A grounded theory of music therapists’ approach to goal processes within their clinical practice.

Author names and affiliations:

Author 1:
Grace Anne Thompson, PhD
The University of Melbourne, Melbourne Conservatorium of Music, Australia

Corresponding Author.
Grace Thompson, PhD
The University of Melbourne, Melbourne Conservatorium of Music, Australia
234 St Kilda Road, Southbank VIC 3006, Australia
Telephone: +61 3 9035 8978
Fax: not applicable
Email: graceat@unimelb.edu.au

Highlights
- Goal process are usually only broadly described in professional standards of practice
- Identifying a therapeutic focus is described as a core part of music therapy practice
- Interactions between the therapist, client and context influence the focus of therapy
- Quality of therapeutic alliance and degree of collaboration effect the therapist’s approach
- Ethical reflexivity is a key part of the therapist’s responsibility in the goal process

Abstract

This study explores the conditions and circumstances that influence the way experienced music therapists identify the therapeutic focus of their practice. Participants included 45 music therapists practicing in 8 different countries who were aged between 33-67 years old and with at least 5 years of professional experience. Participants described their approach to goals/aims within their practice, and the factors they believe influence their process. Grounded theory analysis generated a theoretical explanation of how music therapists engage with both the client and their employment context, and the way the attributes of these actors are likely to affect the process of identifying a therapeutic focus for the work.
Implications for music therapy training and professional development are offered, with an emphasis on the subsequent ethical considerations and responsibilities of the therapist.

*Keywords: goals, therapeutic focus, music therapy, practice ethics, practice standards, grounded theory*
A grounded theory of music therapists’ approach to goal processes within their clinical practice.

The profession of music therapy, similar to other creative arts therapies, is influenced by multiple theoretical frameworks and is broad in its application of methods and techniques depending upon the context in which therapy services are provided. These theoretical frameworks, methods and techniques provide the foundation for the therapist to draw on as they strive to “optimize the client’s health” (Bruscia, 2014, p. 36). Degree courses in music therapy are offered in numerous countries around the world (World Federation of Music Therapy, n.d.) and graduates are typically eligible to be accredited and/or registered with their local professional association, if such an organisation exists in their region. In many countries, these organisations define professional standards for qualified music therapists, such as expected competencies, codes of practice and codes of ethics. Codes of practice vary in each country since they are designed to reflect the health and social systems relevant to the population. These documents may specify key aspects of the therapeutic process, including assessment, goals and objectives, documentation and evaluation. Codes of practice must therefore be broadly expressed to enable therapists working with diverse populations in various settings to apply these general principles to their practice. Accordingly, the principles informing processes for goals and objectives are also broadly expressed. However, given the diversity of therapeutic approaches and theoretical frameworks informing music therapists’ practice, these documents can only provide limited guidance for therapists.

Goal processes relevant to different practice models in music therapy have been previously described by innovator Ken Bruscia who outlines two contrasting approaches, namely ‘outcome-oriented strategies’ and ‘experience-oriented strategies’ (Bruscia, 2014). Within ‘outcome-oriented strategies’, the therapist is thought to take a more directive stance in order to “induce targeted change in the client” (p. 176), and specific goals are formulated to
address a problem that has been pre-identified in a formal assessment process. By contrast, ‘experience-oriented strategies’ are thought to begin with only a preliminary understanding of the client’s needs or reasons for coming to therapy. The therapeutic goals become clearer as the process unfolds, with the therapist taking a more collaborative stance in relation to the client. Bruscia further clarifies that “one of the differences between outcome-oriented and experience-oriented strategies is that the former most often begin with pre-established goals, whereas the latter most often begin with a pre-established model or method.” (p. 180).

In comparison, music therapist Ken Aigen (2014) describes two divergent theoretical positions that are likely to influence a therapist’s identity and practice. While Aigen acknowledges that presenting a dichotomy cannot adequately capture the diversity within the profession, he none-the-less observes the presence of two dominant identities in professional training: the music therapist as medical professional; and the music therapist as psychotherapist. In Aigen’s view, the music therapist who aligns with a medical framework emphasises the use of treatment protocols and observable and measurable outcomes that are clearly articulated in goals and objectives. The music therapist who aligns with psychotherapeutic approaches places more emphasis on client empowerment and agency, and as such goals may be less formally defined.

Regardless of theoretical influences, music therapists, like all therapists, need to articulate why they are doing what they are doing, and provide rationale for their approach. Beyond the creative arts therapies, the process a therapist undertakes to identify goals is often viewed as central to clinical practice (Cooper & Law, 2018). It is likely that the therapist’s goal processes reveal various aspects of their professional identity, such as their theoretical influences, personal values and beliefs, and the philosophy of the work-place setting. Goals are traditionally viewed as representing “internal cognitions about purposive, consciously committed action” (Poulsen, Ziviani, & Cuskelly, 2015, p. 29) which guide actions and
behaviour, and can be expressed as an end, aim or desired future possibility (Cooper & Law, 2018).

Descriptions of music therapy treatment planning in the literature tend to emphasise the technical aspects of goal writing, with some authors advocating for goals and objectives to focus on observable, measurable client behaviour (Hanser, 1999; Polen, Shultis, & Wheeler, 2017). The ensuing guidelines therefore often privilege a medical or behavioural stance where objective, non-musical skills are targeted through pre-determined goals based on a thorough assessment (Davis, Gfeller, & Thaut, 2008; Polen, Shultis, & Wheeler, 2017). However, taking a medical stance in the expression of goals does not authentically represent the diversity of music therapy practice. Despite there being an abundance of literature describing non-medical approaches and orientations to music therapy practice (e.g. Kenny, 1989; Rolvsjord, 2010; Stige, 2002; Stige & Aarø, 2011), specific descriptions of goal processes outside of medical or rehabilitation contexts are rare.

Meeting the expectations of employers and funders is often perceived as vital to sustained professional growth (Aigen, 2014). However, client goals should also genuinely convey the distinct focus of creative arts therapists in addressing clients’ health and wellbeing needs. In situations where employer expectations of creative arts therapies do not align with the therapist’s approach to practice, tensions are likely to develop. For example, the “National Disability and Insurance Scheme” (NDIS) is a funding model for disability services introduced by the Australian Government in 2016. Offering clients choice and control over their goals and the services they receive is a central philosophy of this scheme. The Government regulators understandably want to ensure the cost-effective use of funds directed towards reputable service providers. Clients must therefore submit a plan that outlines the “goals/activities/tasks” they want to achieve in the upcoming year (NDIS, 2019). However, music therapists aligned with psychotherapeutic approaches who typically have less formally defined goals (Aigen,
2014), and those adopting experience-oriented strategies who often determine goals after a period of collaborative exploration (Bruscia, 2014), may feel it is disingenuous to articulate pre-determined client goals. Understanding how other therapists approach goal processes from a variety of theoretical frameworks may assist therapists in this situation to better communicate the relevance and benefits of their work to both clients and funding bodies.

The way therapists define their practice is therefore likely to impact the way they approach goal processes (Aigen, 2014; Bruscia, 2014). Descriptions of goal processes may therefore also reveal important features about what the therapist considers to be the priority in their work with a particular population. There are many ways to define music therapy practice, but to continue the discussion around goal processes I will highlight contrasts between the two stances recognised by Aigen (2014): the music therapist as medical professional; and the music therapist as psychotherapist.

Music therapists aligned with the medical model may describe their work as a ‘treatment’ where music experiences are designed according to a protocol that assumes a similar effect will result when the music ‘stimulus’ is provided to clients with similar presenting issues (Berger, 2009; Hardy & LaGasse, 2018). Goals and objectives are pre-determined and typically emphasise minimising specific problems and deficits related to the clients’ diagnosis and outcomes are objectively measurable and observable behaviours (Berger, 2009; Davis et al., 2008; Hanser, 1999; Sena Moore & LaGasse, 2018). There is a strong expert stance that underpins this approach. While each therapist will have their own interpersonal style that may include more participatory and collaborative principles, the medical model typically places the therapist in the position of decision-making authority. Therefore, goals and objectives are likely to be written by the therapist or therapy team.

Music therapists aligned with psychodynamic and humanistic theories that promote client agency and collaboration in service provision may emphasise the importance of the
client’s culture and sense of their ideal healthy self as providing the focus or direction in the therapy (Loewy, 2000; Rolvsjord, 2010). Approaches to assessment are typically more holistic and consider relational and emotional themes that extend beyond the symptoms or impairments related to a diagnosis (Rolvsjord, 2010). The term ‘assessment’ may even be avoided given its association with an expert medical model, with this phase alternatively described as a hang-out period (Bolger, McFerran, & Stige, 2018), getting a feel for the system (Rickson & McFerran, 2014) or the therapist actively engaging in reflective and ethics-driven collaborations (Stige & Aarø, 2011). The therapist strives to promote mutual understanding and a buy-in to the process for all participants (Bolger et al., 2018). Rather than writing formal goals, some authors instead describe the overall intent of the therapy service through “purpose statements” (Polen et al., 2017, p. 64). For example, music therapists engaged in a social justice framework have described the overall purpose of their work as “to increase social and cultural awareness and bring a sense of societal participation to all concerned” (Vaillancourt, 2012).

The music therapy literature describing goal processes varies in terms of the level of detail provided; from broad principles articulated in professional codes of practice, to general considerations based on the therapist’s theoretical alignment, to more technical descriptions of how to formulate objectives to measure outcomes. What appears to be missing from the available literature is an understanding of how other factors or circumstances might interact together and influence music therapists’ approach to goal processes within their practice. Senior practitioners, supervisors and educators are likely to have refined their understanding of goal processes based on their years of experience and awareness of needing to clearly articulate why they do what they do in their workplace. This research aimed to bring together the perspectives of experts in the field to theoretically conceptualise goal processes beyond a single theoretical stance or area of speciality. A resultant grounded theory may help trainee,
newly graduated and experienced music therapists to consider both the nuances and broader principles at play in their approach to goal processes.

**Method**

**Research design overview**

In-depth interviews with experienced music therapy practitioners, supervisors and educators were the preferred form of data for this study in order to deeply examine the conditions and circumstances that they considered to affect the process around goal formulation in music therapy. Since conditions and circumstances are influenced by context, views from individuals located in different international epicentres for music therapy were purposively sought in order to delve into the nuance of individual approaches. With the research questions seeking to canvas understandings of the types of goal process used in music therapy practice, and how certain approaches or circumstances across multiple areas of practice might interact, grounded theory analysis was chosen. Development of theory was therefore the focus of the analysis (Dey, 2007) which followed a process based on the early work of Strauss and Corbin (1998) beginning with open coding, creation of categories and axial coding. In essence, the analysis attempts to “theorize a social process… and focus on understanding the intentions and strategies of actors involved in that process…[using] a systematic analysis of data through categorization and comparison.” (Dey, 2007, p. 171). In this way, the analysis also took an inductive and constructivist stance (Charmaz, 2011).

**Researcher positioning**

As the researcher undertaking this analysis, my thinking was influenced by my position as a senior lecturer in music therapy at a research university in Melbourne, Australia. The music therapy training program at the University of Melbourne includes course material seeking to
represent the breadth of music therapy practice, and therefore does not privilege a particular theoretical stance. With a practice background in disability and early childhood intervention alongside my research and teaching roles, I struggled to find explanations of goal process beyond those advocating for goals to be expressed in objective, observable and measurable formats. I therefore approached this grounded theory analysis anticipating that the theoretical stance of the music therapist would likely be a factor that interacts with other contextual considerations. Beyond this presumption based on lived experience, there were no further theoretical concepts overlayed onto my approach to the analysis.

**Participants**

A combination of purposive (Creswell & Plano Clark, 2011) and theoretical sampling (Strauss & Corbin, 1998) was utilized to select interview participants who had at least 5 years of experience in either supervising or teaching music therapy students (or both). Cultural influences are key factors in the way music therapy is practiced, and so individuals representing a variety of perspectives and approaches to music therapy practice were approached as the starting point. Over the course of the analysis, additional participants were invited into the project to further explicate the emerging categories. Ethics approval was received from the University of Melbourne (#1851455.1), and data collection took place between August and December of 2018.

In total, 45 music therapists (female n = 31, 69%) were interviewed, ranging in age from 33-67 years old, and having between 5-42 years of professional experience. Of these, 25 were teachers in tertiary level training courses, 5 were clinical supervisors, and 15 were concurrently in educator and supervisor roles. Participants were living and working in 8 different countries (see Table 1) and stated that their clinical work was informed by an average of 3.48 theoretical frameworks (see Figure 1). In terms of clinical experience, 31 participants worked predominantly with children and youth (54%), while 26 worked predominantly with
adults (46%). Based on participants’ descriptions of their practice, 19 broad clinical categories could be determined (see Figure 2).

*Insert Table 1 approximately here*

*Insert Figure 1 approximately here*

*Insert Figure 2 approximately here*

The initial interview guide contained 4 broad questions: 1) What do you consider are the theoretical influences in your work?; 2) Describe your approach to goals/aims within your own music therapy practice?; 3) What do you consider to be the main factors that influence your approach to goals/aims?; and 4) What do you consider to be important when supporting students to understand goals/aim in music therapy? The interview guide was adapted according to the particular perspectives of different participants and to probe further into the theoretical categories as they emerged.

**Data analysis**

*Codes and categories.* Grounded theory strategies for analysis aim to keep the researcher constantly interacting with the data through an iterative process of collection, reflection (memoing) and comparative analysis (Charmaz, 2011). For this study, the analysis process began by taking a broad perspective to open coding where the interview data was broken down into discrete fragments and labelled using vocabulary that remained close to the expression of the participant. Codes that were considered conceptually similar were grouped together into broader categories, while at the same time memo writing attempted to clarify the emerging concepts and their possible significance and/or relationships to other categories (Strauss & Corbin, 1998). This iterative approach to analysis continued to unfold after each interview was conducted, and immediate in vivo coding was lightly undertaken. Rather than coding all of the data after interviews have been completed, inductive categories were generated at various stages throughout the data collection period which allow emerging
concepts to be proposed to participants in subsequent interviews. I used NVivo11 software to support the analysis throughout the process.

In the early stage of analysis, an initial set of categories indicated that there could be a relationship between the therapist’s overarching goal, their values and beliefs, and the demands of the context in which they worked. For example, a therapist working in palliative care described a high level of freedom in their work and explained, “well there is no goal, I mean there is a goal of being there with that person in that moment. That's it.” (participant 6). Another therapist working with families who have a child with a disability described how they explain the broad aim of music therapy to the family as “to get to know the child, to help the child feel reassured” (participant 30).

These early categories were addressed in the subsequent interviews in order to further explicate the emerging theoretical notion that the level of compatibility between the therapist’s values or philosophy and the demands of the context would influence the way they approached and described therapeutic goals in their practice. Further tensions between the therapist’s personal values, the perceived needs of the client, and the scope of practice were described. For example, one therapist reflected specifically on their work in special education, explaining,

“I would get an IEP\(^1\) goal that said, ‘by the end of the year, this child will be able to give a two-step command or follow a two-step command.’ So I would say ‘okay, well, I'll turn that into a stop-start activity [in music therapy]’ But I always, I knew early on that that was just game playing. I was just… it didn’t necessarily ever translate into any of my sessions.” (participant 41).

\(^1\) IEP is a term used in special education meaning “individual education plan”, which documents each student’s goals and the supports needed to achieve them.
For this participant, the tension between their own values and the expectations of their employer were not articulated to the team and seemed to be left unresolved. Theoretical saturation appeared to have been reached following the final two interviews, with the qualities of existing categories seeming to be “sufficiently well developed” (Corbin & Strauss, 2015, p. 140) and no further concepts were introduced.

My early attempts to map the emerging codes suggested there were further, more nuanced, associations between different categories that influenced the therapists’ approach to goal processes. Many participants described a strong sense of their professional responsibility to “identify a therapeutic focus” and indeed, some went so far to say that this responsibility was the core feature of therapy professions: “I don't believe that somebody can go into a therapy session and not have some idea of what they want to do” (participant 30), and further “you have to have some ...you have to have like a direction. This is the target. This is what we're working on. This is why we are meeting.” (participant 16). Additionally, topics such as ethics, advocacy and the therapist-client relationship appeared to be important factors captured in categories initially labelled as “therapists navigate ethics and power dynamics”, “goals are one way for music therapists to advocate for service” and “goal processes play a role in building the therapeutic alliance”.

**Axial coding.** The final phase of analysis involved a process of axial coding where the data is re-assembled through exploring the potential conditions, actions, interactions and consequences suggested through constructing an analytic paradigm (Strauss & Corbin, 1998). A conditional matrix (Strauss & Corbin, 1998) was created in order to look across all of the factors that seemed to impact the facilitation of therapy and the identification of the therapeutic focus. Aligned with Charmaz’s description of “abductive reasoning” (2011, p. 167), this conditional matrix was then applied to the individual participant’s interviews in an attempt to cross-check emerging theory with their real-world descriptions of practice (see Table 2).
The concluding stage of integration sought to identify the central category around which the various codes and categories culminated. During this phase of the analysis I also consulted with a senior research colleague who has extensive experience in grounded theory analysis. Various analytic strategies were used to support the process of taking a step back from being deeply immersed in the details and ask, “in a general sense, what seems to be going on here?” (Corbin & Strauss, 2015, p. 191). Further, a series of preliminary diagrams mapping out the categories and codes were made along with several narrative summaries, or storylines, that attempted to capture how and why (or why not) music therapists work towards therapeutic goals. These diagrams and narratives supported my further reflections on the data, which pointed to the central phenomenon/category being ‘identifying a therapeutic focus is a core professional process’. The resultant grounded theory narrative presented below intends to describe and explain the causal links between the conditions, interactions, and consequences in this social process involving therapists, clients and the broader systems around them.

**Results**

The iterative process of analysis, including several attempts at a conditional matrix, led to the identification of the central category from which various conditions, interactions and consequences theoretically follow. The resultant grounded theory points to a “client-in-context” model for identifying a therapeutic focus in music therapy. Figure 3 provides a visual representation of how the attributes of the music therapist; the client; and context theoretically interact together along with the subcategories from the analysis. Since grounded theory seeks to bring forward an integrated proposition rather than highlight individual stories, each of these factors are described within a detailed narrative below (Dey, 2007), within which the analysis subcategories are highlighted in italics. Later, two fictional composite stories will be presented.
in the discussion that highlight key aspects from various interviews to illustrate the how the “client-in-context” theory might play out in music therapy practice.

*Insert Figure 3 approximately here*

**Central category: identifying a therapeutic focus is a core professional process**

The music therapy educators and senior clinicians interviewed expressed in various ways that the process of *identifying a therapeutic focus* was a core part of their professional role. Different terms were used to describe the product of this process, such as goals, aims, direction or focus. They acknowledged the importance of developing skills in the technical aspects of goal writing, such as: alignment with the client’s needs; checking for relevance and feasibility; and complementing the scope of the broader team. However, these practical concerns were overshadowed by their emphasis on understanding the conditions influencing how the therapist goes about identifying a therapeutic focus, and the possible resulting consequences.

The music therapists identified three distinct aspects that influence the process for identifying a therapeutic focus, namely 1) the music therapist’s attributes, 2) the client’s attributes, and 3) the features of the context. The therapist’s professional responsibility was therefore viewed as working to *meet the needs of the client-in-context*. The qualities that these three facets bring to the process, and how they interact with each other, impacts both the way the therapeutic focus is identified and the essence of the focus.

**Music therapists’ attributes**

---

2 The term “client” is chosen to be economical and universally relevant. This term is intended to refer to the person/s who, in different settings, could be called the consumer, service user, patient or resident. Broadly speaking, they are the person who is the beneficiary of the music therapy service.

3 The term “context” refers to the institution, employer, referrer, funder, family member or individual who either pays the therapist or has governance/responsibility for the health of the client. A therapist running their own private practice would also be considered relevant to this notion of context.
The interviewees described various therapist attributes that play an important role in the process of identifying a therapeutic focus. These include the therapist’s personal values and beliefs, which in turn are strongly related to the theoretical frameworks with which they choose to align. For example, the therapist’s values and beliefs about their role in supporting client agency may lead to a broad therapeutic focus, such as connecting the client to their strengths and identity. The therapist’s clinical knowledge, developed through their training and years of experience with a particular population, helps them to understand the types of focus areas that are likely to be relevant and meaningful. At the same time, the therapist’s ethics of practice should lead them to reflexively consider the power they hold in the goal process, particularly with clients who have complex health needs. Since clients’ needs may change moment to moment or over a longer period of time, the therapist’s comfort with flexibility will often be a factor in the process of identifying a focus for the work. The music therapist may also consider the degree to which they wish to advocate for greater understanding of their scope of practice through clearly articulating a certain type of therapeutic focus to the client and the service context.

Clients’ attributes

The interviewees all expressed that the client’s attributes contribute significantly to the process of identifying a therapeutic focus, since they are the ones referred to music therapy (by others or themselves) for health and wellbeing reasons. These referral themes may provide enough focus in the initial stages of the work, before a more refined aim/goal/objective is identified. The client’s health complexity and communication style are significant conditions impacting the way the therapeutic focus is determined. Client’s may or may not be able to communicate in conventional ways, and so the therapist requires time to come to an understanding of their potential needs/priorities through assessments, developing a relationship with the client, and collaboration with team members. Clients will have varying degrees of
understanding music therapy, which also impacts the focus of the work. For example, some clients may prefer to focus on the tangible aspects of musical experience, such as writing a song or playing an instrument, while others may have limited awareness of their reason for being referred to music therapy and rely on the therapist to provide a direction. The client’s level of engagement in various aspects of their therapy process, from the reason why they are participating in music therapy to their interest in music making, will also impact the process of identifying a therapeutic focus.

Working with clients-in-context

Music therapists work with clients-in-context, and so the features of that context have a strong bearing on the process of identifying a therapeutic focus. Some contexts have a clearly defined philosophy and guidelines that lead to a definitive scope of practice. This means that clients receiving services within a highly regulated context will often be seen to have similar needs and expectations for therapy outcomes. The way therapy services are funded within a context will also impact the therapeutic focus. Some contexts will have strict regulations around the number of sessions funded, or whether group/individual sessions can be provided. Further, each context will have differing team interactions due to their size and composition, such as large multidisciplinary teams, small transdisciplinary teams or an individual therapist’s private practice. The way the team interacts, and the degree of autonomy of team members that is possible within a context, similarly impacts the therapeutic focus. Some contexts will highly value or require collaborative approaches, while others may see team members operate in relative independence from each other. The outcome expectations, or level of understanding of music therapy as a profession, will also influence the process of identifying a therapeutic focus.

Interactions between the actors in the process of identifying a therapeutic focus
The conditions created by each of these three actors interact together in complex ways that create various consequences for the process of identifying the therapeutic focus. The therapist must interact with both the client and the context. The client must interact with both the therapist and the context. The context creates the opportunity for the client and therapist to interact, but also imposes a degree of structure on the way that interaction can take place. The music therapists interviewed described the strength of the therapeutic alliance between themselves and the client, as well as the professional compatibility between themselves and the context, as key factors in how the therapeutic focus was determined.

In terms of the relationship between the client and therapist, the interviewees considered that the level of collaboration possible was an important determinant of the strength of the therapeutic alliance. Where a client’s health and communication are such that they could actively participate in the process of determining the focus of the therapy, many of the therapists interviewed saw this as optimal, and believed collaboration would lead to more effective therapy. The way the therapist attempts to collaborate draws on their values and beliefs, as well as their theoretical influences. At times, there is a risk that a strong allegiance to negotiating the therapeutic focus with clients may inadvertently put the client under pressure due to their poor health or level of cognition. Many participants emphasised their commitment to ethical reflexivity or a broader engagement with disciplined subjectivity. Some interviewees explained the ways they weigh-up the risk of taking power over the direction of the client’s therapy, with empathically recognising there are times when the therapist should take the lead.

In considering the impact of the context, the therapists interviewed reflected that identifying the therapeutic focus was easiest when their own values, beliefs and theoretical framework aligned with their team, employer or funding body. Further, when the context has a more nuanced understanding of music therapy and the outcomes that are possible, this leads to greater respect between the therapist and context, and a supportive level of team
collaboration. This sense of compatibility and professional security creates conditions where the therapist can attune to the needs of the client, reflect on their knowledge base, and follow their practice ethics.

In considering the interactions between the client and the context, the music therapists interviewed viewed the degree of client autonomy as having an important impact on the process of identifying a therapeutic focus. For example, in contexts with a narrow scope of practice, such as rehabilitation, the client goals may be determined by the medical team. The funding model would therefore require all therapists to work towards pre-determined goals and objectives, and even specify the number of sessions permitted, resulting in relatively minimal input from the client. In school contexts, the clients may have clear curriculum and lifeskills goals, but additional goals can be mutually determined by considering the client’s interests and strengths. Other contexts may afford very high levels of client autonomy, such as mental health services that emphasise a client’s right to choose, and clients who self-refer to a therapist in private practice.

Discussion

The “client-in-context” theory for identifying a therapeutic focus in music therapy resulting from this research is grounded in the deep reflections of experienced music therapy practitioners, supervisors and educators. These participants conveyed that the process around identifying a therapeutic focus is a key part of their professional responsibility, with some considering that having no direction means the work can’t be considered therapeutic and typically means that the work is less productive. Identifying and articulating the therapeutic focus (goals/aims/intentions) with the client and team is also part of the therapist’s advocacy for their profession since goals similarly work to communicate what happens in music therapy. The resultant theory therefore brings to life the complex interactions between the attributes of
the therapist, the client and the context, and how these factors help clarify the professional responsibility of the therapist.

Previous music therapy literature and practice standards have tended to either emphasise the more functional aspects of the therapists’ role in assessing, identifying and writing goals (Davis et al., 2008; Hanser, 1999; Polen et al., 2017), or the broader philosophical considerations for a particular orientation (Rolvsjord, 2010; Stige & Aarø, 2011). Other more theoretical conceptualisations of goal processes have set up a dichotomy of music therapy practice based on whether the therapist is “outcome-oriented” or “experience-oriented” (Brusica, 2014, p. 176), or aligned with a medical or psychodynamic framework (Aigen, 2014). This grounded theory, informed by a large and diverse sample of experienced music therapists, suggests there is much more complexity, nuance and depth to the way goal processes develop in music therapy practice.

Usefulness

Charmaz’s (2006) evaluation strategies for grounded theory analysis invites researchers to reflect on whether new insights are provided by the ensuing theory that might indicate a high degree of originality in the findings. This strategy is echoed in Stige, Malterud and Midtgarden’s (2009) agenda for qualitative research evaluation within the item ‘usefulness’, which is indicated by reflexively considering whether the findings can be “applied in everyday settings” (p. 1511).

The in-depth interview invited participants to reflect on how they approached goals/aims in their practice, and what factors influenced their process. Many participants wanted the students that they teach and/or supervise to develop flexibility, responsiveness and reflexivity as part of goal processes rather than focusing solely on the technical aspects of writing clear and relevant goals. The “client-in-context” theory emphasises the weight of ethical responsibility that is often underestimated within more functional descriptions of goal
writing in the literature. For example, the participants were highly aware of their power to determine or sway the focus of the therapy, particularly with clients who have significant health constraints that impact their ability to use conventional forms of communication. Ongoing reflections on when the music therapist should take the lead in the goal process, as well as cultivating ways to remain responsive to the client’s here-and-now priorities within sessions, were considered an essential part of their professional role.

The “client-in-context” theory therefore has the potential to be a useful tool in the training and supervision of music therapists, and perhaps other creative arts therapists, by providing a means to support practitioners to deeply reflect on the different dynamics at play. Applying Charmaz’s (2006) criteria for evaluation, the new insights provided by the resultant theory suggest a high degree of originality in the findings. Being grounded in the participants’ rich descriptions of music therapy practice, the theory aims to provide an interpretation that can applied by therapists across contexts and within their everyday work.

The following are two examples taken from the analytic paradigm analysis strategy described in the method (Strauss & Corbin, 1998). Characteristic of grounded theory analysis, the short narratives below blend several participants’ interview responses illustrating how the conditions, actions/interactions and consequences act together to suggest a particular therapeutic focus (Dey, 2007).

**Example a: Music therapist working in a day program for adults with disabilities.** Imagine an adult client who has unique ways of communicating that take others a long time to understand. They move their body and vocalise in response to some musical structures and when they recognize familiar people. They are not necessarily aware that they are receiving music therapy. Imagine a music therapist who has a strong ethical stance leading to their overarching intention to co-create an environment or a context of care focused on humanity and dignity. Imagine their work context is a day program for adults with disabilities which has
a mission centred around quality of life. However, the team at the day centre is fractured. There are lots of part-time staff who rarely connect with each other, and many staff members view the music therapist as an entertainer. In terms of their autonomy, the client’s disability limits their ability to participate in service planning and they rely on caregivers to interpret their needs. Within the workplace, the music therapist has a lot of autonomy but feels that their work is not well understood, and they have limited interactions with other team members. The client and therapist alliance requires careful reflection from the music therapist on the client’s non-verbal and emotional cues. The music therapist bases the direction of the sessions on their own here-and-now observations and interpretations and seeks to follow the client’s lead and promote agency and autonomy.

The therapeutic focus within this scenario is likely to be that the music therapist prioritises meeting the client where they are on any particular day. The music therapist records broad aims or intentions for the work within the client’s documentation, such as ‘to provide opportunities for agency and autonomy’.

Example b: Music therapist working in an in-patient rehabilitation clinic for adults with acquired brain injury. Imagine an adult client who is in the acute phase of recovery from an acquired brain injury. The client understands that the clinic specialises in supporting speech and motor skills rehabilitation. Imagine a music therapist who has specialised advanced training in this area of practice and believes there is a crucial window of opportunity to support the client’s neurological recovery. Imagine that their work context is a rehabilitation setting with a clearly defined scope of practice and government funding agreement. The multidisciplinary team works together intensely to support the best possible physical recovery in their clients. Within the team, music therapy practice is supported and understood as contributing meaningfully to client outcomes. In terms of their autonomy, the client understands that the funding for the service specifies the parameters of their treatment,
and they accept these terms of service. Within the workplace, the music therapist also respects the service model and the other team members’ roles and expertise. They believe the mission of the organisation is a good fit for them. The client and therapist alliance is characterised by the music therapist directing the sessions as an expert. The music therapist sees their role as being to motivate the client to achieve the goals set by the service, and the client believes that the music experiences are supporting their recovery.

The therapeutic focus within this scenario is likely to be that the client’s goals are set and agreed upon by wider team. Each therapist understands their role in supporting the client to maximise their potential for neurological and physical recovery. The music therapist documents specific goals and objectives where the outcomes can be tangibly evaluated at set intervals in order to track the client’s progress.

**Limitations**

While the resultant theory is grounded in the experiences of a large sample of diverse participants from the profession of music therapy, the relevance of the “client-in-context” model in each and every practice context is unknown. Further research is needed to more deeply understand the usefulness of this theory in music therapy training, supervision, and professional development. Future findings may lead to the development of both general and specialised education resources for music therapists in training and/or professional supervision that help further illuminate the ethical, cultural and contextual factors involved in the process of identifying a therapeutic focus. The application and relevance of the theory to the broader field of creative arts therapies would also be valuable to consider.

The integrity of the grounded theory research process relates to whether the findings are both “trustworthy and believable in that they reflect participants’, researchers’ and readers’ experiences with phenomena, but at the same time, the explanation the theory provides is only one of many possible ‘plausible’ interpretations from the data.” (Corbin & Strauss, 2015, p.
The process of memoing, diagramming, writing narrative summaries and theoretical sampling described in the method demonstrate prolonged engagement in the field and immersion in the data (Creswell, 2013).

**Conclusions**

The perspectives of these 45 participants suggest that the process of identifying a therapeutic focus in music therapy goes well beyond the technical skills involved in writing clear and relevant goals/aims/objectives/purpose statements. The “client-in-context” theory highlights the multitude of power dynamics that are at play between the actors in this process; the therapist, the client and the context. Many participants deeply felt their own professional responsibility in the process, leading to the central category that emphasises that it is the therapist who attempts to balance the tensions between the various actors. Ethical deliberations surround the therapist’s professional responsibility in the process of identifying a therapeutic focus. It is within this act of holding and containing the ethical tensions that can arise from different priorities and values that their professional identity as therapists is strongly defined.

Multiple examples of the power dynamics inherent in the process of identifying a therapeutic focus were described by participants. Within collaborative approaches to practice, some participants perceived a tension between what the client expresses as the priority for music therapy, and what the therapist considers to be valuable to the client. The dynamic nature of the client-therapist relationship was generally described as a balancing act between the therapist having deep empathy for the client’s situation and respect for the client’s wishes, but also leaving opportunity for the therapist to offer an invitation to the client to consider a new possibility.

Another tension experienced by the participants was in balancing the freedom or flow of the work with their desire to collaborate with the client and set clear priorities. There was a sense that constant negotiation around the focus of the work could lead to getting bogged down
in the process, or even result in the client feeling burdened to lead the process. Identifying a therapeutic focus on the one hand provides a kind of boundary to the work that can help define the nature of the agreement to work together, but it can also stifle the therapist and client’s freedom to pursue here-and-now priorities.

These tensions hint at an ambivalence for some participants around the process of identifying a therapeutic focus. Having a clear focus for the work is important, but it can also be stifling. The complex relational dynamics that occur when collaborating to determine the focus of therapy need to be acknowledged since “not all clients who come to therapy are able to articulate their goals [and] some clients may not feel safe enough to disclose their true goals until they have developed sufficient trust in their therapist” (Cooper & McLeod, 2007, p. 137). The therapist has a professional responsibility to articulate what is happening in the therapy process, but taking a power-over attitude is ethically questionable. If the therapist’s priorities for the work are not articulated to the client, this could be respectful of the client’s health and emotional capabilities, or disturbingly manipulative.

Most of these 45 music therapy educators and supervisors described how identifying a therapeutic focus is a core professional process. They believed that the therapist holds an ethical responsibility to appreciate their power within the process and their accountability to both the client and the context. Within this theory, even a deceptively simple question such as “who determines the focus for therapy?” demands a high degree of reflexivity and unravelling from an empathic music therapist. The challenge lies in the multiple perspectives and priorities that each actor in the process brings to answering this question. A greater awareness of the interactions at play, and the potential consequences on the therapeutic focus that ensues, may support music therapists to further advance their scope of practice in a variety of health and community contexts.
Funding.
There is no funding to declare

Disclosure of interest.
The author report no conflicts of interest.

Acknowledgements

Sincere thanks to my colleague and research mentor, Professor Kat McFerran, who supported and dialogued with me at various points in the analysis, including offering her perspective on the axial coding, conditional matrix and drafts of the narrative storyline. Professor McFerran’s generosity and piercing insights are greatly appreciated. I am also exceedingly grateful to the 45 experienced music therapists who made time to openly share their perspectives and beliefs as part of this research.

References


**Author bio:**
Dr Grace Thompson is a music therapist, and senior lecturer in the Master of Music Therapy degree at the University of Melbourne, Australia.
Table 1

Participants’ work and home location

<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
<th>No. of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>4 cities (North East; South East; Mid West)</td>
<td>13</td>
</tr>
<tr>
<td>UK</td>
<td>2 countries</td>
<td>9</td>
</tr>
<tr>
<td>Norway</td>
<td>2 cities</td>
<td>8</td>
</tr>
<tr>
<td>Denmark</td>
<td>1 city</td>
<td>6</td>
</tr>
<tr>
<td>Italy</td>
<td>1 city</td>
<td>5</td>
</tr>
<tr>
<td>Australia</td>
<td>1 city</td>
<td>2</td>
</tr>
<tr>
<td>Sth Korea</td>
<td>1 city</td>
<td>1</td>
</tr>
<tr>
<td>Israel</td>
<td>1 city</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 2

Conditional matrix: examples of mapping the analytic paradigm leading to the resultant grounded theory

<table>
<thead>
<tr>
<th>Participant ID</th>
<th>Client aspects</th>
<th>Therapist aspects</th>
<th>Context aspects</th>
<th>Client/therapist alliance</th>
<th>Context/therapist interactions</th>
<th>THEORETICAL Consequence for therapeutic focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>&quot;...post-acute, in the community, then it might be that there are ways I work with that client that cover the goals of speech and, you know, physio... in a kind of more holistic way.&quot;</td>
<td>Formal knowledge: &quot;We know that the brain... change can be induced in the brain and the way that the brain is connected in a short period of time [following trauma]&quot;. Model of work: &quot;Yes, so it’s following, you know, the NMT procedure basically. You come up with a musical exercise for that... whatever it is.&quot;</td>
<td>&quot;The essentials...are the diagnosis/prognosis; ...the observations of the multidisciplinary team, and family if they’re involved.&quot;</td>
<td>Rapport/understanding: &quot;Getting a sense of what their [the client’s] journey’s been like through life to get to this point.&quot; Therapist takes the lead: &quot;so my attitude when I go and meet a patient...or the patient arrives at a clinic... is, ‘this is what we’re going to do in this session.’ So there isn’t an option. There isn’t going to be any ‘I don’t feel like it’, or you know, too much sort of chatter. Because we’ve got whatever it is, 30 minutes or 50 minutes... to do what you need. And I want you to get enough of what you need.&quot;</td>
<td>Agreement of scope of practice: &quot;...there are windows of opportunity [for brain change].&quot; &quot;If that goal’s been set by the people that I’m working with, then there’s good reason for it... I don’t actually ever think I do put it into those words ‘my goal has changed for today’, because to me that doesn’t make any sense.&quot;</td>
<td>Goals are functional and agreed to by wider team. They strive to meet client’s potential for neurological/physical recovery.</td>
</tr>
<tr>
<td>Client described as having complex health and restricted communication. Their health is such that “improvement is not the focus.”</td>
<td>Therapist values: “I just let my own code of ethics drive me in terms of what I was supposed to be doing.” “My goal is to create or to co-create an environment or a context of care, of humanity, of dignity.”</td>
<td>Employer/organisation does not seek “improvement”. There is no direct expectation for goals coming from the context.</td>
<td>Context gives high autonomy to therapist: “With the Cancer Care... I was given total free reign. Nobody was really evaluating my approach at all. They just said, we just want you as a music therapist.”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client/young disabled person in a special education school context</td>
<td>Therapist values: “I have this time-oriented music thing happening, and I can’t stop what’s happening and say ‘eye contact’, or...break the music to say like, ‘good eyes’.”</td>
<td>Special school setting with IEPs that the team is expected to follow. Observable behavioural outcomes prioritised.</td>
<td>Predetermined goal is set for music therapy. But therapist worried about ethical risks: “because it goes back to mechanism... You’ve stripped the essence of what a great musical experience can be.” Therapist works on the focus that THEY believe is meaningful to client and relevant to MT. Advocates for MT scope of practice.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child’s communication is unclear due to age or condition. Therapist explores: &quot;What kind of needs does this THIS kid have?” Therapist observes: &quot;in what specific way can we work with the music, with THIS specific child?” Assessment links: “You have a general map of what kind of needs music therapy might meet, but you have to create a local map of needs and ways in</td>
<td>Therapist knowledge: &quot;preparation [is important].reading about this specific population.&quot; Therapist values making a connection first: &quot;that’s perhaps my existentialistic and theoretical approach, I think that if there’s no connection..., if there’s no contact,... at best it’s just a waste of time. So I think attuning to another person is a</td>
<td>Works for an autism service that has a focus on maximising development.</td>
<td>Therapist prioritising making a connection and the context agrees this is an important first step. A more specific focus can be identified later.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
which you can actually meet this specific child."

very first goal."

Figures

Figure 1
Participants’ theoretical influences
Figure 2
Participants’ music therapy practice according to client populations
Figure 3
The ‘client-in-context’ theory for identifying a therapeutic focus in music therapy
Author/s:
Thompson, GA

Title:
A grounded theory of music therapists’ approach to goal processes within their clinical practice

Date:
2020

Citation:

Persistent Link:
http://hdl.handle.net/11343/258472