Uniting the Work of Community Musicians and Music Therapists through the Health-Care Continuum: A Grounded Theory Analysis

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Abstract
In some contexts, there is a strong relationship between music therapy and community music practices, especially as music therapy discourse focuses increasingly on notions of community, culture, and context. The aim of the present research was to investigate this relationship, as it manifested through in-depth, semi-structured interviews with music therapists and musicians who worked in community contexts in Victoria, Australia. The grounded theory research method informed the theoretical sampling technique used, as well as the analysis and presentation of results. The following article presents the main result of this study, which is a theory that is offered as one interpretation of the relationship between the community work of music therapists and musicians. The overarching framework for this theory is the construct of health-care as a continuum, involving stages of illness/crisis, rehabilitation, community and well-being. This construct is particularly useful for music therapists and community musicians to consider how they can best support the music participant in each of these stages. It also offers an explanation of the relationship between music therapy and community music, although limited by the self-report of the research participants and their collectively small geographic location. Future directions for research are discussed.

Key words: community music, community music therapy, grounded theory, health-continuum

Introduction

Community, music and therapy are three words that have frequently accompanied each other along the labyrinthine paths of music therapy

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discourse, gaining considerable notoriety as a trio within the last three years. Some music therapists are so excited by the ensemble that they proudly punctuate each word with a capital letter (eg. Pavlicevic & Ansdell, 2004), others more demurely use the lower case (eg. Bruscia, 1998; Stige, 2002). This trio of words has caused discomfort for some and relief for others, while sparking heated debates within the international world of music therapy. Community Music Therapy has been called a phenomenon (Pavlicevic & Ansdell, 2004), a sub-area of practice (Bruscia, 1998), a paradigm shift (Ansdell, 2002), a discourse (Ruud, 2004) and even a professional suicide bid (Erkkila, 2002). Like Erikson’s adolescent, the “young and unsettled” discourse on Community Music Therapy (Stige, 2004, p. 219) is still trying to forge and refine its identity.

One of the tasks undertaken by contributors to the emerging discourse on Community Music Therapy (CoMT) has been to define the relationship between community music and music therapy. As early as 1999, Australian music therapist Catherine Threlfall was openly considering this relationship. She noted that many Australian music therapists were working in community settings and not considering this work as therapy. Her article, published in a local AMTA newsletter, describes how her own community music work was aimed at “creating a healthy and supportive environment” (Threlfall, 1999, p. 12). Interestingly, her own definitions of music therapy and community music were the same: “the creative use of music to facilitate positive change for a person or community” (p. 10). This is despite her belief that community musicians and music therapists bring different skills to community work.

By 2002, British music therapist Ansdell had also published his explorations of the relationship between music therapy and community music. In a discussion paper entitled “Community Music Therapy and the Winds of Change” (2002) he remarked how music therapy’s new status as a State Registered profession in the UK led to questions about how music therapists’ practice differs from that of community musicians. He asked, “Do music therapists and community musicians have different practices, or just different theories?” (p. 111). In this article, Ansdell presented the relationship between music therapy and community music in the form of an individual-communal continuum, with music therapy and community music at opposing ends and CoMT as the underlying basis. Prior to this perspective, Atkinson (2000, as cited by Ansdell, 2002) envisaged community music as the overarching framework under which music therapy existed as a specific practice.

The purpose of the following article is to provide another perspective that unites community music with music therapy. It is based on the results of a recent study conducted by the present authors and involves the health-care
continuum as the underlying basis for explaining both community music and music therapy practices. The concept of health is initially discussed, followed by an explanation of the research method utilised by the present study. The resulting theory is then articulated and discussed. This paper concludes with a discussion of the study’s limitations and implications for future research.

The Concept of Health

As CoMT discourse continues its emphasis on the inextricable influence of culture in music therapy practice, many of the central tenets of music therapy theory are expanding and changing. The concept of health is one such tenet. For example, in the second edition of Defining Music Therapy (Bruscia, 1998), Bruscia elucidates how his own ideas concerning health have changed from being an either-or state to a "process of becoming one's fullest potential for individual and ecological wholeness" (p. 84). Furthermore, scholars who are strongly aware of the influence of culture view health as a process rather than a condition. According to Bloch and Singh (2001), health is a state of balance which people establish within themselves and their environment and which has psychological, physical, emotional, socio-cultural, and spiritual dimensions. Health "exists alongside and merges with illness" (Bloch & Singh, 2001, p. 513).

The results of the present research support these perspectives on health and, more importantly, draw them together as the most significant factor influencing the nature of music-work. The theory resulting from the present study asserts that the undeniable relationship between community music and music therapy is best understood when health is considered as a non-linear process involving myriad factors. The data from the present research directs this perspective to the more specific concept of health-care as a continuum. Before this continuum is presented, however, the methods of data generation and analysis utilised by the present research are outlined.

Method

Method of Data Generation – The In-depth, Semi-Structured Interview

Semi-structured interviews “aim to explore the complexity and in-process nature of meanings and interpretations that cannot be examined using positivist methodologies” (Rice & Ezzy, 1999, p. 53). They are “a way of finding out what others feel and think about their worlds” (Rubin & Rubin, 1995, p. 1) through modification or extension of ordinary conversations
where the content and flow is flexible to match the interviewee’s knowledge and feelings (Rubin & Rubin, 1995).

Semi-structured interviews are used to facilitate focused exploration of a specific topic, using an interview guide (Fossey, Harvey, McDermott, & Davidson, 2002; Rubin & Rubin, 1995). The interview guide is an inventory of important topics to be discussed in the interview (Rice & Ezy, 1999). It is intended to be flexible and to change according to the diversity and organisation of meanings being conveyed within the interview (Holstein & Gubrium, 1995). The following is the interview guide used in this study:

1) Primary details of work – where it occurs, how often, how long, job title
2) Aims – aims for self, aims for clients
3) Role – job expectations, worker identity
4) Perceptions of the role of music for self and clients
5) Methods/Techniques used – musical, non-musical
6) Musical and non-musical influences that have impacted on the worker’s use of music in the community
7) Outcomes – desired and real
8) Nature of relationships with clients
9) Beliefs about what distinguishes the work from that of community music therapists/community musicians

Participants and sampling procedures

Research participants were selected if they currently or recently worked as a musician or a music therapist in a community context. The difficulties in defining community are well acknowledged in the literature (Ansdell, 2002; Cahill, 1998; Hawkins, 1993; Stige, 2002; Twelvetrees, 1991) and therefore the present study sought a variety of contexts that could be labeled community. As a result, the research participants described their work in settings that included a women’s refuge, a therapeutic community, a high school, nursing homes, art centres, health centres and community centres (Table 1). All participants lived locally to the researchers, in Melbourne, Australia and in parts of rural Victoria. Although generalisability and usefulness of the findings may have been improved by sampling nationwide and even internationally, the small scope of the Master’s study did not allow this.

Participants were recruited via personal contacts, the Victorian issue of the Australian Music Therapy Association Inc. (AMTA) register, as well as phone-calls to two community music organizations in Victoria. Initially, the
researchers sampled purposively, preparing a list of three community music therapists and three community musicians. The data that emerged from these interviews then enabled the researchers to sample on an ongoing theoretical basis. For example, a concept that emerged in the first interview was *diagnosis is not important.* The researchers wanted to explore this idea further by examining when it is likely to be important. Thus, they chose to interview a music therapist who worked in both a community mental health setting and a hospital setting on the assumption that both settings may treat diagnosis differently and it would therefore be possible to make comparisons. The process of data generation reached a point where no new relevant data seemed to be emerging and therefore data generation ceased. This resulted in a collection of 15 interviews, 8 with community musicians and 7 with music therapists.

Table 1
The stages of the health-care continuum in which music therapists and community musician’s work.

<table>
<thead>
<tr>
<th>Stage of Health-Care</th>
<th>Music Therapist</th>
<th>Community Musician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-being</td>
<td>Well parents and children (MT 2, MT 4)</td>
<td>Well adults (CM 8)</td>
</tr>
<tr>
<td></td>
<td>Well adults (MT 7)</td>
<td>Well young people (CM 4)</td>
</tr>
<tr>
<td>Community</td>
<td>Adults with non-acute mental illnesses (MT 1, MT 4)</td>
<td>High school students (CM 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Australian residents who were once refugees (CM 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Marginalised young people (CM 3, CM 7)</td>
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<td></td>
<td></td>
<td>Adults no longer in rehabilitation for acquired brain injuries (CM 1)</td>
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<tr>
<td></td>
<td></td>
<td>Aged care (CM 5)</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Adults overcoming substance addiction (MT 6)</td>
<td>-</td>
</tr>
<tr>
<td>Acute illness/crisis</td>
<td>Women and children in refuge (MT 3)</td>
<td>-</td>
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</tbody>
</table>

Method of Data Analysis: Grounded Theory

Grounded theory is “a general methodology for developing theory that is grounded in data systematically gathered and analysed” (Strauss & Corbin, 1994, p. 273). It is arguably the most comprehensive and influential qualitative research methodology available to health researchers (Haig, 1995; Rice & Ezzy, 1999). Strauss and Corbin (1994) emphasise that there should
be three important features of any research design purporting to use pure
grounded theory methodology:
1) the interplay between data and theory, which involves the grounded
theorist constantly making comparisons between the raw data and their own
theoretical constructs which have been inductively derived from the data.
Inductive data analysis challenges the researcher to ascribe theoretical labels
to the data that emerge from repeated readings of the data rather than any
predetermined ideas.
2) theoretical coding, which involves three types and stages of data analysis.
Succinctly described by Rice and Ezzy (1999), the first stage, called open
coding, compares the events, actions and interactions within data and ascribes
descriptive labels to them. The second stage, axial coding, involves
specifying these descriptive labels more rigorously by connecting them into
categories. The third stage is called selective coding and involves unifying the
categories around a core theme. The coding process is considered complete
when theoretical saturation has been achieved, that is, when no new relevant
data emerges.
3) the development of theory, which is the culmination of the theoretical
coding process and, according to Strauss and Corbin (1994), is the most
important feature of grounded theory methodology. “Some researchers
deliberately do not aim at developing theories. Therefore, they ignore this
central feature of the methodology, often using its procedures inappropriately
or overlooking alternative methodologies that could serve their purposes
better” (p. 277). For information on how grounded theory was specifically
applied to this study, please refer to a paper by the present authors (O’Grady
& McFerran-Skeewes, 2007).

According to Strauss and Corbin (1994), theories are “interpretations
made from given perspectives as adopted or researched by researchers” (p.
279). They can be expressed as narrative statements, visual pictures, or a
series of propositions (Creswell, 1998) and although their interpretive nature
means that they are not presented as objective truths, theories can still be
judged on their soundness and usefulness (Strauss & Corbin, 1994). While it
is not within the scope of this article to show how methods for trustworthiness
were implemented, this research was committed to notions of reflexivity and
transparency. Furthermore, peer debriefing, member-checking and negative
case analysis, where “the trick ... is to identify the case that is likely to upset
your thinking and look for it” (Becker, 1998, p. 87), were also employed in
order to enhance the scientific merit of this study.
Results

The following theory is written using the language of the categories and codes that emerged from the grounded theory analysis of the raw data. In order for the reader to become more familiar with what the categories refer to and the way they form the foundation of the theory, the main categories and their dimensions have been outlined in Figure 1. For examples of how these categories were formed from subcategories, codes and raw data, please refer to the tables at the end of the paper.

Uniting the work of community musicians and music therapists through the health-care continuum: A theory

Health is not an either-or condition but a process involving physical, emotional, social, cultural, and spiritual dimensions. Furthermore, this process is not just a linear progression that ends with achieving a state of balance; it is more like a continuum along which people continually move forward and backwards, or cyclically as various physical, emotional, social, cultural, and spiritual factors ebb and flow throughout their life. People’s health needs will depend upon where they are located on this continuum.

The data from this study lends itself to this concept in its construction of health-care as a continuum (Table 2) that involves four major stages: 1) Acute illness/Crisis, 2) Rehabilitation, 3) Community, and 4) Well-being. People move through the stages over time, however, they can spend indefinite periods of time in one of these stages if the physical, social, cultural, or spiritual factors that are contributing to them being there persist. Furthermore, people can move backwards or forwards through these stages, and stages are often skipped. For example, an unforeseen crisis can suddenly move a person’s location on the health-care continuum from the well-being stage to a phase of acute illness/crisis.

The sample from this study suggests that community musicians work less frequently with participants whose location on the health-care continuum is within the acute illness/crisis stage or the rehabilitation stage of health-care (Table 1). This study suggests that music-work carried out by music therapists and musicians who work in the community and well-being stages is very similar and is more dependent upon the music-participant’s experience along the health continuum (Table 3) than whether the music-worker identifies as a musician or a music therapist.
The acute illness/crisis stage – One extreme of the health-care continuum

A person may be located at this extreme of the health-care continuum if symptoms or circumstances prohibit that person from being able to function as he or she normally would. The person, or relevant health professionals, may label this phase as some sort of crisis or acute stage of illness. The person may reach this extreme in a quick and linear pathway straight from being well or via a drawn-out and circular downward spiral that has moved between this end of the continuum and other stages for a long time. At this stage, a person is likely to experience a small degree of distance from symptoms/issues/circumstances, which may engender feelings of helplessness and is likely to see the person searching for an external source that will reduce or alleviate the symptoms/issues/circumstances (Table 6). It may actually be disempowering for a person at this stage of the health process to undergo therapy from a practitioner whose main concern is empowering the person’s self-healing and personal responsibility. This is because people are less able to be active in achieving health for themselves at this stage.

Music-work in the acute illness/crisis stage

When a person is in a stage of acute illness/crisis and involved in music therapy, he or she is most likely there because of circumstance rather than an interest in music, even though the latter may still influence participation. Reasons for involvement at this stage are most likely so that the music or the music-worker can reduce/alleviate the symptoms/issues/circumstances. In this context, a more conventional approach to music-work is warranted where the music-worker makes use of formal procedures, such as assessments and goal planning and diagnosis. For instance, knowledge of the person’s diagnosis may help the music therapist to identify likely symptoms and potential needs more quickly. In this stage, the person may initially project issues onto the music-worker. If so, transference and countertransference issues become important agents of the therapeutic process, thus implicating the appropriateness of psychotherapeutic music therapy at this stage of the health-care continuum.

Because the participant’s location on the health-care continuum, at this stage, is farthest from the music-worker’s own location (which is presumably within the well-being stage), the size of the power differential within the worker/participant relationship is large and weighted towards the music-worker. This is further compounded by the worker’s therapeutic intent and the participant’s reduced ability to learn or access music skills. In this stage,
Figure 1. The resulting theory's major categories and their dimensions. Note that there are no dimensions listed for the first four categories under the major category "Degree of Health Focus". This is because these categories also function as dimensions of the major category.
strict boundaries may be implemented for three reasons: (a) to protect the worker from the participant’s symptoms/issues/circumstances, (b) to protect the participant from further symptoms/issues/circumstances, and (c) to protect the relationship between the worker and the participant. The music-worker may also make use of assessments and goal planning procedures that ensure the patient’s health is not put in any further danger.

In this stage, the participant’s ability to learn or access music skills is not fully realised because his or her focus or energy is taken up by the illness or crisis. Music-work in this context may therefore take the form of more receptive methods, such as music and relaxation, song listening, or psychodynamic methods, such as GIM, where the person can transfer his or her need for help from external sources onto the music-worker or the music. If the music-worker uses active methods during this stage, such as improvisation or songwriting, it is likely that the focus will be more on the process contained within these methods rather than the creation of artistic output, such as CDs or performances. This is primarily because the person does not yet have a sufficient degree of distance from the symptoms/issues/circumstances to be able to share them with others, and because the music skills required in the creation of any artistic output may not be easily accessed by the person in this stage. When using active methods in this stage of the health-care continuum, the music-worker will need to be directive. He or she is likely to have to work hard to empower the participant’s sense of ownership, offering as many choices as the participant is able to make. One-to-one sessions are highly indicated in this stage of the health-care continuum, especially if the participant can not be contained in a group, or if the participant wants to work through issues more deeply and easily.

The well-being stage – The other extreme of the health-care continuum

Wellbeing is at the opposing end of the health-care continuum. Like the acute illness/crisis stage, it is an impermanent stage and requires regular effort and positive circumstances (some of which are out of a person’s control) if it is to be maintained for long periods of time. A person may have reached this stage in a quick and linear progression from acute illness/crisis or he or she may have been moving between this stage and other stages for a long time. If it is the former, the person is likely to experience well-being because symptoms or circumstances have improved to the point where that person is able to function as normally as he or she used to before the crisis or illness. The person will not only have achieved a large degree of distance
from symptoms/issues/circumstances, but will also have integrated these elements into his or her whole being so that they are no longer taking more energy than other dimensions of life. If it is the latter, the person is most probably reaping the benefits of his or her efforts to enhance personal health.

Music-work in the well-being stage

If a person is involved in community music or music therapy in this stage, they are most likely there because of an interest in music rather than circumstance, even though both may still be factors in participation. Because of this, it is appropriate that music steals a little more of the limelight; that is, that there is more of a balance between focusing on the music and on the participant.

With the increase in focus on music, artistic output will often be an explicit aim that may then lead to aesthetic concerns, for instance, trying to create good music or trying to connect with an audience. These concerns may sometimes conflict with the participant’s experience or participant’s sense of ownership. Whether good music or the participant is given more priority may depend upon, amongst other things, whether the music-worker is a music therapist or a community musician. The interviews in this study suggest that community musicians prioritise good music over the participant more frequently than music therapists. This may often be because they are trying to connect with an audience or effect social change. In this way, the work is focused on something bigger than the participant. Although the participant may not feel that his or her sense of ownership or self-expression is of the utmost importance, that participant may still gain much benefit from learning to be part of something bigger. Regardless of the music-worker’s priority, in this stage of health the participant is likely to be far more directive and able to be active in the creative output and therefore the music-worker can afford to be less directive and may find himself or herself in the role of collaborator or even labourer for the participant’s musical vision.

A participant in this stage of health is not focused on reducing, alleviating or exploring their symptoms/issues/circumstances and neither is the music-worker. There may be no health focus at all; those involved may simply be focused on music-making. In this context, the music-worker may describe any health benefits as off-shoots from the participant’s involvement in music-making. If this is the case, an experiential label rather than therapy label is most likely used to communicate the work to prospective participants. However, if there is a focus on music-making to enhance health, the therapy
label is often used, especially if the music-worker views therapy and therapeutic as the same thing.

Therapeutic intent does not feature as strongly in this stage, which enables the size of the power differential within the worker/participant relationship to be much smaller. More equal relationships are created mainly through non-stringent boundaries and an informal approach where diagnosis is not important (if there ever was a diagnosis in the first place). The music-worker may also prefer to let the process evolve rather than planning goals and objectives from the beginning. A relatively equal worker/participant relationship is also more appropriate in this stage because the participant’s location on the health-care continuum is most probably at a similar location to that of the music-worker. This may lead the music-worker to feel less inclined to self-protect and therefore employ a little more worker-disclosure, especially if it is of relevance to the participant’s experience and if the participant’s maturity is well-developed. The music-worker may work towards more equal relationships if the age difference between participant and music-worker is small, and if the participant’s level of musical skill is on a par with the music-worker’s own skill level. The development of the participant’s music skills in this stage is warranted if the participant asks for it and if there is sufficient time.

Rehabilitation and community – The in-between stages of the health-care continuum

Acute illness/crisis and well-being are impermanent stages. The journey to and from health is constantly fluctuating, and therefore so are a person’s health needs. In between the stages of acute illness/crisis and well-being lies a breadth of varying health experiences. If a person is moving out of an acute illness/crisis, he or she may begin to feel less helpless and more able to be active in the progression towards health. That person may move through a rehabilitation stage, where he or she begins to focus on exploring symptoms/issues/circumstances rather than reducing or alleviating them. The person may begin to be dissatisfied with more receptive methods of music-work as he or she gains ability to access or learn music skills.

If a person is moving from a state of well-being downwards along the health-care continuum he or she may be experiencing symptoms/issues/circumstances that are beginning to inhibit optional functioning. This may be described as an imbalance between the physical, emotional, social, cultural, and spiritual dimensions of the person’s life, where one dimension is
requiring more energy. At this stage a person may be involved in music-work
to enhance health through pursuing his or her interest in music.

**Music-work in the rehabilitation and community stages**

Music-work in these stages can employ techniques for empowering the
participant to take more control over his or her health. Many ways of using
music, both in the context of music therapy and community music, are
appropriate here. Initially, the work may follow where the participant leads,
yet as the participant moves closer towards well-being, the work may begin to
follow where the music leads. Music will become increasingly participatory
as the person gains ability to be active and to access or learn music skills.
The participant’s increasing degree of distance from symptoms/
issues/circumstances enables him or her to explore these symptoms/issues/
circumstances and share them with others via some form of artistic output.

As the participant gains more distance from symptoms/issues/
circumstances, he or she will be able to shift focus from the self and onto
others. Therefore, music-work in a group context becomes more appropriate
and effective in enabling the participant to find common ground with others
in the group. The worker/participant relationship can be more equal than in
the acute illness/crisis stage for two reasons: 1) the participant needs less help
from external sources; he or she is gaining ability to be active in helping
himself or herself, and 2) the participant’s location on the health-care
continuum is closer to the music-worker’s location; therefore, the use of
boundaries to protect the worker, the participant and the relationship are less
necessary.

Although stringent boundaries are less necessary in these stages of
health-care, the music-worker may make more use of structured musical
activities or boundaries in the beginning of the program, especially if it is
important to provide safety and familiarity for the participant. The move to a
more equal relationship in these in-between stages may see the music-worker
sharing meals with the participant, chatting with the participant outside the
program, and dressing more casually.

**Summary of the Theory**

The most important context that influences the ways in which music
therapists and musicians describe and attribute meaning to their work is their
music-participants’ location along the health-care continuum. This context
influences the nature of the worker/participant relationship, the degree to
which the work is focused on health as well as the practical applications of the music-work. This context also explains why the work of music therapists and musicians may often be very similar, as they often work with music-participants who are in the same general location along the health-care continuum.

The music-participant’s location along the health-care continuum, however, is not the only context that explains the relationship between music therapists and community musicians. In particular, there are differences that are less influenced by the health-care continuum and more influenced by the distinction between the two occupations. For example, music therapists are less likely to prioritise good music over the participant’s experience of ownership even though the music-participant’s location along the health-care continuum may support it (Table 5, “Priorities of the music-worker”). Furthermore, music therapists generally adhere to the ethical boundaries externally stipulated by their profession while community musicians work from their own internal sense of ethics, sometimes even advocating the need to bend externally-set boundaries if they conflict with their own self-reflexive reasoning (Table 4). For a full discussion of these differences, please refer to please refer to a paper by the present authors (O’Grady & McFerran-Skewes, 2007).

How is this theory grounded in the data?

The reader is directed to the five tables in the appendix for information on how this theory is grounded in the data. Each table represents the raw data, codes, sub-categories and categories that are relevant to a single major category (see Figure 1 for these major categories). Each excerpt of raw data has been assigned the abbreviation CM or MT in order to denote whether it was a quote made by a community musician or a music therapist. Table 2 displays some excerpts from the interviews that led to the construction of the central category health-care as a continuum. It also shows how the four stages of health-care emerged directly from the data. The remaining tables show how the major categories were constructed. Table 3 grounds the theory’s assertions about the music-participant’s experience along the health-care continuum in raw data while Table 4 relates this experience along the health-care continuum to the nature of the worker/participant relationship. It also supports the roles the music-worker may play within this relationship with excerpts from the data. Table 5 demonstrates examples of raw data that led to the development of categories and codes relating to practical
applications of music-work. Lastly, Table 6 shows some of the data that implied various types of health foci.

Discussion

The major aspects of the resulting theory resonate with recent music therapy literature. The construct of health-care as a continuum reflects Bruscia’s evolution from defining health as an either-or state to a process (Bruscia, 1998). Furthermore, this construct explains Ansell and Pavlicevic’s statement that "there is often a time to be private, and a time to be public in music therapy; a time for the nurturing of intimate communication; and a time for the performance of the fruits of achieved communication, skill and confidence” (2004, p. 23). This study asserts that those times are mostly related to where the music participant is located along the health-care continuum.

The implications of the health continuum for music therapy practice are numerous. It is important that the music therapist considers where the participant is located on the health continuum in order to determine appropriate goals and methods for interventions as well as the boundaries that will define the therapist/client relationship. The needs of clients at the acute illness/crisis end of the continuum suggest that an over-emphasis on empowerment and personal choice may actually be contraindicated in this phase. Instead, it may often be more suitable to provide containing frameworks that emphasise more receptive methods and are carefully bounded by a clear therapeutic relationship. In contrast, the use of this approach in the community or well-being stages of the continuum may be experienced as disempowering. In this case, the therapist may need to rely more on active methods and self-reflexively defined boundaries rather than those that have been carefully developed within the field of psychotherapy. Individual situations will need to be examined based on their own merits and the participant should be encouraged to determine the nature of the musical relationship and outcomes. Public performances may fulfill a long-held desire of the participant, and may also work towards community change and greater understanding of the nature of health itself. Here the overlap between community musicians and music therapists is pronounced and perhaps even recommended. It seems, therefore, that viewing health as a process rather than an either-or state not only encourages flexible and varied practice, but also serves to unite the work of community musicians and music therapists.
Methodological Limitations

The design of this study is perhaps most restricted by its reliance on the self-report of musicians and music therapists rather than any direct observation of their practices or interviews with music participants. The research may not really explain the relationship between what music therapists and musicians actually do in their work; it may only explain the relationship between what music therapists and musicians say they do. This is not intended to imply that the interviews were unreliable or dishonest; merely that the interviews may not be actual representations of music-work in community contexts.

Future Research

Many future directions for research are implied by the present study. Most immediately, the theory resulting from this research needs further scrutiny and cross-validation to help discover the limits of its generalisability. Sampling in other contexts where community music exists, such as Britain or the United States, or other states of Australia, will further enhance the theory’s explanatory power. Its main features need to be tested, especially the theory’s suggestion that community musicians do not work in the acute illness/crisis or rehabilitation stages of health-care, since this suggestion may have been a direct result of the sampling procedure.

More generally, CoMT theory needs to be developed through further research in order to fit current practices and to inspire potential new directions for music therapy. This may involve the development of aesthetic theory that is relevant to CoMT. It would also be invaluable to conduct research that results in more detailed theories of health as a continuum, perhaps involving more specific stages than the ones already outlined by this study. In particular, research in this area could help music-workers to consider how their work can best support each of these stages.

Regardless of the specific topic, and similar to the sentiments of Stige (2003), future research should perhaps focus less on what CoMT is and more on what it could be. Its potential to draw from disciplines such as cultural studies, anthropology and musicology suggest that any future CoMT research can be a multidisciplinary approach that informs music therapy as well as the disciplines it draws from. An important role of future CoMT research, therefore, may be in reducing the cultural isolationism of the music therapy profession (Stige, 2002, p. 320) and connecting it to the wider world of scholarly thought.
References


Table 2

Categories and Data Relating to Central Category

<table>
<thead>
<tr>
<th>Health-care as a continuum</th>
<th>Sub-Categories/ Codes</th>
<th>Examples from Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>The health-care continuum involves four major stages</td>
<td>Acute illness/crisis</td>
<td>In the work in the community, they’ve sort of done any acute stages or rehabilitation. I guess, in a way, it’s still rehab but it’s the next level up (MT).</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation Community</td>
<td>Mostly it is well families, not exclusively but more often than not, families that don’t have a diagnosis (MT).</td>
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<tr>
<td></td>
<td>Well-being</td>
<td></td>
</tr>
<tr>
<td>Temporal nature of the health-care continuum</td>
<td>People move through the stages over time</td>
<td>We had to be careful to engage them at the right time, when they were ready to pursue something else (CM).</td>
</tr>
</tbody>
</table>

Key: Formatting style for categories and codes: Major Categories; Categories; Sub-Categories; Codes
### Table 3
**Categories and Data Relating to Major Category**

**Music-participant’s experience along the health-care continuum**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-Categories/ Codes</th>
<th>Examples from Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Degree of distance from symptoms/ issues/ circumstance</strong></td>
<td>Projection of issues onto worker</td>
<td><em>In the session we go from “Oh, (musician’s name), we’re so glad to see you” to around about 20 minutes before I leave he (music participant) starts putting shit on me: “I hate you. Why do you come here all the time?” It’s like a switch and I know that that’s what he gets from his dad (CM).</em></td>
</tr>
</tbody>
</table>
| **Ability to be active**                | Receptive techniques are more effective than active techniques when person is in crisis | *Interviewer: What do you think would have worked with them at the time when they weren’t ready to concentrate on music?*
*Participant: It might have been good if they had just been invited to listen or observe. Or, we didn’t do this but in hindsight I think that there are particular artists and CDs that you can give a person to go and listen to at that time (CM).* |
| **Ability to learn/access music skills** | Difficult for participants in crisis to learn/access music skills | *The only people I ever get to work with are people who may have some skill but if they have some skill it’s a minor miracle because they’re just about to be dumped on the scrap-heap (CM).* |
| **Reasons for music participation**    | • Circumstance         | *Not that these kids (in hospital) didn’t choose to come to therapy but they certainly didn’t refer themselves … So then, the community, it’s smaller, the people have chosen or said themselves that they want to come (MT).*
*Somebody wanted to play the piano, somebody wanted to sing a capella, you know, somebody wanted to sing songs (MT).* |

• Interest in music

Key: Formatting style for categories and codes: **Major Categories**: Categories; **Sub-Categories**: Codes
### Table 4
Categories and Data Relating to Major Category

<table>
<thead>
<tr>
<th>Nature of Worker/Participant Relationship</th>
<th>Categories</th>
<th>Sub-Categories/Codes</th>
<th>Examples from Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size of power differential</td>
<td>Age difference</td>
<td>Interviewer: How would you describe the nature of the relationships that you had with the young people? Participant: Motherly (laughs), and that was probably just due to the age difference (CM).</td>
<td></td>
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<tr>
<td></td>
<td>Participant’s level of music skill</td>
<td>These people aren’t my friends ... I think there might be a point where I could blur that boundary ... If they’d never used in 5 years and they were fully rehabilitated and they had changed their life and they were an excellent musician then maybe that could happen, I guess (MT).</td>
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<td></td>
<td>Participant’s location on health continuum</td>
<td>An obstacle to effective music therapy is sometimes the intention to help people. You know, the fact that you’re called a therapist and that your mindset is “Oh yes, I’m helping this person” (CM)</td>
<td></td>
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<tr>
<td></td>
<td>Therapeutic intent</td>
<td></td>
<td></td>
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<tr>
<td>Use of boundaries</td>
<td>Protect worker</td>
<td>One is safeguarding me as a therapist. I found the environment at the hospital quite clinical and intense, so once I wasn’t there or once a session was over, that was it. And I wouldn’t cross that line. If I was to see them outside or at lunch or something, it’s like, “No, no. This is my space. Don’t come into it” (MT)</td>
<td></td>
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<tr>
<td></td>
<td>Protect participant</td>
<td>When you’re engaged in a therapeutic process with people the boundaries need to be clear, otherwise people don’t feel safe (MT).</td>
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<tr>
<td></td>
<td>Protect relationship</td>
<td>If I ... disclosed a lot about myself, I believe that that would contaminate the transference relationship (MT).</td>
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<tr>
<td></td>
<td>Adherence to boundaries</td>
<td>We probably bend rules a lot more than music therapists (CM).</td>
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<tr>
<td></td>
<td>Bending boundaries</td>
<td>I think there needs to be an allowance for an individual crossing the line when they feel they need to (CM).</td>
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<tr>
<td></td>
<td>Internal sense of ethics</td>
<td>The boundaries that we’d professionally drawn were if a kid confided to us something really serious, potentially criminal, we referred it to our social worker and it left our hands ... but if they were confiding drugs I never took that to anyone because when I was a teenager I tried a lot of things that were illegal as well (CM).</td>
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<tr>
<td></td>
<td>Strict Adherence</td>
<td></td>
<td></td>
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<tr>
<td>Externally-stipulated boundaries</td>
<td>I mean I do see some people but I would never have a personal relationship with someone I’d worked with. You know, if I bumped into someone and they said, “Oh, give me your phone number and let’s jam” I’d say no. I’d say, “You and I did therapeutic work together and the boundary is still there” (MT).</td>
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<tr>
<td>Stringency of boundaries</td>
<td>It’s just a standard thing with professional boundaries. Friendship isn’t really kosher or it’s not ethical, it’s not appropriate to have friendships (MT). It’s not an area where I’ve set myself really strict boundaries. I haven’t felt the need to do that (MT).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degree of worker disclosure</td>
<td>Participant’s maturity</td>
<td>The whole ambiguity was what’s appropriate and what’s not, and that relies entirely on the intelligence and maturity of the kid you’re working with (CM). Within the context of the session itself I don’t usually do a lot of self-disclosure. If I do, it’s within the context of the process itself... I will do that within the group, and sometimes I’m asked directly, so as I’m part of the group (MT). I try and work as honestly and openly with people as possible. But people don’t ask me about my life. That’s not what happens. They don’t say, “Oh, what about you? Tell me about yourself.” That doesn’t happen (MT).</td>
<td></td>
</tr>
<tr>
<td>Relevance to participant</td>
<td>Work concerns participant, not worker</td>
<td></td>
<td></td>
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<tr>
<td>Music-worker’s role towards participant</td>
<td>Director</td>
<td>They were quite disabled and lacking in motivation and quite difficult verbal communication. So it was really hard to get them to take initiative. So, it was always me deciding which way the session was going to go and deciding what we were doing (MT).</td>
<td></td>
</tr>
<tr>
<td>Collaborator</td>
<td>I think that’s what they need more, is to give the people with mental illness that I worked with, the confidence and I guess to empower them to feel able to do that. So, it’s good to come in at a collaborative level (MT).</td>
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<tr>
<td>Labourer</td>
<td>That third group’s got a young man who is ... basically high-functioning... He can make up songs faster than I can, so I’m basically there as his labourer to play the chords and get the beat going (CM).</td>
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<td></td>
</tr>
</tbody>
</table>

Key: Formatting style for categories and codes: Major Categories; Categories; Sub-Categories; Codes
<table>
<thead>
<tr>
<th>Categories of method used</th>
<th>Sub-Categories/ Codes</th>
<th>Examples from Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Types of method used</td>
<td>• Receptive</td>
<td>Some women have come to me soon after arriving and have said, “I’d really like to do a relaxation” (MT).</td>
</tr>
<tr>
<td></td>
<td>• Active</td>
<td>I wanted the kids to see adults making music too, and that was what I always said, “Unless you are part of this and make music then you may as well not be here” (MT).</td>
</tr>
<tr>
<td></td>
<td>• Developing participant’s music skill</td>
<td>There ended up being a bit of (skill development) towards the end, because that’s what they kept asking for. Two women in particular wanted to sing better. So I would sort of incorporate that in (MT).</td>
</tr>
<tr>
<td></td>
<td>• Techniques for empowerment/ ownership</td>
<td>We were rehearsing with the choir and I was at the piano playing this woman’s song and trying to get people singing parts and ... trying to give her different ideas but still trying to let her feel that I wasn’t steamrolling it (MT).</td>
</tr>
</tbody>
</table>

| Constituents             | • Group Finding common ground | It’s in the sharing with others that things come alive and are integrated and they often find someone else who is similar and get blown away by that (MT). |
|                         | Safe to try new things       | Because the groups are big enough people are safe and can try things out (CM). |
|                         | • One-to-one One-to-one to work through issues | To a certain level they can discover things and things can be life-changing within that group environment, but if they really wanted to deal with the grief itself as an issue then it would be needing to go into one-to-one to work with those blocks (MT). |
|                         | When participant can’t be contained in group | Sometimes ... a particular dynamic level might be too much to be able to be contained in a group and so in that situation generally ... we might say, “Let’s do a group without such-and-such and then we’ll spend some time with him or her on their own” (MT). |

| Use of formal procedures | • Use of assessments and goal planning | In one-to-one ... you have the time to screen and to take history and to then plan (MT). |
|                         | Preferences to let process evolve | I really think that the work that you do ... in the community, you can only devise what you’re doing as you go along anyway because you can’t decide what your aims and goals and outcomes are; you can’t decide that beforehand. You can only decide that or be conscious of them as they evolve (MT) |
|                         | • Use of diagnosis Diagnosis not important | One of my choir members, she lives with bi-polar disorder ... it allows her an outlet of expression that is normalized. It’s in the normal community. It’s not a sort of stigmatized thing or a medical thing (CM). |
|                         | Diagnosis can be helpful | I haven’t felt that I needed to know their diagnosis or wanted to know their past history (MT). I can be halfway through the session or at the discussion after the music session and go “Whoa. I wish I knew a lot...” (MT). |
| Artistic output | • Use of structure | more now” (MT). Sometimes that music was structured and familiar, and other times it was being created together. I think the core, at the beginning of the group, the 10 weeks, the music was the structured element and providing familiarity and safety. And then as it went on, the music was able to be not so structured (MT). |
|                | Uses structured activities at the beginning of the program | That was a big part of my work, learning as I went along more about how to make a space where people with disabilities could make great art, not just be participants (MT). The melody can be quite static sometimes so I usually try and introduce some contour (MT). The goal is to involve everyone in the experience and get some music sounding good (MT). It’s my job to make the music have a little bit of class, and to give it a bit of complexity and a bit of detail, and refine it (CM). All I was trying to do was to use the subject matter um as an artist to create good art, and my medium is music, so to create good songs (CM). We never actually did a concert which didn’t have really high music standards (CM). People say, “You sound so good! How do you get this bunch to sound like that?” I keep all my arrangements really simple and strong. So, we might just do two-part songs but they sound good (CM). So, we were rehearsing with the choir and I was at the piano playing this woman’s song and trying to get people singing parts and ... trying to give her different ideas but still trying to let her feel that I wasn’t steamrolling it (MT). I teach them how to be genuinely authentically expressive and to find their true voice and how to have a direct line between their emotion and their sound. Whether that comes out rough or not, I don’t care. It’s about authenticity (CM). |
|                | • Aesthetic concerns | 'Good’ music |
|                | Participant’s sense of ownership | So for me, at the heart of it, I still wanted people to get up there and if that was the stuff they were sharing, that was the stuff they were sharing (MT). I can say to some people that I work with, “No, you’re not singing that song, so-and-so is singing that song because they sing it better than you, right?” Now, I’ll say that and the person might go off in a huff and they might even quit and I don’t really care, right? I’d be very careful about doing that because we’re not in the business of disturbing people but we are in the business of producing good music (CM). |
|                | Participant’s self expression | Effect social change |
|                | ‘Good’ music | Interviewer: So what would you do if a kid did regurgitate the lyrics of Eminem? Participant: Keep the ones I like, discard the ones I... |
|                | |

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Participant is part of something bigger

thought were really bad and we would start from there (CM).

I’m attempting to effect social change as strongly as I can, right, in anyway I can (CM).

I don’t know if you saw the question and answer at the end of this morning’s play where there was a question targeted at the kids by a senior nurse who is deeply involved in working with disturbed adolescents. She was using the language of therapy. She asked a very simple question which was “Do you kids feel that it is helping you in some way?” And there was stony silence. You’d think that’d be the easiest question for them to answer. “Oh yes, it’s wonderful, we get so much out of it, rah, rah, rah.” Now, maybe a few years ago some of those kids may have said that but they’ve matured so much that they realise that what we’re doing is beyond that (CM).

So, it was trying to get them talking to other parts of the community and feeling like they knew that they were part of something bigger (CM).

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**Table 6**

*Categories and Data Relating to Major Category*

<table>
<thead>
<tr>
<th>Type of Health Focus</th>
<th>Categories</th>
<th>Codes</th>
<th>Examples from Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce/alleviate symptoms/issues/ circumstances</td>
<td>Alleviate tension caused by circumstance</td>
<td>For them to be able to experience something that may help ease the tension of being in refuge (MT).</td>
<td></td>
</tr>
<tr>
<td>Explore symptoms/issues/ circumstances</td>
<td>Participant wants assistance with issues</td>
<td>Some come wanting to have a bit of assistance with a decision or a transition in life or are finding it difficult sorting out certain relationships, priorities, values, that sort of thing (MT).</td>
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<td></td>
<td>Distance from issues enables exploration</td>
<td>Issues could be brought out and enough of an emotional and personal distance for them to still be brought out and to be discussed and debated and understood (CM). Working with the anxiety but not necessarily trying to reduce it; trying to get the person to explore it at every level if they can trust enough to experience it (MT).</td>
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<tr>
<td></td>
<td>Exploring anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhance health</td>
<td>Singing is nourishing</td>
<td>Singing with people of like mind is really important. It’s nourishing. That’s why I called it ‘nosh’. It’s nourishing for the body and the spirit (CM).</td>
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<td></td>
<td>Wants to enhance well-being of families</td>
<td>I think there are already a lot of positive things happening in these families and I just want to enhance them and make them stronger (MT).</td>
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</tr>
<tr>
<td>No Health Focus</td>
<td>Participants not focused on health</td>
<td>They’re not there to be cured, to have therapy done to them (CM). I said, “We’re singing.” And they said, “But, what for?” And I said, “For fun and because we want to sing. It’s just singing.” “Oh, I thought it was a therapy.” And I said, “Well, it could be very therapeutic but it’s really just singing” (CM).</td>
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<tr>
<td>Health benefits are offshoots</td>
<td>I’m looking for beauty and a good time and human connection and healthy relationships. And if that makes for change, and it does, actually. I do notice it does, but it’s not what I’m aiming for. It’s an outcome that’s serendipitous (CM). It’s not to do with individual change. That may be a by-product, and if it is you go “Oops, oh look, that person’s improved, oh, they’re back to school, isn’t that interesting?” But that’s not the primary concern (CM).</td>
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<tr>
<td>Therapy Label</td>
<td>Therapy and therapeutic are the same thing</td>
<td>I think that therapy itself has become a far more widely-accepted term (MT). I think that participating in music or art is therapy, for anybody. Just like gardening is therapy, walking is therapy, art is therapy (CM).</td>
<td></td>
</tr>
<tr>
<td>Experiential Label</td>
<td>Uses experiential label</td>
<td>I didn’t call it a music therapy group when it was advertised. It was a “Music Expressions” group because they don’t particularly want them to be in ‘therapy’ because they’re not in acute psychosis or anything like that, and they think that by putting them in therapy will be just another label, which I kind of agree with in that instance (MT).</td>
<td></td>
</tr>
</tbody>
</table>

Associates ‘therapy’ with acute illness

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Key: Formatting style for categories and codes: **Major Categories; Categories; Sub-Categories; Codes**