Am I a founder or am I a fraud?

Music therapists’ experiences of developing services in healthcare organizations

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Abstract

Developing new services is a commonplace responsibility for music therapists worldwide. Starting a job often entails being the first music therapist in a facility, and even the first music therapist many staff and clients will ever have met. To date, little research and reflection is available about the challenges that arise when music therapy is introduced in an established healthcare team. This study was therefore founded with three main aims: 1) to learn more about music therapists’ experiences of developing new services in healthcare organizations, 2) to uncover some effective strategies for introducing and establishing new music therapy services, and 3) to further explore the contribution of qualitative research approaches to understand facets of music therapy service development. Narrative inquiry, arts-based research, and ethnographic fieldwork were employed to reflect on the experiences of twelve experienced music therapists from Australia, Canada, Ireland, the United Kingdom, and the United States. Findings from this novel combination of methods indicate that the processes of music therapy service development are complex. Music therapy respondents conveyed strong feelings of isolation, insecurity, and uncertainty in relation to their service development experiences, but also showed passion and commitment to their development work. Their experiences also indicated that service development may take time and can be influenced by a range of contextual factors. Additionally, music therapists enter a series of complicated interprofessional interactions and negotiations when they introduce music therapy to an established healthcare team. Respondents recounted challenges similar to those that others have documented in developing new healthcare professions, such as role ambiguity and resistance from other workers. The lens of management and organizational theory was found to be useful in reflecting on some facets of these experiences. The outcomes are applicable for music therapy students, clinicians, and university educators, in furthering our understanding of music therapy service development. Further interdisciplinary research and dialogue will lead to greater knowledge about relatively hidden issues in music therapy professional life.
Acknowledgements

At a recent seminar organized by the Careers Service and Graduate School, it was pointed out to me that signing up for a PhD is like signing up for a marathon. As a doctoral researcher and an endurance athlete, this comparison appealed to me. When I ran the Dublin marathon, I could not have made it without the support of family and friends. Similarly, I could not have made it through my PhD without the support of a number of people.

Completing a PhD, like running a marathon, requires time and commitment. I am therefore grateful to the Irish Health Research Board (HRB) for providing me with the funding to carry out this research full-time. Their financial support allowed me to devote my full energy to the PhD these past two years.

When training for a marathon, it helps to have a good coach. I could not have had a better coach in Professor Jane Edwards. Jane helped me enormously to develop my qualitative research skills and to find my own voice in my writing. Jane’s own reflections on service development added an extra flavour to the research, for which I am also thankful. Her enthusiasm for my project was unwavering and kept me motivated throughout. She was there when I experienced doubt and always showed belief in my abilities as a researcher. Jane is a fabulous mentor and I consider myself fortunate to have trained with her all these years. I also appreciate the encouragement and guidance I received from Professor Mike Morley.

When I ran my first marathon, I did all my training with a good friend. Dr Simon Gilbertson was that friend during my PhD studies. He listened, gave great advice, and looked out for me when I needed it. I already miss our coffee breaks and hope that we will have a chance to work together again some day.

On race day, the support and encouragement of fellow runners carries you through. Likewise, I could not have done this research without the contributions of my music therapy colleagues. I learned so much from them and was impressed by their achievements, their creativity, their insightfulness, and their honesty in sharing their service development stories. Special thanks are due to the music therapist who
allowed me to observe the early days of her post, along with other hospital staff who made the ethnographic fieldwork possible. I would also like to acknowledge Dr Joanne Loewy, who was particularly generous in sharing her service development expertise.

In the course of my PhD, there were a number of spectators on the sidelines cheering me on. I would like to thank my friends in the Limerick Triathlon Club for keeping me in good form, and Karen McCrasher and Margot Buchhorn for encouraging me to pick up the pace. Drew Moore came out of nowhere towards the end and gave me that final push across the finish line. Thanks lads.

If you are going to attempt a marathon, a natural ability helps. I would therefore like to dedicate this work to my Dad, who continues to encourage, impress, and inspire me. Dad, I have heard that you worry I have inherited all your least desirable traits. Hopefully this work shows I acquired some of your good features too.
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Chapter One

Introduction

Overview of the Research

Service development in music therapy is familiar to many of its practitioners. Starting a job often entails being the first music therapist in a facility, and even the first music therapist many staff and clients will ever meet. The pressure to be available, professional, competent, and at all times excellent can potentially be overwhelming. In spite of the commonality of start-up work there is an identifiable lack of literature, research and documented practice wisdom about music therapy service development. While the expectation to develop new services is part and parcel of music therapists’ professional experiences, it is a somewhat hidden phenomenon within existing narratives and practice accounts. The possibility that this aspect of music therapy work could be made more explicit and be further nuanced was an exciting starting point for my doctoral research.

Over the course of developing this research three core aims emerged: 1) to learn more about music therapists’ experiences of developing new services in healthcare organizations, 2) to uncover some effective strategies for introducing and establishing new music therapy services, and 3) to further explore the contribution of qualitative research approaches to understand facets of music therapy service development. These aims were explored through a range of methodological approaches including narrative inquiry, arts-based research, and ethnography. A number of data sources were used, including narratives obtained from expert music therapists working in healthcare, a period of ethnographic fieldwork in a hospital where a new music therapy was starting, music therapy training and seminars, and reflections on my own and my doctoral supervisor’s music therapy service development experiences in healthcare organizations. This research approach enabled exploration of music therapy service development from a rich variety of perspectives.
This research provides valuable information about the types of issues that music therapists encounter when they introduce music therapy to an established healthcare organization. Music therapists in this study recalled experiences similar to other professionals in new healthcare roles, such as role ambiguity and interprofessional tension. They conveyed strong emotional responses and showed passion and commitment to their development work. The outcomes also shed light on the inherent complexities of music therapy service development in healthcare organizations. The music therapists reflected that service development takes time and pointed to a number of contextual factors in their service development experiences. As the first large scale multi-method research project about music therapy service development, this study succeeds in elaborating on and extending our understanding of this topic.

Structure of the Thesis

Following on from this introductory chapter where the background to the research is elaborated and some overview materials are provided, a review of literature relevant to service development in healthcare is presented (Chapter 2), and then the research paradigm and methodological considerations for the research are outlined (Chapter 3). The method of the research is then described (Chapter 4) followed by the findings of the research (Chapter 5) and the discussion of these findings (Chapter 6). The final chapter outlines recommendations and conclusions following the experience of conducting the research.

Background to the Research

When it came to deciding on a topic for my doctoral studies, I wanted to choose something that would be of value to practicing music therapists. I had just returned to Ireland after six months in Australia and was struck by differences between the two countries in terms of music therapy service provision. In Australia, I had been working in a children’s hospital as part of a team of three music therapists and five music therapy students. Similar music therapy teams existed in several children’s hospitals throughout Australia. In the Republic of Ireland, only one children’s hospital provides regular music therapy services, and this provision was
limited to two days per week. I was curious to learn whether it would be possible to increase music therapy service provision for children in Ireland and whether there was something I could contribute as a researcher to help create further music therapy posts.

In developing the scope of the research I decided that I would focus on workplace settings where medical services were provided within a healthcare context. My professional work to date has mainly been conducted in the healthcare settings of nursing homes and hospitals, including work as a music therapist at a children’s hospital in Australia and in a health service for older people in Ireland. I experienced unique challenges in these settings and am less familiar with other work environments where music therapy has been established successfully, such as in Special Education or in long-term residential care facilities for people with disabilities.

I began my research by exploring differences between music therapy service provision in Ireland, Australia, the United Kingdom (UK), and the United States (US). The most obvious difference between the countries lay in the status of the music therapy profession. In Australia, the United Kingdom, and the United States, music therapy is a recognised health profession and qualified music therapists require professional registration to practice. In Australia, music therapists must have completed an accredited music therapy degree and be registered with the Australian Music Therapy Association (Australian Music Therapy Association, 2009). In the United Kingdom, music therapy is one of the arts therapies along with art therapy, art psychotherapy, and drama therapy, and is governed by the Health Professions Council (Health Professions Council, 2009). In the United States, a music therapist is a professional who has completed a degree in music therapy and meets the standards of the Certification Board for Music Therapists (American Music Therapy Association, 2002). Graduates of a Master of Arts in Expressive Therapies are also eligible for Board Certification as a music therapist in the US (Lesley University, 2010). Furthermore, in Australia, the UK and the US, award conditions and

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1 It should be noted that these countries differ widely in terms of population. In 2010, the estimated populations of these countries are as follows: Republic of Ireland, 4.5million; Australia, 22.4million; the UK, 62.2million, and the US, 309.6million people (Population Reference Bureau, 2010).
professional development opportunities are available to qualified music therapists (Abad & Williams, 2009; American Music Therapy Association, 1999; Association of Professional Music Therapists, 2008; O’Callaghan, 2002).

In Ireland, there is a Creative Arts Therapists association (IACAT) that lobbies for recognition of the creative arts therapies, including music therapy, art therapy, dance movement therapy, and drama therapy. However, these professions are yet to be defined and recognised within the Irish Health Service Executive (HSE) and there is currently no strategy to indicate how qualified music therapists could eventually be employed within health care settings. Subsequently, music therapists in Ireland are often employed under other occupational titles and music therapy positions tend to be sessional, part-time or temporary (Edwards, 2006b). Irish colleagues have reported that they feel frustrated, under-valued, and insecure in their employment working under such conditions (Browne, Lloyd, & Whyte, 2007; Cosgrove, 2005).

As I explored the potential of this topic, I questioned the place for the qualified music therapist in the Irish health system while music therapy remains unrecognised. I searched HSE policies and practices to identify places where music therapy could fit in. It was encouraging to see that the Vision for Change mental health policy report (Department of Health and Children, 2006) recommended the implementation of creative therapies several times. However, I wondered whether fundamental differences between music therapy practice and Irish healthcare approaches posed an obstacle to the development of further music therapy services. In my experience, teams within the HSE were consultant-led rather than truly multidisciplinary in their approach. The prevailing and dominant model of care appeared to be medical, an approach that focuses on the diagnosis and treatment of disease (Stickley & Timmons, 2007). I had frequently observed instances in healthcare settings where drug treatments were prescribed before psychosocial approaches were considered. In contrast to other healthcare approaches, music therapy does not typically deal with the treatment of primary pathology in medical settings (Edwards, 2005a), nor is it prescriptive. Music therapists working in hospitals use a range of information about patients to design individualised programmes. Outcomes of music therapy depend not only on the presence of music,
but also on the presence of a trained and qualified therapist. I wondered how these aspects might be problematic when a music therapist is attempting to introduce a new service within a medical framework of evidence and treatment. Additionally, I wondered whether efforts to establish music therapy in Ireland are hampered by long-established HSE policies and practices.

I assumed that limited funding was another barrier to the development of music therapy provision in Ireland. Insufficient funding has been cited as an obstacle to music therapy service provision in the United States (Hilliard, 2004) and several colleagues had indicated to me that this was also the case in Ireland. Based on findings from a survey of hospice administrators, Hilliard (2004) stated that music therapists should be equipped to educate administrators about potential funding sources, financial benefits to adding a music therapy programme, as well as professional roles of a music therapist. It struck me that these were areas that were only touched upon in the music therapy training courses with which I was familiar. Music therapy training tended to focus more on developing students’ proficiencies for music therapy work with clients, than on preparing students for work within broader organizational contexts. As service development forms a part of almost every music therapy practitioner’s responsibilities, I perceived an urgent need to learn more about healthcare organizations and the ways in which financial obstacles may be overcome.

As I was developing my early ideas, a nurse contacted my doctoral supervisor looking for advice on how to set-up a music therapy service at the hospital where she worked. My supervisor then arranged to meet with the nurse and two other staff from the hospital, to assist them in developing a music therapy post. I was invited to attend this meeting due to my growing interest in music therapy service development. This meeting was significant for a couple of reasons. Firstly, I was encouraged by the hospital team’s enthusiasm around creating a new music therapy service. The team knew little about how to instigate a new post, but they were convinced that their hospital programme needed music therapy. Secondly, I was impressed by my supervisor’s ability to guide the team in matters of service development. She listened to the needs of the hospital and suggested different models of funding for the new music therapy service. She shared her own music therapy service development experiences and provided the team with some research literature to support the
development of a post. The team left the meeting keen to progress their ideas for a
new music therapy service. I was left wondering what conditions would be necessary
for a new music therapy service to commence.

In reflecting on my own experiences and those of close colleagues, I
considered music therapy service development to provide a series of unique
challenges. Unlike in other allied health professions, a music therapist usually enters
a healthcare organization as the first person in that professional role. Most healthcare
organizations have no previous experience of employing music therapists. This
means that music therapists are often required to define their roles, to respond to
misconceptions about their work, to develop procedures and reporting mechanisms,
and to work hard to sustain their professional future. At conferences, professional
meetings, and social events, I had often heard music therapists referring to these
aspects as frustrating. Although music therapists regularly spoke of the rewards of
working with clients, they also recalled “struggles” and “disappointments” in their
day to day interactions with management and other healthcare staff.

On searching music therapy literature, I was surprised to find that few authors
had explained how their music therapy services had become established. One
exception was Edwards’ (2005a) reflection on the development of a music therapy
programme in a children’s hospital in Brisbane, Australia. Perceived challenges to
establishing a role for music therapy in this setting included fitting music therapy into
a medical context, distinguishing music therapy work from existing uses of music,
and the unpredictable nature of the work. Edwards explained how she developed
roles for music therapy in anxiety reduction and pain management, through drawing
on stress and coping and developmental theories, “observing and developing links
with existing [music therapy] practice” (p. 38), learning from patients, families, and
staff, and reflecting on and writing about the work. Edwards’ reflection suggested
that the role of a music therapist may need to be “emergent and responsive” (p. 43)
over time.

I then began to ponder what kind of specialist skills music therapists require
in order to successfully establish new music therapy services. I also contemplated
whether personal qualities such as confidence and persistence may be an advantage
when a music therapist is introducing music therapy to an established healthcare team. My thoughts progressed as I read Loewy’s (2001) paper about building a music therapy programme in a hospital setting. In this paper, Loewy reflected that a flair for instituting programmes is not something that comes naturally to all music therapists. I found this observation interesting and I began to wonder whether further research could help music therapists to develop their programme building skills. Now that there is a history of music therapy service development that can be captured, I wondered how I might be able to examine the experiences of music therapists in order to identify successful service development strategies that they have used. I anticipated that developing a set of service development strategies could offer useful information to students and new graduates, who are often required to develop new music therapy work. The idea of developing a set of strategies appealed to me as a way that I could help music therapists through my research.

At the same time that I was developing my research topic, I was also developing my methodological ideas. My previous two research projects were experimental studies, in which I employed validated assessment tools to investigate the effects of music therapy and to analyse the results statistically. When I began my doctoral research, I was keen to broaden my palate of research skills and to explore the multiple benefits of qualitative research approaches. I soon realised that adopting a qualitative research approach would require substantial shifts in the way I thought about the processes and functions of research and would challenge my view of the world. However, I remained keen to try new approaches and to further the development of qualitative research approaches in music therapy. This open attitude led me to explore the use of a novel combination of research methods, as will be explained in this thesis.

Summary

Around the world there are many music therapy services being developed in healthcare organizations. It is therefore an opportune time to reflect on the challenges and opportunities that have been experienced in implementing new services and to consider ways in which music therapy services have been established in healthcare. As stated in the opening of the introduction, I started this research with three main
aims: 1) to learn more about music therapists’ experiences of developing new services in healthcare organizations, 2) to uncover some effective strategies for introducing and establishing new music therapy services, and 3) to further explore the contribution of qualitative research approaches to understand facets of music therapy service development. Through sharing this work with music therapy students and practitioners, I hope to make substantial contributions to both practice and research in music therapy.
Chapter Two

Literature Review

This chapter contextualises the topic of this research and provides a surround for the ideas that are pursued in later chapters. As music therapists’ experiences of introducing music therapy to healthcare organizations increasingly became the focus of my research, I perceived the need to familiarize myself with literature from a broad range of disciplines. There is an established literature about healthcare cultures for example, and commentary and theory about organizational change. This material seemed highly relevant for gaining a greater understanding of the contexts in which music therapists develop new work. Engaging with this source material helped me to reflect on the experience of music therapists when they are entering an organization for the first time.

To source literature relevant to the topic of music therapy service development, I used several healthcare databases, including Cinahl, Medline, Nursing & Allied Health Collection, and PsycINFO. Search terms such as “service development”, “new service”, “new role”, “new profession”, “new identity”, and “fit” were used. These search terms gave rise to many useful articles from the field of music therapy, as well as other healthcare professions. A range of music therapy text books was also searched for information about music therapy service development. Professor Mike Morley, Chair of Management at the University of Limerick, further suggested a number of recent articles from the field of management studies (see p. 10). Additional articles were sourced using the reference lists of the articles that Professor Morley suggested. These search strategies yielded many relevant studies which contributed to the development of an understanding of phenomena that I would later encounter in my observation of music therapists’ service development experiences.

Three themes emerged from my close reading of literature in management, change and healthcare research: 1) organizational change, including change theory and possible factors in change acceptance; 2) new healthcare roles, including research and literature about new role bearers’ experiences and strategies for new role
implementation; and 3) interprofessional work, including music therapy literature that has explored ways in which therapists have worked together. Each of these themes are now outlined and elaborated with reference to the topic of music therapy service development in healthcare organizations.

**Theme 1. Organizational Change**

When a new music therapy service begins, a music therapist is usually required to introduce new occupational roles and practices to an established healthcare team. I therefore anticipated that a management lens would be highly useful for understanding important issues in music therapy service development. At the instigation of my supervisor, I met with Professor Mike Morley, Chair of Management at the University of Limerick. In meeting with Mike, I hoped to further explore the degree of fit between the profession and ethos of music therapy and the health service in Ireland. Mike was extremely encouraging of my developing research ideas and expressed a particular interest in the ways that music therapists might need to carve out professional identities alongside other, more established professionals. He subsequently agreed to become a theoretical advisor to my research and our discussions prompted me to read more about organizational change.

*Organizational change research – an overview.*

The fields of management and organizational studies provide a rich source of information about organizational change in the commercial sector. Common themes from this research literature include the roles of power and political behaviour in organizational change, change processes and models, the extent to which change can be planned and controlled, and whether change should be implemented top-down, bottom-up, or sideways (Buchanan et al., 2005; Shanley, 2007; Sturdy & Grey, 2003). Given the focus of this sector, economic forces, such as the need for commercial competitiveness, cost cutting and rationalization are usually presented as the primary reasons for organizational change (Shanley, 2007). Change has routinely been presented as necessary, “inevitable, desirable and/or manageable” (Sturdy & Grey, 2003, p. 659), although some challenge to this dominant view is evident. Recent critiques have questioned whether planned change models reinforce
managerial control and have called for greater attention to the personal and social consequences of organizational change (Shanley, 2007; Sturdy & Grey, 2003).

Reading a wide range of this literature made me start to wonder how the introduction of a music therapy service might impact on other workers aside from the music therapist. Up until this point, I had been focusing on the challenges experienced by music therapists in introducing new services. I now wondered whether the introduction of a new music therapy service could lead to changes and challenges for other workers too, and indeed for the organizations in which they work. Reflection on the research about organizations and their cultures, especially where change was concerned, gave me the chance to consider a wider range of themes relating to my emerging topic.

Organizational change and healthcare.

Major administrative changes occurring in healthcare organizations internationally have led researchers to take interest in the effects of organizational change on healthcare workers. While some healthcare writers have shared cases of successful change ventures, such as the introduction of a self-administration of medication programme (Deegan et al., 2004) or a shared governance management structure (Robertson-Malt & Chapman, 2008), negative outcomes of organizational change are also commonly reported. Doherty’s (2009) interviews with acute care hospital nurses in the United Kingdom indicated that National Health Service (NHS) reforms of nursing roles had met with mixed success. Although reforms were intended to provide workers with greater empowerment, nurses perceived that the changes had led to an intensification of their workloads and a lessening of their ability to care for patients. Nurses were concerned that their work had become geared toward meeting government targets rather than addressing patients’ needs. An Australian study by Wynne (2004) also indicated that organizational restructuring had been detrimental to patient care. Intensive care unit nurses in her study experienced constant pressure, worked within time and resource constraints, and perceived that they had little input into the changes that affected patients. Furthermore, nurses perceived that they had learned more about imminent changes from the media than from their own hospital management. This literature made me consider whether the
The introduction of a music therapy service would entail increased work for other professionals, including some disruption to routines and the need for adjustment to change. If the introduction of a new worker requires this adjustment, it leads to questions about how co-workers should be consulted about a new music therapy service, and the extent to which successful consultation could make a positive contribution to the experience of a new music therapist.

Halford (2003) explored a different organizational change phenomenon in her study of the impact of organizational restructuring on nurses’ individual identities. She interviewed five nurses working in the NHS and found that the nurses responded to changes in multiple and creative ways. Interviews revealed that the nurses worked hard to explain themselves and drew on a range of resources including profession, organization, family, gender, sexuality, and generation to reconstruct their identities. While they may have had little control over the organizational restructuring, they were able to endorse or resist changes through their presentations of self. This observation made me wonder how a music therapist’s identity may change on entering a new healthcare environment, and whether other healthcare workers’ identities could require adjustment with the appointment of a new music therapist.

It has been argued that healthcare practices are firmly entrenched and that healthcare organizations are hesitant to adopt change (Deegan et al., 2004; Dulaney & Stanley, 2005). This view is supported by research into the effects of introducing clinical directorates (CDs), new management structures intended to bring together clinical and organizational aspects of care (Braithwaite et al., 2005; Braithwaite, 2006a, 2006b). Braithwaite’s research raised questions as to whether the introduction of CDs had led to alterations in hospital social structures, including changes in the ways that people act and relate culturally. He observed that despite the introduction of CDs, old structuring behaviours continued – nurses talked to nurses, doctors talked to doctors, and positions were formed behind the scenes rather than through the formal hierarchy. Braithwaite concluded that the establishment of CDs had not markedly altered underlying profession-based values, beliefs, meanings, roles, practices, routines and relationships. Braithwaite’s research seemed highly relevant to the development of music therapy services in healthcare. I had already identified potential differences between music therapy and traditional healthcare approaches.
(see p. 4) and considered that music therapists may come up against long-held traditions when they introduce new music therapy services. It struck me that it may be difficult to understand the impact of these traditions on the introduction of music therapy services or to anticipate when or why tension points would arise. It could take years for a staff member in a new role to decipher how and where hospital decision-making processes occur.

Change theory.

Organizational change theories and models may be helpful if we are to further understand how music therapy can become successfully established. Lewin’s change theory (Cartwright, 1951) is widely cited in studies of organizational change in hospital settings (for examples see Deegan et al., 2004; Dulaney & Stanley, 2005; Shanley, 2007). Lewin portrayed change as a challenging process, which is largely dependent on driving and restraining forces. In his theory, people exist in a force field of social, historical, situational, and physical influences. Forces such as values, past experiences, money, and time can create or limit the possibility for change. In the case of a hospital setting, a driving force could be a past success in adopting change, while restraining forces could include limited funding, resources, staff time and energy (Dulaney & Stanley, 2005). The idea that an organizational change may be driven or constrained by external forces resonated with me as a music therapist. Opportunities for music therapists are often limited due to insufficient funding (see p. 5). I found myself interested to explore other factors which could have a bearing on the introduction of music therapy services in healthcare organizations.

Lewin presented change as a three step process. The first step involves “unfreezing”, which is the process of recognising the need for change. The second step is “moving”, in which the change is enacted. Finally, “refreezing” represents the incorporation of the change into the new system. In Lewin’s view, change requires the removal of deep restraining forces as well as cognitive redefinition. The process of change inevitably involves relinquishing something, and workers may experience fear and resistance to this loss in the event of change.
In hospital settings, it has been observed that the introduction of new practices can lead to workers perceiving that they have lost their former expert role (Dulaney & Stanley, 2005). Deegan et al. (2004) observed a situation in which nurses expressed anxiety about the introduction of a self-administration of medication programme, as it meant that they would lose control of the drug trolley. This observation suggests that an organizational change may require shifts in the balance of power, which may not be welcomed by all. The change to medication regimes, placing power at the disposal of patients, may shake the very foundations of a somewhat hidden aspect of the nursing role and symbolize a reduction in the nurses’ status.

Channels of change.

A further useful aspect of Lewin’s change theory is the concept of “channels”. That is, the routes through which new ideas or practices enter and travel through an organization. In introducing a change, it may be important to identify gatekeepers who have the power to admit or refuse entry to a channel. Dulaney and Stanley (2005) highlighted a need to recognise gatekeepers within both formal and informal power structures of a health care organization. They described how staff members may exert considerable influence despite little formal power, “by virtue of their longevity on a unit, or their clinical expertise, or their close relationship with those who have formal power” (p. 164). It occurs to me that there has been little reflection in music therapy about who holds the power in relation to the introduction of music therapy services. In my experience, music therapists face enough challenges in developing new work, before it is possible to identify locations of power within their organizations. I wonder whether the formation of strategic alliances in music therapy is down to such elements as luck, or connections that are not established by design.

Another change approach that has received recent attention in healthcare is Studer’s (2004) *Hardwiring excellence* approach (Spaulding, Gamm, & Griffith, 2010). Studer’s approach uses straightforward language rather than management terminology and the primary focus is on human resources and human capital. Studer represented the process of change as a dynamic interplay of 3 Ps: passion, principles, and pillar results. The 3 Ps are proposed to operate at the level of individual staff members, at the organizational level, and at any levels existing between them. To
Studer, the central elements of individual motivation for change include purpose, worthwhile work, and making a difference. He has presented several “must have” leadership actions that support and reward workers and add momentum to the adoption of change. These include engaging and seeking feedback from other workers, writing thank you notes, and offering encouraging or supportive words at crucial times. While the Studer approach has been criticized for a lack of clear theoretical basis (Spaulding et al., 2010), I am drawn to its emphasis on building human relationships. Studer’s consideration of the personal aspects of change is highly relevant to music therapists who are entering small interprofessional teams.

*The path of organizational change.*

Both Lewin’s change theory and Studer’s approach imply that organizational changes follow a relatively straightforward, linear progression. However, it can be argued that organizational change is more complex and less predictable than these models suggest. Styhre (2002) drew on what is termed “complexity theory” to explain developments at a Swedish telecommunications company. He tracked a change project at the company for eighteen months and noted that attempts to greater empower workers were affected by unanticipated external influences. Although managers initially invested heavily in the creation of a new workplace environment, changes were abandoned when financial problems arose unexpectedly. For example, the company ceased to employ a consultant to provide training on co-workership and leadership. Styhre observed that periods of rapid development were followed by periods of decline and that the plan for change needed to be much more fluid and evolutionary than originally intended. In Styhre’s view, organizational change is “never solely a one-dimensional series of succeeding activities, but is always taking place amidst the turmoil of transient states and interconnected flows of activities” (p. 349).

An “emergent approach” to change was further advocated by the nursing researcher Shanley (2007). He cited the work of Pettigrew (1990), who proposed that change is complex, occurs over time, and is influenced by multiple, unpredictable variables. Shanley emphasized that the change process can be uncertain, iterative and “messy” (p. 541) and called for greater attention to the role of power and politics in
organizational change. I began to wonder whether music therapy services develop in equally complex and unpredictable ways, and how this development might be captured. I started to realise that little has been written about the ways in which music therapy services unfold. This seemed an important gap or niche towards which I could direct my research endeavours.

Possible factors in change acceptance and sustainability.

The precise mechanisms through which an organizational change becomes accepted and maintained have eluded clear identification. Buchanan et al. (2005) conducted a review of literature on sustaining organizational change and found that few researchers have addressed this topic. Several explanations for a lack of literature about change sustainability were put forward, including the possibility that periods of change are more interesting to researchers than periods of stability, the need for longitudinal research to address the topic of sustainability adequately, and the prevailing view that the ideal organization is one that is continually undergoing adaptation. On reviewing the small amount of literature available, Buchanan et al. identified eleven types of factors which may affect sustainability of organizational change: substantial, individual, managerial, financial, leadership, organizational, cultural, political, processual, contextual, and temporal factors. Buchanan et al. were unable to determine the relative significance of any individual factor and suggested that the most important factors are likely to depend on the internal, external, and historical context of the organization involved. The process of sustaining change was also considered to be dependent on the interplay of multiple factors. They recommended that researchers interested in change sustainability should be “sensitive to context, complexity, ambiguity, uncertainty, competing stakeholders and to the range of potential interlocking influences” (p. 203). Again, this study alerted me to the possibility that, like my own experiences of new service development, establishing a new service involves complex processes.

While it may not be possible to identify the dominant factors leading to change sustainability, studies of hospital organizations have typically emphasized cultural and contextual influences on organizational change (Braithwaite et al., 2005; Dulaney & Stanley, 2005; Viitanen and Piirainen, 2003). Dulaney and Stanley
(2005) stated that change begins with careful assessment of an organization’s readiness for change. Before implementing a change, they recommended examining a hospital’s history of adopting changes and exploring ways in which other recent changes have unfolded. The idea of undertaking a cultural assessment was new to me and I wondered whether other music therapists had devoted time to understanding their organizations in this way.

Another study that explored cultural factors and change implementation was Viitanen and Piirainen’s (2003) action research study of a physiotherapy development project they led. They aimed to increase physiotherapists’ abilities to develop their own work and to substantiate their position within a Finnish hospital. During education sessions, participating physiotherapists were encouraged to reflect on their work, their competencies, and their occupational role. It soon became apparent that the sessions deviated from the hospital’s existing expectations of education. In the first instance, participating physiotherapists were observed to become confused and defensive. Managers then criticized the educators for challenging participants instead of giving clear instructions and expert lectures. Later, when physiotherapists had expanded their work orientation and adopted a more critical view of organizational operations, managers seemed to perceive the education sessions as a threat and they told physiotherapists they were paid for patient care and not service development. Although the project was viewed as a success in developing individual physiotherapists’ expertise, more extensive development work was thought to be harder to achieve. Viitanen and Piirainen explained how they had learned about the hospital’s underlying values and cultures through the process of implementing the project. Although the hospital communicated a message that education was desirable, it became evident that only certain types of education were acceptable. Knowledge dissemination and procedural instruction were perceived to be appropriate, whereas critical reflection on practice was not. The idea that healthcare organizations view some approaches and procedures as more acceptable than others may therefore have a bearing on newer services like music therapy. Additionally, this study indicates that hospitals may have hidden values and cultures which only become evident when change is introduced.
Descriptions of organizational change in hospitals have often stated that communication and collaboration are key in successful change implementation (for examples see Deegan et al., 2004; Dulaney & Stanley, 2005; Wynne, 2004). The basic premise is that workers are more likely to accept and sustain changes if they are actively involved in the change process and have opportunities to voice their concerns (Deegan et al., 2004). At the same time, leadership from one or more change agents appears to be necessary for workers to become involved in implementing the changes. Often a steering group has been formed to plan and implement an organizational change in a hospital, to educate other workers and garner support for the change, to evaluate and communicate change outcomes, and to persist when the change process becomes arduous (Deegan et al., 2004; Dulaney & Stanley, 2005). There is frequent mention of “resistance from stakeholders” (Deegan et al., 2004, p. 26) in some of this research. However, as little detail has been provided about the ways in which those proposing the changes interact with stakeholders it is difficult to be sure of the factors that lead to this response. Further research in this area could assist music therapists engaged in service development who are required to introduce music therapy to co-workers on a daily basis.

Summary of organizational change.

The above literature portrays organizational change as a challenging process, which requires significant shifts in workers’ values, practices, roles, and identities. Previous studies have indicated that attempts at organizational change can have negative consequences, such as increased workloads and fear and resistance among workers. Researchers have been unable to determine the precise mechanisms through which a change becomes accepted, though it is likely that a range of complex and unpredictable factors play a role. Studies of hospital organizations have emphasized the roles of power and culture in change implementation. These are areas that have received comparatively little attention in music therapy. As music therapists are likely to encounter complex historical, contextual, and interpersonal issues when a new music therapy service is being introduced, it is crucial that we learn more about the organizations within which music therapists work.
Theme 2. New Healthcare Roles

The search for literature relevant to my research about music therapists’ experiences of development work revealed an abundance of literature on the implementation of new healthcare roles. I learned that there has been a proliferation of new professional roles in healthcare contexts internationally over the past ten years (Bridges & Meyer, 2007; Cummings, Fraser, & Tarlier, 2003; Stanmore, Ormrod, & Waterman, 2006). This growth has been described as a response to issues such as rising healthcare costs, a growing older population, complex healthcare needs, and staff shortages (Bridges & Meyer, 2007; Cummings et al., 2003; Stanmore et al., 2006; Willard & Luker, 2007). In the UK for example, the development of new healthcare roles has been promoted by government policy (Bridges & Meyer, 2007; Stanmore et al., 2006). These new roles are proposed to improve healthcare efficiency, through complementing or substituting for traditional healthcare roles (Bridges & Meyer, 2007). A range of new assistant and support worker roles have emerged in the UK National Health System (NHS), including the roles of rehabilitation assistant (Stanmore et al., 2006), interprofessional care co-ordinator (Bridges & Meyer, 2007), and operating department practitioner (Timmons & Tanner, 2004).

At the same time that these new healthcare roles have been introduced, traditional health care professions have undergone significant change and expansion. Nurses in particular have entered more specialist and advanced areas of practice (Cummings et al., 2003; Lindblad, Hallman, Gillsjö, Lindblad, & Fagerström, 2010; Willard & Luker, 2007). There is now an array of new nursing titles and roles, including clinical nurse specialists, advanced practice nurses, nurse practitioners, nurse clinicians, and nurse consultants (Lindblad et al., 2010; Willard & Luker, 2007). These nurses work across traditional medical and nursing boundaries and often as part of disease-specific interprofessional teams (Cummings et al., 2003; Willard & Luker, 2007). The scope and training requirements of new nursing roles vary according to country and context, but roles tend to be characterised by additional assessment, decision-making, and leadership responsibilities (Lindblad et al., 2010).
Outcomes of new role implementation.

As new healthcare roles have become more established, researchers have begun to evaluate the impact of these new roles on healthcare practice (Bridges & Meyer, 2007; Lindblad et al., 2010; McLaughlin, Sines, & Long, 2008; Stanmore et al., 2006; Timmons & Tanner, 2004). Early findings have indicated that the outcomes of introducing new healthcare roles are mixed. Reported benefits of new roles have included job satisfaction, increased contact time for patients, greater continuity of care, reduced demands on other professionals, and the promotion of interprofessional collaboration (Lindblad et al., 2010; Stanmore et al., 2006). Undesirable outcomes have included increased workload for professions involved in the role start-up, role ambiguity, as well as competition and conflict between new and more established professions (Cummings et al., 2003; Lindblad et al., 2010; Stanmore et al., 2006; Timmons & Tanner, 2004). As highlighted in the literature on organizational change, the introduction of new roles and practices may lead to consequences for other workers within the same organization.

Barriers to new role implementation.

Barriers to the introduction of new healthcare roles have also been reported. An oft-cited barrier relates to differences in healthcare approaches (Cummings et al., 2003; Stanmore et al., 2006). For example, the introduction of a rehabilitation assistant role was observed to be impeded by an existing culture of nurses “doing for” rather than “enabling” patients (p. 662). A further barrier may be a lack of preparation and support for the new role, including limited resources or insufficient guidance and supervision from existing staff (Bridges & Meyer, 2007; Cummings et al., 2003; McLaughlin et al., 2008; Stanmore et al., 2006). A new role’s position in a team may also be problematic, as certain reporting relationships can be interpreted as a source of power (Cummings et al., 2003).

As I explored this literature about new healthcare roles, it occurred to me that relatively few music therapists have written about barriers to the introduction of music therapy services. Hilliard (2004) identified insufficient funds as a primary reason why music therapists were not employed in US hospices. Daykin and Bunt
(2006) indicated that the provision of music by volunteers and staff other than music therapists may be a barrier to the introduction of music therapy in cancer care. Lehmann and Threlfall (2008) similarly highlighted competition with other music providers as a threat to music therapy development, along with therapist isolation and limited time for promotion of music therapy. However, more could be understood about the potential barriers and threats to the introduction of music therapy services.

New role bearers’ experiences.

Studies of new role bearers’ experiences indicate that key tasks of role introduction include the establishment of a professional role, the attainment of support and acceptance from other professionals, and the search for identity (Cummings et al., 2003; McLaughlin et al., 2008; O’Connor, 2006). A study of eight newly appointed dual diagnosis workers revealed that the task of introducing a new role was experienced as “frightening” or “stressful” by those taking on the new identity (McLaughlin et al., 2008, p. 300). Interview respondents often felt “isolated” (p. 303) and experienced pressure to produce immediate outcomes to justify the need for the new post. One respondent reported that opportunities to demonstrate the value of her work were limited, as she was only referred the patients that “nobody else wants to work with” (p. 300). McLaughlin et al. suggested that managerial support and clinical supervision are important to promote professional development and to reduce occupational stress among new role bearers.

Cummings et al. (2003) interviewed seventeen key players in the implementation of advanced nurse practitioner (ANP) roles on three acute care services within a tertiary care teaching hospital. Those interviewed reported different understandings of the role of the ANP and there was “a trend toward uncertainty regarding the [ANP] role” (p. 141). This lack of role clarity was thought to lead to underutilization of ANPs, such as limited ANP involvement in educational and research activities. Interview responses also indicated that staff nurses and medical residents felt threatened by the new ANP role and that medical residents limited the number of patients that ANPs could work with. However, support for the ANP role appeared to have increased since its implementation and ANPs reported that they now felt more accepted. Cummings et al. (2003) emphasized that new role holders may
need to be more than just highly skilled practitioners. They may also require skills for coping with the dynamics and challenges of implementing a new and innovative role. This includes being able to manage other workers’ experiences of adapting to the presence of the new role.

Previous studies of new role bearers’ experiences have also indicated that establishing a new professional role can take time (Bridges & Meyer, 2007; O’Connor, 2006). O’Connor (2006) shared her reflections on the introduction of the new primary care mental health worker role, from her perspective as the director of a postgraduate training programme which was designed to prepare people for this role. Informed by a social and relational perspective on professional identity, she observed that the new role needed to be established through interaction. The new role didn’t come into existence “fully formed” (p. 93), nor was it the sole responsibility of one person to define the new professional identity. Instead a new professional identity was negotiated through conversations between herself, a line manager, a trainee, and a supervisor. Bridges and Meyer’s (2007) exploration of the introduction of interprofessional care co-ordinator (IPCC) roles noted that roles shifted over time and that IPCCs eventually worked beyond the scope of their initial job descriptions. Although the new role was intended to be clerical, the need for quick patient turnover meant that IPCCs had significant contact with patients and were highly involved in planning, decision-making, and leadership activities. These studies further suggest that workers may need to adopt flexible and collaborative approaches to the introduction of new healthcare roles.

*Implementing new creative arts therapy roles.*

Researchers have begun to explore the experiences of new role bearers in the creative arts therapies. For example, Dulicai and Berger (2005) surveyed dance movement therapists, to explore their experiences of developing dance movement therapy internationally. Throughout the world, the development of new dance movement therapy positions was described as a “struggle” (p. 212). Survey respondents shared experiences in which their profession had been misunderstood and described situations in which they perceived that their status was unequal to that of other health care professionals. Dance movement therapists presented themselves as
busy health care professionals, who were not only involved in providing services to clients, but also in providing education about their profession to other healthcare workers and the general public. Despite this, dance movement therapists believed they were making a “unique” contribution (p. 215) to people’s health and that efforts to develop the profession were worthwhile. These dance movement therapists’ experiences appeared commensurate with my own experiences of developing music therapy positions, as well as the experiences reported to me by my close colleagues. However, music therapists’ experiences of role development are yet to be researched in-depth.

Music therapists’ experiences of introducing a new role.

In looking to the music therapy literature, I was surprised to find that relatively few music therapists have documented their experiences of developing new positions. Edwards (2005a) described the development of a music therapy programme in a children’s hospital in Brisbane, Australia. Loewy (2001) shared how she expanded a music therapy programme in a large New York hospital, from the paediatric ward to most areas of the hospital. O’Neill and Pavlicevic (2003) clarified the new role of a music therapist working in paediatric oncology, through interviews with four stakeholders. A couple of accounts of music therapy service development have also appeared in the online music therapy journal Voices (examples include Miles, 2007; Konieczna, 2009). These music therapists have encountered issues similar to other new health professionals, including isolation (Miles, 2007), role ambiguity (Edwards, 2005a; Loewy, 2001; O’Neill & Pavlicevic, 2003), and competition with other health professionals over areas of practice (Edwards, 2005a). Edwards (2005a) indicated that new music therapy work may be “unpredictable” (p. 37) and that determining your role as a music therapist within a long-standing hospital culture can take time. Konieczna (2009) described the role of a new music therapist as one characterized by both freedom and responsibility. The work of a new music therapist may not be closely supervised and a music therapist may have the opportunity to work autonomously and to explore different techniques. However, alongside this freedom comes a responsibility to represent one’s profession and to provide the best possible service to patients. Additionally, new music therapists have experienced pressure to fit within a medical model of evidence and treatment, to
prove their worth, and to produce measurable outcomes (Edwards, 2005a; Konieczna, 2009). Although music therapists have recounted similar experiences to other healthcare workers in new roles, further reflection is vital if we are to develop our understanding of the processes through which music therapy positions become established.

Strategies for implementing new roles at the individual level.

Implementation strategies that other professionals have used may be applicable to music therapists who are introducing new services. Willard and Luker (2007) investigated the strategies used by twenty-nine specialist cancer nurses to implement their roles. Grounded theory analysis of their observations and interview material revealed that specialist cancer nurses’ key concerns were gaining acceptance from the multiprofessional team, lack of status, lack of autonomy, and the challenge of role ambiguity. Willard and Luker identified two main strategies through which specialist nurses responded to these concerns. Firstly, they built relationships with key colleagues, such as senior doctors, who could facilitate their access to patients. Once specialist nurses received referrals, they could then implement their role and contribute to team discussions. In order to build relationships, specialist nurses employed diplomacy and sensitivity, “avoiding criticism and adopting a gentle approach to the introduction of change” (p. 720). Specialist nurses also built relationships through undertaking service work such as preparing materials for team meetings. Although service work helped the team run smoothly, these tasks were perceived to disempower nurses and to reinforce hierarchical relationships within the hospital. The second implementation strategy was establishing role boundaries. This was achieved by the specialist nurses writing down role descriptions or explaining their role expectations to the team. Willard and Luker indicated that these specialist nurses achieved successful role development through persistence, constant interaction, and gently changing the status quo.

Timmons and Tanner (2004) explored ways in which two similar professions explained their role in the operating theatre. The two professions were that of the long-established “theatre nurse” and the newly-recognised “operating department practitioner” (ODP). Alongside organizational changes in UK hospitals, ODPs were
being increasingly employed as theatre managers (a role previously held predominantly by nurses). Theatre nurses and ODPs were viewed as being in open dispute over role boundaries and nurses were observed to use rhetorical strategies to distinguish themselves from ODPs. Nurses told stories with a strong moral component, in which the nurse was presented as a caring “heroine” and the ODP was portrayed as a “villain” (p. 657), who was less professional, more technical, and acted in support of the doctors. ODPs also used contrastive rhetoric to explain their role, only in their version it was the ODPs who were “caring” and the nurses who were “uncaring” (p. 661). This study showed how similar professions may use contrastive rhetoric to compete for professional survival. In reading this study, I reflected that I too had used contrastive rhetoric in my work as a music therapist, to distinguish my role from a music teacher or performer. I assumed that this was important, to establish my position as a health care professional. Dokter (2001) similarly recalled how her arts therapy team wished to separate themselves from the occupational therapy department in a British psychiatric hospital. A re-structuring that led to the introduction of an independent arts therapy department, including art, music, drama and dance movement therapy, was regarded as an important step towards arts therapists achieving a distinct identity and career structure.

Strategies for implementing new roles at the organizational level.

While the above studies explored strategies used by individuals to establish their roles, others have focused on implementation strategies at a team, management, or organizational level. Drawing on organizational change theories and findings from their study on advanced practitioner roles, Cummings et al. (2003) made five recommendations for the implementation of a new healthcare role. These were: 1) employ a change model to guide the change process, 2) assign one or two champions to support, co-ordinate, and market the new role, 3) communicate a consistent definition and expectations for the role, 4) facilitate open and ongoing communication between key players, and 5) attend to cultural and personal transitions (p. 145). Cummings et al. presented role implementation as a task to be achieved by the whole team and not just the individual role holder. The findings of a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis of the profession of music therapy indicated that music therapists perceive that it is their sole responsibility to introduce
the profession of music therapy (Lehmann & Threlfall, 2008). It is curious why music therapists in this study did not engage others more in the introduction of their music therapy posts.

*Music therapy implementation.*

Although the literature is sparse, some music therapists have started to reflect on the ways in which they have developed music therapy programmes in hospitals. Edwards (2005a) developed roles for music therapy in anxiety reduction and pain management, through drawing on theories, “observing and developing links with existing [music therapy] practice” (p. 38), learning from patients, families, and staff, and reflecting on and writing about her work. Edwards’ reflections suggested that new music therapists may need to respond and adapt to the needs of patients, families, and staff, as well as changes in hospital procedures. Loewy (2001) shared five ways in which she has established a successful music therapy programme – student training, presenting, writing, developing referral and assessment protocols, and researching. Additional recommendations for music therapy service development included identifying gatekeepers and antagonists to the development of music therapy, expressing music therapy requests in terms of patient need, and letting go of demands that can be worked on later. Loewy further stated that there is an international need for music therapy training in grant writing and programme building, as music therapists may not naturally possess these skills. These two papers offer important inroads towards our understanding of the skills music therapists may need to introduce services. However, further reflection is required if we are to deepen our understanding of the ways in which music therapists successfully introduce their roles.

Abad and Williams (2009) emphasized a need for music therapists to adapt to changing employment conditions and to respond to funders’ requests for evaluation data. Drawing on their experience of administering a community-based early intervention parent-infant programme, they recommended seeking corporate funding, factoring evaluation into funding submissions, and forming mutually beneficial partnerships with researchers. In their experience, high quality evaluation of music
therapy work helps music therapists to support their work and to secure further funding. Loewy (2001) described three music therapy research projects that were taking place at the hospital where she works. She recommended research, not only as a way of demonstrating the efficacy of music therapy, but also as a way of gaining feedback and improving the quality of the music therapy service. These studies indicate an important role for research in the development of music therapy services.

Strategies for establishing professional identities and roles.

Researchers in other healthcare disciplines have examined the rhetorical devices used by professionals to legitimize their roles, to justify their positions, and to establish themselves as professionals (Goodrick & Reay, 2010; Timmons & Tanner, 2004). Goodrick and Reay (2010) explored ways in which nurses have legitimized a new professional role by analyzing American introductory nursing textbooks published from 1955 until 1992. In the first part of their study, Goodrick and Reay tracked changes in identity related themes. Their content analysis uncovered incremental changes in nursing identities over time, from “assistants to physicians” to “independent health professionals working in partnership” with patients and other health professionals (p. 68). In the second part of their study, Goodrick and Reay focused on the rhetorical argumentation used by authors when presenting nursing definitions. They identified five ways in which nurses have used language to legitimize changes in their professional role which I have summarized in Table 1. These rhetorical strategies indicate that social and historical factors must be considered when arguing for a new professional identity. Nurses’ arguments for the identity change minimized a sense of breaking from the past and implied that the change was the “appropriate and right thing to do” (p. 78). The nursing identity was observed to have changed significantly over time, but changes in the argumentation for the new identity were almost invisible. Goodrick and Reay concluded that “legitimizing a new role identity relied on rhetorical strategies that minimized disruption and focused on continuity” (p. 79). Their study further emphasizes a need for healthcare professionals to be aware of existing traditions when they are introducing new roles and identities.
Table 1

*Rhetorical Strategies used by Nursing Authors to Legitimize a New Professional Role Identity*

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naturalizing the past</td>
<td>Presenting the new role as a natural descendant of a previously accepted role</td>
</tr>
<tr>
<td>Normalizing new meanings</td>
<td>Presenting the new role as normal not novel; stretching old labels to incorporate new meanings</td>
</tr>
<tr>
<td>Altering identity referents</td>
<td>Minimizing the significance of the change by selectively using different professions as reference groups</td>
</tr>
<tr>
<td>Connecting with the institutional environment</td>
<td>Presenting changes as natural responses to institutional forces or broader societal changes</td>
</tr>
<tr>
<td>Referencing authority</td>
<td>Referencing textbook authors, theorists, and professional associations (or quietly ignoring previous authorities)</td>
</tr>
</tbody>
</table>

*Note. This is a summary of the key findings in “Florence Nightingale endures: Legitimizing a new professional role identity,” by E. Goodrick and T. Reay, 2010, *Journal of Management Studies, 47*(1), p. 74-77. Copyright 2009 by Blackwell Publishing and the Society for the Advancement of Management Studies.*

Waller (2001) described similar rhetorical strategies in her research on the development of state registration for art therapists in Britain. According to Waller, clear thought, communication, protracted negotiations, and the employment of strategy and tactics were required for art therapists to gain recognition. Over time, the British Association of Arts Therapists (BAAT) made shifts in the way that they defined art therapy, as well as in the professional groups that they compared
themselves to. In the early days, BAAT aligned art therapy with art teaching and became part of the National Union of Teachers. Later, it was more profitable for the profession to be aligned with other allied health professions, as a profession “supplementary to medicine” (p. 251). To gain entry into an organization, Waller recommended “working with the system” (p. 249) and making compromises where reasonable. The importance of having experienced mentors was also emphasized.

Although I am not aware of any music therapists who have written about “rhetorical strategies” for establishing a professional role, the challenge of defining and distinguishing music therapy is a common theme in writings about the professionalization of music therapy. Barrington (2008) discussed tensions between the need for clear music therapy definitions and the flexible and creative nature of music therapy practice. She indicated that clear definitions are necessary to develop an identity within the profession and to communicate a professional image externally to government agencies, employers, and the general public. While acknowledging that definitions may fall short of capturing the full complexity and diversity of music therapy approaches, Barrington proposed that they are necessary to protect both the public and the profession. Instead of establishing one fixed definition of music therapy, she recommended that music therapy definitions be fluid and “reactive to the changing nature of the field” (p. 67). In their response to Barrington’s article, Ansdell & Pavlicevic (2008) argued for greater exploration of the “borders between traditional music therapy and its current challengers” (p. 75). They suggested connecting with broader music and health movements, rather than maintaining clear professional boundaries and what they described as “monopolies” (p. 75) of knowledge and expertise. Ansdell and Pavlicevic called for greater respect for people’s own understandings of how music is therapeutic and recommended working in partnership with music therapy participants, musicians, and music and health workers. These studies suggest that music therapy definitions can be problematic and that there may be differences between existing definitions and music therapists’ roles in practice.

In the broader healthcare literature, authors have recommended clear role demarcation as a way to minimize role ambiguity and territorialism among new and more established health care professionals (Cummings et al., 2003; Lindblad et al.,
These authors have emphasized a need for explicit role definitions, professional guidance documents, and discussions among stakeholders about their expectations of the new role. However, Bridges and Meyer (2007) cautioned that it may be erroneous to assume that roles can be clearly delineated in practice. Although IPCCs in their study had a clearly written job description, in practice they were required to be more flexible and responsive to the context in which they were working. It was also noted that less tangible competencies, such as knowledge and skills in psychosocial care, were not included in job descriptions and hospital policy. Bridges and Meyer drew attention to tensions in policy documents between “the need for flexibility . . . and the clarity required to ensure adequate managerial systems are in place” (p. 642). While there may be benefits to flexibility, increasing flexibility may lessen clarity around job responsibilities and training, supervision, and regulation requirements. Clarity may be important to ensure that patients are protected and that professionals are accountable, but it may be difficult to fully specify the competencies of a new and flexible role. Bridges and Meyer’s study further indicated that the development of new job descriptions can be problematic and that the process of role implementation is likely to involve subtleties and complexities.

While some authors have recommended that music therapists establish clear boundaries between themselves and other music practitioners (Daykin & Bunt, 2006; Hilliard, 2004), others have indicated that it is possible for different types of musical interventions to co-exist. Moss (2008) explained how music therapy, live music performance, and recorded music can be utilized in different situations. Her role as a qualified music therapist working in a hospital arts officer post has been to select the most appropriate musical intervention based on the needs of patients and the particular hospital context. Hartley (2008) also played down the need for clear boundaries between music therapists and arts in health practitioners and stated that, “No specific group of artists can give either the organization or our users everything that is needed from the arts” (p. 90). Drawing on a management perspective, he referred to creative arts therapists as “market nichers” who can serve only a limited number of hospice service users. He suggested that in order to remain relevant and sustainable, music therapists should be flexible, broaden their scope of practice, and respond to changing health care agendas. These two studies challenge the prevailing
view that music therapists need to establish clear boundaries to promote their work and ensure their professional survival.

Arts therapy pioneers.

One final area of relevant research is that pertaining to the experiences of arts therapy pioneers. Meekums (2008) collected life narratives from nine British dance movement therapy pioneers, to explore links between their personal histories and their development of a dance movement therapist identity. Her analysis of the narratives gave rise to four main themes. First, dance movement therapy pioneers tended to have survived an earlier period of isolation, resulting from either a geographic dislocation or a serious illness. Meekums speculated whether pioneers’ earlier experiences had led them to acquire the resilience needed to “stand alone” (p. 105) in a marginalized profession. Second, all of the pioneers recalled affectively charged early movement experiences, which may have motivated their interest in dance movement therapy as a profession. Third, many of the pioneers moved into their first posts through serendipitous circumstances, in which stakeholders became aware of the therapeutic value of dance. Another common feature in the pioneers’ narratives was a “beginner’s mind” (p. 104), or childlike attitude. This attitude was viewed as both an advantage and a hindrance, as pioneers remained open to learning from clients yet experienced an inferior status to that of other healthcare workers. Seven of the pioneers had pursued additional training and study to further enhance their skills. Meekums’ research indicated that when developing new creative arts therapy positions, it may be important to strike a balance between exploration and the establishment of expertise, theory, and evidence.

Studies of music therapy pioneers may reveal something about the personal qualities that a new music therapist needs. Hadley’s (2003) narrative inquiry identified possible links between Clive Robbins’ life experiences and his involvement in the development of the improvisational approach known as Creative Music Therapy. Like the pioneers who participated in Meekums (2008) study, Clive Robbins was described as a “loner” (p. 36), who spent time on his own as a child. Through his early experiences, Robbins may have gained the resources needed for work as an independent music therapist later in life. Hadley also pointed to the
possible impact Robbins’ anthroposophic beliefs and his “total engagement in work” (p. 51) had on his ability to maintain a long term commitment to music therapy. By viewing challenges as learning opportunities, Robbins may have been able to persist and to find creative solutions to problems. This possibility appears to correspond with results of a correlational study by Fowler (2006), which measured a correlation between positive mental coping strategies and greater professional longevity among American music therapists. Other qualities that may be advantageous to music therapists are evident in interviews with music therapy pioneers (for examples see Buchanan, 2009; Howard, 2009; Neugebauer, 2010). Music therapy pioneers have demonstrated hard work, commitment, an attitude of exploration, passion about music therapy, and fundraising and promotion skills.

Summar of new role implementation.

The literature on healthcare role implementation that is outlined above reveals that the introduction of new healthcare positions and roles can be complex and even problematic. Workers in new healthcare roles have commonly reported feelings of isolation and have experienced pressure to prove the value of their work. Role misunderstandings and competitions between new and more established professions are also commonly reported. A small amount of literature indicates that music therapists encounter similar experiences when they develop new music therapy services. In reflecting on the small amount of music therapy literature on this topic, I wonder whether music therapists more often share stories in which they have successfully implemented roles. Perhaps we leave out stories of difficult and unsuccessful encounters in service development, because they do not fit with the image of the young, dynamic, and successful profession that we wish to be a part of and promote. For example, my doctoral supervisor and I were involved in a service development opportunity some years ago that did not go well. A funded research study was developed to evaluate the impact of the introduction of music therapy onto a dementia ward in a hospital. In spite of the significant findings of the year-long arts therapies research project in reducing patients’ agitation levels, and good working relations with most staff, the project was not continued. Quite some bitterness was experienced between key project workers. We have agreed that we do not like to re-
visit this experience. While a brief report has been published, the difficulties resulted in the findings not being disseminated further.

Some healthcare authors have suggested that clear role demarcation is a useful way to minimize role ambiguity and territorialism among professionals. However, other authors have argued that new roles may be difficult to define in practice, as they are likely to change over time and in relation to other professionals’ developing roles. There is also an emerging debate within music therapy as to whether it is helpful or harmful to distinguish music therapy from other music practices in healthcare (Ansdell & Pavlicevic, 2008; Hartley, 2008). This further suggests that the issues around music therapy role implementation are likely to be multifaceted and complex.

Music therapists have begun to reflect on the ways in which they have successfully developed new programmes, such as writing, researching, and learning from patients and other healthcare staff. The biographies of creative arts therapy pioneers have further pointed to qualities that could be helpful to a new music therapist, such as previous experiences of isolation, positive coping strategies, persistence, fundraising and promotional skills, and an attitude of exploration. However, these studies have only scratched the surface when it comes to exploring the ways in which music therapists introduce positions successfully. Further research in this area is vital if we are to understand how music therapy services can become established.

Theme 3. Interprofessional Work

One further area of research relevant to the development of new music therapy services in healthcare is interprofessional work. This is somewhat challenging to introduce here, as authors have used a wide range of terminology to refer to situations where different health professionals work together. Literature on this topic includes such diverse terms as multidisciplinary, interdisciplinary, or transdisciplinary working; integrated or integrative healthcare; collaborative working; coordinated care; and team work (Johnson, 2009; Vyt, 2008; Zwarenstein, Goldman, & Reeves, 2009). Sometimes these terms are used interchangeably, but on other occasions, authors make clear distinctions between the terms (Boon, Mior, Barnsley, Ashbury, &
Haig, 2009; Johnson, 2009). For example, Boon, Verhoef, O’Hara & Findlay (2004) placed interprofessional work on a spectrum from “parallel” care, where each professional works separately with patients, to “integrative care”, where professionals work together to care for the whole person, focusing on wellness rather than disease. “Consultative”, “collaborative”, “coordinated”, “multidisciplinary”, and “interdisciplinary” care were presented as stages toward full integration. Elsewhere, the term “integration” has been regarded as problematic, as it can refer to different health professionals working together, or to the situation in which a physician provides complementary and alternative treatments alongside conventional care (Johnson, 2009). Recent research has indicated that health professionals may prefer the term “collaboration” over “integration”, as the term integration may imply a loss of autonomy and professional identity (Boon et al., 2009). Vyt (2008) presented “transdisciplinarity” as an approach above and beyond multidisciplinary and interprofessional teamwork, involving shared care planning and the absence of hierarchical relationships. In reviewing this literature, it became evident that the terminology in this area had a wide range of possible meanings. However, in this thesis, I have chosen to use the term “interprofessional work”, to avoid confusion, and to acknowledge the contributions of different healthcare disciplines. The term “interprofessional work” is understood here to denote all situations in which a variety of health professionals work together for the benefit of patients.

Interprofessional work in healthcare – benefits and barriers.

Recent healthcare discourse has promoted interprofessional work as the key to effective health service administration and delivery (Boon et al., 2009; Johnson, 2009; Reeves & Lewin, 2004; Zwarenstein et al., 2009). Interprofessional work has been presented as both a response and a solution to increases in the incidence of chronic and complex diseases, the growing older population, rising healthcare costs, and resource constraints (Boon et al., 2009; Vyt, 2008). Interprofessional work is perceived to have benefits for patients, for healthcare staff, and for organizations, though research evidence of its value is only starting to emerge (Vyt, 2008; Zwarenstein et al., 2009). For patients, interprofessional work is proposed to lead to more person-centred approaches and to greater consideration of individual needs and preferences (Johnson, 2009). Effective interprofessional communication is reported
to reduce medical error and to improve patient safety (Gotlib Conn et al., 2009). For staff, interprofessional work is perceived to increase respect among workers and to improve job satisfaction (Gotlib Conn et al., 2009; Vyt, 2008). For healthcare organizations, interprofessional work is believed to result in more coordinated and cost-efficient service delivery (Johnson, 2009; Zwarenstein et al., 2009). One randomized control trial reported shorter lengths of stay and fewer medical charges on wards that implemented interprofessional rather than traditional rounds (Curley, McEachern, & Speroff, 1998). These studies suggest that best healthcare practice is achieved when a range of professionals work together. In reading recent literature on interprofessional work, I noted that this view prevails.

Although interprofessional work is presented as an ideal, it is reportedly difficult to achieve in healthcare practice (Atwal & Caldwell, 2005; Boon et al., 2009; Gotlib Conn et al., 2009; Pullon, 2008; Reeves & Lewin, 2004). Reported barriers to effective interprofessional work include diversity in health professionals’ philosophies and approaches, historical differences between health professions, problematic power dynamics, poor communication and conflict between health professionals, inadequate support at an organizational level, and insufficient interprofessional education of health professionals (Atwal & Caldwell, 2005; Gotlib Conn et al., 2009; Hall, 2005; Zwarenstein et al., 2009). These studies indicate that health professionals may encounter challenges as they enter interprofessional work.

Much of the discussion around interprofessional work focuses on issues of identity, role boundaries, and the potential for role-blurring when different health professionals work together. Hall (2005) described different healthcare professions as different cultures with separate values, beliefs, attitudes, customs, language, and behaviour. In her view, the different healthcare professions have evolved through the establishment of distinct areas of expertise. Profession-specific identities are also reinforced through university education and socialization processes. The demarcation of professional boundaries (“boundary work”) may be important for a health professional’s developing sense of self, but lead to barriers when it comes to interprofessional work.
Researchers have further observed that healthcare professionals can show resistance to interprofessional work if they feel that their skills are underutilized, or if they perceive that their scope of practice is intruded upon (Hall, 2005; Kvarnström, 2008; Suter et al., 2009). In times of conflict or organizational change, workers have been noted to retreat into their own professional culture, where there is greater security, certainty, recognition, and freedom to work autonomously (Brown et al., 2000; Hall, 2005). Miller et al. (2008) described a strong professional identification among nurses and attributed this to collective experiences of sub-ordinance within the healthcare system. In their study of general internal medicine wards, nurses were observed to show solidarity to the extent that they actively resisted working with other professionals. Nurses rejected the appointment of an allied health professional as a unit manager and the role was subsequently re-assigned to a nurse. In reading this study, I reflected that I had seen similar comradeship among the nurses in the hospitals and nursing homes where I had worked. I remembered that nurses tended to move around in groups and that as a music therapist, I found it difficult to enter their company.

Another barrier to interprofessional work may be a lack of role understanding. Published studies indicate that health professionals often find it difficult to understand each others’ roles (Atwal, 2002; Moore, Cruickshank, & Haas, 2006; Pellatt, 2005; Suter et al., 2009). In a study conducted by Suter et al. (2009), various health professionals admitted to not knowing others’ roles and being unsure of where they fitted into the team. Occupational therapists interviewed by Moore et al. (2006) perceived that their role was poorly understood by colleagues, clients, and even themselves. Pellatt (2005) conducted interviews with a range of professionals as part of an ethnographic study of a spinal cord injuries unit. Nurses and occupational therapists reported that other health professionals were unaware of their roles and even doctors thought that their own role was misperceived. Pellatt described a “knowing paradox” (p. 148), whereby health professionals believed that they understood others’ contributions to the team, but perceived that they were misunderstood in return. According to Pellatt, this knowing paradox may lead to stereotyping and incongruent role expectations, which may result in conflict between professionals and repercussions for patients. It was highly informative to read this research, as I had previously assumed that music therapists were unique in feeling
that they were misunderstood. These studies indicated that even practitioners in well-established professions can experience doubt as to whether they are understood by others.

“Role blurring” refers to situations where health professionals’ competencies overlap, or where health professionals share responsibilities (Brown, Crawford, & Darongkamas, 2000; Hall, 2005; Suter et al., 2009). It can also be used to describe the ways in which one practitioner might extend their scope of practice into the practice area of another. Wide ranging views exist as to whether role blurring is desirable or damaging in healthcare practice. Authors who advocate interprofessional work tend to encourage flexibility with regard to professional roles (Brown et al., 2000; Pullon, 2008; Suddick & DeSouza, 2007). To these authors, role blurring is a progressive step, which leads to the sharing of workloads, fewer hierarchical relationships, and more socially-oriented care (Brown et al., 2000; Hall, 2005). Others view role blurring as a potential source of conflict, confusion, and burnout among health professionals (Brown et al. 2000; Hall, 2005). In interprofessional teams, health professionals may be uncertain of their role limitations and perceive that others are “meddling” in matters outside their expertise (Brown et al., 2000, p. 430). Role blurring can also be considered dangerous for patients if lines of accountability are unclear (Brown et al., 2000). On reading this literature, I wondered whether the consequences of role blurring may be dependent on the context and the desired outcome of interprofessional work. For example, role blurring may not be problematic when patients’ lives are not at risk or when a professional is not attempting to establish a unique contribution. Further research is needed to determine the types of situations in which role blurring may be advantageous to the goals of the team and the needs of the patients.

An ethnographic study by Reeves and Lewin (2004) indicated that an additional barrier to interprofessional work may be temporospatial constraints. In their view, interprofessional relationships in hospitals can be “short-lived and continually shifting between individuals and organisations” (p. 218). Reeves and Lewin observed interprofessional interactions in two busy hospital wards, which were staffed by nurses and health care support workers and visited by medical teams, therapists, social workers, and pharmacists. Doctors and nurses were observed to
interact most frequently and interactions were mostly limited to doctors communicating information and giving instructions. These exchanges tended to be brief, business-like, and highly task-oriented. Though less frequent in number, interactions between nurses and allied health professionals were seen to be “more friendly, less rushed and often involved a more in-depth discussion of patient care” (p. 222). Differences in professionals’ interactions were attributed to the way care was organized in the hospital. As the medical teams were spread across a number of wards, doctors were required to interact with a range of staff and were possibly less committed to developing rapport with staff on a particular ward. Doctors’ interview responses indicated that they prioritized collaboration with different medical teams or specialties over developing further opportunities for interprofessional collaboration. Reeves and Lewin highlighted a need to recognise different organizational cultures and understandings of collaboration when attending to interprofessional work. In thinking about my own service development experiences, I reflected that I most often collaborated with allied health professionals who shared my workspaces and worked similar hours to me. I perceived that I rarely had opportunities to work collaboratively with visiting doctors and other professionals.

Conditions and strategies for effective interprofessional work.

Researchers have begun to examine factors that may contribute to effective interprofessional work and to explore possible interventions for improving collaboration between healthcare professionals (Suter et al., 2009; Zwarenstein et al., 2009). Suter et al. (2009) aimed to understand core competencies for collaborative healthcare practice, by calling on the perspectives of practicing health professionals. They interviewed sixty health professionals, the majority of whom were female nursing and allied health workers. Semi-structured individual and group interviews focused on factors that enhance effective collaboration. Two core competencies consistently emerged in the interview data: role understanding and appreciation, and communication. A positive attitude, a willingness to collaborate, and a desire for continuous learning and reflection were seen as additional antecedents to collaborative practice. In reading Suter’s study, I became interested in whether similar conditions and competencies may be required if music therapy is to become an established part of an interprofessional team.
Role understanding.

Understanding and acknowledging the role of other health professionals appears to be a fundamental part of interprofessional work (Suter et al., 2009; Vyt, 2008). Suggestions for improved role understanding have included clearly demarcating roles within the team, focusing on patients’ needs instead of role boundaries, and striking a balance between professional interdependence and autonomy (Atwal, 2002; Suter et al., 2009). If health professionals recognise others’ contributions to common goals, they may be more likely to call on each others’ expertise (Suter et al., 2009; Vyt, 2008). These assertions are interesting in light of the “knowing paradox” observed by Pellatt (2005, see p. 36). If health professionals perceive that they already understand others’ roles, how receptive are they to formal education about the roles of other professionals? I wonder what alternative forms of education may be useful to promote effective role understanding.

Interprofessional communication.

Another reported key to successful interprofessional work is effective communication (Gotlib Conn et al., 2009; Suddick & DeSouza, 2007; Suter et al., 2009). Health professionals may need to develop skills and strategies to communicate with a wide range of people with differing philosophies, approaches, and terminology (Suter et al., 2009; Vyt, 2008). In a diverse interprofessional team, health professionals may need to present and defend their opinions clearly and to enter negotiations before a decision is reached (Suter et al., 2009; Vyt, 2008). The need for clear goal setting and shared care planning in interprofessional teams has also been emphasized by several authors (Hall, 2005; Suddick & DeSouza, 2007; Suter et al., 2009; Vyt, 2008). In my own experience as a music therapist, communication skills were vital for working with other team members. To collaborate with other professionals, I perceived that I needed to be confident and to express my opinions in clear and professional ways.

A recent participatory action research study indicated that language may be a powerful way of establishing one’s unique contribution to an interprofessional team.
Occupational therapists in Wilding and Whiteford’s (2008) study met in groups monthly to discuss cases and to explore their practice and articulation of occupational therapy. At the study outset, the occupational therapists reported difficulty in describing occupational therapy and perceived that their role definitions were long and drawn out with unnecessary information. They described how they avoided using the word “occupation”, instead favouring the word “function” when explaining their roles. Through group meetings, the occupational therapists began to question their use of language and resolved to use the word “occupation” more in their day to day work. The word “occupation” was seen to better encapsulate the occupational therapists’ role as “experts in doing” (p. 184). This small change was perceived to lead to a major transformation in the occupational therapists’ identity, “from being unconfident and unclear about their role in the hospital, to being self-assured and articulate as occupation-focused therapists” (p. 185). As music therapists have reported difficulties in defining music therapy practice and negotiating their roles (Barrington, 2008; Lehmann & Threlfall, 2008), this study raises some interesting ideas about how music therapists could construct their identities in healthcare contexts.

Team meetings.

Several authors have referred to the team meeting as an important setting where effective interprofessional communication can occur (Arber, 2007; Gotlib Conn, 2009; Reeves & Lewin, 2004; Vyt, 2008). In team meetings, health professionals can construct professional identities, educate others about their role, learn from others’ experiences, and explore alternative approaches (Arber, 2007; Copley et al., 2007; Lingard, Garwood, Schryer, & Spafford, 2003). In an ethnography of palliative care settings, Arber (2007) observed that team meetings were a place where nurses could establish their expertise in pain management and maintain their professional relationships with medical staff. Within team meetings, specialist palliative care nurses were seen to use a number of communicative strategies to develop reputation and negotiate role boundaries. These included avoidance of criticism, taking a neutral position, using contrastive rhetoric, and telling atrocity stories (stories that emphasize the difference between groups or professions).
Although the potential value of team meetings has been acknowledged, limitations of team meetings have also been identified. The information imparted may not be useful to all present and key health professionals may be missing due to the demands of patient care (Gotlib Conn, 2009; Reeves & Lewin, 2004). Atwal and Caldwell (2005) also highlighted inequalities in hospital workers’ levels of participation in team meetings. They observed that doctors, in particular consultants, had the most dominant role in team meetings. Social workers, occupational therapists, and physiotherapists’ were observed to speak in meetings less frequently. Possible explanations included the large size of teams, the need to compete to be heard, perceived status differentials, and a lack of confidence on the part of staff responsible for functional or social care. In reflecting on my own experiences and the experiences of my students, I remembered that we often approached team meetings with feelings of trepidation. As a music therapist, I found it difficult to be heard in a room full of more established professionals and perceived that I needed to be on constant alert to catch any opportunities to speak. The team meeting may therefore be an important site in which to explore a music therapist’s position in relation to their co-workers.

A recent study by Miller et al. (2008) found that psychosocial care information was rarely conveyed and poorly received within team meetings. They observed that physicians lost attention and interest when nurses brought up psychosocial issues. Physicians cited nursing information as a “major contributor” (p. 338) to the inefficiency of meetings and nurses reported that the format of meetings provoked “discomfort, intimidation, and professional exclusion” (p. 339). Nurses’ non-attendance at meetings was interpreted by Miller et al. as a strategy of “fighting against the system” (p. 338). However, this strategy was regarded as largely counter-productive, as a nursing representative was then restricted to clarifying, obtaining, or accepting orders from physicians. Miller et al. (2008) suggested that interprofessional team members could be more reflective and accountable for power imbalances that exist. This suggestion makes me wonder whether it is both the responsibility of the music therapist and the team to ensure that a music therapy perspective is heard in meetings.
Attempts to make team meetings more democratic and less hierarchical have not always met with success. In one study, mental health professionals experienced that the sharing of meeting tasks led to team members feeling under-prepared (Brown et al., 2000). Rotating the role of meeting chair was perceived to reinforce feelings of inadequacy rather than creating a sense of empowerment. To enhance the quality of team meetings, Vyt (2008) has advocated highly structured approaches such as the preparation of documents, effective leadership and time management, and clear follow-up of goals and tasks. In reading these studies, I wondered to what extent it is possible for music therapists to modify meeting practices and to take on leadership roles within their teams. Where these opportunities are not available to music therapists, is their capacity to influence and reinforce change reduced?

Informal communication.

In healthcare contexts, a great deal of interprofessional communication has been observed to take place informally (DiPalma, 2004; Gotlib Conn, 2009; Miller et al., 2008; Reeves & Lewin, 2004). Unplanned conversations in common areas have been valued as ways to save time, to deal with unexpected care changes, and to discuss patients in more detail than is possible in organized meetings. DiPalma (2004) referred to these informal and private forms of interprofessional communication as “webs” (p. 303). She observed that staff gained power through forming temporary and opportunistic alliances with other healthcare workers. Physicians and nurses were perceived to gain great satisfaction from working outside formal structures and hierarchical expectations for the common goal of meeting patients’ needs. As I had perceived barriers to my participation in team meetings (see p. 41), I wondered whether it could be advantageous for music therapists to interact with others in less formal ways. I also reflected that we actually know very little about the ways in which music therapists relate to other members of their teams.

Personal characteristics and interprofessional relating.

While some authors have sought to determine the necessary skills for interprofessional work, others have reflected on the personal qualities and attitudes required to work in an interprofessional team (Atwal, 2002; Suter et al., 2009; Vyt,
Several authors have proposed that a respect for others is essential when working with a range of health professionals with different backgrounds (Boon et al., 2009; Pullon, 2008; Suter et al., 2009; Vyt, 2009). Suter et al. (2009) also highlighted the importance of a desire for continuous learning when working interprofessionally. Health professionals who strive to improve their practice may be more willing to collaborate and more committed to shared teaching and learning. These studies suggest that a new music therapist’s experience may depend largely on the attributes of their team members. A music therapist may experience challenges in joining a long-established team, regardless of whether he or she is a skilled and experienced team member.

Pullon (2008) referred to respect as a dynamic and integral component of interprofessional relating, rather than an individual attitude. She interviewed primary care doctors and nurses about their relationships and identified a sequential path to the development of interprofessional trust. The first step was a sound understanding of professional identities. Through understanding their own and others’ identities, doctors and nurses were able to demonstrate relevant competence. Doctors and nurses who demonstrated competence then gained respect. Respect for competence led to the development of interprofessional trust, however trust was not automatic and had to be earned over time. Trust only occurred once doctors and nurses had worked together successfully and developed mutual understanding and dependence. Pullon’s study indicated that doctors and nurses can develop successful relationships by gaining an understanding of each others’ identities, demonstrating competence, and nurturing mutual respect. However, little is known about the processes through which music therapists gain the trust of other health professionals. I considered that successful service development might entail significant interprofessional relating, warranting attention to issues of trust between music therapists and other workers.

Management approaches.

Other factors that may contribute to effective interprofessional work include management approaches and administrative procedures (Brown et al., 2000; Suter et al., 2009; Vyt, 2008). Managers have been encouraged to provide a rich environment for interprofessional work, through providing time, resources, and support for
collaboration (Kvarnström, 2008; Suter et al., 2009). The benefits of interprofessional work may need to be explained and a culture of flexibility may need to be promoted through education (Atwal, 2002; Brown et al., 2000). Vyt (2008) proposed that managers of interprofessional teams should be effective leaders, who stimulate openness and self-reflection. Interprofessional work may be further enhanced through the use of information technologies and administrative procedures that promote interprofessional storage and consultation of patient information (Vyt, 2008). These studies suggest that for interprofessional work to be effective, it needs to be promoted at all levels of a healthcare organization.

Music therapy and interprofessional work.

As in the broader healthcare literature, interprofessional work has long been championed by music therapy authors (for early examples see Bruscia, Hesser, & Boxill, 1981; Michel & May, 1974). Interprofessional work is viewed as an essential component of music therapy practice, as music therapy clinicians often collaborate with other health professionals and contribute to the work of healthcare teams (Hobson, 2006b; Kennelly & Brien-Elliot, 2001; Magee & Andrews, 2007; Register, 2002; Twyford & Watson, 2008). Professional competency documents for music therapists include aspects of interprofessional work, such as defining one’s own role, understanding others’ roles, communicating effectively, and working with other professionals to assess patients, devise goals, and implement effective treatment programmes (American Music Therapy Association, 2008; Australian Music Therapy Association, 2004; Health Professions Council, 2007). University courses also include interprofessional education in the training of music therapy students (Copley et al., 2007).

Articles published in music therapy and medical journals have offered a rationale for music therapy’s inclusion in hospital teams (Edwards, 2006a; Kennelly & Brien-Elliot, 2001; Magee, 2005; Rafieyan & Ries, 2007). In these articles, music therapists have described their contributions to teams in settings such as paediatric and adult rehabilitation (Kennelly & Brien-Elliot, 2001; Magee, 2005), mental health (Edwards, 2006a; Rafieyan & Ries, 2007), and hospice services (Amadoru & McFerran, 2007). Although working in quite different practice settings, music
therapists have written about their roles in similar ways. Typically, authors begin with a definition of music therapy, highlighting aspects such as the therapy process, individualized treatment, the presence of a therapeutic relationship, and the therapist’s training and qualifications (Magee, 2005; Rafieyan & Ries, 2007). This is then followed by a review of music therapy research evidence relevant to the particular setting or population (Kennelly & Brien-Elliot, 2001; Magee, 2005; Rafieyan & Ries, 2007). Music therapists then move on to explain the specialist contributions that music therapy can make to the work of the hospital team. Explanations typically refer to the expressive, non-verbal, structural, or motivating qualities of music, music therapy’s value in addressing psychosocial and communication needs, or the possibility that music therapy may evoke responses that are not observed elsewhere (Edwards, 2006a; Hobson, 2006a; Kennelly & Brien-Elliot, 2001; Magee, 2005). Here, words such as “noninvasive” (Magee, 2005, p. 532) are typically used to describe music therapy and to set it apart from other treatments. Case material is often included, to further demonstrate music therapy’s role in the hospital team (Kennelly & Brien-Elliot, 2001; Magee, 2005). These articles have been successful in demonstrating a role for music therapy in healthcare teams, but have revealed little about the challenges that music therapists experience when engaging in interprofessional work.

The most common interprofessional collaborations reported in the literature are between music therapy and speech and language therapy (for recent examples see Bower & Shoemark, 2009; Hobson, 2006b; Kennelly & Brien-Elliot, 2001; Kennelly, Hamilton, & Cross, 2001; Magee, Brumfit, Freeman, & Davidson, 2006). In rehabilitation settings, music therapists and speech and language therapists have worked together to assess patients, to devise treatment goals, or to co-lead therapy sessions for people with acquired speech and language difficulties (Bower & Shoemark, 2009; Hobson, 2006b; Kennelly & Brien-Elliot, 2001; Kennelly, Hamilton, & Cross, 2001; Magee, Brumfit, Freeman, & Davidson, 2006). In these collaborations, a role of the music therapist has been to provide a motivating and enjoyable medium to engage patients in functional communication rehabilitation (Bower & Shoemark, 2009; Kennelly & Brien-Elliot, 2001; Kennelly, Hamilton, & Cross, 2001). Perceived benefits of conjoint music therapy and speech and language therapy work have included improved patient outcomes, greater continuity of care,
shared knowledge and responsibilities, and mutual support among team members (Hobson, 2006b).

There is also emerging evidence that the inclusion of music therapy can contribute to the work of other members of the interprofessional team (Hilliard, 2006; O’Callaghan & Magill, 2009). Hilliard (2006) evaluated the effects of music therapy groups designed to provide psychosocial support, to increase coping mechanisms, and to develop team building among hospice staff. Participants from nursing, social work, and chaplaincy completed compassion fatigue and team building questionnaires before and after six weeks of group music therapy sessions. Though there were no significant differences in participants’ levels of compassion fatigue after music therapy, study results indicated that the groups were successful in bringing together autonomous members of the hospice team. Both improvisatory and pre-planned music therapy groups led to significant increases in participants’ team building scores. Hilliard explained that through participating in music therapy groups, hospice staff experienced opportunities to work together and to discuss thoughts and feelings about the team.

Studies have indicated that health professionals may even benefit from mere exposure to a music therapy programme at the site where they work. Nursing, medical, and allied health staff from two cancer hospitals reported multiple benefits of witnessing patients’ music therapy sessions (O’Callaghan & Magill, 2009). Hospital staff who had witnessed music therapy experienced helpful emotions, moods, self-awareness and teamwork. Observing positive effects of music therapy on patients and families elicited experiences of “being part of a team providing good patient care” (p. 226). The presence of live music and a music therapist was also perceived to lead to an improved work environment for staff. Furthermore, staff believed that the benefits they received enhanced their own care of patients. In these two hospitals, music therapy was considered to be an “incidental, non-cost added, and significant staff support modality” (p. 225). Hospice staff in a study by Amadoru and McFerran (2007) similarly valued witnessing music therapy’s positive effects on patients and their families. While studies have indicated benefits of interprofessional work for patients and staff, ways in which interprofessional work impacts the development of a music therapy service are yet to be established.
Reported challenges for music therapists in interprofessional work.

Music therapists have started to reflect on the drawbacks and challenges they have experienced in interprofessional work (Hobson, 2006b; Miller, 2008; Twyford & Watson, 2008). Magee and Andrews (2007) identified a lack of role understanding as one of the main barriers to music therapy’s inclusion in multidisciplinary neuro-rehabilitation teams. They suggested that little is known about the role of music therapy, as very few multidisciplinary teams have come into contact with music therapists. To explore other professions’ perceptions of music therapy, Magee and Andrews studied patterns of referral to an established music therapy service in a neuro-rehabilitation service in England. Referrals over a two-year period indicated that music therapy was perceived to have a role in addressing communication and emotional needs. Despite research evidence that music therapy can assist with gait training, referral for physical needs occurred less frequently. Speech and language therapists, occupational therapists, and psychologists referred patients to music therapy more frequently than physiotherapists, doctors, and nurses. This study indicated that professionals who were not referring may need further education about the full range of applications of music therapy. Magee and Andrews recommended that music therapists improve communication with key professionals such as doctors, nurses, and physiotherapists, to broaden their contributions to interprofessional teams. They also recommended inclusion in “multidisciplinary team forums” (p. 73) as a way to minimize referrals to music therapy for recreational purposes only.

A study by O’Kelly and Koffman (2007) further indicated a need for increased communication and collaboration between music therapists and other staff. They interviewed twenty multidisciplinary colleagues of music therapists working in five UK hospices, to ascertain their perceptions about music therapy and its integration in palliative care teams. Most interviewees acknowledged multidimensional benefits of music therapy and allied health professionals reported that their own disciplines were enhanced through their work with a music therapist. However, some interviewees showed a lack of understanding of the role of the music therapist, especially nurses. Several nurses expressed fears regarding the emotional
effects of music therapy, or feelings of intimidation related to an expectation that creative ability was required. To raise awareness and increase the acceptance of music therapy services, O’Kelly and Koffman suggested collaborative work, educational workshops, and interventions aimed at improving the palliative care environment.

A study by Darsie (2009) showed that role ambiguity and conflict can occur when a music therapist works as part of an interprofessional team. She surveyed seventeen paediatric oncology and haematology staff prior to and directly following a video in-service on music therapy. Physicians, nurses, psychologists, social workers, child-life specialists, and creative arts therapists indicated the extent to which twenty-five tasks were relevant to music therapy, through the use of a five-point Likert scale. There were significant differences between professional groups in the way that music therapy was perceived. The task of entertainment was scored lower by child-life specialists and creative arts therapists than staff in other professions, indicating that these two professions recognised music therapy’s therapeutic aims more so than others. The task of distraction was scored higher by the nurses than by child-life specialists and creative arts therapists. Darsie explained that child-life specialists may see support and distraction as their role, and that this may be a source of conflict between themselves and music therapists. She recommended that music therapists provide continued education to increase awareness about their role, particularly through video in-servicing. After staff watched a video in-service on music therapy, significantly higher scores were recorded for the tasks of creating developmental assessments, providing support to patients during procedures, and assessing social/emotional needs. Darsie’s findings were similar to those of a previous study by Choi (1997), in which mental health professionals rated the extent to which treatment goals were within a music therapist’s role. Psychologists and social workers recorded significantly lower scores for cognitive goals than for goals in leisure, social and communication, and self-management skills. Choi concluded that psychologists and social workers responded relatively negatively to treatment goals that they regarded to be within their own scope of practice. Additionally, staff who had observed music therapy sessions valued music therapy more than those who had not observed sessions. This study further highlighted the potential for role ambiguity and conflict when a music therapist works in an interprofessional team.
Daykin and Bunt (2006) suggested that changes in cancer care provision have resulted in a lack of clarity around the role of a music therapist. With an increased emphasis on psychosocial care and a rising arts in health movement, a wide range of music practitioners are now working in cancer care in the UK. Music therapists work alongside a diverse group of practitioners, including professional musicians, community musicians, complementary and alternative medicine (CAM) practitioners, and other creative arts therapists. Daykin and Bunt conducted a survey of sixty-seven managers in cancer care organisations and found that “the specific contribution of the professional music therapist is not necessarily well understood” (p. 411). Survey responses revealed that managers did not make clear distinctions between various types of music interventions and used CAM discourses to explain music therapy’s benefits. Daykin and Bunt suggested that the wide variety of music interventions in cancer care may lead to a “complex division of labour” and that music therapists may need to distinguish their specific contribution to cancer care. Although Daykin and Bunt recommended the use of clear distinctions, I wonder whether it is difficult to distinguish the music therapist’s role in practice. Furthermore, other authors have contested the need for clear boundaries between music therapy and other music practices (Ansdell & Pavlicevic, 2008; Hartley, 2008).

Drawing on psychoanalytic theory, Miller (2008) described some of the dynamics and defences that may arise when a music therapist works in an interprofessional mental health team. She highlighted the potential for tension between mental health professionals and the possibility that patients’ emotional and psychological difficulties emerge in interactions between staff. Professional rivalry may occur and staff may have “fantasies and misunderstandings about each other’s role and function” (p. 133). In a setting that has been traditionally medically dominated, team members may be reluctant to draw on music therapy colleagues who are more speculative or emotion-oriented in approach. Music therapists who lead time-boundaried sessions may also be envied, as they are seen to avoid difficult work arising on the ward. Furthermore, Miller emphasized the risk of professional “protectionism”, whereby music therapists develop such strong allegiances to their profession that they are unable to collaborate effectively with other team members. Miller’s study highlights some of the complex interpersonal issues that may arise when a music therapist is introducing music therapy to an interprofessional team. As
our profession becomes better established internationally, music therapists may feel more comfortable in reflecting on the sorts of tensions they have experienced in interprofessional work and the lessons that they may be able to share.

Music therapy and recommendations for interprofessional work.

In recent years, music therapy authors have begun to suggest strategies for successful interprofessional work (Hobson, 2006b; O’Kelly & Koffman, 2007; Twyford & Watson, 2008). Hobson (2006b) made a number of recommendations for ethical and effective interprofessional collaboration, with particular reference to music therapists who work with speech and language pathologists. To minimize “territorialism” (p. 70), Hobson suggested that music therapists identify willing collaborators, prepare to sacrifice some degree of autonomy, avoid dictating responsibilities, lessen their emphasis on professional image, cope with uncertainty, and address practical issues related to collaboration. The importance of consistent and effective communication was also emphasized, as Hobson recommended frequent contact and mutual learning opportunities between music therapists and speech and language pathologists. From an ethical point of view, Hobson recommended that music therapists know their limitations and recognise the strengths of other professionals. She suggested that music therapists familiarize themselves with others’ scope of practice, by consulting the guidance documents of other disciplines.

Twyford and Watson (2008) edited a ground-breaking text on music therapy and interprofessional work, titled Integrated Team Working. These authors presented interprofessional work as a highly valuable way in which music therapists can clarify professional roles and boundaries, convey the importance of their work, gain support, learn from others, and review their own practices. The book included eighteen case studies, in which music therapists collaborated with other health professionals in a range of settings. Most chapters concluded with a list of “good practice guidelines” for collaborative work in the clinical area described. Practical suggestions for music therapists included developing opportunities to share knowledge and learn from other professionals, finding a common language through which to communicate effectively, remaining flexible and willing to work in new ways, pre-empting difficulties and openly discussing role boundaries and anxieties, accepting limitations of music
therapy, acknowledging others’ achievements and expertise, and making time for reflection and supervision. In summarizing core themes of the book, Twyford and Watson indicated that interprofessional work may be particularly important for music therapists who are consolidating their role or working with patients with complex illnesses or disabilities. In reading Twyford and Watson’s text, I wondered whether promoting the benefits of effective interprofessional working may also be helpful for music therapists who are starting new services. As new music therapists often join existing interprofessional teams, there may be some cross-over between the guidelines for interprofessional work and strategies for service development.

**Person-group fit.**

If we are to understand the ways in which music therapists interact with other members of interprofessional teams, further concepts from the field of organizational psychology may be helpful. One concept relates to the degree of compatibility or fit between people and their environments. Several types of person-environment fit have been identified, including person-vocation, person-job, person-organization, person-supervisor, and person-group fit (Kristof-Brown, Zimmerman, & Johnson, 2005). Person-group fit studies have investigated outcomes of compatibility between individuals and their work groups, measured as statistical interactions. Fit on deep-level characteristics such as goals, values, or personality traits has been associated with outcomes such as co-worker and supervisor satisfaction, job satisfaction, group cohesion, contextual performance (co-operation and work towards group goals), and lower intention to quit (Kristof-Brown et al., 2005).

Kristof-Brown et al. (2005) distinguished between two conceptualizations of fit – supplementary and complementary. Supplementary fit refers to a match where the individual and environment are similar. Complementary fit refers to situations where an individual’s characteristics fill a gap in the current environment. It occurs to me that a music therapist could fit into an interprofessional team in either supplementary or complementary ways. A music therapist’s approach could match the approach of the team that they are joining, or could bring new and innovative ways of working to an existing team. In reading about these two types of fit, I wonder whether it is more advantageous for music therapists to emphasize points of
similarity or difference to other team members when starting new posts. This is particularly interesting in light of the tendency for professionals to emphasize their unique contributions.

Hobman, Bordia, and Gallois (2003) examined the influences of different types of perceived dissimilarity on workplace conflict and workgroup involvement. The three types of perceived dissimilarity studied were visible dissimilarity (age, gender, ethnicity), informational dissimilarity (professional background), and value dissimilarity (work motivation for example). Workplace conflict was broken up into two types – relationship and task-related conflict. Work-group involvement referred to the degree of information exchange, collaborative decision-making, and how much an individual feels respected and listened to. Hobman et al.’s survey research found that the more public service employees felt that their values were dissimilar to those of their team, the more likely they were to be involved in relationship and task conflict and the less likely they were to be involved in their work group. It was proposed that value dissimilar members may be excluded deliberately by the group, or may choose to psychologically withdraw from the group themselves. An individual’s perception of the group’s openness to diversity was also identified as an important mediator between perceived dissimilarity and workplace conflict and workgroup involvement. If an individual feels that a workgroup is open to diversity, they may be more likely to contribute to the team and to engage in discussions and constructive conflict. I remember times when I felt dissimilar to other team members in my own work as a music therapist. My natural tendency was to withdraw and to focus on my own work, rather than entering conflict with other team members. I now wonder how other music therapists have managed differences between themselves and other team members.

Summary of interprofessional work.

Interprofessional work is widely promoted in healthcare literature and policy as having benefits for patients, staff, and organizations. Music therapists regularly work with other health professionals and there is evidence that the inclusion of music therapy can enhance the work of interprofessional teams (Hilliard, 2006; Hobson, 2006b; Twyford & Watson, 2008). However, reviewing this literature has indicated
that the role interprofessional work plays in the development of services has only recently become a topic of interest in our profession. Further elaboration of the role and function of interprofessional working in music therapy service development is warranted.

Although interprofessional work may be the preferred approach to healthcare delivery, authors from a range of professional backgrounds have indicated that effective interprofessional collaboration can be difficult to achieve in practice. Previous researchers have observed tensions between interprofessional team members and have highlighted role ambiguity and role blurring as possible barriers to interprofessional work. It is encouraging to see that music therapists are starting to reflect on the challenges of interprofessional work. The ways in which music therapists relate to other professionals and the extent to which these relationships function as a barrier or enabler in service development is of interest. It may be particularly useful to know more about the ways in which music therapists gain power and trust in interprofessional teams.

Healthcare researchers have made many useful suggestions for effective interprofessional work. These include recommendations of flexible approaches, collaborative work, clear articulation of treatment aims, supportive management, and interprofessional education. Results of music therapy studies have further indicated that it may be important for other professionals to observe music therapy sessions, to understand its clinical relevance within their organizations. However, additional exploration of this area is required to determine the types of skills and strategies that new music therapists need.

*Summary of the Literature Review*

This chapter has presented a review of literature in three main thematic areas: 1) organizational change, 2) new healthcare roles, and 3) interprofessional work. Literature from management and other healthcare professions indicates that the introduction of new roles and practices can mark a significant change within an organization. Workers in other healthcare professions have encountered resistance when introducing new roles and experienced role misunderstandings and
competitions with more established professionals. Similar experiences have been recounted by healthcare professionals who work in interprofessional teams. Previous studies have highlighted that a number of complex interpersonal issues may arise when different health professionals work together and proposed strategies for effective interprofessional work. These include increasing role understanding and improving interprofessional communication.

Music therapists have started to reflect on the ways in which they have successfully developed new programmes and worked in interprofessional teams. However, we know comparatively little about the ways in which music therapists introduce a new role to an established healthcare team and the barriers that music therapists experience in developing new work. There is an urgent need for further exploration of the experiences of music therapists in engaging with the complexities and challenges of service development.

I hope that the research I have conducted will go a way toward elaborating some of the gaps in our understanding of service development and respond to some of the questions that this literature review has raised. In the next chapter the methodological considerations for the research I conducted are presented, before my methods of research are described.
Chapter Three

Research Paradigm and Methodology

As stated in the introduction, this research aimed to explore the contribution of qualitative research approaches to an understanding of music therapists’ experiences of service development work. Qualitative research literature was consulted to explore the relevant ontology, epistemology, and methodology of various possible approaches and to inform the choice of methods for the study. The key themes that emerged as relevant from this critical reading are summarised in this chapter, which also includes a justification of the choice to place my approach within the reference frameworks of constructivism, narrative inquiry, and ethnography. As arts-based and reflexive strategies became increasingly important and useful in the research process, these methodological aspects are also introduced and described in this section.

Choosing a Research Paradigm: Constructivism

In their first *Handbook of Qualitative Research*, Guba and Lincoln (1994) emphasized the need for a researcher to be clear about the paradigm that guides his or her approach. In this early writing, they defined a paradigm as “a basic belief or worldview” (p. 105) that informs the inquirer’s thinking and decision-making. They presented four major research paradigms that were outlined according to proponents’ responses to questions of ontology (what is the nature of reality?), epistemology (what is the relationship between the inquirer and the known?), and methodology (what is the best means for acquiring knowledge?) (Guba & Lincoln, 1994; Guba & Lincoln, 2005). These paradigms are positivism, postpositivism, critical theory, and constructivism (Guba & Lincoln, 1994). ²

When reading about these major research paradigms, I felt most drawn to the constructivist research paradigm. The constructivist paradigm emerged as a

² In more recent editions of the handbook, Guba & Lincoln have added a fifth major research paradigm: participatory action frameworks. Furthermore, they have acknowledged that the borders between paradigms are becoming increasingly blurred (Guba & Lincoln, 2005).
breakaway from the realist assumptions of the positivist tradition (Guba & Lincoln, 1994; Schwandt, 1994). Constructivists argue that there is no ultimate objective truth, instead “reality is a social, and, therefore, multiple, construction” (Lincoln, 1990, p. 77). Human beings make sense of the world according to their experiences and the specific contexts within which they are living. Knowledge is not discovered, but created. Constructions change over time and are dependent on the person or group who is creating meaning. There is no one “true” way of understanding the world and multiple versions of reality are possible (Guba & Lincoln, 1994; Schwandt, 1994). As I was planning to study issues in music therapy service development from the present-day perspectives of music therapists, I considered that a constructivist paradigm would be highly appropriate. I planned to learn more about music therapists’ experiences as they reported them and while I hoped my findings would be useful and relevant for music therapists, I did not expect to unearth truths or facts about music therapy service development that could serve as a blueprint or map for others’ decisions.

**Constructivism in health care research.**

As the topic of this thesis concerns research into music therapy service development in healthcare, a relevant starting point for examining constructivist principles was within existing healthcare research that claimed this orientation. There is a growing interest in and acceptance of constructivism within healthcare research (Kuper, Reeves, & Levinson, 2008). Research within a constructivist paradigm has led to a greater understanding of clinical issues and contexts, through gaining the multiple perspectives of various people involved in and affected by healthcare (for recent examples see Garrett, Dickson, Young, Whelan, & Forero, 2008; Wilson & Davies, 2009). Healthcare researchers now recognise that constructivist research can lead to a “more comprehensive understanding of many aspects of the healthcare system” (Kuper, Reeves, & Levinson, 2008, p. 406). It is likely that constructivist research has become more commonplace as the ways in which healthcare is conceptualized and delivered have changed (see p. 64).

The development of music therapy research reflects the development of research in related disciplines (Wheeler, 2005b; Wheeler & Kenny, 2005). While
positivist and postpositivist paradigms prevailed in early music therapy research, several authors have referred to an expansion in music therapy research approaches over the past fifteen years (Edwards, 2005b; O’Callaghan, 1996; Wheeler, 2005b; Wheeler & Kenny, 2005). Although early discussions concentrated on the growing utilization of qualitative methods, there is now greater consideration of the beliefs underpinning them (Bruscia, 1998; Edwards, 1999, 2005b; O’Callaghan, 1996). O’Callaghan and McDermott (2004) explicitly described the use of a constructivist lens in researching music therapy. They explored the relevance of music therapy in a cancer hospital through multiple perspectives, including the perspectives of patients who participated in music therapy, patients who overheard or witnessed music therapy, visitors, staff, and the music therapist-researcher herself. The exploration of participants’ subjective meanings was thought to broaden conceptualisations around the benefits of music therapy for people in this setting. On reading this study, I began to anticipate that a constructivist lens could be applicable in my exploration of music therapists’ experiences of service development.

**Developing a constructivist approach.**

In constructivism, the aim of inquiry is the “understanding and reconstruction” (Guba & Lincoln, 1994, p. 113) of the constructions people hold. Proponents are primarily concerned with people’s experiences and perceptions of their circumstances and situations (Schwandt, 1994). The aim of my research seemed to correspond with this aspect of constructivism. My hope was to further understand and document music therapists’ service development experiences. I was curious to learn more about music therapists’ perceptions of the situations they’d encountered when introducing new services. It was not my intention to prove that their perceptions were correct, nor was I expecting to generalise participants’ experiences to the music therapy community as a whole.

My developing research also seemed to fit within the transactional and subjectivist epistemological foundations of constructivism. In constructivism, the researcher is not expected to be an independent objective observer, but is thought to interact with the object of study (Guba & Lincoln, 1994; Schwandt, 1994). The research findings are seen as a co-creation between the researcher and the participants.
in the study. Values are not something to be removed from the research (as in positivist and postpositivist paradigms), but instead take “pride of place” (Guba & Lincoln, 1994 p. 114). Researchers are encouraged to explore their own backgrounds and assumptions and to consider how their values shape research outcomes (Guba & Lincoln, 1994). This appealed to me as a way to reflect on my own experiences of service development and as a way to elicit and reflect upon the experiences of others.

As a music therapist who was experienced in developing services, I couldn’t help but be actively engaged in my research. I knew that I would be entering the research with certain assumptions and that it would be necessary to examine my values as the research unfolded. Rather than attempting to exclude myself from the research, I wondered whether my perceptions and experiences could contribute additional data for deepening and reflecting on the findings and observations. Furthermore, my intended research participants were my music therapy colleagues. The idea of co-creating findings together was highly attractive to me.

Studies within a constructivist paradigm begin by eliciting constructions from participants. These constructions are refined, juxtaposed, reinterpreted, and represented as a “consensus construction that is more informed and sophisticated than any of the predecessor constructions” (Guba & Lincoln, 1994, p. 111). Careful attention is paid to details, to complexities, and to contextual information (Schwandt, 1994). Instead of focusing on verification or falsification of a hypothesis, studies within a constructivist paradigm work towards building a joint construction that fits the data and furthers understanding (Guba & Lincoln, 1994; Schwandt, 1994). The research unfolds through “negotiations” and “dialogue” (Guba & Lincoln, 2005, p. 204), rather than following a set of predefined procedures.

In previous research projects, I had tested hypotheses using quantitative measurement tools and statistical procedures. I felt comfortable and expert in applying these procedures to research questions. As I read more about constructivism, I realised that I may need to leave the safety net of these previous research approaches. My methods were likely to evolve over time, in response to my data and my emerging ideas. I realised that my doctoral research had the potential to be more dynamic, open-ended, and complicated than my previous research.
anticipated that there could be times when I would be unsure of myself and of which way to turn. I considered it likely that these aspects of constructivist research would be challenging, but I felt ready to test myself and to broaden my research skills. I resolved to continue developing a constructivist framework for my research and moved on to explore some possible methodological approaches.

Narrative Inquiry

As my interest in constructivist research approaches grew, I came across the rich, interdisciplinary tradition of narrative inquiry. In narrative inquiry, researchers use personal accounts or stories to further their understanding of a phenomenon (Greenhalgh & Wengraf, 2008; Polkinghorne, 1995). Commentators on narrative inquiry commonly report that narratives provide researchers with a means of exploring people’s subjective meanings and gaining otherwise unaccessible insights. However, there is substantial disagreement as to what constitutes narrative inquiry and narrative researchers have used a wide range of methods and analytic approaches. Even the very meaning of the word “narrative” has been contested. I will explore some of the diverse applications of narrative inquiry in the following section and expose how this methodology is open to further innovation.

Terminology: Defining narrative

As I read about narrative inquiry, I learned that the term “narrative” has been described and defined in diverse ways. The music therapist Carolyn Kenny (2005) stated that “Story is the simplest and most direct way to define a narrative” (p. 416). However, other writers have differentiated between the terms “story” and “narrative”. For example, literary critics and theorists view “narrative” as comprising both story and narrative discourse. The story is the content, conveyed through narrative discourse (Paley, 1995). The term “narrative” has also been used to describe a wide variety of linguistic expressions, ranging from everyday prosaic discourse to a full story of a person’s entire life (Chase, 2008; Polkinghorne, 1995). As the meaning of “narrative” may be open to interpretation, I wondered whether I should be cautious about my choice of terminology in this thesis.
I looked to further descriptions to enhance my understanding of narrative. Paley (2009) located “narrative” and “story” on a continuum of “narrativity” (p. 18). Every item on the continuum can be classified as “narrative” but only items at one end can be called “stories”. At the low end of narrativity are simple narratives that recount one or more events. To be called a “story” (at the high end of narrativity), a narrative must have several additional features. First, some events must be regarded as consequences of others. Second, stories usually have a central character, a protagonist who is critically involved in the recounted events. Another crucial feature is the tailoring of a story to produce a specific outcome. Stories also tend to have an emotional character, they are told to entertain, to scare, to convince, to impress, to attract sympathy, or to instil hope (Gunaratnam & Oliviere, 2009; Paley, 2009). Paley’s classification suggests that a “story” is a specific type of narrative that is especially emotive or moving.

Within healthcare literature, the terms “story” and “narrative” have often been used synonymously (Bingley, Thomas, Brown, Reeve, & Payne, 2008; Greenhalgh & Wengraf, 2008; Paley, 2009). Gunaratnam and Oliviere (2009) suggested that the term “narrative” is favoured by healthcare academics, while practitioners refer to “stories” and “storytelling”. To remain relevant to both music therapy academics and clinicians, I have decided to use “narrative” and “story” interchangeably in this section. The term “narrative” will also be used broadly, to denote a wide range of approaches, to refer to various spoken and written media, and to encompass stories both “big” and “small” (Squire, Andrews, & Tamboukou, 2008).

**Narratives in everyday life.**

In promoting a role for narrative inquiry, many narrative researchers and commentators have referred to the “ubiquity” of stories in our everyday lives (Bingley et al., 2008; Bury, 2001; Greenhalgh & Wengraf, 2008; Polkinghorne, 2007). Some of our earliest memories are of the stories we were told as children (Pennebaker & Seagal, 1999). In early childhood, stories teach us lessons about how to live “right” (Frank, 2009, p. 170-172). As we grow older, we continue to use stories to communicate our experiences and to make sense of them (Bingley et al., 2008; Polkinghorne, 1995).
Authors such as Hurwitz (2004) and Polkinghorne (1995) have further elaborated on the role of stories in our lives. They have proposed that it is through stories that we evaluate the significance of particular encounters and ascribe meaning to events. Stories may help us to organize and understand our experiences, as they “progress to a solution, clarification, or unraveling of an incomplete situation” (Polkinghorne, 1995, p. 7). By the means of a plot, we can mark the beginning and end of a story, select the relevant events to be included, order events in an unfolding movement towards a conclusion, and clarify the meaning of events in the story as a whole (Paley, 2009; Polkinghorne, 1995). Through the formation of a story, we can retrospectively evaluate relationships among life events and choices (Polkinghorne, 1995).

Other authors have proposed that we not only tell stories, but also “live out” our stories (Carr, Loeser, & Morris, 2005, p. 4). Through stories, it is possible for us to claim identities and to reveal the people we want to be (Frank, 2009; Paley, 2009; Patterson, 2008). Several authors have observed that stories are particularly useful at times of life transition or change, when we work to develop new identities or to incorporate new experiences into our existing perceptions of self (Bingley et al. 2008; Frank, 2009; Matos, Santos, Gonçalves, & Martins, 2009; Wright, 2009). This observation suggests that stories may be an important resource for communicating and understanding our identities.

Ricoeur (1984) drew special attention to the temporal aspects of stories, proposing that the process of emplotment mediates between two temporal dimensions, “one chronological, and the other not” (p. 66). On the one hand, stories are episodic, they tend to be made up of a series of successive events (something happens then something else happens). At the same time, stories are a “grasping together” of different events into a temporal whole (p. 66). The entire plot can be translated into one meaningful “thought”, “point”, or “theme” (p. 67).

Narrative researchers and commentators do not consider stories to be true, objective accounts of past events, but instead regard them as reconstructions shaped by our feelings, perceptions, and experiences (Polkinghorne, 1995). Our stories are
considered to contain both our current perspectives and practices and the perspectives and practices we held at earlier moments in our lives (Wengraf, 2009). Stories have been noted to change over time, with variations in memory, perspectives, and the situations within which they are told. When we construct a story, we may omit elements, or change the time sequence or pace of events (Hurwitz, 2004; Polkinghorne, 1995). On reading about these aspects of stories, I reflected that the act of story construction involves a series of personal choices. In telling a story, people choose to include elements which they consider to be most significant at that particular time and place. It therefore makes sense that researchers have used narrative to gain an understanding of people’s subjective meanings and experiences.

*History of narrative inquiry as an approach to discovery.*

Narrative research is now used in many fields including psychology, education, history, philosophy, literary theory, and the performing arts (Connelly & Clandinin, 1990; Kenny, 2005). Approaches to narrative vary according to the interests and theoretical assumptions of researchers within their respective disciplines (Chase, 2008; Squire et al., 2008). However, all share an interest in “biographical particulars as narrated by the one who lives them” (Chase, 2008, p. 58).

The use of narrative in research has a diverse history (Chase, 2008; Kenny, 2005; Squire et al., 2008). Many different disciplines have contributed to the development of contemporary narrative research and various theoretical antecedents have been identified (Kenny, 2005; Squire et al., 2008). Four important early influences are now briefly included, to provide an historical overview. These early influences are: 1) anthropology, 2) the Chicago School, 3) second wave feminism, and 4) sociolinguistics.

Many academic writers associate the rise of narrative research with the emergence of the academic discipline of anthropology (Chase, 2008; Kenny, 2005). In the early 20th century, anthropologists undertook fieldwork in cultures different to their own, often where there was a strong tradition of oral lore. These researchers recorded stories of their observations and experiences by way of field notes (Kenny, 2005). Stories were also collected from people assumed to be representative of the
community or culture being studied (Chase, 2008). These stories were translated and interpreted to further understand how community members viewed the world, themselves, and others (Kenny, 2005).

Around the same time, sociologists at the Chicago school were collecting individual life stories from people closer to their own geographical location. These groups included participants described as immigrants, juvenile delinquents, and criminal offenders (Chase, 2008). These researchers were primarily interested in the interactions between an individual and his or her sociocultural environment (Chase, 2008). Thomas and Znaniecki (1927, cited in Chase, 2008) explained their interest in life stories as such:

A social institution can be fully understood only if we do not limit ourselves to the abstract study of its formal organization, but analyze the way in which it appears in the personal experience of various members of the group and follow the influence which it has upon their lives. (p. 60)

Sociologists at the Chicago school have since turned their attention to developing other innovative methodologies such as demography and survey analysis (University of Chicago, 2010). However, an interest in narrative remains current. Over the past eighty years, there has also been an expansion in the range of topics studied by sociologists at the Chicago school. Researchers have broadened their interests to include studies in areas such as the sociology of health and medicine and the study of organizations and social networks (University of Chicago, 2010).

The second wave of feminism is also cited as an important influence on the development of narrative research (Chase, 2008). During the 1970s and 80s, feminist researchers studied women’s experiences as recorded in journals and autobiographies, casting doubt on prior social science knowledge and giving voices to women who were not heard in the past (Chase, 2008). Furthermore, these researchers challenged conventional research practices, as they regarded women as subjects rather than objects of research and as “social actors in their own right” (Chase, 2008, p. 62). Feminist research intensified interest in people’s subjective meanings and drew

3 For a recent example of a Chicago school study which used personal narratives, see James, 2010.
attention to the ways in which researchers’ backgrounds and assumptions can shape their research (Chase, 2008; Hadley, 2006; Squire et al., 2008).

Another early form of narrative research was the work of sociolinguists in the 1960s. Labov and Waletzky (1967/1997) argued that people’s everyday spoken narratives are a specific form of discourse serving identifiable social functions. Their analysis of individual and focus group interviews yielded specific structural and sociolinguistic features of spoken narratives, features which contemporary narrative researchers still refer to today (Chase, 2008; Elliot, 2005). The work of Labov and Waletzky has given rise to further exploration into ways in which people narrate their experiences. Labov and Waletzky’s structural understanding of narrative is explained in more detail in the section on narrative research methods (see pp. 74-75).

Over the years, researchers have identified many advantages to using narrative in research. Firstly, narratives may be easily accessible, as people readily tell stories in their everyday lives (Greenhalgh & Wengraf, 2008; Gunaratnam & Oliviere, 2009; Polkinghorne, 1995). Through narratives it may be possible to learn more about people’s actions and the meanings and motivations behind them (Polkinghorne, 1995). Narratives can also be rich, multi-layered, and complex (Bingley et al., 2008; Squire et al., 2008). As they draw together diverse events, narratives retain the complexity of everyday situations and can reveal complicated relationships between people and their circumstances (Polkinghorne, 1995; Gunaratnam & Oliviere, 2009). In addition, narratives may give voice to the marginalized, controversial, or disruptive perspectives that have been “lost in more traditional research methodologies” (Estrella & Forinash, 2007, p. 376).

*Narratives and healthcare.*

Previous authors have suggested that an interest in narrative has arisen alongside changes in the ways in which healthcare is understood and delivered (Greenhalgh & Wengraf, 2008; Kumagai, Murphy, & Ross, 2009). Writers have proposed that shifts in focus from treatment and cure towards management, holistic approaches, and patient-centred care have led to a growing interest in patients’ individual and subjective experiences of illness and healthcare (Bury, 2001; Kumagai
et al., 2009). Health researchers now pay greater attention to the role of biographical factors in a person’s experience of illness (Stamm et al., 2008) and frequently collect what have been termed “illness narratives”, in an attempt to understand the meanings patients ascribe to their experiences (Bingley et al., 2008; Bury, 2001). Recent narrative research studies have reported new insights about people’s experiences of living and coping with illnesses such as cancer (Sinding & Wiernikowski, 2008), motor neurone disease (Brown & Addington-Hall, 2008), and rheumatoid arthritis (Stamm et al., 2008).

It has been argued that narratives hold a special relevance in healthcare, when people are experiencing losses and “biographical disruptions” (Bingley et al., 2008; Bury, 2001; Gunaratnam & Oliviere, 2009). For patients, telling one’s story may be a means of making sense of illness and integrating symptoms into a new sense of self (Bingley et al., 2008; Carllick & Biley, 2004; Gunaratnam & Oliviere, 2009). The sociologist Frank (2009) outlined six benefits of storytelling for people who are ill: 1) stories give shape and direction to seemingly incomprehensible events, 2) stories offer distance and choice with regard to self, 3) stories help to express painful emotions, 4) stories help people regain a sense of personal agency and responsibility, 5) stories can be witnessed, connecting people who are ill with others, and 6) stories help people to express aspects of their bodies which are inexpressible and “mysterious” (p. 167). Within pain and palliative care fields especially, clinicians are encouraged to support patients in the construction of stories (Carr et al., 2005; Frank, 2009; Gunaratnam & Oliviere, 2009). In reviewing this literature, I began to consider how stories can serve an important function when people perceive that they have little power to influence a situation. Perhaps story construction is valued in pain and palliative care treatment, because it remains a creative possibility when other actions appear futile.

The value of narrative in shaping people’s lives is central to narrative approaches to counseling and psychotherapy (Cashin, 2008; O’Connor, Davis, Meakes, Pickering, & Schuman, 2004; Matos et al., 2009). In approaches such as White and Epston’s (1990) model of Narrative Therapy, clients examine and edit their life stories. The underlying premise is that dominant, problem-saturated narratives can constrain people from seeing “alternative ways of acting, feeling,
thinking, or relating” (Matos et al., 2009, p. 68). Narrative therapists therefore help clients to adapt through co-constructing new alternate stories (Matos et al., 2009; O’Connor et al., 2004). A primary task of narrative therapy is to identify discrepancies in a story or moments when a problem didn’t exist. A new alternative plot is then built around these moments and consolidated through conversation, rituals, and/or letter writing. Narrative therapists believe that through being proactive and re-conceptualising themselves, people can lessen their experience of problems (Matos et al., 2009; O’Connor et al., 2004).

In the past twenty years, many studies have indicated that writing a narrative may be beneficial for people’s health and well-being (Bolton, 2009; Slatcher & Pennebaker, 2006; Pennebaker & Seagal, 1999; Wright, 2009). When people have written about their emotional experiences, changes in physiological parameters, self-reported mood, and interpersonal communication have been detected (Bolton, 2009; Slatcher & Pennebaker, 1997; Pennebaker & Seagal, 1999). The practice of therapeutic writing has been likened to expressing one’s self in creative arts therapies, (Pennebaker & Seagal, 1999; Wright, 2009), as writers have experienced control and pride during the creative process (Bolton, 2009). Furthermore, writing in private may eliminate the feelings of shame that some experience when telling someone a story face to face (Wright, 2005; 2009). A written story can be un-said, said in different ways, shared, left unread, or destroyed (Bolton, 2009). These studies suggest that a story is told differently depending on whether it is written or spoken. The mode of storytelling may therefore be an important issue to consider when a researcher is designing a narrative inquiry.

A further use of narrative in healthcare is in the education of health professionals and in quality improvement initiatives (Greenhalgh & Wengraf, 2008; Gunaratnam & Oliviere, 2009; Kumagai et al., 2009). For example, Kumagai et al. (2009) investigated the impact of teaching medical students using stories from people living with diabetes. Interviews with students indicated that exposure to first-person narratives led to more compassion and contributed to the capacity for reflective practice. Kumagai et al. proposed that stories are emotionally poignant and “put a human face” (p. 319) on illnesses and procedures. This study highlights the evocative
nature of stories, which narrative researchers have often pointed to when promoting a role for narrative inquiry (see p. 60).

Narrative research studies are particularly common in the field of nursing. These studies have extended and enhanced understanding of concerns, tensions, and challenges experienced by nurses and nursing students (Carney, 2009; O’Brien & Jackson, 2007; Sochan & Singh, 2007; Stott, 2007). Through collecting and analyzing narratives, researchers have uncovered ways in which nurses have developed skills for work within remote communities (O’Brien & Jackson, 2007) and when implementing new roles and responsibilities (Carney, 2009; Christensen, 2009). Through narrative descriptions, nurses have also shared perceptions of their interactions within healthcare teams and organizations (Carney, 2009; Lindsay, 2008). In thinking about the frequency of the use of narrative in nursing research, it occurs to me that narrative may appeal to nurses as a way in which they can gain a voice. When searching for literature related to my research topic, I came across several studies in which nurses recounted feelings of marginalisation or disempowerment (for examples see Miller et al., 2008; Wynne, 2004). As feelings of isolation are reported in music therapy literature (Lehmann & Threlfall, 2008; Miles, 2007), I wondered whether I could use a narrative inquiry to give voice to the perspectives of music therapists.

Narratives and music therapy.

As I searched music therapy literature for examples of narrative inquiry, it occurred to me that music therapists may be drawn to stories. Many music therapists use narrative form when communicating their work to others, arguing that narratives best capture what happens in music therapy sessions (Kenny, 2005; Loewy, 2000; McFerran & Wigram, 2005). The music therapy literature is filled with case examples, histories, and vignettes, stories of music therapy work with specific clients or client groups (Baker, 2009; Smeijsters & Aasgaard, 2005). Several methods of improvisational analysis involve the generation of narratives, to describe the dynamics of a therapy group (McFerran & Wigram, 2005), to represent the rich complexities of participants’ musical experiences (Arnason, 2002), or to further understand musical and clinical processes in individual therapy (Lee, 2000).
(2007) emphasized that both music and narrative express thoughts, feelings, emotions and meanings. Movement between music and narrative is perceived to result in a more holistic understanding of music therapy work than each element on its own. This frequent use of narrative form suggests that narratives may communicate aspects of music therapy that can not be communicated otherwise. In this section I will show some of the ways that music therapy authors have used narrative.

An affinity with narrative is particularly apparent in the work of Guided Imagery and Music (GIM) practitioners (Kenny, 2005). Inspired by Ricoeur’s theories on metaphor and narrative, Bonde (2005) demonstrated how narrative episodes or complete narratives may be configured by clients during GIM music listening. Narrative genres such as the fairy tale or the hero’s journey may emerge when a client reports imagery in and across GIM sessions. Bonde described a case in which narratives served as a resource for a client in terms of understanding herself and developing new coping strategies.

Narratives also appear when music therapists evaluate services. Shoemark (2009) collected narratives from participants in an arts and health collaboration between the Melbourne Symphony Orchestra and the music therapy team at the Royal Children’s Hospital in Melbourne. After live music sessions on a neonatal ward, all members of the project team (orchestral musicians, music therapists, and a nurse gatekeeper) wrote narratives about their personal experiences. Discussions between the musicians and music therapists were also documented, audio-recorded, and transcribed. Key statements from the narratives and discussions were selected, grouped, reviewed by the project team, and re-organised to form final themes. The final themes were developed into a set of guidelines for musicians who play music in hospitals. Team members’ narratives challenged previous notions of what constitutes “appropriate music” in a neonatal ward and gave insights as to the needs of the musicians involved.

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Guided Imagery and Music (GIM) is a method developed by Helen Bonny, in which classical music and relaxation techniques are used to elicit and support a non-directed spontaneous imagery process. Clients report their inner experiences, which are followed and supported by a facilitator. GIM is practiced primarily in psychotherapy and counselling settings to offer people opportunities to achieve well-being (Association for Music & Imagery, 2010).
A narrative “turn” is evident in contemporary writing about music therapy. In recent years, music therapists have increasingly written in the first person, rather than the more distant third person form (Amir, 2005). Amir suggested that writing as *I* or *me*, “invites the reader into the room”, makes the situation seem more real, enables a better understanding of a client’s experiences, and reveals the author’s viewpoint and identity. The creation of the peer reviewed journal *Voices* (www.voices.no) has provided a space where music therapists can experiment with narrative form. Through this online resource, music therapists regularly share stories of their personal and professional journeys (for examples see Dun, 2007; Gilbertson, 2008; Lee, 2008). The use of narrative form has enabled authors to explore new perspectives and to reflect on their practice and development as music therapists. Additionally, some music therapists have published articles that recount their experiences of professional work and organizational contexts (Edwards, 2005a; Loey, 2001).

As in other healthcare research, the use of narratives in music therapy has emerged alongside a developing interest in clients’ experiences. In 1999, Hibben published an edited book containing thirty-three narratives of clients’ experiences of music therapy. Through collecting narratives, Hibben aimed to honour the multiple meanings that exist in the therapy room and to give greater voice to clients. Narratives were provided by clients or parents, inferred by therapists, or gathered as part of qualitative research studies. In some cases, the creation of a narrative became a valuable part of the therapy process. For many authors, the process of writing a story “produced otherwise unavailable insights” (p. xxi) about music therapy work. For readers, the narratives offer an “accessible and ‘human’ exploration of what music therapy is about” (Jackson, 2005, p. 166).

In reviewing this literature, I noted the consistent promotion of narrative approaches by Carolyn Kenny in particular. Personal and cultural stories appear throughout her writings on music therapy and indigenous studies, brought together in the anthology *Music and life in the field of play* (2006). In a landmark piece on narrative inquiry, Kenny (2005) outlined historical and theoretical foundations of narrative inquiry, described two categories of narrative methods, and provided seven examples of the use of narrative inquiry in music therapy. Kenny presented narrative
inquiry as a legitimate way for music therapists to examine their practices and to convey elements of their work “that would be lost without a story” (2005, p. 416).

*Narrative inquiry and music therapy.*

Although narrative inquiry is now regarded as a possible research method in music therapy, very few music therapy researchers have specifically described their research as “narrative” in approach. Only a few recent examples exist. Music therapy researchers have used the term “narrative” when referring to material gained through interviews with participants or caregivers (Magee, 2007; Magill, 2009). In these studies, narrative accounts have been thematically analysed using procedures such as modified grounded theory (Magee, 2007). Thematic analyses have revealed additional information about the meanings of music to the people who have participated in music therapy (Magee, 2007; Magill, 2009).

Narrative inquiry has also been undertaken when music therapists reflect on their practices and perspectives (Kenny, 2005). For example, Shoemark and Dean (2008) drew on their practice wisdom and personal experience to write narratives about family centred music therapy work with hospitalised infants. These narratives were framed into categories and then major themes, which were later validated by a colleague. Major themes were presented in the form of a journal article, interspersed with the story of an infant and her family. Through the use of narrative form, new insights about the complexities of family centred work were uncovered.

Aasgard (2002) used narrative form to present the findings of his naturalistic inquiry into songs created by children with cancer in music therapy. Data from a range of sources was used to construct the “life histories” of nineteen songs, from the first introduction of song-writing through to later performances of the song. Each life history was presented in a four-column table, including contextual information, accounts of song-related events, as well as commentaries from the music therapist and significant people involved. Three major themes were constructed from the life histories and indicated that the creation and performance of songs had added new elements of health to the lives of the children involved.
An unmistakable example of a narrative inquiry is Hadley’s (2003) exploration of the life and work of music therapy pioneer Clive Robbins. Both the process and the presentation of the research involved the use of narratives. Hadley met with Clive Robbins five times to obtain an oral account of his life. Interview material was transcribed and developed into a chronological story. Clive Robbins was seen as a co-creator and provided feedback on the developing story. The analysis involved identifying themes in Clive Robbins’ life that related to thematic elements in Creative Music Therapy (as identified in significant texts). Through narrative inquiry, Hadley gained a different understanding of Creative Music Therapy and came to reflect more on her own practice as a music therapist.

This brief overview demonstrates the awareness and use of narrative approaches within music therapy research. These examples point to the value of adopting narrative inquiry as a means to gain new insights and understandings about music therapy service development in healthcare.

Summary on narratives and music therapy.

Music therapists have frequently used narratives to communicate a wide range of messages about music therapy work. Narratives may be appealing to music therapists, as they describe aspects which are hard to express, enable reflection, give voice to different perspectives, and reveal insights that would not have been possible otherwise. These benefits may be particularly valuable to members of a profession that is somewhat difficult to describe and define (Barrington, 2008).

Although narratives appear frequently in the writings of music therapists, very few full-scale research studies could be classified as “narrative” in approach. Among the few narrative research studies that exist, the most common approach has been to collect stories from patients, family members, music therapists, and staff. These stories have been analysed through coding or thematic analysis to further understand people’s experiences of music therapy work. There is still great scope in music therapy research to explore the full range of possibilities that are available within narrative inquiry.
Narrative research methods.

Researchers in the narrative tradition assert that there are no standard rules as to how to conduct narrative research (Chase, 2008; Elliot, 2005; Squire et al., 2008). However, differences as to how such research should be conducted or what is legitimate in narrative research are common. Researchers have employed a wide range of methods, depending on such factors as the culture under study, the focus of the research, and the researcher’s individual understanding of “narrative” (Chase, 2008; Elliot, 2005; Polkinghorne, 1995). This section outlines some of the various methods that have been adopted by researchers with an interest in narrative.

Polkinghorne (1995) has distinguished between two types of narrative inquiry, each involving a different type of cognition. These are paradigmatic-type and narrative-type narrative inquiries. In paradigmatic-type narrative inquiries, the researcher gathers stories as data and employs analytic procedures to produce taxonomies or categories out of common elements across the stories. Interviews and coding procedures such as Grounded Theory (Strauss & Corbin, 1990) are frequently used in this type of inquiry. Most of the research studies in music therapy that have a narrative orientation fit within this type of inquiry (Magee, 2007; Shoemark, 2009).

In narrative-type narrative analysis, the researcher gathers events and happenings as data. The data is not usually collected in storied form, most often it comes from sources such as interviews, journals, documents, or observations. The task of the researcher is to create an explanatory story that brings order and new meaning to the data. In other words, the process of narrative-type narrative analysis involves synthesizing features of the data rather than separating the data into its constituent parts. Hadley’s (2003) study of the life of Clive Robbins could be viewed as an example of a narrative-type narrative analysis in music therapy.

Elliot (2005) categorized approaches to narrative research in a different way to Polkinghorne. She referred to three different types of narrative analysis – those that focus on content, those that focus on form, and those that focus on social context. The first type of analysis focuses on what the content of a person’s story reveals about the person’s point of view, the person’s social and cultural situations, and/or the
sequence of the person’s experiences. The emphasis in this type of analysis is on understanding individual narratives as a whole. Individual narratives may be compared to one another and checked for any commonalities. A researcher may also seek to understand what the content of an individual narrative reveals about the person’s broader social world. Content approaches are commonly used by psychologists and sociologists who collect and examine life histories (Chase, 2008; Elliot, 2005).

Researchers who undertake analyses that focus on form are interested in aspects of a story such as its structure, its genre, the development of the plot over time, or the narrator’s coherence system (discursive practices shared by members of a specific culture). Close inspection of these formal aspects may give rise to further valuable information about the meanings people ascribe to situations. The identification of narrative genres or storylines is a common approach used by healthcare researchers when attempting to understand how patients experience illness (Bingley et al., 2008; Brown & Addington-Hall, 2008). In the stories they collect, researchers may recognise established literary genres, such as the tragedy, comedy, or epic, or identify genres specific to the group of people being studied (Bingley et al., 2008; Brown & Addington-Hall, 2008; Elliot, 2005). An awareness of genre has been reported to be highly revealing in terms of patients’ views of themselves and their situations, as well as their strategies for coping (Brown & Addington-Hall, 2008; Frank, 2009).

Elliot’s third category of narrative analysis focuses on the performative or social dimension of narratives. This type of analysis may be undertaken when a researcher wishes to explore the ways in which people tell their stories in certain situations (e.g. around the family dinner table, at work), or the social role that stories play in people’s lives. Socio-linguists and sociologists frequently use this type of approach to further understand people’s everyday narrative practices (Chase, 2008; Elliot, 2005).

While categorization helps to elucidate the wide variety of approaches available to a narrative researcher, any classification of narrative research methods represents “something of an oversimplification” (Elliot, 2005). Researchers often
have more than one focus and narrative inquiry remains a “field in the making” (Chase, 2008, p. 58). In the process of working with narratives, a researcher may draw on a number of different approaches and explore new analytic techniques (Chase, 2008; Elliot, 2005). The three narrative approaches that most informed my research will be outlined in the remainder of this section. These include Labov and Waletzky’s (1967) structural model of analysis, Wengraf’s (2001) Biographic Narrative Interpretive Method (BNIM), and Polkinghorne’s (1995) narrative-type narrative analysis.

One of the most widely used methodological approaches to narrative is Labov and Waletzky’s (1967/1997) structural model of analysis. In this model, narrative is understood first and foremost as text and the focus is on identifying a narrative’s structural components. First, narrative text is broken down into a series of numbered clauses. Then, each clause is assigned a label according to its function in the narrative. Here the researcher chooses from six structural components: abstract, orientation, complicating action, resolution, evaluation, and coda (see Table 2). Highlighting the evaluation components of a narrative may be particularly informative, as these reveal the narrator’s perspective and “make the point or purpose of the story clear” (Elliot, 2005, p. 43).

Although Labov and Waletzky’s model is widely used, researchers have described limitations when applying this approach (Elliot, 2005; Patterson, 2008). One of the emergent criticisms is that research participants do not necessarily provide strictly chronological accounts. It is not always possible to identify an ordered sequence of event clauses in people’s interview transcripts (Elliot, 2005; Patterson, 2008). Riessman (1993) claimed that the model is inadequate for capturing subjective experiences and present and persistent states of being. Patterson (2008) stated that the model tends to “decontextualize narratives” (p. 35), as it does not address the textual and interactional contexts in which narratives are produced. Another criticism is that the model suggests that a “good” narrative is one that fits neatly within the structure of six elements and that those who tell differently constructed narratives are “less than competent” (Patterson, 2008, p. 31). For these reasons, it has been proposed that Labov and Waletzky’s model may best serve as a
starting point, as a source of linguistic terminology, or for analyzing short narrative segments of an interview transcript (Elliot, 2005; Patterson, 2008).

Table 2

*Labov & Waletzky’s Six Structural Components and their Functions*

<table>
<thead>
<tr>
<th>Label</th>
<th>Component</th>
<th>Function</th>
<th>Question answered</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Abstract</td>
<td>Summary of the subject matter</td>
<td>What is the story about?</td>
</tr>
<tr>
<td>O</td>
<td>Orientation</td>
<td>Information about the setting</td>
<td>Who, when, where?</td>
</tr>
<tr>
<td>Ca</td>
<td>Complicating Action</td>
<td>Chronology of events</td>
<td>Then what happened?</td>
</tr>
<tr>
<td>E</td>
<td>Evaluation</td>
<td>What the events mean to the narrator</td>
<td>So what?</td>
</tr>
<tr>
<td>R</td>
<td>Resolution</td>
<td>How it all ended</td>
<td>What finally happened?</td>
</tr>
<tr>
<td>C</td>
<td>Coda</td>
<td>Shift in perspective to present/subject in more general terms</td>
<td>Does not answer question, indicates end of story</td>
</tr>
</tbody>
</table>


Wengraf (2001) outlined a narrative research method that is proposed to allow a richer expression of a person’s concerns, systems of value and significance, and life-world. His BNIM method begins with an interview, in which the researcher’s interventions are initially restricted to a single question. Rather than specifically asking for feelings and evaluations, the researcher carefully asks a subject to tell a story about an experience (“please tell me the story of . . .”). The interviewee is given the space to decide when and how to start the story, what background is required, and when and how to end the story. This enables interviewees to talk about whatever feels most pertinent to them and to disclose as much or as little as they are comfortable with. The researcher does not interrupt the interviewee during storytelling, but instead notes down key phrases used by the interviewee. Once the interviewee is finished speaking, the researcher asks for more story using the interviewee’s exact words. At this time, the researcher pushes for particular incident
narratives (PINs), rich accounts of a specific moment in time, when the interviewee appears to be reliving a past experience. A full verbatim transcript of the interview is later made (Wengraf, 2009).

In the interpretation stage of BNIM, a distinction is made between two tracks in a person’s narrative, “the living of the lived life” and the “telling of the told story” (Wengraf, 2009, p. 81). The living of the lived life track refers to the more objective parts of a person’s story (the events), while the telling of the told story refers to the more subjective aspects, including the person’s current interpretation of his/her experiences. The two narrative tracks are interpreted separately by a panel and then the resulting interpretations are brought together to produce a “case account” (p. 81). Case accounts can be compared to one another and used for further theorization and presentation to various audiences. Wengraf reported that the BNIM method is particularly useful for learning more about developmental change, as well as organizational roles, constraints, and processes.

I gained knowledge and experience of BNIM interviewing and interpretation through a five-day intensive training event in Ireland in 2009. At this training, I gained opportunities to experience the two roles of interviewer and interviewee. When I tried out the role of the interviewer, I was struck by how effective the single question was for eliciting issues of importance to a person. After experiencing the role of the interviewee, I reflected that the spontaneous nature of the spoken interview led me to recount aspects that I did not expect and to reveal more about myself than I had intended. Following the practice interview, I began to think about myself and my biography in new ways and I continued to reflect on the interview for several days after it had ended. This experience highlighted the value of narrative interviewing for gaining new understanding and insight, but it also led me to consider that there may be some risks to telling one’s story spontaneously. I perceived that the narrative interview was extremely powerful, in that it could potentially alter someone’s perceptions of self. As I had experienced music therapy development work as quite demanding, with stressful and even distressing elements, I wondered whether the telling of a service development story could lead to a transformation that would not have occurred otherwise. This led me to eventually choose to elicit written narratives from participants so that they would be able to edit their contributions. Additionally,
I anticipated that some participants would benefit from the opportunity to debrief about writing the narrative and this was included in the information sheet (see Appendix B).

In Polkinghorne’s (1995) narrative-type narrative analysis, the aim is to configure data elements into a coherent story. A story is created through “recursive movement from the data to an emerging thematic plot” (p. 16). Plot ideas are adjusted in accordance with major events and actions described in the initial data. Some data elements may be left out if they do not contradict the plot and are not pertinent to the development of the story. The end result is a scholarly explanation of how a particular outcome came about. As in BNIM, the stories that are created through a narrative-type narrative analysis may be presented as a set of cases and compared and contrasted to develop further insight and understanding. Steps in the narrative-type narrative analysis process are summarized in Figure 1.

**Figure 1.** Narrative-type narrative analysis process (Polkinghorne, 1995).
In reading the literature on narrative research methods, I noted some disagreement as to whether computer software should be used in the interpretation of narratives. While some have used specialized computer software to assist them in narrative analysis, others prefer to work with whole documents (Kenny, 2005). Carpenter and Suto (2008) suggested that there is no need to use specialized software unless dealing with large amounts of text. Several authors have reported that narrative inquiry requires a great deal of time, thought, and effort on the part of the researcher, regardless of whether or not specialized software is used (Brown & Addington-Hall, 2008; Gunaratnam, 2009; Squire et al., 2008).

Narrative research critiques and criteria for quality.

Considerable debate exists as to what constitutes quality in narrative inquiry. Quality criteria remain contested and critiques of narrative inquiry are common. A wide range of opinions have been presented due to academics’ divergent philosophical positions. This section will introduce some of the main debates about quality in narrative inquiry and discuss possible ways in which narrative inquiries can be evaluated.

Positivist critiques of narrative inquiry have focused on whether narrative research findings are “true” and generalisable to large populations (Kenny, 2005; Polkinghorne, 1995). Proponents of narrative inquiry argue that their research should not be judged from a positivist perspective, but from a constructivist perspective instead (Kenny, 2005). Polkinghorne (1995) has argued that it is “inappropriate” (p. 20) to ask if a story is real or true, as narratives are constructions by nature. A story is a “tightening and ordering of an experience” (p. 20), involving processes of selection and produced from a person’s present perspective. In narrative research, a story is intended to provide evidence of personal meaning, not of the factual occurrence of the events reported (Polkinghorne, 2007). Even if an event is perceived to have occurred, the meaning of that event can vary from time to time and from one person to the next (Polkinghorne, 1995). Some authors have suggested that configuring an experience in a particular narrative genre may even lead to fictions, illusions, and “trickery” (Frank, 2009; Kenny, 2005). This fictitious aspect of
narratives may be regarded as a resource, as fictions tell us about the ways in which people view the world and their circumstances.5

A range of narrative possibilities exist at any one time and place (Chase, 2008). What becomes “storyworthy” (Chase, 2008, p. 71) is dependent on a number of factors, including the social setting and the cultural assumptions of both narrator and audience. Narratives are dialogic constructions, produced in interaction between at least two people (Polkinghorne, 1995). The stories we tell are influenced by what is deemed socially desirable, acceptable, and expected (Polkinghorne, 1995; 2007). In this way, narratives should not be considered as an objective reporting of “the facts”.

Narrative inquiries usually have few participants and often the researcher seeks only to understand the life of one individual (Chase, 2008). This leads to questions as to whether the experiences of one person can provide insight about a population as a whole (Chase, 2008; Kenny, 2005). Contemporary narrative researchers tend to reject the idea that the narratives they present must be generalisable (Chase, 2008). Gaining a rich description of the experiences of a small number of people is seen as more important than representing the experiences of a larger cohort (Brown & Addington-Hall, 2008; Stamm et al., 2008).

Recent authors have suggested that narrative research should have its own criteria for evaluating research quality (Greenhalgh & Wengraf, 2008; Polkinghorne, 2007). The types of claims that are made in narrative research are different to those made in more conventional approaches and should be judged accordingly (Polkinghorne, 2007). While conventional approaches aim to eliminate alternative explanations for why something occurs, narrative researchers acknowledge that multiple interpretations are possible. The aim of narrative research is not to provide an accurate explanation, but to provide a plausible and convincing argument about human experience (Polkinghorne, 1995; 2007). For a piece of narrative research to be considered valid, the researcher needs to provide sufficient explanation for readers to judge whether claims are believable. Readers should be able to follow the

5 For further exploration of the similarities and differences between history and fiction, see Biley (2009).
presented evidence and arguments and researchers need to anticipate and respond to any questions readers may have (Polkinghorne, 2007).

While stories may provide the best evidence of personal meanings, feelings, and experiences, they are not without their limitations. Validity issues arise because stories about experienced meanings are not exact reflections of these meanings (Polkinghorne, 2007). The stories people tell are not simple, neutral descriptions of occurrences, but complex co-constructions (Polkinghorne, 1995). Polkinghorne (2007) outlined four threats to validity when working with narratives. First, language may not adequately capture the complexity and depth of the meanings people experience. Secondly, a person may not be fully aware of the meanings he/she ascribes to a situation. Thirdly, people may be resistant to revealing their authentic feelings and experiences to others, especially strangers. Furthermore, when stories are created in research interviews, they are likely to be influenced by the interviewer’s agenda and demeanour. Polkinghorne (2007) has proposed that narrative researchers should be aware of these issues and “produce articulations that lessen the distance between what is said by participants about their experienced meaning and the experienced meaning itself” (p. 482). He suggested gaining feedback from narrative contributors as one way in which researchers can increase confidence in their findings.

Commentators have emphasized the importance of contextualization in narrative inquiry. They have suggested that researchers need to be explicit about the cultural, historical, and interactional contexts in which narratives have been constructed (Chase, 2008; Polkinghorne, 1995; 2007). Furthermore, narrative researchers are urged to reflect on the ways in which they have contributed to the stories presented and acknowledge ways in which they have shaped the research findings (Chase, 2008; Greenhalgh & Wengraf, 2008; Polkinghorne, 1995; 2007). The topic of researcher reflexivity will be discussed in greater depth later in this chapter (see p. 102).
Guidelines for evaluating narrative inquiry.

Greenhalgh and Wengraf (2008) conducted a 3-round Delphi study to produce preliminary guidelines regarding what to classify as narrative research in healthcare and how to evaluate it. Twenty academic researchers, practitioners, and service users active in narrative health research generated a set of statements about narrative research and ranked them on a nine point Likert scale for relevance and validity. A cycle of repeated discussions, revision of statements, individual rankings and aggregation of scores led to the development of a three-fold definition about narrative research (see Figure 2). This definition distinguishes narrative research from the use of stories in health education and service audits and indicates some key features of quality narrative research.

<table>
<thead>
<tr>
<th>Research is purposive, systematic enquiry that aims to contribute to new knowledge.</th>
</tr>
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<tbody>
<tr>
<td>A story or narrative is a personal account of a sequence of actions and events, told to another person (or written for a reader).</td>
</tr>
<tr>
<td>The aim of narrative research is not necessarily to determine a ‘true’ picture of events, but rather to explore such things as how the individual has made sense of these events, their attitude toward them, what meanings the events hold for them, and how these feelings came to be.</td>
</tr>
</tbody>
</table>

Figure 2. Narrative research definitions.


While most of the Delphi study participants agreed to this definition as a starting point for assessing quality in narrative research, some of the wording remained contentious. Greenhalgh and Wengraf explained that this was likely due to the participants’ diverse philosophical positions. Although a set of guidelines for narrative research was presented, the authors highlighted that narrative research is rarely straightforward. They suggested that narrative researchers, ethics committees, and reviewers will need to make “context-specific situational judgements” (p. 246) in
evaluating pieces of narrative research. It may also be crucial that narrative researchers explain their individual frames of reference when writing up their research.

Summary on narrative inquiry.

Narrative inquiry has been used in a diverse range of academic specialties, including music therapy and other healthcare disciplines. In narrative inquiry, researchers collect or create stories to explore people’s identities, perceptions, experiences, and subjective meanings. The aim may be to explore the complexities of a person’s life, to gain a rich explanation of how something came to be, or to further understand interactions between an individual and his/her environment. Across disciplines, narrative inquiry has contributed new insights and given rise to different perspectives.

For those who undertake narrative inquiry, there are no strict rules to be adhered to and there is considerable scope for innovation. Researchers are encouraged to draw and expand on existing methods and to develop an approach that suits their particular research topic, philosophical position, and understanding of narrative. Previous music therapy researchers have tended to use coding or thematic procedures when working with narratives. However, many narrative researchers work with stories in a more holistic way.

When I was searching for a way to explore music therapists’ service development experiences, I was drawn to the interdisciplinary, constructive, and flexible characteristics of narrative inquiry. I was keen to explore new methods and to consider ways in which my own service development experiences could enhance my research. Narrative inquiry also offered a valuable opportunity to learn about service development through other music therapists’ points of view. This was important, as I wished to develop a research study that would be of interest and relevance to music therapists. I also considered that the creative and emotionally poignant aspects of narrative research may appeal to both music therapy clinicians and researchers alike. An opportunity then arose for me to undertake a fieldwork study of a new music therapy service development at a hospital. Later in this chapter
I will show how I chose ethnography as the approach to complete this fieldwork research.

*Arts-based Research*

In the process of considering various approaches to the analysis of music therapists’ narratives, I became aware of the possibilities afforded by arts-based research. Arts-based research uses art forms such as poetry, music, visual art, drama, or dance to explore and process research topics. The arts are considered to be central to the research process and are used to formulate the research question, to generate data, to analyse data, and to present the research findings. Reported benefits of arts-based research include access to new insights that might not be knowable by other means, expression of marginalized perspectives, and communication with audiences who would not normally read academic publications (Austin & Forinash, 2005; Estrella & Forinash, 2007).

Few arts-based research studies have been conducted in music therapy to date (Austin & Forinash, 2005). One example of an arts-based research study undertaken by a music therapist is Austin’s study of the culture of *Alcoholics Anonymous* (Austin, 2005). Austin wrote poetry and rap music to refine her initial research question and created a musical play to analyze and present her findings from *Alcoholics Anonymous* meetings. In undertaking arts-based research, Austin experienced that the use of metaphor was particularly helpful for identifying major themes in her interviews and observations. Furthermore, the recursive act of performing the play was perceived to provide “opportunities to further examine and analyze the data” (Austin & Forinash, 2005, p. 463). Although not a music therapy study per se, Austin’s study revealed the potential for using arts-based research to gain fresh insights about music therapy practice.

The small amount of arts-based research in music therapy is surprising, given that an understanding of the value of non-verbal communication is central to music therapy practice. In reflecting on this observation, I wonder whether music therapy researchers have been reluctant to adopt arts-based research methods due to a concern that their research would be perceived as “light weight”. Perhaps music therapists
have endeavoured to conduct studies that would “fit in” with the types of research that have been traditionally accepted and expected by biomedical researchers. Through my reading around the topic of arts-based research, I was encouraged to discover that the arts have been increasingly used in nursing research and education (for examples see Casey, 2009; Simons & McCormack, 2007). I then began to explore the use of an arts-based approach to analyse music therapists’ narratives. This process of exploration is described in more detail in Chapter 4 (pp. 118-122).

**Ethnography**

Early in my candidature, my doctoral supervisor became an advisor to a proposed development of a hospital-based music therapy service. As she began to work with the hospital, she suggested that the introduction of a music therapy service at this particular hospital could provide a valuable opportunity for me to undertake fieldwork research in my topic. She then encouraged me to develop my understanding of ethnographic research methods. Extensive reading revealed that ethnographers hold a diverse range of positions and have applied a wide range of methods. As with narrative inquiry, there are no standard analytic procedures and writers argue as to what constitutes a good ethnography. This section will attend to the ways in which other healthcare researchers have used ethnography and show how to date, ethnography has been an underutilized methodology for gaining insights about the profession of music therapy.

**Definition.**

Ethnography is an anthropological research method that involves the study of people in groups, teams, organizations, communities, and cultures (Reeves, Kuper, & Hodges, 2008; Stige, 2005). Ethnography involves the researcher entering a group of interest to gain detailed first-hand knowledge about people’s actions and environments. The underlying assumption is that researchers can only begin to understand people’s beliefs, motivations, and behaviour, through observing them within the context in which their actions and interactions are occurring (Roberts, 2009; Tedlock, 2000). By observing and participating alongside the group of study,
Ethnographers aim to gain rich insights about the ways in which people live and work (Reeves et al., 2008).

**Historical overview.**

The earliest ethnographies were anthropological studies of small, non-Western communities. Around the turn of the 20th century, anthropologists decided that first-hand experience was necessary to further understand tribal societies (Tedlock, 2000). Early ethnographers lived in communities for extended periods of time, learned indigenous languages, participated in day to day activities, and recorded their observations (Stige, 2005; Tedlock, 2000). The aim of this work was to gain a rich understanding of customs and practices, by learning to see, think, feel, and even behave as a community member (Tedlock, 2000). Early ethnographers such as Malinowski believed that active involvement and detached observation could lead to an understanding of “the native’s point of view” (cited in Tedlock, 2000, p. 457). This position reflected the imperialist ideas of the time, as well as the strong influence of the physical sciences on early social science research (Stige, 2005; Tedlock, 2000).

Through the 20th century, ethnography came to be used in the study of urban cultures and contexts closer to researchers’ own backgrounds (Reeves et al., 2008; Stige, 2005; Tedlock, 2008). Ethnography was adopted as a useful methodology in many fields, including sociology, social psychology, organization studies, and education. Alongside expansion in the types of contexts studied, there have been changes in the way that ethnography is conceptualised and practiced (Tedlock, 2000). Grasping the point of view of the other is now seen as an “unattainable ideal” (Stige, 2005, p. 394) and contemporary ethnographers are more aware of the ways that their own background influences their interpretations and the culture being studied (Borbasi, Jackson, & Wilkes, 2005; Stige, 2005; Tedlock, 2000). Knowledge is proposed to be “dialogical”, produced in interaction between ethnographers and groups, and ethnographers “observe their own and others’ coparticipation within the ethnographic scene of encounter” (Tedlock, 2000, p. 464). Furthermore, ethnographers pay careful attention to political and ethical issues when writing and publishing ethnographies. This has led to exploration of new ways of writing and publishing to include a multiplicity of voices (Tedlock, 2000). Contemporary
presentations of ethnography are increasingly personal, intersubjective, and emotive (Borbasi et al., 2005; Tedlock, 2000).

*Data collection techniques.*

Those who write about ethnographic methods usually refer to three main types of data collection – observation, interviewing, and archival research (Angrosino, 2007; Stige, 2005). This section will introduce each of these data collection methods, before outlining possible ways of recording, analysing, and presenting the findings of ethnographies. A range of possibilities are presented, to reflect the diversity in approaches taken by ethnographers and the way that methods have evolved in published ethnographies (Lofland et al., 2006; Reeves et al., 2008; Stige, 2005).

An essential component of ethnography is the observation of a particular group of people (Angrosino, 2007; Stige, 2005). Ethnographers visit people in their natural environment (the field) often, or for extended periods of time (Stige, 2005). Once in the field, ethnographers observe and/or take part in the activities of the group, to learn more about the group’s culture and way of life (Stige, 2005). The task of the ethnographer is to remain aware and to take in detailed information from the environment (Angrosino, 2007).

Ethnographers appear to differ in the degree to which they become involved with the groups they are studying. Some ethnographers become fully engaged in the practices of the group, while others maintain distance between themselves and group members (Angrosino, 2007; Stige, 2005). The wide range of possible researcher roles is often depicted on a spectrum, extending from complete observation to complete participation (Angrosino, 2007; Roberts, 2009; Stige, 2005, see Figure 3). The use of a spectrum may give the impression that some roles are more advantageous than others, but it is likely that any research role will result in certain limitations. For example, a complete participant may learn information that is only accessible to insiders of a group, but encounter ethical issues as a result of not revealing his or her research intentions (Angrosino, 2007).
An ethnographer’s theoretical orientation appears to play a part in determining the researcher roles that are adopted. Ethnographers with a more traditional approach to ethnography tend to aspire to a detached impersonal role in their research. Ethnographers influenced by feminist theory are more likely to develop close relationships with group members, through “self-disclosure, reciprocity, and caring” (Borbasi et al., 2005, p. 495). Potential researcher roles may also be influenced by the setting and the group being studied. Some settings allow greater research access than others and often the ethnographer’s degree of participation develops through negotiation with group members (Stige, 2005; Toffoli & Rudge, 2006). Recent authors have indicated that an ethnographer’s position should be flexible and responsive to the needs of the group, the research aims, and the unique situations that arise (Castellano, 2007; Mazzei & O’Brien, 2009; Stige, 2005).

Interviewing is also employed in ethnographic research (Angrosino, 2007; Reeves et al., 2008; Stige, 2005). During their time in the field, ethnographers often identify key informants or a sub-group of individuals worthy of more in-depth study (Reeves et al., 2008; Roberts, 2009). These people are interviewed to further understand people’s actions, to probe emerging issues, or to ask questions about unusual events (Reeves et al., 2008; Roberts, 2009). As with observation, the
interview may require negotiation of roles (Stige, 2005). Some ethnographers undertake semi-structured interviews with questions prepared and an audio-recording device at the ready (Angrosino, 2007; Roberts, 2009). This approach may be useful when an ethnographer wishes to pursue a specific line of inquiry. Other ethnographers undertake less formal, conversational-style interviews, which are reported to be effective in eliciting “candid accounts from individuals” (Reeves et al., 2008, p. 513).

Ethnographers often collect objects or texts related to their research topic or observed group (Angrosino, 2007; Lofland et al., 2006; Roberts, 2009). For example, archival research using photographs, noticeboards, policy documents, or meeting minutes, is common in ethnographies of workplace environments (Reeves et al., 2008; Roberts, 2009). This close inspection of objects can lead to additional insights about the group or culture being studied (Lofland et al., 2006).

Stige (2005) referred to the use of field notes as another central technique of data collection in ethnography. In order to remember and integrate their observations, interactions, and interviews, ethnographers record their experiences on a regular basis (Lofland et al., 2006). Although the use of field notes is common, ethnographers vary widely in the way that they document their experiences. While some settings allow the ethnographer to write continuously, in other settings a sequence of mental notes, jotted notes, and full field notes is required (Lofland et al., 2006). Full field notes can include information such as detailed descriptions of the setting, people, interactions and conversations; direct quotations; memories of previous encounters; personal impressions and sensations; analytic ideas and questions to follow-up (Lofland et al., 2006; Stige, 2005). I have noted that the length and structure of field notes varies according to the ethnographer’s interests and sensitivities, but ethnographers usually aim to record rich detail that can be analysed later (Lofland et al., 2006). Ethnographers also differ in the degree to which they write notes in front of the group that they are studying. Some write notes inconspicuously, as soon as possible after a period of observation. Other ethnographers take notes openly, to show that they are listening and to build rapport with group members (Lofland et al., 2006).
Analytic procedures.

Ethnographers have been criticised for providing scant detail about their analytic procedures (Lofland et al., 2006). Few guidelines for the analysis of ethnographic data exist (Angrosino, 2007; Lofland et al., 2006). The perceived lack of published information on analysis could be attributed to the emergent and inductive nature of most ethnographies (Lofland et al., 2006; Reeves et al., 2008). Perhaps this is because the findings of ethnographies are driven by the data rather than deductively derived via a set of pre-defined procedures (Lofland et al., 2006). Although the inductive approach used can suggest that research findings magically appear, experienced ethnographers have warned that analytic work is not easily accomplished (Lofland et al., 2006). Ethnographies typically yield “messy” amounts of data which are brought together and interpreted through hard work and persistence (Lofland et al., 2006; Stige, 2005). Analysis is presented as a “highly interactive process” in which the ethnographer becomes “immersed” in the data (Lofland et al., 2006, p. 196). Experienced ethnographers have proposed that analysis requires intellectual and creative skills, as well as prior knowledge of relevant theories and bodies of work (Angrosino, 2007; Lofland et al., 2006).

While there are few set procedures for the novice ethnographer to follow, writers such as Lofland et al. (2006) have suggested a few strategies for making sense of ethnographic data. One possibility is the use of coding, the sorting of data chunks into categories or groups of similar concepts or phenomena. Through coding, the ethnographer can organise and render particular data as meaningful. Another strategy is the use of “memoing” to document any thoughts or ideas that arise when working with the data (p. 209). Memos can include points to clarify codes, analytic ideas, practical considerations, and leads to follow-up. A third analytic strategy is the use of diagrams to visually represent the data. Taxonomies, matrices, typologies, concept charts and flow charts can be useful in highlighting patterns and relationships between data elements. Other authors have emphasized the analytic strategy of switching between emic (insider) and etic (outsider) perspectives when working with ethnographic data (Angrosino, 2007; Roberts, 2009). This strategy can help in separating what is meaningful to group members from what is meaningful to the ethnographer (Angrosino, 2007).
A central element of contemporary ethnographies is the consideration of the role of the researcher in the construction of fieldwork findings (Allen, 2004; Borbasi et al., 2005; Reeves et al., 2008). Ethnographers spend time considering ways in which their own backgrounds and behaviour impact on the research (Tedlock, 2000). A researcher’s class, race, gender and cultural background are thought to influence many aspects, from the initial fieldwork motivations to the presentation of the research findings, and researchers are urged to consider how who they are influences their perceptions (Borbasi et al., 2005; Tedlock, 2000). Furthermore, the processes of observation and participation are assumed to alter the very phenomena being studied (Allen, 2004; Roberts, 2009). Contemporary ethnographers engage in “reflexivity” (Allen, 2004; Reeves et al., 2008), to consider how their research is affected by their own histories, biographies, and theoretical perspectives. They reflect deeply on the ways in which their involvement affects group members and ways in which they themselves have changed in the course of their fieldwork (Allen, 2004; Borbasi et al., 2005; Roberts, 2009; Tedlock, 2000). Contemporary ethnographers also attend to ways in which their individual interpretative lenses have shaped the research findings (Allen, 2004; Borbasi et al., 2005). In writing up their research, they explain how they reached their unique conclusions, rather than presenting their findings as the only possible interpretation (Borbasi et al., 2005; Reeves et al. 2008). The topic of reflexivity will be discussed in greater depth later in this chapter (see p. 102).

*Ethnographic writing.*

Many ethnographers present their research findings in traditional scholarly form, publishing theses, monographs, or peer-reviewed articles (Angrosino, 2007). However, these are not the only options available to an ethnographer. In recent years, ethnographers have begun to experiment with alternative forms or “genres” of representation (Tedlock, 2000, p. 459). These include various literature forms such as the biography, novel, or fiction, poems, plays, documentaries, visual exhibits, and web-postings (Angrosino, 2007; Tedlock, 2000). These alternative forms of

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6 Richardson (2008) referred to these forms as “creative analytical processes” rather than alternative or experimental forms of ethnographic representation. This terminology acknowledges creative forms as valid and desirable representations, and writing as process as well as product.
ethnographic representation are often chosen “to achieve a more expressive representation of the lived experiences” of the people who are studied (Angrosino, 2007, p. 79). Other people, including the people studied, can access, learn from, and be moved by the ethnographer’s work (Angrosino, 2007; Tedlock, 2000). Through the use of alternative forms, ethnographers have creatively brought together their perceptions with the voices of group members. In contemporary ethnographic accounts, ethnographers often reveal their own uncertainties and emotions, and present both themselves and group members as “vulnerable experiencing subjects” (Behar, 1996; Tedlock, 2000, p. 467).

Richardson and St Pierre (2008) presented writing as a continuous method or process of ethnography, rather than an act that is only performed at the end of the research. In their view, writing can be a way of thinking, analysing, and discovering throughout the whole course of an ethnography. Writing is regarded as a “field of play”, where ethnographers can explore ideas and nurture their own voices. Through creative writing, ethnographers may discover aspects that they didn’t expect. Richardson and St Pierre suggested several creative writing practices, including experimentation with metaphors, writing formats, and personal and evocative styles of writing.

*Flexibility and negotiation.*

Several authors have indicated that it is helpful to maintain a flexible approach when carrying out an ethnography, rather than deciding on a set of fixed procedures (Lofland et al., 2006; Reeves et al., 2008; Stige, 2005). The value of flexibility is emphasized with reference to various tasks, including gaining research access, relating to group members, and undertaking analytic procedures (Castellano, 2007; Lofland et al., 2006; Mazzei & O’Brien, 2009). Fieldwork settings are presented as complex, unpredictable social situations and ethnographers are encouraged to make situation-specific judgements as the research unfolds (Reeves et al., 2008; Stige, 2005). Experienced ethnographers have found it necessary to negotiate and adapt procedures in response to the fieldwork context, to build rapport with group members, and to manage ethical problems (Castellano, 2007; Mazzei & O’Brien, 2009). Stige (2005) suggested that a tentative, flexible approach communicates
respect for group members and increases the ethnographer’s ability to learn from the community being studied. I was challenged by this to start giving consideration to my own stance, especially how I would cope with any uncertainty I experienced in fieldwork.

Criteria for quality.

Within healthcare, there has been considerable debate as to what constitutes quality in qualitative research projects, including ethnographies (Cohen & Crabtree, 2008; Finlay 2006; Mays & Pope, 2000). Different authors have published different quality criteria, in accordance with their particular research paradigms and epistemological positions (Cohen & Crabtree, 2008; Mays & Pope, 2000; Miyata & Kai, 2009). A range of recently published quality criteria can be seen in Table 3.

In proposing standards for qualitative research, some medical scholars have drawn on the criteria historically used to evaluate quantitative biomedical research (Cohen & Crabtree, 2008; Mays & Pope, 2000). Authors have referred to positivist criteria such as validity, reliability and generalisability and recommended strategies to maximise “rigour”, reduce “error”, and ameliorate “bias” (Kitto et al., 2008; Mays & Pope, 2000). These strategies include representative sampling and triangulation, which is the use of multiple theories, methods, researchers, or sources of data. Other strategies include member-checking, where the researcher asks participants to validate interview transcripts or interpretations, and attendance to negative cases, where the researcher studies examples that contradict the general findings (Kitto, Chesters, & Grbich, 2008; Mays & Pope, 2000).

Other authors have argued that positivist criteria should not be directly applied to qualitative healthcare research and that qualitative research should be judged according to interpretivist ideals (Cohen & Crabtree, 2008; Finlay, 2006). In this approach, the concept of “validity” is replaced with “credibility”, to allow for multiple interpretations. The aim of the researcher is not to produce an approximation of the truth, but to present findings that make sense (Finlay, 2006). The concept of “reliability” is also rejected, as qualitative researchers do not usually expect to gain consistent results (Finlay, 2006). Instead, the term “dependability” is
used to acknowledge that interpretations alter over time and with changes in context and researcher-participant relationships (Finlay, 2006; Miyata & Kai, 2009). Rather than aspiring toward “generalisability”, researchers are encouraged to provide enough contextual detail for findings to be “transferable” to similar settings (Finlay, 2006; Kuper, Lingard, & Levinson, 2008). Strategies such as prolonged fieldwork engagement, persistent observation, triangulation, and member-checking are valued, not as ways of improving the accuracy of the findings, but as ways of enhancing the richness of the data (Finlay, 2006; Kitto et al., 2008; Mays & Pope, 2000). In this interpretivist approach to evaluating qualitative research, an ethnographer is expected to give a clear and detailed account of how findings were reached, including his/her role in the process (Cohen & Crabtree, 2008; Kitto et al., 2008; Mays & Pope, 2000). The onus is then on readers to determine whether the ethnographer’s interpretations are justified and applicable to other healthcare settings (Cohen & Crabtree, 2008; Kitto et al., 2008; Kuper et al., 2008; Mays & Pope, 2000).

With reference to quality in ethnography, Richardson (2008) proposed criteria that emphasise creative and literary dimensions. From her sociological perspective, an high-quality ethnography is one that makes a substantive contribution to our understanding of a phenomenon. Another criterion is aesthetic merit. In Richardson’s view, published ethnographies should be “artistically shaped, satisfying, complex, and not boring” (p. 480). They should have emotional and intellectual impact, generate new questions and “move” the reader (p. 480). Additionally, Richardson stated that reflexivity should be valued as a creative resource rather than as a strategy to eliminate problematic bias and favoured the term “crystallization” over “triangulation”. She suggested that high quality research leads to a “deepened, complex, and thoroughly partial understanding of the topic” (p. 479).

In recent years, healthcare researchers have begun to incorporate creative and literary dimensions into their published criteria for quality in qualitative research. Criteria such as “communicative resonance”, “emotional power” (Finlay, 2006, p. 323), “rich substance”, “immersion”, and “self-reflection” (Cohen & Crabtree, 2008, p. 336) have started to appear in articles published in healthcare journals. To evaluate quality in healthcare research, Miyata and Kai (2009) have recommended placing individual pieces of research on four epistemological axes (see Table 3). In their
view, different epistemological positions will lead to different quality criteria and strategies for ensuring “scientific adequacy”. For example, an ethnographer who values neutrality is likely to adopt the criterion of objectivity and employ strategies to reduce bias. An ethnographer who values flexible, subjective approaches is likely to reject the criteria of validity and objectivity and use strategies such as reflexive journaling, triangulation, and member-checking to enhance credibility and the richness of the findings. Miyata and Kai’s article indicated that it is more important for ethnographers to outline their epistemological frameworks, than to meet a set of established criteria for quality in healthcare research.

Stige, Malterund, and Midtgarden (2009) proposed the use of an evaluation agenda, rather than recommending individualised or “local criteria” (p. 1506). By “agenda”, they meant a flexible framework which embraces diverse qualitative research positions and invites dialogue. By identifying a shared agenda, Stige et al. anticipated that it would be possible for researchers and reviewers to discuss the quality of research through turn-taking, back-and-forth, and clarification. Their agenda, called “EPICURE”, is an open list of issues to be attended to during the research process and when qualitative research projects are evaluated. EPIC refers to issues related to the development of rich and substantive accounts, such as engagement, processing, interpretation, and self-critique. CURE refers to issues that are relevant to the preconditions and consequences of research, such as social-critique, usefulness, relevance, and ethics. Reflexivity is not listed separately, but viewed as central to the EPICURE agenda. Both researchers and reviewers are encouraged to be reflexive in this agenda approach to evaluation.

In reflecting on the wide range of opinions expressed in relation to research quality in ethnography, it is evident that evaluating qualitative research may be a challenging task for researchers, readers, and reviewers. It seems important that ethnographers are able to articulate their intentions, so that readers can judge whether stated research aims have been achieved.
### Table 3

*Published Criteria for Evaluating Quality in Qualitative Research*

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<tr>
<td><strong>Validity</strong></td>
<td>Clarification and justification</td>
<td>Appropriate sample</td>
<td>Ethical research</td>
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<td><strong>Relevance</strong></td>
<td>Procedural rigour</td>
<td>Appropriate method</td>
<td>Importance of research</td>
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<td>(including generalisability)</td>
<td>Representativeness</td>
<td>Appropriate analysis</td>
<td>Clarity and coherence</td>
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<td><strong>Interpretative rigour</strong></td>
<td>Transferability</td>
<td>Reflexivity and ethical</td>
<td>Appropriate and rigorous methods</td>
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<td><strong>Reflexivity and evaluative rigour</strong></td>
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<td>Reflexivity and attendance to bias</td>
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<td><strong>Transferability</strong></td>
<td>Reflexivity and ethical</td>
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<td>Validity/credibility</td>
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<td><strong>Clarity</strong></td>
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<tr>
<td><strong>Substantive contribution</strong></td>
<td>Clarity</td>
<td>Validity/credibility</td>
<td>Engagement</td>
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<td><strong>Aesthetic merit</strong></td>
<td>Credibility</td>
<td>Reliability/dependability</td>
<td>Processing</td>
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<td><strong>Reflexivity</strong></td>
<td>Contribution</td>
<td>Objectivity/confirmability</td>
<td>Interpretation</td>
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<td><strong>Impact</strong></td>
<td>Communicative resonance</td>
<td>Generalisability/transferability</td>
<td>Critique (self &amp; social)</td>
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<td>Caring</td>
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Ethnography and healthcare.

Ethnographic methods are increasingly being employed to explore the behaviour, interactions, meanings, values, and experiences of workers and patients in healthcare settings (Allen, 2004; Reeves, Kuper, & Hodges, 2008). It is likely that this reflects recent changes in healthcare practices and the growing acceptance of qualitative research methods within healthcare research (see p. 64). Healthcare researchers have recognised that ethnography is “particularly effective for researching health and social care provision in the context in which it occurs” (Allen, 2004, p. 14). Through observing and interacting with people in healthcare settings, researchers have developed insights that would not have been possible otherwise (Carnevale, MacDonald, Bluebond-Langner, & McKeever, 2008).

A number of nursing ethnographies have emerged in recent years. This may be because ethnographic approaches are an effective way to explore issues of interest to nurses, such as politics and power relations in healthcare environments (Borbasi et al., 2005; Cummings et al., 2003). The following nursing examples are presented to show how ethnography can be used to explore healthcare cultures and contexts and to identify strategies for effective healthcare practice and interprofessional collaboration.

Kinsman Dean and Gregory (2005) used ethnographic methods to explore the phenomena of humour and laughter in a 30-bed inpatient palliative care unit. Kinsman Dean accompanied six nurses twice weekly for twelve weeks, conversed with patients and families, and conducted semi-structured interviews with various staff on the unit. She recorded her observations and impressions in field notes and a reflexive journal. The analysis of data occurred alongside data collection and focused on identifying patterns, categories, and themes. Kinsman Dean and Gregory’s findings suggested that humour is an important component of nursing care, which builds relationships between patients and nurses and contributes to a sense of community among staff. A number of strategies for using humour in palliative care were identified, including recognising when humour is appropriate. This study
promoted the use of fieldwork as a way of identifying strategies for best healthcare practice.

Arber (2007) undertook an ethnography to explore how specialist palliative care nurses develop their reputation and credibility in pain management. Data was collected through attending and audio-recording eight interdisciplinary team meetings in hospice, hospital, and community palliative settings. Observations and interactions with staff were also recorded in a “field diary” (p. 919). The data was analysed using constant comparison between settings, as well as discourse and applied conversation analysis techniques. Arber’s findings revealed the team meeting as a space where professional stereotypes can be challenged and new identities can be developed. Specialist nurses were seen to use a number of rhetorical strategies to negotiate interprofessional boundaries, including avoidance of criticism, taking a neutral position, and using contrastive rhetoric (distinguishing their assessments from others’ viewpoints). As I had already identified team meetings as an important site in which health professionals establish their professional role (see p. 40), reading this research prompted me to consider how I could use similar methods to uncover strategies used by music therapists when introducing new services.

Gillespie, Wallis, and Chaboyer (2008) conducted a six-week “mini-ethnography” to explore characteristics of the organizational culture of an operating theatre. Gillespie, an experienced theatre nurse, observed and participated in operations, conducted informal and focused interviews with operating theatre staff, kept field notes, and recorded perceptions and assumptions in a reflexive journal. Data was analysed through constant comparison, open coding, categorizing, and identifying themes. Three themes were identified, which focused on aspects of operating theatre culture that are likely to influence the fit between staff and their work environment. Findings indicated that knowledge and competency are required to become accepted as a valued staff member in the operating theatre and that nurses need to be supported to further develop their skills. This study indicated that fieldwork may be highly useful for considering aspects of fit between healthcare professionals and their work teams. This was of particular interest to me, as I had already considered the possibility that person-group fit is an important issue in music therapy service development (see pp. 51-52).
Lauzon Clabo’s (2008) ethnography investigated the influence of the social context on nurses’ pain assessment in two postoperative units. The study took place over nine months and methods of data collection included observation, individual interviews, and small focus groups with nurses. Data were recorded and analysed using a daily event log with observational, theoretical, and methodological notes. Nurses’ pain assessments were compared and contrasted and the analysis focused on developing a description of individual nurses’ practices and the general pattern of pain assessment on each unit. Lauzon Clabo identified two distinct patterns of pain assessment practice. In one unit, objective physiological measures of pain were given primacy, while in the other, the patient’s subjective experience of pain was regarded more highly. Lauzon Clabo recommended that interventions aimed at changing nursing practice should be unit-specific and address a unit’s collective way of working. Her study promoted ethnography as a useful methodology for exploring healthcare practices in context.

Challenges experienced by healthcare ethnographers.

As the use of ethnography has become more widespread, nurse researchers have revealed that certain dilemmas and predicaments can arise when ethnographies are conducted in healthcare settings. Toffoli and Rudge (2006) noted hurdles to gaining research access, such as obtaining the approval of multiple gatekeepers and assuring ethics committees that organizational issues will remain confidential. These authors suggested that the inductive processes of ethnography may lead to problems when applying for ethical approval. It could be difficult for an ethnographer to explain how the research will unfold and to forecast what will be written about in the final report. Furthermore, an ethnographer may not be able to prevent participants from talking amongst themselves and therefore may experience a dilemma in assuring participants of complete confidentiality. Reeves et al. (2008) indicated that an ethnographer’s direct interactions with participants can be viewed with suspicion, as those holding traditional research beliefs expect researchers to be detached rather than involved. Gaining entry to a healthcare organization may take considerable time and research access may need to be “negotiated, maintained, and adjusted throughout the entire lifespan of a project” (Toffoli & Rudge, 2006, p. 605).
Previous authors have further indicated that ethnographers may experience challenges when they possess a dual practitioner-researcher identity (Allen, 2004; Borbasi et al., 2005). In nursing literature, there has been considerable debate as to whether familiarity with the healthcare setting enhances one’s understanding of the field or results in assumptions being made and important issues being overlooked (Allen, 2004; Borbasi et al. 2005). A practitioner-researcher may also be faced with a dilemma if an observed practice is perceived as inappropriate or unsafe (Allen, 2004; Finlay, 1998). In this instance, an ethnographer may need to reconsider his or her level of involvement to protect participants.

Allen (2004) described how her prior nursing background led to concerns about her role as an ethnographer in a large district hospital. Although she intended not to align herself with any one occupational group, she experienced that it was difficult to observe busy nurses without helping out. Allen questioned whether she should participate in nursing activities and considered whether her wish to get involved was driven by her own need to “fit in” (p. 19). She discovered that it was necessary to remain flexible in her role as an ethnographer. There were times when Allen perceived that it was important to distinguish herself as an academic researcher, by restricting her role to observation and wearing a white coat and “research student” badge. However, there were also times when it appeared beneficial for her to become more involved in nursing tasks. Activities such as attending the ward at unsociable times, handling body products, and telling self-effacing stories were seen to be effective ways of building rapport with fieldwork participants and encouraging self-disclosure. Allen indicated that as a dual practitioner-researcher, it is important to become aware of your own needs, to reflect on how your occupational identity may be affecting the research, and to negotiate your involvement in healthcare practices.

Although the practice of ethnography can be demanding in healthcare settings, previous researchers’ experiences suggest that the benefits of ethnographic work outweigh any potential practical concerns (Allen, 2004; Borbasi et al., 2005; Reeves et al., 2008; Toffoli & Rudge, 2006). Ethnography is accepted and recognised as a valuable way of “generating a rich understanding of social action and its subtleties in different contexts” (Reeves et al., 2008, p. 337). Through immersing themselves in
healthcare environments, researchers have gained greater access to “backstage talk” (Allen, 2004, p. 21) and to healthcare practices normally hidden from public view (Reeves et al., 2008). Ethnography is therefore viewed as a highly useful methodology for exploring health professionals’ interactions and relationships, perceptions, and approaches to their work (Reeves et al., 2008).

*Ethnography and music therapy.*

Despite the growing acceptance of ethnography as a valuable approach to healthcare research, ethnography appears to be rarely used in music therapy. Though some ethnographically informed music therapy studies have been identified (Stige, 2005), I was unable to find any full-scale ethnographies in the music therapy literature. Although music therapists work in the same sorts of contexts as those studied by ethnographers in related healthcare disciplines, there was no evidence of any similar studies being undertaken in music therapy. This was surprising, especially as ethnography was included as an extant research methodology in the main research text in the field (Wheeler, 2005a).

Stige (2005) has presented ethnography as a potential way to explore the cultural aspects of music therapy. In his view, ethnography could be used to gain insights about music therapy as “discipline, profession, and practice” (p. 400). Through ethnographic methods, researchers could examine music therapy discourses and practice approaches and enhance our understanding of institutions and communities in which music therapists work. Stige (2005) listed examples of ethnographically informed discipline and practice research in music therapy, including his own doctoral research (2003) and a study undertaken by Forrest (2002). However, he was unable to identify any published ethnographic studies of the music therapy profession. He regarded ethnography as a research possibility yet to be fully explored in music therapy (Stige, 2005).

Music therapists regularly work in contexts such as hospitals and within communities, interprofessional teams, organizations, and institutions. Literature from related healthcare disciplines indicates that these are environments in which the experiences of workers, patients, and families are potentially ripe for exploration.
through ethnographic methods. Previous research in nursing and occupational therapy has shown that ethnography contributes rich insights about the settings in which music therapists develop and deliver services. It is therefore timely for a study of the development of music therapy services to be conducted through ethnographic research.

**Summary on ethnography.**

Ethnography is an established research methodology in anthropology and sociology offering a way to study the interactions and practices of various social groups. While ethnographers’ theoretical approaches and values may vary, ethnography is consistently presented as a methodology for gaining rich insights about people’s actions and environments through close observation. Ethnography may therefore be an ideal methodological approach for exploring music therapists’ service development strategies and work environments.

Approaches to ethnography have evolved since the early 20th century, particularly with regard to the ethnographer’s role and relationships with fieldwork participants. Contemporary approaches to ethnography are more collaborative and increasingly emphasize the importance of negotiation and flexibility in the research process. Recent authors have devoted careful attention to their own fieldwork responses and presented research findings in creative and evocative ways. As with narrative inquiry, ethnography is a methodology in which it is possible to explore new perspectives and approaches.

There is considerable debate as to what constitutes quality in qualitative research, including ethnographies. Writers disagree whether positivist quality criteria should be applied, whether qualitative research needs its own quality criteria, or whether studies should be evaluated individually. Regardless of the position taken, the consensus is that ethnographers need to articulate their research intentions, so that readers can judge whether their research is worthy of merit.

Ethnographies are becoming increasingly commonplace in healthcare research, especially in the field of nursing. Nurse ethnographers have discussed some
of the challenges of carrying out ethnographies in healthcare settings, especially with reference to obtaining research access and negotiating one’s role as a researcher. Despite these challenges, healthcare researchers have demonstrated ethnography to be an effective way of exploring healthcare cultures and contexts, of examining healthcare practices, and of identifying strategies for effective interprofessional collaboration.

Ethnography has been described as a way to increase knowledge about the music therapy profession and provide further understanding about the contexts in which music therapists work. Ethnography therefore seemed an ideal way through which I could explore music therapy service development opportunities and challenges. The next step for me was to consider my role as an ethnographer, which I will now discuss.

*Reflexivity and Role Issues*

A common characteristic of both narrative and ethnographic research is the consideration of the role of the researcher in the collection and interpretation of data (Allen, 2004; Borbasi, Jackson, & Wilkes 2005; Ellis & Bochner, 2000; Reeves, Kuper, & Hodges, 2008). Researchers tend to reflect on how they have influenced the culture being studied and how their experiences and assumptions have informed their representation of the data. Some health researchers have described their reflections as a means of increasing transparency and minimizing researcher bias (Marshall, Fraser, & Baker, 2010; Ritchie, Zwi, Blignault, Bunde-Birouste, & Silove, 2009). It is likely that this is due to a prevailing view that health researchers should be unobtrusive and objective (Edvardsson & Street, 2007). Researchers who place greater emphasis on inter-subjectivity value reflection as a source of additional insight about the culture of interest (Ellis & Bochner, 2000; Finlay, 1998). These researchers propose that it is impossible to eliminate the researcher’s influence and that the research can actually be enhanced by a researcher’s interactions and reflections (Bulpitt & Martin, 2010).

Many qualitative researchers record their reflections by way of reflexive memos or a reflexive journal (Bruscia, 1998/2005; Finlay, 1998; LeGallais, 2008).
This is a place in which researchers can pay attention to their own feelings and thoughts as they interact with research participants. Reflexive writing may help the researcher to consider ways in which his or her unique perspective has shaped the research findings and to explain how the findings were able to be reached (Allen, 2004; Borbasi et al., 2005; Reeves et al. 2008).

Reflexive writing typically contains emotional experiences and can be described as “intimate, personal, and self-conscious” (Ellis & Bochner, 2000, p. 744). Ellis and Bochner (2000) portrayed reflexive writing as meaningful, evocative, and engaging to readers. They recommended that researchers draw on literary devices, such as dialogue between characters, scene setting, strong imagery, suspense, and action, in order to write reflexively. They also encouraged researchers to use their whole bodies, by attending to senses, movement, and feelings. In their experience, reflexive writing can be demanding on multiple levels. Reflexive writing not only requires time, emotional commitment, and consideration of ethical issues, but can also highlight a researcher’s misconceptions, vulnerabilities, and uncertainties (Behar, 1996; Ellis & Bochner, 2000). I anticipated that this last aspect of reflexivity would be challenging, as I had enjoyed the methodological certainty I experienced when carrying out my previous experimental research.

Although reflexive writing is widely valued as a personal form of discourse, several authors have made efforts to distinguish reflexivity from writing that is overly introspective, self-indulgent, or confessional in nature (Davies, 2008; Ellis & Bochner, 2000; Finlay, 1998). These authors have suggested that being reflexive is more complex than every day emotional expression. When researchers attend to their own experiences, there is a risk that their voices become privileged over the voices of participants (Davies, 2008; Finlay, 1998). Experienced ethnographers have therefore emphasized a need to exercise skill and care, so that experiences of participants are not lost (Davies, 2008; Finlay, 1998). Allen (2004) recommended that researchers integrate narratives of the self and the field, to further understand the meaning of field data. In her view, the researcher’s responses should not be considered in isolation, but in relation to the interactions that prompted them and the progress of the research. These authors indicated that reflexive writing is a skill that requires ongoing thought and development.
Reflexivity and dual identities.

When I was looking to develop my own reflexive skills, I came across a number of useful articles in healthcare literature. In the field of nursing especially, researchers have reflected on the implications of possessing a dual practitioner-researcher identity (Allen, 2004; Borbasi et al., 2005). Nurse ethnographers have indicated that being familiar with healthcare environments can enhance one’s understanding of the field or result in assumptions being made and important issues being overlooked (Allen, 2004; Borbasi et al., 2005; Edvardsson & Street, 2007). This appeared highly relevant to me as I developed my study of music therapists’ experiences of introducing new posts. I wondered how my previous experiences of music therapy start-up could be brought into my awareness of salient aspects of music therapy service development.

Previous healthcare experience has sometimes been viewed as an advantage when researching healthcare settings. Borbasi et al. (2005) explained how previous experience as a nurse may facilitate access as an ethnographic researcher. A nurse researcher may be readily accepted by fieldwork participants, due to common language, experiences, and skills. If a researcher is comfortable and confident in a healthcare setting, this is also likely to enhance interactions with participants in the field. Nurses may possess skills that are helpful for research interviewing, due to their previous experience of listening and responding to vulnerable people. While some researchers have reported benefits of a nursing background, others have reported that a dual nurse researcher identity can lead to certain predicaments (Borbasi et al., 2005). For example, the boundary between research and practice can become blurred when research participants disclose highly personal information in the presence of a caring professional (Bulpitt & Martin, 2010). In this situation, a researcher may question whether it is appropriate to include personal information in the final research report. As a trained therapist, I considered it highly likely that I would encounter boundary issues when interacting with research participants and perceived that I would need to give careful consideration to my role before entering the fieldwork context.
Further implications of possessing a dual identity were evident in Allen’s (2004) account of developing her role as a researcher in a large UK hospital. She explained how her role was sometimes driven by her own psychological and emotional needs, including a need to “fit in” on the ward (p. 19). Despite her intention not to participate in any ward work, she often became involved in mundane nursing tasks. She wondered whether she may have done so because she was more comfortable with being a nurse than with being a researcher. Contrary to the experiences recounted by Borbasi et al. (2005), Allen found it difficult to gain trust and acceptance from fieldwork participants. Allen perceived that her need for introduction defined her as an “outsider” and that she was only privy to “careful public accounts” (p. 20). Although Allen explained the aims of her research, fieldwork participants continued to perceive that she was judging the quality of their work. As the research progressed, Allen developed strategies to facilitate further disclosure. These included attending at all hours of the day and night, handling body products, telling self-effacing stories, and undertaking informal interviews. Periods of reflection appeared to assist Allen to develop her role and to negotiate her relationships with fieldwork participants. Allen’s study led me to consider the possibility that I would need to be flexible about my intended role in the course of my ethnography.

From the literature I read, it was evident that extensive involvement in the work of healthcare professionals could be emotionally taxing (Borbasi et al., 2005). Researchers have commonly reported feeling emotionally overwhelmed during qualitative health research, especially when researching sensitive topics (Dickson-Swift, James, Kippen, & Liamputtong, 2006). I did not consider my research topic to be particularly sensitive, in that it did not deal with highly charged issues such as mortality or personal experiences of illness. Nonetheless, I was aware from my own reflections on service development that an emotional impact was possible. I allowed myself time for reflection and supervision and carefully considered the extent of my involvement with research participants.
Strategies for role reflection.

In the broader literature on ethnography, researchers have regularly reflected on their position in relation to fieldwork participants. Researchers have explored how aspects of themselves, such as their gender, cultural identity, or social class, influence their interactions in the field (Behar, 1996; LeGallais, 2008; Mazzei & O’Brien, 2009). By reflecting on their backgrounds and fieldwork interactions, researchers have been able to deploy aspects of themselves to benefit both the research and the people involved (Castellano, 2007; Mazzei & O’Brien, 2009). For example, Castellano (2007) explained how she brought her academic expertise to the fore and advised on organizational conflict within a criminal justice system. Claiming outside expertise was a way that Castellano could contribute to the organization and build trust with fieldwork participants, without taking any one person’s side.

The education researcher LeGallais (2008) shared a number of tools that she used to explore links between her past and present experiences and those of her fieldwork participants. These tools included the writing of a brief autobiography, ongoing journaling, and the creation of tables tracking her position in relation to her fieldwork participants. Through using these tools, LeGallais was able to consider the degree to which she identified with fieldwork participants and to acknowledge her impact on the research settings, participants, and findings.

Early on in my research, I wrote a couple of autobiographical accounts of my own service development experiences. These accounts benefited my research in two ways. First, documenting my accounts drew my attention to the aspects of music therapy service development that I assumed were most important. I wrote about demonstrating the value of music therapy work, attending and participating in interprofessional team meetings, giving music therapy in-services, developing music therapy student placements, and forming allegiances with other staff. I also wrote about possible obstacles to music therapy service development, including limited hours and funding, a lack of management awareness of music therapy, and hierarchical relationships between staff. In introducing music therapy services, it had been important to me that I was valued as a professional, that I was using my expertise, and that I was understood by other staff. I expressed great disappointment
at a time when my investment in the work was not rewarded with increased funding or hours. Exploration of these experiences may have helped me to avoid overlooking accounts that were different to my own.

On another level, it was helpful for me to experience the process of writing an autobiographical narrative about music therapy service development. I was struck by the way in which I constructed my narratives to suit my audience. My awareness that my doctoral supervisor would read the narratives influenced some of the details I included and the details I omitted. I left out some aspects of my experience, knowing that my doctoral supervisor had pre-existing and ongoing relationships with some of the people in my narratives. This led me to wonder how the music therapists in my study would construct their narratives, knowing that my supervisor and I would read them. Another thing that occurred to me was the role of memory in constructing an autobiographical narrative. There were times when I tried to imagine being back in a scene physically and emotionally, but could not recall the full details of a given situation. This experience of writing my own autobiographical narratives reminded me of the partial and situated nature of narratives.

I gradually developed my understanding of the research approaches I had chosen and began some reflexive writing. I was then ready to design a study about music therapists’ service development experiences. In the next chapter, the various research methods that evolved from this process of reflection and review will be presented.
Chapter Four

Method

The four main sources of data used to explore the topic of music therapists’ service development experiences in this project were: 1) narratives obtained from expert music therapists, 2) a period of ethnographic fieldwork, 3) music therapy training and seminars, and 4) reflections on my own and my doctoral supervisor’s music therapy service development experiences. In this chapter, I describe how each of these data sources was developed and offer an explanation as to how I developed my analytic procedures. I also share some of the ethical concerns and considerations that arose when preparing the presentation of my research findings.

Music Therapists’ Narratives

After a period of reflection and literature searching that is outlined in Chapter 3, my data collection on the topic of music therapy service development began. I requested written narratives about service development from expert music therapists around the world. These narratives were perceived to be able to offer rich accounts of the challenges and opportunities experienced by music therapists.

Purposeful sampling was used to recruit music therapists to provide narratives about their service development experiences. To access experienced music therapy service developers, my doctoral supervisor and I looked through our email contacts for potential participants. We approached qualified music therapists who had worked in a health care setting for at least one year and who would therefore have enough experience to be reflecting on the implementation of a music therapy service. A further requirement for selection was that the music therapist had completed music therapy training in English, to ensure my understanding of aspects described in the narratives was not hampered by language issues.

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7 The procedures for this narrative inquiry were approved by the Research Ethics Committee of the Faculty of Arts, Humanities and Social Sciences at the University of Limerick.
Consistent with a narrative approach (Chase, 2008), my intention was to gain an in-depth understanding of a few music therapists’ experiences rather than generalising the research findings to the music therapy community as a whole. Therefore, I did not decide on a specific sample size before commencing the research. It is rare for narrative studies to include large numbers and previous narrative studies have included fewer than fifteen participants (Brown & Addington-Hall, 2008; Stamm et al., 2008). I planned to recruit a minimum of ten and a maximum of twenty-five music therapists to provide narratives for the research. The majority of music therapy practitioners are female though exact numbers internationally are unavailable. Therefore a specific male to female ratio was not sought. It was expected that some of the participants would be male. However there was a possibility that there might only be females in the sample if the men did not respond to requests to participate.

Narratives were sought from music therapists working in various healthcare organizations internationally, in order that the research outcomes would have relevance in healthcare settings in Ireland as well as beyond. Participation was sought from music therapists known to me and/or my doctoral supervisor in Australia, Canada, Ireland, Norway, the United Kingdom, and the United States.

Seventeen music therapists were contacted via email and invited to participate (see recruitment email in Appendix A). An initial email explained the research aims and procedures and included information and consent forms (Appendix B). Music therapists were asked to return consent forms to me by the postal service if they wished to participate in the study. At this time, music therapists were also invited to email me or my supervisor if they had any questions or concerns. This is important as it is known that “even apparently ‘safe’ topics can generate material that triggers personal distress for both researcher and participant” (Valentine, 2007, p. 161).

It is interesting to note the responses to the first email request. Three potential participants wrote asking for further information about the research. These questions related to what should be included in a narrative, how the narratives would be analysed, how confidentiality would be ensured, and the level of time that would be required of them to provide a narrative. When potential participants asked for further
guidance on what to write, I explained that my request to write a story had been deliberately open-ended to elicit a range of responses. My aim was not to gain what might be thought of as historical fact-based accounts of music therapy service development, but to obtain stories of experience based on music therapists’ current perceptions and viewpoints. Participating music therapists would not be required to provide a detailed account of everything that had ever occurred in the development of their respective music therapy services. Instead they could choose to write about encounters they felt were particularly influential.

When potential participants asked “what would be done” with their narratives, I explained that narrative contributions would be read closely, compared to each other and to my own service development experiences, and would ultimately be used to develop a composite story of music therapists’ experiences in implementing services in healthcare organizations. I conveyed how participants’ identities would be concealed through the use of pseudonyms and by mixing up aspects of the narratives where their identities might be guessed by others. For those who expressed concerns about the time commitment required for participation, I explained that participants would not be expected to return their narratives straight away and could take time to prepare their responses. Only one of the potential participants who emailed with further questions decided not to participate, citing time constraints as her reason for not returning a consent form. One respondent rang my doctoral supervisor with some questions about the source of the email and asked for information as to how we had found her contact details.

Once a signed consent form was received, I sent a follow-up email asking the music therapist to write a narrative about his/her service development experiences (see Appendix A). Informed by Wengraf’s (2001) Single Question aimed at Inducing Narrative (SQUIN) method, this email was designed to elicit a story which included aspects of service development that were of significance to the participating music therapist. Each music therapist was asked to record whatever felt important to him/her in developing the music therapy service. No word limit was given and the participants were encouraged to write as little or as much as they wished. Participants were requested to return their stories via email, within two months of this email prompt.
When a narrative had not been received after two months, I sent a reminder email to the participant concerned. In this email, I stated that I hoped the participant would return their narrative soon and requested he/she notify me if any further questions had arisen. Although four participants wrote requesting extra time, eleven music therapists provided some form of narrative within eight months of the initial writing prompt.

Two participants felt unable to provide a written narrative and asked if they could provide a narrative verbally instead. I agreed, as I felt it was important to involve their perspectives as they wished. One of these participants provided a narrative in a phone interview which was recorded, and the other audio-recorded a narrative on a compact disc (CD) and delivered it to me. One potential participant explained that she was too busy to provide a narrative herself but suggested approaching another music therapist, who was a highly experienced music therapist who had started up a new music therapy service at a hospital three months earlier. I then contacted this music therapist, who agreed to provide a narrative in a phone interview eight months after the start of her post. Although this music therapist did not meet the inclusion criterion of having been in post for one year, I decided to include her due to her extensive experience in developing posts elsewhere.

When gaining music therapists’ narratives over the phone, I started with an open-ended question similar to that sent by email. Music therapists were asked to share their story of developing services at the place where they were currently working. Once the music therapist had shared his/her story I then asked some follow-up questions related to the story and my developing findings. Phone interviews were audio-recorded on a digital recorder and later transcribed into text. I also transcribed the narrative that was audio-recorded by the music therapist herself.

As recommended by Oliver, Serovich, and Mason (2005), I reflected on my research intentions in order to make decisions regarding transcription. My reason for transcribing audio material was to speed up the process of analysis. I anticipated that I would be able to locate responses quicker in text than in audio form. I was not intending to show the full transcripts to others as a “true” representation of what was
said. Furthermore, I was more interested in music therapists’ meanings and perceptions than the mechanics of their speech. I therefore did not deem it necessary to transcribe every detail of the music therapists’ natural speech. At the same time, I perceived that it was important to transcribe any verbal or nonverbal information that communicated something about a music therapist’s experience. For this reason, I not only transcribed the words that were said, but also any other communication that appeared meaningful. This communication included involuntary sounds such as laughter, response tokens such as “mm” or “yeah”, and any stresses or emphases in the music therapists’ speech. I also recorded pauses or hesitations when these seemed to indicate a topic of discomfort. The transcripts included both the music therapist’s communication and my own questions and responses.

I considered that some participants may feel slight discomfort, frustration, or uncertainty when recalling and recounting challenges that they had experienced. Therefore, I sent each participant a short debriefing email once I had received a narrative. Participants were encouraged to email me if any new questions or concerns had arisen for them and were informed that I may contact them at a later date to gain further information for the research (see Appendix A).

I continued to recruit music therapists one by one until I perceived that common themes were emerging. After eleven narratives had been received, it became apparent that similar encounters and feelings emerged repeatedly in the stories. New narratives tended to confirm previous findings rather than offering something new to the research. I then decided to stop collecting narratives and to continue with my data analysis phase.

A follow-up face-to-face interview was undertaken with one participant ten months after she provided a written narrative for the research. I became interested in interviewing this participant after she notified me of a significant change in her employment circumstances. I started the interview by asking whether the participant wished to change or add anything to her narrative in light of recent events. When the participant declined to amend the narrative, I asked further questions to gain her current views on experiences she had written about earlier. This interview was audio-recorded and transcribed in the same way as the phone interviews.
Ethnographic Fieldwork

After I began collecting narratives from experienced music therapists, an opportunity arose to conduct a fieldwork study in a hospital where music therapy was being introduced. At the time, my supervisor was consulting on the development of music therapy in this hospital and had put hospital staff members in touch with an experienced music therapist living locally, who had expressed interest in the possibility of working at the hospital. Due to my research interest in music therapy service development, I was invited to attend meetings about the developing music therapy service and to participate in presentations about music therapy at the hospital. My supervisor and I continued to offer service development advice as the proposal to introduce music therapy progressed.

After a lead-in time of twenty months, a charity-funded pilot music therapy programme began at the hospital. By this time, I had read more about ethnography and envisaged that a period of fieldwork would greatly enhance my research. I perceived that the introduction of a music therapy service at this particular hospital provided a rare opportunity to observe strategies used by an experienced music therapist to implement a new post. I anticipated that observing a music therapist first-hand would help me to identify successful strategies for establishing music therapy services. I discussed the fieldwork idea with the music therapist and with her support set about designing a study to take place at the hospital. My fieldwork design was later approved by the research ethics committee at the hospital.

Although ethnographic fieldwork can last for many months or years (Lauzon Clabo, 2008; Sorensen & Iedema, 2007), I decided on a three month time frame for my fieldwork project. I predicted this would be sufficient time to uncover important issues in music therapy service development at the hospital. I also felt that three months was a reasonable length of commitment to ask of the music therapist and achievable within the time constraints of my doctoral studies. The research commenced with an exploratory phase of three weeks, in which I shadowed the music therapist working two mornings per week. I used this time to establish my researcher role at the hospital, to develop relationships with hospital staff, and to familiarise myself with the hospital culture and routines. This phase enabled me to identify key staff members involved with the music
therapy service, as well as appropriate times and settings for further observation. I am grateful to previous healthcare ethnographers (Arber, 2007; Lauzon Clabo, 2008) for demonstrating the use of an exploratory phase.

The main phase of the ethnographic fieldwork lasted two mornings per week for two months (fifteen visits in total). During this main phase, I observed the music therapist’s interactions with staff in settings such as team meetings, one to one meetings and what could be termed “corridor stops”, during which cases or research ideas were discussed. No music therapy sessions with patients were observed. The music therapist and six other key members of staff were interviewed to gain their perceptions about the introduction of the music therapy service. These interviews took place at times convenient to the interviewees and lasted between fifteen and forty-five minutes long. To promote dialogue, I started each interview by asking the interviewee to tell his/her own story of working at the hospital. I then moved on to ask questions specific to the introduction of the music therapy service.

Prior to commencing my fieldwork, I devoted time to considering my role as a researcher at the hospital. I wrote about my intended role in a reflexive journal and discussed possible role dilemmas with my supervisor. Although previous healthcare ethnographers have assisted with caring tasks (Allen, 2004; Marshall et al., 2010), I intended to avoid getting drawn into clinical music therapy duties. I perceived that it was important to establish boundaries between the two roles of researcher and music therapist and to clearly articulate my research aims. I was also cognizant that I was not insured to provide care to patients in my capacity as a doctoral researcher. For this reason, I limited my participation in hospital activities to observation and interviews. My role as an ethnographer will be further discussed in Chapter Six.

I explained the aims of my research in the first team meeting I attended and handed out information and consent forms to staff (see Appendix C). Throughout the study, I reminded staff that if at any time they felt uncomfortable at being observed, they could tell me and I would leave the situation. Signed consent forms were received from eighteen staff, including members of the clinical team and hospital management.
Any interactions with patients and their families occurred incidentally, as I was travelling from place to place in the hospital. During the period of this fieldwork research I explained my role at the hospital to four family members of patients I met in the course of my observation visits. The possibility that I may overhear information about patients and families was explained to these people and all signed forms to indicate their consent to my research access. Throughout the research, I maintained my ethical responsibility to keep information about patients and family members confidential.

My observations were recorded in a fieldwork journal. There, I recorded any actions or behaviours that I assumed were relevant to the introduction of the music therapy service. Where possible, I jotted down exact words or phrases that were said by fieldwork participants. I also noted down the content of my conversations with the music therapist, including her reflections on the developing service. The fieldwork journal was also a place where I recorded my own experiences and senses, such as feelings of sadness, tiredness, or busyness. Interviews were audio-recorded on a digital recorder and later transcribed into text in Microsoft Word. Fieldwork interviews were transcribed in the same way as my interviews with narrative contributors (see pp. 111-112).

Music Therapy Training and Seminars

My research was also informed by two music therapy training events. The first of these was a seminar I organized at the University of Limerick, titled Professional identities, personal stories: Developing creative arts therapies services in healthcare. During this seminar, Dr Bonnie Meekums shared results of research in which she collected narratives from dance movement therapy pioneers. A local music therapist, Triona McCaffrey, then shared her story of developing a music therapy service within the Irish Health Service Executive, before I spoke about my developing research ideas.

An opportunity also arose for me to attend a week long observation and orientation training programme at the Louis Armstrong Centre for Music and Medicine, Beth Israel Hospital, New York City. Dr Joanne Loewy founded a
paediatric music therapy service there in 1994 and has since expanded the service to most areas of the hospital. The Louis Armstrong Centre now employs a team of music therapists, provides training to music therapy students, and has several research projects underway. During the observation and orientation training, Dr Loewy generously shared her story of how she came to start up the music therapy service and elaborated on the “program building” strategies she has written about elsewhere (Loewy, 2001). I was also privileged to observe some of the music therapists at work, including their participation in team meetings and education sessions. These experiences provided further rich opportunities for me to witness service development strategies first-hand.

**Music Therapy Service Development Reflections**

I expected that I would be reminded of my own service development experiences when collecting narratives, carrying out ethnographic fieldwork, and attending training events and seminars. My “disciplinary mastery” (Melrose, 2003/2004) in music therapy allowed me to occupy multiple positions in relation to the texts. My ongoing reflections were therefore recorded in a reflexive journal and regarded as further sources of data for consideration in the analysis and outcomes.

In my reflexive journal I recorded issues such as the ideas that were developing around the research topic. I also used the journal to give consideration to my role as a researcher. It was a place where I could explore feelings evoked by the narratives and recall my own memories of music therapy service development. It was also a useful place to examine any questions, uncertainties, or complexities that had arisen in the research. Journal entries were recorded by hand in an A4 notebook. Writing journal entries by hand was favoured over typing entries into a word-processor, so that thoughts were not lost through the editing of typed material.

When I communicated my developing ideas to my doctoral supervisor, she often responded with additional reflections based on her own music therapy service development experiences. These reflections were treated as a further data source.
It is important to note that while the four sets of data materials were obtained discretely, in the analysis it was not intended to keep them entirely separate. I frequently moved between thinking about my experiences in the hospital-based ethnographic fieldwork while reading a narrative, or while observing at the hospital I was often challenged to reflect on my own prior experiences of service development.

**Ongoing Collaboration with Research Participants**

Consistent with a constructivist approach to research (Guba & Lincoln, 1994), I viewed participants in my research as collaborators. I was therefore keen to keep them informed as to the progress of my research, to provide them with opportunities to give feedback on my emerging findings, and to encourage further dialogue around my research topic. I therefore decided to email newsletter updates to research participants and other colleagues who may be interested in my research (see Appendix D). The idea for a newsletter came from reading the newsletters of Dr Clare O’Callaghan, an associate professor of medicine and a postdoctoral researcher who was studying music’s relevance in the lives of people with cancer and their companions. Clare’s newsletters were compelling reading and I hoped that my own newsletters would sustain people’s interest and participation in similar ways. I perceived that the newsletters were successful in engaging people in my research, as research participants and other music therapists regularly emailed back with comments on what they had read. Comments usually took the form of words of encouragement and were treated as additional data to contribute to the development of the research findings. The newsletters also contained requests for suggestions for further participants in my study, though none were suggested by existing research participants.

After the completion of my ethnographic fieldwork, the participating music therapist continued to email me with updates of significant developments that impacted on the delivery of the music therapy service. These emails were considered as additional data regarding the introduction of music therapy at the hospital.
Analysis

I took considerable time to develop my analytic approach. As stated in Chapter 3, there are no standard approaches to the analysis of narratives and ethnographic fieldwork and researchers are encouraged to develop procedures to suit their particular studies. In seeking an analytic approach, I looked for ways in which I could bring my various sources of data together and contribute new insights about music therapy service development. I also wished to undertake a creative form of analysis, with the expectation that this would lead to rich and evocative findings that could take the reader beyond a description of practices. This led me to explore a wide range of approaches to the analysis of the narratives and fieldwork. I eventually settled on a procedure in which I analysed the findings of the narratives and fieldwork separately, while drawing on my own training and reflections on music therapy service development. I will now describe this analytic procedure in more detail.

Analysis of the narratives.

In working up to the point of starting the analysis of the narratives, I had aimed to develop rich interpretations of the music therapists’ experiences. This desire led me to explore several different analytic approaches in the course of my research. I explored a number of what might be termed “conventional” analytic techniques before I settled on a unique arts-based approach.

I followed the suggestion of Elliot (2005) and used Labov and Waletzky’s (1967/1997) structural model as a starting point for my analysis of the music therapists’ narratives. As I read over the narratives, I marked out the more evaluative sections using the highlighter function in Microsoft Word. This process heightened my awareness of particular feelings expressed by the music therapists and through this close attention, I found myself discovering words and phrases that I had not noticed before. I also became more aware of similarities between the narratives, such as the way in which several music therapists seemed to be evaluating whether their work was worth the effort.
I then tried out the use of a content analysis, in which I marked out possible service development strategies that were evident in the text. This time I highlighted any actions or events in the narratives which could be understood as strategies. This approach helped me to identify possible strategies that I had not noticed during my first readings of the narratives, such as strategies for coping with music therapy development setbacks.

Although such content-based approaches were helpful in highlighting aspects of the text that were of special interest to me in relation to the research topic, I perceived that I had lost something in the process of extracting words or sections from the narratives. I noted that the narratives were more revealing in their entirety and I assumed that the words and sections that I was highlighting and removing were probably much better understood in their context within the narrative. This assumption led me to explore three analytic approaches that were more holistic in approach. First, I adapted the idea of a life course graph (Lieblich, Tuval-Mashiach, & Zilber, 1998) and mapped the development of the music therapists’ services over time. I used a simple line graph to show the ups and downs in each music therapist’s experience (see Appendix E). This analytic approach led me to view the possibility that music therapy services develop in an unpredictable way. I noticed that the music therapists recalled complicated successions of achievements and setbacks, rather than straightforward developments in any one direction.

After working with the life course graph, I moved on to reflect on the genre of the music therapists’ narratives. I had expected to find a “hero triumphing over adversity” narrative in the genre of myth or epic, but was surprised to find a variety of genres in the narratives I received. Although some of the music therapy respondents portrayed themselves as determined heroes, others presented themselves as more tragic figures. While some narratives could be interpreted as optimistic, other narratives ended with a music therapist “losing the battle” or contemplating “giving up”. I struggled to find consistent genres across the narratives I received.

I then explored the concept of narrative coherence (Elliot, 2005) and looked to see if any dominant beliefs could be discerned from the music therapists’ narratives. I noted that there were some commonalities, such as a confidence in the value of
music therapy and a belief that clinical work was rewarding. However, I wanted to explore more of the complexities of music therapists’ service development experiences and so my search for an appropriate analytic approach continued.

For a long time, even before soliciting the narratives, I had planned to undertake a narrative-type narrative analysis (Polkinghorne, 1995). The idea of building a composite story appealed to me as a novel and creative way to work with the narratives I received. I hoped that through constructing a composite story, I could bring together my various sources of data, including my reflections as an experienced music therapist. When I read more of the narratives, I became less confident in adopting a narrative-type approach to the analysis. This was for a number of reasons. For a start, I had noted that there were individual aspects to the music therapists’ stories and that the music therapists often wrote about different outcomes even when experiencing similar events. I began to feel quite daunted by the task of building a composite story, as I wondered how I could bring together such diverse service development experiences. As music therapists had shared quite different stories, I was unsure of how a composite story should unfold. I still wanted to find a way to work with the materials at a deeper level but at this point, my searching reached something of a stalemate and I became less engaged in my research process.

A breakthrough came when I attended a lunchtime concert at work. As I listened to the songs of English folk musician Chris Wood, I was deeply moved by the stories his songs told. Attending this inspiring concert sparked a series of thoughts about how a song might be a powerful way of communicating the feelings and experiences that the narratives had conveyed to me. I discussed this idea with my doctoral supervisor, who encouraged me to develop an interest in arts-based research as a means of engaging with the data that had been generated to date.

On reading and thinking more about arts-based research, I was reminded of a conference paper I had seen at the World Congress of Music Therapy in Brisbane (Austin, 2005). In this paper, Dianne Austin reported findings of her research on Alcoholics Anonymous as a musical play. This struck me as an interesting way to communicate research findings and it occurred to me that additional findings could emerge with each new performance of the play. I was excited by the possibilities
afforded by an arts-based approach and set to work on introducing an arts-based approach to the analysis of the music therapists’ narratives.

I started by making an artistic response to the narrative that I had found to be the most evocative. On re-reading this narrative, I was particularly drawn to a section where the music therapist referred to her service as her “baby”. This prompted me to write a short poem entitled “MT is my baby”, which focused on the music therapist’s level of investment in her work (see poem p. 151). At first, I was a little reluctant to show my poem to anyone, as I perceived that the poem was too simple, a “baby” itself. At the same time, I perceived that the poem’s simple rhyming structure had served an important analytic function. In order to come up with words that rhymed, I found myself drawing on other music therapists’ narratives as well as my own reflections on music therapy service development. I appreciated this integrative aspect of the poem and it inspired me in the decision to write further poems in response to the other music therapists’ narratives.

Through trial and error, I ended up using the following procedure to write each poem: I re-read a narrative, identifying words or phrases that seemed particularly significant or meaningful to me. I then wrote one or two poems in response to the words or phrases that I had previously identified. By the end of this procedure, I had written twelve poems in all. See Appendix F for a presentation of the twelve poems in full, placed in the order in which they were written.

The arts-based approach to analysis brought a new energy to my research and I enjoyed sharing my poems with my doctoral supervisor. Together we reflected that the poems had contributed new insights that would not have been possible otherwise. I continued to work with the poems and began to consider the ways in which they could be included in my thesis.

It was at this point that I considered that I needed to contact the narrative contributors to notify them of my new arts-based approach. At the start of my research, I did not intend to use an arts-based approach and had not anticipated the need to gain consent for this approach from participants. Now that I had written the poems, I perceived that it was important to consider whether there may be any harm
arising from this change in analytic approach. My main concern was that the music therapists might feel that I had trivialised their experiences by developing their narratives into what I believed were simple little poems.

I consulted the chair of the University of Limerick ethics committee, to gain her advice as to whether I should seek participants’ consent to analyse their narratives in this way. We agreed that I should contact the narrative contributors, to explain my arts-based approach and to encourage them to contact me if any concerns arose for them (see Appendix A). I only received two responses to this email. One music therapist commented that it was a wonderful idea to write the poems and another music therapist jokingly wrote “Are your poems any good? Heh heh. . .” These email responses encouraged me to continue working on the poems and to think about sharing the poems with narrative contributors.

Once I had written ten of the twelve poems, I began to reflect on what I had learned through the process of writing poetry. I perceived that the poems had been highly useful for drawing out music therapists’ subjective experiences of service development. Furthermore, I observed that the poems contained some common themes. This observation led me to wonder whether it would be possible for me to present my narrative findings according to themes. I then began exploring ways in which the poems could be grouped together. I gave each poem a title and experimented with some diagrammatic representations of the poems (see Appendix G). When I added the final two poems, seven main themes were apparent. These are the themes that are presented in chapter five of this thesis. In writing up my findings from the narratives, I used the themes and poems as springboards for discussion about the service development issues that I now consider to be important.

Analysis of the ethnography.

My intention in carrying out the ethnographic fieldwork was to identify strategies that the music therapist used to introduce a music therapy service. I therefore searched for service development strategies as I read over my fieldwork notes and reflexive journal. When I detected a possible strategy, I made a memo in the margins of the page. After several re-readings, I extracted these memos and made
a list of possible service development strategies. I then grouped similar strategies together and removed any strategies that appeared to be duplicates. I was left with five categories of strategies and twenty-one strategies in total. I then gave each category a name to describe the nature of the strategies within that group (See Table 4).

I started to write up my fieldwork findings by describing each category of strategy in detail. In describing each category, I included relevant observations, reflections, and excerpts from my fieldwork interviews. As I re-read my interview transcripts, I identified an additional category of service development strategy. I noted that several interviewees had emphasized the role of music therapy advocates in the introduction of the music therapy service. At this time, I decided to add an additional category of “Relying on advocates”. I elaborated on this category in the same way as I had described the other categories.

Confidentiality

As I had encouraged research participants to be as honest and open as possible, I made it my priority to treat their information sensitively. All research data was stored under pseudonyms and any computers used in the research were password protected. All written, electronic, and audio data was stored in locked offices at the University of Limerick.
Table 4

*Service Development Strategies Identified through Fieldwork*

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educating others about music therapy</td>
<td>presenting video footage</td>
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<tr>
<td></td>
<td>disseminating research papers</td>
</tr>
<tr>
<td></td>
<td>referring to theories</td>
</tr>
<tr>
<td></td>
<td>clarifying reasons for referral</td>
</tr>
<tr>
<td></td>
<td>professional conduct</td>
</tr>
<tr>
<td>Interprofessional working</td>
<td>working together with other staff in sessions</td>
</tr>
<tr>
<td></td>
<td>discussing outcomes</td>
</tr>
<tr>
<td></td>
<td>sharing knowledge</td>
</tr>
<tr>
<td></td>
<td>asking for advice</td>
</tr>
<tr>
<td></td>
<td>recognising others’ contributions</td>
</tr>
<tr>
<td></td>
<td>showing concern for others</td>
</tr>
<tr>
<td>Remaining flexible</td>
<td>being open to suggestions</td>
</tr>
<tr>
<td></td>
<td>exploring new areas of practice</td>
</tr>
<tr>
<td></td>
<td>fitting in with existing systems</td>
</tr>
<tr>
<td></td>
<td>negotiating and making compromises</td>
</tr>
<tr>
<td>Generating evidence</td>
<td>speaking up in meetings</td>
</tr>
<tr>
<td></td>
<td>documenting outcomes</td>
</tr>
<tr>
<td></td>
<td>conducting surveys</td>
</tr>
<tr>
<td></td>
<td>writing research papers</td>
</tr>
<tr>
<td>Investing time and energy</td>
<td>taking on additional and unpaid work</td>
</tr>
<tr>
<td></td>
<td>enthusiasm</td>
</tr>
</tbody>
</table>

When I began to analyse data from the narratives and fieldwork, I realised that it was quite challenging to ensure complete confidentiality. I was studying a small sample of music therapists, many of whom were known and respected music therapy pioneers. I therefore considered the possibility that readers would be able to guess participants’ identities from information such as the music therapist’s gender, country of work, or specialist area of practice. For this reason, I introduced additional measures to conceal participants’ identities. I decided not to include whole narratives
in the thesis, avoided linking the narratives to demographic information, and attributed all of the narratives to female authors. I also omitted some details about the fieldwork site, such as the location of the hospital and the particular clinical population served. These measures allowed me to uphold my research contract with the music therapists in my study. The two male participants were notified of my intention to change their identities and both agreed to be represented in this way. The music therapist who participated in the fieldwork was given an opportunity to choose her own pseudonym but replied, “Please feel free to use any name you like.” I then chose the pseudonym “Sarah” for her identity in this research.

Summary of the Method

This study used four main data sources: narratives obtained from expert music therapists, a period of ethnographic fieldwork, music therapy training and seminars, and reflections on my own and my doctoral supervisor’s music therapy service development experiences. These sources allowed me to reflect deeply on service development strategies used by experienced music therapists, and to develop complex and compelling findings. In the next chapter, I will further describe the process of analysis with reference to the findings and outcomes of this research.
Chapter Five

Findings

This chapter outlines the main findings of my research into music therapists’ service development experiences in healthcare organizations. The findings are presented in two sections. The first section summarizes the findings from eleven narratives around seven emergent themes. These are: going solo, looking for a home, building relationships, accepting the challenge, insecurity, investment, and development takes time. As described in the previous chapter, I used poetry writing as a way to discover and reflect on aspects of the themes. These poems are included, contextualised, and described here.

The second section describes and reflects on six aspects I have termed “service development strategies”. These emerged from the ethnographic fieldwork project, in which I spent three months observing the start-up of a music therapy service at a hospital. The service development strategies I identified are educating, interprofessional working, remaining flexible, generating evidence, investing time and energy, and relying on advocates. Reflections on my own training and professional experiences are interwoven throughout these findings, with the aim of expanding the current understanding of music therapy service development in our field.

Section 1. The Narratives

Eleven qualified music therapists, nine female and two male, contributed narratives about their service development experiences in response to an email that requested their participation. The characteristics of the music therapists are summarized in Table 5. The music therapists were located in five countries, Australia, Canada, Ireland, the United Kingdom, and the United States. All had been involved in the establishment of music therapy services in healthcare organizations, including hospices, mental health facilities, oncology services, and paediatric hospitals. Varying degrees of music therapy experience were evident in the group, ranging from two to eighteen years of professional employment as a music therapist.
The length of time employed at their current workplace varied. The duration of current employment ranged from eight months to eighteen years. This meant that for some, many years had passed since they first introduced music therapy to the setting where they worked, while other respondents reflected on relatively recent events.

Table 5

*Characteristics of the Eleven Narrative Contributors*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female (9) Male (2)</td>
</tr>
<tr>
<td>Country of work</td>
<td>Australia (5) Canada (1) Ireland (1) United Kingdom (2) United States (2)</td>
</tr>
<tr>
<td>Healthcare setting</td>
<td>Hospice (2) Mental health (3) Oncology (2) Paediatric hospital (4)</td>
</tr>
<tr>
<td>Years of music therapy experience</td>
<td>Less than 5 years (2) 5-9 years (3) 10-14 years (2) 15 years or more (4)</td>
</tr>
<tr>
<td>Length of employment at current workplace</td>
<td>Less than 2 years (2) 2-4 years (1) 5-9 years (3) 10-14 years (2) 15 years or more (3)</td>
</tr>
</tbody>
</table>

Eight of the narrative contributions were typed, two were provided via phone interview, and one was audio-recorded by the respondent. The typed narratives were similar in length and ranged from one and a half to three and a half single-spaced A4
The two phone interviews lasted fifteen and nineteen minutes respectively and each interview amounted to four and a half A4 pages of typed transcript. The audio-recorded narrative was considerably longer. The music therapist recorded her story of service development in two parts and the transcript of her narrative amounted to ten A4 pages of text.

One music therapist withdrew her original narrative after clarifying my intentions for concealing participants’ identities. I explained that although I was not intending to use names when writing up my research, it was possible that readers may try to guess the music therapists’ identities. The music therapist then decided to amend her narrative and to remove some statements that were of a personal or sensitive nature. The sequence of events in her narrative remained unaltered. I used the revised narrative in my analysis.

A follow-up interview was conducted with one of the music therapists who provided a written narrative. This interview lasted twenty-three minutes and the content was transcribed into eight A4 pages of text. In the interview, the music therapist provided further detail about encounters and events she had written about in her original narrative. This detail enhanced my understanding of her experiences. I therefore decided to include material from the follow-up interview in my analysis of this music therapist’s story.

The general characteristics of the narratives were that they provided details in chronological order, and focused on aspects that the music therapists considered to be important in establishing music therapy services. Two music therapists used thematic headings to structure their narratives. Seven of the narratives concluded with what Labov and Waletzky (1967/1997) described as a coda (see Table 2). These were sections at the end of the narratives, in which the music therapist returned to the present day or reflected on the key messages of her story. It was interesting to note how the style of language used by the music therapists varied. Around half of the participants used formal, professional language, which may reflect the context in which the narratives were created; that is, the telling of a work story to an academic colleague. Other music therapists used more colloquial language and experimented with literary devices to enhance the dramatic effect of the story. One such device was
the use of suspense, accomplished by building tension through a sequence of events. Regardless of the type of language used, all of the narratives conveyed an emotional quality. To me, the narratives were inspiring, heart-warming, surprising, entertaining, and even humorous at times.

Arts-based analysis: using poems to reflect on the materials.

The discovery and contribution of poetry writing as a way to progress the analysis is described in detail in the previous chapter. I read and re-read each of the narratives, wrote down key words, and developed a poem as a response to the feelings, experiences, and events conveyed in the narrative. This arts-based analysis of the narratives revealed seven themes that were present in the music therapists’ narratives of their service development experiences. Each of these themes will now be elaborated. Excerpts from the twelve poems will be referred to where relevant. Direct quotes from the narratives appear in inverted commas. References to other sources such as the University of Limerick seminar and my own service development experience are also included.

Theme 1. Going solo.

This section describes the findings around the theme “going solo”. The music therapists described many aspects of start-up that contributed to this experience of doing things alone. The first poem presented here reflects on one music therapist’s description of the early days of her post.

Hospital Life
It’s hospital, not hospitable,
No room at the inn, no welcome for me,
No guidance, no phone line, no place for my purse,
Just pressure, and politics, and personalities.

I’m like a lone salesman, my profession’s on sale,
I think I’d rather sell doughnuts.
This poem led me to reflect on the ways in which music therapists portrayed service development as a solitary endeavour in a frequently unwelcoming environment. Almost all of the music therapists recalled working on their own to introduce music therapy to staff, to gain access to patients, to acquire necessary resources, or to develop appropriate music therapy interventions. Several reported that they received little orientation or guidance from management and needed to develop their own ways of working. Six music therapists described processes through which they initiated an appropriate system of referral. One music therapist described the creation and sale of a compact disc as a way that she independently secured funding for her music therapy service.

I noted that the music therapists perceived this solitary aspect of service development in different ways. Some music therapists recalled feeling anxious or lonely when working on their own. Others valued the freedom of being able to work independently. One music therapist appreciated opportunities to work autonomously, though also shared feelings of isolation. As the only music therapist in her facility and one of only a few music therapists working in her specialist area, she felt that there were few people with whom she could exchange ideas. She recalled, “I didn’t have too many other people to talk to and bounce ideas off.”

When describing their initial experiences of introducing music therapy, eight music therapists referred to unpleasant encounters with other staff. These music therapists alluded to times when they felt criticised, intimidated, or bullied, though full details were not always disclosed. Several recalled that they felt unwelcome at first and that they needed to convince staff of their role as “clinicians”. While I do not recall any particular instances when I felt unwelcome, I do remember feeling somewhat alone as I developed music therapy services. I recall feeling that it was my sole responsibility to prove myself and to demonstrate my contribution to the team.

One explanation for unpleasant experiences that emerged in the narratives was that other professionals felt threatened when a music therapist joined the clinical team and entered their domain of practice. Two music therapists who worked with highly vulnerable populations noted that nursing colleagues were particularly protective of patients. They perceived that nurses’ concern for patients led them to be resistant
towards unfamiliar interventions and new members of staff. In addition, some of the music therapists reflected on how they had coped with resistance from other staff. Three music therapists reported that supportive management had been helpful, while two music therapists regarded professional supervision as essential for their work as sole music therapy practitioners.

One music therapist offered a detailed reflection on her experience of being the sole music therapy representative within a large hospital. As the only music therapist, she perceived that it was her individual responsibility to make a good impression on staff and to uphold the integrity of the music therapy profession. This responsibility appeared to be experienced as a burden and the music therapist questioned whether she was indeed the best person to take on this role. She wrote, “every single interaction you have with people speaks to your integrity and the integrity of your profession. I felt this even more keenly as the only music therapist in a hospital of 3000 employees...” This reflection highlighted to me the potential for music therapists to feel outnumbered when they are the only music therapist on-staff.

I have previously mused with colleagues and students that the team meeting may be a unique setting in which feelings of being outnumbered can be experienced. Additionally, this is a context in which there is pressure to impress other staff with the contribution music therapy is making towards clinical and treatment goals. One music therapist wrote of the nervousness she experienced when attending her first meeting with a group of busy consultants. Her narrative reminded me of my own experiences of team meetings, in which professionals fought to be heard and music therapy received attention last. I was inspired to write the following poem:

The Team Meeting
Waiting in the boardroom,
Doctors dribble in one by one,
I begin to feel outnumbered
And the temperature is rising.

The meeting starts, we’re off and racing,
So many thoughts, so little time,
I sit and watch the action unfold,
They give their perspectives, I want to share mine.

This poem reveals that a music therapist may feel like an outsider or a visitor when attending team meetings. In my own experience, it was difficult to take the step from being an onlooker in team meetings to an active participant in discussions and decisions. I was rarely asked for my professional opinion but I perceived that I needed to speak up if a music therapy perspective was to be heard. At the same time, I was aware that time for meetings was limited and believed that I should only speak up if I had something important to contribute. At times it was difficult to know which aspects of music therapy to highlight for the team.

In most of the narratives, the music therapists described how they worked more collaboratively as the service became better established. The music therapists tended to work more with others once they had demonstrated the value of their work and had built effective working relationships with staff. One music therapist described changes in staff, as well as increases in team morale and cohesion, as turning points in her experience. She perceived that she had become a more integrated team member once wider changes in the team had taken place. Another music therapist described increased resistance towards music therapy over time. She observed that hospital staff became more threatened once she had grown in confidence and entered into more interdisciplinary domains of practice. Her experiences appeared similar to those described in the literature on interprofessional work and role blurring (Brown et al. 2000; Hall, 2005).

While there was an element of “going solo” evident in each of the narratives, the sense of “isolation” was not universally expressed by respondents. Two music therapists recalled receiving a predominantly warm welcome on entering their facilities and several other music therapists described supportive relationships with other staff. These music therapists considered supportive relationships to be crucial to music therapy service development and this topic will be further discussed under the third theme of building relationships.
Theme 2. Looking for a home.

Accommodation wanted.
Twenty-six year old music therapy professional seeks long-term lease. Self-sufficient, though willing to listen and learn. Looking to share with similar enthusiastic and open-minded people. Piano desirable, but not essential.

This accommodation advertisement was a response to two of the narratives, in which the music therapists suggested that they were looking for “hospitality” or a “home” when introducing music therapy. As I had recently been searching for a new place to rent, I was familiar with the standard content of accommodation advertisements and perhaps this is what led me to create a poem in this style. I wondered whether new music therapists could have similar needs and desires to a potential tenant who is seeking somewhere new to live. When I re-read the narratives, I noted that several music therapists had described their search for a physical space as a challenge in service development, and most respondents had described looking for a place where they could belong. Furthermore, several music therapists expressed a desire to become more comfortable, safe, or secure in their place of work. This included access to the physical space available but also to how they were ‘housed’ within the departmental and organizational structures of the setting.

Three music therapists highlighted the acquisition of a physical home as an important step in developing their music therapy services. These therapists indicated that it was essential that they gain a desk, an appropriate room for sessions, and/or a place to store their instruments. A physical home was seen to be vital on two counts. First, the music therapists perceived that they needed space in order to work effectively. Second, a physical home was seen as a sign of the music therapist’s status as an allied health professional. One music therapist expressed disappointment that after ten years, she was still working in a shared office, had limited storage space, and was without a designated space for music therapy sessions.

The acquisition of a physical space was highlighted as an important service development step during my training experience at Beth Israel Hospital too. Joanne
Loewy explained how she had gained a space for music therapy after a piano had been donated to the hospital. Once a piano was donated, the hospital needed to find a room in which to house it. Joanne also explained how she had claimed spaces for “community jams”, sessions in which patients, families, and staff could join together in music-making. These were places perceived to be particularly accessible and home-like.

In looking for a home, the music therapists appeared to seek a place that was consistent with their identities as allied health professionals. Several narratives indicated that the music therapist did not want to be seen as a volunteer or an entertaining musician, but as a qualified health professional working with “like-minded clinicians”. The music therapists used a number of strategies to establish themselves as professionals. These strategies included educating others about music therapy training requirements, using clinical language in paperwork and meetings, gaining inclusion on an allied health referral form, and documenting music therapy work from assessment through to evaluation. Like other health professionals (Goodrick & Reay, 2010; Waller, 2001), the music therapists appeared to legitimize their roles through demonstrating their equivalency to other professions.

Most of the music therapists included in their narratives a description of how they came to find a home within a particular hospital department or management structure. Music therapists who had joined a team of psychologists, social workers, or other therapists perceived that this arrangement helped them to establish their roles as “clinicians” or “therapists”. These therapists felt that they were better understood or respected, due to their alignment with other allied health professionals. One music therapist explained how she was initially disappointed to be placed within an education-oriented department instead of the psychology department. However, this arrangement proved to be of practical benefit, as it allowed her greater access to inpatients.

One music therapist found a home by identifying gaps in the provision of patient care where a music therapy service could be placed. After a unit manager provided information on existing services, the music therapist took the time to identify services which could be enhanced by music therapy. She identified areas that
were repetitive or lacking in creative approaches and recognised areas of need that were yet to be addressed and could be met by music therapy. The music therapist designed a weekly programme to fill the gaps in existing service, which later received approval from the unit manager. Joanne Loewy described a similar process when I attended the training at Beth Israel hospital. She identified a role for music therapy after observing that a safer, more cost-effective means of sedation was required for children undergoing medical tests. Music therapy was then introduced for sedation and was viewed as successful in filling this “niche”.

One of the music therapists appeared to be searching for what might be described as a “spiritual home”. I detected this in a section of her narrative where she reflected on her plans for the music therapy service. She explained how she longed to create a service within a healthy emotional environment and how she hoped that interpersonal tensions would weaken over time. If her workplace failed to become more “comfortable”, she would contemplate leaving to work elsewhere. She explained, “if the tension continues, and it’s not something that feels, ah, that it moves, as we grow out hospital wide, then I may reconsider [developing the service].”

In several of the narratives, a sense of home was linked to the way in which music therapy was funded. Four music therapists indicated that core-budget funding provided a greater sense of security than philanthropic funding. These music therapists perceived that healthcare organizations showed a commitment or a responsibility towards music therapy when they paid for services directly. One narrative included feelings of dissatisfaction that music therapy was the only clinical service funded by a charity, and that as a result, the team of music therapists were employed on short-term contracts. Another music therapist described how she felt that her organization should provide more funds for music therapy research. Like a potential tenant or first home-buyer, a music therapist developing a new service may be looking for a place where she can feel financially secure.

In a couple of cases, music therapy was portrayed as an essential part of the healthcare environment itself. One music therapist reported that music therapy is always considered when a new programme is developed. Another reported that
music therapy had become so embedded in her organization that music therapists are employed before a new facility opens its doors. In these cases, it appeared as though music therapy had almost become “part of the furniture”.

This theme provides a range of perspectives to new service development. It highlights music therapists’ wishes in developing new services and provokes questions about the extent to which music therapists feel they belong in their healthcare organizations. Most of the respondents referred to the acquisition of a place for music therapy within their organizations, but there were some who seemed to be reporting greater success at ensuring the continuation and security of their music therapy services.

Theme 3. Building relationships.

The theme of building relationships was revealed in various ways throughout the narratives. The following poem reflects on some of the ways in which one music therapist built relationships with other staff.

Lessons for relating
Show not tell
Listen and learn
Share your successes and
Give help in return.

Push for one thing only:
To be part of the team.
Think of others as your peers
And include them in the dream.

It’s just like music therapy.
Only on a broader scale
It’s all about relating
If you respond you can not fail.
I started this poem as a response to a narrative which had conveyed several pieces of advice to new music therapists. The music therapist emphasized the importance of teamwork and encouraged practitioners to be inclusive and responsive towards others. I was especially drawn to the way in which she reflected that she needed to “get to know them [staff] and let them get to know me.” This reflection encouraged me to delve further into the interpersonal aspects of music therapy service development.

Nearly all of the narratives emphasized a need to build relationships with other staff when introducing music therapy services. Narrative contributors frequently used words like “collaboration”, “cooperation”, “negotiation”, and “networking” in their service development stories. Some music therapists expressed a genuine wish to create mutually supportive relationships. Others seemed to be more strategic and appeared to build relationships in the interests of developing the music therapy service. For instance, one music therapist stated that she “played the game” to secure music therapy’s position in the hospital where she worked.

Three of the music therapists strongly emphasized that it was important for them to be seen as a member of the healthcare team. Two music therapists recalled that they had made special efforts to attend team meetings, in order to obtain information about patients’ needs, gain respect, and build professional relationships with other staff. One music therapist wrote how she had “pushed” to be placed in a particular clinical team, so that music therapy could be recognised as a psychosocial intervention and so that she could receive referrals.

Most of the music therapists emphasized that it was important to develop a service that was responsive to the culture of the organization and to the needs of patients, families, and other staff. Music therapists learned about organizational cultures and needs in various ways. Some gained knowledge through observation, some entered formal discussions with management and staff, and some developed an understanding through attending team meetings. Two music therapists learned that they needed to meet staff on a less formal basis. They described how they “spent time” getting to know staff, sharing meals, and listening to others’ perspectives on how music therapy could address their needs. These music therapists’ experiences
indicated that it was important to listen to others and to remain flexible when introducing music therapy to a healthcare setting.

In general, the music therapists reflected that healthcare staff had little knowledge of music therapy prior to its implementation. Most perceived that they needed to educate staff about music therapy and the role of the music therapist before they could work collaboratively. Six music therapists mentioned that they provided education through in-service presentations, one had written a letter to each nursing station, and one shared music therapy literature with staff. The narratives contained some information about the content of the education provided to staff. One music therapist recalled that she provided a definition of music therapy, two reported that they included case material, one emphasized a music therapist’s training and qualifications, and one considered that it was important for staff to have an opportunity to ask questions.

While all of the narratives included references to the education of staff, views on the usefulness of in-service presentations were mixed. Some of the music therapists perceived that in-service presentations increased understanding about music therapy and demonstrated the professional nature of music therapy. Three music therapists were less positive in their views towards in-service presentations. One recalled that doctors “fooled around” while she presented. Another reported that staff were not interested in the information presented and instead asked the music therapists to prove the efficacy of their work. The third music therapist explained that a culture of in-servicing did not exist at her workplace and that she allowed her music to “do the talking” instead. In her presentation at the University of Limerick seminar, Triona McCaffrey explained how her views on in-servicing had changed over time. At first, she had perceived that it was important to provide in-service education on the role and professional attributes of a music therapist. More recently, she considered that she may have crossed a fine line between information sharing and “preaching” through giving in-service presentations. She described how she now prefers to allow staff to draw their own conclusions about music therapy based on their first-hand experience of sessions.
The use of referral procedures to educate staff and to include them in the music therapy process was also described. One music therapist recalled how she enabled staff to make appropriate referrals, by developing a checklist of possible clinical reasons for referral. She perceived that staff came to understand music therapy as an allied health profession when filling out her referral forms. Another music therapist considered that it was important to give feedback to staff members who made referrals, to further develop their understanding of music therapy and to give them the confidence to refer again.

The theme of building relationships was also evident in the way that music therapists described achieving this through demonstrating the value of music therapy. There was a common perception reported in the narratives that music therapy is difficult to explain. This is also evident in the music therapy literature reflecting on the role of the profession (Barrington, 2008; Lehmann & Threlfall, 2008). There was a prevailing view that it is more beneficial to show others the work than to try and explain it. Almost all of the music therapists recounted situations in which they had invited staff to observe or assist in music therapy sessions. Once included, staff could see the benefits of music therapy for themselves. A couple of the narratives included descriptions of how other staff members were moved by seeing patients smile, laugh, sing songs, or cry in sessions they attended. The authors of these narratives perceived that they gained respect when staff observed patients’ improved mood, heard positive feedback from patients or family members, or when music therapy made it easier for them to carry out their own treatment procedures. One music therapist perceived that staff had made more referrals once they had witnessed the benefits of music therapy and then wanted these same benefits for other patients. Another music therapist explained how she included students from another health profession in her group music therapy sessions. This meant that the students had a strong understanding of music therapy if they later became employees of the same healthcare organization. Once employees, the students played a major role in supporting patients to attend the music therapy sessions.

Most music therapists promoted the inclusion of other staff in the development of music therapy in their narratives. However, two respondents highlighted possible contraindications for including other staff in sessions. One
preferred to invite staff to observe groups rather than individual therapy sessions. She considered that it may be overwhelming for patients to be observed closely within an individual session. The other recalled that demonstrating the work on every hospital ward was “time consuming and exhausting”. This music therapist’s experience suggested that it can be tiring to constantly be “on show”. Another music therapist’s narrative indicated that it may be erroneous to expect that demonstrating the benefits of music therapy will automatically lead to increased funding for a music therapy service. She advised music therapists not to implement any new services until sufficient funding has been secured.

Specific people who had helped in the development of music therapy services were mentioned in more than half of the narratives. The people identified tended to be in positions of power and included managers or trusted and respected members of staff. Sometimes the music therapists happened to know influential people prior to starting work and other times the music therapists made useful connections when they began introducing music therapy. One music therapist explained how she identified important people over time and learned to dismiss the opinions of staff members who had little or no impact on the development of the music therapy service. Her allies were the other therapists who showed her the most respect and understanding.

The narratives also revealed ways in which other staff members had contributed to the development of music therapy services. Some staff had advocated for music therapy at management level, some helped by allocating funds to the music therapy service, and some introduced the music therapist to further useful contacts. In many cases, other staff members had helped a music therapist to gain access to patients and to ensure the continuation of the music therapy service. The narratives indicated that other staff can play important roles in the development of a music therapy service. I therefore acknowledged a role for other staff in the following verse of the poem “Time and Place”:

To survive depends on who you know.
A contact can be key
To being taken seriously,
To who you get to see.
The music therapists not only described how they gained help from other staff, but also how they helped others in return. For example, one music therapist described how she agreed to contribute to community events for the benefit of staff, patients, and families. She saw her role in the Christmas concert as more than mere entertainment. By becoming involved, she gained opportunities to collaborate with other staff and to further support patients in their therapeutic process. I found this music therapist’s perspective interesting, as I had previously avoided community, or open public events out of fear of blurring my role as a clinician with that of an entertainer or musical performer.

Other music therapists’ narratives suggested that it was important to be seen to be available and undemanding when introducing music therapy services. A couple of the respondents described how they exercised particular care when asking managers for further music therapy resources. They asked for “small things” or made “only one wish a year”. My reflection on these comments prompted the first verse of a poem I titled “Meeting the Manager”. This verse reads something like a proverb:

You need to earn respect  
And say “yes” instead of “no”  
If you ask for one thing only  
Your MT programme will grow

One music therapist particularly emphasized the importance of forming mutually beneficial relationships with managers and marketers. She recommended giving as well as taking from an organization and becoming a “team player”. One way that she assisted managers was to provide them with information about possible sources of funding for music therapy. In her view, it was then easier for a manager to agree to support new programmes. The music therapist also assisted marketers to promote the organization, by giving presentations about music therapy to the general public and healthcare community. From a marketing perspective, the provision of a music therapy service set the organization apart from similar organizations, and the music therapist sought to capitalise on the way in which music therapy could be highlighted as a valuable “selling point”. One marketer went so far as to attribute business growth to the addition of the music therapy service. This respondent
perceived that music therapy held a secure place in the organization’s funding cycle as a result of its marketing influence. She expressed confidence that music therapy would continue, even if there was a decrease in the amount of funding available to the organization.

Other music therapy respondents mentioned assisting marketers with positive publicity, but expressed some reservations about their involvement in promotion. One music therapist reported that she had little editorial control over publicity and that music therapy tended to be portrayed as “light”. Another expressed frustration that marketers used music therapy to promote the hospital, yet did not provide any funding for the music therapy service.

Another way that music therapists perceived that they could build relationships was to publish their work. Two music therapists held an assumption that by writing academic publications, they could demonstrate the value of the work, impress decision-makers, and obtain additional funding for the expansion of the music therapy service. However, I noted that the narratives indicated that publishing had a greater impact on the development of the individual music therapist’s career than on the development of music therapy within the organization. The prevailing sense of these descriptions was that music therapists who published gained further insight about their work and received the respect of outside colleagues, but rarely experienced recognition within their workplaces. Music therapy publications were sometimes listed in reports of hospital achievements, but the music therapists seemed to believe that few, if any, of their colleagues had read their written work. I recalled a similar disparity between the level of respect I gained from my music therapy colleagues and the level of respect I gained from within my organizations. I reflected that I too received little encouragement or kudos for my academic writing or research activities from the healthcare organizations in which I worked.

In addition to building relationships with other healthcare staff, some of the music therapists described how they had found it useful to connect with music therapists who had developed similar work elsewhere. Two music therapists named particular music therapy colleagues who had helped them to develop their clinical approaches. Another music therapist explained how she gained support and
confidence through presenting her work to other music therapists at conferences. One respondent had not experienced music therapy colleagues as supportive though. Instead, she recalled that other music therapists were critical of her clinical and research approaches. She remembered a time when a journal submission was returned with a comment that her work was “not music therapy”. In this case, difficult interactions with music therapy colleagues made the music therapist more determined to establish and evaluate her music therapy service. Her experience indicated that music therapy colleagues can contribute to the development of a service in very different ways.

Some of the narratives highlighted benefits of building relationships with universities. One music therapist perceived that her affiliation with a university gave her power when it came to negotiating with hospital managers. Another received funding from a university to carry out research at the hospital where she worked. Other music therapists reported that their service had benefited from the inclusion and contribution of music therapy students. Music therapists reported that students provided extra person power, helping them to expand music therapy into new clinical areas and to further increase staff members’ awareness of music therapy. One music therapist identified that a student’s work enabled her to successfully argue the case for an additional post. It was also evident that music therapists gained confidence through providing clinical placement opportunities to students. For example, one therapist recalled that she benefited from watching other staff work collaboratively with her students. She felt more accepted by the team once she had witnessed staff giving help and support to her students. A role for music therapy students in service development is supported by Loewy’s (2001) reflections on programme building. She identified student training as one of five ways in which she developed the music therapy service at Beth Israel hospital.

Theme 4. Accepting the challenge.

This theme was revealed through noting the ways in which music therapists portrayed service development as a challenge in their narratives. The first poem employs the metaphor of a mountain climb to further elaborate this theme.
Reaching for the summit
Cold.
Frosty reception.
Miles to go.
No path to take.
They say it can’t be done.

I start on my journey.
Into the unknown.
I’m a little bit scared but
Excited at the thought of what lies ahead.

I stumble and fall,
Cracks begin to show,
But I will not be defeated
And I pick myself up again.

Little by little I
Find my way up that climb,
One by one others join me,
Their support makes me strong.

I arrive at the top,
Admire the view from up here.
There’s no stopping me now,
Nothing I can not do!

This poem was inspired by my re-reading of one of the narratives. It also resonated with a climbing metaphor that arose during my fieldwork project (see p. 181) and was probably influenced by my experience of some unusually icy weather conditions at the time when I wrote the poem. The narrative on which the poem was based was the one that most conformed to the narrative genre of epic. The music therapist recounted how she rose above experiences of bullying and intimidation to succeed in establishing a music therapy service. Her narrative used powerful imagery
such as the description “I walked in cold”, and her use of the term “no set pathway”. She concluded with a message of optimism, “the opportunities here are endless, as long as I fight for them!”

Other music therapists used imagery in the telling of their service development stories. Service development was variously described as a “fight”, a “rollercoaster ride”, and a long and difficult “road”. Several of the music therapists presented themselves as brave pioneers, who entered unknown territory as they worked to introduce new music therapy services. For most, music therapy service development appeared to be a journey that included both highs and lows. This was captured in a particularly evocative way by one of the respondents who wrote, “IT has been very difficult for me in this place. Part of me wants to leave, yet part of me deeply loves the time with children and that nourishes me.”

Regardless of the imagery used, music therapy service development was commonly portrayed as a challenge. The music therapists frequently described service development using words such as “hard”, “difficult”, “challenging”, or “a struggle”. The aspects that music therapists viewed as challenging included entering new areas of practice, gaining support and acceptance from staff and management, and obtaining financial backing for the continuation and expansion of the music therapy service.

As in the poem, five music therapists described an early phase of excitement around the development of their music therapy services. These music therapists described an initial “honeymoon period”, when music therapy was still perceived as new, novel, and innovative within the healthcare setting. Music therapists shared their excitement in developing new work, exploring new possibilities, and putting their music therapy training into practice. One music therapist reflected that she needed to take risks and test boundaries when developing her music therapy service. She experienced this element of music therapy service development as simultaneously exciting and “scary”.

Nearly all of the music therapists recalled setbacks when recounting their service development stories. Some expressed frustration in the face of continuing
resistance from other staff. Some expressed disappointment when they perceived that their work had been misunderstood or gone unrecognised. One music therapist explained that there was a need to “back track” when changes in staff occurred. Six of the music therapists mentioned a time when they considered giving up and leaving to work elsewhere. These were often times when the music therapists felt tired of proving the value of their work and working to secure further funding. I observed that the music therapists frequently reflected on the extent to which their service development goals had been achieved. This observation encouraged me to write the following short poem:

Taking stock.
Successful programmes, check.
Service expansion, check.
Publications, check.
More funding, no cheque.

The narratives indicated that the music therapists often required persistence to continue developing the music therapy service. Music therapists reported that they needed to “push” ideas forward and to “forge” their own way. One music therapist viewed the ability to “take a few knocks” as essential when developing music therapy services. In almost all cases, the music therapists seemed to be driven forward by the rewards of working with patients and families. Many referred to remarkable moments in sessions as the highlight of developing music therapy services. Seeing patients benefit from their efforts seemed to reinforce the work as worthwhile and helped the music therapists to continue in times of adversity. In addition, four music therapists reported that they had gained a sense of pride through making headway under difficult circumstances. To these music therapists, the introduction of music therapy was seen as a major achievement. I too remember gaining a sense of reward from working with patients and achieving service development goals. I recall the feelings of elation that I experienced when my development efforts resulted in the establishment of a full-time music therapy post between two nursing homes in Australia.
Theme 5. Insecurity.

This theme draws attention to the feelings of insecurity that most of the narratives conveyed to me. I noted that one music therapist asked a number of questions in her narrative and I subsequently reflected that her experience was like that of a person who feels insecure in a relationship. This led me to write the following poem:

Where do I stand?
I’m like a girl who feels neglected
Giving much without return
Longing only to be noticed
For security I yearn

Tell me that you rate me
Tell me why you keep me here
Tell me what is it you value?
How can I keep in the clear?

You broke another promise
Built me up then cut me down
I gave you my submission
But no funding this time ‘round

Should I stay or should I go?
Can’t go on fighting any more
I think I could do better and
I’m tired of this war.

On re-reading the rest of the narratives, I noted that most of the music therapists appeared to be working on temporary contracts and seven indicated that their music therapy services were funded by sources external to their healthcare organizations. Music therapists whose services relied on charity funding indicated that they felt insecure working without a permanent, internally funded contract.
Several music therapists reported that they needed to regularly write service submissions in order for their contracts to be renewed and that there was no guarantee that these submissions would be successful. Even when a submission was approved, funding for the music therapy programme was not necessarily immediate and further paperwork was often required. Four long-term employed music therapists recalled times when they had lost funding and/or music therapy hours. Any plans for further expansion of the music therapy service were then put on hold. One music therapist explained that she was unable to rely on hospital management to allocate funding for music therapy resources. She decided to create her own “safety net” and gained money for her service by producing and selling relaxation CDs.

A further source of insecurity was a perceived lack of administrative power. Four music therapists indicated that they were unable to access the organizational hierarchy and expressed frustration that they were not more involved in the decisions that affected them. In these narratives, people other than music therapists represented music therapy at management levels. Two of the therapists questioned whether music therapy was best represented under this arrangement. One expressed her annoyance that she knew more about funding than the manager who was responsible for making financial decisions. Another music therapist suggested that there was an air of mystery around securing ongoing funding for music therapy. She was uncertain of what she needed to do to convince managers to commit to music therapy long-term and felt that she was yet to find “the right key”.

High staff turnover was mentioned as another source of insecurity in some of the narratives. One music therapist reported that she had four different on-site supervisors in the course of five months and that this held back the development of the music therapy service. She perceived that the most recently appointed supervisor had yet to become comfortable with the music therapist’s inclusion on the ward. Another music therapist linked losses of music therapy funding to changes in management and music therapy personnel. In her view, the music therapy service had become less secure since two influential music therapists had left.

This theme of insecurity was also revealed in the way that self-doubt was conveyed in some of the narratives. Two music therapists doubted their service
development skills and questioned whether they were indeed the best person to be introducing music therapy. Others recalled that they were tentative when introducing new services and worried about other colleagues’ perceptions of their unique approaches to music therapy. One music therapist recalled that as a new graduate, she frequently questioned herself and was unsure of her role as a music therapist. In her view, she required further experience and supportive supervision to become more confident in her role and abilities as a music therapist. Another music therapist considered the possibility that the “music therapy police” might come to take her away. Reflecting on her narrative led me to write the following four lines of verse:

Am I a founder or am I a fraud?
Forging my way through this baffling place,
Struggling daily to make some headway,
Working hard to impress, doing all to save face.

This poem really highlighted for me the degree of personal effort that the music therapist was putting into her music therapy service. I subsequently realised that most of the music therapists portrayed music therapy service development as hard work. From the narratives it was clear that music therapists put in considerable effort to introduce music therapy, to gain acceptance from other staff, to deliver music therapy sessions, and to secure ongoing funding for the music therapy service. When setbacks and disappointments were experienced, music therapists tended to question whether their efforts were worthwhile. I noted that many of the music therapists described how they had considered leaving their places of work or had spent time weighing up the advantages and disadvantages of continuing to offer a music therapy service. These music therapists questioned whether patients’ positive responses were enough of a reward to motivate their ongoing development work. I wrote the following poem to capture this process of questioning that I had discerned from several of the narratives.
**Important Questions**

Is it me, or is that a look of contempt?  
Do I pay too close attention?  
Do I try too hard to win respect  
For my brand new intervention?  

Should we focus on the work itself?  
Keep our heads down to the ground?  
But then there’ll be no-one to represent,  
We won’t even make a sound.  

Motivation comes from patient time,  
It’s my heart that keeps me here,  
But it can not beat forever,  
I have to think of my career.  

I stick up my two fingers  
To the sceptics in this place  
And I wonder, is it worth it?  
Do my efforts go to waste?  

While feelings of insecurity featured heavily in some music therapist’s service development stories, other music therapists seemed more confident in their positions. The reasons why these music therapists were more confident were unclear, however some possible sources of their security were apparent. One music therapist had worked for a hospital for eighteen years, worked within a team of four music therapists, and had survived a previous cut to music therapy services. Another music therapist was convinced that her service received management support, and one described how she had been promoted to a management position herself. An understanding of funding and marketing aspects led one respondent to describe herself as indispensable to her healthcare organization. In times of economic restraint, she had witnessed cuts to other services while music therapy had been retained. Her narrative conveyed the following advice to me:
You must be indispensable
To avoid the chopping block
If you understand the funding
You’re not first to take a knock

*Theme 6. Investment.*

This theme of investment relates to the degree of personal, professional, and temporal investment that was evident in the service development stories. The theme of investment emerged in the first poem that I wrote:

**MT is my baby**
MT is my baby
I do it all day long
See client after client
Sing song after song

MT is my baby
I sell it all day long
From patient to director
The “word” of MT is strong

MT is my baby
As one, we can’t go wrong
But yet there’s something missing
To feel like we belong

This poem was based on a narrative in which the music therapist referred to her service as her “baby”. I enjoyed playing with the metaphor of a baby for a number of reasons. First, I reflected that a new music therapist could be like a parent who is protective of his or her own offspring. I wondered whether, like proud parents, we are fiercely protective but also charmed by what is emerging from our commitment, nurturance and care. The metaphor of a “baby” also seemed appropriate as I was questioning whether a music therapist needs to take “baby steps”
in developing a music therapy service and this relates to the next theme “development takes time” (p. 154). I also liked the metaphor of a baby as it reminded me of Joanne Loewy’s portrayal of music therapy as the “child that got its own”, with reference to the song by Billie Holiday (Loewy, 2001, p. 3). However, the main thing I wanted to capture was my sense in reading the narratives that the degree of investment conveyed was similar to a parent’s preoccupation and involvement with a child.

In reading and listening to the service development stories, it was hard to separate the development of a music therapy service from the music therapist as a person. I noted that the music therapists tended to use the pronoun “I” interchangeably with “music therapy”. This could be seen to reflect their strong personal investment in the development of music therapy. Four of the music therapists referred to music therapy as a “love” or a “passion” in their lives, or spoke of carrying out their personal “vision” for music therapy. One music therapist expressed a desire to “leave a legacy” by laying the foundations for a successful music therapy service. The narratives also reflected a firm belief that music therapy was valuable. Even music therapists who experienced setbacks maintained faith that their work was important.

“Belief” in music therapy was often considered an essential motivating factor for music therapists in these stories of service development, but there also appeared to be some drawbacks to the personal investment required. Three music therapists indicated that they had brought in their own resources to the workplace, such as musical instruments or a laptop, which lessened the onus on their healthcare facilities to provide these. One described how it was important not to ask too much of her facility and the other two indicated that, with the wisdom of hindsight, they wished they had negotiated the provision of resources before starting a service. One music therapist explained how she took on some unpaid work with an expectation that if successful, her unpaid work would lead to increased funding. Her narrative reflected she felt she had been “naïve” to invest her own equipment and hours, as a period of time elapsed before funding was secured. Another music therapist reflected that her enthusiasm led her to take on large, exhausting projects and that she had a tendency to “over-justify” her employment as a music therapist. To her, music therapy was more than “just work”. She reflected, “you kind of really put your heart out there, um, even
though it’s, it’s just your work, it’s so much more, ’cause there’s that passion with the music.”

It is possible that this high level of personal investment leads to feelings of extreme disappointment when a music therapist experiences setbacks. When music therapists in the study perceived that their work had gone unrecognised, they expressed strong feelings of anger, “demoralisation”, or “rejection”. It was apparent that music therapists took management decisions personally and took offence when services were cut back or denied funding. The music therapists managed their emotional responses in different ways. One sought external supervision to “gain perspective” as she put it. She recommended that other music therapists have a self-care plan in place. One found it useful to view difficulties as consequences of historical rather than personal factors. Another narrative conveyed how the music therapist had “shut down” part of her self to cope with the daily challenges she experienced.

In the University of Limerick seminar, Triona McCaffrey explained how she too had “fallen into the trap” of taking setbacks personally. A turning point in her experience was gaining mentorship from a clinical psychologist. Through this mentorship, Triona learned to distinguish herself from her professional role. She described how she had come to the following realisation, “I am not a music therapist, I work as a music therapist.” Once Triona came to this realisation, she felt she developed a greater sense of clarity around service development issues.

A couple of the narratives suggested that being less personal and more cunning when it comes to the business side of music therapy service development was an advantage. Two music therapists reported that they sought further knowledge and skills to better equip themselves for negotiations around funding. One explicitly stated that music therapists need to understand how their organizations are financed and how music therapy may be funded. In her view, managers can recognise the benefits of music therapy but may not know how to fund it. She recommended that music therapists become informed about financial systems so that they can advise managers of possible sources of funding.
Theme 7. Development takes time.

The final theme to emerge from the narratives was that music therapy service development takes time. The following poem was a response to one music therapist’s narrative.

Time and Place
The story started long before
The day you came along.
A history of relationships
And services now gone.

Development takes patience,
It won’t happen overnight.
You might never feel “established”
So just work towards “alright”.

This poem was inspired by the music therapist’s emphasis on the historical and temporal dimensions of her music therapy service development experiences. She started her narrative at a time-point fourteen years before the commencement of the music therapy service. I was also drawn to a statement in her narrative, in which she reflected that she was reporting on music therapy service “growth (not establishment)”. These and other aspects of her narrative indicated that music therapy service development can take considerable time.

Other narratives further indicated that music therapy service development takes time. The music therapists often used adverbs such as “slowly”, “steadily”, “gradually”, “finally”, or “eventually” in the telling of their service development stories. Furthermore, a number of service development tasks were described as processes that occurred over time. These tasks included securing funding and adequate resources for the music therapy service, gaining the acceptance of other staff and building trust, recognising gatekeepers and obtaining access to patients, finding a role for music therapy and identifying appropriate music therapy interventions, developing suitable referral systems, developing one’s own confidence and
capabilities, and establishing music therapy as an integral part of the healthcare organization. As I noted that many tasks were described as requiring time, I wondered whether music therapists may need to be patient when developing music therapy services, and how to best identify or describe the function of this “patience” that the narratives revealed as essential.

Several of the music therapists stated that there had been a long lead-in time between the initial idea of introducing music therapy and the music therapist’s first day of employment. Where reported, lead-in times ranged from four months to several years. This is consistent with the ethnographic study reported later in this chapter, in which the service commenced after a preparation time of twenty months. During lead-in times, the music therapists were often required to attend several meetings and to give a series of presentations to support the introduction of a music therapy service. Two music therapists explained that it took months for them to gain a meeting with the ultimate decision-maker in the organization. Once this person’s support had been secured, the plans to introduce music therapy progressed.

Consistent with literature on organizational change (Deegan et al., 2004; Dulaney & Stanley, 2005), four music therapists emphasized that healthcare organizations are cultures that possess long-held traditions and multiple previous experiences of change. These music therapists reflected that in order for music therapy to be accepted, they needed to adapt to existing cultures and build histories of their own. A history of successful music therapy provision was presented as essential for service continuation and expansion. One music therapist recalled that it took at least six months for her to overturn the “bad impression” left by a previous music provider. Only then was she able to “rest on” her own history. The possibility that historical factors play a role in music therapy service development was also apparent in the narrative which started with a description of events at a time-point fourteen years before the commencement of the music therapy service. The music therapists’ recognition of historical factors was highlighted by the following two lines of the poem called “The Team Meeting”.

Perhaps it’ll take a little more time for
Me to build some history here.
When I created the life course graphs (see p. 119), I noted that most of the music therapists described a non-linear pattern of music therapy service development, characterised by changes, waxes and wanes, or ups and downs in the amount of music therapy provided. Music therapists indicated that their services had been affected by such aspects as changes in the economic climate, healthcare policy, and management and clinical staff. One music therapist presented her service as one that had switched between periods of “growth”, “regression”, and “recovery”. At the time of telling her story, she perceived that she was limited to working in just one clinical area and expected that it would be some time before she could branch into other areas of practice. Her portrayal of her situation inspired the following poem:

Progress
One leap forward, and two steps back,
Maybe more momentum down the track,
The rate of growth is not determined by me
It’s decided by others and emotional needs.
When there are lives at stake, there’s tension all around,
Resistance, defences, anxieties abound.
Many changes in staff aren’t helpful to my cause
And neither are the rivalries and unresolved wars.

I’m now being watched by the manager’s eye.
Perhaps I need to hold on ‘til this moment goes by,
Before I make another step to further my position,
Before the staff are comfortable to make the right decision
To allow me the space, to fulfil my potential,
To build on opportunities as much as I am able.
Until that time, I’ll play it safe, I’ll hold the status quo,
I’ll wait until the climate’s right for MT’s place to grow.

This poem picked up on one music therapist’s suggestion that there may be a right time to introduce new music therapy services. She articulated plans to expand her music therapy service, but perceived that it was not the right time to put her plans into action. A change in staff had recently occurred and she doubted whether the
current staff were ready for further change. She stated that she needed to show staff that she understood their culture and needs, before attempting to introduce additional services. In her view, the pace of the service development would not be directed by her, but by the “comfort of the culture”. She accepted that growth would be slow and was waiting for a time when staff were more comfortable and familiar with music therapy.

Another music therapist explained how she recognised an opportunity to gain a second music therapy post, after a successful student placement, when managers were satisfied with the music therapy service, and at a time when other allied health staff were being employed. She reflected that she had approached managers at precisely the right time, as her proposal for the second post was accepted. In reading this music therapist’s narrative, I was reminded of my own experiences in developing a full-time music therapy post. My application for increased hours was successful after another full-time music therapy post was approved within the same healthcare organization.

From the narratives, it was evident that music therapists considered their services as “works in progress”. Several reflected that they had laid a “foundation”, but were yet to fully establish music therapy’s position in the place where they worked. Some music therapists proposed their plans for the future, but were not always optimistic that these plans would be realised. One music therapist explained that the longer she stayed in her facility, the bigger her service development ideas became. As her confidence and capabilities developed, she wanted to implement and evaluate increasingly complex interventions. After experiencing resistance to her recent ideas, the music therapist began to question whether she had outgrown her facility. She wondered whether it was time for her to leave and to allow another music therapist to continue the “vision”. Two other music therapists raised similar questions and were considering a move to pursue their ideas further. In reflecting on my own music therapy work in nursing homes some years ago now, I also remember feeling that I had developed the service as far as was possible at that particular time. It was then that I enrolled in my Masters of Philosophy degree, as a way to further develop my ideas and skills.
Summary.

This analysis of the eleven narratives has highlighted some well-established but also unique aspects of music therapy service development. After some trial and error with various methods that is described in detail in the previous chapter, the process of analysis ultimately focused around seven themes that emerged from reflection on the narratives. These themes were discovered by writing poems in response to highly charged or ‘stand out’ features of the materials. These findings will be discussed further in the chapter that follows. The next section presents the main findings from the ethnographic fieldwork study of a new service development in a hospital.

Section 2. The Ethnography of a New Service

This ethnographic study was developed in order to describe and reflect on the strategies used by an experienced music therapist, “Sarah”, to introduce a new music therapy service in a hospital. This section begins with a description of the context in which the ethnography was undertaken. I then move on to describe six categories of service development strategy which I observed that Sarah used during the course of the fieldwork.

The ethnographic study provided a wonderful opportunity to be part of a service development initiative as a designated researcher rather than as the person founding the programme. As ethnography is a methodology that allows the discovery of detailed first-hand knowledge about people’s actions and environments, my aim was to further deepen and extend my understanding of music therapy service development with reference to as much of the context that I could encounter in this fieldwork. The project was conducted in what might be considered a typical start-up situation. The music therapist was being introduced to an established team, many of whom had never worked with a music therapist previously.

The fieldwork context including descriptions of the physical space, the music therapy service, and the team work environment are provided here to give a strong flavour of the work setting. This section reports observations of the service and its
relationship within the team, and includes references to excerpts from interviews in inverted commas.

Description of the fieldwork context.

My fieldwork study was undertaken in a medium-sized hospital, located on the outskirts of a large urban centre. This hospital provides medical services to inpatients and outpatients from all over the country in which it is situated. The hospital has 119 beds, spread across three floors and eight wards.

Historically, the hospital was arranged in departments by professional discipline. There were separate departments for medicine, psychology, social work, each of the therapies, and so on. At the time of the fieldwork, the hospital was seeking international accreditation and was introducing a new model of service delivery. The hospital was being organised into four separate programmes according to clinical specialty. This new arrangement was intended to promote further interprofessional work.

Although interprofessional work was regarded as best practice, I immediately observed that there were barriers to the development of interprofessional relationships. Different professional disciplines were located in separate areas of the hospital and hospital staff tended to remain within their professional groups. This was most apparent at mealtimes, when different professional groups sat at different tables in the hospital canteen. The wards, office spaces, and meeting rooms were all in different locations in the hospital, which meant that staff members often walked long distances between appointments and moved about in a hurried fashion. A new building had been planned and designed to support the new programme model of service delivery. However, building work had been delayed due to a downturn in the economic climate.

Each year, the hospital received a limited amount of government funding for a fixed number of posts. The hospital had applied for additional funding previously and been unsuccessful in gaining more money for posts. This meant that a position needed to become vacant before a new post could be introduced. Several staff
reported that this scenario led to competition between professional disciplines for new positions. At the time of the fieldwork, a music therapy post was just one of a number of new positions in demand.

**Music therapy service.**

After a series of presentations, proposals, and negotiations with hospital management, a music therapy service commenced at the hospital towards the end of 2008. The music therapy service was introduced as a one year “pilot” and Sarah was employed two mornings per week, with eight hours total being paid for her service. The pilot was funded by charitable donations. Sarah’s salary came from money donated to the hospital trust fund and other staff members had donated money for musical instruments. The hospital school provided Sarah with an electronic keyboard for her use in sessions. Although the music therapy service was funded by charity, Sarah was treated in other respects as though she was a hospital employee. Her position was administered by human resources, she had a payroll number, and tax was deducted before she received her pay. From Sarah’s perspective, this arrangement helped her to feel “more established” than if she was on a sessional contract and sending monthly invoices to the hospital accounts department.

Music therapy was offered as part of one of the four programmes in the hospital. This was the smallest programme in the hospital, with only eight inpatients at any one time. The programme team consisted of a range of professionals. The team was led by a medical consultant, who visited the hospital one to two days per week. An internal programme manager and a clinical nurse manager also held administrative responsibilities. The rest of the clinical team was made up of doctors, registered nurses and health care assistants, a psychologist, two social workers, two physiotherapists, two occupational therapists, a speech and language therapist, and students of the various allied health professions. The nurses and other therapists were clearly identifiable by their uniforms. The doctors, social workers, programme manager, psychologist, and music therapist dressed professionally but did not wear uniforms. Only one member of the programme team had prior experience of working alongside a music therapist and a couple of others had worked with practitioners from other creative arts therapy disciplines in the past.
Four of the team members were actively involved in the introduction of the music therapy service. These team members advocated for music therapy at management level, assisted in preparing music therapy submissions, or worked on securing funding for the music therapy service. A family member of a previous patient worked with the team to increase the public’s awareness of music therapy and to raise further funds for the continuation of the music therapy service.

Sarah’s desk was located within a small office space allocated to the programme area that included music therapy. Music therapy sessions were conducted in a range of settings, including a large sitting room, the physiotherapy gym, and a tiny room at the end of the gym. The sitting room contained a piano, which had been donated to the programme. I noted that none of the above rooms were sound-proof and Sarah needed to transport her instruments from place to place.

Although Sarah was unfamiliar with this particular hospital context, she was able to draw on almost twenty years of experience working as a music therapist in other health and education settings. She had managed a large team of music therapists previously and possessed considerable university teaching and student and professional supervision experience. In introducing music therapy to the hospital, Sarah perceived that she was returning to the “real work” of conducting sessions and setting up a music therapy service.

My first observation was that Sarah was incredibly busy for her eight hours per week. Meetings sometimes took up a large proportion of her time, leaving only a couple of hours in which she could see patients. Sarah typically saw two or three patients in a morning’s work. As she conducted her sessions in different locations, she also needed to allocate time to setting up her instruments. When not in meetings or sessions, she worked towards the continuation of the music therapy service. I observed her working hard to demonstrate the value of music therapy and discussing fundraising possibilities with other staff members. I noted that this left Sarah with little time for attending to paperwork responsibilities. I regularly observed her documenting her clinical sessions during meetings and she reported that she completed any unfinished paperwork at home.
Observations.

My fieldwork commenced about three months after Sarah had started her work at the hospital. I visited the hospital a total of twenty-one times and undertook approximately eighty hours of observation during my fieldwork. Observations were conducted on the mornings that Sarah was employed and were structured around her meeting times. At the start of most mornings, I met Sarah to co-ordinate our schedules. She let me know of meetings that I could attend and notified me of times when she planned to undertake music therapy sessions. During music therapy session times, I usually remained at Sarah’s desk, writing up my field notes, studying hospital documentation, or reading literature relevant to my research. I also used these times to take breaks in the coffee shop, or to conduct interviews with hospital staff.

The majority of my observations took place during the hospital programme’s three regular meetings. The first of these was the weekly team meeting, in which patients’ needs and treatment were discussed. In these meetings, all except one or two registered nurses sat around a large triangular table in the boardroom. Patient records were brought to the room on a chart trolley. The process of the meeting necessitated that nursing staff stood up repeatedly to take folders back to the trolley and collect new ones.

Another meeting that I observed was the weekly timetabling meeting, which involved nursing, psychology, social work, and therapy staff. This was when timetables were created for patients and when team members scheduled their session times for the coming week. Conjoint sessions were also arranged at this time. Timetabling meetings took place in the programme office and I noted that these meetings were less formal than the weekly team meetings. Very few staff members attended for the full meeting. Staff either called in briefly to arrange their session times or completed paperwork tasks simultaneously.

The third type of meeting that I regularly observed was the fortnightly administrative meeting. These meetings were devoted to problem solving and programme improvement. All of the team except the doctors usually attended. The meeting was held during the lunch period and sandwiches were provided from the
hospital kitchen. I observed that the programme manager set the agenda for the meeting and led proceedings. Often she used the meeting to gain team members’ input on programme changes and decisions. In my experience, it was in these administrative meetings that team members most often shared their responses to the work. It became apparent that several team members perceived their work as demanding. I noted that team members described their work with families as challenging and regularly complained of lacking adequate resources and time. Most were employed only part-time, but worked beyond their job descriptions for the benefit of patients and families. One staff member explained that she felt “stressed” as she never gained the satisfaction of completing tasks.

Power imbalances in team meetings were referred to frequently in the literature I had critically reviewed in the development of my research topic (Atwal & Caldwell, 2005; Miller et al., 2005). Therefore, I was not surprised when I observed tensions in administrative meetings. One of the words that was regularly invoked was “caring”. I noted that when tensions arose, the suggestion that some team members were less caring than others invariably surfaced. Another unstated phenomenon was what could be described as the presence of a “work hard” culture. I observed that staff often put forward objections to proposals on the basis that they were already overloaded with work, or had no time to devote to the additional duties that would be required to achieve the intended objectives. This was interesting to me, as I was reminded of my previous experience of working within healthcare organizations. I recalled team meetings as a time when everyone worked hard to appear as though they should be off doing something more important.

I attempted to keep my participation in team meetings to a minimum. I sat quietly among the staff and jotted down any statements or interactions that stood out to me. Although I often experienced an urge to help or to give my professional opinion, I rarely made a sound. There were only a couple of occasions when I noticed myself contributing to a joke or giving a knowing look when staff described the challenges they were experiencing. Otherwise, my behaviour remained fairly understated. It is also likely that my appearance rendered my presence as inconspicuous. As a young, white, middle class woman, I looked relatively similar to most members of the team and I perceived that I blended in with the group.
I also attended some scheduled meetings between Sarah and one or two other members of the team. These were meetings in which Sarah and other staff discussed a specific patient’s needs, planned or reviewed conjoint sessions, or developed research ideas. In these meetings, I remained a quiet observer unless spoken to or asked a question. On two occasions, I gave my professional opinion. One was when Sarah asked for my perspective on a patient’s progress and the other was a request for my input about some research ideas. I also assisted by operating a DVD player on one occasion. I agreed to help Sarah in these ways, as I believed that she could have accessed this sort of assistance from me regardless of whether the fieldwork was taking place.

I not only observed the team interacting in scheduled meeting times, but also in more informal ways. Often staff conversed before a meeting started or stayed on after meetings to talk in pairs or threes. Due to the physical layout of the hospital, it was also common for staff to meet and talk in corridors. I observed that staff used these informal meeting times for a number of purposes. Sometimes informal meetings were used to follow up on referrals, to discuss patients’ progress, or to share positive feedback from families. Other times the staff used informal meetings to attend to administrative issues or to arrange meetings or conjoint sessions. I noted that informal meetings tended to be more personal than the scheduled meetings I attended. Staff members often debriefed about difficult team meetings or complicated family issues and frequently conversed about life outside the hospital. I perceived that informal meetings were highly revealing in terms of the way the team functioned. From my perspective, issues were more often resolved through these informal interactions than in the formal scheduled meetings I attended. In reflecting on my observations of these informal interactions I was reminded of DiPalma’s (2004) concept of “webs” (p. 303). DiPalma observed that healthcare workers gained power and work satisfaction through working outside of formal hospital structures. Learning how to engage with informal structures seemed to be an important way that Sarah was finding her feet in the organisation.

Although I had met some staff prior to starting the fieldwork, during the period of the fieldwork I observed hospital staff members off-site on two occasions.
The first of these occasions was a fundraising morning tea for the music therapy service. On another occasion, I was invited to attend the team’s Christmas party in a local hotel. I was reluctant to attend this event, as I did not consider myself to be part of the team. I also worried that my presence might limit team members’ enjoyment of the party, as they may feel that they were being watched. However, I did eventually agree to attend after several team members insisted that I come along. Sarah and I travelled to the hotel together and this proved to be a valuable opportunity for us to discuss the development of the music therapy service further.

*Interviews.*

I conducted seven interviews with a range of professionals who were involved in the development of the music therapy service. Those interviewed included the medical consultant, the programme manager, the clinical nurse manager, two members of the allied health team, one of the hospital managers, and of course, Sarah. Interviews were conducted at times convenient to the interviewees and in locations such as the programme office, the interviewee’s office, or an available boardroom. Each interview focused on the interviewee’s views of the introduction of the music therapy service. The interviewees shared what they perceived to be the strengths of the music therapy service and revealed possibilities for the future development of music therapy. Interview responses also helped to highlight certain contextual aspects that may have influenced the introduction of music therapy in this particular hospital. These will be discussed further in Chapter 6.

I entered less formal discussions with Sarah during coffee breaks or at times when there were meeting or session cancellations. We also met at the end of most mornings to discuss events and any issues arising from the research. At these times, Sarah reflected on the opportunities and challenges she was experiencing and shared her responses to her service development work.

*Role considerations.*

When I entered the hospital as an ethnographic researcher, a number of previously held roles and identities came in with me. In the past, I had worked in
hospitals as a student, a music therapist, a colleague, a researcher-practitioner, and a clinical placement supervisor. Returning to the familiar setting of a hospital therefore brought to the fore a set of previously held positions and behaviours. For example, after my first day of fieldwork, I reflected that it had felt much like my first day of placement as a music therapy student. When I arrived at the hospital, I sat nervously in reception, not knowing how my fieldwork would unfold. Another example occurred when I was sitting in the hospital coffee shop. A nurse enquired as to my role at the hospital and in no time I was giving my best music therapy sales pitch. In the past, I had regularly used opportunities like these to promote music therapy and to secure my position as a music therapist in a hospital.

My role as a researcher took time to develop and changed in response to the various situations that arose. There were times when I maintained strict boundaries between my role as a researcher and my previously held roles. Other times, I crossed boundaries in the interests of building rapport and showing appreciation to the people who contributed to my research. In the course of my ethnography, I experienced a great deal of uncertainty as to how I should interact with fieldwork participants. I therefore used strategies such as reflexive journaling and attending regular research supervision. These strategies allowed me to develop my role in a considered way. I was able to explore the range of multiple identities one holds in such a position and in turn, this ensured that I could maintain ethical conduct. Additionally, I welcomed these strategies as they showed me their value in allowing me to reflect on and manage my own responses to the fieldwork.

Strategies.

Once I had completed my fieldwork observation period, during which I wrote extensive notes and memos, kept a reflexive journal, and transcribed all of the interviews, I was able to read and reflect on these materials to explore and identify some of the main phenomena that emerged in this new service development context. Through this process, I identified six main categories of strategy that Sarah used to introduce music therapy at the hospital: educating, interprofessional working, 

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8 A more detailed discussion of this topic is presented in Ledger, 2010.
remaining flexible, generating evidence, investing time and energy, and relying on advocates (see Table 4). Each of these strategies will now be described in detail.


Strategy 1. Educating.

Sarah indicated to me that education of staff was one of her priorities in introducing music therapy to the hospital. She gave several talks about music therapy to staff prior to starting at the hospital. I attended one of these talks, in which my doctoral supervisor also gave a research presentation. Sarah’s presentation included music therapy definitions and case examples and Sarah brought in her own television/video machine so that she could show video footage of music therapy sessions. I also noted that Sarah placed particular emphasis on the role of the music therapist in the interprofessional team.

During Sarah’s presentation, I noticed that staff appeared most engaged during the video footage of music therapy sessions. I observed nods and sighs of delight, as if the role of music therapy was becoming clearer. Sarah also allocated a time at the end for questions, in which staff asked how music therapy could address specific conditions and assist particular patients. This allowed Sarah to share further case examples from her work. Sarah later explained that she valued the opportunity to share case material, as she believed that music therapy was difficult to define. This belief was consistent with views conveyed in music therapy literature (Barrington, 2008) and by the narrative contributors in my study.

Interview responses indicated that the Sarah’s presentations were highly effective in educating staff about music therapy. Two interviewees referred to Sarah’s presentations as a time when the therapeutic value of music therapy became apparent. One interviewee explained how she had expected music therapy to be play-oriented and “woolly”. However, on seeing Sarah’s video footage, she immediately recognised similarities and applications to her own therapy work. In her opinion, it was informative to see as well as hear about music therapy. She said, “what sold it for me really was watching the video and seeing it, in action”. Another two interviewees perceived that Sarah was a particularly skilled presenter. One interviewee reported that Sarah was “easy to understand” and “a joy to listen to”.

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had also noted Sarah’s enthusiasm in communicating information about music therapy to staff.

A further way that I observed Sarah educating others was through disseminating music therapy research papers to staff. I witnessed her sharing literature with the psychologists in particular. At the time of the fieldwork, Sarah and two clinical psychologists had started writing an article about their conjoint sessions. Sarah shared literature with the psychologists as they developed their ideas for this article. I also observed Sarah referring to psychoanalytic theories when she interacted with the psychologists. For example, she mentioned the theories of Winnicott as she and the psychologists reviewed a piece of video footage. These forms of education may have helped to demonstrate music therapy as an evidence-based and theoretically-informed allied health profession. Team members’ interview responses further indicated that they recognised Sarah as an educated and knowledgeable practitioner. Additionally, Sarah reported to me that her qualifications had never been called into question by staff.

I noted that Sarah used team meetings as another opportunity to educate other staff about music therapy. When a referral was received, she educated staff by clarifying the reason for the referral. For example, when a staff member referred a particular patient because “she plays piano,” Sarah attempted to draw out further clinical reasons for the referral. She suggested that music therapy could address the patient’s need for emotional expression. Another staff member then added that piano playing might help to improve the patient’s posture. Interactions such as these were commonplace in team meetings.

I noticed that Sarah provided additional information about music therapy in the way that she presented herself. She dressed professionally and used medical language and terminology typical of the hospital setting. It was evident that other members of the clinical team saw Sarah as an experienced professional. One interviewee stated “she seems a very well qualified and skilled and experienced person” and referred to her “sense that [Sarah] knew what she was doing”. In emphasizing the professional aspects of her role, Sarah may have played down her identity as a musician. She reported that staff rarely commented on her musical
abilities and that she hadn’t detected any signs of what she termed “music envy”. She expressed relief that this was the case, explaining that it was more important for her to be seen as a therapy professional. After discussing this topic with Sarah, I reflected that I too had wanted to be seen as a “good therapist” in my prior music therapy work. It was less important for me to be seen as a “good musician”. Although I had not been aware of it previously, I began to think about how music therapists navigate this difficult terrain of how to highlight their clinical rather than musical expertise.

Another interviewee’s comments indicated that staff gained knowledge about music therapy from the ways in which Sarah presented herself. This interviewee explained that prior to seeing the way that Sarah worked she had viewed music therapy as “indulgent”. She said that she came to see music therapy differently after Sarah presented herself as “confident”, “serious”, “structured”, and “on equal footing with other therapists”.

Sarah explained to me how she deliberately distanced herself from fundraising activities in order to present herself as a professional. She attempted to limit her involvement in fundraising to providing information about music therapy at fundraising events, and insisted that the money was raised for the music therapy service and not for her self. This distinction may have helped this perception of her being on an “equal footing” with other professionals, as no other staff members were required to raise money for their own posts.

When asked for recommendations as to how a music therapist should go about introducing music therapy, several interviewees emphasized the importance of education. Three interviewees acknowledged that little is known about music therapy, as it lacks the history and profile that more established health professions hold. These interviewees suggested that music therapists are in a unique position, in that they need to frequently inform others about the nature of their work. They recommended that music therapists should provide education, not only to healthcare staff, but also to the wider community. One interviewee proposed that music therapists create a DVD to communicate the benefits of music therapy to the general public. Interviewees’ responses suggested that wider social changes were required before music therapy could become more established.
Strategy 2. Interprofessional working.

Sarah regularly stated that her main service development strategy was to engage in as much “conjoint working” as possible. She shared her hope that through interprofessional work, other staff would come to see the benefits of music therapy and then fight for the continuation of the music therapy service. I observed that Sarah rarely worked alone and regularly worked in collaboration with other team members. She worked with others to assess patients’ needs, to plan interventions, to conduct sessions, and to share and evaluate treatment outcomes. She frequently exchanged knowledge with other staff and showed care and concern for her fellow workers. As I followed Sarah about the hospital, I was highly impressed by her ability to work with other staff.

Most of Sarah’s sessions were interdisciplinary, in that they included more than one professional. Although I was not present for any sessions, I gained knowledge about Sarah’s interprofessional work through our conversations, through observing meetings, and through interviewing staff members who had worked with Sarah in sessions. I learned that Sarah adapted her clinical approach depending on the particular professional she was working with. Sometimes the music added structure and routine to other interventions, sometimes the music provided a nonverbal means of communication, and sometimes the music was used to build rapport or to motivate a patient to participate in treatment. The level of planning for interprofessional work depended on the people involved. Sometimes conjoint sessions were conducted with only a small amount of preparation, such as a brief discussion about session aims. Other times Sarah took the time to negotiate her role with the other professionals and provided information about the ways in which others could assist her in achieving the music therapy goals.

Interview responses indicated that staff came to understand music therapy as a “real therapy” when working with Sarah in sessions. Interviewees shared ways in which music therapy had helped them to achieve their own therapy goals and had opened their eyes to new treatment possibilities. Music therapy was welcomed as a “fun” or “creative” contribution, which was more engaging than existing interventions. Interviewees also explained how they came to see different aspects of
patients through working with Sarah. They described how Sarah had exposed them to new skills and approaches, which they could then apply in their individual sessions with patients. One interviewee reported that she had even tried using music in her own work since collaborating with Sarah. Furthermore, interviewees reported that successful interprofessional work with Sarah had encouraged them to seek further interprofessional work with other team members. As I listened back to my fieldwork interviews, I was delighted to hear other staff talking about music therapy in these terms. At the same time, I wondered if this enthusiasm might be an artefact of the new and novel status of music therapy in the hospital.

Interviewees commented that Sarah was exceptional, in that she encouraged others to observe her work. One interviewee explained that other staff members tended to be “protective of their profession and their knowledge” and that it was unusual to find that Sarah was so “open”. I noted that most team members accepted invitations to observe music therapy and regularly requested that Sarah help them in their own sessions. I also observed many instances in which Sarah shared her knowledge and sought others’ professional opinions. In both formal meetings and corridor stops, she and others frequently discussed patients’ conditions and exchanged observations and treatment ideas. The following interview excerpt further suggests that Sarah’s interprofessional work was a factor in gaining team members’ acceptance:

The music therapy here is part of the team. She contributes to the team meetings, and then she works in close, close to the team and very often the music therapy and the physio, the music therapy and the OT and they work with the child. So it’s really a team approach I think that makes it, that makes it . . ah beneficial.

At times when we met, Sarah reported that conjoint sessions were less challenging than working alone and she reported that she enjoyed working in this way. Our discussions reminded me of times in my previous work when I valued the presence of another therapist, as providing an additional perspective, or even as an extra pair of hands. I reflected that some of my most satisfying moments as a music therapist were when I worked with other therapists in sessions. Through gaining the support of other therapists, I felt more able to meet patients’ needs and more accepted
as part of the allied health team. I also valued the chance to learn more about other therapists’ roles and areas of practice.

Although Sarah regularly referred to interprofessional work as a service development strategy, she did convey some reservations about conjoint sessions. She shared her concerns that conjoint sessions were being driven by staff members’ needs and not by the needs of patients and families. She worried that she was carrying out conjoint sessions to advance the music therapy service and to lessen the demands on staff, rather than responding to signs from the patient that interprofessional work was required. She reflected on the conjoint sessions she had conducted previously and was relieved to discern that all but one patient had shown a need for conjoint sessions. Sarah also expressed a concern that she may have taken on a “musical accompaniment” role in some of the conjoint sessions. As mentioned previously (see pp. 168-169), it was important to Sarah that she was treated as a therapy professional and not just a music provider. However, she stated that she was willing to provide music for others if it helped her to build relationships with the team.

I regularly observed Sarah engaging in interprofessional work during team meetings. In meetings, Sarah worked with other staff to devise goals and to share outcomes. She reported outcomes from music therapy sessions and other staff shared positive feedback about music therapy that they had received from patients and families. Sometimes team members even remarked on carry-over effects of music therapy between sessions. In observing team meetings, I wondered whether this sharing of outcomes increased staff members’ investment in the music therapy service. I noted that other staff expressed enthusiasm and excitement about patients’ progress in music therapy, through nodding, smiling, and making affirmative statements.

Another type of interprofessional work that I observed was Sarah’s research collaboration with two psychologists. During my fieldwork, Sarah and two psychologists reviewed a series of conjoint sessions and developed ideas for a journal article on their work with a particular patient. In a meeting that I attended, Sarah and the psychologists watched conjoint sessions on video, pointed out significant features to each other, and shared their observations and discoveries. One of the psychologists
came to see a patient in a new way and expressed excitement about her revelations. She said that she was looking forward to sharing her new insights with the patient’s family. Sarah and the psychologists then commenced work on an article about their conjoint work. Together they determined the focus of the article, decided on an appropriate journal to which they would submit the paper, and made a plan to complete the article in a timely fashion. For the remainder of my fieldwork, Sarah and the psychologists exchanged relevant literature and sections of the article that they had written separately.

I also observed a number of private, informal collaborations between Sarah and other staff. One example occurred when there was a lack of agreement within the team as to whether a patient should be discharged. Some team members believed that they had done all they could for this patient, while others perceived that further progress was still possible. Sarah and two other team members stayed on to discuss this topic after a timetabling meeting. The other team members expressed concern that the patient’s family would “lose hope” if the patient was discharged. They requested that Sarah attend a family meeting to share the patient’s positive progress in music therapy. Sarah expressed concern that she would contradict others’ professional opinions if she were to present a more optimistic view. However, she agreed to attend the family meeting and to report on the patient’s participation in music therapy sessions. Following Sarah’s contribution to the meeting, it was decided that the patient would be discharged but receive ongoing music therapy on an outpatient basis. This arrangement was interpreted by staff as a means to “wean” the patient off hospital services. Later conversations about the meeting indicated that the decision to continue music therapy had led to team members feeling less guilty about the patient’s discharge. Thinking back on my witnessing of this scenario, I am reminded of an article which identified a role for music therapy in offering others hope about the progress of the patient (Magee, 2005).

I observed that Sarah played an important role in caring for other team members. She frequently recognised the contributions of other staff and showed concern when others appeared stressed. In informal conversations before and after meetings, I watched Sarah empathizing with team members who had expressed tiredness or uncertainty around complicated work situations or interactions with
patients’ families. I also observed instances when other staff approached Sarah for support and advice about workplace tensions. During these sorts of encounters, Sarah often emphasized similarities between her own experiences and the experiences of others. This was done on both professional and personal levels. I observed one instance in which Sarah identified with another staff member who was struggling to come up with “measurable goals”. At other times, I observed Sarah enquiring about others’ personal lives or talking about her children with other mothers on the team. Emphasizing common interests and experiences may have served to increase her degree of acceptance within the team.

When Sarah talked about her interprofessional work, she explained how she was cautious not to align herself with any one particular discipline. She had noted certain tensions within the team and considered that it could be disadvantageous to work solely with any one professional. She preferred to think of herself as a “floater” and said that she wanted to maintain a “fluid” position within the team. She reported that she enjoyed working with a variety of professionals and felt drawn to different disciplines at different times. Sarah’s position in relation to the hospital canteen was a topic that we frequently discussed. She explained that she had made a conscious decision to avoid eating there, where staff sat together in disciplinary groups. She predicted that she would indicate an allegiance if she sat with a particular group and that this allegiance could preclude her from working with other disciplines. One interviewee’s comments supported Sarah’s decision not to align herself with any one group. This interviewee perceived that a strength of the new music therapy service was that it helped to unite the team: “it [music therapy] kind of infiltrates all the... different roles in the team and kind of pulls things together in a very kind of different way.” This interviewee appeared to recognise the “team tying” capacity of music therapy that has been referred to by music therapy authors (Hilliard, 2006; Loewy, 2001).

**Strategy 3. Remaining flexible.**

I observed that Sarah remained flexible in relation to many aspects of her music therapy service. I noted that she was attempting to create a music therapy service to match the particular hospital context, rather than implementing fixed ideas
about music therapy. She remained open to suggestions from other team members and tried to fit in with existing systems where possible. One example was the development of a form on which to record music therapy activity. Sarah worked with the programme secretary to adapt a pre-existing form for music therapy purposes. On the form, Sarah recorded her day to day activities in units of fifteen minutes. Although she experienced this task as time-consuming, she considered that it was “worthwhile” to record activity data. Decisions at management level were reported to be based on “efficiency” and it was possible that this sort of data would be helpful later in persuading managers of music therapy’s value for money.

I also noted that Sarah was flexible about which patients received music therapy. She reported that her initial intention had been to restrict the music therapy service to inpatients. However, she later provided sessions to outpatients, in response to requests from team members. I was also aware of a situation in which a team member offered a patient music therapy before consulting Sarah. Despite having limited time to spare, Sarah agreed to see this patient. Her reasoning was that she wanted to give something back to this team member, who had been a strong advocate of the introduction of music therapy at the hospital.

Another way that Sarah showed flexibility was to explore new approaches and areas of practice. In our meetings, she indicated that she had adapted her approach in response to patients’ needs and for her work with other professionals. She reported that she had used mainly improvisational methods in her previous work as a music therapist. Since starting at this hospital, she had begun to use more recreative methods, including the use of recorded music. She reflected that she was learning to be “flexible” and to do “whatever works”. Sarah questioned whether she was still practising “music therapy” while exploring different methods. However, she concluded that she was maintaining her music therapy role as long as she observed therapeutic outcomes and continued to think “psychodynamically”. As I had noted other music therapists questioning their roles (see pp. 148-149), I began to consider that this may be a common phenomenon among music therapists who are entering new territory.
In timetabling meetings, I observed Sarah showing flexibility and courtesy towards other team members. Team members often wanted to see the same patient and they needed to negotiate who would see which patient when. I observed that team members showed mutual respect for each other when arranging session times. For instance, they often arranged conjoint sessions, so that a number of professionals could see a patient at once. I noted that Sarah frequently re-scheduled sessions to give others priority in accessing patients. I would have expected this gesture to lessen Sarah’s status within the team. However, one interviewee’s comments suggested that Sarah was viewed as an equal player in timetabling meetings. This interviewee reflected:

I think she has put herself very much on an equal footing with other therapists, rather than kind of trying to fit around us and say “oh well the music can fit in somewhere else.” No, no, this is just like physio and this is just like OT and I think that very much we have taken it as that and I see it now as . . . on an equal footing with what we do.

Sarah explained how she was prepared to make some compromises while developing the music therapy service. One compromise was the agreement to conduct music therapy sessions in various locations throughout the hospital. Without a designated space for music therapy sessions, Sarah felt like she had “stepped backward” and was “starting again”. However, she reminded herself that the hospital’s employment of a music therapist represented a significant step. She considered that the hospital did show some level of commitment to music therapy, by providing her with access to a sitting room, a desk, office supplies, line management, human resources, and secretarial services. She stated that she had decided not to complain about the lack of music therapy space, but hoped that staff would notice her struggling to move instruments from place to place. There were signs that team members had taken notice. In one administrative meeting that I observed, several staff members expressed concern that Sarah was unable to work in a “private” space.

Sarah viewed her involvement in promotional activities as a further compromise. To assist in fundraising, Sarah posed for photographs and regularly explained the benefits of music therapy to potential funders. She said that she felt uncomfortable about these activities, as they made her feel like a “commodity” to be
“sold”. She also worried that her involvement in fundraising represented a “conflict of interest”, in that she was engaged to provide services that benefitted patients, not to develop a service that would be attractive to funders. However, she perceived that further charity money was vital for securing the continuation of the music therapy service. She therefore continued to participate in promotional activities, though tried to limit her involvement to providing information about music therapy.

The fact that the music therapy service was charity-funded was also seen to be a compromise. Sarah explained that this funding arrangement failed to give a “good impression of professionality”. She pointed out that other team members were not required to raise money for their posts or equipment. She expressed discomfort that team members had been asked to donate money for instruments, when they “wouldn’t be asked to pay for a walking frame”. Although Sarah viewed the funding arrangement as less than ideal, she conceded that music therapy could only be introduced in this way in the current economic and organizational context. She reported that she strongly believed that the team and patients could benefit from a music therapy service and that she wanted to establish the service regardless of how it was funded.

**Strategy 4. Generating evidence.**

As the music therapy service was introduced as a pilot, Sarah was required to provide evidence to support further continuation of the music therapy service. The hospital executive asked for a music therapy evaluation report to be submitted nine months after the pilot began. Even before she began work at the hospital, Sarah shared her plans for evaluating the pilot. She planned a “three-pronged” evaluation to show the benefits of music therapy for patients and families, other staff, and the hospital in general. She showed me surveys which she had designed for gaining feedback from families and staff, and forms on which she recorded referrals, the frequency of music therapy sessions, and the number of patients awaiting music therapy treatment. I noted that Sarah spent a large proportion of the fieldwork period gathering evidence to support future music therapy proposals.
I observed that Sarah reported outcomes of music therapy sessions in both verbal and nonverbal ways. She spoke up in team meetings to report patients’ progress in music therapy and she documented sessions in patients’ charts. At the time of the fieldwork, she was also planning to present some video footage of her conjoint sessions to the team. She said that she hoped other team members would understand the “emotional” aims of music therapy once they had seen this work on video.

Sarah described how there was an element of “risk” to speaking up in meetings. She acknowledged that there were a number of people present with important perspectives and that it was difficult to know when to insert her professional opinion. I noted that she spoke up most frequently when her patients were discussed. Other times, she remained quiet and avoided joining in on team discussions. This was particularly the case when management issues arose or when there were disagreements between professionals. At these times, Sarah reflected that she needed to “sit on her hands” and to remain “just the music therapist” instead of taking a public stand. She waited until after meetings to show her support for other team members.

Another possible form of evidence was Sarah’s research collaboration with the psychologists. Sarah expressed a hope that her position would become more secure through publishing and presenting internationally. She expected that management would recognise research as a valuable way to raise the hospital’s profile and that her research contributions would provide a rationale for the continuation of the music therapy service. This expectation was shared by one interviewee. I observed that it was reasonable to assume that research would demonstrate music therapy’s equivalency to other professional disciplines. Other team members were expected to engage in research and time for research was even included in some team members’ job descriptions.

Sarah reported that she felt under pressure to constantly “prove” herself and the value of music therapy. She worried that the music therapy service would end and experienced demands to perform and to “be on display”. She explained that she was unable to concentrate solely on meeting patients’ needs, as she needed to take
advantage of opportunities to secure music therapy’s position. She felt that she needed to be constantly on alert and often asked herself, “should I say this?” or “should I do this?” or “how do I present this?” A further source of pressure was her awareness that team members had fought long and hard for the introduction of a music therapy service. She perceived that she had a responsibility to fulfil team members’ high expectations.

Although Sarah recognised a need to develop a strong case to support the continuation of music therapy at the hospital, she also worried that patients and families were affected by the pressure to produce music therapy outcomes. She shared one example in which a family member placed high expectations on a patient who was receiving music therapy. Sarah was concerned that the family member had sensed the urgency to produce music therapy outcomes and had reacted by placing undue pressure on the patient to succeed in sessions. She later spoke with the family member and encouraged the family member to allow the patient to participate within his capabilities and interests. The family member then responded by taking a less active role in the sessions that followed. Through this experience, Sarah became more aware of her own anxiety around producing positive outcomes. She considered that it was important not to add to the stress experienced by patients and families and tried to avoid bringing her own anxiety into sessions. In listening to Sarah’s story, I was reminded of my experiences as a music therapy clinical placement supervisor. I recalled how patients picked up on students’ anxiety when I attended sessions to observe and to evaluate their progress. I reflected that the students’ experiences may be similar to those of a music therapist engaged in new service development, who is also under constant evaluation.

When I started my fieldwork, I was impressed by the amount of evidence that Sarah had generated for the purposes of convincing hospital managers. Two interviewees questioned whether hospital managers would be able to understand the benefits of music therapy though. One interviewee asked, “how can they assess it if they don’t know anything about it?” while another perceived that it would be impossible for music therapy to compete with more established professions for additional hours. This second interviewee predicted that music therapy would be seen as a luxury, even if Sarah was able to demonstrate efficacy. In this person’s
opinion, “recognised therapies” would be considered before further music therapy funding could be secured. These interviewees’ comments indicated that gaining management approval for ongoing music therapy would be a challenge.

Strategy 5. Investing time and energy.

I observed that Sarah invested considerable time and energy into the introduction of the new music therapy service. Even before the service began, Sarah invested many hours of unpaid time in planning, presenting, and proposal writing. She reported that she had developed many of her documentation and evaluation materials in her own time off-site. These included an activity sheet for recording referrals and the number of patients seen, parent and family feedback forms, a staff questionnaire, a consent form for sessions to be documented on video, a referral form, a music therapy information sheet, and an instrument inventory. Any academic writing also took place off-site and often late at night. Sarah said that she used her own time to reflect on music therapy sessions and made outside appearances at charity events to explain music therapy to potential funders. Furthermore, I noted that Sarah rarely took meal breaks and hardly ever left the hospital on time. Although she reflected that she was working “above and beyond” what she was paid for, Sarah perceived that this additional work was necessary for music therapy to become more established.

There were indications that other staff recognised Sarah’s degree of investment in her work. Throughout the fieldwork, I observed many instances in which team members mentioned the amount of time and effort that Sarah was putting into the service. The programme manager regularly suggested that Sarah take time off to make up for hours spent on paperwork at home. Responses to a staff questionnaire about the music therapy service stressed that more hours were required for music therapy. In passing conversations with me, team members showed an awareness that Sarah was working under pressure. For example, one team member expressed reluctance to make music therapy referrals, as she didn’t want to place any additional demands on the music therapist. Several interviewees also acknowledged that Sarah’s time was limited and that she needed to work hard to see patients and to generate evidence to support the continuation of the music therapy service.
Furthermore, interviewees frequently referred to the “energy” and “enthusiasm” that Sarah contributed to interprofessional work.

As I carried out the fieldwork, I wondered whether Sarah’s strong work ethic contributed to her acceptance in the team. One interviewee expressed admiration that Sarah was working “full steam” despite only being employed on a short-term contract. Perhaps this is unsurprising in an environment in which a “work hard” culture seemed to prevail (see p. 163).

At the end of several mornings, Sarah commented on how tiring the work was. She reflected that it was demanding to be working in a tense environment and to be constantly proving the value of her work. Even as an observer, I experienced the short mornings as tiring. I was reminded of my busy work life as a music therapist. I recalled that I always rushed around, rarely took meal breaks, and often felt exhausted by the end of a day’s work. I assumed that work was quite pressurised for staff who worked at the hospital full-time.

Although Sarah described her service development work as an “uphill struggle”, she remained optimistic and maintained a strong belief in the value of music therapy. She expressed enthusiasm about her clinical work and often said that she enjoyed working with a range of patients with diverse needs. She believed that music therapy could make an important contribution to patients’ health and the work of the team. The more we talked, it became evident that Sarah had a “dream” for the music therapy service. Her dream service was one that was on par with more established services elsewhere. She explained that she hoped that her position would become established and full-time, that at least one other music therapist would be employed, that she would have a purpose-built music therapy room, and that she would have opportunities to supervise music therapy students and newly qualified music therapists. Perhaps it was this dream that motivated her ongoing efforts to establish the music therapy service.

Sarah regularly credited other team members for their work in introducing the music therapy service. She imagined that she would not have received the opportunity to introduce music therapy had she approached the hospital independently and reflected that she could not have introduced music therapy on her own. I noted that it did appear advantageous to receive the support of a committee when introducing new services at this particular hospital. Towards the end of the fieldwork, a new “recreation therapist” position had received approval and was being funded by the hospital trust. This service development had been led by a steering committee of clinicians, managers, and financial employees. When I heard about the new recreation therapist position, I was reminded of the literature I had read on organizational change. Previous authors (Deegan et al., 2005; Dulaney & Stanley, 2005) have recommended the formation of a steering group to plan and implement change in hospitals.

Four interviewees pointed to the medical consultant’s role in introducing music therapy services. The medical consultant had seen music therapy implemented successfully elsewhere and had supported the proposal to introduce music therapy at the hospital where my fieldwork took place. Hospital staff reflected that medical consultants traditionally held considerable power and played a major role in hospital decision-making. Although one interviewee referred to a lessening of medical consultants’ authority in recent times, most interviewees believed that the medical consultant continued to hold power over hospital management. Interviewees shared a common view that the support of the medical consultant was essential in gaining management approval for music therapy. One interviewee stated,

that’s a strong point for it, so in some services, where the consultant wouldn’t have a, a music therapy history or background and things like that, you know, if the consultant is not behind it there’s not a chance in (AL: yes, laughs). i-, in, in whatever to get it in, so I think that was one of the key aspects for ah getting the service started too (AL: mm), was you had a strong advocate.

Sarah reported that she was relying on other team members to represent music therapy at management level while she worked to establish music therapy’s place
within the programme team. I observed that she rarely communicated with hospital management directly and used other team members as intermediaries. This appeared to be a deliberate strategy on Sarah’s part. She explained that it was her intention to make music therapy’s place in the programme so “concrete” that other team members would fight for its continuation. She hoped that team members would stand up for the music therapy service in the event that hospital management decided to “pull the plug”. When Sarah told me about her strategy, I tried to put myself in her shoes. First of all, I reflected that I would be uncomfortable putting my survival into other people’s hands. I thought that I would prefer to present my case to managers more directly. It also occurred to me that the strategy of relying on advocates involves a great deal of risk. I reflected that Sarah must have considerable faith in her work to use this service development strategy.

Although I observed that other team members were strong supporters of the music therapy service, I questioned whether they were best positioned to be music therapy advocates. In interviews, it became evident that other team members held assumptions about hospital management based on previous administrative decisions. I assumed that team members’ advocacy of music therapy was driven by their own professional histories, relationships, and agendas, as well as their wish to improve patient care. Advocates conveyed uncertainty around what was needed to gain management support for music therapy and questioned whether they were asking for music therapy in the “right way”. They also expressed discomfort in talking about music therapy and indicated that Sarah was the best person to be explaining the benefits to hospital managers. One interviewee explicitly stated that there was “no better person from within the hospital to actually promote and educate people about music therapy”. Although this interviewee perceived that advocacy was important, her responses suggested that there may be times when it is more beneficial for the music therapist to speak with managers directly.

Further reflections.

The above strategies appeared to be successful in establishing music therapy’s place in the programme team. Team members spoke highly of the music therapy service, reporting that the service had benefited patients and families, enhanced
existing services, exposed new possibilities, and encouraged further interprofessional working. Team members no longer viewed music therapy as a “luxury”, but as a service which should become more regularly available.

At the time of the fieldwork, music therapy’s place in the wider hospital was yet to be established. Although Sarah’s team members saw potential for expanding the music therapy service hospital-wide, I noted that there was little awareness of the music therapy service outside of their programme. Interviewees perceived that further communication with management and staff of other programmes was required, if music therapy was to become established within the broader hospital. Since the fieldwork, Sarah has worked with staff of other programmes to develop a proposal to expand the music therapy service into other areas within the hospital. I look forward to hearing of the outcomes.

Summary

This chapter has described the main emergent findings of the narratives and ethnographic fieldwork. Through the identification of themes, it was possible to highlight aspects of music therapists’ experiences in developing new work. This analysis also revealed a number of possible service development strategies available for use by those engaged in new service development. The next chapter will synthesise the two main parts of my research and provide an in-depth discussion of these findings.
Chapter Six

Discussion

This chapter provides a review and discussion of the main contributions of my research about music therapy service development in healthcare organizations. First, I reflect on the service development issues that were identified through the narratives and fieldwork, drawing on literature from music therapy, healthcare, and management fields. Successful music therapy development is revealed as a highly complex process, for which there are no simple steps to achieve success. Finally, I discuss the contributions and limitations of my methodological approach in understanding facets of music therapy service development.

Issues in Music Therapy Service Development

Although the topic of music therapy service development has appeared in music therapy literature previously, this is the first time that it has been explored in depth in the form of a large scale multi method research project. As such, my research adds support to experiences documented by music therapists about service development and extends and augments the current state of the art as to best practice in practitioner-led service introduction and implementation. Findings from the narratives and ethnographic fieldwork in this thesis are congruent with themes that have emerged in anecdotal accounts of music therapists’ service development experiences, literature on music therapy as a developing profession, and writings about music therapy and interprofessional work. In the section that follows, common music therapy service development experiences that emerged through the research are summarized under the headings of working as a sole practitioner, insecurity, service development as challenging, and interprofessional work.

Working as a sole practitioner.

When a music therapist introduces a new music therapy service, he or she typically becomes the only music therapist within a team of more established professionals (Lehmann & Threlfall, 2008). The music therapists in my study
experienced this aspect of music therapy service development in different ways. Some music therapists described a need to constantly educate other staff about their roles and to demonstrate the value of their work. They provided information about music therapy in various forms and often invited staff to observe and assist in music therapy sessions. Sarah reflected that as the sole music therapist in a new post, she was unable to concentrate solely on her clinical work. Instead, she perceived that she needed to be constantly aware of opportunities to inform others about music therapy. Previous reflections on music therapy service development have similarly highlighted a need to continually promote and educate others about the nature of music therapy work. For example, Loewy (2001) described how she regularly takes advantages of opportunities to educate, during clinical rounds or in “the time it takes the elevator to move 3 floors” (p. 3). Miles (2007) similarly recalled “constantly promoting our work” when developing music therapy services in Western Australia.

Alongside the need to educate, some music therapists felt a responsibility to be adequate representatives for their profession. As sole practitioners, these music therapists were concerned that they left others with a good impression of the music therapy profession as a whole, rather than just their own work within the organization. Two music therapists conveyed anxiety that they weren’t actually practising music therapy and that they may be “caught out” by music therapy mentors and colleagues. One music therapist’s mention of a “music therapy police” was particularly striking. As I reflect on these comments, I wonder whether a fear of being caught stems from music therapy training and socialization processes. Music therapists have often been advised to maintain clear boundaries and to distinguish their professional role from the roles of other workers. Ansdell and Pavlicevic (2008) noted a tendency for music therapists to maintain clear boundaries and “monopolies” and described this as a “political response” (p. 75) to a prevailing anxiety regarding music therapy’s status as a profession. The responses from some of the music therapists in this study suggest that such anxieties can lead to feelings of uncertainty when a music therapist is working at the margins of what he or she regards as traditional music therapy practice. I noted that Sarah questioned her role when she was exploring approaches that were different to those that were part of her prior training and professional experience.
The narratives and fieldwork indicated a common belief that music therapy is a difficult profession to define and to describe to others. Barrington (2008) has previously written about the problems of defining and distinguishing music therapy with reference to the professionalization of music therapy. In her view, definitions may be necessary to communicate a professional identity, but may not capture the full range of possible approaches to music therapy practice. It may also be difficult to explain music therapy when the music therapist is yet to determine how music therapy can address the needs of patients, staff, and the organization in general.

Music therapists and other professionals in my study consistently reported that it was easier for them to demonstrate music therapy than to explain music therapy in words or through definitions. Several music therapists described how they had used case material to show the benefits of music therapy and video footage was considered to be particularly effective for communicating the nature of the work. These music therapists’ experiences may be helpful to other music therapists who are looking for ideas as to how to describe and explain what they do to others.

Some music therapists conveyed deep feelings of isolation through their narratives. These music therapists recalled times when they felt “lonely” or “alone”, or when they perceived that they had few people with whom to exchange ideas. I felt particularly moved by these experiences, which is revealed in the way that I included themes of isolation in several of my poems. Themes of isolation have also arisen at music therapy meetings I’ve attended, in previous accounts of music therapy service development (Konieczna, 2009; Miles, 2007), as well as in studies of other developing health professions such as dual diagnosis work (McLaughlin et al., 2008), and dance movement therapy (Meekums, 2008). Not all participants recounted experiences of isolation, but feelings of isolation seemed particularly intense when they were included. For example, one of the narrative contributors recalled that she felt “very alone” when developing new clinical and research approaches. It remains an important issue as to what type of support is available and needed by music therapists who are developing new services. Music therapists in my research sought support from other health professionals or from music therapists working in similar situations elsewhere. Professional supervision, conference attendance, and the establishment of links with music therapy training courses were also described as further means of reducing isolation. One narrative contributor even referred to
talking and working through issues in supervision as “one of the biggest growing points for me... as a person and as a therapist.”

Solitary working was not always presented as a negative aspect of music therapy service development. The music therapists in my study also described some positive aspects of working alone. Some music therapists explained that as sole practitioners, they were able to introduce the type of music therapy service that they believed would be most effective, as they were not bound by pre-existing expectations. Konieczna (2009) previously wrote about the freedom she experienced when introducing a music therapy service to a 24-hour care facility in Poland. As the first and only music therapist in this facility, she felt able to explore music therapy approaches and to develop a service that was responsive to residents’ needs. Music therapists who participated in my research appeared to have similar opportunities for exploration. In my conversations with Sarah, it became apparent that she was enjoying exploring different approaches and new areas of music therapy practice. Narrative contributors also wrote of the excitement they felt in testing boundaries and exploring new possibilities. For example, one music therapist recalled that she was “incredibly excited at all the scope I had to try new ideas”. Another music therapist stated, “to take risks and to really see what the possibilities are, that, that’s the really exciting part of developing something.”

I observed that the music therapists in my research not only worked alone, but also worked to belong and to be respected as members of a clinical team. Several music therapists reflected that they wanted to be accepted as “clinicians” and “allied health professionals” and dreaded being mistaken for music teachers, entertainers, or volunteers. Several music therapists also mentioned their efforts to gain inclusion in team meetings or to secure placement of music therapy within a particular psychosocial team. These music therapists explained that their inclusion in teams positioned music therapy as a discipline akin to other allied health professions. Previous articles about the role of the music therapist have similarly emphasized the music therapist’s position within a healthcare team (Edwards, 2006a; Kennelly & Brien-Elliot, 2001; Magee, 2005). In reflecting on the narratives, fieldwork, and related literature, I wonder whether team inclusion helps music therapists to communicate a professional identity. I observed the music therapists working to
establish professional identities in a variety of ways. These included educating others about a music therapist’s qualifications, using clinical language in paperwork and meetings, gaining inclusion on an allied health referral form, and documenting music therapy work from assessment through to evaluation. After describing a number of strategies through which she communicated her role, one music therapist advised, “you want . . . that music therapist never to look like a volunteer, or never to look like an entertaining musician, but a professional health care provider.” In reflecting on this statement, I wonder whether music therapists gain a sense of pride through professionalism. I remember feeling proud to be a member of a professional allied health team when I worked as a music therapist in a hospital.

Insecurity.

As I read over the narratives again and again, I reflected that most of the music therapists conveyed feelings of insecurity. This reflection was highlighted by the poem “Where do I stand?” (see p. 147). The music therapists’ experiences I was reading seemed similar to those described in a previous study of music therapists’ occupational stressors, in which a lack of government funding was presented as a possible source of stress (Clements-Cortés, 2006). When I read the narratives, I noted that the music therapists’ contracts were mostly temporary and were often funded by sources external to the healthcare organization. Several music therapists indicated that they felt insecure working under these conditions and that they perceived that they had little say in their professional survival. One music therapist recalled a frustrating process in which she was asked by her organization to write funding submissions, only to be denied funding once her proposals were submitted. After a series of unexpected service cuts, she asked, “Why on earth do I stay. . . and cop all this crap?”

The music therapists in my study frequently recalled pressure to prove the value of music therapy and to produce positive and measurable outcomes. I observed that Sarah spent a large amount of time documenting the benefits of the music therapy service, both inside and outside of work hours. When we met, she said that her biggest worry was that the music therapy service would end without sufficient evidence to support its continuation. Additionally, two interviewees in the
ethnographic study indicated that it was vital that Sarah struck a balance between patient contact and service evaluation, if music therapy was to have any chance of “survival”. These findings are consistent with previous discussions of music therapy work. Other music therapists have experienced pressure to prove their worth (Konieczna, 2009) or juggled the multiple demands of providing sessions and evaluating a music therapy service (Clements-Cortés, 2006; Loewy, 2001).

Service development as challenging.

I have often reflected with colleagues about the difficult nature of music therapy service development. It was therefore unsurprising to me that the narrative contributors portrayed service development as a challenge. Some of the aspects that the music therapists referred to as challenging were entering new territory, starting “from scratch”, gaining support and acceptance from more established staff, and obtaining financial backing for the continuation and expansion of the music therapy service. In order to cope with these challenges, the music therapists seemed to require a particular level of passion and persistence. I was struck by the way in which music therapists held firm beliefs about the value of music therapy and gained a strong sense of reward through working with patients and families. Seeing patients benefit from sessions appeared to be a powerful motivating force for music therapists who were struggling to develop their services. Even those who had experienced setbacks continued to work hard for the benefit of patients. Themes of hard work, commitment, and a passion for music therapy have also been reflected in the documented histories of music therapy pioneers (Buchanan, 2009; Hadley, 2003; Howard, 2009; Neugebauer, 2010).

Some music therapists recalled times when they perceived that their passion for music therapy was problematic. These music therapists expressed concern that their enthusiasm led them to “over-justify” their positions and to take on too much work. Others experienced strong feelings of disappointment when their services were cut back or when their funding requests were denied. These music therapists appeared to take setbacks “to heart” and recalled feeling angry, demoralised, or rejected upon hearing disappointing news. In the seminar at the University of Limerick, Triona McCaffrey reflected that she took setbacks personally because she
invested so much of her self in her work. In her view, it was only once she entered a mentor relationship with a psychologist, that she was able to separate her self from her job. One of the music therapy narratives in this study recounted a similar experience. In this narrative, the music therapist reported that the support of an experienced service developer had enabled her to manage feelings and to gain “perspective”.

In the narratives I received, music therapists presented themselves as lone pioneers, who worked independently to develop music therapy services in the healthcare settings where they were employed. Narrative contributors recalled that they had carried out service development tasks unaided and some reported that they had received little orientation or guidance from their employers. Authors of previous accounts of music therapy service development have also presented themselves as lone practitioners, working alone to introduce music therapy (for examples see Konieczna, 2009; Miles, 2007). In reflecting on this aspect, I considered the possibility that music therapists gain a sense of achievement when they develop music therapy services on their own. When reading the narratives, I noticed that several music therapists explicitly stated that they were the “first” to be employed in their positions. I reflected that I have drawn strength and pride from achieving milestones in music therapy, whether it was the “first” music therapy position in a particular healthcare organization, the “first” research masters degree in music therapy at the University of Queensland, or the “first” successful music therapy submission to an esteemed health research body. I now wonder whether music therapists are drawn to the profession of music therapy because it is an occupation in which they can be “the first”. One narrative contributor referred to her “pioneering spirit” in developing music therapy services. An ability to “stand alone” was also common in the biographies of British dance movement therapy pioneers (Meekums, 2008). Reflection on this aspect has led me to wonder whether music therapists tend to be the types of people who prefer to be challenged and whether those who survive are the music therapists who possess the necessary resilience for solitary work.

These findings suggest there could be a strong isolation/insecure isolation dichotomy in service development work. Managing the insecure isolation position may require psychological resources to cope with the attendant stress. With reference
to the title of the thesis, the music therapist could experience themselves as a founder when in the secure isolation position, and ‘fraudulent’ and inadequate when experiencing the insecure isolation position.

Interprofessional work.

The music therapists who participated in my study reported multiple benefits of interprofessional work, including benefits for patients, for other staff, and for the development of the music therapy service. In the course of my fieldwork, several team members reflected that their work had been enhanced through collaborating with the music therapist. With the addition of music therapy, patients were seen to be more engaged in treatment and team members reported that they had learned new insights and ways of working. When the music therapist and other staff worked together, patients were seen to benefit from a variety of professional perspectives. These findings are highly consistent with previous writings about music therapy and the benefits and possibilities inherent in interprofessional work. Hobson (2006b) highlighted the value of interprofessional work for patients and workers, with particular reference to conjoint music therapy and speech-language pathology work. Twyford and Watson (2008) presented many examples of interprofessional work, in which music therapists and other professionals gained from sharing knowledge and learning from each other.

In the ethnographic fieldwork study, I also observed that the introduction of a music therapy service lessened the burden experienced by other team members. After seeing the benefits of music therapy, team members were keen to work with the new music therapist and expressed enthusiasm around their conjoint sessions. I now wonder whether the addition of a music therapy service gives team members a renewed sense of hope when they are working with complex and difficult cases. Magee (2005) proposed that music therapy engenders hope when a patient’s progress in rehabilitation is slow and O’Callaghan and Magill (2009) found that hospital staff who had witnessed music therapy perceived that they were part of an organisation that valued good quality care.
The fieldwork interview responses indicated that the new music therapy service may have even helped to unite the team. It is possible that by addressing diverse areas of need, music therapy can bring several diverse disciplines together. Previous authors (Hilliard, 2006; Loewy, 2001) have written of the capacity of music therapy to “tie teams together” (Loewy, 2001, p. 3). This seemed to be the case in my fieldwork, when team members reported that they had engaged in further interprofessional work since they had collaborated with the music therapist.

The fieldwork and narratives further indicated that music therapists may gain respect through being open to interprofessional work. Fieldwork interviewees reported that they had come to understand music therapy as an allied health profession by working with the music therapist in sessions. Narrative contributors recalled that they had gained respect once other staff had observed or assisted in music therapy sessions and had seen the benefits of music therapy for themselves. Several music therapists shared an assumption that team members would help to support the continuation of the music therapy service after they had seen music therapy in action. I observed that fieldwork participants were strongly in favour of continuing the music therapy service, but it remained to be seen whether this support would translate into further music therapy funding. Nonetheless, the importance of forging productive alliances was evident in the findings.

Management and Marketing Perspectives

One of the valuable contributions of my research to the area of music therapy service development is my application of concepts from the field of management and marketing. This section shows how concepts such as organizational change, person-group fit, and role ambiguity may further our understanding of aspects of music therapy service development.

Organizational change literature.

Literature on organizational change was highly useful to me in reflecting on music therapists’ experiences of service development. Theorists such as Lewin have portrayed organizational change as a challenging process that requires unfreezing of
deeply embedded values and practices (Cartwright, 1951). Complex historical, contextual, and interprofessional issues are thought to come into play when a new change is introduced. Healthcare organizations have often been described as resistant to change and many healthcare practices are perceived to be firmly entrenched (Deegan et al., 2004; Dulaney & Stanley, 2005). These views were endorsed by some fieldwork interviewees, who expressed reservations about recent organizational changes or referred to their colleagues as “resistant to change”. One interviewee reported that hospital practices had been “happening for many a year” and that it was difficult to introduce changes to the way things were done.

If organizational change is required for music therapy service development to occur and for music therapy to become fully integrated into the wider service, it is possible or even inevitable that the introduction of music therapy will lead to tensions within a team. In healthcare settings, the introduction of new practices has been observed to lead to workers feeling that they have lost their former expertise (Dulaney & Stanley, 2005) or surrendered professional territory (Lindblad et al., 2010). The introduction of a new role can be experienced as threatening and competition can be created between new and more established professions (Cummings et al., 2003; Lindblad et al., 2010; Timmons & Tanner, 2004). The resultant conflict can be difficult to manage, especially, one might imagine, for the person responsible for the new service implementation.

Eight of the music therapists in my research referred to unpleasant encounters with staff, in which they felt unwelcome, intimidated, criticised, or even bullied. It was evident from the narratives that the music therapists experienced these encounters as frustrating, distressing, or disappointing. When writing the poems, I experienced a heightened awareness of the way that music therapists were hurt by their negative interactions with staff and I perceived that unpleasant encounters intensified any feelings of isolation that may have been present. I wondered whether it may be helpful for music therapists to understand unpleasant encounters as a common part of new role introduction. Two of the narrative contributors who worked with highly vulnerable populations perceived that their nursing colleagues were particularly protective of patients. One music therapist explained how she tried not to take resistance personally and acknowledged that she was working in the “the most
defended area of the hospital.” She reflected that supervision and “self-care” were important for managing what she described as “transitional reactivity”.

Although unpleasant encounters were common, interpersonal tensions were not reported by all and most music therapists reflected that they had gained greater acceptance from staff over time. Almost all of the music therapists explained how they had built relationships with other staff and involved them in the development of their music therapy services. I noted that the narrative contributors built relationships with staff in a number of ways. First, music therapists listened to other staff members’ perspectives on how music therapy could best meet their needs. They met with staff in formal and informal ways and endeavoured to develop a service that was responsive to the needs expressed by staff. Another way that music therapists built relationships was to assist staff in making appropriate referrals to music therapy. One music therapist developed a checklist of possible reasons for referral, while another offered feedback on sessions so that staff would have the confidence to refer again. The music therapists also responded to requests for help from staff and often became involved in promotional activities or community events. Though some music therapists expressed uncertainty as to whether they should help out in these ways, they may have become appreciated as “team players” through contributing to the work of others.

I observed that Sarah worked closely with other team members when introducing the music therapy service. She sought team members’ advice and feedback on the service and exchanged observations with staff in both team meetings and “corridor stops” (see p. 164). She regularly shared positive outcomes with other staff, rather than taking the full credit for patients’ progress in music therapy. Interviewees welcomed the music therapist’s “openness” and expressed excitement about their involvement with the music therapy service. I also observed that Sarah was particularly thoughtful and considerate in her interactions with other team members. She acknowledged others’ contributions and showed courtesy to others when timetabling sessions. In times of tension or stress, Sarah showed other team members care and concern. In observing Sarah’s interactions with other staff members, I wondered whether these actions served to increase her acceptance as a valued team member.
Previous healthcare service literature has indicated that workers need to have an investment in an organizational change if the change is to be accepted (Deegan et al., 2005; Spaulding et al., 2010; Studer, 2004). Organizational change approaches such as the Hardwiring Excellence approach (Studer, 2004) have emphasized the need to build relationships and to engage and seek feedback from workers when introducing change. There is also research to support that workers’ levels of motivation are an important factor as to whether an organizational change venture is successful (Dulaney & Stanley, 2005; Spaulding et al., 2010). In reflecting on this literature, I perceive that music therapists in this study gained acceptance through involving and engaging others in the development of music therapy. Perhaps team members are motivated to support the music therapist once they recognise the benefits of music therapy for themselves. I also wonder whether through being “new” and “creative”, music therapy has a unique potential to engage health professionals as well as patients. Fieldwork interview responses indicated that other team members saw music therapy as a novel intervention. They expressed excitement about being exposed to different approaches and about seeing patients in new ways. It would be interesting to find out whether this excitement persists over time or whether there comes a point when the novelty of music therapy wears off. One narrative contributor perceived greater resistance among staff once music therapy was no longer new and when music therapy was more integrated into a wider range of hospital programmes. It would be interesting to conduct further research to explore what happens to enthusiasm about music therapy over time.

Another useful contribution from the literature on organizational change is its emphasis on the role of “gatekeepers” (Dulaney & Stanley, 2005) or “champions” (Cummings et al., 2005) in the introduction of new roles and practices. As I read the narratives, I noticed that the music therapists identified people who had helped them to introduce music therapy. The music therapists recalled that other staff had assisted them to advocate for music therapy, to obtain necessary funding, to gain access to patients, or to build networks with other staff. In the hospital where I undertook my fieldwork, I observed four staff members who were actively involved in the introduction of the music therapy service. One of these was perceived to hold considerable power and influence with the hospital management. Several
interviewees assumed that it was this person’s “buy-in” that had convinced managers to approve the introduction of the music therapy service. This finding may provoke further interest in our profession about who holds power in relation to development and support of positions, and what are the means by which this power can best be accessed and utilised.

Some music therapists described how they were fortunate to have pre-existing relationships with people who had power and influence, such as a manager or a respected member of staff. Other music therapists identified gatekeepers once they began their new posts. Similar to the findings reported by Dulaney & Stanley (2005), I noted that music therapy gatekeepers were not always those in formal positions of power. Sometimes a music therapy service was reported to benefit from gatekeepers who held power due to their length of experience, their advocacy skills, or their proximity to people who did have formal power. For example, one music therapist reflected that her pre-existing relationship with a well-respected staff member was “an influential component of setting up networks around the hospital and gaining respect, recognition and being taken seriously”. She considered herself “very fortunate” to have this staff person’s support.

Loewy (2001) previously reported the need for music therapists to identify gatekeepers and antagonists to the development of a music therapy service. I therefore wonder how or whether further training around healthcare cultures and issues of power might impact the field of music therapy and its individual professionals. While it may not be possible to include these topics in the music therapy training required to practice, it could be feasible to offer this sort of training at an advanced level. Professional music therapy associations or universities may be able to draw on the expertise of leaders from other fields such as management and marketing, to enhance music therapists’ understanding of interprofessional and organizational issues in service development.

*Person-group fit.*

If this thesis is to identify strategies for successful music therapy service development, then the concept of person-group fit (Kristof-Brown et al., 2005) may
be helpful in this endeavour. In my research, I noticed that music therapists could fit into teams in both supplementary and complementary ways. In the fieldwork, I observed that Sarah made efforts to match existing practices where possible. For example, she kept her session reporting and documentation consistent with other professionals’ and introduced measures to show that music therapy could meet the hospital remit of “efficacy and efficiency”. I also noted ways in which Sarah appeared similar to other allied health professionals. I was reminded of Hobman et al.’s (2003) survey research and reflected that Sarah was similar to her team in visible, informational, and value-based ways. I observed that she looked and dressed alike, readily used similar language and treatment goals, and appeared to hold a similar work ethic to other members of her team. I also witnessed Sarah exchanging parenting experiences with other mothers on the team. Although Sarah may not have been pointing out these similarities consciously, it was interesting to consider whether these similarities played a role in her acceptance by the team. I was further intrigued when one interviewee referred to Sarah as her “equal”.

One of the narrative contributors explained how she achieved complementary fit with her healthcare team. On learning about existing services at the hospital, this music therapist identified areas that were repetitive or lacking in creative approaches. Rather than replicating services already provided, she developed a music therapy service to address unmet needs and to fill the gaps in the existing service provision. On reading this music therapist’s narrative, I reflected on how she had identified clinical areas where she could make a unique contribution. Finding a “niche” was also a strategy that Joanne Loewy referred to during the observation and orientation training I attended at Beth Israel hospital. Loewy explained how she recognised a role for music therapy in sedating patients. She discovered that the hospital needed a less expensive sedation intervention that could include caregivers and involve less risk. Music therapy was then introduced successfully to address this need (Loewy, Hallan, Friedman, & Martinez, 2005).

In my experience, music therapists frequently perceive and present themselves as unique and different to other professions. This tendency has also been highlighted in literature related to the professionalisation of music therapy (Ansdell & Pavlicevic, 2008; Daykin & Bunt, 2006). Literature on fit suggests that there may be some
undesirable outcomes when workers perceive that they are different to the other members of their work team. A previous study indicated that workers may withdraw when they see themselves as different and when they doubt that their team is open to diversity (Hobman et al., 2003). When writing the poems, I became aware that some music therapists felt misunderstood by their managers and other team members. A common response was to “keep the head down”, to focus on the clinical work and avoid interactions with other staff. It was unclear from the narratives whether the music therapists’ withdrawal helped or hindered the development of their music therapy services, especially as the findings seem to suggest that some negative or hostile behaviour is grist for the service development mill. However, when music therapists in this study reported negative behaviour, they recalled that they reacted by becoming quieter and less visible.

My observations and reflections around this concept of “fit” indicate that the decision to present one’s self as similar or different may be a complex one. Perhaps there are times when it is advantageous to present one’s self as similar and times when it is more beneficial to highlight differences. For example, it may be beneficial to emphasise differences when a music therapist is seeking employment and music is already provided by other workers (Daykin & Bunt, 2006).

Sensitivity to context.

Organizational change literature emphasises the need to be sensitive to the organizational context when implementing change (Buchanan et al., 2005; Dulaney & Stanley, 2005). Forces such as workers’ previous experiences of change, levels of time and energy, and the amount of available funding and resources are thought to markedly influence whether a change is accepted (Dulaney & Stanley, 2005). Whether or not a change is sustained is also assumed to depend on the interplay of multiple contextual factors (Buchanan et al., 2005). Some of the music therapists in my study acknowledged that historical factors had played a role in their experiences of developing services. These music therapists reflected that they needed to respect long-held traditions, before building histories of their own. Furthermore, several fieldwork interviewees mentioned historical factors that they believed had impacted on Sarah’s experience of introducing music therapy. It was evident from both the
narratives and the fieldwork that building a history takes time and effort. One narrative contributor recalled that it had taken at least six months to build some history. I observed that Sarah worked hard to make the music therapy service “concrete”. The potentially time-consuming and exhausting nature of service development will be discussed in more detail below (see p. 209).

A couple of music therapists recalled that they needed to wait for “the right time” to introduce new music therapy services. One music therapist reported that further developments became possible when managers were satisfied with the music therapy service and the actions of a recent music therapy student. Another music therapist recognised that her colleagues were not yet comfortable with the music therapy service and that further time was needed before the service could expand. In the broader literature on healthcare organizations and change, authors have encouraged others to assess an organization’s readiness for change before a change is implemented (Dulaney & Stanley, 2005). However, the assessment of organizational cultures is a topic which has received little attention in music therapy to date. Further exploration could determine the types of conditions which may be necessary for the successful introduction of music therapy services.

I further noted that music therapy service development could be fortuitous. Several of the music therapists’ service developments followed after a lucky acquaintance or a serendipitous circumstance. Serendipitous circumstances are also a common theme in the biographies of dance movement therapy pioneers (Meekums, 2008). The observation that service development can result from a “happy collision of circumstances” (Meekums, 2008, p. 104), suggests that a music therapist seeking new service development experience may need to be open and alert to opportunities.

One music therapist explained how she had learned about the financial context of her organization when introducing music therapy. She recalled that it was important to gain an understanding of how her organization was funded, so that she could advise managers of possible ways to fund music therapy. Interestingly, this music therapist was one of only a few music therapists who portrayed themselves as secure in their positions. She explained that she had formed mutually beneficial relationships with managers and therefore became indispensable to her organization.
Other music therapists in the study appeared much less confident about their positions within their organizations. These music therapists recalled that they were unable to access healthcare management or had little power to influence the decisions that affected them. After a number of unsuccessful submissions to management, one music therapist expressed uncertainty about what was required to gain management support. This uncertainty was shared by Sarah’s advocates, who questioned whether they were asking for music therapy in the “right way”. It raises the question as to what extent music therapists could benefit from further training in financial matters and human resources. Hilliard (2004) has previously emphasized a need for training in the financial aspects of music therapy service provision.

My research findings suggest that while music therapists constantly educate others, they also have knowledge needs. The acquisition of knowledge about power, funding, and strategic allegiances was presented as a key step in some music therapists’ stories. Other stories indicated that music therapists can have a knowledge gap. This information offers some possible topics for useful professional development training in future.

*Role flexibility.*

Previous authors have advocated an emergent approach to change implementation (Pettigrew, 1990; Shanley, 2007; Styhre, 2002). These authors have proposed that change is complex, occurs over time, and is influenced by multiple, unpredictable variables. This was evident in the way that the music therapists described their roles as developing over time. Instead of implementing fixed roles, the music therapists recalled that their roles developed in response to organizational cultures and the needs of patients, families, and staff. Some further explained that they were working in new areas of music therapy practice and that they needed time to develop appropriate interventions. I was particularly struck by one music therapist’s narrative, in which she likened the development of a service to the music therapy process. She wrote:

Essentially, the development of a music therapy service can be seen as a reflection of the development of a music therapy session. It is crucial that the therapist establishes a relationship with the organisation/caseload. The
strengths and needs should be identified and through ‘improvising’ with the resources and skills available a strategy is implemented.

I observed that Sarah remained highly flexible when introducing her music therapy service. She listened to team members’ views on what was needed and was open to exploring new therapy approaches. She had even begun to explore approaches that were quite different to the approach that she was taught. Flexible approaches have been promoted by music therapy authors previously. Role flexibility has been described as a way for music therapists to best meet the needs of patients (Edwards, 2005a), to work effectively with other professionals (Twyford & Watson, 2008), and to remain relevant and sustainable (Hartley, 2008).

However, it is not enough to indicate that role flexibility was reported as a plus for service development in this research. I also observed that role flexibility can lead to negative consequences. One music therapist recalled that she frequently questioned herself and was uncertain of her role as a music therapist. She remembered feeling that she had been “thrown in the deep end” and described her early work as a “time in the dark”. Although music therapy literature was helpful, she had not observed another music therapist working in her clinical area and wondered whether she was doing the “right thing”. She also reflected that her experience was influenced by her position as a new graduate music therapist. In her telling of events, she gained greater self-confidence after further experience and supportive supervision. Professional supervision is recommended for all music therapists (Forinash, 2001), but the extent to which it influences outcomes for new graduates who are developing services has not yet been established. This research highlights some obvious consequences of role uncertainty and further study of this topic is warranted, especially since the literature in healthcare service development suggests that music therapists are not the only practitioners to experience this phenomenon.

I also considered that flexibility in the music therapist’s role potentially leads to role ambiguity. Role ambiguity has been reported previously in literature on new healthcare roles, in music therapy service development reflections (Edwards, 2005a; Loewy, 2001; O’Neill & Pavlicevic, 2003), as well as in a music therapy study of
interprofessional working (Darsie, 2009). Staff might be unclear about the music therapist’s role during the period when the music therapist is developing a suitable role within the organization. One narrative contributor indicated that music therapy had been misunderstood as “something diversional or entertainment” and another reflected that it took time for other staff to understand her role. This music therapist stated, “They [other staff] did not completely understand what I did until they saw it in action.”

In carrying out this research, I was surprised to learn that music therapists are not the only health professionals who feel misunderstood. Previous studies have found that health professionals frequently find it difficult to understand each others’ roles (Atwal, 2002; Moore et al., 2006; Suter et al., 2009) and even practitioners in well-established professions such as medicine and nursing have felt misunderstood (Pellatt, 2005). During my fieldwork, Sarah’s colleagues also recounted situations in which they felt that their role had been misperceived. This insight led me to wonder whether it might be helpful for music therapists to understand role ambiguity as a normal part of interprofessional work, rather than a demeaning slight that functions to reduce their professional status. Furthermore, I reflected that music therapists are yet to attend to the positive side of role ambiguity. Research in other healthcare fields has indicated that there can be some advantages to “role blurring”, including the sharing of workloads, fewer hierarchical relationships, and more socially-oriented care (Hall, 2005; Brown et al., 2000). Greater reflection on the music therapist’s role in relation to interprofessional work is emerging (Twyford & Watson, 2008) and my research shows that it is an inevitable and important part of new service development.

Service Development as Complex

The narratives and fieldwork exposed music therapy service development as a complicated process. Although I had intended to identify some helpful strategies for new graduate music therapists and music therapy students, I learned that there were no straightforward recipes for successful service development. I observed that the strategies that the music therapists used depended on their particular healthcare contexts. I also noted that the music therapists experienced dilemmas regarding the best approach to developing their music therapy services. These dilemmas included
whether to provide in-services, whether to become involved in service promotion, whether to engage in research, whether it was useful to align the music therapy service with other disciplines, and whether it was profitable to speak up for the music therapy service. Several music therapists had also begun to question whether their hard work was worthwhile. While it may be disappointing to read that music therapists questioned their contributions, this observation also points to the possibility that service development inevitably involves a questioning phase.

_To in-service or not to in-service?_

There was some disagreement among the music therapists about whether in-service presentations were useful for educating other staff members about music therapy. Some music therapists recalled that in-service presentations increased understanding and demonstrated music therapy as an allied health profession. Fieldwork interviewees also referred to Sarah’s in-service presentations as a time when the therapeutic value of music therapy became apparent. Other music therapists questioned the value of in-service presentations and conveyed disappointment about the low level of interest shown by staff. Triona McCaffrey also questioned the value of in-service presentations, referring to a “fine line” between information sharing and “preaching”. She worried that her presentations may have been perceived as condescending and questioned whether she might have more usefully allowed staff to draw their own conclusions about music therapy.

The findings also indicate that in some healthcare settings it may be beneficial to educate staff in more subtle ways. One music therapist explained that she allowed her music to “do the talking”, as a culture of in-servicing did not exist within her healthcare organization. I also observed that Sarah educated staff in a number of subtle ways. In team meetings and corridor stops, she educated staff by sharing music therapy outcomes and drawing out clinical reasons for referral. She also educated staff by including them in music therapy sessions. In both the narratives and the fieldwork, I gained a sense that staff members understood music therapy more clearly once they saw it in action. Narrative contributors recalled that they had gained respect once staff had seen their work, and fieldwork interviewees reflected that they had come to appreciate music therapy through working with the music
Music therapists may also provide information about music therapy through their appearance and behaviour. I observed that Sarah dressed professionally and used clinical language in her interactions with other staff. These attributes may have contributed to her acceptance as a “very well qualified and skilled and experienced person”. The recollections of two other music therapists further highlighted the value of self-presentation in promoting music therapy as a professional therapy discipline. Triona McCaffrey remembered a situation in which a staff member expressed surprise that she was dressed “normally” and not in “tie die clothes and dreadlocks” and one of the narrative contributors explained how she referred to her qualifications, so that staff knew that music therapy training was more than “a weekend of banging on the drums and drinking lattes”. I wonder whether small presentational measures like these may be as effective as in-service presentations in some healthcare contexts.

To promote or not to promote?

Another dilemma some music therapists grappled with was involvement in promotional activities and fund raising. One music therapist expressed conviction that her involvement in the marketing of her healthcare organization had benefited the music therapy service. She reflected that she had established a firm place for music therapy in the organization’s funding cycle, through helping marketers to “sell” the organization. Others appeared less certain that their services had benefited from their involvement in promotional activities. One music therapist conveyed a concern about the way that music therapy was portrayed, while another recalled feeling exploited when her organization used music therapy for marketing purposes. In the fieldwork, Sarah became involved in promotional activities, but shared feelings of uneasiness around this arrangement. She worried that she gave stakeholders a poor impression of music therapy by explaining the benefits of music therapy to potential funders. She considered that she may not have given a “good impression of professionalism” when giving her “sales pitch” to funders. However, these concerns appeared to be
offset by her desire to gain further funding for the music therapy service. Sarah’s experiences suggest that the decision to become involved in promotion may not be a straightforward one. The advantages and disadvantages of music therapy promotion is another topic which could receive further attention in music therapy literature and research.

To write or not to write?

Several music therapists shared a view that by writing academic publications, they could demonstrate the value of the work, impress decision-makers, and obtain additional funding for the expansion of the music therapy service. However, two music therapists questioned whether their research activities had led to further service expansion. These music therapists recalled that their academic achievements had gone largely unnoticed by their healthcare organizations. I similarly remember a discrepancy between my status within the music therapy community and the amount of recognition I received within the nursing homes where I worked. Although it may be questionable whether publishing leads to further service development, I did observe that there were personal benefits to publication. Music therapists who had published or presented reported that they had gained further insight, skills, and confidence through this type of work. Most also gained support and recognition through sharing their work with music therapy colleagues. This finding indicates that research and writing may function as a means by which a music therapist can gain self-confidence and support for their work. This may be particularly important when further funding is not forthcoming.

To belong or not to belong?

Most of the music therapists reported that they had gained respect by aligning themselves with other professionals such as psychologists and social workers. Narrative contributors shared a common view that they were recognised as therapists when music therapy was placed among a group of psychosocial professionals. In contrast, Sarah described how she was cautious not to align herself with particular professionals. Although she worked hard to build relationships with other staff, she avoided aligning herself with any one professional in particular. She explained how
she had detected certain tensions within the team and did not want to be seen to be taking sides. Instead, she planned to assume a “fluid” position and refrained from getting involved in interprofessional conflicts. From her perspective, this allowed her to maintain good relationships with everyone and to work with different team members at different times. Sarah’s experience further highlights the complexities of working as a sole music therapist in an interprofessional team.

One narrative contributor explained how the placement of music therapy within an education-oriented department increased her access to patients. On reading her narrative, I was reminded of my own experiences when introducing music therapy to nursing homes in Australia. My allies were often the “diversional therapists”, who organised social and recreational activities for the nursing home residents. Diversional therapists had usually been working in the nursing homes for many years and had long-established routines and timetables. Due to the high turnover of nursing staff, they also tended to know the residents better than other workers. I therefore found it beneficial to work closely with the diversional therapists, to co-ordinate schedules and to learn about residents’ needs. It was the diversional therapists who introduced me to residents and helped me to implement appropriate sessions at appropriate times. Through them, I learned how the nursing home “really worked”. Since I have read literature on anthropology and ethnography, I have reflected that the diversional therapists were valuable “culture bearers” (Uchendu, 2007, p. 174), who helped me to find my way in a new environment. I now wonder whether suitable allies can only be determined in context. Different music therapists mentioned different allies and there seemed to be no one best department for music therapy. Perhaps, as suggested by Loewy (2001), it is the job of each music therapist to identify allies with whom he/she can grow.

To speak up or keep the head down?

Some music therapists conveyed dissatisfaction about their working conditions. Possible sources of job dissatisfaction included a lack of physical space for music therapy, limited music therapy hours, and reliance on philanthropic funding. These constraints were also cited as stressors in a previous study of four music therapists working in palliative care (Clements-Cortés, 2006). It was unclear
from my research whether music therapists should “speak up” when they perceived that their job conditions were less than ideal. Some reflected that it was important to voice their concerns so that patients could receive the best music therapy service possible. One narrative contributor explained that she didn’t “speak out” because she was “just so grateful to have a job”. Several music therapists explained how they relied on other staff to advocate for music therapy instead of speaking up themselves. However, some then questioned whether music therapy was best represented under this arrangement. In the fieldwork, some of Sarah’s colleagues conveyed doubts about their advocacy roles and suggested that Sarah was better positioned to communicate the value of music therapy. Not much is known about other staff members’ experiences of advocating for music therapy.

Two narrative contributors reflected that it was important to recognise financial constraints when asking management for further funding or resources. These music therapists asked for “small things” only or made “only one wish a year”. Other music therapists recalled times when they had decided to focus on providing sessions rather than seeking a change in their working conditions. These music therapists’ experiences indicated that it may be important to wait for the “right time” to make demands. This suggests that it is important to broach topics gently with managers. Nursing authors have similarly proposed that it may be beneficial to minimize disruption and to down-play the significance of a change when a new healthcare role is introduced (Goodrick & Reay, 2010, Willard & Luker, 2007).

I observed that Sarah compromised on several aspects of her music therapy service. One compromise was the lack of a designated music therapy space. Sarah conveyed disappointment that she no longer worked in a purpose-built music therapy room and instead worked in a variety of less suitable locations. However, she explained that she had decided not to complain about this arrangement and realised that her employment had been a significant enough of a step for the hospital. I also observed that Sarah compromised on her professional role as she worked to introduce the music therapy service. When we met, Sarah reflected on situations in which she assumed the role of a musician rather than the role of a qualified music therapist. She explained that it was important for her to be seen as a therapy professional, but she was willing to provide music if this role helped her to build relationships with the
team. Loewy (2001) has previously highlighted a need to prioritize when developing music therapy services. She recommended that music therapists identify service aspects which are essential and let go of aspects which can be worked on later. Sarah seemed to go through a similar process of reflection in deciding where she would compromise. Through the experience of conducting this research, I became aware of my long-held assumption that it was important to fight to achieve optimal music therapy working conditions. I now wonder whether music therapy students and graduates would benefit from learning about ways in which experienced music therapists have compromised.

To stay or to leave?

The music therapists in my study reported that they had invested a considerable amount of time, energy, and resources in the development of their music therapy services. Several mentioned that they had worked additional unpaid hours and taken on large workloads or projects. Additionally, several reflected that their service development work had been time-consuming and tiring. When setbacks in the service development were experienced, some music therapists questioned whether their hard work was worthwhile. Six of the narrative contributors divulged that they had considered giving up their services and leaving to work elsewhere. These music therapists had started to question whether the rewards of working with patients were enough to sustain their motivation to continue. One music therapist had also begun to question whether she had “outgrown” her healthcare organization. She reflected on the possibility that she had developed the service as far as she could and that she may need to go elsewhere to continue building on her ideas. These findings may have implications for retention of music therapists. If healthcare managers wish to hold onto music therapists, they may need to ensure that adequate support structures are in place. Music therapists in my study recalled that they had benefited from supportive supervision and continuing professional development opportunities. Further research is warranted to explore whether the provision of these supports leads to greater retention of music therapists. Research on this topic would be of interest to managers and music therapists alike.
The narratives and fieldwork indicated that music therapy service development takes time. I noted that service development milestones were not easily achieved and it was months or even years before some goals were reached. A wide range of tasks were reported to take time. Music therapists explained that they needed time to secure adequate funding and resources, to gain the acceptance of other staff, to recognise gatekeepers and to obtain access to patients. It also took time for music therapists to find a role for music therapy, to identify appropriate music therapy interventions, and to develop suitable referral systems. In some cases, a music therapy service only began after many months or years of protracted negotiations.

The narratives also indicated that music therapy service development is rarely a linear process. Music therapists recalled a fluctuating pattern of music therapy service development, including setbacks as well as service achievements. Music therapy service development was portrayed as unpredictable and highly subject to changes in economic conditions, healthcare policies, and staff. For example, one narrative contributor described her development as “toing and froing – services up and down”. She attributed this pattern of development to unforeseen changes in staff and economic conditions.

I also noted that although music therapists perceived that they had laid important “foundations”, they rarely presented their services as fully “established”. This observation further indicates that music therapy service development may not be easily or quickly achieved. Although music therapists may have a vision for the development of music therapy, it may take some time before the dream is realised.

Contributions and Limitations of the Methods

One of the main aims of my research was to explore the value of qualitative research approaches for understanding facets of music therapy service development (see Chapter 1). In addressing this aim, I developed a novel research approach which combined the use of narrative inquiry, arts-based analysis, and ethnographic fieldwork. I discovered that each of these methods contributed a unique perspective
on the topic of music therapy service development. In this section, I discuss the relative merits and limitations of my chosen methods and reflect on the benefits of reflexive journaling and newsletter communication for gaining further insight about music therapists’ experiences. This section also provides some reflections about my experiences of engaging in this research.

*Narrative inquiry.*

In collecting narratives from experienced music therapists, I wanted to learn about their experiences of developing new programmes in healthcare organizations. The music therapists’ narratives were highly revealing to me in this regard. On first reading, I was immediately struck by the emotional character of the narratives. The music therapists’ narratives were heart-warming, entertaining, inspiring, and astonishing. As I read the narratives, I experienced strong feelings of admiration and respect for the music therapists and their achievements. I felt sadness when music therapists recounted difficult work encounters and empathy when a particular feeling or situation resonated with what I had previously experienced in service development. I was impressed by the music therapists’ reflexive capabilities and I felt extremely privileged to read such honest accounts. The narrative format drew me in and also helped me to remember my own service development experiences.

Through reading the narratives, I gained a sense of the people that the music therapists wanted to be. Most presented themselves as pioneers, who were working independently and rising to the challenge of introducing music therapy services. Although some music therapists recounted difficult encounters, most maintained an optimistic outlook and were inclined to point out the rewards of working with patients. It is possible that this portrayal was shaped by my position as a qualified music therapist and academic. The music therapists may have wanted to appear competent, so that I would continue to respect them as colleagues. Polkinghorne (1995) has previously emphasized the dialogic nature of narrative construction. In telling their stories, it is likely that the music therapists presented themselves in ways that they deemed acceptable to me as an experienced music therapist. For example, I noted that two music therapists were particularly positive in the telling of their stories. These music therapists were both recently qualified music therapists and I wondered
whether it was important for them to demonstrate to me that they were coping with
the demands of service development.

The narratives may have been further shaped by my previous relationships
with the music therapists involved. Five of the narrative contributors were close
colleagues, or had previously been fieldwork or coursework students of mine. I noted
that some of the music therapists who were better known to me were particularly
frank in the telling of their stories. For example, one music therapist used curse
words in her narrative and openly shared her uncertainty about her service
development skills. I consider it likely that this narrative was influenced by our close
relationship and the fact that I was familiar with the workplace she described. The
narratives of other music therapists with whom I didn’t have such a close relationship
tended to be more professional in style and perhaps had undergone different processes
of revision and refinement before submission. Academic language was more
common in these narratives and two music therapists even cited their academic
publications. This observation led me to wonder to what extent a researcher should
reflect on the ways that they have known contributors prior to inviting them in to a
research project. Close relationships may have increased my access to music
therapists’ subjective experiences, or limited my understanding of certain aspects.
Strong themes of insecurity and isolation emerged in the narratives I collected. I
wonder whether these themes would have been as prominent had I not known some
of my research participants. Nonetheless, these themes have offered useful
opportunities for reflection on the complexities of service development and have
revealed some striking and challenging observations of this work.

Through constructing narratives, the music therapists shared past events and
experiences from the vantage-point of present realities and values. I therefore learned
something of how the music therapists interpreted their service development
experiences. Music therapists’ responses to setbacks such as a reduction in funding
or an unsuccessful service development proposal were often poignantly expressed.
Some music therapists described their extreme disappointment when setbacks
occurred and appeared to take management decisions personally. In these cases,
decisions were often attributed to a lack of management support rather than a lack of
available funding. This observation was crucial for understanding the music
Another revealing aspect of the narratives was the music therapists’ use of metaphor. Several music therapists used powerful imagery, such as a rollercoaster ride or a long and difficult journey, when describing their service development experiences. These metaphors helped to highlight the shifting and unpredictable nature of music therapy service development. The music therapists’ use of battle terminology was also compelling. Three music therapists wrote of their need to “fight to stay alive” and their struggle to continue building on service development opportunities. The likening of service development to a battle indicated that some music therapists felt considerably marginalised in their positions. The comparison of service development to a “life and death” situation further revealed the degree to which the music therapists were invested in their work. Additionally, I was able to identify similarities between the metaphors used by narrative contributors and a climbing metaphor used by Sarah later in the fieldwork.

The narratives further increased my awareness of the music therapists’ motivations in developing music therapy services. For most of the music therapists, a strong motivating force appeared to be patients’ responses to sessions. Several music therapists cited the rewards of working with patients as a reason to persist in developing music therapy services. When setbacks were experienced, music therapists tended to withdraw and turned their focus to their clinical work. This approach may have assisted them to cope with feelings of disappointment. A more subtle motivating factor appeared to be an aspiration to be an innovator or a “pioneer”. Several music therapists mentioned being the “first” in their narratives and I considered the possibility that the music therapists gained a sense of achievement through developing new services.

When recruiting, I noted that the idea of creating a story was quite appealing to music therapists. In email correspondence, several of the narrative contributors indicated that they were captivated by my project and my novel methods. One music therapist wrote, “I love to write stories so it’s right up my alley and would probably be good catharsis”. As discussed earlier in the thesis (see Chapter 3), it is possible
that music therapists recognise the expressive possibilities of a story. Music therapists often read case studies and regularly use narrative form to describe and reflect on their work. The use of narrative was an effective way of engaging music therapists in this research.

It is possible that the music therapists benefited from constructing a narrative of their service development experiences. Literature about illness narratives, narrative approaches to psychotherapy, and autoethnography has indicated that narrative construction can lead to new insights and understandings about one’s self (Frank, 2009; Matos et al., 2009; Wright, 2009). Reported benefits of narrative construction also include self-expression, being “heard” or “witnessed”, and an increased sense of personal agency (Frank, 2009). The possibility that narrative construction resulted in benefits for research participants was most apparent in a follow-up interview with one of the narrative contributors. This music therapist explained that the request to write a story had come at a crucial point in her career, when she was attempting to make some difficult work decisions. Shortly after writing her narrative, she decided to make a significant change to her work circumstances. In her view, the process of writing a narrative had acted as a “trigger” or a catalyst to “move things along”. At the time of her interview, she stated that she was satisfied with her decision and had no intention of “going back”. This music therapist’s experience indicated that it may be helpful for research participants to have opportunities to reflect on their current circumstances. Furthermore, her experience shows that the process of writing a story may not be a trivial or inconsequential act. I am therefore glad that I offered research participants opportunities to debrief, even though none of the music therapists decided to avail of these opportunities.

I chose to collect written narratives for ease of communication with music therapists internationally. This meant that music therapists could construct their narratives wherever they wished, at a time of their choosing, and at their own pace. They were also able to edit their stories before emailing me the final version. This was considered important so that the research requirements would not be perceived as demanding or threatening. Furthermore, email correspondence from one narrative contributor indicated that there may have been a “right time” to write your service
development story. She reported that she was “finally ready” to construct her story after a period of instability had settled and she was clearer about her position in the hospital. This music therapist’s experience indicated that it was helpful for her to have adequate time to prepare her story. The use of written stories led to additional practical advantages. Firstly, the collection of written stories cut down on the need for interview transcription and secondly, it enabled me to read over music therapists’ narratives swiftly and repeatedly. I discovered that repeated readings were essential, as I gained new insights every time I read each narrative.

Despite my intention not to place undue demands on participants, it became evident that some potential participants expected the writing task to take considerable time. During the recruitment process, five music therapists expressed concern about the time needed to write a narrative. Two music therapists withdrew from the research at this point, explaining that they were too busy to participate and that they did not want to delay the research. One music therapist agreed to write a narrative after I explained that she was not required to recall every step in her service development in detail. One music therapist offered to provide her narrative in an interview and another offered to record her narrative onto compact disc instead. I decided to remain flexible about the way in which a narrative was provided, as I considered that it was less important to remain consistent than to gain access to music therapists’ stories.

When I listened back to my phone interviews and the narrative recorded on compact disc, I realised that spoken and written narratives have different features. The experience of listening to a music therapist recounting her story was quite different to my earlier experiences of reading written narratives. It was powerful to hear the music therapist’s voice and I perceived that the verbal narratives I elicited were even more evocative than the written ones. It was revealing to hear a music therapist’s tone of voice, her way of speaking, and the points at which she remained silent or took time to gather her thoughts. As the music therapists described scenarios verbally, I could easily picture the players and the settings in which events unfolded. In the BNIM method (Wengraf, 2001), the researcher gains a narrative by asking a person to tell a story in an interview. According to Wengraf (2009), accessing a narrative in this way allows the researcher to hear any silences or hesitations in the
person’s story. The acoustics of the interview are considered to provide crucial information about “possible (denied) emotions and possible (buried) stories” (p. 572). In a face-to-face interview, a researcher is also able to observe inconsistencies between a person’s body language and verbal messages (Wengraf, 2009).

I discovered that Wengraf’s (2001) SQUIN method was highly effective in eliciting a narrative from the music therapists in my study. By asking a single, deliberately open-ended question, I was able to gain narratives about service development aspects that were important to the music therapists involved. The music therapists wrote about the events and encounters which they considered to be most significant, rather than the aspects that I assumed were critical. Additionally, the SQUIN method allowed music therapists to write as little or as much as they wished. The music therapists could decide how much they wished to disclose. This was considered essential due to the music therapists’ time constraints and our ongoing relationships as colleagues. I did not wish to place any pressure on music therapists to participate or to suggest that they were required to disclose highly sensitive information.

Although I provided little guidance in my story writing request, the narratives turned out to be highly relevant to my research topic. Most of the narratives were filled with service development feelings and experiences and there was little text that could be considered immaterial. Although I had intended to undertake follow-up interviews to obtain additional information, I only perceived a need to conduct one such interview. In this instance, my reason for the interview was not a lack of data in the narrative, but a significant change in the music therapist’s work circumstances. Furthermore, most of the music therapists appeared undaunted by the open-ended request for a narrative. Only one music therapist asked for clarification around the participation requirements. In this case, the music therapist requested more information about the time required and the ways in which I would conceal participants’ identities. I therefore explained that a detailed account was not required and that music therapists could choose which occurrences to include in their narratives. I also reiterated my intention to disguise identities, through using pseudonyms and mixing narratives together. The music therapist then agreed to
create a narrative. (For a more in-depth discussion of ethical considerations, see pp. 228-231.)

As wise elders have observed in developing their approach to this method, an oft-cited criticism of narrative inquiry is that stories aren’t true (Kenny, 2005; Polkinghorne, 1995). In collecting the music therapists’ narratives, it was not my intention to gain detailed and fact-based accounts of music therapy service development. Instead I was interested to learn how music therapists experienced and interpreted the events and encounters that had been part of their service development story. I was aware that the music therapists’ interpretations were likely to change over time, with variations in memory, perspectives, and the contexts within which service development stories were told. This aspect of narrative research became apparent to me when I tried writing my own service development stories. At times, my memory of events felt “sketchy” and I struggled to remember the exact wording of conversations. I also felt limited in what I could write as I planned to show my stories to my supervisor. I perceived that I needed to be “diplomatic” in describing my interactions with music therapy colleagues, as I did not wish to alter my supervisor’s opinion of these people or myself. From this experience, I consider it likely that the music therapists in my study censored aspects of their narratives as they were aware that my supervisor and I would read them. While the narratives were highly revealing in terms of music therapists’ experiences, it is important to acknowledge this framing of their responses.

The narrative contributors had been working in their current positions for different lengths of time. This meant that some music therapists were recalling recent events, while some were recalling events that occurred over ten years ago. It is possible that the differences in the length of employment led to variation in the music therapists’ experiences of constructing their narratives. During the recruitment process, one of the more experienced music therapists expressed concern that she would fail to remember “the particulars” from the early days of her post. This was the only time when a narrative contributor ever mentioned concern about her memory of service development. It was interesting to note that this music therapist’s narrative was no less detailed than the narratives that were provided by other music therapists. Again, this shows the place of narratives as constructions produced from a person’s
present perspective. The narratives provided evidence of the music therapists’ meanings at the time of construction, rather than evidence of the actual events that occurred.

It was not my intention to generalise the findings from the narratives to the broader population of music therapists internationally. Instead, I hoped to explore the experiences of a small sample of music therapists in depth. I was therefore not too concerned about obtaining a representative sample for my research. The recruitment strategy of using my and my supervisor’s email contacts meant that a large proportion of the sample were either Australian (five music therapists) or worked with children (six music therapists). Readers should therefore exercise caution when applying my research findings to music therapy service developments in other countries and to music therapy services targeted at different clinical populations. My research findings lead me to strongly encourage music therapists to gain an understanding of their own healthcare contexts and to develop their music therapy services accordingly.

Arts-based analysis.

The adoption of an arts-based approach was a significant turning point in my analysis of the narratives. Until I began writing the poems, I struggled to find a way that I could bring the music therapists’ narratives together. I wanted to keep the narratives intact and resisted fragmenting the text into separate words and statements. I was attracted to the creative process of Polkinghorne’s (1995) narrative-type narrative analysis, but expected that the chronological arrangement of data would lead to event-oriented findings. Instead of identifying a set of stages in music therapy service development, I wanted to find an analytic approach that could assist me to draw out music therapists’ subjective experiences. The process of writing poems was extremely helpful to me in this regard. My poems served to highlight music therapists’ feelings of insecurity and isolation and emphasized the music therapists’ degree of investment in their work. I was then able to identify seven main themes in the music therapists’ narratives.
Through writing the poems, I became more aware of similarities and complexities in the music therapists’ narratives. Although I made a creative response to each narrative individually, the process of writing a poem helped to highlight common themes across the narratives. For example, as I chose words for the poem “Where do I stand?” (see p. 147), I realised that a music therapist had asked many “what” and “why” questions throughout her narrative. This increased my awareness of the degree to which other narrative contributors used self-questioning statements in their narratives. After noting a high frequency of self-questioning across the narratives, I identified “insecurity” as a common theme.

The process of writing the poems also highlighted possible contradictions and inconsistencies in the narratives. As I wrote the verse “Am I a founder or am I a fraud?” (see p. 149), I played around with alternative meanings of the word “forgery” (the music therapist had written about “forging her way” in the hospital where she worked). I began to think about the fraudulent connotation of the word “forgery”. This drew my attention to the more tentative sections of the music therapist’s narrative, in which she wrote of a fear that the “music therapy police” would come to take her away. These sections were markedly different to other sections of the narrative, where she wrote confidently about the assets that helped her to be a “pioneer”. On noting this apparent contradiction, I considered the possibility that the music therapist held these perspectives at different times. Perhaps she doubted herself at the time of introducing music therapy, but at the time of writing the story she perceived that she had risen to the challenge. This observation helped me to appreciate the complex nature of narratives and of music therapy service development. I then discovered further contradictions in other music therapists’ narratives, such as a simultaneous need to be unique and to belong.

Through writing the poems, I explored different metaphors aside from the more obvious “service development as a battle” picture. I experimented with the images of the music therapist as a neglected lover, a home-seeker, and a mountain climber, and played around with the metaphor of music therapy as a baby. It was interesting and informative to see aspects of music therapy service development from different perspectives. I found the baby metaphor to be particularly compelling. This highlighted the protectiveness that some music therapists felt towards their profession.
and also pointed to the slow, prolonged progress typical of many music therapy service developments. Furthermore, I reflected that a music therapist may need to take “baby steps” when introducing services, rather than making excessive demands on management.

Although the poems were originally thought of as singular responses to an individual narrative, I noted that I was bringing in multiple sources of data as I wrote the poems. I felt as though the poems were a culmination of everything I had learned, through reading literature, through the narratives, through my fieldwork, through my training at Beth Israel, and through my own experiences as a music therapist. The rhyming structure of the poems played an important role in organizing these multiple sources of data. Having to decide on a word that rhymed forced me to think of a phrase that would fit. I drew on all my readings, observations and experiences to come up with a suitable phrase that would be relevant to music therapy service development. I reflected that this process was similar to the process of creating a composite story, as both processes involve the synthesis of multiple sources of data into a coherent whole. The rhyming structure of a poem seemed to serve an important organizational function, much like the plot in a narrative-type narrative analysis (Polkinghorne, 1995).

The processes of selecting significant words and phrases in the narratives and drawing on multiple sources of data meant that the poems were highly interpretative. I not only found myself drawing on my professional experiences as a music therapist, but also on recent personal experiences. At the time of writing the poems, I had recently ended a long-term relationship and had moved into a new home. I note on reflection that the poems brought out themes of “going solo”, “insecurity”, and “looking for a home,” which I found relevant in examining the narrative contributions. It is likely that a different researcher in different personal circumstances would have identified different themes. However, I believe that my unique set of circumstances helped me to recognise and identify these deep feelings that were conveyed by the music therapists in their narratives. The poems should not be thought of as simple, neutral portrayals of music therapists’ experiences, but as complex co-constructions. Now as I look back on the poems, it is difficult to disentangle which feelings belong to whom. I see this as a strength rather than a
limitation of my arts-based approach, which provided an opportunity to create a rich mixture of multiple perspectives.

A further strength of the arts-based approach was that it offered an effective means of communicating and collaborating with narrative contributors. Once I had informed narrative contributors of my arts-based approach via email, I shared two of my poems in my *Music Therapy Stories* newsletter (see Appendix D). When research participants and music therapy colleagues received my newsletter, they emailed me with comments on the novelty and relevance of these poems. Two narrative contributors reported that the poems had “resonated” with them and offered further reflections and updates on the development of their services. Sharing the poems was not only a way of keeping participants informed, but also a way that I could receive encouragement for my work. I was initially quite tentative in writing the poems and often doubted my artistic abilities. It was therefore reassuring to hear that my poems were not as “crappy” as I thought, but were perceived as “creative”, “powerful”, and “punchy”. When I started to write the poems, I also worried that the music therapists would feel that I had trivialised their experiences by transforming their experiences into what I considered to be simple prose. Narrative contributors’ positive comments helped to alleviate this anxiety. I received no indication that the poems were negatively received and am reasonably confident that participants had sufficient opportunities to express their concerns.

Arts-based research traditionally involves the use of the arts throughout an entire research project (Austin & Forinash, 2005). I learned that there were no disadvantages to introducing an arts-based approach for my analysis phase only. Instead, I discovered that the arts-based approach was a highly effective way of developing complex, meaningful, and evocative findings. I would therefore recommend that other researchers consider the use of an arts-based research approach, even if it is just for one phase of the research. I have now developed a passion for arts-based research approaches and am keen to explore the use of different artistic media. I am also eager to develop a larger scale arts-based research study.
Ethnography.

The three months of ethnographic fieldwork added a wealth of data to what I had already learned through reading the narratives and writing the poems. Witnessing another music therapist in the start-up phase furthered my understanding about music therapy service development in three main ways. Firstly, the fieldwork renewed my appreciation of what it is like to work as a music therapist in a highly pressurized environment. Once again I sensed the busyness of working with patients and their families, liaising with other staff, all the while working hard to establish your position in the hospital. As I followed the music therapist, I too snatched a conversation with someone in a corridor, rushed to fit in a toilet break, and celebrated when I had enough time to sit down for morning tea. I re-experienced the sorts of tensions felt when working with patients and families undergoing extreme challenges. As I sat in on meetings, I sometimes felt overwhelmed by the stories I heard and the levels of trauma that were described. As it was over a year since I had worked in a hospital setting, it was enlightening for me to re-experience the sorts of feelings and sensations that arise in hospital-based music therapy work.

Secondly, I became much more aware of contextual factors that may impact on a music therapist’s experience. My fieldwork notes captured considerable detail about the nature of the hospital environment and ways in which Sarah’s experience could have been influenced by historical factors, hospital systems, and her interactions with other staff. I was also able to detect possible opportunities and obstacles to service development in this hospital. The complexity of patients’ difficulties, as well as the hospital’s administrative procedures, staffing levels, limited resources and funding all appeared to have an impact on Sarah’s service development experiences.

Thirdly, the fieldwork enabled me to gain the perspectives of people other than music therapists. Through interviews, I learned about other staff members’ perceptions of Sarah and the new music therapy service. I also realised that the other hospital staff worked under similar conditions to the music therapist. Sarah was not the only one who was working part-time and managing time constraints and the need to prioritize. Furthermore, I discovered that Sarah was not the only staff member who
felt misunderstood. One by one, others recounted times when they felt that their roles had been misrepresented. My interviews with staff challenged my previous assumption that the music therapist’s experience of role misunderstanding is a highly unique one.

The fieldwork not only contributed greatly to my research, but also appeared to have benefits for Sarah and the development of the music therapy service. Firstly, Sarah reported that my presence added legitimacy to her new appointment. In her view, the presence of a doctoral researcher, affiliated with a university and funded by an esteemed health research body, reinforced music therapy as a bona fide, evidence-based health profession. She anticipated that my fieldwork would help her to raise the profile of music therapy and was pleased when my research was included in the hospital programme’s annual report. In our final debriefing meeting, Sarah explained that she viewed her participation in my fieldwork as an investment in the development of the music therapy service. When I asked whether fieldwork participation had been time-consuming, Sarah disclosed that the fieldwork had taken time, but that she considered it to be time well-spent.

There were also indications that it may have been helpful for Sarah to have a second music therapist in the hospital. Most of the other therapists had at least one other professional colleague with whom they shared meals and discussed patient care. In several of our interactions, it became apparent that Sarah valued my company. She expressed delight and appreciation when I joined her in attending the team’s Christmas function and later shared a concern that she would have no-one to share meals with once the fieldwork was over. It is also possible that by increasing the number of music therapists in the hospital, my presence helped to raise awareness about the music therapy service. The narrative contributors and a previous music therapy author (Loewy, 2001) have reported a similar phenomenon when writing about the benefits of taking on music therapy students.

Sarah reported that she valued the opportunities for reflection that were afforded by the fieldwork. She regularly used our debriefing times to reflect on her development work and her interactions with other staff. In our last meeting, I expressed concern that my fieldwork may have over-sensitized her to certain aspects
of music therapy service development. However, Sarah did not perceive that her behaviour had been significantly altered by the fieldwork. She reported that she already had a tendency to be sensitive to team dynamics and interprofessional interactions. In my reflexive journal, I noted that Sarah was a particularly “reflective” and “insightful” person. I wonder whether Sarah valued the fieldwork because she already saw the benefits of self-reflection. At the same time, I believe that my fieldwork was enhanced by Sarah’s reflexive capabilities.

While I was at the hospital, Sarah drew on my academic resources, knowledge, and experience. I agreed to assist her in a number of ways. I sourced some relevant music therapy articles, which Sarah later used to promote her role to other staff. I also shared advice on publishing and presenting and gave feedback on the article she was preparing with the psychologists. I considered the possibility that these gestures might influence the natural development of the music therapy service, but decided to help Sarah.

The fieldwork was extremely revealing, but it was not without its challenges. The process of undertaking ethnographic research involved a series of complicated steps, including gaining access to the hospital, developing research participants’ trust, and considering and revising my role as a researcher. I soon discovered that ethnographic fieldwork could be a complex, unpredictable journey, requiring ongoing thought and negotiation. As my previous music therapy research had used constant, predetermined procedures, this aspect of ethnography was new to me. I needed to learn to be patient, responsive, and open to opportunities, in order to gain the most from my ethnographic fieldwork.

Gaining access to the hospital was not a straightforward task. Before I could begin my fieldwork, I needed to gain the support of the medical consultant, bring him into the research proposal as the principal investigator, and obtain approval from four separate hospital committees in succession. As I was not already working at the hospital, it took time for me to obtain the various meeting schedules and to find out who to contact regarding my research proposal. The ethical approval process took several months to complete, but progressed relatively quickly once I reached the final stage of presenting my proposal to the ethics committee. The next step was to gain
staff members’ consent to participate in my research. It took patience and persistence to gain signed consent forms. I wanted to progress my research, but I did not want staff to perceive pressure to participate. I was conscious that staff members were busy meeting the needs of patients and families and had little time to devote to my research. I gently reminded staff about consent forms in staff meetings and always held spare forms in case someone wished to sign one there and then. I continued to invite questions and concerns and requested that staff approach me if they were ever uncomfortable in my presence. I considered this approach to be vital for gaining research participants’ trust.

A signed consent form was just the beginning of my relationship with staff. In order to build trust, I needed to continue to provide information about the research. In the initial exploratory phase of the fieldwork, staff appeared welcoming. They greeted me warmly, answered my questions, and accepted invitations to meet. First and foremost, they appeared to value the opportunity to vent their feelings and frustrations about working at the hospital. As I entered the main observation phase, staff seemed to become more aware of my research aims and more careful in my presence. They queried whether they were “opening up too much”, how the information would be used, and whether the research would affect their professional relationships. These were important questions which challenged me to think more about how I would present my fieldwork findings. It was difficult for me to forecast what my fieldwork would reveal, but I was able to reassure staff that I would make efforts to disguise identities in my final write-up. I wrote a half-page example of a way in which the research findings could be presented, to demonstrate how information could be mixed together and kept confidential. I showed this to staff when we discussed possible risks of participating in the research. Kaiser (2009) has proposed that ongoing discussions such as these can lead to the inclusion of important data that otherwise would have gone unpublished.

In my conversations with staff, it became evident that some team members hoped that my research would convince hospital management to continue the music therapy service. As my research focused more on learning about a music therapist’s start-up experiences and was not evaluating the effects of music therapy, I did not feel that I could guarantee this outcome. I considered that it was possible that my
fieldwork could lead to increased awareness of music therapy within the hospital, but doubted whether my findings would lead to increased music therapy provision. I was therefore cautious not to make any promises regarding the implications of my findings.

At other times, team members expressed anxiety that my fieldwork might damage music therapy’s chances of continuation. They seemed to believe that the music therapy service was on tenterhooks and I observed that they were anxious to ensure that the service continued. This anxiety was particularly noticeable when I interviewed one of the hospital managers. In the process of setting up the interview, several team members became aware of my intention to speak with the manager. Once the interview had taken place, these staff members were curious to know what had been said about music therapy and asked me to share what I had learned. I was keen to preserve the rapport I had built with these staff and my natural instinct was to want to help them. However, I decided not to disclose information as I had already promised the manager and the ethics committee that I would keep the content of interviews confidential. I explained this decision to team members who had requested information. In retrospect, I wonder whether I could have alleviated team members’ anxieties by finding a way to keep my appointment with the manager more discrete. I did not see any evidence that my fieldwork had negatively affected managers’ perceptions of the music therapy service. The music therapist’s hours were increased after the fieldwork had taken place.

The task of developing my role as an ethnographer was the most demanding aspect of my fieldwork. As I was aware that nurse ethnographers had encountered role dilemmas when undertaking fieldwork (Allen, 2004; Borbasi et al., 2005), I spent time considering my role prior to my own fieldwork. I wrote about my intended role in my reflexive journal and discussed possible role dilemmas with my doctoral supervisor. This preparation was useful, but it was only once I entered the hospital that my researcher role truly developed. Instead of establishing a singular researcher role, I found myself emphasizing different aspects of myself at different times. Returning to the familiar setting of a hospital brought to the fore a set of previously held roles and relationships and a number of situations arose that I hadn’t predicted. As well as managing the roles of researcher and therapist, I also juggled my identities
as a colleague, friend, and student. I found that I needed to explore these multiple
identities, in order to progress my research, to gain research access, to fulfil research
responsibilities, and to negotiate complicated interactions.

Although I had intended to down-play my music therapist identity, there came
times when it appeared advantageous to present myself as a music therapist. On
reflection, I believe that my appearance as a music therapist enhanced my acceptance
in team meetings. As a white, middle class, professionally dressed female, I looked
like most of the team and I imagine that I was relatively inconspicuous. At no time
during meetings did I gain a sense that team members were censoring what was said.
At other times, I wondered whether my appearance as a music therapist could have
limited my access to sensitive information. Sarah and I shared an office, took coffee
breaks together, and often arrived for meetings at the same time. I regularly heard
staff referring to us as “the music therapists”. I therefore consider it likely that my
music therapist identity had an impact on the degree to which staff disclosed their
authentic impressions of the new music therapy service. When interviewed, team
members had only very positive things to say about Sarah and the new music therapy
service.

My relationship with Sarah was the most challenging to negotiate. I had
known her prior as a colleague and it was difficult for me to relate to her in any other
way. Furthermore, her part-time employment meant that we met in settings outside
work to discuss my research. Sarah and I reflected on events in her car or at her
home, and often as we shared meals. I considered Sarah to be generous in allowing
me to observe the early days of her post and in giving me her time outside of working
hours. In this respect, our relationship seemed more like a friendship than a research
contract. I then experienced a dilemma when she asked for advice regarding the
introduction of music therapy and sought reassurance that she was doing “the right
thing”. I felt a strong desire to help, but decided to hold back for fear of influencing
the natural development of the music therapy service. I wanted to observe how Sarah
would introduce the music therapy service, not how I would introduce the service. I
explained this to Sarah instead of giving excessive pieces of advice. Although
rapport and reciprocity are valued in feminist discussions of research roles and
relationships (Borbasi et al., 2005; Duncombe & Jessop, 2000), I discovered that my
close relationship with Sarah led to complicated situations at times. There were times when our closeness was beneficial to the research, but there were also times when I perceived that it was helpful to maintain some distance between us.

Another role that I explored was that of student. In undertaking the fieldwork, I felt much like a student on clinical placement, who was getting to know faces, names, and roles, finding her way around the hospital, learning the way the ward operated, and keeping out of the way when necessary. Highlighting this aspect of my self seemed to further promote participation from staff. When I came from a position of not knowing, staff seemed willing to teach me what they had learned over years of working at the hospital. An enquiring attitude and an interested ear seemed to go a long way toward encouraging hospital staff to share their points of view. This stance could be likened to what previous authors have termed “strategic incompetence” (Lofland et al., 2006; p. 70) or “becoming a nonexpert” (Castellano, 2007, p. 712).

Previous discussions about the role of the ethnographer have weighed up the advantages and disadvantages of occupying insider or outsider positions (Allen, 2004; Angrosino, 2007), or dual practitioner-researcher identities (Allen, 2004; Borbasi et al., 2005). I believe that my exploration of multiple identities added a further layer of complexity to my fieldwork that would not have been possible otherwise. Paying attention to my emotional responses as a researcher, music therapist, friend, and student deepened my insights and enhanced my understanding of issues in music therapy service development. This process helped me to develop rich findings that I hope will especially resonate with music therapists who read this research.

**Further ethical considerations.**

The combination of narrative inquiry, arts-based research, and ethnography allowed me to explore the experiences of a small number of music therapists in-depth. However, these methodological choices led to some ethical dilemmas when it came to presenting the research findings. Most notably, I experienced that it was difficult to assure complete confidentiality when I was studying a small number of members of a small professional group. In writing up my findings, I needed to strike a balance
between my wish to produce rich and meaningful findings and my promise of confidentiality.

When I was recruiting music therapists to provide narratives, some potential participants expressed concern as to how they would be represented. Two asked for further information about my methods of analysis and two requested further reassurance that their narratives would remain anonymous. I reiterated my intention not to use any names in my thesis and explained that I planned to mix up music therapists' narratives. However, I could not guarantee that readers would not attempt to guess identities from contextual details provided, such as a music therapist’s country of work, clinical population, or length of employment. After I explained this further, one music therapist chose to amend her original narrative and removed some personal and sensitive statements from her story. This amendment could potentially have reduced my degree of understanding of this music therapist’s narrative. However, I noticed that the essence and the sequence of the music therapist’s story remained intact.

As I wrote up my findings from the narratives, I made efforts to keep the narrative contributors’ identities secret. However, this limited the degree to which I could link the music therapists’ experiences to their particular circumstances and contexts. One example was my decision to use female pronouns for all of the narrative contributors. While the use of female pronouns made male participants less identifiable, it also disguised potential differences between the male and female participants’ experiences. As I read the narratives, I thought that the male participants were more confident in the telling of their service development stories. In contrast, I observed that the female participants expressed stronger feelings, frustrations, and uncertainties. In detecting a difference between the genders, I wondered whether gender may play a role in music therapy service development. I considered the possibility that men I had worked with were more readily accepted as professionals when they joined a healthcare team. Perhaps the male music therapists in my study may have been respected as skilled and knowledgeable by virtue of being male. McIntosh (2001) termed this “unearned male privilege”. Through her reflection on teaching this concept she realised that as a white person she also enjoyed the benefits of unearned privileges that her whiteness affords. She described this
through the imagery of an invisible weightless knapsack. It is beyond the scope of my research to develop these ideas further, but some interesting questions about maleness in healthcare and the relationship of maleness to authority in service development are raised by my study.

I explored one music therapy service development context through ethnographic fieldwork. This procedure led to certain predicaments when it came to writing up the fieldwork findings. At various points in the research, Sarah asked for more information about my writing intentions and expressed concern that my research would impact on her growing relationships with hospital staff. She reflected that she had been “very honest” in her interactions with me and was worried about how I would use the information obtained in the fieldwork. She also shared a concern that team members could potentially read my work and recognise themselves and others in the thesis. I attempted to reassure her by explaining that I planned to disguise fieldwork participants’ identities and intended to mix up my fieldwork observations with other music therapists’ stories. Later, when I decided that I wished to write up my fieldwork findings separately, I emailed Sarah to notify her of this change in procedure. At this time, I re-stated my intention to disguise participants’ identities and invited Sarah to raise any questions or concerns. Sarah responded positively by wishing me well with the remainder of my research.

In keeping with the ethnographic research tradition, I wanted to include rich contextual detail in the write-up of my ethnographic findings. I considered that this was important so that readers could judge for themselves whether my findings were credible and applicable to other healthcare contexts. However, the more contextual detail that I provided, the more identifiable Sarah became. Aspects such as the location of the hospital, the hospital’s philosophy of care and funding arrangements, the type of patients Sarah worked with, Sarah’s background and experience gave obvious clues to her identity. I considered that anyone who knew Sarah would be able to guess who I was writing about. Furthermore, by identifying Sarah I could potentially reveal the identities of the other fieldwork participants or even patients and their families. As I had promised participants that I would keep their contributions confidential, I decided to limit the amount of contextual detail that I provided.
As I have omitted some contextual details, I have been unable to fully explore the impact of contextual aspects on a music therapist’s experience. One aspect deserving of mention is the type of patients that Sarah worked with. At the time of the fieldwork, Sarah was introducing a music therapy service for patients with particularly complex medical needs. Sarah and her colleagues not only worked with patients, but also with family members in extreme distress. Sometimes patients responded little to treatment and I observed that team members experienced their work as particularly tiring, demanding, and stressful. At the time, I reflected that this may have impacted on the way that Sarah was accepted by the team. Team members appeared to welcome any intervention that could potentially help patients and regularly sought the assistance of others to achieve positive outcomes for patients and families. Fieldwork interviewees’ responses indicated that they viewed music therapy as a new and novel intervention which could help them in meeting the complex needs of patients and families. Although this contextual information was valuable, I decided to focus on Sarah’s experience of service development, rather than the details of the service provided. This focus enabled me to gain rich insights about Sarah’s motivations and intentions in developing a music therapy service.

Reflexive journaling.

My original motivation for keeping a reflexive journal was to keep track of my own assumptions about music therapy service development. I was aware that I already held views about service development based on my own experiences as a qualified music therapist. I perceived that it was important to explore these views and to consider ways in which my own music therapy background could inform my interpretations. I therefore recorded any memories and thoughts regarding my own experiences as I read the narratives and carried out the fieldwork. For the most part, my experiences appeared quite similar to the music therapists in my study. I recalled similar feelings of excitement, frustration, and disappointment in developing new services and reflected that I too wished to be seen as a clinician, a professional, and a pioneer. Like the music therapists in my study, I remembered occasions when it was helpful to build relationships with other staff and times when I questioned whether to stay or to leave my place of employment. It is possible that I privileged experiences that were similar to my own when I wrote up my research. However, I believe that
my reflections assisted me to further recognise and understand the experiences of the
music therapists who participated in my study.

I also believe that reflexive journaling highlighted perceptions and
experiences that were different to my own. When starting my research, I assumed
that it was crucial to be assertive when introducing new music therapy services. In
my journal, I reflected that it was important to “start as you mean to go on” rather
than accepting less than ideal work circumstances. I remembered times when I was
cautious to avoid working at home and occasions when I evaded activities that were
outside my definition of “music therapy”. Reflecting on these experiences helped me
to detect differences in other music therapists’ experiences. Several music therapists
recommended a subtle approach to music therapy service development, instead of
“preaching” to colleagues or making excessive demands. Additionally, a couple of
music therapists remembered taking on non-music therapy activities, in the interests
of building relationships and demonstrating a contribution to the team. Through
reflexive journaling, I was able to acknowledge these different experiences and to
ensure that they were sufficiently captured in my results.

I experienced that the reflexive journal was most beneficial for managing my
emotional responses and developing my role as a researcher. In the course of my
ethnography, I often experienced anxiety as to how I should interact with research
participants. Although I was familiar with hospital environments, unforeseen
circumstances arose and there were times when I was uncertain how to respond. As
discussed earlier (see p. 224), I found this uncertainty unnerving. The reflexive
journal was a place where I could express my anxieties and uncertainties and weigh
up the merits and disadvantages of various roles and approaches. This writing helped
me to make important decisions regarding my role, such as my level of participation
in team meetings and the nature of my relationships with Sarah. Writing in my
reflexive journal also helped me to avoid communicating my anxieties to Sarah. My
doctoral supervisor and I considered that this was important, so that Sarah would not
become overly burdened by my fieldwork issues.

Reflexive journaling was also helpful to me in deciding how to bring the
different data sources together. Once I had finished data collection, I was uncertain
what I should do with the findings from the narratives, the poems, the fieldwork observations and interviews. Writing in my reflexive journal helped me to identify the unique contribution of each data source and to consider possible approaches to the presentation of my findings. Through this writing, I arrived at an approach in which the narratives and fieldwork were dealt with separately.

When writing my thesis, I struggled to find my own voice. My supervisor and I noted that I had a tendency to write clearly and concisely, rather than highlighting contradictions and complexities. Furthermore, I tended to write authoritatively, instead of adopting a more tentative and subjective stance. I wrote in a style more typical of quantitative research reports than of qualitative research writing. Writing in a reflexive journal helped me to develop a more personal writing style. Through reflexive journaling, I became more aware of my own thoughts and responses and became more comfortable in revealing my uncertainties. I hope that these developments are evident in the writing of this thesis.

The technique of reflexive journaling helped me to explore my own responses and assumptions, to develop my role as a researcher, to make research decisions, and to find my own voice. I am extremely grateful to my doctoral supervisor for encouraging me to use this resource.

Newsletters.

My research was greatly enhanced by the introduction of a newsletter for research participants and colleagues. I first heard of the use of newsletters through Dr Clare O’Callaghan’s research with cancer patients in Australia. My supervisor forwarded me a copy and suggested we think about using the newsletter to keep participants involved with developments in the research. These newsletters contained updates on the progress of my research and my emerging findings (see Appendix D). In writing the newsletters, I hoped to encourage further collaboration and dialogue around my research topic. I wanted to demonstrate my authenticity as a researcher and to show participants that I valued their contributions to my research. I also considered that research participants may be interested to know how their contributions were being used. I experienced that the newsletters were highly
successful in achieving these aims. Each time I released a newsletter, I received several email responses from research participants and colleagues. Research participants thanked me for sharing findings and for keeping them abreast of developments in the research. On a couple of occasions, research participants even requested that I resend them an earlier newsletter. Email responses further indicated that the newsletters helped to maintain people’s interest in my research. Readers commented that the newsletters were “interesting”, “thought-provoking” or “exciting”.

The process of writing the newsletters was further helpful in meeting my needs as a researcher. Through writing the newsletters, I gained opportunities to articulate my developing analytic ideas and to reflect on my progress in the research. Then once I had sent out a newsletter, I received encouragement, positive feedback on my interpretations, and further service development reflections from readers in return. Research participants and colleagues’ emails not only served to verify my interpretations, but also helped me to feel less isolated. I no longer felt like I was alone in my research and instead gained a sense that I was collaborating with other music therapists. I would therefore strongly recommend that other researchers consider how they might use a device such as a newsletter to sustain lines of communication and collaboration.

Summary

This chapter has presented a discussion of the findings of the research. The four main contributions of this research to the current state of the art in the field of music therapy have also been highlighted here, including 1) in-depth exploration of music therapists’ service development experiences, 2) application of management concepts to understand aspects of music therapy service development, 3) elaboration of the complexities of music therapy service development, and 4) demonstration of a novel combination of qualitative research methodologies. In the next chapter, I further reflect on these contributions and summarize the main opportunities that my research offers to development work in music therapy.
Chapter Seven

Recommendations and Conclusions

This chapter presents the final material of the thesis including the conclusions reached and the recommendations for practice and research.

When I first began writing this chapter, my tendency was to want to impart advice to music therapists and students. On reflection, I think this was because my initial research motivation was a desire to help practicing music therapists to improve their service development skills and successes. I hoped that I would uncover some successful service development strategies, which I could later pass on as sage advice to music therapy students and new graduates. When I began sharing drafts with my doctoral supervisor, we reflected that my imparting of advice was at odds with my qualitative research approach and my actual findings. My research did not lead to a neat set of effective service development strategies. Instead, the findings showed that development experiences were context-rich and non-linear.

My research has provided an in-depth investigation of music therapists’ service development experiences. I have therefore tried to find other ways of presenting the conclusions than offering advice. This chapter provides a further reflection on the research findings. As advice-giving was my first instinct, I have placed some general service development pointers in a letter to a new graduate (see Appendix H). I wrote this letter at the prompting of my supervisor, who suggested that this could be a useful device through which I could satisfy my instinct to use the findings to help new practitioners.

Recommendations for Music Therapy Practice and Training

When starting out this research, it was my intention to uncover some strategies that may be useful for music therapy students and new graduates who were developing new music therapy services. While the research findings did point to some similar experiences among participants that might be useful for practitioners new to service development, I also learned that music therapy service development
can be a complicated task and that there may be no simple recipes that can be followed when introducing new music therapy services. In reading the narratives and carrying out the fieldwork, I observed that music therapy service developments were often slow, unpredictable, and dependent on multiple contextual factors. Service development efforts appeared to be helped or hampered by a variety of factors, such as the financial and organizational climate and the needs of patients and staff. Music therapists recalled both gains and setbacks in the development of their services and experienced dilemmas as to the best service development approach to adopt. Furthermore, some service developments appeared to be fortuitous rather than the result of any particular action on the music therapist’s part. I now consider it misleading to offer clear-cut recommendations for successful service development.

*Right time: right place.*

The experiences of the music therapists in my study indicated that for many of them there seemed to be a “right time” for introducing music therapy. Music therapists recalled that they had successfully introduced new services when there was money available, once staff had witnessed the benefits of music therapy, or when other team members were perceived to be ready for a change. Several music therapists also considered that it was important to be aware of historical factors within their organizations. Healthcare traditions were portrayed as powerful and music therapists recalled that they needed to build a history of music therapy service provision before further development was possible. They reflected that it had taken them time to gain an understanding of their organizations. Their experiences indicated that patience may be required and that to be successful in a start-up venture, a music therapist may need to seize opportunities as they arise. As I carried out my research, I was constantly impressed by the sensitivity, thoughtfulness, and responsiveness shown by the experienced music therapists in my study.

It became evident that several of the music therapists in my study had an ideal vision for their music therapy services. At the same time, they reflected that it was important to respond to the needs of patients, staff, and the broader healthcare organization when attempting to introduce a new service. Several music therapists described how they had developed a relevant and sustainable music therapy service,
by identifying and responding to the needs of others. Furthermore, I noted that the music therapists often reported ways in which they had compromised on their ideal vision for the music therapy service. They recalled compromises in such areas as the amount of music therapy hours, funding arrangements, or the environment in which they carried out sessions. Although some expressed dissatisfaction with the degree to which they had compromised, others perceived that it was important to be reasonable and to acknowledge an organization’s funding and resource constraints. This suggests that in developing new services, it may be helpful for music therapists to reflect on which aspects of a service are most essential and which aspects they are willing to compromise. Each music therapist’s priorities are likely to be different and in reflecting on my findings, I would encourage music therapists to consider what is most important to them when negotiating details of their position or services.

Building relationships.

The relational aspects of music therapy service development featured heavily in the narratives and fieldwork. Music therapists described how they had built relationships with other staff, through listening to others’ perspectives, seeking advice and feedback, exchanging observations, sharing positive outcomes, and responding to requests for help. I also observed that Sarah showed consideration and courtesy towards other team members while developing a music therapy service.

Recent literature on music therapy and interprofessional work has emphasized a need for music therapists to build relationships with other staff (Hobson, 2006b; Twyford & Watson, 2008). However, this literature has tended to promote interprofessional work for the benefits of patients and staff. My research findings additionally suggest that interprofessional work may have benefits for music therapy service development. Music therapists in my study reflected that they had obtained access to patients, gained support for the music therapy service, and demonstrated their place as a team member through building relationships with other staff. I also noted that the music therapists presented themselves as “equals” when they formed relationships with others.
Further to the above, the music therapists’ experiences exposed some possible contraindications to interprofessional work. Two music therapists recalled times when patients had benefited more from individual music therapy than interprofessional work and several music therapists described their interprofessional work as tiring. Sarah also reflected that there were risks to interprofessional work with other team members. She avoided aligning herself too closely with any one professional area, so that she could maintain relationships with the whole team. These music therapists’ experiences suggested that the benefits of interprofessional work should not be accepted unquestionably.

The music therapists frequently mentioned other people who they believed had helped or hindered their efforts to establish music therapy services. Often these were people in formal or informal positions of power, who had the potential to increase the music therapist’s access to patients or funding. The identification of possible “gatekeepers” is recognised as an important step in implementing organizational change (Dulaney & Stanley, 2005). However, the possibility that music therapists may benefit from identifying gatekeepers has received only passing attention in music therapy literature (Loewy, 2001). I don’t recall ever reflecting on issues of power when developing my own music therapy services. I therefore wonder how or whether music therapists could benefit from further training around healthcare cultures and relations of power within organizations. Perhaps the profession of music therapy could benefit from the input of experts in the field of management and marketing. Education around these topics may be a training need that universities or professional music therapy associations could address in future. It is also the kind of material that could be provided as an online educational resource for use in professional development training.

Gaining management perspectives.

I experienced that a management lens was extremely useful for understanding my own and other music therapists’ service development experiences. Organizational psychology concepts such as “role blurring” (Brown et al., 2000), “role ambiguity” (Willard & Luker, 2007), and “supplementary and complementary fit” (Kristof-Brown et al., 2005) appeared applicable to music therapists’ experiences of
implementing and establishing a new role. A management perspective was also helpful for understanding territorial or resistant behaviour as a common phenomenon in the implementation of new healthcare roles, instead of a problem specific to the field of music therapy. Many of the narrative contributors recalled unpleasant encounters with staff and two reflected that their colleagues were particularly resistant to the introduction of music therapy. I therefore wonder whether music therapists could benefit from further education around common issues in new role implementation. Experts in human relations could be accessed to support training in our profession, and consultations about strategies for managing interprofessional tensions might be helpful for the further development of our field.

Education around funding was another possible training need that emerged in my research. Several music therapists expressed uncertainty about what they needed to do to gain support from managers and to secure further funding for music therapy. One narrative contributor expressed doubts about her management skills and assumed that a more “administratively savvy” therapist would have been more successful in consolidating music therapy’s place in the organization. Similar concerns were expressed by Sarah’s colleagues and supporters at the hospital. Other music therapists attributed their levels of job security to their understanding of financial matters and a belief that they had formed mutually beneficial relationships with managers. I now wonder whether music therapists could gain greater confidence and bargaining power through developing their administrative knowledge and skills. Hilliard (2004) has previously emphasized a need for training in the financial aspects of music therapy service provision. My research supports the need for such training.

Reflecting on and managing emotional responses.

Information gleaned from the narratives and fieldwork indicated that music therapy service development can be experienced as a challenge. As sole practitioners, several music therapists reflected on the pressure they experienced to represent their profession and to prove their worth. Some music therapists conveyed intense feelings of isolation, insecurity, and uncertainty and recalled difficult encounters with other staff. Although tensions were not common to all of the music therapists in my study, strong emotional responses were expressed by those who did remember difficult
encounters. Furthermore, several therapists recalled feelings of tiredness or
disappointment after investing large amounts of time and energy into their service
developments. While a need for professional supervision has been identified by
previous music therapy authors (Forinash, 2001; Jackson, 2008), the introduction of a
new service may be a particular time when supervision is essential. Several
participants in my study reported that they had benefited from supportive
relationships with managers, other healthcare professionals, or music therapists
working in similar situations elsewhere. There may be a further role for supervision
in supporting music therapists to cope with service development demands and
disappointments, and perhaps also in helping music therapists to manage emotional
responses to development work. Additionally, music therapists may find it helpful to
look outside their organizations for support and recognition. Music therapists in my
study who had published or presented reported that they had gained greater
confidence through sharing their work with professional colleagues.

**Recommendations for Healthcare Managers**

Findings from the fieldwork and narratives may also have implications for
healthcare managers. My observations and interviews with hospital staff indicated
that the new music therapy service was seen to make a valuable contribution to the
work of a clinical team. Sarah’s co-workers spoke highly of the music therapy
service, reporting that the service had benefited patients and families, enhanced
existing services, exposed new possibilities, and encouraged further interprofessional
working. Several team members commented that they no longer viewed music
therapy as a “luxury”, but as a service which should be more regularly available to
patients. Furthermore, some interviewees’ comments indicated that the introduction
of a new music therapy service had helped the team to become more integrated.
Previous music therapy authors have similarly reflected on music therapy’s capacity
to tie teams together (Hilliard, 2006; Loewy, 2001). Therefore managers may choose
to explore the introduction of a music therapy service, not just as a patient-oriented
service, but also as a way of bringing a diverse healthcare team together. Through
addressing a range of patients’ needs and collaborating with multiple professionals, a
music therapist may play a valuable role in uniting a team.
The music therapists’ narratives indicated that it was important for them to be recognised as “clinicians” and “allied health professionals”. Music therapists stated that they did not want to be mistaken for music teachers, entertainers, or volunteers. Through small measures, healthcare managers may be able to assist music therapists in establishing and maintaining a professional identity. The music therapists perceived that they were viewed as professionals when they were placed within psychosocial teams or when they were included in team meetings. It may be helpful for healthcare managers to further understand music therapists’ motivations for seeking team inclusion.

Findings from the narratives and fieldwork indicated that the music therapists experienced multiple service development demands. In addition to providing music therapy sessions for patients and families in need, the music therapists reflected that they were required to constantly educate others about music therapy, provide evidence of its efficacy, and obtain ongoing support for the continuation of the music therapy service. The music therapists also indicated that it could be demanding to enter new domains of music therapy practice. Eight of the music therapists recalled difficult encounters with other staff and experienced competition and conflict similar to other health professionals in new roles (Cummings et al., 2003; Timmons & Tanner, 2004). Several music therapists also expressed strong emotions when recounting their service development stories. In coping with multiple demands, several music therapists reported that they had benefited from supportive relationships with managers and colleagues. Healthcare managers may therefore wish to consider whether there are adequate supports available before introducing a new music therapy service. It may also be important for managers and music therapists to discuss available supports before a music therapy service commences.

My research may also have some implications for the retention of music therapists. In reading the narratives and undertaking the fieldwork, I noted that the music therapists frequently questioned whether their hard work was worthwhile. A number of the music therapists had even begun to consider leaving their facilities, so that they could continue to develop new ideas and approaches. One music therapist explained that she was feeling “stilted” in her position and that she wanted additional opportunities to test practice boundaries and to write about her work. Two others
were considering a move to pursue their research ideas. These music therapists’ experiences suggested that it was important for them to work in an organization where they could grow and change. Once they had laid the foundations of a music therapy service, the music therapists appeared to desire further opportunities to develop their skills and ideas. Several music therapists reported that they had benefited from opportunities to attend conferences and to write about their work. Continuing professional development may be another important issue for managers and music therapists to discuss.

Recommendations for Further Research

One of the main contributions of this research is the demonstration of the successful use of three methodological approaches: narrative inquiry, arts-based research, and ethnography. Using three different methodological approaches allowed me to learn about music therapists’ service development experiences from multiple perspectives. Through collecting narratives, I gained an understanding of music therapists’ meanings and motivations in service development. Through writing the poems, I was able to draw out music therapists’ emotional responses to their development work. The introduction of an ethnography to the mix allowed me to observe and experience a music therapy service development first-hand. Through using more than one methodology, I believe I gained a rich picture of music therapy service development. I would therefore recommend that other researchers consider the use of more than one method when developing their own research projects. The particular combination of narrative inquiry, arts-based research, and ethnography may be useful for exploring other stakeholders’ experiences of music therapy. I expect that it would be fascinating to work with patients and healthcare professionals on other topics of inquiry in the ways that I collaborated with music therapists in my research.

One of the most enlightening moments in my research was my interview with a healthcare manager. In this interview, I was able to gain a manager’s perspective on important issues in music therapy service development. The manager shared perceptions about the music therapist’s approach, compared the music therapy service to another service that was starting at the same time, and revealed something of the
nature of the relationships between the different hospital programmes. Several music therapists in my study perceived that they were unable to access managers, or were unclear about what managers were looking for in relation to music therapy services. It may therefore be important to ensure the inclusion of managers in further research on music therapy service development. Previous studies have used survey questionnaires to gain managers’ perspectives on music therapy services (Daykin & Bunt, 2006; Hilliard, 2004). My experience suggested that it may be even more revealing to gain managers’ perspectives through interviews. It is possible that interview methods will lead to additional insights about managers’ feelings, understandings, and expectations of music therapy.

By viewing music therapy service development through an organizational psychology lens, I gained further insights about the environments in which music therapists work. Healthcare organizations are assumed to be hierarchical environments, filled with power plays, professional rivalries, and battles for territory (Deegan et al., 2004; DiPalma, 2004; Viitanen & Piirainen, 2003). The narratives and fieldwork seemed to support this assumption. Several music therapists in my study experienced difficulties in accessing organizational hierarchies or in gaining acceptance from more established healthcare staff. Furthermore, a number of the music therapists acknowledged that their services had benefited from the support of people in positions of power. Up until now, there has been little reflection about issues of power in relation to music therapy service development. Further ethnographic research may lead to increased knowledge about who holds power when a music therapist introduces music therapy to an established healthcare team. Research in this area may also increase our understanding of the ways in which music therapists can develop alliances and negotiate successfully within these power structures.

Several of the music therapists experienced role uncertainty as they were developing their music therapy services. These music therapists explained that it was hard to know whether they were doing “the right thing” as they entered new territory. One music therapist recalled that in developing a new service, she needed to take risks and test the boundaries of what she considered to be traditional music therapy practice. She remembered the early days of her post as a “time in the dark”. Now
that music therapy has become more established internationally, it may be timely to explore music therapists’ fears and uncertainties in development work. Research in this area could help to promote understanding about the processes involved in music therapy role implementation. Additionally, research in this area could be valuable for identifying new music therapists’ training and support needs.

In reading the narratives and undertaking the fieldwork, I noted that music therapists frequently questioned themselves. There were periods when the music therapists asked, “Am I doing the right thing?”, “Should I stay?”, or “Is it worth it?” It may be interesting to investigate this experience of periods of uncertainty and to explore the consequences of this type of questioning behaviour. Researchers could further examine temporal aspects of this type of questioning and whether they occur at particular points in a music therapy service development. Longitudinal research may be particularly helpful in this regard. It may be that such questioning helps clarify the stage of service development, or assists in identifying next steps. However, it may also be that it heralds difficult times, or a possible change of work. Greater knowledge in this area could further our understanding of important issues in music therapy job satisfaction and retention.

In carrying out a qualitative research study, there were many times when I myself was uncertain and unsure of which path to follow. This was particularly the case during my ethnographic research at the hospital, when I was developing my role and managing my relationships with fieldwork participants. As ethnographic methods were new to me, I experienced this uncertainty as unsettling. Strategies such as reflexive journaling, remaining flexible, and seeking support from my supervisor were extremely helpful to me in coping with uncertainty and deciding on my next move in the research. Through these strategies, I came to appreciate uncertainty as a rich, revealing, and fascinating part of ethnography rather than something to be removed from the research process. I would therefore recommend that novice ethnographers put in place strategies for addressing and documenting any uncertainties that may arise in the research. I would also highly recommend the use of a newsletter as a way to communicate with research participants. I learned that a research newsletter was not only an effective means of communicating and
collaborating with research participants, but also a way for me to gain support for my research.

Conclusions

This is the first time the topic of music therapy service development has been explored in the form of a large scale multi-method research project. As such, it provides valuable information about the types of issues that music therapists may encounter when introducing new music therapy services to an established healthcare organization. Music therapists in this study shared strong feelings of isolation, insecurity, and uncertainty in relation to their service development experiences. At the same time, music therapists showed passion and commitment and worked hard to demonstrate their worth, to build relationships with other staff, to obtain funding and resources, and to carve out spaces for music therapy within their organizations. Music therapists in this study highlighted the multiple demands of service development work, but also described their work as rewarding and exciting. They recalled that they had gained a sense of achievement through working with patients and developing new services on their own.

Music therapists in this study portrayed music therapy service development as a complicated process. The narratives and fieldwork indicated that service development may take time and be influenced by a range of contextual factors, including a healthcare organization’s history and financial arrangements and the needs of patients, families, and staff. Furthermore, no clear-cut service development strategies emerged through the narratives and fieldwork. Music therapists used a range of different strategies in different ways and frequently experienced dilemmas as to the best service development approach. What did emerge though was that the respondents were thoughtful and flexible in their approach to developing music therapy services. They listened to stakeholders’ perspectives about what was required and waited for opportunities to introduce change. The music therapists also perceived that they had made compromises in the development of their services, by accepting philanthropic funding or working without a designated treatment space. While some music therapists expressed dissatisfaction with their level of compromise, most were willing to make allowances in the interests of building relationships with managers.
and staff. Although there may be no straightforward formulas for establishing music therapy services successfully, several music therapists recalled that they had successfully introduced music therapy by responding to the needs of patients, families, co-workers, and organizations.

Literature on role implementation and organizational change may be highly useful for understanding music therapist’s experiences of service development. In recounting their service development experiences, the music therapists in this study recalled encounters that were similar to those experienced by others in new and emerging healthcare professions. Like other professionals in new healthcare roles, some of the music therapists experienced role ambiguity or detected resistance from more established professionals. The music therapists also referred to aspects of service development that have been identified in studies of organizational change. These included the important role of advocates or gatekeepers in the development of music therapy services and the various ways in which new music therapists can fit into work teams. This research revealed that some service development aspects may not be discipline-specific and that the profession of music therapy could benefit from further interdisciplinary research. Interdisciplinary research may be particularly helpful for gaining further insights about the processes of music therapy role implementation and development.

The novel combination of narrative inquiry, arts-based analysis, and ethnographic fieldwork enabled a rich exploration of music therapy service development from a variety of perspectives. Each of these methods provided unique insights that contributed to the production of meaningful and evocative findings. The introduction of both an ethnography and an arts-based approach to analysis led to additional interpretations of the materials and topic that would not have been possible otherwise. Music therapy researchers are strongly encouraged to consider the use of newer methodologies and to remain open to introducing additional methodologies in the course of their research.
References


Dokter, D. (2001). Arts therapies in the asylum. The development of an arts therapies team. In L. Kossolapow, S. Scoble & D. Waller (Eds.), Arts-therapies-


of baseline patterns for improved interprofessional collaboration. *Qualitative Health Research, 19*(7), 943-953.


Miller, K., Reeves, S., Zwarenstein, M., Beales, J. D., Kenaschuk, C., & Gotlib Conn, L. (2008). Nursing emotion work and interprofessional collaboration in


Zwarenstein, M., Goldman, J., & Reeves, S. (2009). Interprofessional collaboration: Effects of practice-based interventions on professional practice and healthcare outcomes. [Cochrane Review]. In Cochrane Database of Systematic Reviews,
Appendix A

Email Correspondence with Narrative Contributors

Recruitment Email

Dear Music Therapist,

I am studying my PhD under the supervision of Professor Jane Edwards at the University of Limerick, Ireland. I am conducting a research project to learn more about music therapists’ experiences of implementing music therapy services in health care settings. It is hoped that this project will reveal possibilities for further development of music therapy services within health care settings throughout the world.

You are being invited to participate in the project due to your extensive experience in developing music therapy services. Please take a moment to read the attached information about the project. If you would like any further information about the project, please email Professor Jane Edwards (Jane.Edwards@ul.ie) or myself (Alison.Ledger@ul.ie). We can also be reached by telephone on +353 61 213122.

Participation in the project is voluntary. Please take time to consider your participation. Should you decide that you wish to participate after reading the information sheet, please sign and return the attached consent form via post or fax (Postal address: Alison Ledger, PhD Student, Irish World Academy of Music and Dance, University of Limerick, Limerick, Ireland; Fax no: +353 61 202589).

Thank you for your time,
Alison Ledger
Health Research Board Fellow
University of Limerick
Dear Music Therapist,

Thank you for agreeing to participate in this PhD research project about music therapy service implementation. The next step is for you to write a story about your music therapy service development experiences.

Drawing on your extensive and highly regarded expertise in developing music therapy services, please use your own words to write about the implementation of music therapy services in the health care setting where you currently work. Please feel free to write whatever comes into your mind when reflecting on your experiences. You may wish to describe particular events and encounters that were important to you in setting up a new service in your work place. As your own story is unique, there is no specific structure required. There is no word limit, however it would be appreciated if your response could be returned by January 28th, 2009.

If you have any further questions or wish to clarify any aspects of the project, please email Professor Jane Edwards Jane.Edwards@ul.ie or me Alison.Ledger@ul.ie or phone us on +353 61 213122. Please also make contact if at any time you decide to withdraw from the study or cannot meet the response deadline.

Yours sincerely,

Alison Ledger
Health Research Board Fellow.
Dear Music Therapist,

Thank you for participating in the first phase of my PhD research project about music therapy service implementation.

It is usual practice to follow up research contributions with an offer of debriefing. It is possible that questions or concerns arose for you when recounting your experiences as a music therapist. In that case, please feel free to contact me. If you wish to discuss any aspect of the project with someone independent, you may contact the Chairman of the University of Limerick Research Ethics Committee, c/o the Vice President Academic and Registrar’s Office, University of Limerick (Tel: +353 61 202022).

I am currently in the process of collecting other music therapists’ stories. I may contact you at a later stage to request further information for the project.

Yours sincerely,

Alison Ledger
Health Research Board Fellow.
Notification of Arts-based Analysis

Dear Music Therapist,

I’m writing to update you on the progress of my research on music therapists’ service development experiences.

Over the past few months, I have introduced an arts-based approach to my analysis of your stories. I have been writing poems in response to the stories I received. These poems have helped to highlight music therapists’ subjective experiences and persistent states of being. I may include these poems in my write-up, as part of the analysis or when presenting my research findings. No identifying information appears in these poems.

It is standard qualitative research practice to inform participants of any new developments in the research. Please email me if you have any questions or concerns regarding this arts-based approach to analysis.

Best wishes,
Alison Ledger.
Appendix B

Narrative Inquiry Information and Consent Forms

UNIVERSITY of LIMERICK
Ollscoil Luimnigh

Information Sheet

Title of Project:
Music therapists’ experiences of service implementation in health care settings

Names of Researchers:
Professor Jane Edwards, Music Therapy Course Director, University of Limerick
Alison Ledger, PhD Student, University of Limerick

What is the study about?
The aim of this study is to learn more about music therapists’ experiences in implementing services within healthcare settings.

What will I have to do?
You will be asked to write a story about your experiences of implementing music therapy services in a healthcare setting. You can choose what to write about and there is no word limit – you can write as much or as little as you like. Up to 18 months after writing the story, you may be asked to provide further information or to verify findings. The investigators may request to meet with you in person to obtain further information. In this case, meetings will be audio-recorded and should last no longer than 1 hour.

What are the benefits?
If you agree to participate, you will be contributing to knowledge about music therapist’s experiences in implementing services. You may help to reveal possibilities for further development of music therapy services in health care settings.

What are the risks?
There is a slight possibility that you may feel discomfort in recalling and recounting experiences from your work as a music therapist. You will be offered debriefing...
opportunities following story-writing and face-to-face meetings, and are encouraged to seek professional supervision or counselling if you feel distressed at any time during the study.

**What are the alternatives?**

There is no alternative way of participating in the study. It is your choice whether or not to participate.

**What if I do not want to take part?**

There are no penalties if you choose not to take part. You are free to change your mind and to withdraw from the study at any time. Please contact the investigators if you no longer want to participate in the study.

**What happens to the information?**

Any information provided verbally will be transcribed (typed into a word processor). Your story and any verbal transcriptions will be read and discussed by the investigators, and compared to contributions from other music therapists. Issues in music therapy service implementation will then be identified. Your name and place of work will be changed when the data is stored, so that only the investigators will be aware of your identity. Any data that you provide will be stored securely for 10 years, before being destroyed.

**Who else is taking part?**

Qualified music therapists working in health care settings in Ireland, Australia, the United States, and Europe have been invited to participate in this study.

**What happens at the end of the study?**

Research findings will be reported in the form of a PhD thesis. Findings may also be presented at international conferences and published in peer-reviewed journals.

**What if I have more questions or do not understand something?**

Feel free to contact the investigators at any time if you have any further questions or wish to clarify something:

Professor Jane Edwards, Music Therapy Course Director, University of Limerick
Alison Ledger, PhD Student, University of Limerick
Tel: +353 61 213122

If you have concerns about this study and wish to contact someone independent, you may contact The Chairman of the University of Limerick Research Ethics Committee

c/o Vice President Academic and Registrar’s Office
University of Limerick
Limerick
Tel: +353 61 202022
Informed Consent Form

Title of Project:
Music therapists’ experiences of service implementation in health care settings

Names of Researchers:
Professor Jane Edwards, Music Therapy Course Director, University of Limerick
Alison Ledger, PhD Student, University of Limerick

Name of Participant:

1. I agree to participate in the above research project.
2. I have read and understood the participant information sheet.
3. I am aware that:
   a) My participation is voluntary and that I can change my mind and withdraw from the project at any stage.
   b) My contributions to the research project will be kept confidential.

Signed: ................................................................. Date:..............................
Appendix C

Ethnography Information and Consent Forms

Information Sheet - Staff

Title of Project:
Music therapists’ strategies in implementing new posts within health care settings

Names of Researchers:
Dr XYZ, Consultant [name omitted to preserve anonymity]
Professor Jane Edwards, Music Therapy Course Director, University of Limerick
Alison Ledger, Health Research Board Fellow, University of Limerick

What is the study about?
The aim of this study is to learn more about possible strategies for setting up music therapy services within healthcare settings.

What will I have to do?
A researcher will be observing the work of the newly appointed qualified music therapist in setting up the music therapy service at [name of hospital]. The researcher may ask to observe your interactions with the music therapist in settings such as team meetings, staff education sessions, and informal conversations in corridors or at lunch. Some staff members will be interviewed to gain their perceptions of the music therapy service. If you are asked to be interviewed, the interview will take place at a time convenient to you and should last no longer than 1 hour. Interviews will be audio-recorded, so that your thoughts can be adequately captured.

What are the benefits?
If you agree to participate, you will be contributing to knowledge about music therapy service implementation. You may help to reveal possibilities for the development of more music therapy services in hospitals.

What are the risks?
There is a slight possibility that you may feel discomfort when being observed or when sharing your thoughts about the music therapy service. If you have any concerns, please discuss these with the researcher. If you do not wish to be observed, tell the researcher and she will leave the room.
What are the alternatives?
There is no alternative way of participating in the study. It is your choice whether or not to participate.

What if I do not want to take part?
There are no penalties if you choose not to take part. You are free to change your mind and to withdraw from the study at any time. Please contact the researchers if you no longer want to participate in the study.

What happens to the information?
The researcher will be recording her observations in a fieldwork journal and interview material will be transcribed (typed into a word processor). At this time, your name will be changed so that only the researchers will be aware of your true identity. Journal entries and interview transcripts will be read and discussed by the researchers, to identify issues in music therapy service implementation. Any information that you provide will be stored securely for 10 years, before being destroyed.

Who else is taking part?
All people who are present on [name of ward] at the time of the study will be invited to participate. This includes all staff, patients and visiting family members.

What happens at the end of the study?
Research findings will be reported in the form of a PhD thesis and a report for [name of hospital]. Findings may also be presented at international conferences and published in professional journals.

What if I have more questions or do not understand something?
Feel free to contact the researchers at any time if you have any further questions or wish to clarify something:
Professor Jane Edwards, Music Therapy Course Director, University of Limerick
Alison Ledger, PhD Student, University of Limerick
Tel: 061 213122

If you have concerns about this study, you may contact: [contact details of consultant]
Information Sheet – Music Therapist

Title of Project:
Music therapists’ strategies in implementing new posts within health care settings

Names of Researchers:
Dr XYZ, Consultant [name omitted to preserve anonymity]
Professor Jane Edwards, Music Therapy Course Director, University of Limerick
Alison Ledger, Health Research Board Fellow, University of Limerick

What is the study about?
The aim of this study is to learn more about possible strategies for implementing music therapy services within healthcare settings.

What will I have to do?
A researcher will be observing your work in implementing the new music therapy service at [name of hospital]. The researcher will attend [name of hospital] for 2 half days per week, for up to 3 months. The researcher may request to observe your interactions with staff in various situations, such as team meetings, staff education sessions, and informal conversations in corridors or at lunch. Appropriate times and settings for observation will be determined through discussions with you. You are free to choose not to be observed at any time.

Once a week, you will be requested to meet the music therapist, to reflect on your experiences over the past week, to discuss developments in the music therapy service, and to debrief about your participation in the research. These meetings should last about 30 minutes and will be audio-recorded so that your thoughts can be sufficiently captured.

What are the benefits?
If you agree to participate, you will be contributing to knowledge about music therapy service implementation. You may help to reveal possibilities for the development of further music therapy services in health care settings.

What are the risks?
There is a slight possibility that you may feel discomfort when being observed and/or discussing experiences from your work as a music therapist. Therefore, you are free to choose when and where you will be observed. If you choose not to be observed at a particular time, the researcher will leave the room. The signal for this can be arranged in advance by mutual agreement. Weekly debriefing opportunities will be provided so that you can discuss any concerns arising from the study. You are also encouraged to receive professional supervision throughout the study.
What are the alternatives?

There is no alternative way of participating in the study. It is your choice whether or not to participate.

What if I do not want to take part?

There are no penalties if you choose not to take part. You are free to change your mind and to withdraw from the study at any time. Please contact the researchers if you no longer want to participate in the study.

What happens to the information?

The researcher will be recording her observations in a fieldwork journal and weekly meetings will be transcribed (typed into a word processor). At this time, your name will be changed to a pseudonym. Journal entries and interview transcripts will be read and discussed by the researchers, to explore possible strategies for establishing music therapy services. Any information that you provide will be stored securely for 10 years, before being destroyed.

Who else is taking part?

You are the only music therapist being observed for this study. All people who are present on [name of ward] will be informed of the study (staff, patients and their family members). The researcher will observe only those people who have consented to participation in the study. Some staff members will be interviewed about their perceptions of the music therapy service.

What happens at the end of the study?

Research findings will be reported in the form of a PhD thesis and a report for [name of hospital]. Findings may also be presented at international conferences and published in peer-reviewed journals.

What if I have more questions or do not understand something?

Feel free to contact the researchers at any time if you have any further questions or wish to clarify something:

Professor Jane Edwards, Music Therapy Course Director, University of Limerick
Alison Ledger, PhD Student, University of Limerick
Tel: 061 213122

If you have concerns about this study, you may contact: [contact details of consultant]
Informed Consent Form – Staff (including music therapist)

Title of Project:
Music therapists’ strategies in implementing new posts within health care settings

Names of Researchers:
Dr XYZ, Consultant [name omitted to preserve anonymity]
Professor Jane Edwards, Music Therapy Course Director, University of Limerick
Alison Ledger, Health Research Board Fellow, University of Limerick

________________________________________________________________________
I ……………………………………………….have read the information about the above study and its requirements have been explained to me by a nurse/researcher. I have had an opportunity to ask questions and all of my questions have been answered at this time. I have been given sufficient time to consider my participation in this study.

I hereby give my informed consent for my participation in this study. I understand participation or non-participation in this study does not affect my entitlements in any way. I understand that I can withdraw my consent for my participation at any time without any penalty. I have been given a copy of this information and of this informed consent.

I understand that any identifiable information about me will be kept confidential.

________________________________________________________________________
Subject: Name/Initials/ (print)

________________________________________________  _____________________
Subject signature      Date

I have explained the requirements of the study and have obtained written consent from the subject prior to the subject’s participation in this study.

________________________________________________________________________
Investigator’s Name/Initials (print)

________________________________________________  _____________________
Investigator Signature      Date

3 copies to be made: 1 for participant, 1 for Principal Investigator and 1 for hospital records.
This is the first newsletter sent to people who may be interested in the progress of my PhD research into music therapists’ experiences of setting up new posts. My intention is to keep research participants up to date with emerging findings and to encourage further dialogue around my research topic.

The idea for a newsletter came from reading the newsletters of Dr Clare O’Callaghan, an associate professor of medicine and a postdoctoral researcher in Melbourne who is studying music’s relevance in the lives of people with cancer and their companions. I am grateful to Clare for demonstrating this as a way of engaging others in her research.

The Study
For those who are not yet acquainted with my research, I aim to learn about music therapists’ experiences in setting up new posts. Music therapists often enter a hospital or other healthcare setting as “the first” music therapist. This means that they are required to define their roles, set the parameters of their work, and develop reporting mechanisms. I’m interested in learning more about the challenges and opportunities that arise, and to identify strategies that music therapists employ to sustain and develop music therapy services. It is hoped that greater understanding in this area will help future music therapists and health care providers to establish music therapy posts.

There are two main parts to my research. The first part involves narrative research methods. I am collecting written narratives (stories) from music therapists who have extensive experience in developing music therapy services. I repeatedly read these narratives to draw out and reflect on ways in which music therapists successfully establish new posts.

The second part of my research involves ethnographic fieldwork. This means that I am spending time observing a music therapist who is developing a new music therapy post. This is allowing me to witness a music therapist developing her role and relationships within a healthcare team first hand. Throughout both parts of the research, I am recording my own memories, thoughts and feelings in a reflexive journal. This helps me to explore my own assumptions about music therapy service development and adds to the data collected from the narratives and fieldwork.

My research is now funded by the Health Research Board of Ireland (HRB). In order to gain this funding, I needed to fill out a very detailed application, hold up to review from local and international experts, and attend a panel interview in Dublin. This took a fair amount of time and energy away from the research itself, but the effort
was well worth it. I now have a salary to complete my research over the next 2 years, as well as money for equipment and travel.

I’m based within the Irish World Academy of Music and Dance at the University of Limerick (UL). Thanks are due to the Director of the Irish World Academy Professor Micheál Ó Súilleabháin and my colleagues for their ongoing support. Professor Jane Edwards is my PhD supervisor and Professor Michael Morley, Professor of Management at UL, is an advisor to my research.

I’m still recruiting music therapists to contribute narratives about their service development experiences in healthcare contexts, especially hospitals. I expect that there are many more music therapists out there with relevant experience. I would welcome your suggestions for participants. Please contact me if you would like to suggest someone who may be interested in participating in my research, or ask them to email me at Alison.Ledger@ul.ie

Recent work
Eight music therapists have consented to providing narratives and I have received five narratives so far. The narratives received are inspiring, heart-warming, entertaining, and astonishing. I am so appreciative of the music therapists for their time and openness in sharing their professional triumphs and difficult work encounters. I regard it as a privilege to read these stories. Over the past few months, I’ve been trying out different ways of analysing the narratives. The current plan is to undertake what Polkinghorne (1995) has termed a narrative-type narrative analysis. This involves building a collective or combined story from the narratives I’ve received. To do this, I’ve been highlighting certain aspects of the narratives, such as evaluative statements, climaxes and outcomes of the stories. I’m also fascinated to consider ways in which music therapists tell their stories – the words they use, the length, and the genre of the stories. I look forward to sharing more of my analysis once more narratives have been received.

It is a relief to have finally commenced fieldwork, as it was in the pipeline for a long time. I’m observing a highly experienced music therapist who began a new post in a hospital this year. Although the music therapist started in August, I’ve been tracking the development of this post since it was first talked about in March 2007. I’ve now gained ethical approval from the hospital to undertake research and have completed an initial three weeks of fieldwork there. So far, I’ve focused on orienting myself to the hospital and the music therapy routine, gained consent for research participation from hospital staff, and developed my researcher role at the hospital. Even within a short space of time, I’ve been reminded of so many aspects of music therapy service implementation. It is valuable to experience being in a hospital again and to sense the busyness of the work for myself. I am extremely grateful to the music therapist and hospital staff for allowing me this opportunity.

There is always plenty of reading and writing to be done! In the last while, I’ve discovered similar research being undertaken in other allied health professions and creative arts therapies. I am surprised to learn that our experiences as music therapists are not so unique. Other professionals such as occupational therapists and dance/movement therapists have reported feeling misunderstood in their day to day work. It has also been fascinating to read ethnographic studies of dynamics within healthcare teams. The team meeting seems a particularly rich and revealing environment in which to observe team members’ roles and interactions.
Plans for the year ahead
Now that I have the HRB funding, I can devote my full attention to my research. I plan to continue the hospital fieldwork throughout January and February, using this time to conduct some more in-depth interviews with staff involved in the development of the music therapy service. I will also continue to collect and analyse narratives and hope to do some follow-up interviews with some of the authors.

A seminar on my research topic will be held here at the University of Limerick on March 11th from 2.30-5pm (further details to follow). I’m also looking forward to sharing some of my fieldwork experiences at the Nordic Conference of Music Therapy in Denmark in May.

Before I finish up, I would like to take this opportunity to acknowledge my supervisor, Professor Jane Edwards, for all her support throughout the year. Jane’s expert guidance, encouragement, and enthusiasm for the research are unwavering.

Best wishes to all this festive season,

Alison Ledger
Health Research Board Fellow
Irish World Academy of Music and Dance
University of Limerick, Limerick, Ireland
Alison.Ledger@ul.ie

Reference

Music Therapy Stories
Alison Ledger
Health Research Board Fellow
Irish World Academy, University of Limerick

No. 2 April 2009

This is the second newsletter about my research into music therapists’ experiences of setting up new posts. This research is to fulfil requirements of a PhD degree at the Irish World Academy of Music and Dance and is supervised by Professor Jane Edwards.

I write this next instalment fresh from a seminar around my research topic, titled *Professional identities, personal stories: Developing creative arts therapies services in healthcare*. This was held as part of the *Comhaimseartha* (Of our times) seminar series here at the Irish World Academy of Music and Dance. I was thrilled that Dr Bonnie Meekums and Triona McCaffrey were available to present as part of this seminar. Thanks to Jane for chairing the seminar and Dr Simon Gilbertson for helping out on the day.

Dr Bonnie Meekums presented her research, in which nine British dance movement therapy pioneers contributed narratives about their training and experiential
influences. Bonnie identified some interesting similarities between the pioneers’ biographies, including emotion-charged early movement experiences, an element of serendipity or happenstance, and a beginner’s mind (childlike attitude). This led me to think more about what had led me to develop music therapy services and whether there are similar characteristics among music therapy pioneers. To read more about Bonnie’s research, see her paper in *The Arts in Psychotherapy* (reference below).

Triona McCaffrey shared her story of developing music therapy services within mental health services here in Ireland. Titled *Practitioner, Pioneer or both*, this presentation explored whether the skills one needs to be a music therapy practitioner and pioneer are complementary or conflicting. I was moved by Triona’s honest and at times humorous account of her interactions with other staff. She recalled a first meeting with one staff member, who said, “I thought you were going to show up in tie-dye clothes and dreadlocks but you’re really quite normal looking aren’t you?”. It seems that stereotypes of music therapists exist everywhere, even in Ireland where we are few in number!

My section of the seminar focussed on my ethnographic fieldwork, in which I observed an experienced music therapist starting up a new post in a hospital. I observed the music therapist in settings such as team meetings, meetings with other therapists, the coffee shop, and in “corridor stops” (chance encounters with other staff). This allowed me to witness some of the strategies the music therapist is using to establish the new post, such as collaborative working. I was also fortunate to interview members of staff regarding their perceptions of the new music therapy service. This gave me a valuable insight into the day to day experiences of other staff members. I have since been able to consider which experiences are music therapy-specific and which experiences are common to a number of professionals working in healthcare contexts. I am extremely grateful to the music therapist and other staff for so generously giving their time to my research.

My seminar presentation explored emerging possibilities and practicalities in ethnographic research in music therapy. I outlined some of the ethical and role issues I encountered in my fieldwork, as well as the value I discovered in carrying out this type of research. I will present a re-working of this paper at the upcoming Nordic Music Therapy Conference in Denmark in May.

I’ve now received 8 narratives from music therapists who have developed new music therapy services. I continue to read and re-read these stories, noting similarities and divergences between the music therapists’ experiences. At present I am curious as to whether a music therapist’s experience is influenced by “who you know”. Several music therapists have mentioned an ally - an understanding line manager, an esteemed Doctor, or a clinical psychologist - who has helped them to develop music therapy services along the way.

I’m still recruiting music therapists to contribute narratives about their service development experiences in healthcare contexts, especially hospitals. I would welcome your suggestions for participants.

Please contact me if you would like to suggest someone who may be interested in participating in my research, or ask them to email me at Alison.Ledger@ul.ie

I’m now heading home to Australia for a few weeks. While there, I hope to carry out follow-up interviews with a couple of music therapists who contributed narratives early on in the research. These interviews will give participants the opportunity to
alter or augment their stories based on more recent experiences. The interviews will also help me to clarify my developing ideas around ways to establish music therapy services.

I’m also excited to be involved in the organisation of the International Association for Music and Medicine Conference hosted by the Irish World Academy in Limerick on June 6th, 2009. Many internationally renowned music therapists will be with us for this event and I hope that I will have a chance to promote further interest in my research. For information on this event, see http://web.mac.com/nordoff_robbins/iWeb/IAMM/ireland.html

Thank you to those who sent feedback on my first newsletter. I was delighted to learn that you took the time to engage with my research.

Best wishes to all,

Alison Ledger
Health Research Board Fellow
Irish World Academy of Music and Dance
University of Limerick, Limerick, Ireland
Alison.Ledger@ul.ie

Reference

Music Therapy Stories

No. 3 July 2009

Greetings from the Big Apple! These past few weeks I’ve been talking to music therapists in New York about the development of their services. I’ve also had the chance to witness some service development strategies first hand, including a grand round presentation on music therapy at a hospital where a music therapist is soon to be employed. When the grand round was over, the presenter was invited to talk informally with a team the new music therapist will be working closely with. This struck me as a rare opportunity to prepare a team for the arrival of a music therapist, to explore possible ways of working together, and to problem solve issues that may arise when the music therapist begins. I was impressed by the way the presenter encouraged staff to ask questions and to raise their concerns about music therapy. I don’t think I’ve ever been so brave when introducing music therapy services!

One word has come up frequently in my research these past few months: niche. As I re-read my fieldwork notes and the stories I’ve collected, I’m discovering that introducing music therapy involves more than “fitting in” to an existing team. A music therapist is required to find a space, develop an identity, and identify a clinical area where he/she can make a unique contribution. Often a music therapist explores new
ways of working and his/her previous definitions of music therapy are tested. The word *niche* seems to capture these aspects of music therapy service development and I like that the word has a marketing feel about it. (Several music therapists in my research have referred to “selling” music therapy to the “powers that be”.)

Since I last wrote, I’ve devoted a good bit of time to writing and presenting. I presented a paper on my fieldwork experiences at the Nordic Music Therapy Conference in Denmark in May. It was great to receive some encouragement for my research and to learn that my early observations resonated with music therapists there. I’m now developing this paper into an article for publication in a peer-reviewed journal. I’m also turning my attention to presenting at the Australian Music Therapy Association Conference in Sydney in September. The pressure’s on to have some preliminary findings together by then! The trip to Sydney should be the last of the travel for a while. It’s beginning to feel like time to knuckle down and write my thesis.

It’s also been an exciting few months for my team within the Irish World Academy. In June, Professor Edwards, Dr Simon Gilbertson, and I were the main organisers for the inaugural meeting of the International Association for Music & Medicine (IAMM), chaired by Jane. We are still buzzing from our interactions with more than 20 IAMM founding members from 12 countries, all international experts in the field of music and medicine. During this event, we also welcomed 130 people to a day long conference comprising presentations from IAMM founding members. This conference received terrific media coverage in Ireland and the US. A further development is that Jane, Simon, and I have received official recognition as the “Music & Health Research Group” at the University of Limerick. We are choosing our logo and working on some joint publications to put the name of our research group on the map. Watch this space!

Thank you to all who’ve contributed to my research in recent months. Your input is greatly valued.

Best wishes,

Alison Ledger
Health Research Board Fellow
Music & Health Research Group
Irish World Academy of Music and Dance
University of Limerick, Limerick, Ireland
Alison.Ledger@ul.ie

Music Therapy Stories
Alison Ledger
Health Research Board Fellow
Music & Health Research Group
Irish World Academy, University of Limerick

No. 4 March 2010

Greetings from my desk at the University of Limerick, where I seem to be spending most of my time these days. Recently I have been working steadily on various
pieces of writing. I have written an article that I hope will be published in a peer-reviewed journal and am making good progress on the write-up of my PhD thesis.

I have also been doing some creative writing in response to the stories I received about music therapy service development. This is consistent with a qualitative research approach in which writing is considered to be an important part of the analysis and not just a product of the research\(^9\). I have written a set of ten poems using words and phrases from the music therapists’ stories. These poems have helped to highlight music therapists’ subjective experiences and persistent feeling states in developing music therapy services.

I have decided to share two poems here, to give readers a taste for some of my emerging findings. In doing so, I think it is important to emphasize that these poems were created in response to a single story written by one music therapist. The poems are not intended to represent the experiences of every music therapist working internationally. It is possible that some music therapists will have had different experiences to those depicted in the poems. However, it is also possible that music therapists will recognise some of the feelings that are expressed. The two poems are called *Taking stock* and *Asking questions*.

*Taking stock*

Successful programmes, check.
Service expansion, check.
Publications, check.
More funding, no cheque.

*Asking questions*

Is it me, or is that a look of contempt?
Do I pay too close attention?
Do I try too hard to win respect
For my brand new intervention?

Should we focus on the work itself?
Keep our heads down to the ground?
But then there’ll be no-one to represent,
We won’t even make a sound.

Motivation comes from patient time,
It’s my heart that keeps me here,
But it can not beat forever,
I have to think of my career.

As I stick up my two fingers
To the sceptics in this place
I wonder, is it worth it?
Do my efforts go to waste?

The first poem suggests that securing adequate funding can be a major challenge for music therapists who are developing services. A music therapist can demonstrate the value of his or her work, but this doesn’t always result in further funding. It can be disappointing for a music therapist to miss out on funding, especially when considerable time and energy has been spent on proving music therapy’s worth. The second poem highlights the ongoing uncertainty expressed by music therapists in my study. Several music therapists appeared to question whether they were doing “the right thing”, whether they were trying too hard, whether they should be speaking up for their profession, and whether they should stay in their places of work.

I would be interested to hear whether these poems resonate with music therapists who are reading this newsletter. Please feel free to email me if you would like to share your reactions to the poems or to discuss anything further. Any email correspondence will be appreciated and treated confidentially.

Since I last wrote, I have been delighted to hear updates from some of the music therapists who participated in the early phases of my research. Hearing about recent developments has been encouraging and has helped me to further progress my analytic ideas. Thank you to those who have contributed to my research in recent months.

Best wishes,
Alison Ledger (Alison.Ledger@ul.ie)
Health Research Board Fellow
Music & Health Research Group
Irish World Academy of Music and Dance
University of Limerick, Limerick, Ireland
Appendix E

Examples of Life Course Graphs

Figure A1. Life course graphs of a music therapy service development over time.
Appendix F

*The Poems*

*MT is my baby*

MT is my baby
I do it all day long
See client after client
Sing song after song

MT is my baby
I sell it all day long
From patient to director
“The word” of MT is strong

MT is my baby
As one, we can’t go wrong
But yet there’s something missing
To feel like we belong

*Where do I stand?*

I’m like a girl who feels neglected
Giving much without return
Longing only to be noticed
For security I yearn

Tell me that you rate me
Tell me why you keep me here
Tell me what it is you value
How can I keep in the clear?
You broke another promise
Built me up then cut me down
I gave you my submission
But no funding this time ‘round

Should I stay or should I go?
Can’t go on fighting any more
I think I could do better and
I’m tired of this war.

Hospital Life

It’s hospital, not hospitable,
No room at the inn, no welcome for me,
No guidance, no phone line, no place for my purse,
Just pressure, and politics, and personalities.

Am I a founder or am I a fraud?
Forging my way through this baffling place,
Struggling daily to make some headway,
Working hard to impress, doing all to save face.

I’m like a lone salesman, my profession’s on sale,
I think I’d rather sell doughnuts.

Accommodation wanted
Twenty-six year old music therapy professional seeks long-term lease.
Self-sufficient, though willing to listen and learn. Looking to share with similar enthusiastic and open-minded people. Piano desirable, but not essential.
The Team Meeting

Waiting in the boardroom,
Doctors dribble in one by one,
I begin to feel outnumbered
And the temperature is rising.

The meeting starts, we’re off and racing,
So many thoughts, so little time,
I sit and watch the action unfold,
They give their perspectives, I want to share mine.

They begin to dribble out again now.
I still have things to say.
Perhaps it’ll take a little more time for
Me to build some history here.

Reaching for the Summit

Cold.
Frosty reception.
Miles to go.
No path to take.
They say it can’t be done.

I start on my journey.
Into the unknown.
I’m a little bit scared but
Excited at the thought of what lies ahead.

I stumble and fall,
Cracks begin to show,
But I will not be defeated
And I pick myself up again.
Little by little I
Find my way up that climb
One by one others join me
Their support makes me strong.

I arrive at the top,
Admire the view from up here.
There’s no stopping me now,
Nothing I can not do!

*Taking stock*
Successful programmes, check.
Service expansion, check.
Publications, check.
More funding, no cheque.

*Important questions*

Is it me, or is that a look of contempt?
Do I pay too close attention?
Do I try too hard to win respect
For my brand new intervention?

Should we focus on the work itself?
Keep our heads down to the ground?
But then there’ll be no-one to represent,
We won’t even make a sound.

Motivation comes from patient time,
It’s my heart that keeps me here,
But it can not beat forever,
I have to think of my career.
As I stick up my two fingers
To the sceptics in this place
I wonder, is it worth it?
Do my efforts go to waste?

Lessons for relating

Show not tell
Listen and learn
Share your successes and
Give help in return.

Push for one thing only:
To be part of the team.
Think of others as your peers
And include them in the dream.

It’s just like music therapy,
Only on a broader scale
It’s all about relating
If you respond you can not fail.

Time and Place

The story started long before
The day you came along.
A history of relationships
And services now gone.

To survive depends on who you know.
A contact can be key
To being taken seriously,
To who you get to see.
Development takes patience,
It won’t happen overnight.
You might never feel “established”
So just work towards “alright”.

Meeting the manager

You need to earn respect
And say “yes” instead of “no”
If you ask for one thing only
Your MT programme will grow

You must be indispensable
To avoid the chopping block
If you understand the funding
You’re not first to take a knock

Progress

One leap forward, and two steps back,
Maybe more momentum down the track,
The rate of growth is not determined by me
It’s decided by others and emotional needs.
When there are lives at stake, there’s tension all around,
Resistance, defences, anxieties abound.
Many changes in staff aren’t helpful to my cause
And neither are the rivalries and unresolved wars.
I’m now being watched by the manager’s eye.
Perhaps I need to hold on til this moment’s gone by,
Before I make another step to further my position,
Before the staff are comfortable to make the right decision
To allow me the space, to fulfil my potential,
To build on opportunities as much as I am able.
Until that time, I’ll play it safe, I’ll hold the status quo,
I’ll wait until the climate’s right for MT’s place to grow.
Appendix G

Diagrammatic Representations of Poems

Where do I belong?
MT is my baby
Accommodation wanted

Where am I?
Hospital Life
Lessons for relating
The team meeting
Time and place

Should I stay?
Taking stock
Where do I stand?
Important questions

Persistence
Reaching for the summit

Figure A2. Diagram highlighting questioning aspect of service development.

Persistence Departure
Reaching for the summit Accommodation wanted Important questions
Time and place Team meeting Where do I stand?
Lessons for relating Taking stock Hospital Life
MT is my baby

Figure A3. Placement of poems on a continuum between persistence and departure.
Figure A4. Identification of connections and common themes between the poems.

<table>
<thead>
<tr>
<th>Poems</th>
<th>Themes</th>
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<tbody>
<tr>
<td>Hospital Life</td>
<td>Going solo</td>
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<tr>
<td>Accommodation</td>
<td>Looking for a home</td>
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<tr>
<td>wanted</td>
<td>Building relationships</td>
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<tr>
<td>The Team Meeting</td>
<td>Accepting the challenge</td>
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<td>Meeting the</td>
<td>Insecurity</td>
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<td>Manager</td>
<td>Investment</td>
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<td>Lessons for</td>
<td>Development takes time</td>
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<td>relating</td>
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<td>The team</td>
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<td>meeting</td>
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<td>Time and place</td>
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<tr>
<td>Where do I stand?</td>
<td>Taking Stock</td>
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<td>Important</td>
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<td>questions</td>
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<td>Taking Stock</td>
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<td>MT is my Baby</td>
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<td>Progress</td>
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<td>Time and Place</td>
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</table>

Figure A5. Diagram of the emergence of themes from the poems.
Appendix H

Letter to a New Graduate Music Therapist

Dear Lorraine,

Thank you for your interest in my research on the topic of music therapy service development. I have thought about your email and will respond to your questions here.

In your email, you asked how my research findings might provide some advice on strategies for introducing music therapy services successfully. My research was interesting in this regard, as I did initially believe that I would uncover a series of strategies that I could share with music therapists and students. However, my findings indicate that there are no straightforward recipes for introducing music therapy. The music therapists in my study used a wide range of strategies to develop their services, and music therapists sometimes viewed the same strategy in different ways. The best I can offer here are some general pointers for developing a music therapy service.

The first thing I would suggest is that you gain an understanding of the particular healthcare environment in which you are working. Healthcare traditions can be strong and a new service may be influenced by a range of historical, financial, and interpersonal factors. I would therefore encourage you to pay attention to the culture of your workplace. Some of the music therapists in my study reported that they had successfully introduced services by attending to the needs of fellow staff as well as patients. It may be beneficial for you to identify people in positions of power in relation to decisions about new posts and to gain the support of a more established professional. A well-established professional may be able to teach you about existing systems and assist you to introduce music therapy to others.

The music therapists in my study indicated that they had become valued team members after they had built collaborative relationships with other staff. Rather than working on their own, the music therapists worked closely with other members of the team. They listened to others’ perspectives, sought advice and feedback, exchanged
observations, shared therapy outcomes, and responded to requests for help. These actions may have led to the music therapists’ acceptance as equal members of their healthcare teams. I would therefore encourage you to explore ways in which you could form mutually beneficial relationships with other members of staff.

I observed that service development can take time. Healthcare professionals are known to be resistant to change and the introduction of a new role can lead to interprofessional tensions. You may need to wait for the right time to introduce new services and to seize opportunities as they arise. You may need to be patient and persistent. Also, a degree of compromise may be required at first. Many of the music therapists in my study perceived that they had compromised in areas such as the therapy space or the amount of music therapy hours. Compromise in these areas was seen as a ‘trade off’ for gaining an opportunity to demonstrate the value of music therapy. At this point, you may wish to consider what areas you would be willing to overlook for the benefit of introducing a new music therapy service.

My research indicated that music therapy service development work can lead to a range of emotions, including excitement, uncertainty, isolation, frustration, and disappointment. I certainly have been aware of this myself in my own development work. Although many of the music therapists reported that they enjoyed their clinical work, they often described service development as a challenge. I would therefore recommend that you make provisions for professional supervision before starting your new service. Please feel free to contact me again if you would like any assistance with finding a suitable supervisor.

I wish you all the best with your new service and please keep me posted with how the service unfolds!

Best wishes,
Alison Ledger.