ARTICLE

Reflections upon boundary complexities in the clinical practice of Croatian and Polish music therapists

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ABSTRACT

Boundaries separate and limit the territories of individuals' needs, feelings, behaviours and thoughts. In the context of therapy, boundaries might be considered a framework for the whole therapeutic process. The focus of this study was to determine how professional boundaries are understood by Polish and Croatian music therapists, and to identify whether there are any differences between these two groups. Twenty music therapists (ten Polish and ten Croatian) participated in the study. Data was gathered using a modified version of a questionnaire by Miller, Commons and Gutheil (2006), with open questions added. The results show differences between the two groups in the perception of behaviours that are regarded as both harmful and beneficial, such as using private spaces, sharing meals, offering gifts, using social media and specific language. Possible reasons regarding these results are discussed.

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INTRODUCTION

In general, boundaries separate and limit the territories of individuals' needs, feelings, behaviours and thoughts. Professional boundaries are defined as "a fluctuating, reasonably neutral, safe space that enables the dynamic, psychological interaction between therapist and patient to unfold" (Simon, 2001, p. 287). They are considered to be an important component of the therapeutic process. In the context of therapy, boundaries might be considered from two perspectives: (1) as a theme for therapy, an issue that is being worked on; and (2) as a framework for the whole therapeutic process. The latter understanding will be the focus of the subject study.

As Dileo (2000, p. 124) suggests, "the way boundaries are established can be the key factor in the development of trust and safety within the relationship and also in how the client responds to and progresses in treatment". The balance between keeping a distance and yet being close enough for the client plays a significant role in any therapeutic action. Boundaries are a difficult subject to reflect on from a universal perspective, because "there is no one boundary that fits all clients" (Dileo, 2000,
p. 124). They need to be adapted according to the clients' specific needs, as well as multiple intersectional aspects of their identities, including age, gender, ethnicity and culture. Therefore, the boundary-setting might differ from client to client and may change during the course of therapy.

The problems of ethical thinking in psychotherapeutic and psychiatric contexts have been explored in great depth. The literature has focused on ethical dilemmas specific to different factors regarding clinical practice, such as ages and problems of the clients (child and adolescent psychiatry – Belitz & Bailey, 2009; perinatal mental health – Miller, 2009; geriatric psychiatry – Walaszek, 2009; substance use – Geppert & Bogenschultz, 2009), different frameworks for providing the treatment (community psychiatry – Everett & Huffine, 2009; military psychiatry – Warner, Appenzeller, Grieger, Benedek & Roberts, 2009) boundaries and confidentiality issues in psychotherapy (Jain & Roberts, 2009), or conducting research (Barry, 2009; Jain, Kuppili, Pattanayak, & Sagar, 2017). Boundary crossing and boundary violations have also been scrutinised. The first term, boundary crossing, is considered neutral and it covers any deviation from typical, traditional practice. The second term, boundary violations, means crossing that is harmful and includes exploitation of the client (Gutheil & Gabbard, 1993).

Literature from the fields of psychotherapy and psychiatry bring rich material on boundary crossing and violation, with different perspectives and extensive arguments included (Blatt, 2001; Gabbard, 2001; Kroll, 2001; Simon, 2001). Gutheil and Gabbard (1993) identify critical areas regarding potentially harmful boundary issues. Role, time, place and space, money, gifts, clothing, language, self-disclosure and physical contact are listed there. These authors state that boundary crossing might sometimes be salutary, sometimes neutral, and sometimes harmful. Nonetheless, they suggest that any departure from usual practice should be carefully considered and documented with clear reasons presented, and that there is a risk of boundary crossing leading down the slippery slope to exploitive sexual relationships. Other authors claim that, in some situations, boundary crossings can enrich therapy, be a part of the treatment plan, and strengthen the therapist–client working relationship, increasing the effectiveness of therapeutic work (Pope & Keith-Spiegel, 2008; Zur, 2004). Zur (2004, p. 30) even states that "boundary crossing, like any other intervention, should be a part of a well-constructed and clearly articulated treatment plan which takes into consideration the client's problem, personality, situation, history, culture, etc. and the therapeutic setting and context".

In the music therapy world, the area of boundaries in general, including problems of crossing and violations, seems to be under-investigated. In *Ethical Thinking in Music Therapy* – a comprehensive source of material relating to ethics in the therapeutic process – Dileo (2000) reflects on boundaries, elaborating on problems similar to those mentioned before in psychotherapeutic sources: boundary crossing and violations, dual relationships, use of touch, accepting gifts, therapist's self-disclosure, the setting of the therapy, bartering and post-therapy dual relationships.

Her book is probably the only music therapy publication fully dedicated to ethics in music therapy practice. Medcalf (2016b) proposed in-depth considerations regarding transferring boundary-related issues (not only such as boundary crossing or violation but also self-awareness, culture, spirituality and music) to the musical arena, noticing the differences between perceiving these issues in psychotherapy versus music therapy. In her perspective, musical interactions allow for much safer exploring and crossing of boundaries within a musical context. Another book, *A Guide to Research Ethics for Arts Therapists and Arts and Health Practitioners,* by Farrant, Pavlicevic and Tsiris (2014) offers valuable information regarding the general realm of ethics, however it focuses on research, without addressing some issues pertaining to music therapy practice.

Some other books include chapters on similar topics (Bruscia & Grocke, 2002; Bunt & Hoskyns, 2002; Forinash, 2001; Hadley, 2007; Wheeler, 2015; Whitehead-Pleaux & Tan, 2016). In a relatively recent text, Bates (2015) identifies areas of potential boundary risks, such as confidentiality, multiple relationships, and gifts. She also points to the new subject of ethical issues, considering the use of technology, including social media.

The standards regarding boundary issues and other ethical problems are posed in guidelines formulated at national and international level by competent authorities. Sometimes the rules provided are only general; sometimes, they are more precise. The Ethical Code of the European Music Therapy Confederation (EMTC) claims that "the music therapist shall be aware of the degree of dependency inherent to a therapeutic relationship. (S)he shall in no circumstance act in order to satisfy her/his own personal interests (e.g., emotional, sexual, social, or economic interests)" (article 4, point 4.1). The *2010 Guidelines for Creating Music Therapy Codes of Ethics* by the World Federation of Music Therapy (WFMT), includes one point which reads: "The music therapist delivers services only in the context of a professional relationship and in settings which assure safety for the client" (part A, number 4). The strictest perspective is provided by the American Music Therapy Association (AMTA) Code of Ethics (2019), and it says that "the music therapist will […] avoid entering into dual relationships when doing so would violate professional boundaries or clinical objectivity" (Principles of Ethical Practice, Principle 1, point 1.9).

The significance and role of this kind of codes or guidelines form a controversial topic. Despite the noble values and ideas that probably inspired the authors of these documents, others claim that "principles and standards defined top-down by professional associations and regulatory bodies with the declared intention of protecting clients could be used to affirm asymmetries in the relationships between music therapists and participants" (Stige & Aarø, 2012, p. 283).

Similarly to the psychotherapeutic discourse, differences in opinion regarding boundary crossing and violations occur in music therapy practice. This is not surprising considering that setting boundaries in any therapy depends on many factors – from personal aspects, individual capabilities, values, morals and cultures, to the theoretical orientation and approach of the therapist. The therapist's theoretical background highly influences the ways in which boundary issues are seen (Kroll, 2001; Zur, 2004). Different approaches might form different opinions on where or how boundaries should or should not be situated, and what harms or benefits they might bring.

Singer (1992, as cited in Dileo, 2000) stresses the need for keeping to the designated time, space and intent of the sessions, and maintaining the exclusivity of the therapeutic relationship. Similarly, time, space and length of the session are listed by Bunt and Hoskyns (2002) as factors

ensuring safety and security of the client during the music therapy process. Considering this issue from a psychodynamic perspective, Stewart and Stewart (2002) mention almost the same elements as those that provide environmental and mental containment for the client. These elements are: consistency of time, consistency of setting, consistency of attitude. However, these conditions are not crucial in other perspectives; and, in some, they are actually quite rare. For example, in community music therapy, boundaries of time and space are usually flexible (Stige & Aarø, 2012), and roles, attitudes and relationships are frequently multiple and treated as a resource. The fact that the therapists might switch between being therapist, director, co-musician and so on, sharing authority and responsibility with all the participants allows for unique collaborative and democratic experience, offering inspiring perspectives (Stige, Ansdell, Elefant & Pavlicevic, 2010).

Cultural differences are another factor that needs to be considered carefully while reflecting on boundary issues. Not much research, however, is available on this subject. Miller, Commons and Gutheil (2006) analysed differences in evaluating boundary violations between American and Brazilian mental health professionals. The results showed mostly uniformity across the two cultures, with only small deviations regarding, for example, routine touching (handshake or kissing on the cheek). Interestingly, Brazilian professionals tended to rate items included in the study as more harmful. It was speculated that individuals with less experience treat rules as being less flexible. In music therapy literature, Papadopoulou (2012) interviewed three Greek music therapists regarding their perception of boundaries in clinical practice in light of their educational and cultural backgrounds. She concluded that they use boundaries in accordance with European music therapy professional standards and express the need for flexibility in adapting boundaries to individual needs.

In the picture provided by the literature, it seems that music therapy practitioners' perspectives on boundaries have not been explored enough. This is perhaps surprising given that "heightened awareness of the concepts of boundaries […] will improve patients' care and contribute to effective risk management" (Gutheil & Gabbard, 1993, p.195). Regarding the fact that clinicians are the ones who make everyday decisions on this matter, investigating their experiences is a good way to start analysing the uses of boundaries from an ethical as well as a practical point of view. The research question of the current study is boundary-related issues viewed by practitioners from Croatia and Poland; specifically, awareness of boundaries, potential risks and benefits, as well as ethical considerations. The research questions are:

- Are there any differences between Croatian and Polish music therapists regarding perspectives on professional boundaries?
- How do Croatian and Polish music therapists approach ethical dilemmas and resolve them in hypothetical situations and their own current practice?

METHOD

The research questions were explored through a survey based on a modified questionnaire by Miller, Commons and Gutheil (2006), with open questions added at the end. The survey was conducted between November 2015 and January 2016 and was distributed via email. All individuals were asked to fill out the questionnaire and return it via email within a period of six weeks. It was sent to 29

Polish music therapists and 15 Croatian music therapists. The response rate for Croatian music therapists was 66% (10 out of 15 music therapists returned the questionnaire), while, for Polish music therapists, it was 34% (10 out of 29).

Participants

Twenty participants took part in the survey: ten Polish (nine female; one male) and ten Croatian (all female). Most Croatian respondents had a master's degree (eight participants), two had doctoral degrees. The Polish group included four professionals with bachelor's degrees, five with master's degrees and one with a doctoral degree. All Croatian participants finished their training abroad (Table 1). The Polish group of participants consisted of certified professionals and graduates of the music therapy programme at The Karol Szymanowski Academy of Music in Katowice.

The average number of hours in clinical work per week was 12.9 in the Croatian group and 14.9 in the Polish group. These numbers of hours included work with children, adults and the elderly. The average number of hours per week with these populations was 7.3 (children), 4.3 (adults), 0.8 (the elderly) in Croatian music therapists, and 10 (children), 4.3 (adults), and 1.1 (the elderly) for Polish professionals.

	Polish music therapists	Croatian music therapists
	10	10
Gender		
Male	1	0
Female	9	10
Degree n		
Bachelor's	4	0
Master's	5	8
PhD	1	2
Years of practice (Median)	14.9	12.9
Hours of work per week with (Median)		
Children	10	7.3
Adults	4.3	4.3
Elderly	1.1	0.8
Challenges of clients		
Developmental disabilities	9	8
Neurological problems	7	2
Mental health	3	0
Correctional	0	0
Music therapy model applied in practice		
Nordoff-Robbins	1	0
Analytical	0	0
Improvisational	0	6
GIM	0	0
Neurologic music therapy	1	4
Community music therapy	0	0
Eclectic	8	0

Table 1: Socio-demographic characteristic of study participants

Measurement

In order to better assess certain professional experiences, after consultation with one of the authors of the original survey questionnaire (Miller), the Miller, Commons and Gutheil (2006) questionnaire was slightly amended: a few questions were rephrased, some were left out and two were added.

Participants were asked to evaluate (on a six-point Likert scale, 0 – never, 1 – very rarely, 2 – rarely, 3 – sometimes, 4 – often, 5 – always) hypothetical cases in which it would be *harmful* to the client if a colleague behaved in the manner described, and, concurrently, to rate hypothetical cases in which the same behaviour could have been *beneficial*.

The technique of asking about colleagues' behaviour rather than a clinician's own behaviour was used to minimise defensive reactions that might otherwise occur. Lastly, participants were asked to rate how often they perform the described behaviour in their own, current practice.

All the questions and instructions were in Polish for the Polish sample and in Croatian for the Croatian sample. Open questions were placed at the end of the survey and were as follows: (1) Do you consider keeping appropriate boundaries to be an important element of therapeutic practice? Why?; and (2) How do you deal with doubts regarding boundaries in your practice?

Data analysis

The non-parametric Mann-Whitney test was performed for quantitative data analysis, and the level $p < 0.05$ was considered as the cut-off value for significance.

Qualitative data gathered through open questions was analysed by repeated open reading, which revealed simple categories summarising respondents' perspectives. As the material emerging from the qualitative analysis was not very broad, it was considered complementary information.

RESULTS

The item-by-item analysis was conducted in order to see which items participants generally differed on. Only items with significant difference between groups are included below.

Harmful behaviour

When rating behaviour described as harmful, groups presented significant differences in six items (Table 2). The following items were rated as more harmful within the group of Croatian participants: item 37: "Allowing client, who has no other place to stay, to spend the night in your home" ($Z = - 2.680$, $p = 0.007$); item 42: "Giving client an inexpensive gift during treatment" ($Z = - 2.088$, $p = 0.037$); item 58: "Client passing through living area to music therapy room" ($Z = - 2.971$, $p = 0.003$); item 64: "Chatting with client on Facebook or other messengers on therapy-related subjects" ($Z = - 2.447$, $p = 0.014$), and item 67: " Seeking client data outside professional channels" ($Z = - 2.716$, $p = 0.007$).

Only item 23: "Making fun of client" ($Z = - 3.080$, $p = 0.002$) was rated by Polish professionals as more harmful (90% of cases) than Croatian colleagues (22% of cases).

Item	Mann-Whitney U	Wilcoxon W	Z	p
Making fun of client	11.500	56.500	-3.080	0.002
Allowing client, who has no other place to stay, to spend the night in your home	13.500	68.500	-2.680	0.007
Giving client an inexpensive gift	20.500	75.500	-2.088	0.037
Client passing through living area	11.000	56.000	-2.971	0.003
Chatting with client on Facebook or other messengers	17.500	72.500	-2.447	0.014
Seeking client data outside professional channels	14.000	69.000	-2.716	0.007

Table 2: Significant differences between Polish and Croatian professionals in terms of behaviours rated as harmful

Beneficial behaviour

When rating described behaviour as beneficial, groups presented significant differences in three items (Table 3). The following items were rated as more beneficial within the group of Polish participants: item 9: "Using words in diminutive form" (Z = - 2.797, p = 0.005), item 27: "Having lunch with client" (Z = - 3.488, p = 0.000), and item 65: "Adding client as a friend on Facebook" (Z = - 2.780, p = 0.005).

Item	Mann-Whitney U	Wilcoxon W	Z	p
Using words in diminutive form	13.000	58.000	-2.797	0.005
Having lunch with client	3.500	48.500	-3.488	0.000
Adding client as a friend on Facebook	13.000	58.000	-2.780	0.005

Table 3: Significant differences between Polish and Croatian professionals in terms of behaviours rated as beneficial

Performing behaviour in one's own practice

In comparing the behaviour of clinicians in their own practice, we found significant differences in three items (Table 4): item 23: "Making fun of client" (Z = - 3.317, p = 0.001), where 33% of the Croatian participants sometimes engage in this type of behaviour, while Polish participants do not use this behaviour in their practice at all; item 27: "Having lunch with client" (Z = - 2.681, p = 0.007), with 30% of Polish participants sometimes performing this behaviour and 90% of Croatian participants never behaving this way; and item 65: "Adding client as a friend on Facebook" (Z = - 2.675, p = 0.007) with 30% of Polish music therapists often performing this type of behaviour, while Croatian therapists do not use this behaviour in practice at all.

Item	Mann-Whitney U	Wilcoxon W	Z	p
Making fun of client	10.000	65.000	-3.317	0.001
Having lunch with client	18.000	63.000	-2.681	0.007
Adding client as a friend on Facebook	18.000	63.000	-2.675	0.007

Table 4: Significant differences between Polish and Croatian professionals in terms of behaviours performed in their own practice

Qualitative data

Responses to the open questions were usually short and not very in-depth. The reason for this could have been that the questionnaire was long, and open-ended questions were placed at the end. The fact that questions were leading and closed-ended in first part of the questionnaire could also have contributed to the limitation of the answers. Nevertheless, the data gathered suggest that boundaries are considered important and quite a difficult area for the respondents.

In terms of the first research question (Do you consider keeping appropriate boundaries an important element of therapeutic practice? Why?) all the participants stated "yes", giving reasons such as: the need for professionalism, comfort and safety of the client and therapist, the need for delineation between social and professional life. However, the answers of two participants from Poland could be categorised as "yes, but...". They claimed that there is no one-and-only set of appropriate boundaries, some boundaries can and should vary, and that they need to be analysed individually and consulted on with the client. In their responses, they pointed to the risks coming from keeping fixed codes of ethics and following rules without questioning their contents.

Regarding the second question (How do you deal with doubts regarding boundaries in your practice?), two Croatian music therapists said they never have any doubts, and one Polish respondent has doubts only rarely. The rest – both Polish and Croatian participants – voiced the importance of supervision and consulting with colleagues; mentioning also the need for reflection on their own past experiences as therapists. Interestingly, only one person mentioned a code of ethics as a useful tool here. It might be due to the fact that codes are usually very generalised and, therefore, not found to be helpful in specific, everyday situations. Maybe, also, in countries like Poland and Croatia, where the history of music therapy is not very long, the information about the existence of codes is not common and therapists have not yet developed the habit of consulting such documents.

DISCUSSION

The purpose of the subject study was to explore the commonalities and the differences between Polish and Croatian music therapists regarding professional boundaries. It also aimed at finding out which situations are considered harmful and which are beneficial for therapy from the clinicians' perspectives.

The analysis of differences in the mean ratings of individual items does suggest that there are commonalities across Polish and Croatian music therapists. For example, all respondents seem to agree that certain behaviours are seriously harmful, such as some that are sexual or physically abusive. Commonly highly unacceptable were the behaviours related to doing business with the client and disclosing financial or romantic information. In the case of certain other behaviours, involving the mixing of therapy with personal behaviour (e.g., having meal with a client or using social media in contact with them), Croatian practitioners seemed more often to rate these items as more harmful in comparison to practitioners from Poland. The possible reasons for these differences may have different sources. They may be linked to cultural differences, training that the music therapists received, their clinical experience, the populations they work with, the specific facility they

work at, and their personal ways of being. They may also be related to the dominating populations that are being served in both countries. Although basic boundaries are the same regardless of the age and ability of the client, there might be nuances that differ in certain aspects of the therapeutic relationship with an adult and with a child. The average number of hours that music therapists work with children was higher in the Polish group, while the number of hours being worked with adults was the same. Items like "Using words in diminutive form" can be rated differently when thinking of children than while reflecting on work with adults.

As stated by Medcalf (2016a), in music therapy practice we can experience profound moments of connection through musical interactions, which can impact on the concept of therapeutic boundaries. Moreover, the context of each area of music therapy practice can also influence therapeutic boundaries and unique elements of the context itself should be carefully considered (Medcalf, 2016b). In light of this, the facility within which music therapy services are being provided influences the boundaries in some situations. "Having lunch with client", when taking place in a big organisation that provides meals for all the residents and staff members is again completely different to making a purposeful appointment to eat together. Unfortunately, information regarding the facilities that participants were employed in was not gathered in this study – and this is one of its limitations.

Training might also be one of the factors that influences music therapists' perceptions of boundaries. Most Polish participants had training at bachelor's level, where most Croatian music therapists had training at master's level. Maybe education at a higher university level led to more careful perception of certain behaviours such as using Facebook or other methods of communication to contact their clients.

One of the limitations of the study was the small number of participants. To our knowledge, however, the survey included all professional music therapists practising in Croatia. In Poland, on the other hand, there are a higher number of people practising music therapy, but their training varies, ranging from a regular, standardised higher education qualification to one-day training workshops or even self-styled 'professionals'. Boundary issues, which may arise in music therapy practice, require regular training that should include supervision and culture-specific guidelines on boundaries (Ghuloum et al., 2013).

Music therapy both in Poland (Stachyra, 2015) and in Croatia is at quite an early developmental stage. In both countries, the profession is undergoing important changes: there are more and more educational options available (academic programmes, workshops and seminars), the awareness of the profession is growing in the communities, and the clients' interest in the services is increasing. Moreover, from a historic and cultural perspective, these countries can be considered somewhat similar having the shared history of communistic regime. In future, it would be interesting to investigate perspectives on boundaries between countries that are more diverse in their cultural heritage.

Nevertheless, it seems that exploring boundaries and ethical issues deserves close examination and research with regard to setting boundaries in music therapy; and the relationship between boundaries and treatment strategies and effectiveness is important. As these issues are highly context- and culture-sensitive, boundaries need to be set carefully and cautiously to best serve both clients and therapists. Although finding final, definite answers regarding setting the boundaries

and constructing relationships within therapy is not only impossible but also unnecessary. It is crucial to remain reflective and observe subtle nuances in these matters, which might be important influential factors in the therapeutic processes.

REFERENCES

Barry, L. (2009). Ethical issues in psychiatric research. *Psychiatric Clinics, 32*(2), 271-81.

Bates, D. (2015). Ethics in music therapy. In B. Wheeler (Ed.), *Music therapy handbook* (pp. 64-75). New York, NY: Guildford Press.

Belitz, J., & Bailey, R. (2009). Clinical ethics for the treatment of children and adolescents: A guide for general psychiatrists. *Psychiatric Clinics*, *32*(2), 243-257.

Blatt, S. (2001). Commentary: The therapeutic process and professional boundary guidelines. *The Journal of the American Academy of Psychiatry and the Law, 29*(3), 290-293.

Bruscia, K., & Grocke, D (2002). *Guided Imagery and Music: The Bonny Method and Beyond*. Gilsum, NH: Barcelona Publishers.

Bunt, L., & Hoskyns, S. (Eds.). (2002). *Handbook of music therapy*. New York, NY: Routledge.

Dileo, C. (2000). *Ethical thinking in music therapy*. Cherry Hill, NJ: Jeffrey Books.

Everett, A., & Huffine, C. (2009). Ethics in contemporary community psychiatry. *Psychiatric Clinics*, *32*(2), 329-341.

Farrant, E., Pavlicevic, M., & Tsiris, G. (2014). *A guide to research ethics for arts therapists and arts and health practitioners*. London: Jessica Kingsley Publishers.

Forinash, M. (Ed.). (2001). *Music therapy supervision*. Gilsum, NH: Barcelona Publishers.

Gabbard, G. (2001). Commentary: Boundaries, culture, and psychotherapy. *The Journal of the American Academy of Psychiatry and the Law*, *29*(3), 284-286.

Geppert, G., & Bogenschultz, M. (2009). Ethics in substance use disorder treatment. *Psychiatric Clinics, 32*(2), 283-297.

Ghuloum, S., Bener, A., Commons, M., Miller, P.M., Burgut, T., & Bhugra, D. (2013). Perception of boundaries and cultural influences in Qatar. *International Journal of Social Psychiatry*, *59*(3), 199-206.

Gutheil, T., & Gabbard, G. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *American Journal of Psychiatry*, *150*(2), 188.

Hadley, S. (Ed.). (2007). *Feminist perspectives in music therapy*. Gilsum, NH: Barcelona Publishers.

Jain, S., & Roberts, L. (2009). Ethics in psychotherapy: A focus on professional boundaries and confidentiality practices. *Psychiatric Clinics, 32*(2), 299−314.

Jain, S., Kuppili, P., Pattanayak, R., & Sagar, R. (2017). Ethics in psychiatric research: Issues and recommendations. *Indian Journal of Psychological Medicine, 39*(5), 558-565.

Kroll, J. (2001). Boundary violations: A culture-bound syndrome. *The Journal of the American Academy of Psychiatry and the Law, 29*(3), 274-83.

Medcalf, L. (2016a). Considerations for therapeutic boundaries when using the intimate medium of music. *Voices: A World Forum for Music Therapy*, *16*(2). Retrieved from: https://voices.no/index.php/voices/article/view/2313/2068

Medcalf, L. (2016b). *Musical intimacy and the negotiation of boundary challenges in contemporary music therapy practice.* Doctoral dissertation, The University of Melbourne, Australia. Retrieved from: http://hdl.handle.net/11343/115241

Miller, L. (2009). Ethical issues in perinatal mental health. *Psychiatric Clinics, 32*(2), 259-270.

Miller, P., Commons, M., & Gutheil, T. (2006). Clinicians' perceptions of boundaries in Brazil and the United States. *The Journal of the American Academy of Psychiatry and the Law, 34*(1), 33-42.

Papadopoulou, M. C. (2012). Boundaries and music therapy practices in Greece: A small qualitative study. *Approaches: Music Therapy & Special Music Education, 4*(1), 23-33. Retrieved from: http://approaches.gr/volume-4-1-2012

Pope, K., & Keith-Spiegel, P. (2008). A practical approach to boundaries in psychotherapy: Making decisions, bypassing blunders, and mending fences. *Journal of Clinical Psychology, 64*(5), 638-652.

Simon, R. (2001). Commentary: Treatment boundaries—flexible guidelines, not rigid standards. *The Journal of the American Academy of Psychiatry and the Law, 29*(3), 287-289.

Singer, J. (1992). Closeness and androgyny. In H.A. Wilmer (Ed.), *Closeness in personal and professional relationships* (pp. 11-33). Boston: Shambhala.

Stachyra, K. (2015). Towards professionalisation of music therapy: A model of training and certification in Poland. *Approaches: Music Therapy & Special Music Education, 7*(1), 110-117. Retrieved from http://approaches.gr/special-issue-7-1-2015

Stewart, R., & Stewart, D. (2002). See me, hear me, play with me. Working with the trauma of early abandonment and deprivation in psychodynamic music therapy. In J. Sutton (Ed.), *Music, music therapy and trauma: International perspectives* (pp. 133-152). London: Jessica Kingsley Publishers.

Stige, B., & Aarø, L. (2012). *Invitation to community music therapy*. New York, NY: Routledge.

Stige, B., Ansdell, G., Elefant, C. & Pavlicevic, M. (2010). *Where music helps: Community music therapy in action and reflection*. Farnham: Ashgate.

Walaszek, A. (2009). Clinical ethics issues in geriatric psychiatry. *Psychiatric Clinics, 32*(2), 343-59.

Warner, C., Appenzeller, G., Grieger, T., Benedek, D., & Roberts, L. (2009). Ethical considerations in military psychiatry. *Psychiatric Clinics, 32*(2), 271-281.

Wheeler, B. (Ed.). (2015). *Music therapy handbook*. New York, NY: Guilford Press.

Whitehead-Pleaux, A., & Tan, X. (Eds.). (2016). *Cultural intersections in music therapy: Music, health and the person.* Gilsum, NH: Barcelona Publishers.

Zur, O. (2004). To cross or not to cross. Do boundaries in therapy protect or harm? *Psychotherapy Bulletin, 39*(3), 27-32.

Σκέψεις για τις πολυπλοκότητες των ορίων στην κλινική πρακτική των Κροατών και των Πολωνών μουσικοθεραπευτών

Ana Katušić | Ludwika Konieczna-Nowak

ΠΕΡΙΛΗΨΗ

Τα όρια διαχωρίζουν και οριοθετούν τις περιοχές των ατομικών αναγκών, συναισθημάτων, συμπεριφορών και σκέψεων. Στο πλαίσιο της θεραπείας, τα όρια θα μπορούσαν να θεωρηθούν ως ένα πλαίσιο για το σύνολο της θεραπευτικής διαδικασίας. Το επίκεντρο αυτής της μελέτης ήταν να προσδιορίσει το πώς γίνονται κατανοητά τα επαγγελματικά όρια από τους Πολωνούς και τους Κροάτες μουσικοθεραπευτές, και να προσδιορίσει εάν υπάρχουν διαφορές μεταξύ αυτών των δύο ομάδων. Στη μελέτη συμμετείχαν 20 μουσικοθεραπευτές (δέκα Πολωνοί και δέκα Κροάτες). Τα δεδομένα συγκεντρώθηκαν χρησιμοποιώντας μια τροποποιημένη έκδοση ενός ερωτηματολογίου από τους Miller, Commons και Gutheil (2006) όπου προστέθηκαν ανοικτού τύπου ερωτήσεις. Τα αποτελέσματα δείχνουν διαφορές μεταξύ των δύο ομάδων στην αντίληψη συμπεριφορών που θεωρούνται τόσο επιβλαβείς όσο και ευεργετικές, όπως η χρήση ιδιωτικών χώρων, τα κοινά γεύματα, η προσφορά δώρων, η χρήση κοινωνικών μέσων δικτύωσης και συγκεκριμένης γλώσσας. Πιθανοί λόγοι σχετικά με τα αποτελέσματα συζητιούνται.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσικοθεραπεία, θεραπευτικά όρια, κλινική πρακτική, Κροατία, Πολωνία