Full-Length Article

Challenges to Music Therapy Programming: *A Case Study of Innovation, Burden, and Resilience in United States Hospitals*

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Abstract

Healthcare, as a business, has grown exponentially in the past several decades and has faced growing expectations of a consumer population subscribing to institutional regimens. Simultaneously, there has been a growing trend toward holistic lifestyle, where people are considering the impact of making healthier life choices. These culminating factors create greater demand on hospitals and clinics to provide services that are inclusive of both pharmacologic and non-pharmacologic treatment. The provision of integrative treatment options such as music therapy to meet such demands has become a competitive feature of corporate healthcare, and yet, the full integration of music therapy services are challenged in a myriad of ways.

The purpose of this study was to gain insight into challenges faced by 8 music therapy programs across the U.S., and the strategies employed by the respective directors/supervisors, in order to inform other programs facing similar challenges. In-depth, semi-structured interviews were conducted with 5 directors/supervisors of 8 merited programs that either closed or had sustained substantial reduction in programming. Each interview spanned 3 thematic areas of query: *Beginnings, Winds of Change,* and *Retrospective Introspection*. Interview content, analyzed using the Listening Guide: A Voice-Centered Relational Method, divulged broad themes of innovation, internal and external burden, and resilience.

Keywords*: integrative, complementary, qualitative, operationalized, philanthropy* multilingual abstract | **mmd.iammonline.com**

Introduction

Music therapy as a form of integrative care has grown substantially over the past 30 years, surmounting challenges to professional identity across multiple domains including milieu,[1-14] proof of clinical efficacy and cost effectiveness.[4,6,15,16] Joining the medical milieu has posed a challenging frontier for the profession. In spite of abundant literature on music therapy across the lifespan and across a range of clinical populations, lending testament to its efficacy and positive impact on patient satisfaction,4, [6,7,10-15] programming nationwide has faced obstacles in its trajectory of development. Integrative care as an emerging movement in healthcare, stems as far back as the 1970s,[28-35] and has provided a foundation upon which music therapy's presence has found assured footing. However challenges of sustainability centering on cost effectiveness,[15,6,7,28, 31,34,35] and proof of efficacy in medical outcomes [6,7,10-16, 36,37] seemingly remain as obstacles that at times, prevent optimal growth of music therapy as a profession, most particularly within medical contexts.

Obstacles to new programming and setbacks in existing programs occur across clinical milieus, but in the medical paradigm such scenarios abound due to contextual challenges of the medical model itself.[28,29,33] The predominance of a paternalistic narrative hard-focused on efficacy measurable in physiological terms, has at times, inadvertently marginalized the understanding and integration of relational therapies such as music therapy.[10,38-40] Hospitals' need for reimbursement in order to justify program budgeting has placed music therapy in a precarious position to produce efficacy trials alongside medical trials reliant on financially lucrative support from pharmaceutical companies and other investors. [6,7,10-14]

A desire to understand the magnitude of how these challenges impact music therapy programs inspired me to interview 5 directors/supervisors of 8 merited programs[16-27] offering music therapy either exclusively or in conjunction with other disciplines including various arts therapies, child life, and/or recreation therapy. Each of these programs had sustained losses in programming in the forms of reconfiguration of services or elimination of positions over the past decade. The interview participants' titles, programs, and primary populations are provided in Table 1.

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1 **Table 1**

Program	Participant	Services	Population
Norton Healthcare Louisville, Kentucky	Jenny Branson MS, MT-BC Supervisor of Music Therapy	5-6 music therapists, half /part time. Creative and flexible programming with per diem positions. All full time and part time salaries operationalized 5-6 active lines supported in part by philanthropy.	Inpatient NICU through adult, end of life, and psychiatric.
Baltic Street Brooklyn NY	Peter Jampel DA, LCAT, MT-BC Supervisor/Director Music Therapy President of a 501c3 of Baltic Street into Action	Formerly transitional care from inpatient emergency room, acute care, and rehabilitation) to outpatient and community. Change in past 10 years to day programming and a tiered rehabilitation incentive program, scheduled post hospitalization as outpatient. 2 music therapists funded through New York State Office of Mental Health.	Seriously and persistently mentally ill adult psychiatric rehab. *1997 shift to outpatient.
Beth Abraham The Bronx, NY	Connie Tomaino DA, LCAT, MT-BC, Founding Director Music Therapy/ Institute for Music and Neurologic Function (IMNF)	Inpatient individual and group music therapy across the facility. 4 full time and 2 part time music therapists. Music therapy grew to 7 music therapists. All salaries and benefits operationalized. Funding also inclusive of philanthropy and research grant funding	Adult long term medical, rehab and day services. Adult daycare and short term rehab added
Center Light The Bronx, NY	Connie Tomaino DA, LCAT, MT-BC, Director	Music therapy services offered throughout regional nursing homes under the umbrella of Center Light. P/T music therapists paid per diem.	Geriatric/Regional nursing homes
Elizabeth Seton Pediatric Center New York, NY	Jennifer Townsend MMT, MT-BC, CCLS Coordinator, Creative Arts Therapies and Child Life	Recreation therapy originally housing creative arts therapy and child life. Music therapy grew from initiatives to round on music therapy case work and provision of adapted environmental music therapy. Grant funded positions transitioning to full operationalized positions. Philanthropy and grant funding for instruments and supplies.	Medical long term and acute pediatric skilled nursing facility
Dell Children's Austin, TX	Jennifer Townsend MMT, MT-BC, Clinical Director of Child Life/Creative Arts Therapy	Child Life team-15-16 full time Child life, 1 part time music therapist, 1 part time art therapist, 1 part time expressive arts therapist (20 hours each/week). All salaries operationalized. Philanthropy paid to move music therapy to full time after presentation to board of trustees.	Acute pediatric care ages 0-21-300 beds including NICU and Level 1 Trauma Center. No adult or birthing unit
Children's Memorial Hermann of Texas Med Center. Houston, TX	Jennifer Townsend MMT, MT-BC, Director Creative Arts Therapy	Child Life and Expressive Arts Department. 2 music therapists, 1 Art therapist. Salaries operationalized with philanthropic support included.	Acute Care NICU-(162 beds) and pediatrics 0-21, Level 1 Trauma Center. Texas Med Center largest in world w 2 children's hospitals; not-for-profit. "Pay or Mix"- ratio of income from Medicaid, philanthropy, or charitable dollars. Mix pertains to range of insurance providers.
Nordoff-Robbins Center, Steinhardt School of Education of New York University, New York, NY	Alan Turry DA, LCAT, MT-BC, Director	Music centered music therapy outpatient and community individual to group. 10 senior staff to 2 full time staff, 3-4 part time staff, trainees. Positions funded through revenue generated from trainings, clinical services, research grants, and philanthropy..	3 phases: 1) Autism/developmental delay 2) self-referrals and some medical 3) adult/child services available to any and all.

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Interviewing participants to learn about the unique challenges faced by each respective program evolved into a case study of the overarching themes. The identification of innovation, burden, and resilience across interviews imbued the study with universality that seemed more relevant collectively than individually reported. As per current definition of case study, qualitative researchers may "regard multiple cases as instances of the same phenomenon." [41, (p.26)]

Method

Participants of this study were identified as strong contributors to the field of music therapy by way of their active roles in the building or directing of programs providing exemplary service. Access to these individuals was navigated through the researcher's collegial history with each participant that had been forged over the past 18 years either through academia or through the professional sector. The study protocol was submitted for IRB approval, and was deemed exempt due its focus on retrieving information that was considered both historical and potentially public domain. The researcher initiated contact with the participants in compliance with the protocol that had been submitted. All participants were informed that the interviews were serving as the primary data source for generating a qualitative understanding of broad themes faced by music therapy programs in healthcare facilities.[41-44] The interview content was considered pilot data that would provide context for the researcher's ongoing doctoral research. Verbal agreement that participants would have the opportunity to review and edit the transcriptions prior to analysis was made prior to starting each interview. 60-70 minute semi-structured interviews were conducted with each participant, 2 of which were conducted in person, and 3 by skype. The use of semi-structured interview was selected in order to facilitate a fluid forum in which the participants could expound upon and digress from the themed questions as desired.[46]

Following an initial review of program logistics and patient demographics (Table 1), 3 broad areas of inquiry were subsequently explored by the researcher: 1) beginnings, 2) winds of change) and 3) retrospection. All 5 interviews were recorded on the I-Phone 6. Transcriptions were generated using a professional service selected from several providers after ascertaining and reviewing each providers' statement of ethical responsibility, consumer reviews, and reported degree of accuracy. Delivered transcripts were reviewed for accuracy and congruence to the audio recordings by the researcher, and then returned to each respective participant for accuracy to their intention. Upon approval or modification of the transcript by each respective participant, the researcher analyzed the data according to the progressive steps of the Listening Guide. 47 This method of analysis requires engagement with the interview content through multiple readings with specific focus applied to each reading. The first reading of content is focused on identifying the overarching themes of the participants' narratives. The second step or reading is to identify I-poems. I-poems are created by isolating and stacking statements beginning with "I" into a poem format. This process potentially conveys a layer of narrative that reflects placement or displacement of participants' power. The third step focuses on the identification of contrapuntal themes that emerge across the participants' interview content. These seeming polarities within an interview, illuminate resistance to, or accommodation with the main narrative of the institution, which in this study was institutional healthcare. Examples of this interpretivist approach served to further guide my use of the Listening Guide as a method analysis.[48-52]

All analysis phases are organized and presented across the three areas of inquiry, with I-poems made available in Appendix 1. Selected interview content, themes, and contrapuntal themes are presented together as they were interpreted in each phase of the interview respectively in Appendixes 2, 3, and 4. A final reading, or fourth step of the Listening Guide, was done to re-examine the original themes. Themes that were illuminated during this re-examination step are addressed in the discussion section. Following the analysis of the data, all audio recordings and interview notes were stored on the researcher's personal password accessible laptop computer.

Results

Beginnings

During Step 1 of the Listening Guide to interview analysis, there were significant themes identified across the 3 interview questions. The "beginnings" part of the interviews, divulged a shared sense of a "honeymoon phase" in which creative freedom in clinical work, writing, and research and program generativity was high across sites. There was a unanimous sense of autonomy in the designing and implementation of innovative programming during this phase. Several participants recalled that much of the work of program-building including research, grant searching and fund-raising occurred after work hours during evenings and weekends. One participant likened the beginning years to "Disney magic", in that there was seemingly infinite support and respect for music therapy from administration and units alike, with a position being added annually. Whether referred to as "honeymoon" or likened to "Disney", the beginning period for each participant remarkably reflected strong union of departments typically juxtaposed in hospital culture: the financial strategies of healthcare as a business versus the creative and relational aspects of care itself.

Step 2 focused on the identification of I-poems. I-poems for this phase, "I came", "I built", "I started", "I became", reflected an optimism ensuing from autonomy in the running and developing of programming. There was minimal, if any

conflict with administration, finance, and development departments during this phase, and there existed across sites a general celebratory climate around the novelty of music therapy, the spirit of innovation in marketing and fundraising initiatives, and in the potential of individualized care across the life span afforded in music therapy to draw philanthropic support, public interest, and positive accolades to the respective institutions. During this phase, salaries generally funded philanthropically were in balance with the respective institutions' affordance of capital in the forms of physical space and infrastructural support such as intelligence technology (IT), telephone, and utilities. 3 of the sites enjoyed operationalization of positions (administratively underwritten salaries) simultaneous to receiving unconditional support in the above essential areas. For these programs, the institutional messaging centered on a quid pro-quo understanding that programming would be supported administratively if the respective participants demonstrated earnest in striving for philanthropic support.

The third step of the Listening Guide, allowed for contrapuntal themes to emerge that reflected participants' accommodation and resistance to the overriding expectations of the systems in which they existed respectively. *Pragmatism versus idealism, abundance versus scarcity, naiveté versus shrewdness,* and *clinical versus administrative* were interpreted from the interview content as reflecting a general sense of initiative, innovation, and industry in establishing and maintaining vitality in the respective settings.

Divergences in the data generated from the first area of query were consistent across the participants' reported experiences in terms of actual factors of sustainability occurring in gradations of operationalized funding, philanthropy, and grants. Agency in the arena of fundraising was inconsistent across interviews, with one participant reporting on the importance of navigating degrees of visibility and invisibility both internally and in the external world of philanthropy. This proved to be a noteworthy discrepancy across three of the sites. Roles and responsibilities also emerged as consistent and continuous across all sites in the form of the balance between clinical and administrative work. The feeling of dividing one's time between these focuses was palpable across sites, and was understood as an accepted factor in sustaining music therapy programming. Self-determined professional identity often juxtaposed clinical obligations with scholarly aspirations, with one participant reporting added burden during the "honeymoon" phase, of having to remind music therapy staff to prioritize clinical care over writing and research. Another participant expressed having to reconcile scarcity versus abundance, in terms of music therapists' availability being compared by staff to abundant volunteer presence. For this latter participant, regular staff education about the differences between the professional work of credentialed music therapists and volunteers was a consistent part of their role. *Scarcity versus abundance* and *visibility versus invisibility* were recurrent polarities throughout the interview phases for all of the participants and will be discussed accordingly.

Winds of Change

The source of disruption to the "honeymoon" phase was reported across a range of contributing factors including administrative changes, shifts in the direction of institutional missions, budget-related issues, and governmental mandates affecting insurance reimbursement. Each participant reported varying degrees of pressure felt directly, with one particular director speaking about heightened attention from administration as to philanthropic and grant funds that had been generated. In this case, the positive accolades and generated funds were not enough to offset rising institutional costs. Consequently, some of the infrastructural supports previously provided au gratis were scrutinized by the chief financial officer (CFO) as potential sources of income for the institution. This participant reported that rent for physical space and billing for IT services became part of the new dialogue with administration as the department accrued healthy philanthropic support. Simultaneous to this sharpened lens on the program's success, the new CFO ironically began to question the validity of the department's research initiatives and efficacy claims of music therapy in general.

Another participant cited a major shift in institutional initiatives from supporting direct patient care services to reallocation of funds for the architectural design of a new facility. This participant remained vigilant to the mission of the institution as it shifted from patient to fiscally centered. Several participants reported the winds of change as being both visible and palpable in the reallocation of funds originally earmarked for music therapy, to other job lines including child life and recreation therapy. Another cited changes in the governmental involvement in reimbursable healthcare services as having monumental impact on programming. Two participants specifically cited broader social shifts within the music recording industry as the beginning of change in terms of potential fundraising. The rise of music related "pet projects" of both artists and industry executives diluted a previously lucrative source of fundraising.

One particular program experienced a dismantling of music therapy programming that had been established as a centralized department from which positions were coordinated. This scenario, particularly reflective of a divide and conquer mentality, resulted in fragmented music therapy services that reported to individual unit leaders or nurse managers. Clinical supervision forums specific to music therapy were diminished as disconnected therapists were made accountable to non-music therapy figures. Additionally, in this same program, there was a resistance to the use of the word "integrative" to describe music therapy services in spite of the very integration of music therapy in the clinical care and treatment planning. Administration asserted that the term

insinuated that medical providers were providing the service, and consequently the term "alternative" was preferred. The importance of language in defining and compartmentalizing music therapy in this particular program reflects dynamics of power and control utilized in organizational communication strategies.[52-55] Divided and marginalized as "alternative" rendered a narrative counterintuitive to integrative philosophy.

The I-poems that emerged from this section of the interviews demonstrated certain losses of autonomy. The shift from "I can" and "I did" to "I can't" and I couldn't" was present across the interviews. The I-poems also reflected a general theme of accommodation to the financial and budgeting narratives of the respective hospital systems that housed each program. For one participant, this propensity to "roll with it", reflected a belief in the integrity of the institution's vision of patient centered care that had been inclusive of music therapy. The I-poems also divulged across participants, an astute awareness of change and the imminent impact on patient care and program stability that it carried. "I knew", "I saw", "I needed", and "I realized" reflect this profound understanding.

Here the contrapuntal themes were less prevalent, demonstrating more optimism than pessimism in the face of change. Across the participants there was a sense of loyalty to the system and a willingness to adapt and and adjust programming as needed. *Acquiescence versus confrontation, determination versus passivity, composure versus dismay, optimism versus despair, steadfastness versus despondence,* and *collegiality versus adversity* prevailed with the latter reflecting a subtext of growing tension during the threatening reality of immanent change.

Retrospective Introspection

Across the retrospective reports of the participants, there was an expected sadness at the impact of changes on patient care. For three participants, patient accessibility to care had decreased considerably, but had been sustained to some degree nevertheless. Across these three sites, diminished staff required lowering the number of therapeutic offerings and dedicating more staff to patients needing assistance with ambulating to groups. For a fourth participant, the elimination of many services and clinical space for those services that remained, was devastating. Changes in this program reflected broad social changes that were sweeping across healthcare nationwide. For the fifth participant, the loss of services due to cuts in staffing translated into shorter sessions and longer hours.

In spite of these respective losses, there was a unanimous reflection across participants on the earlier period when program development and maintenance was achieved through conviction and hard work. The synthesis of creative agency in program development and control in decision making were pivotal to the growth that each participant had experienced. Participants returned to reflecting on their respective senses of freedom in strategic thinking, planning, and fundraising. Across participants, there was pride in having contributed to the growth and vitality of the music therapy profession. There was no animosity detected in the fact that much of the initial time spent on program building often extended well beyond the work day. Additionally, multi-tasking to ensure visibility, vitality, and clinical productivity were thematic across the participants' reports. Participants unanimously maintained that they had worked hard in earnest from the outset of their respective programs' successful growth, and that they would not have changed their approaches to directing or building their programs. To this end, all reflected on their attendance to tasks such as grant writing, fundraising, scholarly pursuits of writing and research, and public relations as normal and accepted aspects of their roles. One director reflected on the balance between visibility through clinical presence and professional development through scholarly pursuits, as being scrutinized by administrators narrowly focused on patient outcome scores.

One participant expressed regret at having not advocated to formally operationalize donated monies more actively rather than settling on good faith that earmarked funds would be used accordingly. This participant has taken a present stance of asking and requiring confirmation about the use of such funds. Another participant reflecting on the sequence of events leading up to program cuts, came to a realization that more effort could have been made at solidifying departmentally funded positions resilient to administrative change. Still another expressed being dismayed by the swiftness of job line elimination that occurred within their hospital. This participant described the magnitude of change as insurmountable in its ensuing from governmental and bureaucratic forces.

A particularly interesting point of retrospection for one participant in identifying proactive strategies of sustainability, focused on real estate and investment in other physical resources that might ensure independence at a time of institutional change. Investment in both physical space to house the clinical service, and a large reservoir of musical instruments, was cited as an important strategy of sustainability. Additionally, this individual simultaneously reflected on the positive aspects of affiliate relationships with institutions that had afforded security of another kind- that of identity enhancement and social capital. Social capital in the form of reputation by association and philanthropic interest was seen as an assured benefit of institutional alliance.

In spite of the overriding sentiment that little could be done to reverse the changes that occurred across the respective sites, I-poems drawn from this part of the interviews demonstrated varying degrees of want, regret, and felt loss. "I managed", "I thought", and "I didn't", are a few of these statements. Contrarily, "I will", "I am", and "I decide" reflect certain resilience in moving forward.

Contrapuntal themes that emerged at this point reflected both an increase in restrictions to creativity and a certain will to prevail through the changes that came. These included *perseverance versus ambivalence, conviction versus apathy, composure versus dismay, acquiescence versus confrontation, disillusionment versus steadfastness, ambivalence versus resolution, nurturance versus deprivation, disillusionment versus steadfastness,* and *optimism versus despair*.

Embedded within these divergent themes are rich references to the creative freedom, innovation, and ingenuity that led to program development initially. These same themes point to the resilience of each participant as they discussed the aftermath of change.

Discussion

Re-examining the themes that emerged during the first reading of the interview content, divulged a deepened comprehension of personal investment and conviction to sustain accessibility to services in spite of immanent challenges. A major theme across most of the sites was ongoing systemic resistance to the professional identity of music therapy. The irony here was that while all participants maintained that their respective sites required that staff have board certification (MT-BC), and by 2005, licensure for creative arts therapists in the state of New York (LCAT), barriers to full integration toward institutional culture were maintained in various ways. The music therapy profession is one that in its trajectory toward integration, has sustained marginalization and relegation to secondary consideration within a hierarchal healthcare paradigm. Given the many facets contributing to the culture of healthcare, administrators, front-line staff, physicians, nurses, clerical, and environmental workers, all engage in sense-making and enactment on a daily basis, and are responsible for the work culture that exists.53 Enactment is a human mechanism critical to building and shaping the work environment in a way that is manageable and acceptable. Medical culture and patient care enhanced through music therapy programming aren't sustainable without the active engagement and participation of the workforce. The use of terminology like "distraction", "alternative", and "entertainment", and inaccurate grouping with merited but non-clinical offerings such as volunteer musicians and pet therapy reflects this dilemma. Tokenism,55 discussed as an outward expression of failed integration in the working environment has relevance here as music therapy strives for integration that is resilient to institutional change.

Understandably, reexamination of the interview content divulged unexpected divergent themes of *credentialed professionalism versus amateur status, acknowledgement versus dismissal,* and *nurturance versus deprivation*. Resilience to institutional and programmatic change may very well ensue from constant navigation of these polarizations, as well as the responsibility of those in director or leadership roles to mitigate the impact of change on team morale. In spite of these cultural obstacles, the stance taken by all participants in the aftermath of change was one of forward momentum, or *pro-action* versus *defeat.* For one participant, survival translated into staunch attendance to visibility and notoriety in order to ensure ongoing accolades to the host institution. This was, and still is achieved through ongoing dedication to quality clinical care, research, and publishing. Here again, the work often extends beyond the standard 8-hour day. Another participant maintained creative control by securing brand ownership, and by embracing the model of care provision that had supplanted the original program, and recreating a service-for-contract model relevant in the current trend toward community service. Two of the other participants seized opportunities for professional development and advancement through both academic and lateral movement within the music therapy profession. The fifth participant continues to pioneer new ways of approaching the challenging limitations of a healthcare system in the throes of change, by focusing on music therapy in community wellness. In general, the participants remained positive about music therapy as an integral component of best practice and remain committed to furthering the profession by persevering through myriad challenges.

Interviewing 5 dynamic contributors to the growth of the music therapy profession about institutional challenges and programmatic losses carried tremendous meaning for me on a personal level because of my own professional trajectory. Checking my own transference with the subject was of critical importance. To this end, trustworthiness defined in terms of credibility, transferability, dependability, and confirmability 56 was met by checking the content and my interpretation of it with the participants at strategic times during the interview process and in the post interview process; peer debriefing with a pioneer of music therapy and expert in qualitative methodology; inclusion of interview content contrasting with my beliefs and experience on the topic; and by interviewing multiple participants hailing from different regions of the country, types of institutions, and clinical models. Regarding my own subjectivity with a topic on which I feel passionate, I established a culture of trustworthiness by consistently naming and defining the purpose of the research to the participants and peers directly and peripherally involved.

Conclusion

Integrative care marks the newest frontier in the business of healthcare by addressing many of the forces identified in this study, yet potentially challenging others. Music therapy as a form of integrative care contributes to best practice on many levels. Its presence as a relational therapy however, disrupts a

medical narrative focused on physiological parameters as the gauge for efficacy that ensures reimbursement. Music therapy and its proponents pose an assured "interruption" to such established norms, and the "arousal" that results from such interruption causes one to take notice and even question the status quo.

The narratives that each participant shared drew from their respective journeys and reflected skilled navigation of institutional hierarchy and bureaucratic systems. There was an overarching theme of profound tenacity and belief in music therapy as a modality integral to best practice in treatment planning and provision. Also prevalent across each participant's way of being was a propensity to redefine institutional culture, surmount seeming obstacles, to look beyond the "no" in dialogues, and to see opportunity for improvement of patient care beyond systemic limitation.

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Biographical Statements

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Appendix 1: I –Poems from each Interview

Beginnings	I came I had I did I got I followed I was I became I am	I can I think I am I mean I was I see I grew	I built I was I had I made I just I met I came I was I told I worked I built	I would I think I don't I know I remember I have I never I mean I haven't I don't I think	I was I gave I became I did I went I presented I moved I advocated I think I actually I started I want I took I said I remember I guess I wrote I would
Winds of Change	I have I was I started I had I was I needed	I tried I would I was I really I became I don't	I realized I talked I was I knew I would I saw I really I left I think I didn't	I couldn't I am I don't I mean I can't I think I believe	I think I believe I don't I was I started I really I had I feel I could I mean I left
Retrospective Introspection	I told I knew I had I was I knew I think I went I found I met I think I will	I was I don't I tried I feel I have I really I tried I see I view I would I met I trained	I think I don't I managed I decide I have I felt I had I would I can I definitely I heard I left I know I am I thought	I was I will I did I made I am I always I want I really I gotta I could I thought I wouldn't I think I would	I didn't I left I knew I thought I was I have I don't I know I assume I will I ask I guess I think I would I kind of I am I ask

Appendix 2: Interview Phase 1

Beginnings	**Quotes**	**Overarching Themes**	**Contrapuntal Themes**
	"…amazing honeymoon period where everything is supported, nobody is asking about budgets, salaries are done. I'm just approving the year budget for expenses and travel."	Success and Innovation	Pragmatism versus idealism
	"…honestly, it was kind of a magical Walt Disney progression in how everything grew so consistently every year, because there were several years when we were adding a position every year".		
	"The positions themselves were typically operationally funded or became ... We were able to operationalize them once they were in. The equipment costs were almost exclusively philanthropically funded."		abundance versus scarcity
	"…each music therapist is in their individual facility, supervised by a non-music therapist but that advocates for them and maintains them in their operating budget".		
	"Any new program that we wanted to initiate was ... We were encouraged to use grant funding for those."		
	"I was allowed some really creative bookkeeping… permanent per diem's…. willing to work full time for little stretches….it was really just kind of creative recruiting and scheduling, and there was a lot of give and take but it worked for us."		
	"We wanted one large corporate music therapy ... Actually, we wanted an alternative therapies department so that we would include art therapy, pet therapy, everything."		naiveté versus shrewdness
	"We started tracking patients who came for rehab that wouldn't have come … if it weren't for the music therapy program."		
	"we had to develop…to track the patient record of every patient we saw for a year and then go back to the Press Ganey return and see how many of them had returned a survey… patients who would seek music therapy rated their overall visit higher for…mentions like pain, spiritual support, overall satisfaction."	Validation	
	"I had on an average of about 12 cases, and I was half time administrator and fulltime primary therapist. That 12 would translate to 24 if I was only doing case work".		clinical versus administrative
	"…working 24 hours; at night making sure everything was done – don't worry about how you're going to pay people for working 24 hours. This is what we have to do…"	Tireless commitment	
	"We're not bringing in money to the hospital as a provider, but we're bringing in money from a philanthropic stand point and as a non-profit institution, that's a lot. That means a lot to them."		
	There was not a grant writing committee. Any grants that were pertaining to creative arts therapies or child life came through me…sometimes other staff wrote them, and I would edit them. Or, I would write them … send them to development. We had two people in our development team".		
	"I preferred complimentary or integrated but somewhere in compensation or with the CFO or HR they determined that alternative therapist was what they wanted. So there really wasn't an option".		
	"I didn't like "alternative…. I really preferred integrated, but they had an integrative medicine team that was nurses and physicians they wanted to separate the two".	Language and identity	

Appendix 3: Interview Phase 2

Winds of Change	**Quotes**	**Overarching Themes**	**Contrapuntal Themes**
	"it became very clear from the beginning of those administrations that the style of leadership was very different…goals were shifting from patient centered and staff retention models to, "We want to make lots of money and it's our way or the highway".	Administrative changes	
	"when I saw the new administration moving in to place, I realized that would make everyone's job more vulnerable...I talked to the CFO about that he agreed: "You guys are one large corporate cost center. When it comes time to trim things, that will make it much more visible and much more vulnerable…so at that time we opted to leave everyone in their individual cost centers…"		Acquiescence versus confrontation
	"…the current administration made it very clear that they didn't want it (music therapy) unified. They wanted it separated."		
	"… the administrator decided to hire recreation people thinking they had all this money, not realizing … there there was a commitment to music therapy. They ended up hiring for new recreation people that now made the budget too high."		
	"…they started adding high level administrators who started nitpicking and micromanaging everything."		
	"state was moving away from the sense of therapeutic community; of a therapeutic milieu… moved out of the role of institutional provider in the late 1960s and early '70s"	External Stress	
	"In 1997, (the) state office decided … day treatment programs were an extravagance…that went on too long, and didn't address individualized treatment plans…seen as inefficient and ineffective."		
	"COO cutting budgets…(yet) they were making… absolutely astronomical salaries and yet they were nitpicking the small stuff…The more money I brought in the more they would up that corporate overhead".	Internal budgetary stress	Collegiality versus adversity
	"When my budget got cut completely and I had to let people go… he (COO) said, "You know, we can get a music therapist off the street for $50 an hour … why are we paying benefits and salaries?"		Composure versus dismay
	"We would have to give cost of living increases. In fact, I didn't take them half the time or I would cut myself down with increases because I said, We can't sustain that.".		
	"Every time they made more money it's like these guy's salaries went up and then I'd have to pay a certain percentage of my budget, 2% of my budget went to their salaries"		
	"The president recognized the work and thought it was really important but said, "Unless you raise the money we really can't support it…He (COO) was so busy with growing the business that we were like this little blip. I kept under the radar."		Determination versus passivity
	"The president starts looking at budgets…saying, "Gee, it's a lot of money to pay for something that's not reimbursed… but I was bringing in enough money to offset it".	Reimbursement challenges	
	"Insurance issues …because they're not gonna pay for transitional visits, so it's up to the hospital if they want to throw that in as an extra and people don't throw in extra services if they're not compensated for them…"		
	"…diminished community resources and increased long-term care distribution and resources".		
	"state is now demanding that they identify non-Medicaid billing organizations that provide services that can address their primary need areas with these populations"		
	"Medicaid is changing their reimbursement rate… there's a real consciousness…they (administration) can only sustain things that are paid for…"		optimism versus despair
	"difficult … to have continued fundraising appeal without a concrete product or focus. Something that was more socially visible and also more academically rigorous".		
	"A big wind of change was when the music industry could no longer have events that would raise significant amount of monies for us…"	Fundraising pressure	
	"Musicians On Call came up and all these other groups…then the Grammy Association started to form Music Cares, and. Each One Counts, …another one where they had music instruments for kids.People who used to donate and musicians who used to give a lot and help us with fundraising all of a sudden had their own little pet projects".		

Appendix 4: Interview Phase 3

Retrospective Introspection	Quotes	Overarching Themes	Contrapuntal Themes
	"…there wasn't a development person at that point… it was just the events and small grants that I got".	Struggling for survival	Perseverance versus ambivalence
	"It (annual fundraiser) didn't do as well as ... At the same time, we were running this big event we were busy writing these reports".		Conviction versus apathy
	"I went back to administration and said, "Look, we're included here (LCAT). You should be billing for groups." They said, "No. We don't have the staff to do that. It takes a lot of time… we can't bill. The finance department came back. It was a very well-thought out position paper saying that ... There was no precedence for it."		Composure versus dismay
	"The thing to happen too is that benefits went up. That became astronomical. That was really the problem was the benefits."		Acquiescence versus confrontation
	"I used to fight with them too because we would have to give cost of living increases. In fact, I didn't take them half the time or I would cut myself down with increases because I said, "We can't sustain that."		
	"We did try cutting back on group and having creative arts therapists pair up, creative arts and child life specialists pair up so that you had more of a team. It meant more kids were able to get to that one group. It meant less groups were happening throughout the week."	Impact on patient care	disillusionment versus steadfastness
	"I needed clinicians. I needed people on the ground to actually do the clinical work. I needed clinicians who were going to do groups. You know? I used to do four groups a day"		ambivalence versus resolution
	"…patients and the recreation staff plastered the walls … "Save the music, save the music,…save music therapy …music is power". …family members calling, "Don't cut this. Don't take away the program. This is so important" Administration didn't ... couldn't care less."		
	"I didn't have the opportunity to say goodbye or anything so I had no closure with my patients."		
	"huge caseloads with people doing less and less treatment, less and less direct services, less creative work, and doing more and more forms…"		
	"Coordinate services rather than provide services."		
	"…my associate and I were too busy doing all these reports for the chairman to prove that we were worth ..."		
	"I wanted somebody who recognized me and the value I brought. .."		
	"I think I would've worked with the administration a little bit more. I think I didn't have the experience at that time to fully understand. I kind of had to live it to know how it was going to affect."	Cost to professional identity	Nurturance versus deprivation
	"…so you get invited to a conference and you go for free – what's the message…? Am I supposed to feel bad because I'm asking for money? … What message are you giving when you say… don't pay me, I'll just do it because I'm…a nice, generous person"		Disillusionment versus steadfastness
	"I think if I had more of an aggressive nature to me I probably could have…"		
	"Hospitals are faced with this challenge about meeting these qualitative elements that people are asking for, that evaluators are asking for…you need to have that qualitative, that person-interactive caring piece".		
	"There's enough research out there now that shows that the interpersonal piece of care is more important or more effective and financially more effective than just treating the illness"		
	"…administrators are the first to hire somebody or to change something if a study comes out and it becomes the new big thing".		
	"How do we become something that is identified as unique and different but yet working within a system".	Moving forward	Optimism versus despair
	"what should've been done was to have an endowment before doing things. That was a big mistake, … they should've had enough of an endowment so they knew they could fund the (work) without worrying".		
	"got real estate; bought a building… had an endowment.. hired people for fundraising".		
	"…now I'm ... I just ask more questions. I just want to know. Where is that money and how does that get earmarked? How is it shown that this is what it's for when it comes in? I ask a lot of those questions now."		