselves. This theme emerged during the analysis of strategies to manage musical intimacy.

**Initial responses.**

Many of the music therapists described the initial responses that they would use following a musically intimate experience (13 participants). During the focussed coding stage, the strategies were examined further. By re-examining the data and specifically looking for the strategies, a number of processes emerged. This central theme includes the processes that the music therapists described using after the musically intimate experience. These were processes of how they would work through anything that emerged during the moment of making music. The full list of initial responses is listed in Table 5.5. This table also includes the total number of times that theme appeared and the number of participants who contributed. The two common themes within this were, 1) verbally checking in, and 2) addressing what comes up in the musical interaction. These will now be discussed in detail.

<table>
<thead>
<tr>
<th>Table 5.4</th>
<th>Initial Responses after the Musically Intimate Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>After the moment strategies</td>
<td>Total times found</td>
</tr>
<tr>
<td>Verbal check in</td>
<td>16</td>
</tr>
<tr>
<td>You have to address it</td>
<td>11</td>
</tr>
<tr>
<td>Checking in</td>
<td>5</td>
</tr>
<tr>
<td>Checking in with myself</td>
<td>5</td>
</tr>
<tr>
<td>Musical countertransference discussed</td>
<td>3</td>
</tr>
<tr>
<td>Continually negotiate with clients</td>
<td>1</td>
</tr>
</tbody>
</table>

**Verbally checking in.**
Verbally checking in with the clients after a musically intimate interaction emerged from 8 music therapists. As I identified this strategy, I reflected how processing musical interactions in this way is a common process in music therapy. This theme reflected the music therapist’s ways of checking that their clients were coping all right through discussion after a musically intimate experience. One music therapist discussed:

I looked up certain Hungarian songs, and, when he listens, there’s an absolute outpour of emotion. So the first time when I saw him I asked him, ‘do you want me to stop? This seem to be quite an emotional experience for you.’ And he said ‘no, no, don’t stop. I just want it to continue. (Participant six)

This music therapist made the decision to stop the music making to verbally check in on their client. This verbal check in seemed to provide this music therapist with a concrete way of checking that the emotional trigger was still a helpful experience for the person he was working with. The way that this music therapist described this suggested that it was a natural process that he uses in his practice.

For another music therapist, it was important to check in on his clients, often stopping the music to ask. This music therapist worked with adults who have mental health issues and he felt that he needed to be aware of how his clients were coping, which sometimes meant stopping the music to ask verbally. He commented:

Then I would stop. There have been times where I have stopped and asked if are you ok? And if they say, “I think so, or I don’t know”, then we would talk a little bit. (Participant 10)

This was the music therapist’s way of checking in and working through any potential issues that were coming up through making music together.

Through the music therapist’s descriptions, it was clear they felt this was an important aspect to their work. To verbally check in with their clients appeared to be an essential tool to help manage emotions or experiences that happened in and around the music. These experiences may be challenging for both the client and the music therapist, but the verbal processing of these issues seemed to help aid the therapeutic process and keep the experience safe for both parties.

**Addressing what comes up in the musical interaction.**

Some music therapists described how they would address anything that had
come during the music making (seven participants). They would address it verbally or with further exploration through making music with their clients. Many of them described that you have to address issues or intense feelings that arise during making music as it would be detrimental to the therapeutic process if they did not.

One music therapist reflected:

We always have to work on that afterwards. We can’t just go ‘oh well you had a cry’. So our skills in terms of managing that intimate emotional connection are important, is what I’ve found. (Participant two)

Through this music therapist’s descriptions, it was clear that she felt the need to work through anything that came up during the music making experience. This process was a way of directly addressing any issues that had arisen out of the music making experience.

Another music therapist described her approach in dealing with what she labelled as musical transference and counter-transference:

I operate with subjective countertransference and inter-subjective countertransference. Meaning, during the intimate improvisation in the music, I might pick up on some feelings that the client might not pick up upon. That could be inter-subjective countertransference because it’s related to what is subconscious in the client’s music, there could be some feeling evoked in me that is personal countertransference. Meaning that, if the client is kicking up something in my past that did happen and maybe I haven’t worked through those issues deeply enough, that’s my countertransference. (Participant seven)

As I listened to this music therapist, it was clear that she has reflected a lot about this process. She described picking up on emotional feelings through her clients’ expressions in the music and how she has to address that afterwards. She particularly emphasised the intimate nature of these interactions as contributing to this idea of musical-countertransference.

Later reflections - supervision and reflection.

Some of the music therapists described later reflective processes that they undertake to work through issues that have arisen with their clients (eight participants). Although this theme relates to all process in music therapy, some of the music therapists commented on how it is particularly useful with musical intimacy.
This was due to the idea that many of the challenging experiences that arise with musical intimacy are non-verbal. Because they are non-verbal, these music therapists stated that it is helpful to get another perspective. Some of these aspects relate to self-care strategies that music therapists use as part of their clinical practice.

One of us described this aspect commenting:

That’s why you want to have supervision so that in those cases where there might be blurred boundaries because we work in music, you can get help to clear the boundaries a little bit more, and also get help to understand what is going on, even though it’s non-verbal. (Participant seven)

This music therapist had described how she uses supervision to work through challenging aspects that may happen because we work with music. To manage the nuanced elements of musical intimacy and continue to keep the environment safe for both parties, supervision played an important role for this music therapist.

The other idea that many of us described was using reflection as part of their processes. One music therapist reflected:

So I think that I have learned from the times where I’ve not been so exquisitely sensitive, and I’ve realised one could reflect (on that) and go ‘oh I’ve been frustrated with them and my music will push’. I have to feel my presence, because we communicate so much without talking. If I’m eager for them to get somewhere then I’ll keep pushing. (Participant 15)

This music therapist has described how she will reflect on her processes in music therapy, especially when things may not have gone as well as she would have hoped. Reflection and supervision are two ideas that are found in music therapy discourse. They merged here as a way to help the music therapist process musically intimate experiences, especially because some of them are non-verbal experiences.

**Predetermined factors**

In addition to the ways of being and responding, there were pre-determined factors that influenced musical intimacy and the ways that we respond to it. These ideas are centred on components of music therapy that are pre-determined before we interact with our clients in music therapy. These ideas include; 1) our individual approach and experience with boundaries (eight participants), 2) how we set up the music therapy session and process beforehand (nine participants), and 3) our approach.
to music therapy (six participants). These ideas also emerged out of the stream of analysis in focussed coding that specifically examined how the music therapists were managing musical intimacy. These will now be explained in detail.

**Boundaries.**

Some of the music therapists described boundaries as essential in managing any issues that can arise with musical intimacy in our music therapy practice (nine participants). For these music therapists, boundaries varied greatly due to training, theoretical approach, the context where they worked, the people that they worked with and their own individual approach. The music therapists also believed that boundaries related to many areas of music therapy practice. One music therapist commented:

I have to manage those boundaries and I have to say yes, shaking your hand for a socially appropriate amount of time is good. So where’s my line, where do I draw that and sitting next to me with our legs touching, that’s not appropriate. So I know where my boundaries are and I have to manage that.

(Participant two)

For this music therapist, she needs to be aware of where her personal as well as professional boundaries are. She explained that this continues through the musical interactions, using an example of when she was playing and a client sat next to her and put his hand on her knee. For her, this was a boundary moment that had to be negotiated with her client. Through her descriptions, I became aware of the potentially challenging nature of musical intimacy in regards to managing her boundaries.

Another music therapist works in a community approach to music therapy. He described some of the complexities around boundaries in this context.

It’s a band community and things are difficult. I think the team should be shared and that should also include me. So I think there are some kind of rules for things you cannot do, so you have to follow those rules for society, so that makes some boundaries. A lot of things that I do, are maybe in conflict (with a) traditional treatment view. You really need to be aware that there are ethical considerations. You need to reflect and you need to know what you’re doing and be very aware of that. (Participant nine)
For this music therapist, he felt that there were certain ‘rules’ in society that could guide his work, because it took place in the community. For this music therapist, he was working in the community and often in individual’s homes. Through his descriptions, the need to be very aware and reflexive about his ethical decisions was evident. Additionally, he described this work as a band community. The way he describes this suggested other complexities with this band culture in the negotiation of boundaries. This may speak to how boundaries are influenced in the different contexts in which we work, and how musical intimacy is experienced in each context.

Boundaries are often implicit in the understanding of how we should interact and respond in our music therapy practices. Through these music therapists’ experiences, boundaries appeared to play an important role in managing musical intimacy. Boundaries seemed to be interconnected with the processes and responses to the sometimes challenging and complex situations that arose through and around musical intimacy.

One music therapist commented on the variation in boundaries that are needed. He noted; “It's not just when the music is quiet and very intimate, there are boundaries at the other end as well. You have to be aware of a lot all the time” (participant one). Another music therapist reflected on boundaries particularly around the use of music. She commented; “They find it easier to relate to me because I'm a musician. That level of relationship is easily achieved but has to managed to be sure of our boundaries” (participant two).

In a similar way, another music therapist reflected about the complexities around boundaries because we use music;

It's a place of peace and strength in this work, accepting that, with music, there is no boundary. We could share music here and then hear the same song on the radio. Or the song I've just created with the person can go round and round my head. It's not bad. It's the nature of music, it moves in time and it brings continuity. (Participant 17)

This is an interesting example as it speaks to the idea that music is everywhere. As music therapists, we may have unique complexities as the music we use in our practice may be present in other aspects of our personal lives.

Setting up beforehand.
Some of the music therapists described intentionally setting up the space, the room or mentally preparing themselves before going into the musically intimate experiences. This was their way of preparing for the musically intimate experiences to try and make sure they were a positive experience for their clients. One music therapists reflected on a sense of safety needed for musical intimacy. She commented:

So I think we do have to have the safety, whether it’s the therapeutic relationship or the space that we’re working in. Safety is going to come from different places for different people, but we have to have that there in order to facilitate and for intimacy to occur. (Participant 20)

Differently, another music therapist commented on his preparation. He notes:

What I do to get rid of all that, to make myself really relaxed and comfortable to make sure this works. When I walk into the room, I just close my eyes for a second and just say ‘what am I doing today?’ and I say, ‘I’m going to become them, I’m going to become one of them, I’m going to become them’. I’m going to talk on their level; I want to know what it’s like to be them.

( Participant 16)

This music therapist stressed the need to take a moment for himself in order to become on the same level as his clients. He emphasised that he did not mean that he was above them, but more that he wanted to try and understand what these experiences were like for them.

**Approach.**

The approaches of the music therapists varied greatly. These differences appeared to influence how musical intimacy was experienced and understood. The music therapists identified with a range of theoretical orientations including; psychodynamic, humanistic, creative, neurological, community, resource orientated and developmental approaches to music therapy. In addition, some of the music therapists described particular individual approaches to their musical therapy work. These were often context or client specific approaches that changed the way that musical intimacy was experienced for the music therapists. One of the music therapists described her work with children with multiple and physical disabilities. She commented:
I cannot be afraid of using my body, my voice or everything. I think that’s how we communicate the intimacy, everything. Because, when I have children with no language, they read my feelings, my body language, they read all the other things that aren’t spoken words. I think it’s very important what I’m doing with my whole body. (Participant 13)

For this music therapist, her approach is to use everything in her body to get in contact with her clients. For her, this allows the intimacy to happen and also for her clients to see what she is communicating through her body. In this sense, this music therapist’s approach influenced how music intimacy is experienced for herself. She perceived that this also helps her clients to understand her and communicate with her through the music at a level of intimacy that is comfortable for them.

**Conclusion and summary of emergent theoretical framework**

This chapter has detailed the theoretical framework of ‘musical intimacy and the ways of being and responding’, that emerged through a rigorous grounded theory analysis. The core concepts within the theoretical framework include; 1) interpersonal experiences, 2) intrinsic components of music, 3) a spectrum of experiences in musical intimacy, and 4) ways of being and responding to musical intimacy. This theoretical framework answers the research question: how are music therapists negotiating the boundary challenges that can occur in the musically intimate context of practice?

Through this research, musical intimacy has been defined. The grounded essence of the musical intimacy experience captures the core characteristic of what musical intimacy is about, which is: the therapist experiences a powerful moment of connection in and around the music that triggers an acute sense of vulnerability and reveals the need for boundaries to keep things safe. The next chapter will discuss the theoretical framework in relation to current theories, music therapy literature and its relevance to the music therapy profession.
References

Chapter 6
Discussion

Introduction.

Through this research I have explored the actions, processes and experiences of music and boundaries from the perspective of twenty music therapists. The most interesting idea to emerge from this research is the concept of musical intimacy. Musical intimacy captures an intrinsic aspect of music therapy practice, which draws attention to the intimate nature of music-making and the complexities surrounding it. The concept of musical intimacy may provide a way for music therapists to be aware of the potential for challenging situations in and around our interpersonal experiences with music. The ‘ways of being and responding’ may add to music therapy discourse as they could encourage music therapists to consider boundaries in a way that is flexible and related to context. In addition, music therapists could reflect on their theoretical approach and personal foundations, in and around the musically intimate context in which we practice.

This critical investigation, using a grounded theory approach, resulted in a theoretical framework of musical intimacy that was detailed in the previous chapter (see Figure 6.0). The primary concepts within this theoretical framework are; 1) the interpersonal experiences in and around music, 2) the intrinsic components of music, 3) the spectrum of experiences that are influenced by the grounded essence, and 4) the ways of being and responding to musical intimacy. This theoretical framework presents aspects of music therapy that have not been extensively explored before. Furthermore, this interaction of music and boundaries captures a spectrum of experiences in music therapy that can be intimate, challenging and powerful.
In the centre of this theoretical framework, the grounded essence of the musical intimacy experience emerged. This is one of the most interesting findings as it captures the core idea of how musical intimacy illuminates the intricate and intimate moments in music therapy practice that happen in and around the music. The grounded essence is: the therapist experiences a powerful moment of connection, in and around the music that triggers an acute sense of vulnerability and reveals the need for boundaries to keep things safe. The grounded essence of musical intimacy conveys the underlying experience of what musical intimacy is. The music therapists
in this study experienced musical intimacy in various forms. They reflected, guessed and interpreted their client’s experiences of what they perceived to be musically intimate moments in music therapy. They all described powerful moments of connection, that captured moments where there was potential for things to be challenging through the exposing nature of the experience. These moments were strong experiences for the music therapists and were often described as a ‘gut feeling’ where they felt that something powerful had occurred or was currently happening.

This is similar to Kenny (2006) who deliberated with finding the language to describe her work, noting “without losing the immediacy and vibrant movement of the dance we sounded in the music, in the relationships” (2006). This language comes close to describe the ‘dance’ of musical intimacy. To quote one of the participants; “there’s reciprocity and a flow, that’s where the powerful moments come from” (participant four). Musical intimacy captures the unspoken, intricate elements that make up the multiple interactions we experience when making music with people.

Influencing this grounded essence are the concepts that may contribute to music intimacy: the interpersonal experiences and intrinsic components of music. The interpersonal experiences cover the range of interactions that we have in and around music. The intrinsic components of music refer to the ideas about how music has natural abilities that contribute to our musically intimate interactions.

Surrounding this framework, a new approach to boundaries emerged entitled ‘ways of being and responding’. This approach details how the music therapists in this study reflexively reacted to their experiences in and around musical intimacy.

This theoretical framework for musical intimacy emerged from the participants’ experiences, memories and reflections that I gathered through intensive interviews. Through these descriptions, I uncovered underlying experiences in and around the music where the participants described powerful moments of connection and challenging situations. These moments were defined by an acute sense of vulnerability observed in the music therapists’ descriptions, bodily language and expressions, and my reactions and interpretations during later analysis. One interesting finding was the idea that musical intimacy brings to the surface our implicit assumptions about the intrinsic power of music, viewing music as naturally powerful, intimate, inviting and revealing. The intimate nature of these experiences has revealed some potential challenges of using music in music therapy.

Through this research, I have discovered an array of experiences of musical...
intimacy from the twenty music therapists who participated in this study. Nineteen of them responded with apparent enthusiasm to the idea of musical intimacy. This seemed to be fuelled by their individual experiences of what they perceived musical intimacy to be. However, one music therapist was not comfortable with the term intimacy and preferred to describe their experiences as ‘musical interactions’. Even though this music therapist did not agree with the term, he described situations, which I interpreted as intimate through and around music.

Upon entering this research journey I was keenly interested in boundary theories, questioning if they were relevant to contemporary music therapy practice. Central to these ideas were experiences in and around music where I felt challenged by traditional concepts of boundary theories that were assumed to guide this work. These traditional boundary theories did not capture the complexities of the intimate interactions experienced in my practice. In the initial stages of this research, musical intimacy emerged as an interesting finding from a critical interpretive synthesis of case studies in music therapy practice (Medcalf & Mcferran, 2016). This focused my research to centre on the concept of musical intimacy and explore how music therapists were negotiating the boundary challenges around that. My assumption was that musical intimacy was present across all music therapy practice. I also sensed that musical intimacy could both be a powerful component in music therapy and also create challenges that were unique to music therapy practice. I had experienced these powerful moments of connection in my own practice that had led me to question “is this safe for me and the people I work with?” and “how do these powerful moments of connection influence my practice of music therapy?”

Outline of the chapter.

The emergence of this theoretical framework has encouraged me to reflect on certain aspects of music therapy discourse. The first idea that I will reflect on is the power of music that emerged through the theme of the intrinsic components of music. How can ideas on music and identity, and music and emotion influence the experience or our understanding of musical intimacy? Does this perceived power of music influence the power dynamics in the therapeutic relationship? I will explore these ideas by reflecting on contemporary approaches to music therapy, which have questioned the traditional power dynamics in the therapeutic relationship.
Another interesting component of this research is the spectrum of experiences that were described by the music therapists. Some music therapists have explored the idea of powerful moments of connection, such as meaningful moments (Amir, 1992), pivotal moments (Grocke, 2006), and significant moments (Trondalen, 2005). Challenging experiences have rarely been explored in the music therapy literature and I will reflect on these experiences using some of the emerging literature on unhealthy uses of music.

Following this, I will outline some of the prominent theoretical models of music therapy and discuss how they understand and use music. Through this, I will demonstrate how musical intimacy may be a concept that is relevant to the different theoretical approaches. The theoretical approaches that I will reflect on are: 1) consensus model (Ansdell, 2002), 2) psychodynamic, 3) music centred, 4) community music therapy (CoMT), and 5) resource orientated music therapy (ROMT). I will then outline the ‘ways of being and responding’, linking this with literature on therapeutic boundaries. This will include discussion on roles, context, personal foundations and assumptions, and ideas on embodiment. I will follow this with a discussion on the relevance and value of musical intimacy in contemporary music therapy practice. Finally, I will provide a critical reflection on this research, describing some of the limitations of this project.

The power of music

“Music can be a natural healer, whether we realise it or not, both preventative and curative” (Kenny, 2006, p.12). What power are we attributing to the music in music therapy? The music therapists in this study all described music as doing something to themselves, their clients or the therapeutic process, which contributed to the concept of the intrinsic powers of music, and the wider concept of musical intimacy. The language the music therapists used revealed their perception of the power of music, and that they believed this to be an implicit understanding in music therapy practice. Furthermore, there was a sense that the music therapists may not be taking responsibility for this power; that it was the music itself that was creating powerful or challenging experiences, not the interactional contexts or relationships that were leading them to unsafe territory. By placing power on the music itself, we are in danger of being unethical, and as Stige (2002) states: “is it the power of
musicking, not the power of music itself that is central to the practice of music therapy” (Stige, 2002).

In some sense, the power of what music can afford us is central to music therapy practice. Ruud (2010) suggests, “music, because of its arousing power, its ability to make us feel, is the difference that makes the difference” (p. 41). Here he is alluding to the natural power of music that we draw upon in music therapy practice. In light of this study, how we understand and use music in music therapy is important to reflect on. If we place power on the music itself, this may create challenging situations or influence the power dynamics. There is the possibility of moving responsibility away from the therapist, shifting our awareness of the impact of music and potentially causing harm for the people we work with. In this research, discussions on the power of music in music therapy emerged and contributed to the concept of intrinsic powers of music. Some ways it was described included the power of music to trigger emotion, to easily create connections, to communicate on different levels, to bypass defences and to reveal information about the people we work with. This power in the music may influence the dynamics in the therapeutic relationship in multiple ways and the way it is used and acknowledged should be something that we continually reflect on.

Through this next section, I will discuss some of the areas that have arisen in relation to the power of music in music therapy. The power of music in our own individual lives will be examined, reflecting on how this may translate to music therapy work. The therapeutic relationship and how music and power are intertwined will be examined, using examples from different theoretical frameworks. In addition, the growing notion of unhealthy uses of music in everyday life, and how this may transfer to unhealthy uses in music therapy, will be outlined. The musical intimacy theoretical framework has illuminated the complexities of our musical experiences. Furthermore, it has questioned how the perceived power of music influences the intimate and powerful moments in music therapy practice.

The power of music in our individual experience and the power of music in therapy.

The power of music in our individual lives is one of the strengths that we draw upon as music therapists. How music is appropriated (DeNora, 2000) in everyday life
influences music therapy practice, particularly in the powerful moments of connection present in musical intimacy. Two areas that have received much attention in the literature include; 1) music and identity, and 2) music, emotion and mood management. The relationship between music and identity is strong and this impacts how we experience music in music therapy. Our individual musical relationship may influence the musically intimate interactions and the management of boundaries. Furthermore, how much we ‘perform’ (Ruud, 1998) our identity through our musical interactions, may impact the powerful moments of connection or the challenging experiences in a myriad of ways.

Music and emotion are inextricably linked, and their influence on musical intimacy was strong throughout this research. Music was discussed as triggering emotion in the interpersonal experiences, and the musical interactions were often described as highly emotional. The need to consider music and emotion and how this influences the spectrum of experiences in music therapy became apparent through the discovery of this theoretical framework. The strong links of music and emotion, and music and identity, may influence how we understand musical intimacy and the spectrum of experiences that are created. I will now outline some of the relevant theories on music and identity, and, music and emotion, reflecting on their influence on music therapy and how they are related to this theoretical framework.

Music, identity and musical experiences.

The connection between music and identity is an interesting concept that has received wide attention in music therapy and related disciplines. For some of the music therapists in this study, the way that the individual’s identity interacted with music seemed to influence the musically intimate experiences. The interpersonal experiences in and around music are a key aspect of the theoretical framework of musical intimacy. These experiences contained emotional, social, personal, physical and communicative elements, and often the personal musical relationship was revealed. The interaction of music and identity is wrapped up in the experience of musical intimacy, and appeared to influence how music therapists respond to and manage these situations.

Music and identity has been the topic of interest for many (DeNora, 2000; MacDonald, Hargreaves, & Miell, 2009; Ruud, 2010), with varying views about the
nature of how music may influence, interact or reflect different parts of our identities, or contribute to identity construction. Ruud (1998) stated, “listening to, performing and talking about music is not as much a reflection of identity as a way of performing our sense of ourselves, our identity” (p. 3). This ‘performance’ of our identity, influences how we interact in and around the music in music therapy. Identity in itself is a multilayered concept that is defined in many different ways. The interaction between music and identity is a stimulating concept for music therapists and Ruud (1998) suggests that “identity may provide a bridging concept between music therapists and Ruud music in everyday life” (p. 38). Also interesting is how Firth (2013) described music and identity as a dynamic experience, where individuals continually engage in an active process where music is an integral part of shaping their identity. The nature of our musical interactions, may be strongly influenced by the interaction of music and identity, and therefore influence our musically intimate experiences.

North and Hargreaves (1999) put forward the notion of a musical identity that affords social roles. Here they suggest that music strongly impacts individual identity in a way that it becomes an essential characteristic of who they are. Music stereotypes are a common concept with music psychologists, and they suggest that association of non-musical attributes to particular genres draws people to particular music, thus contributing to their identity construction (North & Hargreaves, 1999; Tarrant, North, & Hargreaves, 2002). In an investigation into music stereotypes with 80 young people in Brittan, Rentford, MacDonald and Oldmeadow (Rentfrow, McDonald, & Oldmeadow, 2009) found that the participants similarly recognised particular psychological, cultural and social aspects to different music genre groups. For some, musical identities may provide a way to recognise social qualities that are similar to our own. For music therapy this may influence how individuals interact with music, impacting on the musically intimate experiences in practice.

An example of how music and identity influences musical intimacy was highlighted by one participant’s reflection on an experience with a young person in an acute mental health setting. Through their improvising and playing together, the music therapist felt that he had built up a strong relationship with the individual. He described powerful moments of connection through music, which he suggested was part of musical intimacy. His client used to perform in bands with friends, and the music therapists felt that this was a big part of his identity. After having these musically intimate experiences, the client asked the music therapist if his band (who
he had not played with for a long time) could come into the hospital, rehearse and work towards performing for a festival in the city. He wanted the music therapist to be his drummer, and often referred to him this way. Although the music therapist could not allow this (due to the boundaries of the hospital context), he was able to support this part of his client’s identity through their musically intimate experiences. The musical identity appeared strong for this individual and, through the musically intimate experiences, it became a part of his recovery process. In addition, the individual’s musical identity was enhanced and encouraged by the powerful moments of connection in musical intimacy.

This is similar to Rolvsjord (2010) and Solli (2015), who suggest the potential of musical identity to contribute to positive health changes through the intrinsic interaction of music and individual resources. This interaction of music and personal resources, may contribute to how the powerful moments of connection are experienced. In the above example, it seemed as though the intimate musical interactions were tapping into the client’s musical identity, in a way that supported the inner resources that he held through his use of music. His strong musical identity, influenced the powerful moments of connection and in turn his recovery process.

Similarly, Hense, Skewes McFerran and McGorry (Hense, McFerran, & McGorry, 2014) explored the notion of young peoples’ recovery of their musical identity in mental illness. Through a constructive grounded theory study with 11 young people who identified with a mental illness, three phases of change in the process of recovering musical identity emerged. These are, 1) expressing the isolated musical identity, 2) bridging musical identity through music therapy, and 3) goals of playing out musical identity in the community (p. 597). One interesting concept was the idea of the relationship between musical identity and symptoms. They described how musical identity can both represent an expression of the participant’s pathology during an acute illness stage, but also act as a bridging process from isolation to community. For musical intimacy, how a patient may express their pathology through their musical identity could contribute to the spectrum of experiences in musical intimacy.

Hense, Skewes Mcferran and McGorry (Hense et al., 2014) assert that the engagement of the isolated musical identity through music therapy, acts as a bridge moving people from isolation to social connection. This assumes that the process of music therapy provides a space to enable this to happen. However, it may be possible
in music therapy to tap into these isolated musical moments and miss opportunities to help and empower the individual to ‘bridge’ to a healthy use of music. These authors state

Processes of recovery also involve the music therapist’s capacity to facilitate a range of musical experiences appropriate to the individual’s trajectory, from musical symptom through to preparation of playing our musical identity in the community. (p. 602)

Here, they have noted the complex role of the music therapist to include capabilities that help this process along. The awareness of musical intimacy and its potential for challenging situations, may help music therapists to facilitate this process. In addition, the music therapist ability to identify their ways of being and responding to these moments, would be essential in helping the client with their recovery process.

The interaction of music and identity is complex and may influence how the individuals we work with experience music therapy. What this theoretical framework has revealed is that the interpersonal experiences are intimate, and have the potential to access different parts of our identity. Music and identity may also have implications for ethics in music therapy practice. Ruud (2010) states; “specific to ethics of music therapy there will be recognition of the idiosyncratic musical identity we encounter in each of our clients” (p. 37). Here, I believe Ruud is alluding to the way that the musical identity of our clients is intertwined with the complexity of ethics. An individual’s relationship and identity with music can contribute to how they interact with music in music therapy. The client’s musical identity may influence the process of musical intimacy and the powerful moments of connection, potentially creating complex situations for the music therapist. Being aware of these complexities, may help music therapists to navigate their way through the multilayered musically intimate interactions. This may help music therapists to move through challenging and positive experiences, and potential help their clients improve their health and well-being.

**Music and emotion.**

Music, emotion and mood regulation has been a topic of interest for many music therapists. The emotion felt and described in musical intimacy was a central component of the participants’ experiences and contributed to the theme of the
intrinsic powers of music. Many of the music therapists discussed how music could elicit strong emotions in their clients. They described emotional outpours from their clients and moments where they felt emotionally affected through the music-making experience. Music psychologist Juslin (2009) states, “people use music to change emotions, to release emotions, to match their current emotion, to comfort themselves or relieve stress” (p. 131). To understand the theoretical framework of musical intimacy, we need to consider some of the relevant literature on music and emotion.

Music and emotion is a complex area. There are different theories about music and emotion, which can be simplified to include areas of the cognitivists (Bigand et al. 2005; Gabrielsson, 2009) and the emotivists (DeNora, 2000; Juslin, 2009; Juslin & Laukka, 2004). The debate largely revolves around the idea that music induces emotions in the music, or that music actually elicits emotional responses and/or experiences in the listener. Emotion can be defined as “brief but intense responses to potentially important events or changes in the external or internal environment” (Juslin, 2009, p. 131). However we understand emotion, its presence in musical intimacy was prominent in the participant’s descriptions, which adds another layer of meaning to musical intimacy.

Saarikallio and Erkkila (2007) explored the role of music in adolescent mood regulation. Through a grounded theory study, they interviewed eight adolescents trying to deepen theoretical understanding of the emotional functions of music. One interesting finding, was how some data revealed examples where negative mood was temporarily maintained or even increased through music listening (Saarikallio & Erkkila, 2007, p. 14). The idea of music maintaining or increasing negative moods is relevant to the concept of music intimacy. Music therapists should be conscious of the potential for negative responses in music and how this could create challenging situations in the musically intimate environment. In the same study, the researchers also found that the experience of music is linked with enjoyment and positive experience. They state, “the importance and power of music in mood regulation may be found on its versatility in satisfying multiple goals” (Saarikallio & Erkkilä, 2007, p. 15). The complexity in music eliciting multiple emotions, makes it important for music therapists to reflect on the musically intimate interactions, and recognise the potential for positive and negative experiences in relation to emotion and music.

One interesting topic that De Nora (2000) presents, is how music is used to shift mood or energy as a self-care or self-regulatory strategy (p. 53). She notes how
individuals, when choosing music to meet a need, are engaging in self-conscious articulation work, where they can choose music based on what affordances they perceive it to have. In other words, individuals will choose music for how they perceive it to ‘work’ for them (DeNora, 2000, p. 54). In relation to musical intimacy, the music that is used may shift or regulate mood in our clients. This may suggest the importance of clients selecting their own music and for music therapists to be aware of this when engaging in musically intimate interactions. Bruscia has eluded to this idea and states:

There are also times when clients are not emotionally ready to experience music to its fullest, as this would bring them too close to their problems. Sometimes even the best music presents a world of experience that a client cannot handle - physically, emotionally, or mentally” (Bruscia, 2014, p. 114).

Music and emotion is a complex area, yet the prevalence of emotion in the participants descriptions of musical intimacy, makes it important to reflect on current theories and concepts.

**Therapeutic relationship and power dynamics with music.**

The emergence of musical intimacy, with the intrinsic powers of music, brings attention to the power dynamics in the therapeutic relationship, in and around the use of music. The intrinsic powers of music suggest that sometimes the power of music is attributed to the music itself, not to other contributing factors. The concept of music as powerful emerged as a major theme within the intrinsic powers of music. This led me to question, what power are the music therapists putting on the music itself, and does this power influence the power dynamics in the therapeutic relationship? With newer models of music therapy calling for more equal therapeutic relationships (CoMT, ROMT), it may be timely to consider how the power of music is viewed within the therapeutic relationships and in music therapy practice.

What is also interesting is the idea that, in the moments of musical intimacy, the music therapists described feeling on the same level as their clients. This could suggest that through the experience of musical intimacy, we may be creating more equal therapeutic relationships, regardless of which theoretical approach we align with. I believe that these ideas are best presented by locating the discussion in newer models of music therapy. In addition, I will present my belief that the way music is
conceptualised in the consensus model (Ansdell, 2002) has potential to disempower the people we are working with. By adopting a model that encourages equal therapeutic relationships, we may be able to empower the people we work with through the use and understanding of musical intimacy.

Discussions on the therapeutic relationship in music therapy have received renewed focus in the last ten years (Pavlicevic & Ansdell, 2004; Rolvsjord, 2006, 2010). Through the developments of community music therapy (Ansdell, 2002; Pavlicevic & Ansdell, 2004; Stige, 2011), and resource orientated music therapy (Rolvsjord, 2010) the power imbalances inherent in a traditional therapeutic relationship have been brought into question. This has been enriched with the inclusion and discussion on feminist theory and music therapy (Hadley, 2006) and anti-oppressive practice (Baines, 2013), where social undercurrents of inequality have been brought into the music therapy sphere.

Community music therapy crystallised in the early 2000’s with Garry Ansdell’s article on music therapy and the winds of change (Ansdell, 2002). Here Ansdell articulated that current music therapy practice did not match current theories in music therapy. Community music therapy (CoMT) is an approach that moves away from what Ansdell labelled as the consensus model, a term to describe traditional models in music therapy that stem from a medically-based understanding of an expert-client framework. Community music therapy has been hard to define due to the contextual and evolving nature of its practice. The therapeutic relationship in community music therapy aims to be equal, fostering an environment of empowerment that extends to individuals and communities in an “inwards-outwards approach” (Stige & Edvard Aarø, 2011). How music interacts with culture and community contexts is seen as crucial and music therapists working in this approach will aim to tap into musical communities through a mutual and collaborative relationship.

Within a community music therapy framework, it would be difficult to instil the intrinsic powers of music, where music is seen to have intrinsic powers over the clients responses or the therapeutic process. This stems from my assumptions about the way that a community music therapy approach is implemented and practiced. Within a community music therapy approach, goals are mutually collaborated with the aim of following and empowering the individual. This is very different to the consensus model, where goals are determined by the music therapist based on an
assessment of their needs according to their illness ideology. This is an important difference, especially considering the implementation of music experiences and the intrinsic powers discussed by the participants in this study. In the consensus model, there is danger of placing power on music in a way that disempowers the people we work with. This, of course, is possible in a CoMT approach, yet I feel the differences in power dynamics of the therapeutic relationship render it less so. Due to the intimate nature of music, I feel we need to work in a way that is collaborative, so that music is used as a resource to empower the people we work with, rather than a tool used in a power over relationship.

Similarly to community music therapy, resource orientated music therapy also aims to created equal therapeutic relationships (Rolvsjord, 2010). This approach asserts that music is a resource that can be used to empower individuals to help their own health and well-being. Rolvsjord (2010) rejects the notions of the expert-therapist model that pushes an illness ideology, ultimately disempowering the people we work with. She questions the medical model way of working by suggesting that it disempowers our clients by instilling in them processes and power structures. She states, “such a focus upon the therapist’s musical intervention causing an effect in the client leads to a discourse which attributes power to the intervening music therapist, or to the music itself” (Rolvsjord, 2006, p. 5). Here she has highlighted the potential for a music therapist to place power on the music itself, and in this process disempower the individual they are working with.

In a resource orientated approach, music is viewed as a resource to help empower the individual to help with their health and well-being. These intrinsic powers of music could be used to help empower the people we are working with. Rolvsjord explains:

The power of music is not so much related to the music itself but to the subjective and contextualised use of music, then we must ask questions about the equality of access to music, within society in general but also within music therapy. Could it be that we have not only attributed too much of the mechanisms of music therapy to an un-contextualised and autonomous “music object” but also erroneously attributed the power of music to the therapist rather than to the client. (Rolvsjord, 2010, p. 68)

Here, Rolsvjord has articulated some of the potential problems associated with attributing power to the music itself. She asserts that we need to consider the
subjective and contextualised use of music and move away from a model that attributes power to the music itself and the music therapist. This is similar to Ansdel (Ansdell, 2014) who states; “music is no more or less powerful than the people who appropriate it within particular circumstances” (Ansdell, 2014, p. xvii). Here, Ansdel has pointed out how music in itself is not powerful, it is in the way that people use it in a socio-musical context which gives it power. This is an important argument that may help music therapists to steer away from placing power on the music object itself, to reflect on the social, contextual and individualised power of music in music therapy.

Looking at power in the therapeutic relationship, and how music may potentially disempower the people we work with, leads to discussion on empowerment theory. Empowerment discourse has been brought into music therapy through the writings of Proctor, (2001), Oosthuizen, (2012) and Rolsvjord (2006, 2010). Proctor (2001) asserts that the medical model way of working actually disempowers the people we work with, and he advocates for an empowerment approach in mental health care. Empowerment theory is connected with collaboration and respect, and is a multi-level construct (Oosthuizen, 2012). To include these concepts in music therapy practice, is to aim for a process that is empowering. This may be achieved through the relationships and processes that are mutually collaborated and driven by the client. Empowerment theory has influenced music therapy approaches such as community music therapy and resource orientated music therapy. Rolsvjord (2010) states that, “mutuality and active participation in musicking may be important constituents of empowerment in music therapy, but this does not necessarily mean that music therapy is always empowering” (Rolsvjord, 2010, p. 42).

Another welcome addition to music therapy discourse is anti-oppressive practice (Baines, 2013; Baines & Edwards, 2015; Matsumura, 2010). Anti-oppressive practice is a term that had been adopted in many health practices, which aims to highlight the underlying social currents of inequality that stem from power imbalances related to race, class, gender, sexual identity, health, ability and income (Baines, 2013). It emphasizes social justice and social change, and questions practices that have stemmed out of a ‘white male privilege’ context. By adopting the lens of anti-oppressive practice, we can begin to see how some facets of the consensus model feed into these oppressive structures.
Similarly, feminist perspectives have also been brought into music therapy discourse in the last ten years (Curtis, 2013; Edwards & Hadley, 2007; Hadley, 2006; Rolvsjord & Halstead, 2013). Feminist theory questions assumptions around the power structures embedded in a system that aims to promote power in men, while disempowering women (Hadley, 2006). The inherent patriarchy power imbalances in the consensus model stem from the context that favours white male privilege. Community music therapy, resource orientated music therapy, anti-oppressive practice and feminist perspectives have all questioned the assumed process of how therapy should work.

But what is the real danger in placing the power on the music itself? The music therapists in this study believed that the music itself could ‘open’ people up, that it was inviting, seductive, powerful, intimate and directing. These ideas suggest that the music can in a sense control certain aspects of the therapeutic process and break down some barriers presented by their clients. This ‘power’ is something to be treated carefully and considered within the interacting contexts of the people that we work with. We should be cautious that this power is not used to break down barriers that the people we work with are not ready to share. It should be their choice. If we decide how music is used, what it is used for, and for what purpose then we are reinforcing our expert power over our clients. This ignores the inner resources that music holds for individuals, and subtly disempowers our clients through the use of music.

The intimate interpersonal interactions in musical intimacy also pose questions for the therapeutic relationship. Does musical intimacy highlight how our therapeutic relationships are essentially equal because of the way intimacy is created and experienced in and around the music? The use of the word intimacy was intentional and appropriate. The word intimacy can be described as including equal contributions by both parties and may refer to ideas of the personal, close and connecting interactions. This word carries with it assumptions about the nature of the interactions and the meaning that is carried with them. I wanted this idea to speak to the intimate nature of our work, as well as acknowledging the potential vulnerabilities in and around this intimacy that is created in music therapy. Frank, Clough and Seidman (2013) state, “intimacy in the psychoanalytic setting is a more elusive subject, bringing with it a wide range of everyday uses, and a suggestion of intensely maintained bonds of love and sexuality” (Frank et al., 2013, p. 241). They note that
the word intimacy carries with it many different understandings. For music therapy, the term musical intimacy may suggest a different relationship than what is promoted in the more conventional consensus model. The inclusion of this concept into music therapy discourse, may further the discussion on the therapeutic relationship and how we can approach our practice.

A spectrum of experiences in musical intimacy
The music in musical intimacy.

Central to the concept of musical intimacy is that it takes place in and around musical experiences in music therapy. This extends to the interpersonal experiences that happen in the moment of making music, and the influences these have on the therapeutic process and relationship. How music is understood in music therapy and in other related fields has been challenged and developed over the last few years. How music is understood and used in music therapy may influence the experience of musical intimacy.

Small (1998) appropriated the word ‘musicking’ as a new way of conceptualising the process of music. This was an influential step as it moved the definition of music from a product, to an active process engaged by people and their relationships through it. He wanted to challenge the traditional notion of the privilege of music, extending to all who engage in music from the ticket sellers, to musicians and listeners. This idea has been taken up by many music therapy scholars and informs some theoretical approaches, such as community music therapy and resource orientated music therapy. Small’s idea helps us to understand that musical intimacy is an active process that is influenced by the interpersonal interaction in and around music.

Another scholar who has influenced the discourse on music is DeNora (2000). Located in the sociology of music, DeNora (2000) describes music as an active process that helps us to afford health prospects, contributing to an overall sense of our identity that is mirrored in our music choices. In addition, she describes how individuals can recognise particular affordances that music can bring in relation to their health possibilities. What is also central to her argument is that it is the interaction of musicking and context that helps individuals recognise the potential affordances in the music. Her work has also been popular in music therapy discourse,
contribute to music therapy approaches such as community music therapy and resource orientated music therapy.

Both Small’s ‘musicking’ and DeNora’s work are relevant concepts to draw upon in understanding musical intimacy. Small helps us to recognise that music is not a product but a process, and that there are multiple ways of ‘musicking’ in everyday life. Many music therapists understand this and draw upon this aspect in their work. What DeNora adds is the notion of context and how it interacts with our ‘musicking’ possibilities. Musical intimacy is a process that takes place in the particular context. It relates to the individual’s history of music’s affordances, how it reflects their identity, and how they have experienced ‘musicking’ in the past. Thus, the interaction of process, context and identity contribute to the powerful moments of connection, which can be experienced as anything from magic moments to challenging situations (Aigen, 2013).

Another strong influence in music therapy thinking, is the notion, detailed by Malloch and Trevarthan (2010), labelled ‘communicative musicality’. ‘Communicative musicality’ is the idea that we have an innate ability to communicate through musical-like interactions. This ability was first discovered through observing the musical interactions between a mother and child. This communication through musicality is a way to facilitate meaning in communication. It is based on the assumption that we move in rhythmic time together, which helps us to tune into our feelings to share in the energy of relating and meaning. This idea may also be relevant to musical intimacy as it potentially highlights the communicative and connective aspects of musical intimacy. Many of the participants relayed stories about communicating through music, being in time with their clients, and creating shared meaningful experiences. The idea that we have innate communicative abilities through the act of ‘musicking’ resonates with the participants in this research as well as other music therapy literature.

These ideas all influence the understanding of music in music therapy. What is also important for musical intimacy is the different methods used with music in music therapy. Bruscia et al. (2014) described four main methods of music experience in music therapy. He asserts that these are; 1) improvising, 2) re-creating, 3) composing, and 4) performing (Bruscia et al., 2014, p. 127). These four main methods can serve as a useful starting point for a discussion around how musical intimacy was described in different music therapy methods. These four categories
provide a way of thinking about music therapy methods. What helps us to understand them more, is to explain them in more detail according to how they are used in different theoretical approaches.

The participants in this study described many different music therapy methods when reflecting on their experiences. Many experienced powerful moments of connection when improvising with clients, reflecting on the intimate and communicative nature of improvisation. Others described how using live songs can create musically intimate moments. Many discussed how sharing songs with individuals could create intense emotionally experiences where they felt musically intimate connections with their clients. Some also discussed song writing, when clients would share intimate details through the process of writing songs. One music therapist reflected on creating a song with a client and experiencing a very intimate moment when they shared that with their loved one. What is important to note is that musical intimacy was not limited to a particular music therapy method, but is something that extends too many aspects of music therapy practice.

A powerful moment of connection.

The music therapists in this study described powerful moments of connection. These connections were felt to be intense and sometimes created challenging situations for the music therapists. These moments were coupled with the music therapist’s descriptions of music as intrinsically powerful. Powerful moments of connection have been explored in other related literature. One interesting concept related to these moments is Stern’s (2010) idea of ‘forms of vitality’. The dynamic forms of vitality relate to the “psychological, subjective phenomena that emerge from the encounter with dynamic events” (Stern, 2010, p. 7). These experiences are felt in the act of movement, and of mental movement, and they include a force of attaching feeling perception to movement. Stern argues that the dynamic forms of vitality are the primary experience that is felt with interpersonal interaction. He states; “the dynamic flow of music, dance, theatre, sweeps us up at moments and then releases us, only to sweep us up again quickly just downstream” (p. 6). Stern’s forms of vitality have relevance for musical intimacy, as it is a felt experience in movement between people. These intricate moments of movement can been seen as forms of vitality, where each interaction and movement is a dynamic interplay that is the foundation of
the felt experience of musical intimacy.

Meaningful moments, pivotal moments or powerful moments have been explored in some music therapy literature. Dorit Amir (1992) explored some of these ideas in her dissertation on meaningful moments in music therapy practice and one of the themes that emerged she entitled ‘musical intimacy’. She describes musical intimacy as when a therapist felt a “powerful moment of musical connection with their clients” (Amir, 1992, p. 153). One of the participants in her study described this, stating, “we were together, as one” (Amir, 1992, p. 154). Interestingly, all of the music therapists in the study described the critical importance of music to produce meaningful moments for both themselves and their clients (Amir, 1992, p. 157). Although musical intimacy was only one small theme in this study, the influence of music on most of the meaningful moments was present throughout the dissertation.

In Amir’s research, these meaningful moments were mainly experienced as positive. However, there was one theme described as moments of anger, fear and pain. This theme included descriptions of intense emotions where the therapists perceived their clients to be accessing deep emotions and past experiences in and around the use of music. Amir’s exploration into meaningful moments reflects much of what musical intimacy is about. Musical intimacy has gone further in examining the powerful moments of connection by exploring the challenging experiences and then linking them with boundaries in music therapy practice.

Powerful moments of connection in music therapy have been discussed in other ways. Similar to Amir’s research, Grocke (2006) explored pivotal moments in guided imagery in music (GIM) with both clients and therapists. Although she was investigating GIM, there are similarities with the notion of powerful moments in music therapy. The pivotal moments in this study had intense emotion and were embodied experiences that were sometimes distressing or uncomfortable. In addition, they were felt to be transformational experiences that helped the clients to make life changes. Interestingly, these moments were experienced by both the clients and the therapists interviewed in this study. Also present was the interplay between the client, the therapist’s silence and the therapist’s intervention that helped to facilitate these pivotal moments. Furthermore, the role of the music was very influential to these pivotal experiences. This is similar to the current study where the interplay of the client, the therapist and the music helped to create these powerful moments of connection found in the musically intimate context of practice. The moments in this
study were also felt to include intense emotion that sometimes created challenging experiences for the music therapists.

Similarly, Trondallen (2005) has explored the notion of significant moments in music therapy with young people suffering from anorexia nervosa. She described significant moments as including “sequences of regulation which are mutually harmonised by the therapist and client in the musical interplay” (Trondalen, 2005, p. 417). She has explored the notion of the musical interplay, which resonates with some aspects in musical intimacy. The idea of the client and therapist as being mutually harmonised reflects how the music therapists in this study described feeling connected in these powerful moments in musical intimacy.

Another example is from Shoemark (2007), who explored music therapy with medically fragile infants. Here she describes a ‘moment of meeting’ as a “transformational moment which is a singularly significant event in therapy” (Shoemark, 2007, p. 206-207). She describes the role of the music in this context as not typically found in music therapy practice. Rather, the music here is mostly made by the music therapist and the infant will respond to it. It is interesting that some of the moments of meeting did not contain music in that particular moment. Shoemark asserts that the surrounding music environment, along with the markers of interplay are what helps lead to these moments of meeting.

With a different population, Lee (2014) explored interpersonal relationships between music therapists and people with profound intellectual and multiple disabilities. She found many instances of meaningful moments that were described by the music therapists in her study, and which she also observed in her interpretative phenomenological video analysis. These meaningful moments were experienced by the music therapists in this study and were felt to be significant for the music therapist.

Differently, Dilllard (2006) explored the concept of musical counter-transference. She interviewed nine psychodynamic music therapists about their experiences of musical counter-transference. One of the central themes to emerge was the idea that musical counter-transference was a means of communication through music. This communication reflected the interpersonal dynamics of the therapeutic relationship. Although an interesting area to explore, it seems that musical counter-transference is only one of the possible complexities present when we interact through music. The participant’s descriptions of feeling emotions and
wanting to respond in a certain way through the music do not seem to be only related to musical counter-transference. These findings seem to be similar to the ones in the current study, where the complexities of the musical relationship are sometimes challenging because of the intimate nature of music.

These examples of magic moments in music therapy literature (Amir, 1992; Grocke, 2006; Trondalen, 2005) are all relevant for musical intimacy, as they describe the process of the felt experience in similar ways. What is interesting is that these studies are from different theoretical approaches and with varying populations, yet they are all alluding to the similar idea of powerful moments in music therapy. As such, powerful moments in music therapy are a familiar concept. Surrounding these ideas with the concept of musical intimacy, and acknowledging the challenging experiences, further contextualised these concepts and helps us to understand them in the overall process of ‘health musicking’ (Stige, 2002) with people.

**Challenging experiences in and around musical intimacy.**

One of the important findings from this study was the idea that musical intimacy can be harmful. This may not be surprising, however, there is a distinct lack of literature about the potential harmful experiences that can be created in music therapy practice. Nineteen of the music therapists described one or more challenging situations that happened in and around musical intimacy. This is interesting and raises important questions about the potential risks and challenges that we should be aware of when using music in therapy with potentially vulnerable people. However, when searching music therapy literature, it is difficult to find much literature that has explored challenging or negative aspects in music therapy practice. Similarly, therapeutic boundaries are an important area to discuss for the growth of the music therapy profession, yet there is only a handful of literature that has delved into the topic. It seems timely to highlight and examine when music therapy doesn’t work and how this can help us in to grow in the future.

So what can we learn from these challenging experiences, and how does this help the quality of our profession? Being aware of musical intimacy can help us to be more aware of the potential challenges in our practice. As examined in chapter two, by looking deeper at our literature through the critical interpretive synthesis, we can begin to see some of the complexities that are present across music therapy practice.
These case studies described some challenging experiences in and around the music. In addition, it was clear that any traditional boundary concepts were not known by the authors and did not appear relevant.

Looking from a European psychotherapy perspective, De Backer, Sutton and Williams (2014) state, “we believe that music takes place at the same level as the trauma experienced by the patients and thus is an ideal modality for treatment in this way” (De Backer & Sutton, 2014, p. 16). This is an interesting idea within this process, and suggests the potential vulnerability of using music to work so closely with these traumas. For one of the participants in this study, they recalled an experience of working with an adult who had suffered from multiple forms of abuse and trauma in her early life. This music therapist described how, through this improvisation, they were able to access this experience, and in turn, were strongly affected themselves. The music therapist described this as a challenging experience, as it brought to the surface strong emotions, as well as the fact it came about very quickly in their first session together.

Kottler and Hunter (2010) discuss how clients are our best teachers in the development of our practice. They suggest that we can learn best from the people we work with and the experiences that we have. They state:

So even though I would prefer to tell shining examples of being transformed and travelling along exciting new paths with my clients, my experiences tend to be more confusing, mundane and opaque. (Kottler & Hunter, 2010, p.8)

Here they have alluded to the often confusing nature of the therapy process. However, they assert that we can learn the most from our participants and the sometimes challenging situations, as long as we are open to these new learnings. These challenging experiences described by the participants in this study, could help music therapists to reflect and grow, especially around the concept of musical intimacy.

The impact upon the music therapists as individuals was also interesting. When describing the challenging situations, I sensed and observed how these experiences had impacted them personally. This were demonstrated in their body language, their tone of their voice and in the way they described the situations. Some of them described; “it was very hard” when discussing particularly challenging experiences. Quiroga (2015) explored challenging moments with four music therapists. He found that the challenging experiences elicited a wide range of
emotions and feelings in the music therapists. Some of these included, a sense of uncertainty, not knowing how to respond, helplessness or disappointment (p. 18). One interesting idea that emerged was that in these challenging experiences the music therapists tried to re-establish a connection and would sometimes use music to achieve this. This did not always work, but was an interesting concept to emerge from this research.

Challenging experiences in music therapy are important to continue to reflect on. Through this research the participants described many experiences of powerful moments of connection and challenging experiences. It is important to note that these experiences were usually not perceived as dichotomies of positive or negative, but rather they revealed the complex web of experiences that can happen in and around musical intimacy in music therapy practice.

Unhealthy uses of music in music therapy.

The unhealthy use of music in our everyday lives is a growing area of interest for music therapy. These concepts may be relevant to musical intimacy, especially around the challenging experiences that can arise. Some music therapy scholars are beginning to question ways in which music is used in a healthy or an unhealthy way (Garrido & Schubert, 2011; McFerran & Saarikallio, 2014; North & Hargreaves, 2006). Research into the potentially negative use of music by adolescents has been especially interesting in the past few years (Baker & Bor, 2008; McFerran & Saarikallio, 2014). This is a complex area, which has often been simplified to suggest that ‘problem music’ (North & Hargreaves, 2006) can lead to negative behaviours or outcomes. As most of the music therapists in this study experienced challenging situations in their practice in and around music, it’s important to consider how music can potentially be used in an unhealthy way in music therapy. If an individual’s relationship with music outside of music therapy is unhealthy then this may cause complications for keeping musical intimacy safe, for both the music therapist and the person they are working with.

Music is often defined by its powers and positive experiences that make us want to engage with it more. For music therapy, this idea has traditionally been utilised as engaging in music to address needs and help promote health and well-being. However, there is a need to explore the more challenging side of the music
experience. When is music not a good experience? When is music therapy not a good experience? It is imperative that we explore the ‘negative’ impacts of music given that it is our primary medium in music therapy practice. In this research, the negative effects of music were described as music as a trigger, music bypassing defences, and the challenging experiences described by the music therapists.

Hense (2015) explored musical identities in young people who were recovering from mental illness. Through this exploration, the idea of a musical symptom emerged, in which a client may present the challenges of their illness through their relationship with music. Hense asserts that changes in their experience of music were an expression of their pathology. These ideas suggest that music therapists need to be acutely aware of what the music, or musical experiences may represent for our clients. She also described privatised musical symptoms, which were characterised by substituting the social qualities of life with music; by turning to music as a surrogate friend and musically nurturing the self in private rather than seeking social support (Hense, 2015, p. 597). These experiences represent the potentially powerful influence that music and musical identities could have on individuals in this setting. What is important for music therapists to be aware of, is the potential for them to inadvertently promote these negative relationships with music.

Mcferran and Saarikallio (2014) explored young people’s relationship with music. They interviewed 40 young people about their experience, applying a grounded theory analysis to the data. They state; “these young people describe themselves to be ‘under the influence of music’… and continuing music despite sometimes negative or ineffective consequences” (McFerran & Saarikallio, 2014, p. 6). The powerful pull of music with these young people was very strong, even though they had some negative experiences. The persona relationship with music is a complicated one that is brought into music therapy practice and contributes to the musically intimate experiences. Music therapists need to be aware of this complicated relationship as it may influence the powerful moments of connection, potentially creating challenging experiences that may not benefit the individual.

**Theoretical approach and musical intimacy**

Musical intimacy emerged as a new theoretical framework that may resonate
with many music therapy approaches. Musical intimacy is a step towards developing an indigenous theory that captures the complexities in our work, especially around the use of music. I feel that there are points of interest with musical intimacy that speak to a unique area of music therapy: music, intimacy and boundaries. Although we have researched intimacy in some form (Hedigan, 2010; Procter, 2013) and some aspects of boundaries including the therapeutic relationship, (Foster, 2007) and ethics, (Padula, 2006), we have not explored how music, intimacy and boundaries intersect and influence our work. My exploration into this area has seen a development of musical intimacy and new conceptualisations about how music therapists can respond to music, intimacy and boundaries.

The music therapy profession has grown in and around other theoretical frameworks taken largely from other related professions (Aigen, 2013; Bruscia, 2014). Previously the prominent theories and models emerged from psychodynamic, humanistic, behavioural and medical thinking. For some music therapists, these approaches helped to define where and why we work in a particular context and whom we seek to help through our music therapy practices. These theories have been useful, however, the lack of awareness of the inherent power dynamics in the therapeutic relationship and an understanding of the influence of context and culture has seen them lacking. Furthermore, some of them have reduced music to a tool that neglects its full capacity and meaning for individuals, communities and culture (Aigen, 2005). In addition, Smeijsters (2012) points out that these models do not explain the ‘how and why’ of the essence of music therapy, and furthermore, that music therapy theory should be addressed and described in musical terms (Smeijsters, 2012, p. 229).

Some music therapy scholars have discussed the need for indigenous music therapy theory (Aigen, 1991; Ansdell, 1995; Kenny, 2006). In recent times, this need has stemmed out of a renewed focus on music, which has left many music therapy scholars pondering how we define what we do in a way that captures the complexities of our music therapy practice (Kenny, 2005). Furthermore, as Rolvsjord and Stige (2015) state; “There seems to be a need for theory development of music therapy both as a complex intervention and as an event within complex systems” (Rolvsjord & Stige, 2015, p. 59).

Aigen (Aigen, 2013) notes that the three most well developed and common indigenous music therapy theories are Analytical music therapy (Eschen, 2002;
Priestley, 1994), Guided imagery and music (Bonny, 1976; Bruscia & Grocke, 2002) and Nordoff-Robbins (Nordoff, Robbins, & Marcus, 2007). He further asserts that these models developed experientially and with no highly developed theory to guide the work. Stige (2015) has questioned the relationship between theory, research and practice. Here, Stige has offered critical discussion on the need for the development of practice theory and for thinking about how it relates to the development of music therapy practice. In relation to practice theory, he comments on the “zooming in on action and interaction in local context, but also ‘zooming out’ on the multiple practices that structure local practice” (Stige, 2015, p. 5).

In recent years there has been a stronger focus on the music in music therapy. As such, there is a need to explore and uncover the inner workings of the musical experience in music therapy practice. Some newer models in music therapy have put a renewed focus on the music in music therapy, such as music centred music therapy (Aigen, 2005), community music therapy (Ansdell, 2002; Pavlicevic & Ansdell, 2004; Stige, 2011) and resource orientated music therapy (Rolvsjord, 2010). In light of this, Aigen (2013) states:

What is striking about the contemporary orientations taken as a whole, is the universal argument presented for a stronger role for music and musical phenomena in music therapy theory and practice. (p. 239)

There seems to be a growing interest not only in the music in music therapy but in developing theories to define and contextualise what we do and why we do it. Musical intimacy contributes to this development.

**The music in music therapy approaches.**

Each theoretical approach in music therapy understands and contextualises music slightly differently. The music therapists in this study identified with a range of theoretical approaches yet they were all able to identify musically intimate experiences in their practice. This may suggest that it is widely applicable across the landscape of music therapy practice. Aigen (2013) has noted that one of the most important issues facing contemporary music therapy practice is “the fundamental way that the use of music is conceptualised” (Aigen, 2013, p. 250). Along with this, he has suggested that a way to define music therapy is too examine music in each theoretical orientation (Aigen, 2013).
Looking at some of the different theoretical models of music therapy, we can see differences in the belief, use and understanding of music. On a basic level, we can look at a medical approach to music therapy where the belief in music is in its ability to access neural networks to work primarily as medical treatment (Crowe, 2004; Davis, Gfeller, & Thaut, 2008; Thaut & Hoemberg, 2014). Here, music sits neatly into the medical model and is applied in a way that uses music as a therapeutic tool that can be implemented to cause a positive effect. In contrast, we can look at a music centred approach to music therapy (Aigen, 2005; Nordoff, Robbins & Marcus, 2007) where the primary potentials of music therapy are inherent with the music itself. Here, the focus is on the musical experiences that are encouraged by the therapeutic relationship, with a strong focus for the individual’s ‘musical child’ to emerge (Nordoff, Robbins & Marcus, 2007). For further contrast, we can look at psychodynamic informed approaches (De Backer & Sutton, 2014; Hadley, 2003). In a European psychodynamic approach, music may be used to symbolise deep psychological issues that can be worked through in the music. For further difference, we can look at newer theoretical orientations such as community music therapy (Ansdell, 2002; Pavlicevic & Ansdell, 2004) where music is viewed as a socially constructed resource that can empower the individuals and communities that we work with through mutual and collaborative music experiences.

Evan Ruud (1998) noted that the various frameworks in music therapy understand music differently, stating; “there is no agreement about the nature of music in music therapy” (p. 70). More recently, Aigen (2013) proposed that varying theoretical orientations present different routes for how people understand music in music therapy. He further stipulates that these routes are influenced by the metaphysical assumptions about music, the construction of the music therapy profession and how we view our roles within that.

Regardless of theoretical approach, the music therapists in this study experience powerful moments of connection in and around the music. In these moments there is a vulnerability where the need for boundaries is triggered. Musical intimacy is the theoretical framework that explores this important element of music therapy practice. Through this next section I will outline some different theoretical approaches and how they understand music. In doing this, I hope to show the complexity of music and therapy and illustrate how musical intimacy as a dynamic defining feature, can be understood in a variety of theoretical approaches.
Consensus model.

Many music therapists over the years have felt pressure to align with a medical model of practice (Aigen, 2013). In the Australian context, this has stemmed from the landscape of healthcare practices that are largely driven and funded by a strong focus on evidenced based practice. Behavioural, neurological or medical music therapy, what Ansdell labelled as the consensus model (Ansdell, 2002), align with similar uses and understandings of the way that music can be used as an intervention to facilitate change in an individual. These frameworks are often considered to be more clinically orientated where specific, measurable and attainable goals are put in place by the music therapist to help address the needs of their clients. These understandings view music more as a tool or almost as a type of medication that can be used and manipulated to address non-musical goals.

Thaut and Hoemberg (2014) argue strongly for music therapy to be situated in a medical approach. Furthermore, they assert that the advancement of music therapy is to sit firmly in a neurological understating of the benefits of music for health and well-being. These authors believe that the only way forward in music therapy is to ground it as a neuro-scientific approach that sits, in its own right, within the medical model. They are strong advocates for this approach, aligning with philosophies that underline the medical model and evidenced based practice. This view may narrow the field of music therapy and overlook many aspects that are considered integral to other music therapy approaches, such as the relationships, the emotional aspect, empowerment possibilities, inner resources and the relationships that develop through the social act of making music with people.

Smeijsters (2012) accepts the notion of the medical model but suggests novel ways to implement the music therapy processes in a more holistic way. Influenced by Sterns forms of vitality (Stern, 2010), Smeijsters puts forward the notion of analogy in music therapy theory where the vitality effects are a basic musical experience where there are “spontaneous, intuitive and felt experiences without associations” (Smeijsters, 2012, p. 234). He further explains that, by accepting this notion, we understand that in music therapy our clients are invited to “experience the music as a lived experience that is intuitively and spontaneously processed and felt by means of the non-reflective core consciousness” (Smeijsters, 2012, p. 234). Smeijsters here is
aligning with the notion that music effects changes in the body and mind, that are in effect not controlled by the individual. However, he differs from Thaut in that he has framed this as a lived experience where there are emotional and bodily responses, which are from the music itself but from not any associations.

Music in the medically focussed models refers to the neuro-scientific understandings of music’s effect on the brain. This is one strong view of music therapy of what it can and should be. I would argue that musical intimacy may still be a useful concept in this approach to music therapy as the musical relationship and intimate engagement through music is essential in using music as a tool to promote health and well-being. In Forsblon’s and Ala-Ruona (2012) study they interviewed music therapists who work in post stroke rehabilitation. One of the key findings was the idea that the level of interaction with their clients was important for their recovery. They noted that being too objective with their clients made the process harder and actually hindered their client’s recovery. This highlights how the therapeutic and musical relationships are important even in a neurologic approach to music therapy.

**Psychodynamic.**

Psychodynamic theories have had a strong impact on music therapy practice. They have formed the foundation for what much of music therapy practice was built on and gained much ground in the early years of the music therapy profession (Aigen, 2013). Additionally, psychodynamic approaches are often described as being inherently intimate (De Backer & Sutton, 2014), due to the highly personal nature of the work. Some psychodynamic theories rely on the understandings of how music can represent the psychology of the individual and how deep psychological issues can be worked through in the music. In line with this, De Backer, Sutton and Williams (2014) state; “We aim to consider not only the musical focus of music therapeutic work, but also the simplex musical phenomena and processes that we experience in clinical work” (De Backer & Sutton, 2014, p. 14).

Many psychodynamic theories rely on concepts developed by Bion, (Bion), Klein (Klein), Freud (Lear, 2015) and Winnicott (Karnac, 2007). The therapeutic frame is an important concept, which is where therapy takes place in a safe, predictable and contained space. Some psychodynamic practices identify with processes such as transference, counter-transference, holding, containment and
projective identification (De Backer & Sutton, 2014). In the centre of this is the therapeutic relationship, which is processed and developed through musical improvisation exchanges. For some, their main belief with music is that trauma takes place on the same level as music and therefore psychic problems can be processed and addressed through musical improvisation.

In this framework, intimacy is often present and forms and integral part of the therapeutic process and relationship. Improvisation is often the prominent method and involves many musical exchanges over the course of the therapy process. Some music therapists practice in a way that involves largely improvisation and verbal processing as their main methods. As one of the participants in this study described; “the method that I use has intimacy in it at all times” (participant seven). This music therapist identified as using music psychotherapy and could easily relate to the concept of musical intimacy.

Loewy and Quentzel (2011) described a case study with Paula (a musician) using a music psychotherapy approach. They described music improvisation as vital to this work and state; ‘clinical improvisation may give insight into unconscious issues, and into the interpersonal tendencies that are often encapsulated by the role one tends to assign to music” (Loewy & Quentzel, 2011). p. 299). They describe work with Paula as centred around using music for self-care, musical intimacy, awareness and trust. Although they don’t explicitly define musical intimacy, through their descriptions of their intimate encounters the intimacy in and around the music is evident. The authors describe their first meeting with Paula with a spontaneous improvisation on guitar, and signing along the hallway to help her transition into the music therapy space. They commented how they were in the ‘music sphere’ and connecting through music in this space. This musical intimacy seemed to emanate across the work with Paula creating many moments of connectedness through their musical improvisations.

**Music-centred music therapy.**

Musical intimacy and music centred approaches seem to align well. Music centred approaches are music focussed and centred on the potential for the intrinsic power of music to help the people we are working with. One of the most influential and foundational music centred approaches is creative music therapy. Developed by
Paul Nordoff and Clive Robbins, the framework grew experientially out of their work mainly with children with intellectual, developmental and physical disabilities. Music improvisation was and is a prominent method as they aimed to bring out the musical child through playful and responsive interactions in music. More recently, Aigen (2005) has detailed a music centred approach to music therapy. Here he argues for a music centred approach where the focus is on the music and what this can afford the people we work with. He describes one of the basic premises; “musical experience and expression are inherently beneficial human activities that are legitimate ways to address the reasons why people come to therapy” (Aigen, 2005, p. 56). Musical goals are often prominent in this approach, with health and wellness seen as an added benefit of engaging in music. This is one of the stark differences from the consensus model, where music is used as tool to effect change.

Some participants (five) in this study were influenced by a creative music therapy approach. The central focus on music experiences in this approach naturally led to many powerful moments of connection in and around the music. As the medium of music is the central focus of this approach, which is processed through musical interactions, the application of musical intimacy aligns well.

**Community music therapy.**

Community music therapy is a newer model of music therapy that was first written about in the early 2000’s. Brynjulf Stige explored the notion of community music therapy in his dissertation on the topic (Stige, 2003). Similarly, Gary Ansdell (2002) articulated the community music therapy approach, giving voice and meaning to what he describes as ways that we have been practicing for some time (Ansdell, 2002). This article sparked much discussion around the concept of community music therapy and, since then the approach has been accepted and practiced in many music therapy contexts.

Community music therapy is an approach that aims to empower the communities we work with, acknowledge music as a resource, work in mutually collaborative relationships and acknowledge the influence of culture in and around music therapy. The understanding of music in this approach is more holistic in that it does not reduce music to a tool (consensus model). Community music therapy shares some similarities with creative music therapy as Aigen (2013) states:
While there are differences among them, community music therapy and music centred music therapy, share the notion that music is an intrinsically valuable experience and that the human motivation for musical experience is self-justification for music therapy treatment” (p. 260).

Many instances of musically intimate moments can be found in the community music therapy literature. Pavlicevic (2010) describes magic moments in a community music therapy project with children in South Africa. She describes these as active moments of collaborative musicking stating them as; “effortless synchronic musicking within and between each of the young folk” (Pavlicevic, 2010, p. 102). Similarly, Ansdell (Ansdell, 2010) described a project called ‘scrap metal’ detailing their performance in Southern England. Here, the performance was described as a moment where a “community was being performed and that they became more than the sum of their parts” (Garry Ansdell, 2010, p. 175). There was a sense that these were more than just ‘performances’ but rather that they tied this community together with their audience in a new musical experience.

The notion of performance is prominent in a community approach. One of the music therapists in this study described a magic moment of connection while performing with a group of clients (participant 9). He identified as working in a community music therapy approach and had vivid descriptions of the performances. He described feeling connected to the other group members and the audience, and stated that the experience lifted the group to a new level. Musical intimacy in this approach can be seen in the moments of peak performance to shared social musicking experiences.

**Summary the music in music therapy approaches.**

These theoretical frameworks all define and use music differently yet the one thing they all have in common is the use and belief in music to help in some way. This may seem to be a simplistic summary, however, underlying all of our theoretical frameworks lies a certain trust in music to help health and well-being. On top of this belief is our own layers of interpretation and justification as to why we use music in a particular way. Furthermore, the way that we describe and use music demonstrates our affiliations with certain theoretical orientations and philosophical underpinnings about the role of music therapy in health and well-being practices. The degree to
which musical intimacy is recognised, used or understood may depend on the specific theoretical orientation and the way that music is viewed within that. We may all be doing very similar things with music in music therapy yet how we explain, justify or interpret the potentials of music is what sets us apart.

In discussing and presenting theoretical orientations I must acknowledge that the theoretical position of this research is varied. Coming from the Australian music therapy context, I am influenced by theoretical models of humanism, community music therapy, strength based approaches such as resource orientated music therapy (Rolsvjord, 2006). Approaches that fit into the medical model, behavioural or even psychodynamic are not so familiar for me. The participants in this study predominantly identified with psychodynamic and humanistic orientations. Interestingly, only one music therapist discussed using just one approach in her work. The rest of the music therapists described a minimum of two approaches, with most describing their work as influenced by a variety of approaches. This is interesting as it may suggest that music therapists draw on a range of theoretical orientations to guide their work. This may be viewed as an eclectic or perhaps a pragmatic approach to music therapy practice. This is intriguing, however it is only a representation from these music therapists and cannot be generalised.

Musical intimacy is not a model of music therapy or a theoretical orientation. The theoretical framework of musical intimacy allows us to see the potentials and challenges that can exist in the intimate space of making music with people. The focus on musical intimacy is important as it reflects and addresses emerging trends in music therapy for a renewed focus on music and music therapy theory. Furthermore, Aigen (2013) states:

Contemporary orientations in music therapy taken as a whole is the universal argument for a stronger role for music and musical phenomena in music therapy theory and practice, something that has historically not received adequate attention. (p. 259)

Musical intimacy can serve as a framework for understanding more about the intimate musical interactions, and how we can respond to them in and around the spectrum of experiences in music therapy. Acknowledging musical intimacy across different theoretical approaches may help us to become aware of some of the potential challenges in and around music in music therapy.
Boundaries

The emergence of this theoretical framework revealed that the boundary theories we refer to as a profession may not align with intimate music experiences in music therapy. The complexities of these experiences, the intimate nature of the musical interactions and the challenging situations all suggest this. However, it is important to acknowledge the innate problems with making general statements in a diverse profession such as music therapy. It is inherently hard to define music therapy as a whole, given the vast array of theoretical approaches that are present across our practice. The participants in this study identified as using a range of theoretical approaches yet were all able to identify musically intimate moments in their work. This may suggest that musical intimacy and the different contextual approaches to boundaries may be applicable to many theoretical methodologies in music therapy practice. It also highlights that a new way of conceptualising boundaries in music therapy may be needed.

Much of the literature that I have discovered about traditional boundaries in music therapy was from a medical, behavioural (Davis et al., 2008; Standley, 2005), or a psychodynamic approach (Bruscia et al., 2014; Dileo, 2000; Wheeler, 2014). Differently, boundary discussions have entered community music therapy discourse where traditional boundary theories have been questioned (Ansdell, 2002; Ansdell & Pavlicevic, 2004; O'Grady & McFerran, 2007). In these discussions, boundaries have been critiqued with the authors suggesting some potential problems as well as new ways of approaching them. However, they have not been explored deeply enough nor has there been any development of a detailed theory that reflects current music therapy practice. Regardless of these developments, the majority of literature in music therapy describing boundaries, largely uses traditional frameworks as guidelines for boundary management.

I began this investigation with the inkling that these boundary theories, however useful they appeared, did not capture the complexities of engaging in music therapeutically with people. The presentation of these boundary theories in psychotherapy in the 70’s spurred an overreaction and even Gutheil and Gabbard have noted this overreaction noting that that it was not their intention (1998). However, if we accept the notion of musical intimacy, then many of these theories simply do not align with these new concepts. In addition, they appear to oversimplify
the therapeutic process as it happens in music therapy practice.

Dileo (2000) has provided the most comprehensive writing on the topic of boundaries in music therapy. She aligns with traditional psychodynamic theories on boundaries and clearly outlines the processes in which she believes will help the music therapist to navigate their way through the swamp of psychological and physical boundaries. She appropriately points to the importance of boundaries in order to gain trust and ensure the safety of the therapists and the client in any given music therapy interaction. However, the lack of consideration on the impact of the musical experience, and contextual and cultural influences, equates to a discussion on boundaries that merely captures the surface of the complexities.

As discussed in the literature chapters, boundary crossings and boundary violations are a common concept presented in psychotherapy and other related fields (Gutheil & Gabbard, 1993). Boundaries are seldom considered in any other terms and have had significant impact on boundary management processes in psychotherapy, psychiatry, counselling and social work (Langs, 1998; Radden & Appelbaum, 2013). Boundary crossings in traditional therapy are considered to be benign departures from the normative processes in therapy and boundary violations are boundary crossings that cause harm. Traditional boundary crossings may include the exchange of gifts, self-disclosing personal information to our clients, forming dual relationships with clients and not adhering to a regular time, place or setting for therapy to take place. Some would say that boundary crossings lead down the slippery slope to boundary violations (Coe, 2008) and that they should be avoided (Dileo, 2000; Reamer, 2013). Others state that they are a normal part of therapy and can be considered helpful in building the therapeutic relationship and process (Lazarus, 2013).

Boundary crossings and boundary violations are murky, confusing, ambiguous and contradictory (Radden & Appelbaum, 2013, p. 287). Using music with people is intimate, social and personal and we naturally cross these types of boundaries by the intimate environment created by using music with people. I believe that ‘boundary crossings’ do not pose problems for music therapists, but rather they call for us to re-define our concepts and understandings of boundaries in music therapy practice, rather than continue to rely on theories that do not support current music therapy practice. Boundary crossings and violations as a concept may not be the best way to conceptualise this complex and multilayered area of practice. It leads us to realise, as Garry Ansdell (2002) first suggested, that maybe what is happening in practice is very
different from the theories that we rely on to guide and legitimate our work (Ansdell, 2002, p. 139).

**A new conceptualisation of boundaries – ‘ways of being and responding to musical intimacy’**.

The music therapists’ experiences in this study suggested that the instances of boundary crossings were common in their practice. This was demonstrated by the spectrum of experiences described by the music therapists, including a complex web of challenging situations and powerful moments of connection in and around the music. In addition, the music therapists’ descriptions of their ‘ways of being and responding’ to manage the intimate musical interactions do not align with the theoretical concepts on boundaries that seem to be supporting our work. These new ‘ways of being and responding’ suggest a more flexible intuitive approach to boundaries that considers the context of location, population, culture (work and personal), and the individual tailored nature of therapy, as well as the unique contribution and experiences in and around music.

What was also interesting was the many and varied approaches of managing intimacy in the moment of making music. This seemed to describe the intrinsic ways of what music therapists do during the moment of making music. Through the analysis of the music therapists’ transcriptions, other themes around boundaries emerged. These included ideas around the role of the music therapist, contextual influences, personal foundations and assumptions, and ideas on the felt embodied experience of boundaries. These are interesting and have potential to add to discussion in music therapy discourse about boundary theories. They may also suggest that traditional boundary theories are not applicable to contemporary music therapy practice.

Here is a quote referring to a traditional stance on boundary theories.

The potential for boundary violations derives from the space that exists between the knowledgeable professional and the vulnerable client. The inequality between us, the power differential, creates the need for protection. Boundaries define formally and informally how professionals are to exercise their power inside the relationship. When professionals maintain these limits, the power differential presents no problems. However, when professionals
abuse the privilege of their power, they violate the boundary that protects the space and place us (clients) in jeopardy. (Peterson, 1992, p. 126)

This quote seems to capture some of the foundations of the traditional approach to therapeutic boundaries. The labelling of the ‘knowledgeable professional’ and the ‘vulnerable client’ asserts inherent power imbalances that are present in a traditional approach to therapy. As described before in this chapter, the therapeutic relationship and the power dynamics within that have been questioned over the last 15 years with the development of newer models of music therapy. This quote aligns with traditional approaches to therapy, where the power in therapeutic relationship is seen as belonging to the therapist and it is their responsibility to maintain appropriate boundaries.

Most of the music therapists in this study did not practice in this way and did not describe a traditional approach to boundaries. Only one music therapist identified as using traditional approaches to boundaries, where she described boundary crossings and violations as a framework for her work. She also described many intimate experiences through and around music and commented; “It's very easy to create an intimate relationship with a client through playing together. With that comes the risk of blurred boundaries” (participant seven). Although she adhered to somewhat strict rules about boundaries she found these to be challenged in and around the music in her practice.

**The role of the music therapist.**

The music therapists in this study described musically intimate experiences from their perspective, reflecting on their roles and the interactions that they have had with their clients in and around music. What was interesting was how their descriptions illuminated how they viewed their role with the people they worked with. Many described aiming for equal relationships, where they wanted to respect their clients, through acknowledging them as individuals. Interestingly, this was present in some music therapists who identified with theoretical approaches where traditionally equal therapeutic relationships are not encouraged. Others were more conventional in their approach to the therapeutic relationship and would use stricter boundaries within that. These reflections urged me to consider how roles are understood or experienced within the powerful moments of connection and if they reflect a particular theoretical
A traditional role of the music therapist is described as the helping professional who assess and delivers an intervention to clients who need help (Bruscia et al., 2014). This approach stems out of the medically based model and adheres to an illness ideology about how therapy should work (Rolvsjord, 2010). In these orientations, the expert therapist holds the power in the therapeutic relationship and the way that therapy is practiced has the potential to disempower the people that they work with. Some popular theoretical approaches in music therapy have adopted this idea of the role of the music therapist, which includes neurological music therapy (Hoemberg & Thaut, 2014; Wheeler, 2014), behavioural/medical music therapy (Dileo & Bradt, 2005; Standley, 2005) and psychodynamic music therapy (De Backer & Sutton, 2014; Erkkilä, Ala-Ruona, Punkanen, & Fachner, 2011; Hadley, 2003).

Rolvsjord and Stige (2015) state:

The problem with the medical model is that it has been transplanted where there is less of a fit between the model and the problems and possibilities that people have. (Rolvsjord & Stige, 2015, p. 48)

Here they propose that the medical model, along with its assumptions about roles, has been placed inappropriately into a music therapy context where it does not benefit the individuals within it. Additionally, these traditional ideas, about roles in music therapy, do not appear to align with musical intimacy; in some part demonstrated during the powerful moments of connection where the music therapists felt to be on an equal level with their clients.

Along with the therapeutic relationship, the role of the music therapist has been questioned and critiqued through the development of community music therapy (Pavlicevic & Ansdell, 2004; Stige, Ansdell, Elefant, & Pavlicevic, 2010; Stige & Edvard Aaro, 2011) and resource orientated music therapy (Rolvsjord, 2010). These two models have illuminated how music therapists often take on a multitude of roles in their practice; serving as therapist, facilitator, musician, friend, organiser or promoter. Through their questioning of the traditional therapeutic relationship, the traditional role of a helping professional has been questioned.

These varying roles are particularly highlighted in a community music therapy approach. The ecological concept of engaging in context is paramount as well as empowering individuals to direct the process of the music therapy work. Bolger’s (2015) concept of ‘players’ is a relevant way of describing the roles imbedded within
this approach. This idea emerged from a participatory action research project conducted across three sites in Melbourne, Australia. Here, Bolger reflected on the process of collaboration and used the term ‘players’ to describe the people involved in the project. The word ‘players’ reflects the negotiation of shared power between all people participating in the project. In addition, Bolger highlights; “how effective collaboration requires mutual investment by all players” (Bolger, 2015, p. 100). Bolger’s (2015) concept of ‘players’ reflects how many of the music therapists in this study described their role in the therapeutic process.

Pavlicevic (2010) has also reflected on roles in her description of a community music therapy project in Heideveld, South Africa. She interviewed, recorded and observed this project and described the process as “collaborative musicing” (Ansdell & Pavlicevic, 2005). She states, “collaborative musicing identifies and describes the acts and intentions of all participants in group music therapy, as they collaboratively enact optimal group musicing” (Pavlicevic, 2010, p. 100). She further described how the music therapists combine many different roles and “flow in and out of overtly therapy roles to being therapist, director, co-musician, facilitator, collaborator” (Pavlicevic, 2010, p. 110).

The idea of ‘players’ (Bolger, 2015) and ‘collaborative musicing’ (Stige et al., 2010) aligns with certain aspects of musical intimacy. The notion of ‘players’ is relevant to the musical intimacy concept as it highlights the invested role that the music therapists in this study had in their intimate musical experiences. The music therapist also perceived their clients to be equally involved in the musically intimate experiences. The concept of players does seem to align with the music therapist’s belief in their approach and reflects their experiences of what they felt to be mutual collaboration in the intimate musical experiences.

Much of the literature and research in music therapy considers it from the perspective of the music therapist. This is no different in this research, however, it does pose questions about how clients are represented and described by the participant’s experiences of musical intimacy. Randi Rolsvjd (2015) has explored ideas around what clients do in music therapy. This music therapy article delves into the client’s experience of music therapy, how they feel about their therapist and the process of music therapy. One of the main findings was the idea that the clients care about their therapists and the process of therapy. They were also invested in the process and sought to make the process successful for themselves. This may relate to
musical intimacy where the music therapist believed that their clients were equally invested in the experience, which was particularly highlighted in the powerful moments of connection.

In musical intimacy, the participants described a sense of ‘letting go’, not thinking and just being with their clients. These ideas are in line with Kenny’s view of the role of the music therapist. She states; “The attending music therapist serves merely as a resource person and supportive guide” (Kenny, 2006, p. 13). She is asserting that music therapists remain alongside their clients, rather than in a place of power. Through these powerful moments of connection, the music therapists experienced moments of togetherness where traditional power hierarchies were not present.

**Context.**

Musical intimacy was experienced within interacting contexts. By contexts, I mean the places of work, the people worked with and the context of the therapy sessions themselves. The music therapists described how different contexts influenced the powerful moments of connection in and around musical intimacy. One music therapist described how the moments of connection through music were more powerful in the context of a hospital, as these kinds of connections were so rare in this environment. This is an important element of the musical intimacy experience as the interacting contexts and contextual influences impacted on the intensity of the powerful moment of connection. Another music therapist described the influence of performing in public and how the audience reactions intensified the powerful experience. The way that the context of the workplace, the people and the music therapy work interacted called for the music therapists to be more flexible in their approach to boundaries.

The importance of context in music therapy has recently been highlighted through the developments of culture centred music therapy (Stige, 2002), community music therapy (Ansdell, 2002; Pavlicevic & Ansdell, 2004; Stige, 2011) and resource orientated music therapy (Rolvsjord, 2010). Ruud (2010) has been critical in the discourse on context in music therapy. He states:

How we experience music and how music will effect us will depend on our musical background, the influence of the music we have chosen, and the
particular situation in which we experience the music. In such a contextual understanding, the music, the person, and the situation work together in a relational or mutual relation where changes in any of these components will change the meaning produced. (Ruud, 2010, p. 57)

Here, Ruud has eloquently described how this contextual understanding of music influences the meaning in any music therapy moment. I feel this description aligns with musical intimacy as the powerful moments of connection described by the music therapists changed depending on these different contextual influences. The varying experiences described by the participants suggested contextual influences on how these experiences came about and were experienced.

Rolvsjord and Stige (2015) have provided a theoretical discussion about the role of context in music therapy practice, how it is presented, discussed and understood. They note that the different aspects of context as presented in the music therapy literature include; 1) music therapy in context, 2) music therapy as context, and 3) music therapy as interacting contexts (Rolvsjord & Stige, 2015, p. 51). They argue how these different ways of understanding context appear to align with different prominent models in music therapy practice. They also discuss context in relation to music stating; “The musical-cultural context becomes important because it becomes a part of the clients belief system related to their thoughts about how music therapy can contribute to their lives” (Rolvsjord & Stige, 2015, p. 52).

Musical intimacy and its surrounding influences align with Rolvsjord’s and Stige’s (2015) concept of interacting contexts. They argue that music therapy, as interacting contexts, includes processes that are interlinked and operate with a broader ecology of contexts. This may include “the community, the setting, the musical culture, health care politics and the context of academic interdisciplinary discourse” (Rolvsjord & Stige, 2015, p. 13). Similarly, the experience of musical intimacy is influenced by the broader ecology of contexts. The local community may influence the individual and how they interact within the music. The setting may influence how and why the music therapist and client can interact together in music. In the moment of musical intimacy, the interacting contexts may contribute to and influence how that moment is experienced.

**Personal foundations and assumptions.**
Many personal foundations and assumptions appeared to influence the intimate musical interactions experienced by the music therapists in their practice. These cover a range of influences on practice and can broadly include our ways of practicing music therapy, our training, our personal beliefs, our views and values, our culture and beliefs about spirituality. These complex areas often overlap and mix with each other. These of course do not always influence musical intimacy all the time and often their impact is subtle. However, I feel that there are certain personal foundations and assumptions that influence the experience of musical intimacy for the participants in this study. These will be different for each individual music therapist and for each individual that we work with. All of these components make up who we are as people and who we are as therapists.

Dileo (2000) notes that values are deeply embedded and are brought into every therapy session. This in turn influences our experiences of powerful moments of connection with the people we are working with. In addition, this may be extended to our views on music and what value we place on it. What do we perceive as the value of music for the people we work with? One participant who worked in forensic care outlined their style of having an unconditional positive regard for their clients. They felt that other staff members were often judgmental and came from a place of fear and were placing their views and values onto the clients. They described how their own unconditional positive regard helped them to connect with their clients and stated; “We share an experience. The patient thinks I know how they feel or I'm able to affect them musically. Because we have those intimate encounters through music it deepens the relationship” (participant two).

Embodyment.

One of the key aspects in musical intimacy was the discovery that it was an embodied or felt experience. This was demonstrated through the participant’s body language, their tone of voice and the language that they used to described the experiences. Many of the music therapists described following their ‘gut’, or having a feeling that something more was happening in the music making experience. Of particular importance was the reflection on challenging experiences that revealed the underlying embodied experience for the music therapists. In describing these challenging experiences, I could see, hear and feel the uncomfortable reaction that
they had experienced in these challenging situations. The term ‘acute sense of vulnerability’, which formed part of the grounded essence, seems to capture the felt experience in this moment.

Finlay (2006) has explored the embodied experience in phenomenological research. She explains that there are new learnings and understandings when becoming aware of your embodied reaction to the data. She asserts that researchers should be aware of their body and has outlined three layers of this process. These are; 1) bodily empathy, 2) embodied self-awareness, and 3) embodied inter-subjectivity. Bodily empathy means attending to and being aware of the bodily movements of your participants, through experiencing their body through your own perceptions and assumptions. Embodied self-awareness is about questioning and examining our own body responses to all aspects of the research process. Embodied inter-subjectivity relates to awareness of both the researcher’s and participant’s body experiences.

Finlay’s (2006) three concepts of embodiment awareness in research can relate to the embodied experience in musical intimacy. Being acutely aware of the embodied experiences in our clients, ourselves and the interaction between us may help reveal the moments of vulnerability where there is a need for boundaries. When reflecting on one music therapist’s challenging experience, I can vividly remember sensing how she felt. She was sitting forward and her facial expressions suggested that this experience was uncomfortable. Her hand gestures echoed her gut feelings that something was wrong. I too felt this sense of uncomfortableness and found myself listening intently to every word she spoke. What emerged from her experience was how she felt this challenging experience in her body. Comparing these experiences to Finlay’s (2006) ideas, there are differences in the immediacy of the experience of musical intimacy, these embodied experiences are happening in the powerful moments of connection, rather than in later interaction with data. This embodied awareness wraps around and is integral to the therapeutic process in music therapy, yet the added layer of complexity for music therapists is to be aware of this in and through the music.

Smeijsters (2012) has also delved into the embodied experience in music therapy. He aligns with Sterns forms of vitality as a means of describing the felt, embodied experience between movement and interaction. He states:

If it is possible to connect the body to emotions and to music, then it becomes clear that we can use bodily metaphors to described emotion and music as
well. (Smeijsters, 2012, p. 237)
Here he has emphasised the link between the body, emotions and music. This is useful for the concept of musical intimacy as it may allow us to be more acutely aware of the felt experience of emotions through music, with our interpersonal experiences.

These ideas also related to some of the music therapists ways of being and responding to musical intimacy. Their sense of following their intuition and being flexible suggested that they use the embodied experience of musical intimacy to manage the intimacy in these interpersonal experiences. The embodied experiences also related to the spectrum of experiences in and around musical intimacy. The music therapists described how they felt that something special had happened, or that they felt uncomfortable with the situation they were describing. The acute sense of vulnerability, from the grounded essence, captures the embodied experience of musical intimacy and how this can be used to help manage these experiences in music therapy.

**Musical intimacy value and importance for music therapy practice**

Musical intimacy brings to our awareness the implicit and underlying assumptions about how we manage and deal with intimacy and music in music therapy practice. By acknowledging this aspect of music therapy practice, we can bring our awareness to these issues, which may serve to help us in the challenging situations that we will face over the course of our practice as music therapists. The knowledge that musical intimacy is an embodied experience helps us to be aware of the multilayered aspects of these experiences and how we can use our own intuition to navigate through them. The value and importance of musical intimacy includes recommendations for training programs in music therapy.

On speaking to music therapy lecturers and music therapists about training in boundaries, there seems to be great variations in how boundaries are covered in music therapy courses. The greatest differences are located in the varying theoretical approaches that particular courses focus on. Some courses appear to cover boundaries in some detail while others only refer to them briefly. This reflects how boundaries are understood and implemented in different theoretical approaches in music therapy.

This new way of conceptualising boundaries in music therapy could serve as a
useful starting point for students. When lecturing on boundaries to music therapy students, I am often faced with similar questions. Questions relating to what they should do in a specific situation, what is a right or wrong response and where can they get information about how to handle these situations are common. This new conceptualisation offers much more than the theories we have been relying on as a profession. The experiences shared by these music therapists offer unique perspectives about their experiences and how they have managed these situations in the past. The ‘in the moment’ processes are particularly useful as they outline the often implicit strategies that music therapists use in the moments of making music with their clients.

The descriptions of the challenging experiences also offer opportunities for great learning. Hearing about these challenging situations and how the music therapists managed them, would help music therapy students in developing their understandings of the complexities surrounding musical intimacy and boundaries. These findings may be useful for the training of music therapists in the future, as music intimacy could serve as a framework to discuss potential challenges in the contemporary approaches to music therapy practice. This would encourage future music therapists to become aware of their bodily responses to boundary issues in and around the music in music therapy, and to reflect on what their ‘ways of being and responding’ to these challenges could be. This would also encourage student music therapists to develop an awareness of their own boundaries and how they can work within that.

Critical reflection and evaluation of this research.

It is imperative to critically reflect on this research to understand how it can contribute to the wider music therapy profession. In this section, I will reflect on the limitations and potentials of this research project. Evaluating qualitative research has been an area of much discussion (Stige, Malterud, & Midtgarden, 2011). As qualitative research grew in popularity, discussion turned to how we could evaluate research that is greatly influenced by the researcher; essentially what makes a good quality qualitative study. Stige, Malterud and Midtgarden (2011) have outlined a process for evaluating qualitative research entitled EPICURE. The first part, ‘EPIC’, is described as ways of engagement, processing, interpretation and (self)-critique.
The second part ‘CURE’ refers to critique, usefulness, relevance and ethics. This framework offers a unique way of evaluating qualitative research.

Through this section I will focus on the first part of the Stige, Malterud and Midtgarden (2011) evaluation method. The areas that I will cover are; 1) the music therapist’s perspective, 2) the small number of music therapists in this study, 3) language and interpretation, 4) the influence of the primary researcher, 5) distance from the experiences, 6) discussion on the grounded theory methodology, and 7) developing an active reflexive voice through grounded theory research. These areas all relate to the ways that I have engaged, processed, interpreted and critiqued this grounded theory study.

**Music therapist’s perspective.**

One of the first limitations of this study is that it is from the perspective of the music therapists only. This point of view is of course interesting, however, there is a lack of diversity in the findings, as there is no voice of the consumer. I chose to focus on the perspectives of the music therapist because musical intimacy and boundaries was a new concept to be explored in music therapy. My interest was based in boundaries and I felt the need to explore this area, in order to help music therapists navigate their way through these musically intimate interactions. I felt that there was little information in literature in music therapy around boundaries, especially around the complex negotiations in and around the music. As such, I chose to focus this research on the perspectives and experiences of music therapists.

In the participant’s descriptions of musical intimacy, they always discussed their clients. The music therapists described how they saw their clients responding and what they perceived their experience to be. Through these descriptions, the clients were present, but only in the shadow of the music therapist. This leads the descriptions to feel, at times, as being expert over the client, as the music therapists made assumptions about how their clients experienced these situations. The way that the participants talked about the power of music also suggests an expert-client model, where the music therapists were placing power on the music itself and potentially not taking full responsibility for the impact.

I feel that it is very important to gain the clients voice about these issues to add their perspective about music intimacy and boundaries. Further research could
focus on the clients themselves, or perhaps client and therapist duos, to try to gain multiple perspectives of the same therapeutic interactions. We do need to recognise the role that clients play in therapy, as Rolsvjord has outlined in her recent research (Rolsvjord, 2015). This would be an important step forward in deepening the understating of musical intimacy, as intimacy in itself suggests a two-way interpersonal process.

A small number of music therapists with limited diversity.

Another important reflection is that this is only a small handful of music therapists. Although qualitative research is about the quality of the experiences not the quantity, I feel that adding more diversity in culture, class or gender would enrich the findings. I was able to recruit twenty music therapists from the USA, Canada, the UK, Denmark, Norway and Australia. The participants in this study were from western or European backgrounds, were middle class and included fourteen women and six men. There was a distinct lack of cultural diversity and further studies could include music therapists from a wider range of cultural backgrounds. This would enrich the findings providing more perspectives on the complex phenomenon of musical intimacy.

The theoretical orientations of the music therapists primarily identified with humanistic and psychodynamic frameworks. Only a small number of music therapists identified as using a behavioural, medical or neurologic a form of music therapy. Although there is a wide variety of theoretical approaches in music therapy, the distinct lack of perspectives from a medical or behavioural approach is noted. There were also only two music therapists who identified as using community music therapy approach. There are a few reasons why this may have happened. One is that the theoretical orientations and beliefs of my supervisor were on some level echoed through her music therapy contacts, thus reaching an audience who aligned with the same methods. Two, the nature of this topic may potentially attract music therapists who practice in a more humanistic or psychodynamic informed practice, because of the focus on boundaries and musical intimacy. Three, some of the countries where the participants were from are largely informed by humanistic for psychodynamic practices.
Language and interpretation.

As seven of the participants had English as a second language it is important to note that the interpretation of their language cannot be guaranteed. Care was taken to understand the participant’s meanings of their descriptions in the interview itself and in the following analysis. At times during the interviews, the participants would be searching for the right word in English to convey their thoughts. I could sense that at times this was difficult for them to truly express their thoughts and would try to help them find the right words. This was also one of the main reasons why participants were sent parts of their analysis to verify. This allowed them the opportunity to correct any parts that did not accurately represent their experience. However, there is still a possibility that I misinterpreted their descriptions of what they were trying to convey.

The influence of the primary researcher.

With any qualitative research, reflection is needed to address the impact of the researcher on the findings. There are differing opinions about how best to deal with this aspect of qualitative research. Some believe that you can bracket out your assumptions to identify and become aware of them so they don’t influence the research findings (Husserl, 2012; Moustakas, 1994). Others believe that you can’t bracket out your assumptions and that the role of the researcher is part of the constructed nature of the findings in qualitative research (Charmaz, 2014). In this research I believed that my opinions, assumptions and experiences could not be bracketed out of the analysis, as I felt they were integral to my experience as a researcher and how the findings were constructed. I acknowledge that this research is constructed (Charmaz, 2014) by the participants and myself and I have actively sought reflexive strategies in every stage of the research to help make this research transparent. I have also sought to embed reflexivity into the writing up of this thesis. In this way, I hope to make transparent how my assumptions and views have helped to share these findings.

Distance from the experiences and double interpretation.
The next limitation is that I was interviewing music therapists about intimacy they have experienced in and around the music in their practice. They were reflecting on their whole carers as music therapists and, as such, used the examples that have influenced them the most. Although this may reveal what were the most challenging or pivotal experiences in their career, it also places some of them further away from the experience. Some of the participant’s reflected on experiences that had happened up to thirty years ago and were reliant on their memory of the situation. The data was based on how the participants expressed these experiences and how much they chose to share.

The process of collecting these experiences may also have been influenced by the different relationship dynamics that formed during the interview process. When conducting the interviews, the intimacy of the interviews was something that I reflected on. With some of the interviews, I felt like I had to work through some barriers, or gain some trust before the music therapist would reveal the more challenging aspects to their work. As a younger clinician, I was also aware that my experience as a music therapist was somewhat less than some of the participants. In one interview I felt more like a student, it was harder to gain their trust and to really get this participant to share some of her more challenging experiences. This dynamic was something that I worked through in the interview and also carried with me into the analysis.

By adopting the constructivist lens (Charmaz, 2014), I acknowledged that this research was constructed by myself and the participants. This leads to a complex interpretation, where the music therapists were interpreting their client’s experiences and their own, then I was placing my interpretation on top of this.

**Developing a reflexive voice through grounded theory research.**

The inclusion of reflexivity in the research was integrated into every part of the process. This is a reflection of my beliefs about qualitative research and the need to be reflexive throughout the whole process. Reflexivity is not a new process in qualitative research and many describe how important it is in evaluating qualitative research studies (Linda, 2002; Lynch, 2000; Pillow, 2003). Reflexivity was an important part of every process in this research from reviewing and analysing the literature, to designing the study, interviewing, analysing and finally writing up. In
the final writing up of this research, it became important to consider how best to represent the reflexivity process. I adopted a writing style that included different pronouns to articulate my influence on the research and demonstrate how these impacted on my interpretation of the participant’s experience. Throughout this thesis I have aimed to embed my assumptions that underpin this researcher, hoping to be transparent about how these findings were constructed.

Conclusion

Through this chapter I have discussed some interesting points that have arisen from the findings in this research. I have integrated these ideas with relevant music therapy concepts, in the hope to situate these findings within the current context of music therapy discourse. Underpinning this research was the belief that the boundary theories we refer to as a profession do not align with contemporary approaches to music therapy practice. I use the work contemporary as a way of described what music therapy is now. Contemporary music therapy practice includes many varied approaches and frameworks that combine to make up the landscape of music therapy practice.

The theoretical framework of musical intimacy provides a start to incorporate critical discussions on musical intimacy in music therapy practice. The concept of musical intimacy calls for us, as music therapists, to explore what musical intimacy might mean for our own practice. We can then further extend this to our understandings of boundaries, and what boundary constructs would be useful in our contemporary practice. Within musical intimacy the music therapists described a spectrum of experiences, from challenging experiences to powerful moments of connection. These examples illustrate that complex web of experiences that we deal with in and around making music with people.

The next chapter will conclude this thesis with my final thoughts about the findings from this research. I will also summarize this research project and suggest recommendations for further research into musical intimacy and boundaries.
References


Chapter 7
Conclusion and recommendations

Introduction

The aim of this research was to explore the concept of musical intimacy and examine how music therapists were managing boundaries in and around the music in music therapy. The research question was; “how are music therapists managing the boundary challenges that can occur in the musically intimate context of practice?” These concepts emerged from my own experience as a music therapist as well as the critical interpretive synthesis, which examined traditional boundary theories in music therapy case studies. This critical interpretive synthesis solidified musical intimacy as an interesting concept to be explored in this study.

During my initial search of literature it was evident that boundaries had not been explored in any great detail in music therapy practice. We appeared to be relying on theories, mainly from psychotherapy, about how to manage boundary issues in our practice. These traditional ideas felt rigid and unsuited to the multilayered process of music therapy. They also stemmed from a medically informed approach to practice, where power in the therapeutic relationship is usually afforded to the therapist. Some contemporary approaches had noted the need to redefine boundaries, however, they had yet to be explored in any great depth.

In light of this context, I felt the need to explore our literature more deeply and decided to conduct a critical interpretive synthesis on case studies (Medcalf & Mcferran, 2016). The critical integrative synthesis allowed me to examine different aspects of the case studies and explore to see if traditional boundary crossings, were present. I found many instances of traditional boundary crossings and this surprised me. What was also interesting was the way that many of these traditional boundary crossings were happening in and around the music in music therapy. This critical analysis also revealed ‘musical intimacy’ as a new concept, which set in motion the focus for this research. This led me to concentrate on musical intimacy, on what it might mean and how it may be experienced. In addition, musical intimacy was the influenced by the interaction of therapeutic boundaries. I was keenly interested to explore how music therapists were managing their boundaries in and around the
musically intimate context of contemporary practice.

**Grounded theory study on musical intimacy and boundaries**

Following the critical examination of literature, I undertook a grounded theory study examining musical intimacy and boundaries. I interviewed twenty music therapists from the USA, Canada, the UK, Denmark, Norway and Australia. I applied a grounded theory analysis that was influenced by the notion of constructivist grounded theory (Charmaz, 2014), and by grounded theory ideas from Corbin and Strauss (Corbin & Strauss, 2008; Strauss & Corbin, 1998). The grounded theory analysis used concepts from both Charmaz’s constructivist approach (2014) and strategies from Strauss and Corbin (2008). The whole research process was also heavily informed by reflexive practices, through literature analysis, data collection and analysis, and in the writing up of this thesis. These strategies helped to reveal my own assumptions and influence on the construction of this theoretical framework, as I view qualitative research as constructed by both the participants and researcher (Charmaz, 2014).

The grounded theory analysis revealed a theoretical framework of musical intimacy and a new conceptualisation of therapeutic boundaries. This framework provides a definition of musical intimacy, outlines the actions and process that may influence it, provides a grounded essence of the musically intimate experience, and outlines the ways of being and responding, which articulate how boundaries are played out in and around musical intimacy. The grounded essence of the musically intimate experience was the last point to emerge, and captures the core characteristics of the musically intimate experience.

**Main points of interest**

**The introduction of musical intimacy.**

Musical intimacy may be one defining feature that binds all the diverse approaches in music therapy practice. It can serve as a framework for understanding the multiple levels of interactions and possibilities that can happen in and around the music in music therapy. It may also help music therapists to be mindful of the potential for musical intimacy to be harmful, and to be aware of how the powerful
moments of connection may influence the therapeutic relationship, the therapeutic process and the individual. This framework can help music therapists to be mindful of their personal foundations and assumptions, which may influence the process of musical intimacy.

For the music therapists involved in this study, musical intimacy included a spectrum of experiences. These were the powerful moments of connection and challenging situations that were experienced in and around the music. This complex web of experiences highlights the complexities and multiple layers of experiences in musical intimacy. What is also interesting, is the idea that neither the powerful moments nor challenging situations, were experienced as purely positive or negative. This web of experiences calls for us to not view them as dichotomies of good or bad, but rather, to sit within the notion of multilayered experiences that are hopefully helpful for the health and well-being of the people we work with.

The emergence of challenging experiences from these music therapists is also important for the growth of the music therapy profession. Through exploring these experiences and reflecting on practice, this could help music therapists to be more aware of their own challenges. As 19 of the 20 music therapists interviewed identified some challenging experiences, in and around music, this may suggest the importance of understanding the potential for harm in music therapy. It also calls for music therapists to be aware of the potentially challenging impact that musical experiences may have on the people we work with. It is our responsibility to be aware of these challenges, and that we can use resources, such as our embodied experiences, to continually be aware of these potentials.

The music therapists in this study described their musical intimacy experiences. These included a variety of interpersonal interactions, and ideas about how music has intrinsic components that influence music therapy practice. Ideas of the power of music and how music naturally creates strong connections, were prominent throughout the music therapist’s descriptions. Musical intimacy captures the complexities of the interactions that we have in and around music in music therapy.

**A new way of conceptualising boundaries.**

The strategies described by the music therapists in this study, to manage the musically intimate situations, may help music therapists be mindful of ways to
approach the intimacy created in and around the music in music therapy. The ‘ways of being and responding’ are the beginning of a new way of conceptualising boundaries in music therapy practice. The ‘in the moment processes’ that emerged from the music therapists, detail some of the implicit ways that music therapists intuitively manage the intimacy created through music. These are a useful beginning, and may help music therapists to identify their own implicit ways that they manage intimacy in their musical interactions.

This research was not a comprehensive exploration into therapeutic boundaries in music therapy practice. The emergence of these boundary ideas was in relation to the understanding and development of musical intimacy. It is my hope that this will begin a wider discussion on therapeutic boundaries in the music therapy profession, helping us to move away from traditional models of therapeutic boundaries. Perhaps this will lead to a new understanding, that includes contemporary considerations such as context, cultural influence, and also lead to a redefining of roles and relationships that develop through the nature of ‘musicking’ with people.

Implications for further research

This research is only the beginning of what could be explored with musical intimacy and therapeutic boundaries. One way to explore this concept in more detail would be to gather the perspectives of clients on musical intimacy. The clients’ voice is not in this research and this somewhat limits the findings. Further researcher could explore the clients’ perspective of musical intimacy, and how they manage these intimate moments experienced through making music. This could also lead to research that explored musical intimacy from both perspectives. It would be interesting to examine dyads, music therapists and their clients, to see how they both perceive the concept of musical intimacy. In addition, the music that these dyads create could also be analysed to add further insight into this concept. This could highlight differences and similarities, and shed further light on the concept of musical intimacy in music therapy practice.

This research has explored the concept of boundaries in connection to musical intimacy. However there are many more areas of boundaries that can be explored in music therapy practice. Some further research could look at boundaries in different theoretical approaches or contexts. For example, how would community music
therapy or behavioural music therapy approaches differ in their understandings of boundaries? Another interesting area could be to examine if the term ‘therapeutic boundaries’ is actually useful in music therapy practice. Does this term align with the contemporary approaches to music therapy that have moved away from the traditional medical model of practice?

Further research could include more diversity in culture and location of music therapists. This could include examining musical intimacy from different cultural locations to explore any differences or similarities in the findings. Additional research could also explore challenging experiences in music therapy practice. This could examine the challenges in all aspects of music therapy practice and would shed more light on the actions and processes that music therapists use in their day-to-day practice. This would also delve into therapeutic boundaries as it is in the challenging experiences where therapeutic boundaries are often tested and developed.

Conclusion

Musical intimacy has been defined and explored through this research. It is my hope that musical intimacy will enter music therapy discourse to raise questions about how we interact in and around music with the people we work with. It is paramount that we recognise our musically intimate interactions and how they can create a spectrum of experiences that can be challenging and powerful. Furthermore, music therapy as a profession needs to reflect on the traditional ideas of therapeutic boundaries and question if they are relevant to the way that we practice in contemporary music therapy practice.
References


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