

Article

Exploring Multiple Identities as a Health Care Ethnographer

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Abstract

Previous discussions about the role of the ethnographer have weighed the advantages and disadvantages of occupying insider or outsider positions, or dual practitioner-researcher identities. In the author's experience, additional identities can come to the fore when a seasoned health professional returns to the field as a novice ethnographer. In this article she reflects on ways in which she shifted between the identities of researcher, therapist, friend, and student in her ethnography about music therapy service development. These experiences are presented to reveal the inherent complexity of the researcher role and to encourage health care ethnographers to consider ways in which they can hold multiple identities in their own research.

Keywords: institutional ethnography, workplace health care, researcher-participant relationships, field methods, music therapy

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Introduction

Careful attention to the role of the researcher is widely regarded as a mark of quality in ethnography. Commentators on ethnography encourage researchers to consider how their backgrounds influence their interpretations of people's behavior and to acknowledge that their presence can affect the very phenomena being studied (Allen, 2004; Borbasi, Jackson, & Wilkes, 2005; Reeves, Kuper, & Hodges, 2008). The rationale for considering the researcher's role differs depending on the commentator's ontological position. Role consideration has been variously described as a strategy to minimize bias, to increase transparency, to enhance the richness of the data, or to ensure that research findings are credible (Bulpitt & Martin, 2010; Finlay, 2006; Marshall, Fraser, & Baker, 2010; Ritchie, Zwi, Blignault, Bunde-Birouste, & Silove, 2009).

When I was planning to undertake an ethnography in the field in which I had previously practiced as a music therapist, I turned to published discussions of how the researcher's role has been perceived. Within anthropology and sociology, reflections have traditionally focused on the relative merits and disadvantages of "insider" and "outsider" researcher positions (Allen, 2004; Angrosino, 2007). These reflections have explored whether it is advantageous for a researcher to be familiar with the culture of the group being studied. Researchers who advocate for an insider position have indicated that familiarity leads to easier access and a fuller understanding of group practices. Researchers who have maintained an outsider position have argued that familiarity can lead to assumptions being made and issues being overlooked. From this perspective, an outsider is better situated to gain new insights about a group and its culture (Allen, 2004; Borbasi et al., 2005).

Nursing researchers have commonly reflected on the research implications of possessing a dual practitioner-researcher identity (Allen, 2004; Borbasi et al., 2005). A nursing background has been viewed as both a help and a hindrance when undertaking ethnographies in health care settings. Some nursing researchers have perceived that possessing common language, skills, and experience facilitates research access and acceptance by health care workers (Borbasi et al., 2005). Other researchers have found it difficult to gain trust and acceptance due to a persistent view that they are judging others' work (Allen, 2004; Marshall et al., 2010). Another possible implication of possessing a dual practitioner-researcher identity is that the boundaries between researcher and caring professional can become blurred. In the presence of a trained nurse, fieldwork participants might come to disclose more intimate details than they would have in a different research situation. A practitioner-researcher may then question the degree to which personal information should be included in the final research report (Borbasi et al., 2005). Nurse researchers have also experienced ethical dilemmas when an observed practice has been perceived to be inappropriate or unsafe (Allen, 2004; Marshall et al., 2010). This suggests that professional expertise can add a layer of complexity to the observation of practices in fieldwork based research.

Another debate relates to whether nursing researchers should participate in the practices of the group that they are studying. Nursing and midwifery researchers have typically become involved in clinical work while carrying out their ethnographies (Allen, 2004; Marshall et al., 2010). Allen carried out mundane nursing tasks despite an earlier intention not to participate in ward work. She wondered whether she may have done so because she was more comfortable with being a nurse than with being a researcher. It was likely that her role was driven by her own psychological and emotional needs, including a need to "fit in" (p. 19). Allen questioned whether her involvement in nursing tasks connected her to certain occupational groups and limited her access to others.

Although participation in the work of health professionals might feel familiar, previous authors have also considered that researchers may be at risk of emotional exhaustion when they become extensively involved (Borbasi et al., 2005).

Although it was helpful to explore previous discussions of the researcher role, I found myself uncomfortable with a polarized view of the researcher role as insider versus outsider, practitioner versus researcher, or participant versus nonparticipant. I perceived that this view of the researcher role had limited application to my ethnography about music therapy service development. Rather than assuming a single or dual researcher role, I found myself juggling multiple identities¹ when returning to a hospital as an ethnographic researcher. Developing my role turned out to be more complicated than I expected, as I was required to grapple with a number of boundary issues² that I had not anticipated. I therefore resolved to share my experiences, to assist other health care ethnographers to prepare for the complexities of researcher role development. In this article I reflect on the multiple identities that emerged in my ethnography and consider the various implications of my role as a researcher.

Background to the study

My doctoral research is in the area of music therapy service development. As music therapy is a relatively new professional therapy discipline, many music therapists need to introduce, uphold, and develop an inaugural post in a setting where music therapy has no existing history or contextual frame (Edwards, 2005; Loewy, 2001). My aim is to learn more about the challenges and opportunities that arise when a music therapist is the first to introduce music therapy to an established health care site. Specifically, I hope to identify effective strategies to recommend to student and new graduate music therapists who are looking to establish new music therapy services.

The opportunity to undertake an ethnographic fieldwork study arose fortuitously, when my doctoral supervisor and I became aware that an Irish hospital was contemplating introducing a music therapy service. A nurse from the hospital phoned my supervisor looking for advice as to how best to introduce music therapy at her place of work. Over the next 20 months, my supervisor and I provided service development advice and assisted the hospital in recruiting a qualified music therapist. It was my supervisor who first recognized the opportunity for me to undertake an ethnography at the hospital. She encouraged me to read about ethnographic methods, so I turned my attention to qualitative research textbooks and published health care ethnographies. I learned that nursing researchers had employed ethnography to explore health care cultures and to identify strategies for effective clinical practice and interprofessional work (Arber, 2007; Gillespie, Wallis, & Chaboyer, 2008; Kinsman Dean & Gregory, 2005; Lauzon Clabo, 2008). I therefore anticipated that ethnography would be an ideal methodological approach for exploring new music therapists' experiences and identifying strategies for the introduction of music therapy posts. I was particularly excited by the possibility of observing ways in which a new music therapist would interact with members of an established health care team. I discussed the idea of an ethnography with the music therapist who was due to commence work two mornings per week. With her support, I set to work on planning an ethnography to explore the introduction of the music therapy service.

After reading previous ethnographies of health care settings (Arber, 2007; Lauzon Clabo, 2008), I decided that it would be advantageous to carry out my ethnography in two phases. In the first exploratory phase, I focused on establishing my role as a researcher within the hospital, developing relationships with hospital staff, and familiarizing myself with the hospital culture and routines. I then moved on to a main observation phase, in which I observed the music therapist's

interactions with hospital staff in various settings. I shadowed the music therapist around the hospital, recorded my observations in a fieldwork journal, and interviewed seven key members of staff involved with the introduction of the music therapy service. Interviews were audio-recorded, transcribed, and analyzed to uncover possible strategies for establishing music therapy services successfully. The aim of my fieldwork was to describe and reflect on the service development strategies that the music therapist used rather than to evaluate whether the music therapist was providing an effective service.

Although ethnographic fieldwork can last much longer (Lauzon Clabo, 2008; Sorensen & Iedema, 2007), I decided on a three month time frame for my fieldwork project. I anticipated this would be sufficient time to uncover important issues in music therapy service development at the hospital. I also perceived that three months was a reasonable length of commitment to ask of the music therapist and achievable within the time constraints of my doctoral studies. The exploratory phase commenced in December 2008, which allowed me the Christmas break to reflect on what I still wished to find out, to consider appropriate times and settings for further observation, and to decide who I wished to interview. The main observation phase then took place in the first two months of the following year.

Developing my role as a researcher

Aware that previous researchers had encountered role issues when undertaking health care ethnographies (Allen, 2004; Borbasi et al., 2005), I devoted time to considering my role as a researcher prior to carrying out my ethnography. I wrote about my intended role in a reflexive journal and discussed possible role dilemmas with my doctoral supervisor. These discussions focused mainly on distinguishing differences between the two roles of researcher and music therapist. I planned to present myself as a researcher more than a therapist and practiced ways that I could avoid getting drawn into clinical music therapy work. This preparation was useful, but it was only once I entered the hospital that my researcher role truly developed. Instead of establishing a singular researcher role, I found myself emphasizing different aspects of myself at different times. I discovered that a certain degree of experimentation was necessary, as situations arose that I had not predicted. As well as managing the roles of researcher and therapist, I also juggled my identities as a colleague, friend, and student. The impact of these various identities will now be explained in more detail.

The researcher

One way that I distinguished myself as a researcher was to avoid situations where patients and families were present. As I was interested in ways that the music therapist interacted with other hospital staff, it was not essential that I attended patients' music therapy sessions. Instead, I accompanied the music therapist to meetings and observed many a "corridor stop" between staff. In meetings I was more of an observer than a participant. I sat quietly, watched interactions, took notes, and attended to research issues such as consent and confidentiality.

Previous authors have indicated that the tasks of gaining consent and assuring confidentiality are not always straightforward when a researcher is using ethnographic methods (Duncombe & Jessop, 2002; Kaiser, 2009; Mitchell & Irvine, 2008). This was also my experience when attending to research responsibilities. To obtain staff members' consent for participation in my research, I gave a short presentation in one of the weekly staff meetings. At this time, I introduced myself and the aims of my research, handed out project information sheets, and asked staff to return consent forms if they were willing to be observed and interviewed. However, I soon

discovered that my initial presentation and handouts were not enough to gain signed consent forms. Staff members were busy meeting the needs of patients and families and had little time to devote to my research. It therefore took patience and persistence to gain signed consent forms. In my reflexive journal, I wrote of balancing the need to progress my research with a desire not to pressure staff to participate in my research. I decided that the best way forward was to gently remind staff of my consent forms in subsequent staff meetings and to keep spare ones in case anyone wished to sign one there and then. I continued to invite questions and concerns and requested that staff approach me if they were ever uncomfortable in my presence. Gaining consent forms from staff took considerable time and remained a concern for the duration of my time at the hospital.

The process of recruitment did not end with a signed consent form, and I learned that I needed to make additional efforts to secure research participation from staff. In the initial exploratory phase, staff appeared welcoming. They greeted me warmly, answered my questions, and accepted invitations to meet. First and foremost, they appeared to value the opportunity to vent their feelings and frustrations about working at the hospital. As I entered the main observation phase, staff seemed to become much more aware of my research aims and more careful in my presence. They queried whether they were “opening up too much,” how the information would be used, and whether the research would affect their professional relationships. These were important questions that challenged me to think more about how I would present my ethnographic findings. It was difficult for me to forecast what my ethnography would reveal, but I tried to reassure staff that I would make efforts to protect their anonymity in my final write-up. I wrote a half-page example of a way in which the research findings could be presented to demonstrate how identities could be changed or disguised. I showed this example to staff when we discussed possible risks of participating in the research and this appeared to alleviate staff members’ concerns. Kaiser (2009) proposed that ongoing discussions such as these are valuable and can lead to the inclusion of important data that otherwise would have gone unpublished.

For most of the time, the researcher role came quite naturally to me, but there were times when I was less comfortable. On one occasion, for example, a nurse introduced me to a colleague we happened to meet in the corridor. On hearing that I was a “PhD researcher,” the nursing colleague stopped, bowed, and then curtseyed. This came as a surprise to me as someone more used to fighting for recognition as a music therapist. I was taken aback and felt embarrassed by the nurse’s expression of reverence. I considered the possibility that I was no longer seen as a “hands-on” clinician and was reminded that the words *PhD* and *researcher* can suggest a position of power and authority. I tried not to take my researcher role for granted and took care to show my appreciation to staff who contributed to my research. Another example occurred as I was sitting quietly in a staff meeting. During a tense discussion between staff members, one of the therapists turned to me and quipped, “Put *that* in your PhD thesis!” This encounter reminded me that I was not observing a “true” unfolding of events but coproducing knowledge through my interactions with staff. Even when I was silent, my presence as a researcher could alter the way that staff members behaved and related.

There were also indications that my role as a researcher influenced the new music therapist’s degree of acceptance in the hospital. The music therapist reported that my presence added legitimacy to her new appointment. In her experience, the presence of a doctoral researcher affiliated with a university and an esteemed health research body reinforced music therapy as a bona fide, evidence-based health profession.

The music therapist

Although my involvement in the clinical work of the ward was minimal, I was not an entirely objective observer. Thoughts came to me as a music therapist with previous experience of working in medical settings. The hospital environment was familiar, and it was difficult for me to withhold my professional opinion in meetings. A couple of times I caught myself joining in on a joke or giving a knowing look when staff described day-to-day challenges. I recognized the demands of working with people experiencing extreme challenges and was affected by the stories I heard and the levels of trauma described. I also found it difficult to let go of an opportunity to educate others about music therapy. One morning a nurse joined my table when I was sitting on my own in the coffee shop. She inquired as to my role at the hospital, and in no time I was giving my best music therapy sales pitch. In the past I had regularly used opportunities like these to promote music therapy and to secure my position as a music therapist in a hospital.

It is likely that my identity as a music therapist enhanced my access to information about issues that affected the introduction of the music therapy service. When attending weekly clinical rounds, I joined a group of predominantly White, middle-class, female health professionals. The medical consultant was usually the only male in the room. As I sat in one of the chairs around a large round table, I felt as though I was indistinguishable from the other members of the team. I, too, was a White, middle-class, female health professional. I imagined that an onlooker would see me as fitting into that scene. Although the team might have welcomed a researcher with a different background, it is possible that my identity as a music therapist eased my acceptance in clinical rounds. In the rounds that I attended, I did not gain a sense that team members were censoring what was said.

In observing the introduction of the music therapy service, I became closely associated with the newly employed music therapist. We shared an office, took coffee breaks together, and often arrived for meetings at the same time. We also dressed alike, in professional attire typical of allied health professionals. It was quite common for hospital staff to refer to us as “the music therapists.” I wondered how this influenced the level to which hospital staff disclosed their authentic impressions of the new music therapy service. Perhaps unsurprisingly, the clinical team had only very positive things to say about the music therapist and the new service she was introducing. I considered the possibility that my close relationship with the music therapist could be viewed as a threat to the credibility of my study. However, the purpose of my ethnography was not to evaluate whether the music therapist was doing a good job. Instead, I intended to describe and reflect on the strategies that the music therapist used to introduce music therapy to an established health care team. I do not believe that my identity as a music therapist affected the degree to which staff members shared the ways in which they had come to understand music therapy as an allied health profession.

Nurse researchers have identified points of intersection between the skills necessary for ethnographic work and those associated with effective nursing practice (Borbasi et al., 2005). These researchers have used their nursing skills to develop fieldwork relationships characterized by “intimacy, self-disclosure, reciprocity, and caring” (Borbasi et al., 2005, p. 495). Likewise, I believe that my training and experience as a music therapist helped me in my ethnographic research. Interviewing hospital staff about their experiences was in some ways similar to my previous music therapy work with older adults. In both situations I used my interpersonal skills to observe, to listen carefully, and to encourage people to tell their stories.

Although I attempted to limit my participation in hospital activities to observation and interviews, I recognized that I was using therapeutic skills when interacting with hospital staff. In interviews, I employed active listening to draw out staff members' perceptions and experiences. I initially viewed my therapeutic skills as an advantage, as staff opened up to me and took up opportunities to voice their feelings and frustrations. Later, when staff began to question how their disclosures would be used, I wondered whether my therapist identity led to confusion about my fieldwork intentions. Conscious of my ethical responsibilities, I decided that it was important to clarify project aims and possible risks of participation. I found that it was necessary to discuss the nature of my fieldwork with staff throughout interactions and as new topics emerged.

A number of qualitative researchers have reflected on the therapeutic potential of research interviews (Birch & Miller, 2000; Dickson-Swift, James, Kippen, & Liamputtong, 2006; Mitchell & Irvine, 2008). Interviewers have observed that interviewees have come to understand their situations in new ways and interviewees have valued opportunities to express their experiences and be heard (Birch & Miller, 2000; Dickson-Swift et al., 2006; Mitchell & Irvine, 2008). At the same time, interviewers have expressed uncertainty as to what they should do when interviewees become emotional or disclose sensitive information. Interviewers without counseling or psychotherapy experience have questioned whether they are equipped to respond appropriately and have recommended redirecting attention from distressing topics, organizing debriefing sessions, or disseminating information about local support services when participants become overwhelmed or upset (Birch & Miller, 2000; Mitchell & Irvine, 2008).

Role reflections by researchers who possess therapeutic training and skills appear to be less common in the literature on ethnography. An exception is a recent paper in which an experienced counselor shared dilemmas which she encountered while developing her role as a qualitative research interviewer (Bulpitt & Martin, 2010). When interviewing a range of mental health professionals, Bulpitt began to question the implications of transferring her counseling skills into the research interview setting. Like me, she was struck by similarities between research interview techniques and therapy techniques such as empathy, nondirective questioning, and silence. While acknowledging that counseling skills could be beneficial to the research process, she suggested that it was important to distinguish between the aims of research and therapy. In her view, both research and therapy can lead to increased understanding and change, but each has a different purpose. The purpose of a research interview is to increase the researcher's intellectual understanding, whereas the aims of therapy are to help the other person and to ease "psychological distress" (p. 11). From this perspective, interviewees help researchers, but in therapy the therapist helps the client. Bulpitt proposed that there is a potential for the researcher to become manipulative and unethical if the roles of "helped" and "helper" become switched. A desire to help others was something that I grappled with repeatedly and will be discussed further in relation to my interactions with the new music therapist.

In the broader literature on ethnography, fieldworkers are encouraged to bring different aspects of themselves to the fore in response to the particular context and the various situations that arise (Castellano, 2007; Mazzei & O'Brien, 2009). Anchoring or distancing one's self from either researcher or participant positions is thought to facilitate greater research access and rapport and to assist the researcher to manage expectations and ethical problems (Castellano, 2007). In my ethnography, I was no longer contributing to the clinical work of the team and hospital staff members were no longer my peers. There were times when it seemed natural to offer the sort of support and advice that I had given to coworkers in the past. However, there were also times when I decided that I needed to establish role boundaries, to make my fieldwork intentions clear,

and to best capture the experiences of staff. I then tried to stand back and avoided aligning myself too closely with the role of a health care professional. In this way, my position altered over time and in response to the particular situations that emerged.

The friend

My relationship with the music therapist was the most challenging to navigate. I had known her previously as a colleague, as she had taught on modules I coordinated at the university where I work. I liked and respected the music therapist and could see similarities between us. As I followed the music therapist around the hospital, I easily fell into her movement patterns and routines. I, too, snatched a conversation with someone in a corridor, rushed to fit in a toilet break, and celebrated when I had enough time to sit down for morning tea. The music therapist's part-time employment at the hospital also meant that we met in intimate settings to discuss my research. We reflected on events at the hospital out of hours in the music therapist's car or home and often while sharing meals. I considered the music therapist to be generous in allowing me to observe the early days of her post and in giving me her time outside of working hours. In this respect, our relationship seemed more like a friendship than a researcher-participant relationship.

Sometimes the music therapist asked for advice regarding the introduction of music therapy and sought reassurance that she was doing "the right thing." I experienced a strong urge to help, possibly because of our close relationship and my training and experience as a music therapist. I wanted to share my ideas but decided to hold back for fear of influencing the natural development of the music therapy service. As I was there to observe how this music therapist introduced music therapy, it did not seem appropriate to give advice about what I thought was necessary. I tried explaining this to the music therapist rather than giving excessive pieces of advice.

The most challenging time occurred when I organized an interview with one of the hospital managers. In the process of setting up the interview, several members of the small health care team became aware of my intention to speak with the manager. Once the interview had taken place, these staff members were curious as to what had been said and asked me to share what I had learned. I was keen to preserve the rapport I had built with these staff and my natural instinct was to want to help them. However, I decided not to disclose information as I had already promised the manager and the ethics committee that I would keep the content of interviews confidential. I then experienced guilt at being unable to help the staff and turned to my supervisor for reassurance and support. In retrospect, I wonder whether I could have avoided the tension I experienced and found a way to keep my appointment with the manager more discreet.

In a chapter on fieldwork and police work, Fielding (2006) stated that "fieldworkers have few gifts to bring" (p. 282). A way in which I discovered I could help the music therapist was to provide administrative and research support. This included sharing knowledge about technology, literature, publishing, and presenting, and was advice that she could have accessed from me at the university regardless of the fieldwork taking place. These gestures were a small way that I could show gratitude to the music therapist for the time and energy she contributed to my research.

At the time, I questioned whether my urge to help was motivated by altruism, a desire to reciprocate, a need to build rapport, or a wish to be liked. I worried that the reason I wanted to help was to relieve my discomfort at taking time and knowledge from the music therapist. I wondered how my actions affected both the music therapist and my research and whether I should have maintained a greater distance. This issue remains largely unresolved for me. Rapport and reciprocity are valued in feminist discussions of research roles and relationships (Borbasi et al., 2005; Dickson-Swift et al., 2006; Duncombe & Jessop, 2000; Mitchell & Irvine, 2008).

However, complicated situations can arise when researchers develop close relationships with interviewees (Duncombe & Jessop, 2000; Mitchell & Irvine, 2008). Duncombe and Jessop reported that the process of building rapport can be “ethically dubious” (p. 112) and can lead to disclosures which are outside the scope of the research. They recommended careful consideration of relationship issues and warned against blurring the boundaries of research and friendship.

A blurring of boundaries was evident toward the end of my ethnography, when I began preparations to leave the hospital. On discussing my imminent departure, the music therapist and I expressed sadness that we would no longer be meeting and sharing meals on a regular basis. The music therapist predicted that she would miss our weekly conversations about occurrences at the hospital. I therefore decided that it was important that the music therapist and I discuss the nature of our ongoing relationship before the fieldwork ended. I offered to keep the music therapist informed as to the progress of my research and she offered to provide updates relevant to the development of the music therapy service. I anticipated that I would e-mail the music therapist during my write-up phase to provide her with an opportunity to comment on the ways in which I represented her work. We also considered the possibility that we would meet at future music therapy meetings and events and have further opportunities to collaborate. Projecting into the future (McGuire & Smeltekop, 1994) is a strategy that I have often used in ending music therapy relationships. I found this strategy helpful to bring my time at the hospital to a close and to distinguish my research role from my ongoing relationship with the music therapist as a colleague.

The student

Tedlock (2000) wrote that “many ethnographers have been able to combine the talents of scholar with those of apprentice” (p. 458). After several years of working as a music therapy lecturer and supervisor, it seemed a little strange to be an apprentice again. In commencing the fieldwork, I acted much like a student on clinical placement, who is getting to know faces, names, and roles, finding her way around, learning the way the ward operates, and keeping out of the way when necessary. I was no longer a confident music therapy practitioner, but instead a novice ethnographer, feeling my way through new experiences. There were many times when I was unsure how to interact with the music therapist and other staff and needed to learn approaches through experience, reflection, and supervision.

The music therapy student experience has been described as a journey in which students develop an understanding of their role and learn to use their interpersonal skills effectively (Wheeler, Shultis, & Polen, 2005). It is expected that students will take time to develop their roles as therapists and to discover approaches that suit the particular setting where the therapy is provided (Wheeler et al., 2005). Liking the fieldwork process to the student journey was helpful to me in coping with feelings of uncertainty. While there may be a degree of shame in being unsure as a qualified music therapist, it is perfectly acceptable to not know everything as a music therapy student. Thinking of myself as a student assisted me to recognize uncertainties as opportunities, to further explore my role, and to gain additional insights about the introduction of music therapy at the hospital. As I became more comfortable with expressing my uncertainties, I was also able to gain more out of my meetings with my doctoral supervisor.

Although my identity as a student felt unsettling at first, it appeared to promote participation from staff. Assuming a stance similar to what previous authors have described as “strategic incompetence” (Lofland, Snow, Anderson, & Lofland, 2006, p. 70) or “becoming a nonexpert” (Castellano, 2007, p. 712) was often advantageous in gaining access to people’s experiences.

When I came from a position of not knowing, staff seemed willing to teach me what they had learned over years of working at the hospital. An inquiring attitude and an interested ear seemed to go a long way in encouraging hospital staff to share their points of view.

Discussion

Developing my role as a researcher was the most demanding aspect of carrying out my ethnography. I discovered that I needed to become much more flexible and responsive than I had been in my previous role as a researcher. In the past, I had carried out experimental research with predetermined procedures and had maintained a relatively distant role. In my ethnography, I needed to develop my role over time and to explore and be aware of my multiple identities. This exploration enabled me to progress my research, to gain research access, to fulfill research responsibilities, and to negotiate a series of complicated interactions.

Returning to the familiar setting of a hospital brought to the fore a set of previously held positions and behaviors. I needed to manage not only the boundary between researcher and music therapist but also the boundaries between researcher and colleague, researcher and friend, and experienced music therapist and student. These boundaries needed to be negotiated and renegotiated throughout the duration of my ethnography. There were times when it was helpful to cross boundaries in order to build rapport and to show appreciation to the staff who contributed to my research. However, there were also times when I needed to establish clear boundaries and to reiterate my research intentions. This was particularly true when ethical issues emerged and when the blurring of boundaries would mean breaking a previous research agreement, as was the case when I was asked to share the content of one of my interviews. The completion of fieldwork was a further time when I perceived that it was important to clarify the boundaries between the research relationship and other forms of collaboration.

As I closely observed the music therapist, I was reminded of the psychotherapeutic concept of projective identification (Clarkson, 2003; Rowan & Jacobs, 2002). In psychotherapy practice, projective identification can occur when a client's feelings evoke similar emotions in the therapist. These emotions are not necessarily perceived as problematic and can assist the therapist to understand the client's experience (Rowan & Jacobs, 2002). In my role as a researcher at the hospital, I regularly experienced feelings and situations parallel to what the music therapist was describing. As the music therapist worked hard to become accepted as part of the clinical team, I, too, worked hard to establish my place as a researcher in the setting. As the music therapist expressed apprehension about ending therapy with one of the patients, I, too, became concerned with closure toward the end of my fieldwork. During a number of our exchanges, the music therapist mentioned experiencing the burden of others' expectations. She hoped that staff members were satisfied with her work after fighting to establish a music therapy service for several years. As a researcher at the hospital, I, too, sensed a weight of expectation. In my conversations with staff, it became evident that some hoped my research would convince hospital management to continue the music therapy service. As my research focused more on learning about a music therapist's start-up experiences than on evaluating the effects of music therapy, I was unable to guarantee this outcome. I worried that staff would be disappointed after being so helpful to me in my research. These responses may have helped me to comprehend what the music therapist was experiencing in her own work. At the same time, it is possible that my awareness of the music therapist's experiences and feelings intensified my reactions to the research process.

It is likely that my training as a music therapist heightened my sensitivity to boundary and relationship issues during my ethnography. The importance of managing boundaries is emphasized in music therapy literature (Dileo, 2000) and music therapy students are taught to maintain a professional distance from clients (Wheeler et al., 2005). The establishment of boundaries is thought to assist music therapy practitioners to avoid inadvertent exploitation of clients, to reduce the risk that they will become burdened by clients' needs, and to meet professional standards of practice (Dileo, 2000). As a clinical placement supervisor I had often helped music therapy students to develop strategies for maintaining a professional role. I therefore experienced reluctance to develop more personal relationships in my fieldwork and was frequently concerned for the well-being of hospital staff. Ethnographers with similar therapy training might be equally sensitive to boundary issues and might require strategies to consider whether close relationships are harmful or helpful to fieldwork participants. Additionally, therapeutic terminology and concepts may be helpful to other health care ethnographers who are negotiating complex roles and relationships.

In the course of my ethnography, I used a number of strategies to develop my role, to explore multiple identities, and to manage my responses to the work. These included reflexive journaling, research supervision, and ongoing negotiation of my relationships with hospital staff. Although I did not set out to explore a particularly sensitive topic, I still experienced anxiety as to how to interact with the staff who participated in my research. Despite my familiarity with the hospital context, unforeseen circumstances inevitable arose, and there were times when I was uncertain how to respond. Ethical considerations remained a dominant concern throughout the course of my ethnography. It was therefore essential that I take the time to express my uncertainties, to consider alternative approaches, and to gain emotional support. Writing down my responses and meeting with an experienced music therapy clinician and researcher were particularly helpful to me in this regard. Previous authors have also recommended that qualitative researchers put in place strategies for the management of research relationships and boundaries (Arber, 2006; Dickson-Swift et al., 2006).

When I carried out my ethnography, it was not my intention to be an independent, objective observer. Instead, I planned to come into close contact with my research topic and to cocreate knowledge with hospital staff. I did not expect to uncover truths about music therapy service development but hoped to coproduce a set of findings that were convincing and credible. I believe that my exploration of multiple identities added a layer of complexity to the research that would not have been possible otherwise. Paying attention to my emotional responses as a researcher, music therapist, friend, and student deepened my insights and enhanced my understanding of issues in music therapy service development. This process helped me to develop rich findings that I hope will resonate with music therapists who read my research. Furthermore, by elaborating on my multiple identities in the writing up of my research, I can show how my interpretations were informed by my individual perspectives. Readers will then be able to judge whether my interpretations are credible.

Conclusions and recommendations

An experienced health care professional might possess multiple identities when returning to a hospital as an ethnographer. An ethnographer might interact with hospital staff in familiar ways or develop new roles and relationships as the research unfolds. Although ethnographers are encouraged to consider their roles prior to commencing fieldwork, in my experience suitable positions can only be determined through interaction with fieldwork participants. It is only over time that ethnographers can develop relationships to suit the particular hospital context and

further their understanding about the cultures that exist. Health care ethnographers should not expect to establish a fixed role in their fieldwork. Instead, they should plan to remain flexible, to experiment with different aspects of themselves, and to make situation-specific decisions.

The practice of ethnography can be daunting for health care researchers with experience of methodologies with predetermined procedures. Although role flexibility can seem unsettling, it is through trial and error that new insights are gained and previous assumptions are tested. Novice ethnographers should acknowledge that it is impossible to be fully prepared for each and every research encounter and put in place strategies to address uncertainty, such as reflexive journaling and supervision. By remaining thoughtful, responsive, and open to opportunities, novice ethnographers can successfully manage ethical responsibilities and further our knowledge about complex health care cultures.

Notes

1. In literature on ethnography, the terms *role* and *identity* are often used interchangeably. In this article the term *role* refers to the part I was taking on as an ethnographic researcher. The term *identity* is used when referring to the different aspects of myself that shaped the research process. This reflects a contextual view of identity, in which people are thought to choose from a variety of identities “depending on the matter in hand” (Bruce & Yearley, 2006, p. 144).
2. The term *boundary* is used in the therapy professions to refer to a distance between persons or to make a distinction between separate identities or roles (Dileo, 2000; Dickson-Swift et al., 2006). In practice, therapists are required to manage the boundaries between the roles of therapist and client and to distinguish between therapist-client relationships and more personal forms of interaction. An understanding of boundary issues is thought to protect both the client and the therapist and is considered crucial for ethical practice in music therapy (Dileo, 2000).

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