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Therapeutic narrative analysis: A methodological proposal for the interpretation of music therapy traces

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Abstract

We can begin to understand the process of therapy by looking directly at what happens in the therapy using material from therapeutic sessions. We have used the word "traces" here as a general term referring to the material left behind as an indicator that something has happened. These traces are empirical data. How these events are described and interpreted as therapeutic process is the stuff of methodology. The interpretative process in qualitative research is referred to as hermeneutics.What we have in this paper is a suitable methodology for eliciting understandings and how such understandings are constructed.

In the process of interpretation there are varying stages of abstraction, and we use differing sets of meanings. By combining a constructivist approach with a communications perspective, meanings are chained together to understand the therapeutic process. This is form of narrative analysis applied to the therapeutic process that we call "Therapeutic Narrative Analysis".

In this paper we intend to present a way of analysing the various traces that we have before us as creative arts therapy researchers, albeit from the perspective of music therapy research. We are using the word trace here to describe either a piece of written material, a transcription or a case report, a musical score, or a taped recording. It could as well be a picture, a series of photographs or videotaped material and may include quantitative material. In laboratory settings these traces would be samples of blood or print-outs from a machine combined with hospital notes and questionnaire scores. These traces must be interpreted, they mean something within a system of meanings.

The difficulty facing most of us in our clinical work is how to analyse the piece of work that we have before us using a systematic procedure that has therapeutic and clinical validity, and that remains true to the art medium itself. If we wish to discover how a particular creative art therapy works, then it is of paramount importance to maintain a focus on the work using the material traces of that work. What we need to develop is a means of discerning at what level we are describing, or interpreting, the traces before us. We will also present

a method for analysing trace texts suitable for music therapy research that is not bound to any particular music therapy orientation and that can be applied to other creative therapy orientations. Thus for music therapy research we may use recordings, transcriptions as musical scores, transcriptions from interviews as texts, and some may indeed use drawings. In this sense, the method proposed in this paper is retrospective although the approach can be used prospectively.

In other contexts we have written of health as narrative performance (Aldridge 2000) and in this paper we present a research method that we now call "Therapeutic Narrative Analysis". It is intended as a method for the creative arts therapies and has been developed from previous writings about therapy (Aldridge 1985; Aldridge 1988; Aldridge 1990; Aldridge 1992b; Aldridge 1996; Aldridge 1999; Aldridge and Pietroni 1987; Aldridge and Rossiter 1983), and from working with doctoral students during their various methodological quests (Aldridge 1998b; Pilz 1999).

It is a *flexible* form of research design, and may include quantitative data. At its heart it is *hermeneutic*; it is based on understanding the meaning of what happens to us in the process of therapy and how we make sense of the world . We refer here to "us"; researchers, therapists and patients. The choice of the term flexible design is used here as the tiresome debate about quantitative / qualitative methods has been superseded with the terms "fixed" and "flexible" much more applicable to clinical practice researching (Robson 2002). In this way we can include quantitative data alongside qualitative material.

I have chosen to use *narrative* here as this is a broad concept well-suited to research in the creative arts therapies. Central to the narrative methodology presented is the idea of *episodes* (Aldridge 1999; Harre and Secord 1971). An episode is an event, incident or sequence of events that forms part of a narrative. Taken from the Greek epi = in addition and eisodios = coming in, we have the notion that it is something that is added along the way (eis = in and hodos = way, road or manner). Thus therapeutic narratives are composed of episodes, and it is episodes that we will consider as the basic units for our research methodology. Narrative will be the story that brings these episodes together. In this way we can use a variety of textual materials; written reports, spoken stories, visual media, recorded materials and musical material in the telling of the story. The research part is the analysis of those materials that bring forth new therapeutic understandings; hence, Therapeutic Narrative Analysis.

The process of interpretation

What I want to emphasise in this first section is that we move from the phenomena of the music therapy experience itself through a series of abstractions that are, by their very nature as abstractions, removed from that very initial experience. Such abstraction is inevitable as soon as we try to explain the situation in which we are acting. It is important to know the level at which we are working such that we can begin to understand the various terms and descriptions that are being used. If I were to play you a recording taken from a music therapy session, you would hear in the extract of music that I play an experience that is at one-step removed from the original session. It is tape-recorded and has thereby lost some qualities, although

within the limits of recording fidelity it stays true to the original experience. It is still auditory and in the realm of music. Using the word "music" has already made a statement about the sounds that we have heard. Even attributing the term music to the experience has separated it from random sounds or organised noise. We are in effect making the statement "Construe these sounds you have hear as *music*", and we can also add that "This *music* is in the context of music therapy". Knowing the context is necessary for defining events.

In the second part of the paper we will demonstrate a method of describing how therapeutic understandings of events can be transcribed as if they were rules of process. This is an attempt to generate expert knowledge from practice. It is important to emphasize that there really are no such "rules", or a "rule book in the head". Our intention is to act "as if" there are rules and to see what understandings are gleaned from trying to re-construct our therapeutic actions. Events are inevitably linked together when we describe what we do. "What happened next" is at the centre of the story-teller's art and is also crucial to the therapeutic plot. Formally expressed in other systems of understanding, it is concerned with therapeutic outcome and an expression of what happened at "follow-up". It is the basic method that we used in studies of family narratives(Aldridge 1985; Aldridge 1998a) and the development of melody (Aldridge 1998b). In this way or working we are not simply concerned with what happened but also how "it" happened, and the happenings on the way.

When we chain understandings together to make a story or a case history, then we are composing a narrative account. When we begin to try and understand such narrative accounts then we are using a *hermeneutic* method of therapeutic narrative analysis.

Therapeutic Narrative Analysis as process.

As an introduction we offer an overview of phases in the research process. These phases will be elaborated later in the paper:

Phase 1 Identify the narrative

Gather the material together that will form the narrative. This may be a case study, or it may be a series of case studies. It is the story that you wish to tell.

Phase 2 Define the ecology of ideas and settings

Explicate the theoretical ideas present in the literature or from your own standpoint. This is the initial locating of the research context in the wider perspective of current knowledge (Context 1). While this may appear as a literature review, the intention is not to give an exhaustive account of all possible papers but to locate the study in an ecology of ideas. It may well be that this enfolding of the study into literature contexts will occur throughout the study. Indeed, when we study, we read and collect new material. Similarly, at the end of a study we are challenged to put our new findings into either a new theoretical construct or place it within an established landscape of thought.

Define the setting in which the narrative occurred. This will include details of the place of practice, the demographic details of those involved and may include historical details (Context 2). Contexts 1 and 2 are ecological explanations; the subjects of the researching are placed in an ecology of ideas, times and situations (Aldridge 1985; Aldridge 1992a; Aldridge 1998a; Bateson 1972; Bateson 1978).

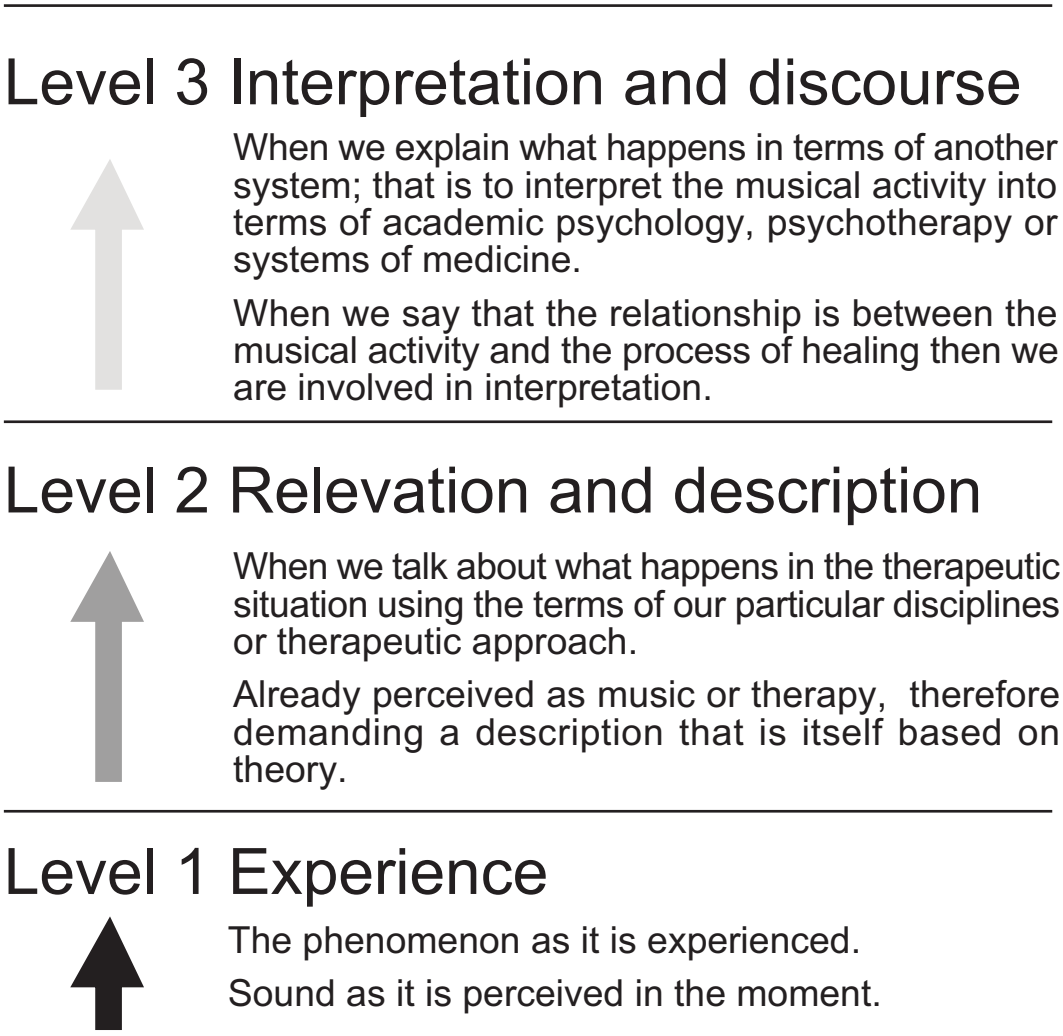

Figure 1: levels of interpretation

Phase 3 identify the episodes and generate categories.

Identify episodes that are crucial for analysis. This is inevitably a subjective process but this process can be validated by giving the material to colleagues to see if they identify the same episodes. When we collect a wealth of case study material, we cannot often analyse it all. There has to be a discriminatory choice of what we will focus upon.

Generate a set of constructs from that episodic material and identify categories for analysis.

Phase 4 Submit the episodes to analysis.

The episodes are the analysed according to their contents using the guiding framework of the constructs. At this stage it is possible to use a regulative rules based hypothesis.

It is also possible to submit episodes for categorical confirmation to colleagues (see the work from a former doctoral student of mine Pilz 1999) as a way to validate clinical concepts from systematic observations (Eisler, Szmulker, and Dare

1985).

Phase 5 Explicate the research narrative.

This is the completed narrative based on the understandings gleaned from the analysis of the episodes. We weave together the categories of understandings from the previous phases and is the process of synthesis following analysis.

Getting at knowledge

One of the tasks of the researcher in a qualitative approach is to make tacit knowledge, as a therapist, available as a propositional knowledge. The purpose of some research is indeed to find out what we know. A conversational paradigm is used here to draw out how researchers understand their own work, and elicit the structure of those understandings that are not immediately apparent in everyday life. From this perspective such work is hermeneutic; that is, it is concerned with the significance of human understandings and their interpretation.

A strength of qualitative research is that it concerns itself with interpretation. It is hermeneutic (Moustakas 1990), and therefore has a resonance with the very processes involved in music therapy as the therapist tries to understand his, or her, patient. It is important to note here that I am working from the premise that therapists invest their practice with an element of deep personal meaning. As the music semiologist Nattiez himself remarks, "*The musicologists persona is present behind his or her own discourse*" (Nattiez 1990) (p210).

It is also important to emphasise that talking about therapy is always at several steps removed from the actual activity in which we partake. Dancing, painting, singing, acting, doing therapy are different activities to talking about dancing, talking about singing, talking about painting and talking about doing therapy.

We need to emphasise that there are also different levels of interpretation as we see in Figure 1 (see also Aldridge 1996).

Level 1. Experience. Here we have the phenomenon as it is experienced. This is what transpires in the therapy session. It lives and exists in the moment, and is only partially understood. It cannot be wholly reported. We can see, feel, smell, taste and hear what is happening. These are the individual expressive acts themselves as they are performed, painted or posed. We can capture these events onto a medium like videotape or audiotape, although these moments too are "interpreted" through the use of the medium. We can take only a limited perspective from a camera angle, through the orientation of a microphone, and there is always a loss no matter how good the equipment is.

These are the raw data of our experience in practice before we begin to reflect upon them.

Level 2. Revelation and description.

We can talk about what happens in the therapeutic situation in the particular terms of our artistic disciplines. These descriptions are accessible to verification and they emerge into conscious with lexical labels. For example, we can talk about the particular notes and rhythms in music therapy and the particular colours and patterns in art. We play our recorded tapes or show our pictures and describe with words what has happened. This is

the shared element of language that is available for systematic study and is part of our common everyday discourse and is what Nattiez (1990) would regard as the trace or the neutral level of understanding. Whereas level 1 would be "sounds", this level 2 is already perceived as music, therefore demanding a description, which is itself based on a theory implicit to the listener. When we begin to score the music that we include in our narratives, the very process of scoring is an interpretation, the choice of symbols and time divisions, particularly related to improvisation, is an interpretation and belongs to a cultural context.

Level 3. Interpretation and discourse.

When we come to explain what happens in terms of another system, i.e. to transpose the musical changes into terms of academic psychology, psychotherapy or a system of medicine, or to say what the relationship between the activity is and the process of healing then we are involved in interpretation. For the musicologist Nattiez (1990), this would be the level at which poiesis and esthesis take place; that is, conclusions are drawn about the music. At this level, we make interpretations of what is happening in the therapy; what the activities of therapist and patient mean. In a current climate of evidence-based medicine, we are being challenged to demonstrate that changes occur. However, what many of us have asked in our research over the years is not just what changes occur but what do those changes mean to the sufferer and the practitioner. Consider the dying patient suffering form intractable pain as a consequence of advanced cancer who, when asked by her physician after a music therapy session, reports " I am in Beauty". This demands interpretation and is significant for the patients, and as it turns out for the well-being of her family and friends. But it would not appear on a questionnaire. The medical outcome was negative, the patient died shortly afterwards. The existential outcome was positive and requires another form of research evidence.

A shared language

At the level of performance, what passes in the therapeutic session exists for itself. However, as therapists working together with patients we do need to talk to each other about what happens and what we do. We also need to talk with our patients about what has happened and understand how they make sense of the therapy. Knowing at which level we are talking will aid our discussion and prevent confusion. My contention is that we can need to find a basic shared language at Level 2*,* which is based upon descriptions of the artistic process, yet not too far removed from the activity of therapy itself. This is the level where personal construings emerge as revelations, where we put a name to what is going on. It is a level of description. By doing so, we can then discern when the therapeutic process is being described at level 3, i.e. that of interpretation and inference. At this level we begin to find commonalities between individual discourses and these are the languages of the therapeutic discourses that we are trained in. This is a step forward on the road to establishing the meaning of events in clinical practice. There may indeed be further levels of interpretation. Take for example the various schools of psychoanalytic therapy, or the different humanistic approaches; each will have a varying interpretation system that may

	Analytical situations after Nattiez	**Music therapy interpretations** The music therapy session	**Constitutive and regulative rules** **Constitutive rules** **Level 1** the sounds themselves, the experience as itself, the performance as phenomena
I	Immanent analysis, neutral ground of the music, the physical corpus being studied, the trace	the score as a description of musical events	**Level 2** revelation and description descriptions of what happens in the therapeutic situation
II	Inductive poietics	the music therapy index of events	
III	External poietics	clinical reports from other practitioners, drawings from art therapists	
IV	Inductive esthesics	music therapy meanings, interpretations of therapeutic significance	**Level 3** interpretation and discourse relationship between the musical or clinical activity and the system of interpretations
V	External esthesics	sampling methods from psychology or expert assessment of chosen episodes as part of a research methodology	
VI	A complex immanent analysis relating the neutral ground of the music to both the poietic and the esthesic	therapeutic interpretation from a fixed point but intuitively used in the therapeutic explanation	**Regulative rules**

Figure 2: The relationships between Nattiez's analytic situations, music therapy interpretations and constitutive and regulative rules.

find some commonality at a meta-level of interpretation.This is not confined solely to qualitative research; clinical reports, assessment using standardised questionnaires and reference to statistics are formal systems of interpretation.

Nattiez (1990, p140-142) gives examples of varying relationships between the description of the music and the interpretations of meaning that those description hold for the researcher. These relationships can be translated into the music therapy situation, and the music therapy research approach. In Figure 2 we see in situations III and V the inclusion of external interpretations of the therapeutic events that will include more than the music itself.

Note that Nattiez, as a musicologist, is willing to include in an analysis more than the musical events themselves. We have a similar situation in music therapy in clinical settings where not only is the music available as a tape recording (situation I) enhanced by a commentary form the therapist (situation II), but there are also clinical reports available from other practitioners (III). What significance those descriptions and interpretations have for practice will then be assumed under situation IV and V, inductive and external esthesics.

Personal construct theory

The personal construct theory of George Kelly (Kelly 1955), and the repertory grid method that is allied to it, were designed specifically to elicit such systems of meaning. This approach does not concern itself with identifying a normative pattern, rather it makes explicit idiosyncratic meanings. However, while each set of meanings is personal, and therefore unique, there is built into the theory awareness that we live in shared cultures and that we can share experiences and meanings with others. The personal construct theory method allows us to make our understandings, our construings, of the world clear to others such that we can identify shared meanings. As Kelly (1955) devised this conversational method for teaching situations, counselling and therapy, we can see the potential relevance for the creative arts therapies and for supervision. Indeed, Kelly discusses human beings as having a scientific approach. He proposes that we develop ideas about the world as hypotheses and then test them out in practice. According to the experiences we have, we then revise our hypotheses in the light of what has happened. Our experiences shape, and are shaped by, our construings. Each situation offers the potential for an alternative construction of reality. The personal construct approach allows us to elicit meanings about specific natural settings as we have experienced, or can imagine, them.

The important factor in this method is that it allows the therapist to stay close to his or her practice and use the appropriate language related to that practice. What it offers is a means of validating subjectivity, we see how the therapist, as researcher, is basing his language in experience. Furthermore, it challenges the researcher to understand that descriptions are not neutral, and to understand the transition from description to interpretation.

Qualitative methods, and particularly, those proposed by Lincoln and Guba (Guba and Lincoln 1989; Lincoln and Guba 1985), present themselves as being constructivist. Therefore, there should be a historical link with Kelly's personal construct theory. However, nowhere in any of the major books related to qualitative research cited above do we find any

reference to Kelly. It is only in Moustakas (Moustakas 1990) that we find a reference to Kelly in terms of "immersion" where, during the collection of research data, the researcher as "subject" is asked what he or she thinks is being done. While some commentators have found Kelly to be rather cognitive in his approach, this may be due to the way in which he is taught. A reading of Kelly himself stresses the application of beliefs about the world in practice, and that the words that are used to identify constructs are NOT the constructs themselves. He argues that we each of us have a personal belief system by which we actively interpret the world. We create and change the world along with our theories. While we may be charged with bringing those beliefs into the realm of words and conscious expression, it does not mean to say that those beliefs are verbal, or necessarily conscious. This is an important point for the music therapist who is often asked to translate his musical experiences and understandings into the realm of verbal expression. Knowing that some slippage occurs between these realms is an important stage in our understanding.

Making clear constructions of the world is important for establishing credibility. We can see how the world is constructed. The therapist can reflect upon her own construction of the world of clinical practice. Such understandings are discovered when we talk to each other, sometimes called the "conversational paradigm" (Thomas and Harri-Augstein 1985). Each person has their own set of personal meanings that can be communicated, but these meanings can be shared with another person. In this way of working, the personal construing of the world is primary in evaluating the world and leans towards the narrative methods of qualitative research. Sharing those meanings with others must be negotiated and is, therefore, a social activity. To establish our credibility and trustworthiness as researchers, then we need to make explicit our understandings of the world in some form or other. The repertory grid approach is one such way of eliciting and presenting such understandings as a formal process or method.

THE PROCESS

Phase 1 is where the materials to be studied together are gathered together. Narratives have a structure, there are themes and plots that are played out in scenes and vignettes. This is where we gather together the stuff of our story following the definition of our research question. In the tradition of qualitative research, this may be a stage in the process that is re-iterated. We may find as the story unfolds that other scenes need to be included. It is a stage of focussing effort and gathering together the case material to be used. The selection of material may also be influenced by Phase 2.

In **Phase 2** we locate our narrative amongst the other stories being told. It is a contextual act where we locate the story in a particular culture of stories. Indeed, we may ask our readers to consider the therapeutic narrative from a particular methodological perspective; as ethnomethodology for example, or as ethnomusicology. Or we may locate that narrative in a theoretical framework like the traditions of psychotherapy and medicine. Others may want to base their stories in concrete data traces drawing from published literature. This phase is where the content of the study is placed into context.

In considering influential theories, these too may influence the choice of case material. This is a process of theoretical sampling NOT random sampling. What is being presented here is a retrospective method.

Phase 3 brings us to the stage of identifying the categories inherent in what we have collected together. It is a major step of abstraction. From the material that we have before us we need to select episodes that illustrate our focus of interest. This approach is a conceptual method and depends upon the researcher's ability to identify abstract categories. Abstraction, like interpretation, is a process, often invisible to the researcher, and itself based in a discourse. What we are looking for is recurrent patterns within the material, and then, as Bateson (1978) suggests, the pattern that connects.

We have to identify episodes and then, elicit constructs from those episodes to define the categories for interpretation of the material.

Selection of episodes as punctuation

Social scientists have become interested in the way in which we select meaningful patterns of behaviour from the ceaseless stream of events occurring in daily life. This selective structuring has been referred to as *punctuation* (Bateson 1972). To an outside observer, a series of communications can be viewed as an uninterrupted sequence of interchanges but the participants themselves may introduce episodes of interchange which for them has clear beginnings and endings. Punctuation is seen as organizing behavioural events and is vital to interaction. Culturally we share many conventions of punctuation that serve to organize common and important interactional transactions. We observe this when someone says "*He started the argument*" or "*It first began when her work ended*".

The punctuation of events occurs as episodes that we identify. Harre and Secord (Harre and Secord 1971) define an episode as "*any part of human life, involving one or more people, in which some internal structure can be determined*" (p153). Although imprecise, this definition offers a tool for considering behaviour in that behaviour is located interpersonally and structured (Pearce, Cronen, and Conklin 1979). Episodes can be described in ways that represent the process of construing, and that construing can occur at differing levels of meaning (Aldridge 1999).

The punctuation of events into episodes serves the same function as phrasing in musical time. We organise time to make sense in terms of the performed activity. Thus, if we are looking at videotaped material for examples of interaction with a particular quality , we will identify when that interaction begins and when it ends. We may of course identify differing *categories* of episode. How we choose to label those episodes is also a matter of construing.

Personally, episodes can be seen as patterns of meanings and behaviours in the minds of individuals. This is a privatised meaning that represents an individuals understanding of the forms of social interaction in which she is participating, or wishes to participate. In a study by Parker (Parker 1981), girls deliberately harming themselves describe what they do as similar to being alone and crying or getting drunk. This construing is quite different to a medical perspective that sees the activity as manipulative or as a cry for help.

Relationally, episodes may be construed

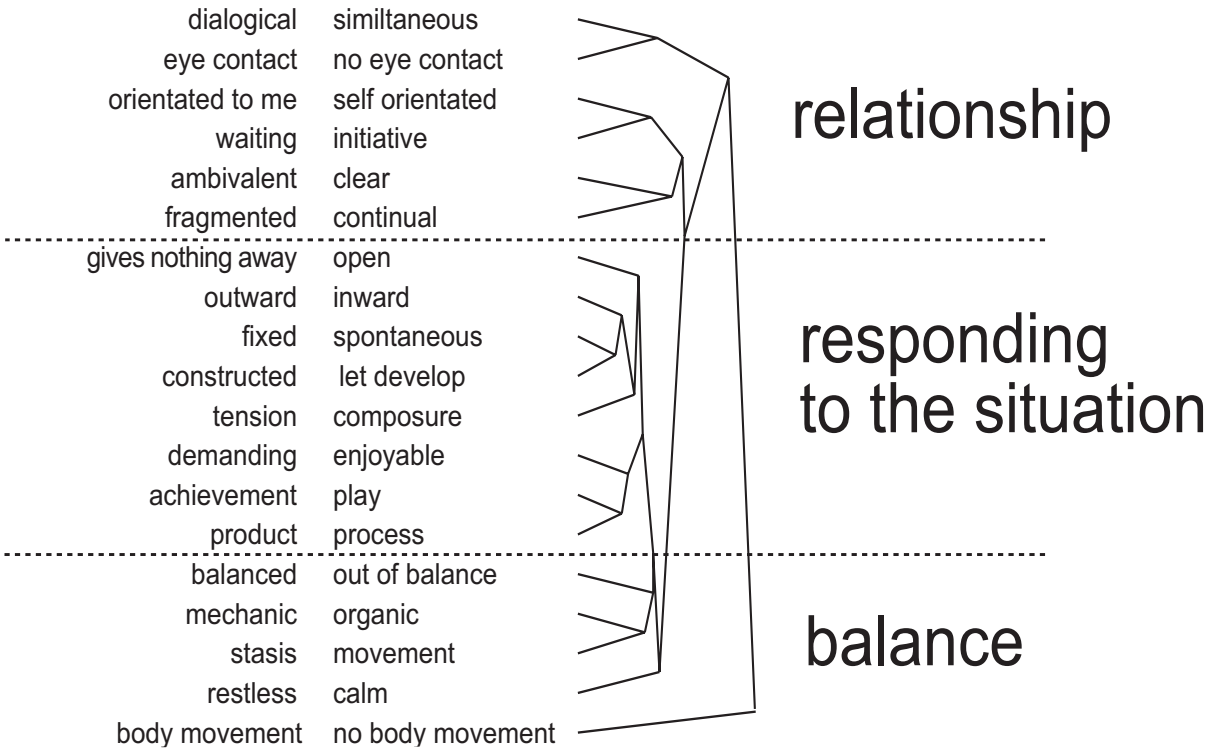

Figure 3: A Focus grid analysis of a therapists construing of adult clients

as common patterns of actions that assume a reciprocal perspective (Aldridge and Dallos 1986; Dallos and Aldridge 1987). Such construings are developed through interaction, In the way that people live and play together they co-ordinate an understanding of what experience means. In therapy, when people are used to playing music together, they begin to construe their musical playing mutually. Note that this mutual construing is musical, it is not necessarily verbal. Our challenge is to convert this musical construing of events into a lexical realm if we want to write about it. The basis of the research material will be audiotape or videotape material.

Culturally episodes are patterns of meanings and behaviours that are culturally sanctioned and that exist independently of any particular individual meaning. This is perhaps best seen by the "*cry for help*" notion of distress. Such construings reflect the concept of significant symbols described by Mead (Mead 1934) that reflect public shared meanings. We would see such cultural construings in the way in which rituals such as marriages and funerals are understood, and ritualized ways of dealing with social events such as greetings, deference and leaving (Geertz 1957). These are seen in music therapy as formalized and ritualized greeting and leaving songs.

Eliciting constructs

The first step in this narrative analysis approach is to identify the episodes. The second step is to identify those episodes with names and then to compare those episodes and elicit constructs (see Aldridge 1996).

An advantage of this way of working, as Kelly himself proposed, is that it elicits

verbal labels for constructs that may be pre-verbal. In terms of a researcher's understanding, and bias, the explications from a musico-therapeutic realm of experience into a verbal realm may be of benefit for practice, supervision and research (Aldridge and Aldridge 1996). The verbalization of musical experiences is one step on the way to establishing credibility by getting the practitioner to say what he or she means in his or her own words. However, the strength of this approach is that the basis is the practice and that can be a non-verbal musical trace.

An example from practice

A colleague working with patients is interested in understanding the process of their joint musical playing. He is asked to select episodes as examples that he believes in some way are important in understanding what is happening. He selects thirteen episodes of varying length from his videotapes of sessions and gives those episodes names. the names already are worded around a generalised impression that he has of the content. The names are not restricted to one word, as you will see they may be a phrase such as "Swing in my brain".

We the elicit constructs by considering three of the selected episodes and asking how one episode is different from the other two, and what makes the other two similar. Constructs are assumed to be bi-polar; for example "outward-inward" is a construct of response with "outward" at one pole and "inward" at the opposite pole (see Figure 3).

There are two principal forms of data analysis and presentation. One is in the form of a principal components analysis that shows a spatial conceptual structure of the data (see Figure 4). The other is in the form of a focus analysis that shows an hierarchical conceptual structure of the constructs (as we have seen in Figure 3). Each can be displayed graphically. Both displays offer ways of presenting the data for further analysis. The discussion of the presented data is a part of the technique. It is not a finished analysis in terms of unequivocal results. Like all methods of research, the results demand interpretation.

The clinician is then asked if this presentation makes any sense to him and any interpretations are noted. It is important to note here that the construings and their interpretations are always made in the words used by the therapist. An advantage of this method is that a phrase can also be used to represent the pole of a construct; for example, "gives nothing away" (Figure 3).

The supervisor or consultant can then also suggest the patterns that she recognizes within the data that make sense for her too. This negotiating of a common sense is a part of the supervisory activity and the ground for establishing validity in a qualitative paradigm. As we see in Figure 3, it is possible to bundle the constructs together to form categories that are then labelled as "relationship", "responding to the situation" and "balance".

The computational analysis takes the values of the construct as they are assigned to the elements as if they represented points in space. The dimensions of that space are determined by the number of elements involved. The purpose of the analysis is to determine the relationship between the constructs as defined by the elemental space. The

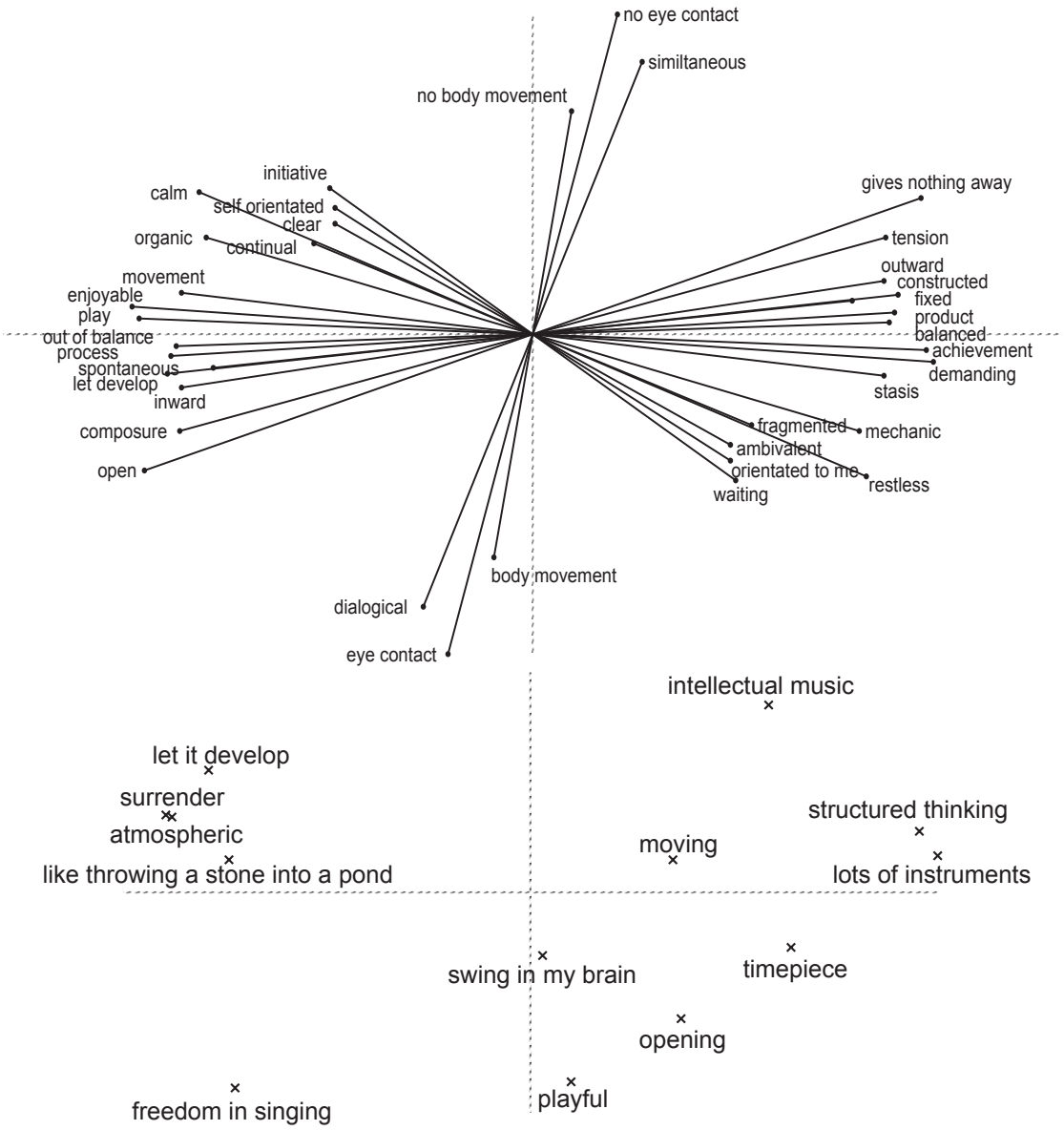

Figure 4: A principal components analysis of a therapists construing of episodes with the constructs arranged above and the elements arranged below but using the same axes.

computation is looking for patterns in the data and organises the constructs and elements until patterns are found. This is termed cluster analysis, in that cluster of similar data are organised together. What we see is how similar the constructs are when they are plotted in space. Two constructs that appear close together may be being used in the same way. Other constructs may not be equivalent and will effect the whole of the data as a constellation. Indeed, the principal components analysis of the data presents such a stellar appearance (see Figure 4). Here the two principal components of the data are used as axes onto which the constructs are projected. This allows the researcher to gauge the major dimensions

on which the experiences of clients are being construed. These two axes appear as horizontal and vertical dotted lines in the figures. We see how balanced-out of balance and play- achievement are located along this horizontal play/balance axis, while eye-contact, body movement and dialogue are constructs aligned near to the vertical axis. the task is then to put these constructs together as a concept by asking the therapist what these could mean when considered as a concept.

The Focus analysis structures constructs and elements that are closest together in the dimensional space into a linear order. These are then sorted into matching rated scores and mapped according to their similarity (as percentages). Clusters of constructs are then computed by selecting the most similar ratings and presented as an hierarchical tree diagram that shows the linkages between groups of constructs (see Figure 3). In the figures, similar constructs are arranged together so that we have a visual display, albeit two-dimensional, of how meanings are linked together.

The results of both forms of analyses are then discussed to see what sense emerges from the analysis. At this stage the researcher is encouraged to find labels for construct groupings and these labels themselves represent constructs at a greater level of abstraction. These labels are a step in finding categories for use in analysing case material in qualitative research. There are analogies here with the process of category generation in grounded theory methods and are based on empirical data. For phenomenological research, such categories, once they have been articulated in this way, could be bracketed out of the analysis.

Phase 4 is the stage where the episodes are analysed in terms of the constructs and the overarching categories that have been generated. At this stage it is possible to use a more dynamic understanding based upon constitutive and regulative rules (Aldridge 1985; Aldridge 1992a; Aldridge 1996; Aldridge and Aldridge 1996; Aldridge 1998b).

Meaning and its consequences, the dynamics of understanding

However, while we may find out how the world is constructed by the therapist, we also need to know are the consequences of that meaning. We know the ”what” of meaning. We can understand what this means to the therapist. “What happens next” is the appropriate question to ask. Given that we know how a therapists construes a therapeutic event, what does he or she do about is also a vital piece of knowledge. Further more, in the process of therapy, we also need to know what the patient will do next and also interpret what that means. Thus we have a chain of understandings and actions from the perspective of the therapist and the patient. Of course, these interactive understandings are dynamic, they change during the play. In some way, this is at the heart of therapy, while being rule based, what will happen is not fixed, there is always the possibility of something new happening.

Construings and interpretations at different levels can be woven together to formalise a clinical narrative. Such clinical narratives are constructed and based upon rules of interpretation and play.

Rules for the making of sense

Understanding levels of description and interpretation may not be enough in itself. A critic of the construct approach is that

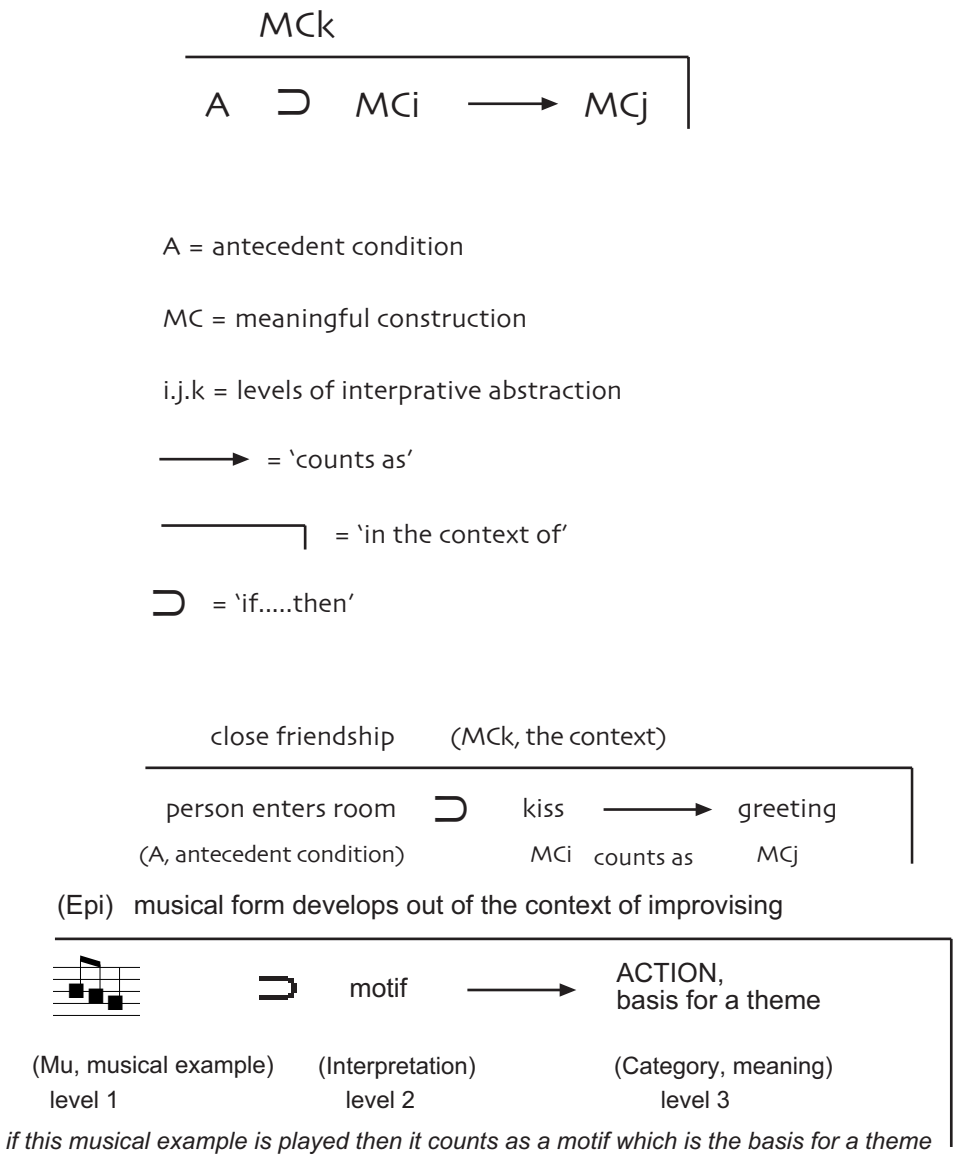

Figure 5: A formula for constructing a constitutive rule and two examples.

it is rather static, a vertical understanding of events leading to descriptions and interpretations, yet it does not bring that dynamic horizontal level of linking in time that music has; that is, performance. In trying to make sense of what people do, we can look at how they construct those understandings in a vertical sense, which is seen in levels 1, 2 and 3, based on a constructivist perspective. But, we can also see how sense is actively made by linking those construings in an horizontal form. An everyday example of this is when we question someone about why they have done something (reasons) and then ask them what they did next (action). We seek an understanding, and then we want to know what the consequent action was. A formalised approach can be made in terms of constitutive and regulative

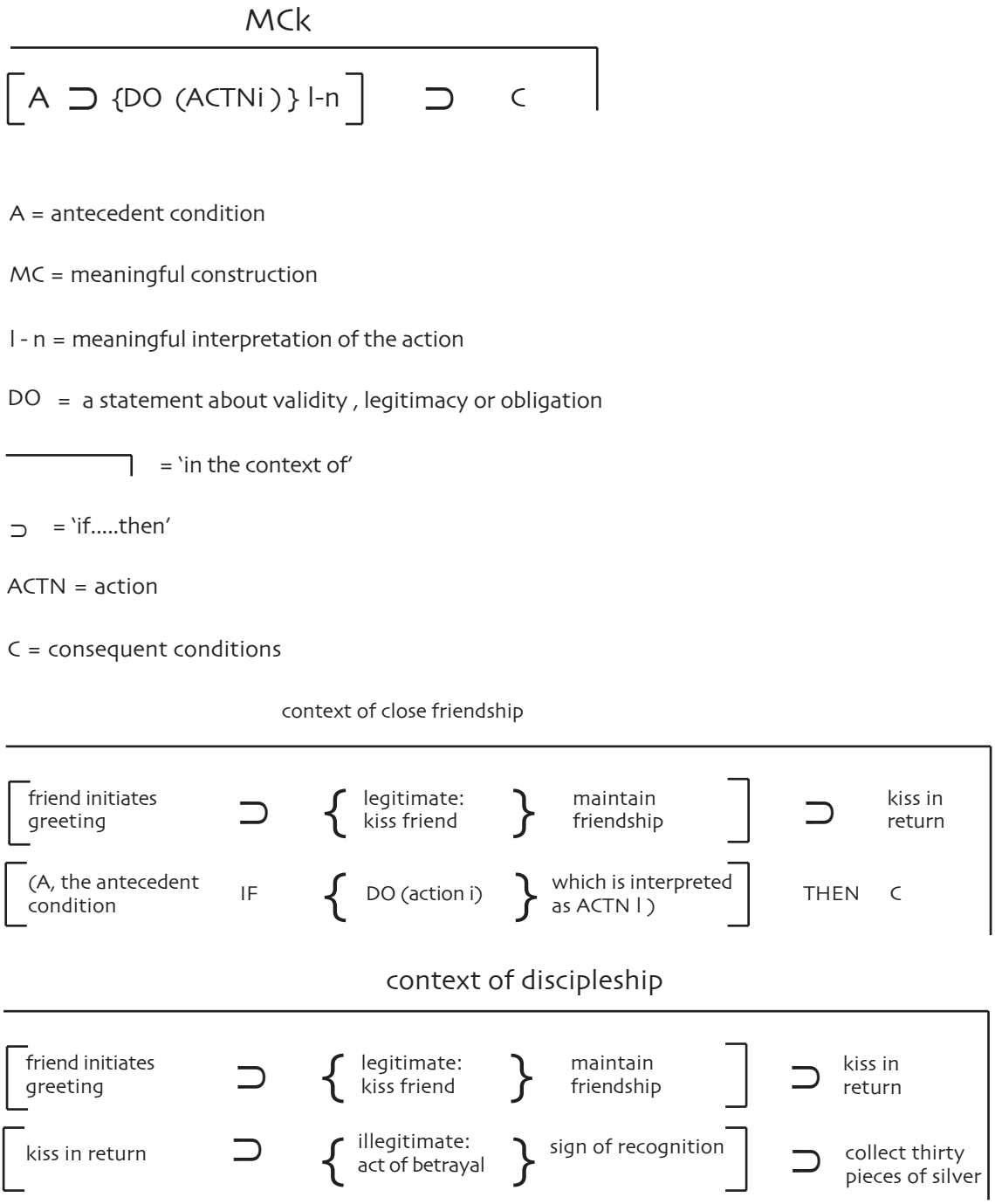

Figure 6: A formula for constructing a regulative rule, and examples

rules based upon personal construings (Aldridge 1999).

A number of authors suggest that 'making sense ' is rule based (Harre and Secord 1971; Pearce et al. 1979). These rules can be separated into two forms. One, there are rules of constitution. Two, there are rules of regulation (see Figures 5 and 6).

A constitutive rule would be invoked when, in the context of a close relationship, a

TEXT	CONSTRUCTS
A prominent feature of the way in which these patients play music is that they appear to have **no personal connection** with what they are playing.	**No personal connection/engaged playing**
They appear to play with a '**distance**' from what they are playing. This distance is evident in their **posture**.	**Distance from playing/ nearness to the playing** **Posture (see below)**
When they are strong enough to stand their **posture** is often such that both feet are **not firmly on the ground**, i.e. **their legs are crossed**.	**not firmly on the ground/firmly grounded** **legs are crossed,** *as evidence of* **not firmly on the ground**
The drumsticks are held loosely in the hands with the **inner wrist uppermost**, and they play from the wrists without involving the whole body.	**inner wrist uppermost,** *as evidence of*
This seemingly **uncommitted** posture make it difficult to play a clear beat on the drum.	**uncommitted posture/committed posture**
Any **drum beats are loose**.	**drum beats loose/accurate beating** *as evidence of*
Beaters are allowed to fall and rebound rather than being used in a **directed intended beating movement**.	**directed intended beating movement/haphazard beating**

Such texts can then be used to generate constitutive rules (see Figure 8)

Figure 7: A text of clinical description and related constructs

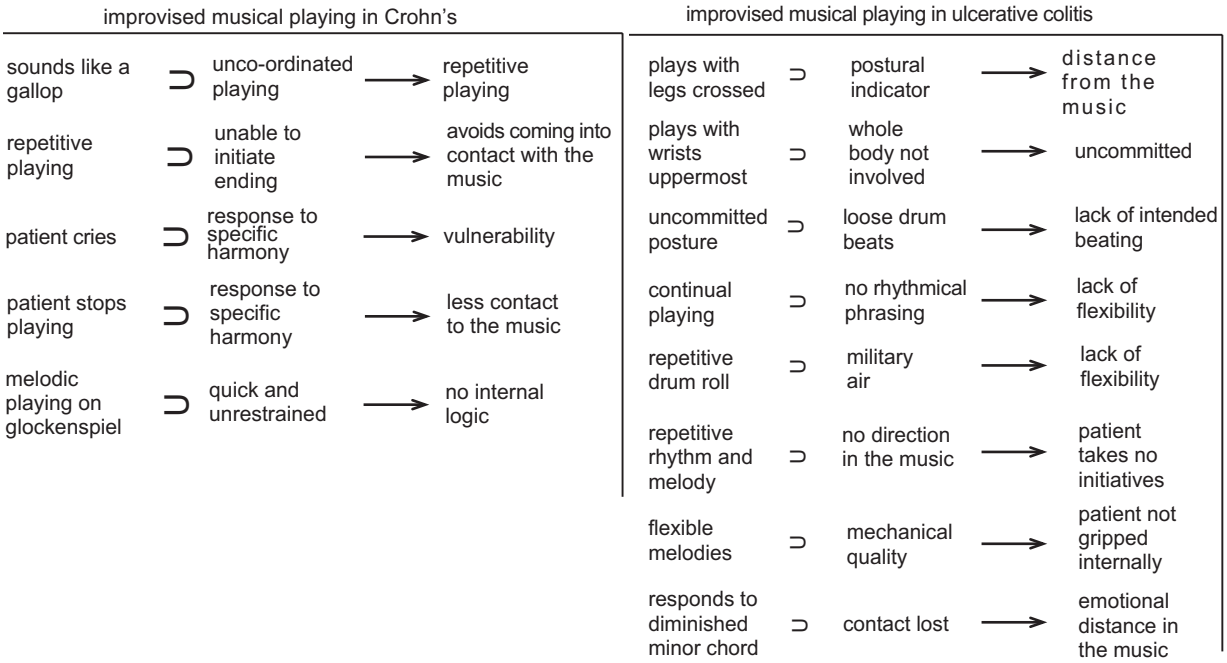

Figure 8: Constitutive rules generated from a clinical description by one therapist regarding the improvisation of patients with chronic bowel disease

person enters the room and we say that a particular behaviour (a kiss) counts as evidence of another state (a greeting). Figure 6 shows a formula for constructing

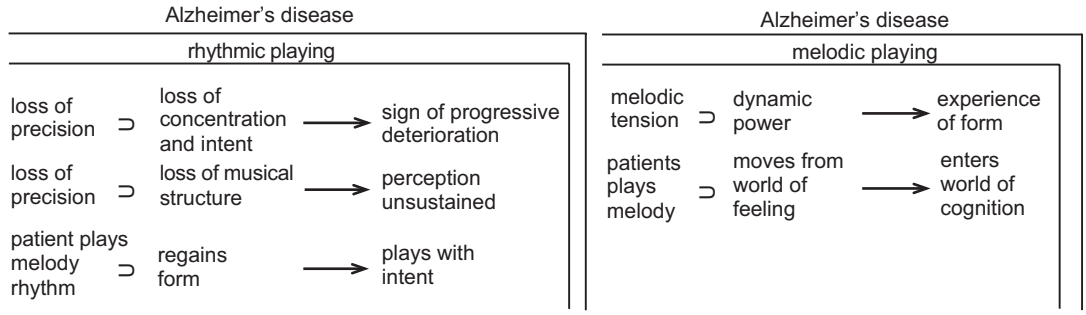

Figure 9: Constitutive rules related to the rhythmic and melodic improvised playing of Alzheimer's patients.

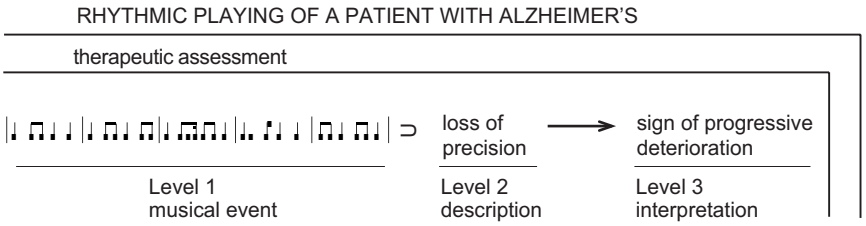

Figure 10: Textual understandings of a musical phenomenon in therapeutic assessment.

such a rule.

If we changed the context, from one of a close relationship to that of lovers, then the meaning of the same behaviour may change. Instead of being a greeting, it may become an invitation. If we change the context again, and this time make it one of Jesus and his disciples, the kiss becomes an act of betrayal. Context is emphasised as being important for the construction of meaning based on the same behaviour. In this example a kiss constitutes a greeting, an invitation or a betrayal. In our original schema it is an interpretation at level 2 (see Figure 1).

But, as anyone who has been kissed will tell you, it is what happens next that is important.

What happens next is understood and interpreted through regulative rules (see Figure 6). A regulative rule would be invoked when we say if this behaviour (a kiss) counts as evidence of a particular state (maintaining friendship) then do a particular activity (kiss in return).

In Figures 7and 8 we see how rules of regulation can be linked to piece together behaviour in a music therapy session. In the upper half of the diagram we see a sample of text taken from a case description. Key words are highlighted and noted as relevant constructs. We can read that personal connection is important, and that there are certain behavioural indicators such as posture and the positioning of the limbs that can be interpreted as indicators for the music therapy.

In the lower half of Figure 8 these constructs have been assembled into regulative rules using the clinicians report. We see how textual data can be assembled according to a hierarchy of understandings to demonstrate at what level the musical behaviour is being

described, and how those descriptions are further interpreted. Thus we have an indicator of the complexity of the music therapy discourse that is taking place. This allows music therapists to explicate both what is taking place and their understandings related to what is taking place. There could of course be other interpretations of the same behaviour, and these could be useful to engage in a comparative discourse.

Such an approach gives a way of formally charting what meanings are associated with therapeutic activity and change. Meanings cannot be counted or measured, but they can be expressed and analysed. In Figure 9 we see that interpreting a loss of precision in the rhythmic playing of patients suffering with Alzheimer's disease, then this counts as a loss of concentration and intent that is interpreted as a sign of progressive deterioration. In the context of melodic playing, when melodic tension arises, this counts as an example of dynamic power and is interpreted as a an experience of form. the benefit of this approach is that we see the chain or reasoning between events as they are described and the interpretations that are made.

We can then combine our understandings of levels of interpretation (in Figures 1 and 2) with those of constitution and apply them to understanding musical texts. In Figure 10 we see how a musical motif counts as loss of precision and this in interpreted as assign of progressive deterioration. The benefit of this approach is that we can base our interpretation on a musical trace, originally the recorded sounds, and make that bridge to a lexical description showing how we arrived at the interpretation as it occurs in a specific context. We emphasis context here as the intention is not to make a generalised interpretation, yet, but to make a specific localised statement.

Validation of categories

Once particular categories are recognised then it is possible to submit these examples to other therapists or researchers for validation. For example, Wolgang Pilz (Pilz 1999) focussed on the concept of "resistance in music therapy" in his doctoral dissertation. He asked various panels of listeners to hear audiotape examples of what he described as resistance distributed amongst an equal number of audio examples where there seemed to be "no resistance". Other experienced therapists were able to recognise this clinical phenomenon, and more importantly, novice listeners could also be taught to recognise the phenomenon.

Peter Hoffmann (2002), has identified those moments in music therapy when phrasing occurs. He has submitted examples of phrased and un-phrased playing to a panel of colleagues, and they were able to identify the phenomena accurately. Thus we are able to validate our subjective understandings made at an abstract level by submitting examples for validation to the broader community of practitioners or inquirers. This is the point that Glaser makes, subjective understanding when abstracted from empirical data become objective. I have expressed this elsewhere as the relationship between personal construing and cultural construings; although we are individuals our understandings are also related to the cultures in which we actively participate (this also means non-verbally).

Phase Five is the stage where the understandings are then woven together to form the narrative again based upon the categories discovered during the

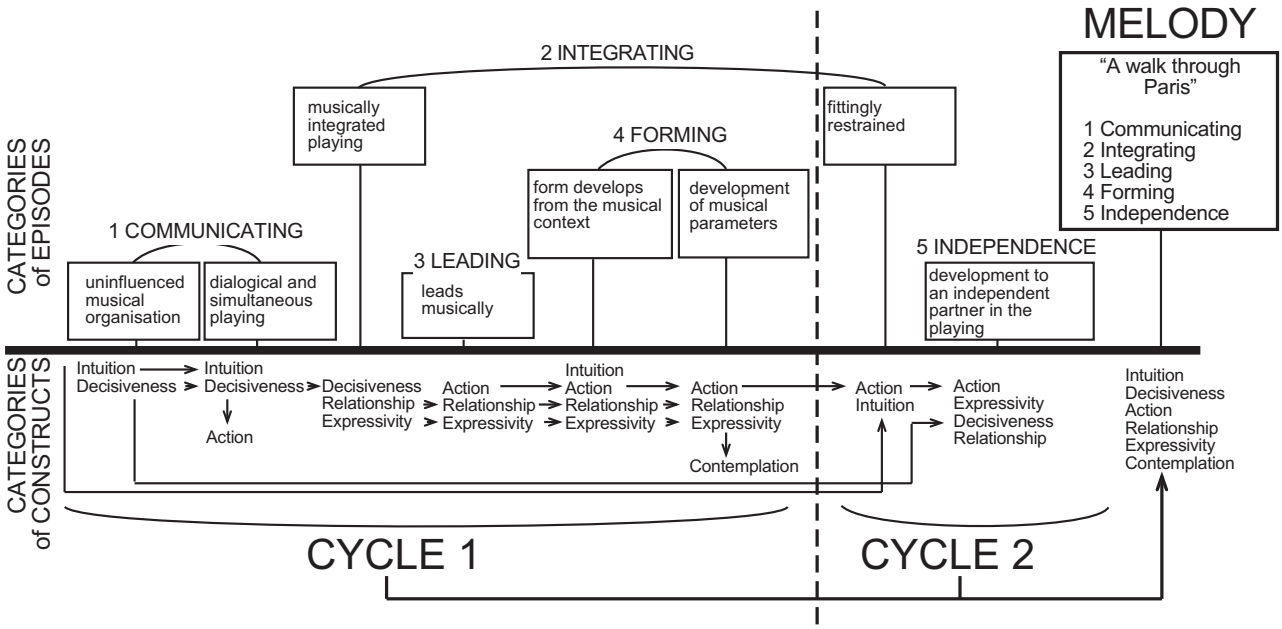

Figure 11: A therapeutic narrative analysis showing the development of a melody based upon the categories of constructs and the categories of episodes.

analysis. We see this in Gudrun Aldridge's (1998) work where she takes categories generated from constructs and categories generated from episodes to describe the development of a melody. Here the narrative structure is involved initially with episodes of communicating, integrating, leading and forming. It is the concept of integrating that then leads into the phase of independent playing that precedes the final completed melody (see Figure 11).

Conclusion

We can begin to understand the process of therapy by looking directly at what happens in the therapy using material from therapeutic sessions. We have used the word "traces" here as a general term referring to the material left behind as an indicator that something has happened. These traces are empirical data. How these events are described and interpreted as therapeutic process is the stuff of methodology. The interpretative process in qualitative research is referred to a hermeneutics. What we have in this paper is a suitable methodology for eliciting understandings and how such understandings are constructed.

In the process of interpretation there are varying stages of abstraction, and we use differing sets of meanings. By using a constructivist approach we can elicit meanings from events and see how events are understood as a system of meanings. Furthermore, by combining a constructivist approach with a communications perspective, we see how meanings are chained together to understand the therapeutic process. This is form of narrative analysis applied to the therapeutic process that we call "Therapeutic narrative analysis".

Communication is dependent upon linking behaviours together. How those links are made, and what they constitute is basis of this form of research analysis. Narrative

structures are the abstract form of case histories, clinical reports and what our patients tell us about their lives. Events gain meaning in the way in which they are linked together. Therapeutic narrative analysis elicits those links between events, the hermeneutic lies in the linking are much as in the events. Meaning has to be made, it is an activity. The same can be said of science, it is not static but is a dynamic process of understanding.

Central to the understandings is the concept of context. Culture itself is a context, and within a cultural context events will gain different meanings. These nested forms of understandings within specific are given a formality here in terms of constitutive and regulative rules. By explicating how we describe what happens from the traces of therapy, we begin to make the processes of therapy accessible to others and lend credibility to our accounts.

Language is a joint event by which we understand the coherence of what happens in our lives. The maintenance of meaning in everyday life is a social act. What we are asked to do is to elicit the hidden rules by which meaning is being constantly constituted and regulated. To this end, we can share our own meanings of the world with our colleagues and promote a community of inquiry.

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Phase 1 Identify the narrative	Gather the material together that will form the narrative. This may be a case study, or it may be a series of case studies. It is the story that you wish to tell.
Phase 2 Define the ecology of ideas and settings	Explicate the theoretical ideas present in the literature or from your own standpoint. This is the initial locating of the research context in the wider perspective of current knowledge (Context 1). Define the setting in which the narrative occurred. This will include details of the place of practice, the demographic details of those involved and may include historical details (Context 2).
Phase 3 identify the episodes and generate categories.	Identify episodes that are crucial for analysis. Generate a set of constructs from that episodic material and identify categories for analysis
Phase 4 Submit the episodes to analysis	The episodes are the analysed according to their contents using the guiding framework of the constructs. At this stage it is possible to use a regulative rules based hypothesis. It is also possible to submit episodes for categorical confirmation to colleagues.
Phase 5 Explicate the research narrative.	Interpretations based on therapeutic traces are synthesised to form a therapeutic narrative.

Phases of Therapeutic Narrative Analysis overview