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An exploration of blurred lines between voice habilitation and rehabilitation in contemporary voice care.

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Project Proposal

Background and justification

Voice care today involves a broad range of professionals, including singing teachers, vocal coaches, speech-language pathologists (SLPs), otolaryngologists, and other healthcare practitioners (Hawkshaw, 2002). This multidisciplinary approach can improve the quality of care; however, the differences between habilitation aimed at optimising vocal function and rehabilitation restoring function after illness or injury remain unclear (Graham, Oates, & Jones, 2022, Flock et al., 2023);

The concept of vocology, introduced by Titze (1996), emphasises the integration of voice science, pedagogy, and therapy. Singing teachers, for example, play a key role in identifying vocal problems, sometimes being the first to notice dysfunction (Sataloff, 1998). However, their contribution to clinical management is not always clearly defined (Achey & He, 2016; Phyland, Oates, & Greenwood, 1999). Similarly, speech-language pathologists may lack the pedagogical expertise needed to support the artistic voice (Loar, 2020), and many training programmes give limited attention to professional or singing voice issues (Sataloff, 1992).

Voice disorders involve changes in physiology, acoustics, or perception that affect vocal quality and communication (Stemple, Roy, & Klaben, 2014). While the physiological factors are well-documented, gaps remain in the evidence regarding therapeutic approaches (Roy et al., 2005). This emphasises the importance of multidisciplinary collaboration as effective care depends on input from both clinicians and educators (Gilman, Nix, & Hapner, 2010a, (Schmidt, 2024). Although such collaboration is regarded as best

defining specific roles remains a challenge (Turner & Fonder, 2024).

Recent advances, such as vocal health first aid, vocal massage, and habilitative exercise training, have provided singing teachers with access to therapy-informed techniques (Vocal

Health Education, n.d.). While these developments expand teaching practice, they also blur professional boundaries and raise safety concerns when non-clinicians deliver physical interventions (Brown, 2024). This study aims to clarify the difference between habilitation and rehabilitation while promoting interdisciplinary dialogue. It also examines the ethical responsibilities of voice educators across artistic and clinical settings (Moniz, 2025).

Intended Impact

This study aims to shed light on how the boundaries between voice pedagogy and clinical practice are understood and negotiated. By drawing together the perspectives of teachers, therapists, and hybrid practitioners, the research seeks to:

- Explore areas of overlap between singing teachers and voice therapy specialists in supporting vocal health.
- Examine the ethical, legal, and practical challenges that shape and complicate professional boundaries.
- Propose interdisciplinary guidelines that clarify responsibilities across professional groups and encourage more integrated models of care.
- Support education and policy initiatives that combine clinical and artistic expertise, ensuring continuing training and a stronger infrastructure for vocal health provision.

Research Methodology and Ontology

This research is grounded in a pragmatic framework that draws on intersubjectivity and action-based knowledge (Dewey, 2005), recognising that voice habilitation and rehabilitation are best understood through collaborative practice. Within this perspective, voice care is seen as a shared process that values participation and cooperation between professionals and voice users (Craig et al., 2015). To manage the complexity of this interaction, a mixed-methods design has been adopted. This allows for the integration of qualitative insights from lived experience with real-world, problem-focused data (Miller & Cameron, 2011), ensuring that

both practical and contextual aspects are captured (Hildebrand, 2011). Triangulation is used to enhance validity by combining multiple forms of evidence with existing scholarship (Clark & Ivankova, 2016).

Alongside this pragmatic stance, the study is guided by hermeneutic phenomenology, drawing on the works of Heidegger (1927), Gadamer (1975), and van Manen (1990). This philosophical approach enables an exploration of how voice professionals construct meaning around habilitation and rehabilitation within interprofessional practice (Lavery, 2003). Hermeneutic phenomenology thus complements the pragmatic focus by providing the interpretive basis needed to understand participants' experiences (Aguilar, 2004; Ajjawi & Higgs, 2007).

Research Location

This research will be conducted across various online environments, my studio, consulting rooms, universities, and other professional workplaces. The inclusion of both online and physical locations will allow exploration of diverse experiences, interactions, and contextual factors in voice habilitation and rehabilitation (Creswell & Clark, 2018; Yin, 2018).

Participants

The research audience comprises voice professionals, speech-language pathologists, singing teachers, vocal coaches, and voice pedagogues. A purposive sampling strategy will be employed to target participants with relevant expertise in habilitation and rehabilitation, as this approach is well-suited for qualitative studies that require in-depth insights from informed professionals (Ziegler & Hapner, 2013). Recruitment will be conducted through professional networks, academic institutions, and online platforms, ensuring access to a diverse range of perspectives (Braun & Clarke, 2013). The sample will aim to balance clinical, pedagogical, and performance expertise to support meaningful interdisciplinary dialogue in vocal health management (Kenny, Driscoll, & Ackermann, 2016).

Methods

Literature Review

A systematic literature review will evaluate current scholarship on voice habilitation and rehabilitation (Siddaway, Wood, & Hedges, 2019). It will map definitions and applications, identify areas of overlap, and synthesise findings from peer-reviewed journals, scholarly texts, and clinical guidelines (Verdolini Abbott & Till, 2018; Gartner-Schmidt & Rosen, 2018; Creswell & Creswell, 2018). The aim is to highlight gaps in existing research and support further interdisciplinary development (Lippi et al., 2023).

Semi-structured Interviews

Interviews will be conducted with approximately 4 participants from diverse professional backgrounds. Questions will be developed from themes in the literature review, ensuring they are grounded in scholarship and practice. Open-ended prompts will encourage participants to share their perspectives on habilitation and rehabilitation in both clinical and pedagogical contexts (DeJonckheere & Vaughn, 2019; Yunes & Szymanski, 2005).

Questionnaires

Questionnaires will be distributed to a broader group of professionals to expand data collection (Ponto, 2015). These will combine closed and open-ended questions to capture both quantifiable information and reflective insights (Myers, Manternach, & Cox, 2021). They will focus on professional roles, training backgrounds, interdisciplinary collaboration, and ethical issues. This aligns with best practice for securing diverse perspectives (Francis, 2017).

Analysis

Qualitative data will be analysed thematically to identify patterns in participants' accounts (Jowsey, Deng, & Weller, 2021). Analysis will follow the hermeneutic cycle, moving iteratively between reading, reflective writing, and interpretation. Questionnaire data will be analysed using descriptive and inferential statistics (Boell & Cecez-Kecmanovic, 2014), with software

such as SPSS to manage responses. Findings will be presented through charts, tables, and thematic maps to visualise relationships in the data (Divecha, Tullu, & Karande, 2023).

Insider Research

As the study is conducted within a professional community of which I am a member, issues of bias and reflexivity are acknowledged. A reflexive stance will be maintained throughout to examine assumptions and reduce their impact on interpretation critically (Mercer, 2007; Savvides et al., 2014).

Ethical Considerations

Ethical approval will be obtained from the university before the commencement of the study (Smith, 2019). Informed consent will be obtained from all participants, who will be fully informed of the study's purpose, procedures, risks, benefits, and their right to withdraw at any time (Beauchamp, 2011). Data handling will comply with GDPR requirements (Ducato, 2020). Confidentiality will be safeguarded through anonymisation and secure storage, with access limited to authorised researchers (Kaiser, 2009). All data will be deleted after the project in line with institutional policy (Dawson et al., 2023). These measures will ensure participant well-being and uphold recognised ethical standards (Resnik, 2020).

Personal Learning Outcomes

Through this research, I aim to deepen my knowledge of voice habilitation and rehabilitation across different contexts. A key outcome will be strengthening my reflexivity, especially in recognising and addressing my own assumptions as both a singing teacher and researcher. The project will also improve my skills in designing and analysing research, enabling me to handle qualitative and quantitative data within a coherent interpretive framework. By engaging with interdisciplinary perspectives from speech-language pathology, vocal pedagogy, laryngology, and clinical voice care, I aim to develop a more comprehensive understanding of

professional collaboration. By situating my work within the broader debates in voice pedagogy, I aim to contribute to the scholarship while refining my own practice. The project will also enhance my skills in designing and analysing research, enabling me to manage qualitative and quantitative data within a coherent interpretive framework. By engaging with interdisciplinary perspectives from speech-language pathology, vocal pedagogy, laryngology, and clinical voice care, I aim to develop a more comprehensive understanding of professional collaboration. By situating my work within the broader debates in voice pedagogy, I aim to contribute to the scholarship while refining my own practice.

Project timeline

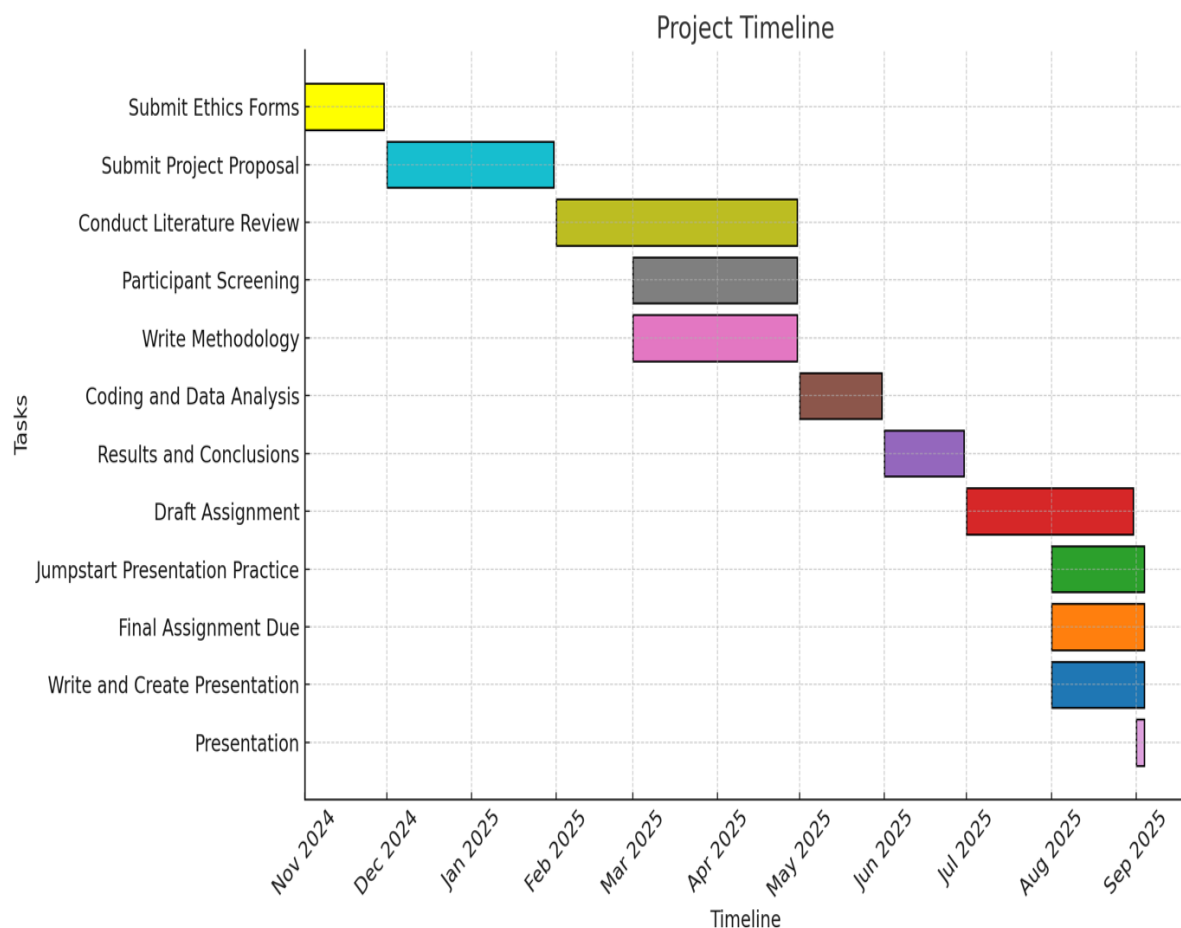


Figure 1 – Gantt chart project timeline.

Project Report

Introduction

The human voice does more than produce sound it carries identity, emotion, and presence, making it both a biological mechanism and a means of expression (McGettigan, 2015). The voice is more than just a tool for many professionals, such as singers, educators, actors, and public speakers. It is essential to their work, artistic expression, and interpersonal relationships (Scherer, 1995). Because of this dual role, caring for the voice is complex and requires contributions from both clinical and pedagogical perspectives (Bretl & Rosow, 2022).

In recent decades, increasing demands on professional voice use have coincided with a surge in research, education, and clinical practice focused on voice preservation, optimisation, and recovery (Behlau, Postma De López & Madazio, 2015). Despite these developments, voice care is still divided, most often into two categories: habilitation and rehabilitation. Habilitation focuses on developing and maintaining healthy voice use while rehabilitation addresses the restoration of voice after injury or illness (Van Stan et al., 2015, 2021; Behrman, Borzak, & Guthrie, 2008).

Traditionally, the responsibility for voice care has been split, with singing teachers and vocal coaches focusing on one area, while clinicians such as speech-language pathologists and laryngologists have worked in another (Carroll and Searce, 2020a). In practice, though, these roles increasingly overlap (Sataloff, Baroddy and Carroll, 2017). A performer recovering from vocal fold injury, for example, may complete clinical therapy and then continue training with a teacher to prevent reinjury and further develop performance skills (Denizoglu & Sahin Orhon, no.date.) This merging of roles calls for a re-evaluation of professional responsibilities, ethics, and interdisciplinary collaboration (Van Stan, 2021).

The traditional split between habilitation, usually handled by teachers, and rehabilitation, managed by clinicians, has led to silos that often prevent a more collaborative approach to voice care (Sundberg, 2018). Although these boundaries help protect the expertise of each discipline, they can also limit communication (Davies et al., 2007). To satisfy the complex needs of professional voice users, recent research emphasises the necessity of establishing more defined boundaries around the scope of practice and creating more organised methods of collaboration (Neubauer et al., 2021; Flock et al., 2023). While clinicians deal with the diagnosis and treatment of disorders, singing instructors and coaches typically concentrate on vocal technique, style, and performance (Van Stan et al., 2021). These lines are often blurred: many voice users move between pedagogical and clinical care, and professionals increasingly share tools, strategies, and even terminology (Fleming, 2024, Schriefer, Roy, & Smith, 2022).

Interdisciplinary models, shared decision-making, and valuing each other's expertise have been shown to help reduce risks in these overlaps (Flock et al., 2023). Voice professionals are being forced to reconsider how they define their roles in shared spaces as care models continue to change and client needs become more complex (Best & Williams, 2019). As client needs become more complicated and care models continue to evolve, voice professionals are challenged to rethink how they define their roles within shared spaces (Weston, Gochman, & Schneider, 2023). This project takes these debates as its starting point, exploring how pedagogical and clinical perspectives intersect in contemporary voice work and what this means for professional practice.

Rationale for the study

As voice professions become more interdisciplinary, the need for clear roles, mutual respect, and collaborative skills is becoming increasingly important (Carroll & Searce, 2020a). The growth of frameworks such as vocology, which brings together clinical, scientific, and pedagogical knowledge, shows a shift toward more joined-up ways of understanding voice

care (Titze, 1996). Even so, gaps in regulation and ongoing inconsistencies in training and terminology continue to make genuine collaboration difficult (Gilman, Nix, & Hapner, 2010).

This study recognises that interdisciplinary voice care is no longer optional but vital (Starmer et al., 2014). Without clear boundaries, collaboration risks professional overreach, ethical issues, and reduced effectiveness (Best and Williams, 2019). This dissertation examines how habilitation and rehabilitation work together in practice, how professionals handle areas of overlap, and how more explicit guidance and training can improve client outcomes. At the same time, more practitioners are taking on hybrid roles, such as singing voice specialists, teachers supporting students recovering from vocal issues, speech-language pathologists with vocal pedagogy training, or clinicians coaching performers combining elements of teaching and clinical care (J. Gerhard, 2016; Fleming, 2024). The findings will enhance the theoretical understanding of voice care and offer practical recommendations for professional practice.

Aim

To investigate how professional roles are defined and negotiated at the intersection of voice habilitation and rehabilitation, with particular focus on interdisciplinary collaboration and ethical practice

Objectives

- To critically analyse how habilitation and rehabilitation are conceptualised in both scholarship and professional practice.
- To explore the lived experiences and perspectives of voice professionals working across pedagogical and clinical domains.
- To examine training, policy, and regulatory gaps that influence role clarity, ethical responsibility, and interdisciplinary collaboration.
- To investigate ethical challenges that arise when professional boundaries overlap.

- To propose evidence-informed recommendations for more collaborative and integrated models of voice care.

This study is underpinned by concepts from interprofessional practice, boundary work theory, and vocology, which together provide a lens for examining how disciplinary roles intersect, conflict, and converge in voice care.

Positionality, Lived Experience, and Reflexivity

My position as a researcher is inherently dual as I am both a singing teacher with professional training in vocal health and someone with personal experience of vocal injury. Being an insider can give the researcher a deeper level of understanding and empathy that adds richness to interpreting the data. Still, it also calls for careful reflexivity to keep potential biases in check (Finefter-Rosenbluh, 1998). To maintain integrity and balance, I have engaged in reflexive journaling, peer debriefing, and transparent methodological reporting throughout the research process. My background informs the research questions and gives context to the findings, but it does not determine them. Instead, it serves as a bridge between theory and lived practice, enabling richer and more meaningful analysis.

This dual perspective influences my approach to literature and data analysis. Having experienced vocal injury myself and within my family, I recognise that the boundaries between habilitation and rehabilitation are not abstract but lived and embodied realities (Randolph, 2009; Savvides et al., 2014). Drawing on phenomenology, I have aimed to conduct thematic analysis in a way that honours both qualitative insight and theoretical critique. In line with this, I began the review with bracketing, a methodological step in which I acknowledge my positionality as both practitioner and researcher (Larkin, Watts, & Clifton, 2006). Rather than restricting the research, this reflexive stance strengthens it by providing context for

interpretation, encouraging transparency, and fostering connections between the often-siloed worlds of study and practice (Gearing, 2004).

Viewing voice care through this lens emphasises the fragile, changeable, and deeply personal nature of the voice itself (Edwards, 2022). Voice difficulties are more than mechanical faults to be corrected; they can affect a person's sense of identity, self-expression, and even their ability to earn a living (Döllinger et al., 2019). Keeping this in mind shapes my reflexive approach, reminding me that the study is not only about professional practice but also about lived human experience.

Personal Learning Outcomes

- To develop a deeper understanding of the distinctions and overlaps between voice habilitation and rehabilitation, with particular attention to the professional, ethical, and clinical boundaries that shape both.
- To critically examine interprofessional collaboration in voice care, focusing on the complementary roles of singing teachers, speech and language therapists, and clinical voice specialists.
- To remain reflexive and reflective throughout the research process, I will evaluate my positionality as a voice teacher within the broader voice care team.
- To strengthen my knowledge of vocal anatomy, physiology, and pathology, enabling me to teach in ways that are ethically responsible, scientifically informed, and supportive of collaborative models of care.
- To present research findings in a clear, professional format that contributes to dialogue across both pedagogical and clinical voice communities.

These learning outcomes point to the need to engage with existing scholarship. The following literature review explores how habilitation and rehabilitation are defined, how pedagogical and

clinical roles intersect, and how interdisciplinary collaboration is addressed in voice care research.

Literature Review

This narrative literature review adopts an interpretivist approach selected over a full systematic review due to the multidisciplinary nature voice care does not fit into traditional clinical research frameworks (Snyder, 2019). The data includes clinical perspectives, pedagogical scholarship, and professional practice, necessitating flexibility while maintaining rigour (Hutchings, Huber and Ciccone, 2011).

I recognised that professional boundaries in voice care are not fixed but are continually negotiated through practice (Gieryn, 1983). This involved examining both academic literature and professional publications, recognising that much of our understanding of voice care exists within practice communities rather than solely in peer-reviewed journals. Therefore, this review draws on peer-reviewed and grey literature to examine how traditional distinctions between voice therapy and pedagogical instruction have become increasingly blurred, presenting both opportunities and challenges for interdisciplinary practice (Gainanova & Yudichev, 2024). The review adopts a phenomenological perspective, recognising that professional practice is best understood through the lived experiences of those involved (Randolph, 2009). As a trained singing teacher with experience of vocal injury, I bring a reflexive awareness of how personal background shapes interpretation. Reflexivity enables me to approach the literature critically, acknowledging how my professional identity influences my engagement (Savvides et al., 2014; Van Oorsouw, Van Den Berg, & Kalf, 2022).

Search strategy

I searched multiple databases to cover the range of relevant disciplines, including Mendeley, PubMed, and journal-specific searches such as The Journal of Voice, The Journal of Singing, and Logopaedics, Phoniatrics, and Vocology. Google Scholar helped find grey literature, while websites of professional organisations (ASHA, NATS, PAVA, VASTA) offered practice-based insights. My search period spanned from 1990 to 2025. Search terms combined systematic and free-text approaches using Boolean operators. Key combinations included: ("voice habilitation" OR "vocology") AND ("interdisciplinary" OR "collaborative") AND ("singer*" OR "professional voice user*") AND ("speech-language patholog*" OR "voice teacher*").

I included sources that addressed voice habilitation or rehabilitation in professional voice users, discussed professional roles or collaboration, were published in English, and represented credible research or professional guidelines. I excluded solely paediatric studies, technical papers without practical implications, and sources that focused only on medical interventions without considering functional training.

Screening and selection

My initial search retrieved 1,247 sources. After removing duplicates and screening titles and abstracts, 300 sources proceeded to a full-text review. Following quality assessment, I included 198 sources: 156 peer-reviewed articles, 28 professional guidelines, and 14 grey literature studies.

Data extraction and quality assessment

When extracting data, I noted key information from each study, including whether it was empirical, theoretical, or grey literature, the population or professional group involved, and its focus regarding voice care. I paid particular attention to points about professional boundaries,

interdisciplinary collaboration, and any theoretical frameworks used, as well as practical implications for both pedagogy and clinical voice work. To assess quality, I used the CASP (Critical Appraisal Skills Programme) checklists for empirical studies (Long, 2020). I applied adapted criteria from Booth and Carroll (2020) for theoretical and grey literature to ensure consistent and rigorous evaluation across all sources.

Synthesis and reflexivity

I employed thematic synthesis, integrating theory-driven analysis with themes emerging from the data (Thomas and Harden, 2008). Throughout this process, I maintained reflexivity regarding my position as both practitioner and researcher, using structured approaches to reduce potential bias while recognising that my insider knowledge provided valuable interpretive insights (Finlay, 2002).

Defining Voice Habilitation and Rehabilitation

Voice habilitation concentrates on optimising healthy voice use. Its roots come from the Latin *habilis*, meaning “fit” or “able,” and it relates to developing efficient, sustainable function, particularly in vocally demanding professions such as teaching, acting, and singing (Hayton & Dimitriou, 2019; Verdolini Abbott & Titze, 2012; LeBorgne & Rosenberg, 2020). Habilitation highlights prevention, technique, and resilience, aligning with motor learning principles and evidence-based training (Titze, 2021). Although its formal recognition in clinical discourse is recent, it has long been an important part of singing pedagogy and voice coaching traditions (sansom, 2019). **Habilitation focuses on prevention, resilience,** and technique, drawing on principles of motor learning and evidence-based training (titze, 2021). Although voice habilitation has only recently gained formal recognition in clinical literature, its foundational practices, such as cultivating stamina, efficient technique, and vocal health, have been central to singing pedagogy for many years longer (Hoch, 2019). These methods, including breath management and resonance work, are now understood within scientific models of

sustainability and injury prevention (Schalling, Johansson and Hartelius, 2017). More recently, structured programmes such as the Vocal Health First Aider *course* in the UK, the Vocology Certificate at the National Center for Voice and Speech in the US, and PAVA's international workshops have formalised this connection between pedagogy and science, embedding habilitation more deeply within interdisciplinary voice care (Gerhard, 2016).

In contrast, voice rehabilitation is a medicalised process aimed at restoring function after illness, surgery, injury, or misuse (Lorenz, 2017). It depends on diagnostic and therapeutic interventions that target physiological, acoustic, and functional impairments, typically delivered by speech-language pathologists working alongside otolaryngologists and other specialists (Stemple, Roy, & Klaben, 2014; Stemple et al., 2010; Gartner-Schmidt & Rosen, 2018; Van Stan et al., 2015). Wade (2020) highlights its broader objective as enabling participation in daily life, beyond simply achieving recovery.

Although they originate from different traditions—pedagogy and performance for habilitation, medicine and therapy for rehabilitation—habilitation and rehabilitation are often described as separate processes (Pan American Vocology Association, & Voice and Speech Trainers Association, 2024). However, they frequently share similar principles and employ many of the same methods. Consequently, it is becoming increasingly challenging to treat them as entirely distinct categories. (Roy, Barkmeier-Kraemer, & Duffy, 2021; Phyland & Miles, 2019).

Vocology: An Integrative Framework

Titze (1996) established the concept of vocology as both a science and a practice that integrates pedagogy, speech science, and clinical care. Vocology provides a unifying language for clinicians and teachers, grounded in acoustics, physiology, and neuromuscular training (Banks, 2002; Titze & Abbott, 2012). It emphasises functional approaches that prioritise how the voice operates in context, rather than focusing on form alone (Abbott & Titze, 2015).

The framework is supported by principles of motor learning and behavioural change, as well as recognition of psychosocial factors and vocal identity (Radionoff, 2004; Smith, 2021). In practice, this means interventions aim not only at technical efficiency but also at sustainable and authentic expression (Jones & Squires, 2019). Vocology therefore underpins collaborative practice by enabling consistent communication across disciplines (Schriefer, Roy, & Smith, 2022).

Its reach is increasingly international. The *National Center for Voice and Speech* (NCVS) in the US offers a Vocology Certificate; the Pan American Vocology Association (PAVA) runs workshops across the Americas; and European centres such as the University of Tampere (Finland) integrate vocology into training (Simberg et al., 2020). In Australasia, vocology informs interdisciplinary practice in Australia and New Zealand (Payten et al., 2024). This demonstrates that vocology is shaping practice globally, not only in North America.

Convergence of Rehabilitation and Habilitation

In current practice, the distinction between rehabilitation and habilitation is often blurred. Singers and other voice users frequently transition from clinical therapy to performance-oriented training, or vice versa, and professionals may also switch between these roles (Van Stan, Roy, & Hillman, 2015; Stadelmann & Tschopp, 2018). A common example is a performer who undergoes rehabilitation after surgery, then continues with habilitative work to prevent recurrence and enhance artistic voice use (Denizoglu & Sahin Orhon, 2021). In many ways, it appears the definition of voice habilitation was intended to encourage such overlap, permitting space for both artistic and medical perspectives to coexist and recognising the role of teachers within broader voice care (Nix, Holding, Johnston, LeBorgne, & Thorpe).

Voice therapists, singing voice specialists, and teachers now regularly work across both domains, supporting performers recovering from injury as well as maintaining healthy voices (Schneider & Sataloff, 2007; Gilman, Nix, & Hapner, 2010). What was once framed as voice

teaching has increasingly been incorporated into clinical discourse as voice habilitation (Titze, 2000; Behlau, Postma de López, & Madazio, 2015). This shift reflects the complex and changing needs of voice users and supports the move towards flexible, integrated models of care (Titze & Abbott, 2012).

Shared Techniques and Adaptable Applications

Despite differing goals, habilitation and rehabilitation often employ similar tools. Techniques such as semi-occluded vocal tract exercises (SOVTEs), resonance training, and posture alignment are used in both clinical and pedagogical contexts (Behrman, Borzak, & Guthrie, 2008; Andrade et al., 2014; Nguyen & Kenny, 2009). Their value lies in adaptability: they can support recovery, prevention, or performance optimisation (Kapsner-Smith et al., 2015).

For instance, straw phonation may reduce vocal load in a recovering patient or serve as a warm-up for an actor (Manternach & Daugherty, 2017). A growing number of training programmes now promote these methods, such as the *Vocal Health First Aider* course in the UK, NCVS's Vocology Certificate in the US, and PAVA workshops internationally (Vermeulen et al., 2022). However, ethical risks arise when non-clinicians apply therapy-informed practices without cross-disciplinary training, potentially delaying medical intervention or compromising client safety. This concern is distinct from *music therapy*, which is a separate profession; here, the issue lies in clinicians using pedagogical techniques or teachers applying therapy-like methods outside their scope.

From Historical Divides to Contemporary Shifts

Voice rehabilitation developed within laryngology and speech correction (Bień et al., 2008), while teachers historically focused on artistry (Sataloff, 1991; Sataloff, Spiegel, & Heuer, 2006). These fields remained separate until the rise of interdisciplinary teams in the 1990s, including organisations such as PAVA, which promoted integrated models of care (Carroll & Searce, 2020; ASHA & PAVA, 2024).

Today, boundaries are less rigid. Teachers have incorporated therapy-informed strategies such as hygiene protocols and SOVTEs (Miller & Ling, 2017; Nallamuthu et al., 2023), supported by new health-focused training pathways (Vermeulen et al., 2022). Clinicians, meanwhile, have borrowed pedagogical strategies to support better performers (Carroll & Searce, 2020; Millman et al., 2023). Rather than two distinct spheres, therapy and teaching are increasingly viewed as points along the same continuum (Behlau et al., 2023; Schriefer, Roy, & Smith, 2022). Yet, terminology remains inconsistent, creating confusion (Rinta & Welch, 2008).

Role Ambiguity and Professional Identity

The Singing Voice Specialist (SVS) role exemplifies attempts to formalise interdisciplinary expertise (Carroll & Searce, 2020; Radionoff, 2004). While it blends pedagogical and clinical skills, the absence of formal accreditation or training pathways leaves scope unclear (Sharon Radionoff, 2004).

Hersey, Searce, & Johnson (2020) found that SLPs often avoid artistic concerns, while teachers hesitate to perform clinical work. Smith (2021) notes that studio teaching strategies often resemble therapy, even unintentionally. This role ambiguity risks fragmented care or missed referrals, underscoring the need for clarity.

Interdisciplinary Collaboration: Challenges and Opportunities

Collaboration across disciplines is widely encouraged, but it comes with its challenges (Nichol, Morrison and Rammage, 1993). Sataloff (2017) describes a case where a singing teacher, focusing on posture and breath, overlooked signs of muscle tension dysphonia, which delayed treatment. This illustrates the risk that, even with expertise, teachers may miss underlying issues, leaving problems unresolved or worsening over time. Conversely, Loar (2020) reports a speech-language pathologist advising a recovering singer to adopt a speech-based tonal quality. While the advice made clinical sense, it conflicted with the stylistic requirements of

classical performance and left the singer anxious, damaging their artistic confidence. These examples show how disciplinary blind spots—whether clinical or stylistic—can threaten both wellbeing and professional identity.

The risks go beyond isolated cases. Fleming et al. (2024) found that nearly half of pedagogues worked with post-injury students without clinical consultation, raising concerns about scope of practice and safety. This indicates that, in practice, the boundaries between teaching and therapy are often negotiated informally, which can leave singers vulnerable. In contrast, the Multidisciplinary Practitioner Pilot Study (2024) shows that structured collaboration, where medical, pedagogical, and artistic expertise are combined, significantly improves outcomes. Such approaches support evidence that care is most effective when it is holistic and includes multiple perspectives (Gilman, Nix, & Hapner, 2010; Goffi-Fynn & Carroll, 2013).

Nevertheless, tensions persist around terminology, scope, and regulation, which continue to impede consistent practice (Carroll & Searce, 2020). Without a shared vocabulary, goals can be misunderstood, and unclear boundaries may lead professionals to either overstep their remit or hold back excessively, both of which disrupt the flow of care. Regulatory gaps further complicate matters, as few formal pathways exist for recognising hybrid expertise such as the singing voice specialist. Collaboration has clear benefits, but for it to be effective in practice, it requires clear frameworks, mutual respect, and shared training that can bridge the cultural and knowledge gaps between professions.

Ethical and Legal Implications

Blurring professional boundaries raises significant ethical challenges. Teachers adopting therapy-like methods without supervision may delay diagnosis (Van Houtte et al., 2011), while clinicians advising stylistic changes without pedagogical training risk undermining artistic development (“Singing Voice: Special Considerations,” 2020). Clear referral processes and scope recognition are therefore critical (Achey & He, 2016; Rubin & Codino, 2019).

Manternach et al. (2022) highlight the complex negotiations required when navigating professional overlaps, emphasising emotional and ethical challenges as well as legal ones. Hybrid practices highlight the need for robust guidance to safeguard clients while supporting collaboration (Brown, 2025; Gilman, Nix, & Date, 2010). Improved training is also essential: teachers need greater knowledge of anatomy and pathology, while clinicians must understand stylistic nuance (Heman-Ackah, 2003; Zeller, 2016; McCoy, 2021).

Training and Education Gaps

Training pathways remain siloed. Speech-language pathology courses often neglect the professional voice, while pedagogy curricula rarely include in-depth anatomy or health content (Loar, 2020). Radionoff (2004) and others argue for dual-discipline training through programmes such as the NCVS Vocology Certificate or interdisciplinary master's courses. Professional organisations — ASHA, NATS, PAVA, and VASTA (2024) — have issued joint guidance promoting mutual respect, but consistent adoption remains limited.

Critical Evaluation and Research Gaps

Recurring themes in the literature include overlapping methods, inconsistent terminology, role ambiguity, ethical issues, and gaps in training. Van Stan et al. (2021) proposed a taxonomy dividing therapy into direct (physiological), indirect (educational), and combined approaches, but this framework lacks nuance for artistic voice users. Hillman et al. (2023) presented clinical models of intervention, but again risk overlooking pedagogical subtleties.

Pedagogical research is addressing this gap. Works such as *Voice Pedagogy for the 21st Century* (Nix et al., 2022) and the Voice Summit reports show increasing engagement with science, but highlight inconsistencies across institutions. Interdisciplinary attempts, such as eclectic therapy models (D'haeseleer et al., 2023) or post-phonosurgery training (Zhou et al., 2021), are promising yet limited by methodological weaknesses and lack of long-term follow-up.

Psychological dimensions are also neglected. Aldridge-Waddon et al. (2024) show the clear association between voice disorders and psychological distress, yet mental health is rarely integrated into care. Persistent role confusion is further underlined by Sataloff (2021) and Gilman & Carroll (2023), pointing to the need for clearer regulation and culturally sensitive frameworks (Sataloff, Spiegel, & Heuer, 2006).

Maxfield & Ragan's (2021) Evidence-Based Voice Pedagogy (EBVP) model offers a way forward, aligning pedagogy with evidence-based practice in SLP. While this establishes common ground, its reliance on measurable outcomes risks underestimating artistry and undervaluing experiential knowledge. This limitation highlights the need for balanced frameworks that acknowledge both scientific rigour and creative practice.

The literature reveals growing convergence between habilitation and rehabilitation, but also unresolved tensions around roles, ethics, and education. Vocology provides a promising integrative framework, and models like EBVP push for evidence-based alignment. Yet, gaps remain in training, terminology, and long-term research. Addressing these will be essential for developing sustainable, interdisciplinary approaches to voice care.

Methodology

Ontology and Epistemology

My philosophical stance has influenced both the design and my interpretation of this study (Kennedy et al., 2024). Making these assumptions explicit is essential for coherence and transparency, as Lincoln and Guba (1994) emphasise.

Ontology concerns the nature of reality, what can be known, and the topics that are covered (Guba & Lincoln, 1994). I adopt the view that voice rehabilitation and habilitation are socially constructed, context-dependent, and neither universally accepted nor fixed. Social

interactions, professional culture, and the context in which they are employed all influence these ideas (Goldkuhl, 2012). Such a stance is beneficial for qualitative work, as it allows attention to the lived and contextual nature of practice (Kelly & Cordeiro, 2020).

Epistemology examines what constitutes knowledge and how it is acquired (Crotty, 1998). I have adopted a hermeneutic phenomenological approach, framed pragmatically. Interpreting lived experience gives meaning, and dialogue is seen as a means of co-constructing knowledge (Busacchi, Nieddu & Michel, 2022). This approach enabled me to explore how practitioners define and negotiate rehabilitation and habilitation, as well as to record different viewpoints on professional identity and teamwork (Todd & Von Essen, 2023).

Being unambiguous about this position lessened the possibility that any one expert opinion would take precedence (Johnson, Adkins, & Chauvin, 2020). Additionally, it reinforced my belief that various types of evidence from clinical practice, instruction, and educational experiences are equally significant in comprehending voice care (Gupta et al., 2025). In short, my ontological view of reality as socially constructed aligns consistently with my epistemological belief in dialogic, co-created knowledge, providing a coherent foundation for the research.

Linking ontology and epistemology together forms a research paradigm (Kivunja & Kuyini, 2017). This study is rooted in a pragmatic–interpretivist paradigm. This reflects my own background as a singing and voice teacher and my lived experience of navigating vocal health. The pragmatic element indicates that the emphasis is on producing knowledge that is practically useful rather than solely theoretical. It also enabled me to be adaptable in my approach, combining qualitative methods, such as interviews, with quantitative tools, like questionnaires. I was able to thoroughly examine lived experiences while also spotting more general patterns and trends thanks to this combination. My aim to comprehend how professionals interpret their identities and work is reflected in the interpretivist component. All

things considered, this paradigm backs up my emphasis on interdisciplinary cooperation, professional boundaries, and knowledge sharing in the voice care industry.

To combine qualitative and quantitative strategies, a mixed-methods approach was employed (Oranga, Matere, & Njura, 2025). While quantitative data from a questionnaire showed quantifiable trends, semi-structured interviews and a comprehensive literature review produced qualitative insights (Ahmed & Kimberly, 2024). I was able to compare and validate results by using both kinds of evidence, which gave a more comprehensive and impartial view.

To reach professionals directly involved in voice care, whether in habilitation, rehabilitation, or both, purposeful sampling was used. SLPs, SVSs, vocal coaches, and singing instructors were among the participants. Social media, professional networks, and pertinent organisations were used for recruitment. Three practitioners participated in in-depth interviews, and a total of twenty-five practitioners answered the questionnaire. Despite its small size, the sample included a wide range of highly relevant perspectives.

Data Collection

Three forms of data collection were used:

1. Literature Review – A narrative review of existing research provided the theoretical frame and allowed me to place the data in context.
2. Questionnaire – An online survey with both closed (Likert scales, multiple choice) and open-ended questions. This gave a broad picture of professional backgrounds and attitudes, while also capturing personal reflections.
3. Interviews – Semi-structured interviews with selected participants, conducted online.

These explored professional identity, collaboration, ethical challenges, and practice boundaries in more depth. Interviews were recorded (with consent) and transcribed verbatim.

The research design followed a sequence where each stage informed the next (Fetters, Curry and Creswell, 2013). The literature review established the theoretical background and shaped the focus of the later stages. The questionnaire then provided a broad overview of professional contexts and highlighted themes that needed further exploration, which were examined in more depth through interviews. By moving from broad mapping to detailed enquiry and comparing insights across these different sources, the triangulated design added both depth and credibility to the findings (Saraswati, 2023).

Data Analysis

Descriptive statistics (frequencies, percentages, tables, and graphs) were used to analyse the questionnaire data. Following Braun and Clarke's (2006) six-phase framework, familiarisation, coding, theme development, review, definition, and reporting, the open-text responses and interview transcripts were subjected to a thematic analysis (Figure 2).

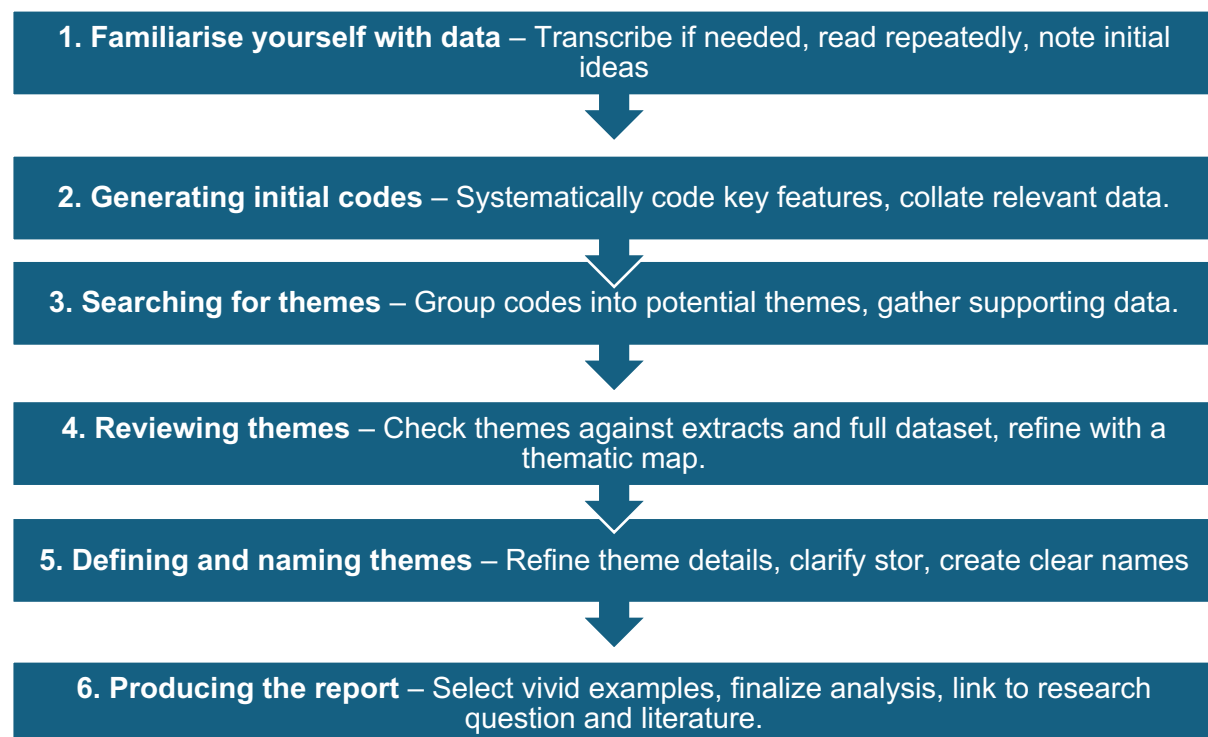


Figure 2: Braun and Clarke's (2006) six-phase framework for thematic analysis.

Iterative analysis was employed, and codes were refined as trends emerged. The results were then interpreted and compared to the literature to highlight areas of similarity and difference. The six phases of Braun and Clarke's framework are summarised in Figure 2.

Researcher Positionality

My background as a voice pedagogue inevitably shaped this research. This insider knowledge helped me understand terminology and context, but it also risked bias. To manage this, I worked reflexively (Savvides et al., 2014), keeping a positionality journal and reflecting on how my identity as a practitioner might influence the choices I made in design, analysis, and interpretation. Validity, Reliability, and Trustworthiness. Several strategies were used to strengthen the trustworthiness of the research:

- Triangulation – combining questionnaires, interviews, and literature.
- Transparency – documenting sampling, data collection, and analysis in detail.
- Reflexivity – ongoing attention to how my background shaped the research.
- Member Checking and Peer Debriefing – To strengthen credibility, I used member checking and peer debriefing. To ensure my interpretations aligned, participants reviewed and clarified their interview summaries. I also spoke with coworkers outside the project about coding and themes, and their input improved my strategy. These actions increased the finding's credibility and provided additional validation.

Ethical Considerations

The UWTSD ethics board gave its approval. All participants provided their informed consent after being given information sheets that explained the study and their withdrawal rights. By anonymising responses and safely storing all files, confidentiality was preserved. Participants had the option to refuse to answer any question, and delicate topics, such as professional boundaries, were handled carefully.

Findings

This chapter presents the findings of the study, focusing on how professional roles are negotiated where voice habilitation and rehabilitation overlap. A neutral stance is maintained throughout, with data from questionnaires and interviews combined to illustrate both broad patterns and individual perspectives. Through Thematic analysis eight themes were developed and presented below with participant extracts (see Figure 2).

Abbreviations

SLT – Speech and Language Therapist (UK); **SLP** – Speech-Language Pathologist (US)

ENT – Ear, Nose and Throat specialist (otolaryngologist)

SVS – Singing Voice Specialist

MDT – Multidisciplinary Team

CPD – Continuing Professional Development

A total of 25 participants completed the questionnaire, with most identifying as singing teachers or vocal coaches (56%), while a smaller proportion, 20%, identified as specialists such as Singing Voice Specialists (SVS), Speech and Language Pathologists, and only one participant identified as a spoken voice coach (Figure 3). Where referred to within this report, they will be referred to as participants.

Which one below best describes your primary professional role?

25 responses

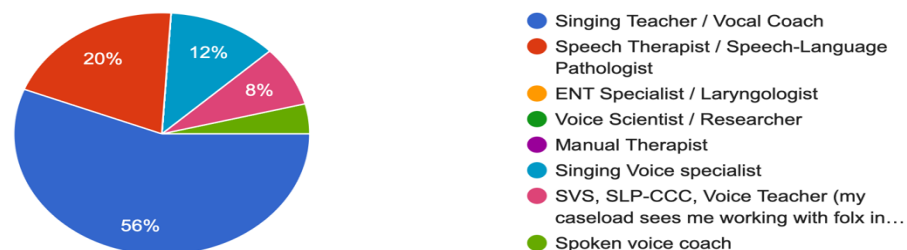


Figure 3 - Pie chart showing professional role of questionnaire respondents.

The participants' professional experience varied: 8% had between 1–5 years, 32% had 6–10 years, 24% had 11–15 years, and 28% had over 20 years in the field. This distribution is illustrated in Figure 4, which presents a pie chart of years worked in the field by questionnaire participants. In terms of qualifications, most held a university or master's degree in a voice-related area, with a few reporting professional certificates or diplomas (Figure 5)

Figure 4: Pie chart of years of experience.

How many years have you worked in this field?

25 responses

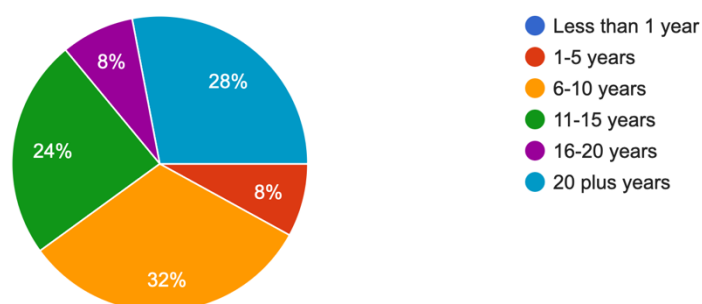
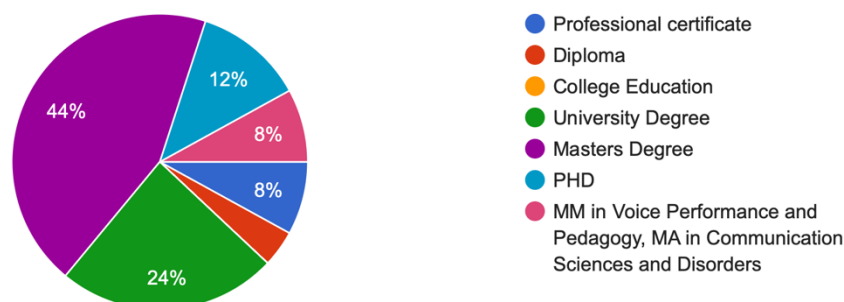


Figure 5: Pie chart of the highest formal qualification.

What is your highest formal qualification in voice care or related areas?

25 responses



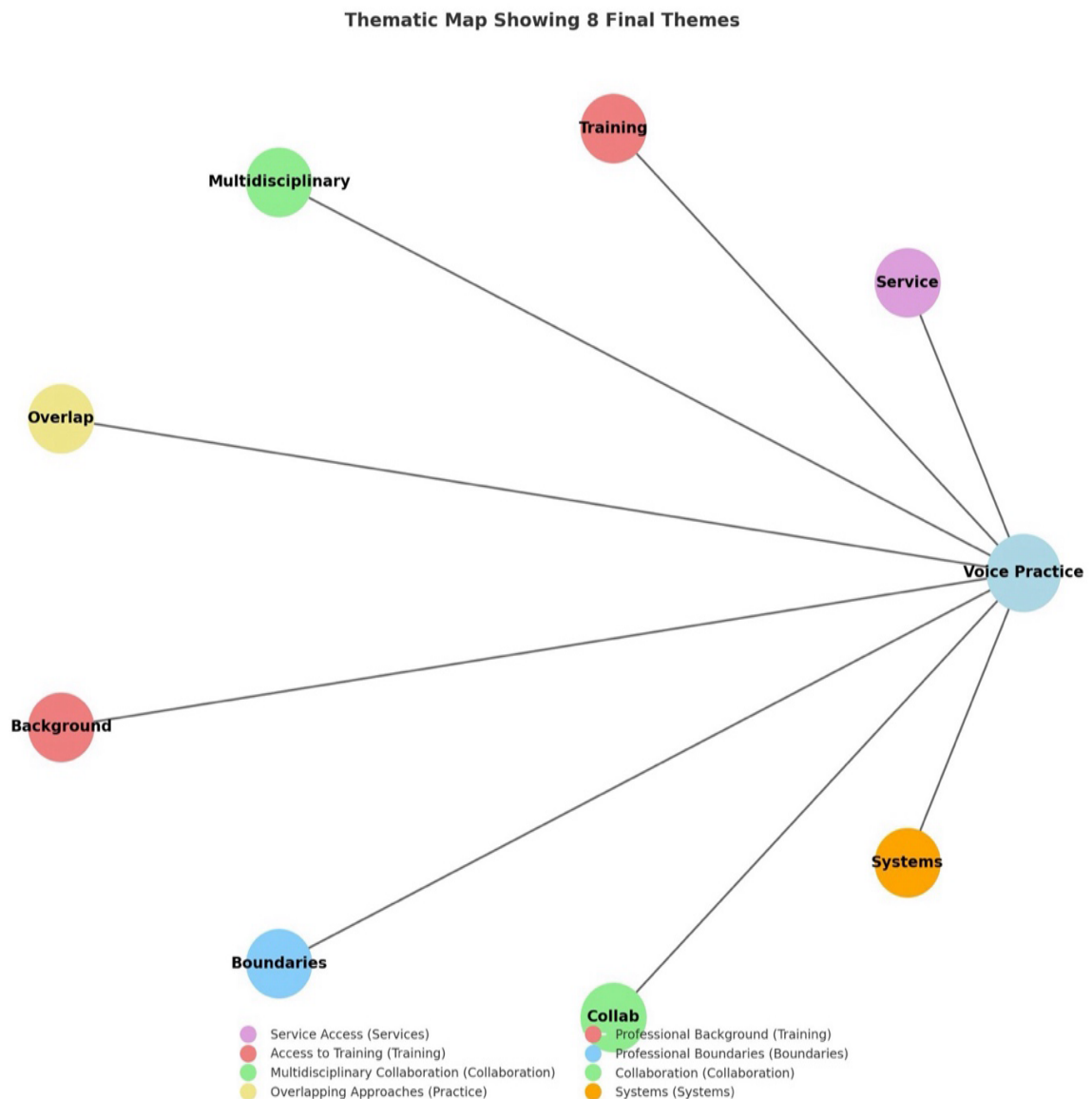
Three semi-structured interviews were also conducted with two SLPs and one singing teacher/voice pedagogue. Their backgrounds are shown in Figure 6, and they are referred to in this report as Participants 1, 2, and 3. These participants were selected purposively to ensure both clinical and pedagogical perspectives were included. Although the interview sample was small, the conversations provided detailed and insightful accounts that enriched the broader questionnaire data. Using both methods together allowed for data triangulation: the questionnaire offered an overview of familiar patterns, while the interviews provided more individual perspectives. Combined, they contributed to a more comprehensive picture, capturing both collective trends and personal experiences within voice care.

Figure 6: Interview participant backgrounds.

Participant	Role	Main Focus	Experience
1	SLT – Neurological Rehabilitation	Rehabilitation (voice in neurological conditions)	Clinical SLT training (paediatrics → adult neuro care); several years progressing to team lead (exact years not specified).
2	Clinical Lead for Voice (SLT)	Rehabilitation (voice disorders), some habilitation overlaps	>15 years in voice specialisation; additional specialist training, courses, and networks.
3	Singing Teacher & Voice Pedagogue	Habilitation (healthy voices, prevention), some rehabilitation	Performance/teaching career + Master's in voice pedagogy, specialist certificates, ongoing study.

After collecting the data, through thematic analysis, 82 initial codes were created and organised into sub-themes and later refined into eight main themes. This process is shown in the thematic map (Figure 7), and the final themes are outlined below.

Figure 7: Thematic map showing eight final themes



Final themes through thematic analysis

1. **Professional background:** The routes professionals take into specialist voice work, their qualifications, and ongoing learning pathways.
2. **Access to training:** Considers how accessible training, mentorship, and peer support are.

3. **Multidisciplinary collaboration:** Explores collaborative and individual approaches to daily voice care practice.
4. **Overlapping approaches:** Examines how different practitioners define and implement both habilitation and rehabilitation.
5. **Service access:** Describes how clients seek assistance, including referral routes and gaining access to services.
6. **Professional Boundaries:** How professionals set and maintain boundaries, clarify roles, and respond to legal or ethical dilemmas.
7. **Collaboration challenges:** Successes and challenges in teamwork, interdisciplinary communication, and their impact on patient care.
8. **Systems: Highlights:** Systemic factors such as funding, regulation, and innovation.

Figure 8 below shows how these themes were spread across the interview data, comparing participants and highlighting both shared patterns and individual differences.

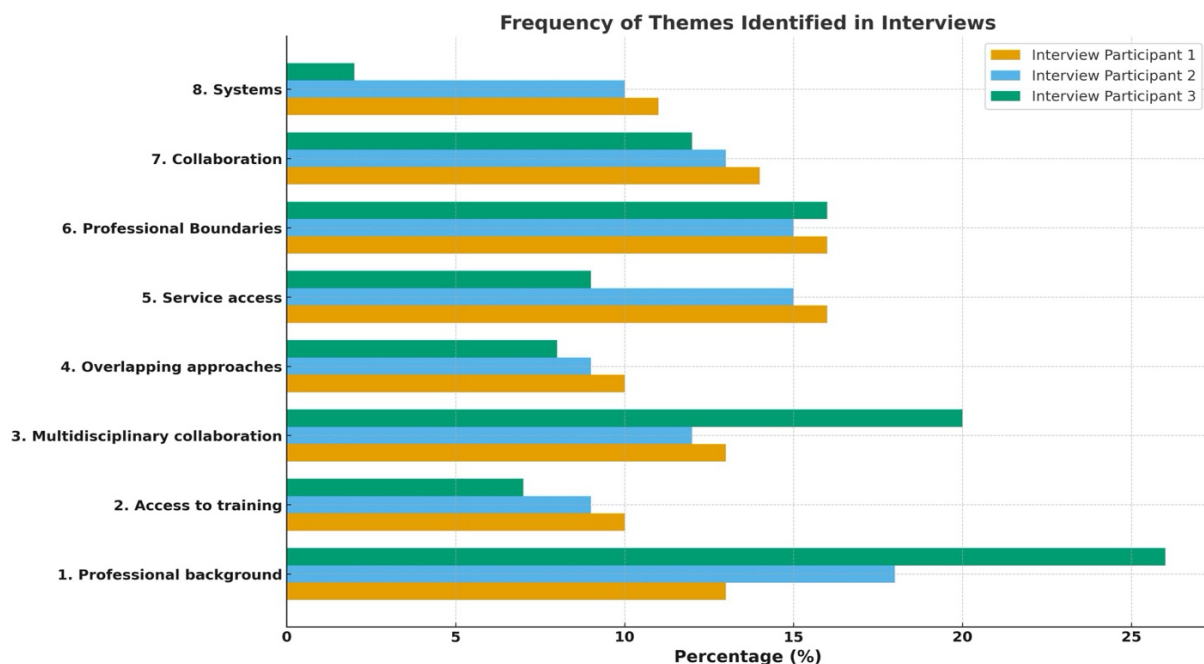


Figure 8: Comparison of themes raised by three interview participants.

The themes identified and explored through the three interview participants show both overlap and variation in the themes raised by each participant. Although all themes were mentioned to some extent, the emphasis on them varied. Participant 3, for example, focused more on multidisciplinary working and professional background, training, and ongoing development, while Participants 1 and 2 spread their focus more evenly. These differences suggest that professional role and background can influence perspectives. Analysing these three professional viewpoints highlights shared concerns that are more specific to individual roles within voice habilitation and rehabilitation.

The following section will present the findings of all 8 themes.

Theme 1. Professional Background

The findings indicate that professionals enter voice care through various pathways, often beginning in performance before transitioning to teaching, clinical, or hybrid roles. This diversity was validated by questionnaire responses, which included training pathways that ranged from clinical qualifications to music degrees, as well as certificates and diplomas. (see Figure 9) These diverse backgrounds are central to understanding how professional identities emerge at the boundary between voice habilitation and rehabilitation.

Participant 1 described a mixed career spanning schools, universities, and private practice, supported by extensive pedagogical and clinical training. With a master's degree in voice pedagogy, additional certificates in vocal health, Estill, trauma-informed practice, and mental health for singers, they explained: "My training has helped me prepare for this role very well... I've also done tons of other training outside of that, and I'm currently training to be a voice habilitation professional." Their account illustrates the complex, developmental pathways in which teaching and rehabilitation overlap through ongoing professional learning. Another participant reflected on the fragmentation of professional development: "You're very

dependent on where you work, what courses happen to come up and who's training you." This variability echoes concerns in the literature about inconsistent preparation and unclear role boundaries in voice care (Kenny et al., 2016), highlighting uneven training provision and a lack of clear frameworks.

Others emphasised performance as the starting point. As one respondent reflected: "The initial training I undertook was in performance it is highly unlikely you will get information about collaborating with medical disciplines through the lens of a teacher on a performance course." This reflects Boone et al. (2020) and Rosenberg's (2019,) who observe that pedagogues often ground their professional identity in performance. Another participant put it more bluntly: "I truly believe that I needed every second of schooling and professional experience as a voice teacher and singer and clinician to prepare me for the work I do with the individuals I serve." Such comments support Nix and Carey's (2021) description of hybrid roles, such as the SVS, which deliberately bridge the pedagogical and clinical domains.

Interviews reinforced the variability of initial training. Participant 2 recalled: "At uni, you basically do about two days' worth of lectures on voice and that's it. So, it's very much a case of learning on the job, through more experienced therapists or courses." They described relying on CPD, postgraduate study, and Clinical Excellence Networks, later completing specialist courses from endoscopic voice analysis to manual therapy with Lieberman and Walt Fritz. This illustrates what PAVA (2019) points out, that the field lacks agreed core competencies, leaving professionals to "patch together" expertise.

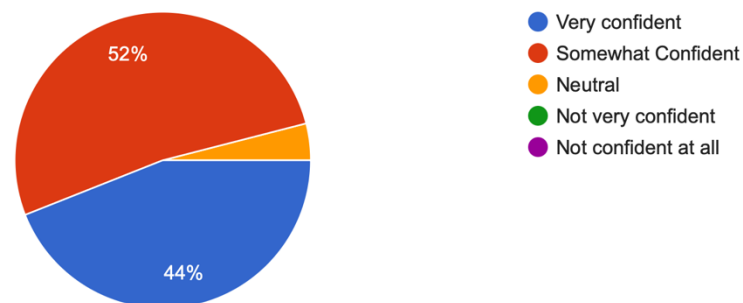
One teacher reflected: "As an undergraduate and graduate student, I had teachers that tried to work on rehabilitating my MTD (muscle tension dysphonia) in ways that I now believe were outside of their scope of practice." They suggested that "more structured interdisciplinary exposure during training would have been beneficial," supporting the ethical conundrums and

scope issues raised by Kenny et al. (2016). Questionnaire data mirrored this inconsistency: as shown in Figure 9, confidence in identifying vocal pathology symptoms was mixed, with some respondents highly confident and others considerably less so. This points to a wide variation in practitioner readiness linked to training and development.

Figure 9: Confidence in recognising pathology

How confident are you in recognising signs of vocal pathology in your clients or students? Scale: 1 (Not at all confident) – 5 (Extremely confident)

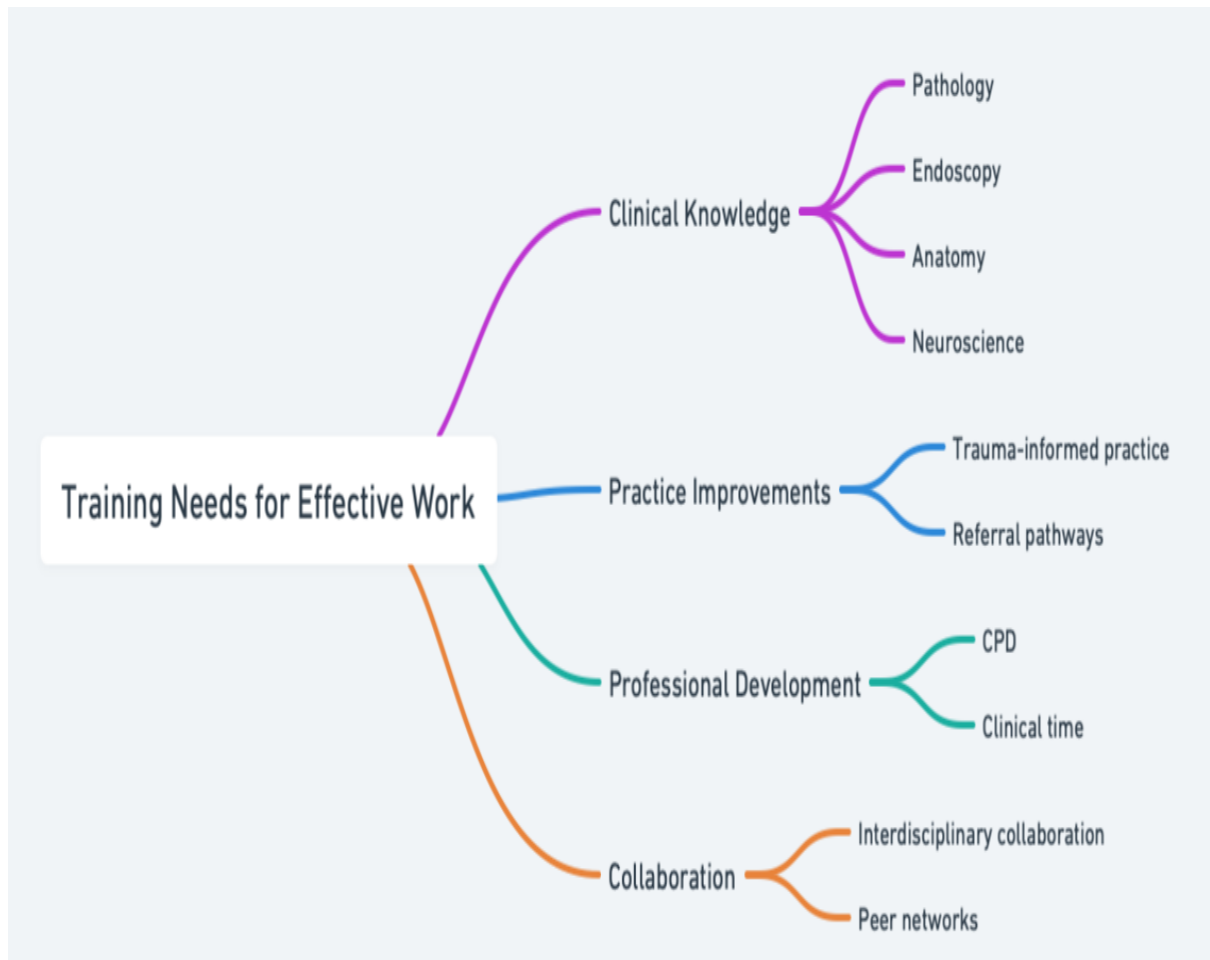
25 responses



Others noted that knowing “basic vocal demands, typical vocal load/use schedules, and about voice classification” is crucial, given that premature or incorrect classification can increase risks to vocal health.

Several participants argued that formal training in pathology, endoscopy, anatomy, and neuroscience would enhance competence. Others called for cross-disciplinary training with SLTs, ENTs, and laryngology students to “break down barriers and increase respect between disciplines.” Figure 10 summarises what participants said would most support their work, ranging from increased clinical knowledge to stronger peer networks and more opportunities for collaboration.

Figure 10: Key training needs identified by participants.



One questionnaire participant noted: “Just when you think you may have ‘heard it all,’ some new situation comes along!” They linked this to the importance of continuous CPD, whether through “reading recent research papers, clinic observations, and joint projects with SLT or laryngology students.

Across the dataset, lifelong development was seen as essential. One respondent captured the ethos: “There is ALWAYS more to learn, whether from medical specialists who have literally thousands of hours of experience or voice teachers who specialise in styles less

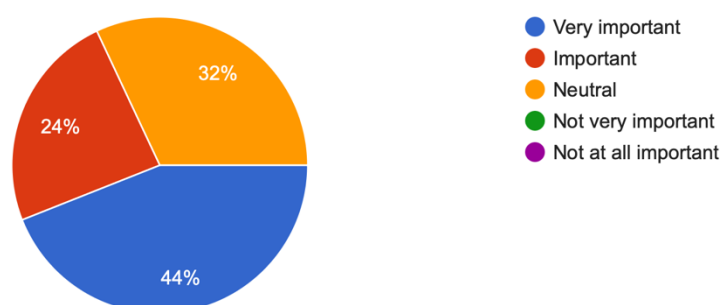
familiar to you.” Another added: “For good interdisciplinary work, it’s really important to be open to others’ opinions, listening to others and valuing their different input.” This resonates with Hersey, Searce and Johnson’s (2020) argument that humility and openness are core skills for interdisciplinary practice.

Finally, participants debated the need for formalised certification. While some welcomed clearer standards, such as SVS credentials or national-level referral protocols, others were wary. Questionnaire data reflected this tension, with participants divided on the importance of developing formal interdisciplinary qualifications or certifications, such as the (see Figure 11). Less than half believed it was essential, and a large number regarded it as neutral.

Figure 11: Importance of interdisciplinary qualifications.

How important is it to develop formal interdisciplinary qualifications or certifications (e.g., Singing Voice Specialist)?

25 responses



One participant warned: “The cynic in me fears that schools will look at this opportunity as a way to attract students and collect tuition, not create a population of individuals with lived expertise.” An SLT suggested a systemic solution: “It would be amazing if the NHS would get to the point where there was a standard referral process and practice for voice.”

Overall, voice-care professionals take highly diverse routes into the field, with ongoing learning at the core of practice. Persistent concerns remain around legitimacy, scope of practice, and uneven access to structured training. The tension between formal qualifications and lived experience underscores the complexity of professional identity in this field.

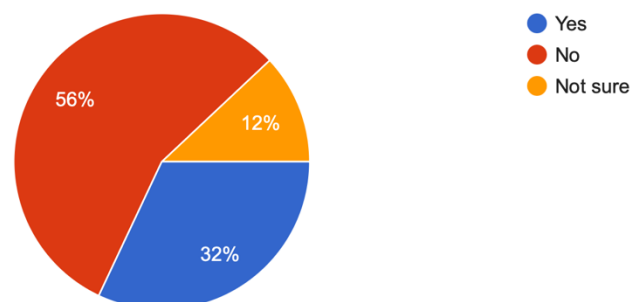
Theme 2: Access to Training and Support

Participants reported mixed experiences of accessing training and peer support. Questionnaire responses showed that most participants reported their initial training did not include interdisciplinary content, with only a small proportion describing formal exposure to both clinical and pedagogical training (Figure 12).

Figure 12: Pie chart: Initial training inclusion of interdisciplinary content.

Did your initial training include interdisciplinary content (e.g., modules on both clinical and pedagogical voice care)?

25 responses



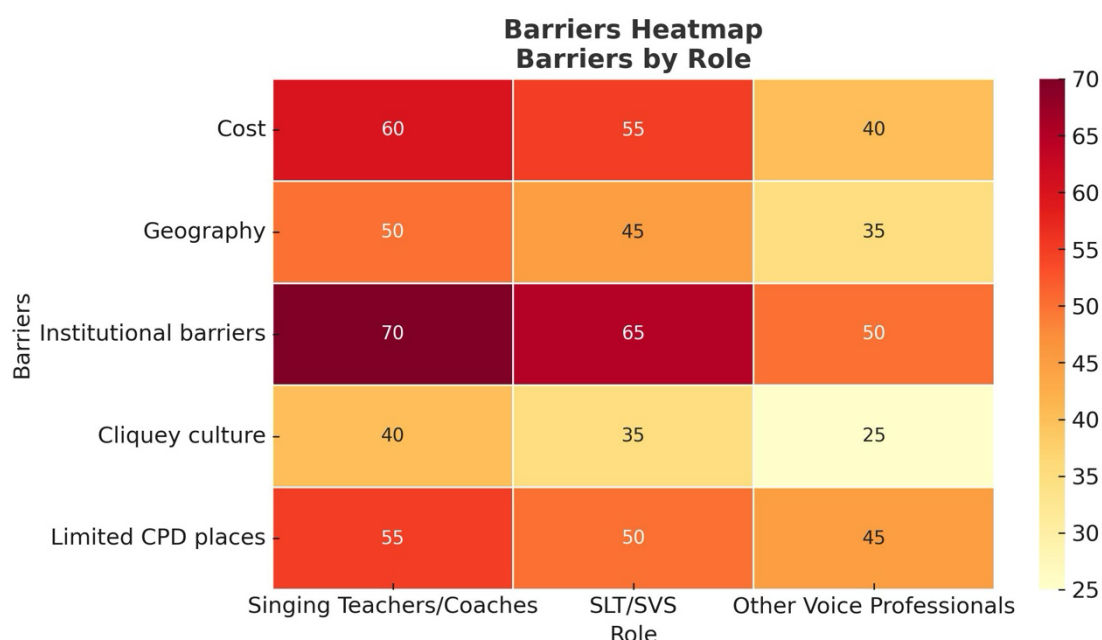
One participant explained: “The Northwest Voice Conference... has been instrumental in developing relationships between voice teachers, SVS, SLPs, ENTs, and clinical and non-clinical professionals in care of the singing voice.” Another recalled that “yearly seminars with voice specialists (ENT, speech therapists) ... were the only course I had the chance to learn directly from these specialists.” Several emphasised the role of peer networks, such as Clinical Excellence Networks, in providing training where no formal pathways existed: “Within

that, we sort of run courses for therapists... I've done quite a few courses through that." These accounts reflect the importance of CPD and interdisciplinary gatherings for sustaining professional development and legitimacy (Loar, 2020; Maxfield & Ragan, 2021).

Barriers were also widely reported. Some participants found specialist CPD intimidating, with one admitting: "The clinical CPD is so detailed and intense I don't feel like it's going to be penetrable or applicable for me at all". Others noted the culture of peer networks, describing some online spaces as "a bit cliquey." Access was also shaped by circumstance rather than design: "You're very dependent on where you work, what courses happen to come up and who's training you." A further participant argued that "for actual teaching and for the singer teacher, I don't think there's enough training out there which helps collaborate between different disciplines." These experiences align with Radionoff's (2004) concern that dual-discipline pathways remain underdeveloped and Zeller's (2016) observation that access to training is often dependent on geography and networks rather than structured provision.

Figure 13 illustrates the most frequently reported barriers to training and support. Institutional issues, including limited MDT opportunities and unclear pathways, were the most common, followed by practical obstacles such as a lack of time and geographical distance. Cultural challenges, such as the perception of specific peer networks as "cliquey," were noted less often but still contributed to exclusion.

Figure 13: Heatmap of barriers by role.



The heatmap in Figure 13 illustrates which barriers to training and support were mentioned most frequently by participants, with darker shades indicating higher occurrence. Institutional issues, including limited MDT opportunities and unclear training pathways, as well as practical barriers such as time and geography, were the most prevalent. Cultural challenges, including the perception of specific peer networks as “cliquey,” appeared less often.

Barriers were described as including a sense of exclusion: “Some well-known social media platforms are often the same faces and feel a bit cliquey.” Several participants requested more opportunities to shadow clinicians or attend joint clinics, believing this access would make collaboration more tangible. A long-serving participant reflected that “there is a lot of training available now... as new information is released through research, new modules or courses can be developed,” but emphasised the need for *practical mentoring rather than solely formal classes*. This aligns with Carroll and Searce’s (2020) point that embodied, practice-based learning often has more long-term value than didactic CPD.

Structural barriers also influenced access. Participant 2 pointed out the *postcode lottery* of NHS services: “In some NHS services, you will be sat within an MDT. In others, you won’t be. It just depends on what’s commissioned, where, by whom.” They called for more structured pathways: “It would help if there was a more prescriptive training programme for therapists wanting to go into voice.” They also reflected on the isolation of their previous role: “In my previous job, I was the only voice therapist, so I very much had to go elsewhere to build my competency.”

Participant 3 highlighted the scarcity of voice-trained SLTs, describing voice as “a specialism within a specialism.” They called for more undergraduate training in voice and suggested: “a national network of voice specialists for clinical support when you’ve reached the limit of your knowledge.” Their comments echo Behlau et al.’s (2015) view that structured professional support and access to recognised expertise are vital for legitimacy and clarity of role in voice care.

Participation depends on factors such as cost, geography, institutional systems, and professional culture. Without national-level referral procedures, structured postgraduate pathways, and expanded access to CPD, the profession risks further fragmentation and inequality of standards, issues already highlighted in the literature (Loar, 2020; Radionoff, 2004; Zeller, 2016; Maxfield & Ragan, 2021; Behlau et al., 2015). Taken together, the questionnaire and interviews suggest that uneven access to interdisciplinary training directly contributes to the project’s core concern: the fragmented pathways into voice care and the blurred boundaries between habilitation and rehabilitation.

Theme 3: Multidisciplinary Ways of Working

Collaboration was described in very different ways throughout the dataset, ranging from one-to-one client work to structured team clinics and more informal exchanges of

knowledge. Questionnaire results also reflected this unevenness. Figure 11 shows that collaboration varies widely, with some participants working across disciplines weekly, while others reported only rare or no collaboration. This inconsistency suggests that opportunities depend heavily on role and context, which directly relates to the project's aim of examining where habilitation and rehabilitation meet. For those with regular collaboration, boundaries are easier to negotiate, whereas limited opportunities can leave gaps and uncertainty.

Figure 14: Pie chart how often do you collaborate.

How often do you collaborate or consult with professionals from other voice-related disciplines?
25 responses

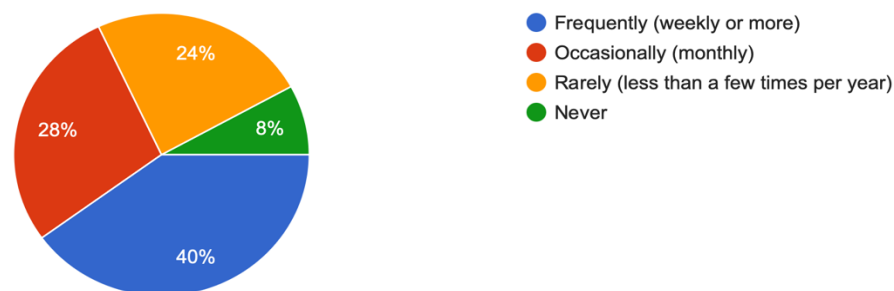


Figure 15 illustrates the main professional connections discussed by participants. Some relationships, like between SLTs and ENTs, appeared frequently and seem well established, while others, such as links between singing teachers and psychologists, were mentioned much less often. This indicates that collaboration across the field is unevenly strong in certain areas but limited in others. This gap sets the scene for the interview findings, where participants provided more detail about how these partnerships operate daily and the barriers that can hinder their sustainability. It also relates to one of the project's aims: not just to identify where collaboration is already effective, but to explore where professionals might work in isolation or clients may not receive fully integrated support.

Figure 15: Collaboration of partners.

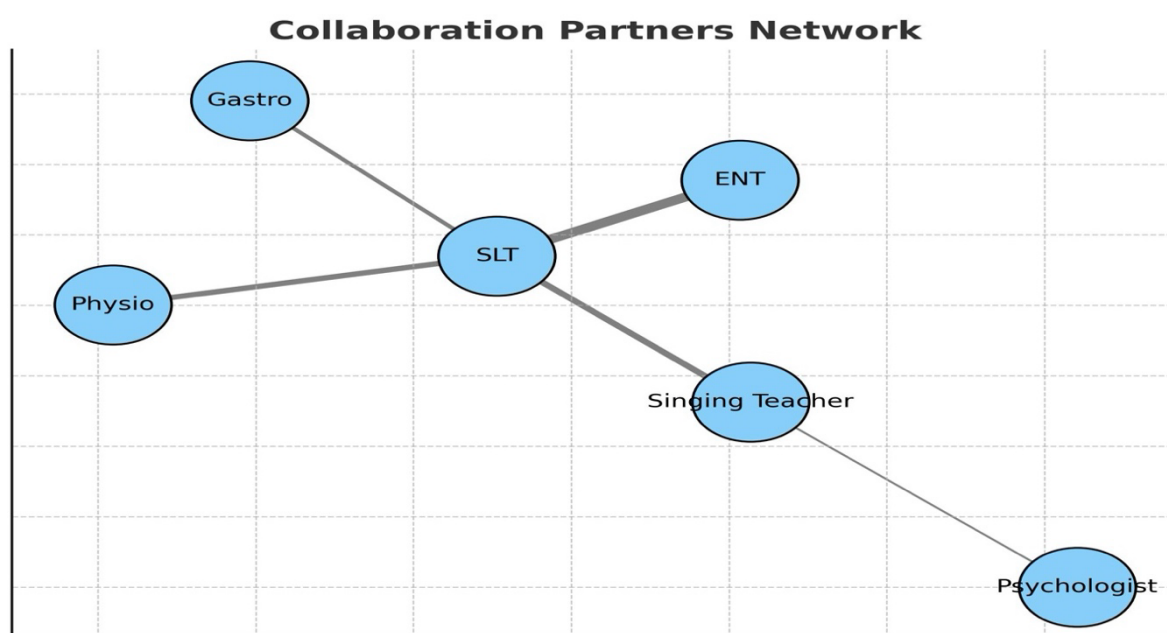
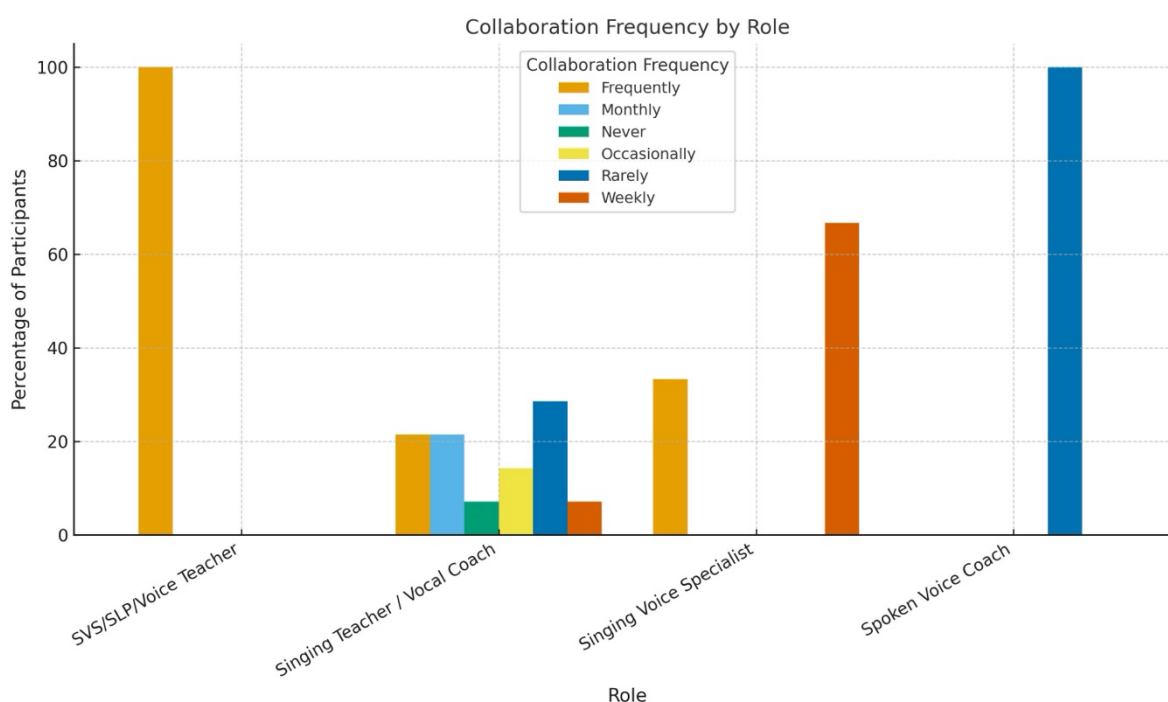


Figure 16 displays the frequency of collaboration in value by the thickness of the connecting line; more frequent collaboration is usually seen through team-based clinics, while singing teachers and vocal coaches tend to collaborate only occasionally or rarely. This indicates that collaboration is not solely a matter of personal choice but is heavily influenced by a person's role and work environment. This ties back to the project's aim of demonstrating how opportunities for interdisciplinary work can be shaped or limited by wider professional and institutional contexts.

Figure 16: Graph showing collaboration frequency by role.



The interviews gave a clearer picture of what collaboration looks like day to day, from structured MDT clinics to more informal sharing of knowledge and support. Participant 1 gave an example of how wide-ranging this work can be: “At the college I work at, I work with other singing teachers with different qualifications and backgrounds, musical directors, and singers. I also work with a laryngeal physio, and we’ve done some work together.” They stressed the importance of interpersonal openness: “For good interdisciplinary work, it’s crucial to be open to others’ opinions, and valuing their different input.” This focus on respect for one another is consistent with Carroll and Searce's (2020) assertion that collaboration involves more than just technical knowledge.

Participant 2 highlighted the benefits of formal multidisciplinary clinics: “The most successful MDT working that I’ve done has been alongside ENT, just being in the same place, working with the same clients, learning from each other and what each role gives to the management of a patient.” They also worked with respiratory physios, gastroenterology, and clinical psychology, but admitted these opportunities were less frequent: “Clinical psychology is one of the key groups I’d like to work with more closely, but they’re so few and far between.” For them, the main barrier was not willingness but logistics: “It’s not that people don’t want to work together it’s getting our diaries to line up so we can be in the same place at the same time.” These reflections mirror Goffi-Fynn and Carroll’s (2013) finding that even when collaboration is well intentioned, systemic and practical barriers often limit its implementation. Participant 3 described collaboration as a policy requirement: “It’s policy that we can’t do voice work until patients have been scoped to rule out pathology.” Their practice also included working with laryngeal manipulation specialists, though only those based in ENT clinics. They reflected that collaboration was generally smooth: “Clinical voice is such a small world... people are generally open and respectful of different perspectives.” This speaks to Titze and Abbott’s (2012) concept of vocology as an integrating discipline, where clinical and pedagogical expertise can overlap under shared principles of vocal function.

Not all collaboration was formal. Informal exchanges and shared discussions were also seen as valuable. “Comparisons of systems and protocols... even a basic crossover can be helpful to pass on verbal knowledge and redirection.” Another added that “partnerships between voice teachers and rehabilitators with cross-referrals and collaboration” were crucial, emphasising that taking the time to comprehend one another’s viewpoints was equally as essential as having technical know-how. This is in line with Radionoff’s (2004) theory that hybrid positions like the SVS work best when they are based on both structured instruction and unstructured, practice-based communication.

Despite this optimism, concerns arose about blurred boundaries. One teacher reflected: “Somewhat blurred... I have encountered singing teachers diagnosing vocal pathologies without any clinical evidence and continuing to work with them rather than referring.” An SLT raised a similar issue when working with colleagues in gastroenterology and respiratory care: “We know a lot about reflux and how it could impact the larynx, but we’re not necessarily the right people to be managing the cause... boundaries can get a bit blurred.” These concerns echo Sataloff’s (2017) warnings that an unclear scope of practice can delay necessary treatment, and Rinta and Welch’s (2008) observation that inconsistent terminology continues to create confusion across disciplines.

Systemic barriers were another recurring theme. One US-based teacher described long delays in accessing care: “One of my students had a vocal injury and it took a year to get in to see someone. She hasn’t seen them yet! The appointments in 2 more months and I’ll probably have her completely rehabilitated before that time.” In the UK, Participant 2 described the “postcode lottery” of NHS services: “In some services you will be sat within an MDT. In others, you won’t be. It just depends what’s commissioned, where, by whom.” These examples reinforce Titze’s (2012) concern that inequities in access remain one of the most significant obstacles for voice users, especially those whose livelihoods depend on timely care.

Some also raised the problem of having “too many cooks in the kitchen,” where unclear role divisions risk confusing clients. Yet the overall tone remained hopeful, with one participant concluding: “There are frequently decisions to be made around at which point the patient should access a singing teacher or vocal coach... there needs to be greater clarity around the roles, training and boundaries.” This reflects Boone et al.’s (2020) argument that while role clarity remains contested, the profession is moving towards more integrated, team-based approaches.

Taken together, these accounts suggest that multidisciplinary working is both highly valued and unevenly applied. Where collaboration succeeds, it relies on trust, respect, and access to shared spaces. When it fails, the obstacles are either cultural, systemic, or scope related. This is in line with recent research that advocates for more precise frameworks and competencies to promote collaborative, safe, and sustainable voice care (Boone et al., 2020; Titze & Abbott, 2012; Carroll & Searce, 2020). These findings link back to the aims of the project, showing that although people value working across disciplines, the chance to do so isn't always guaranteed. This inconsistency has a direct impact on how habilitation and rehabilitation overlap in practice, influencing not only professional boundaries but also what clients experience.

Theme 4: Overlapping approaches

Throughout the data, many participants noted that the distinction between habilitation and rehabilitation is not always clear. While some provided straightforward definitions describing habilitation as the process of building or maintaining healthy voice use, and rehabilitation as restoring the voice after illness or injury in practice, these terms were not always used consistently. This lack of clarity was also reflected in the questionnaire results. When asked how distinct they felt the boundaries were, responses varied widely, with some viewing them as separate areas and others seeing them as overlapping (see Figure 12).

This variation links back to one of the main aims of the project, which is to show how the different routes people take into voice care shape not only the way they work, but also how they understand where habilitation stops, and rehabilitation begins. These broader patterns were then reflected in the interviews, where participants described in more detail how they navigate these overlaps in their day-to-day work.

Participant 2 described rehabilitation as *“trying to put something right when it’s gone wrong”* and habilitation as *“making the best of what somebody’s got.”* Participant 3, however,

admitted: “We don’t really talk about habilitation... all the voices I see are atypical and need rehabilitation.” These accounts echo Stadelmann and Tschopp’s (2018) observation that, although theoretically separate, habilitation and rehabilitation are often negotiated in context rather than used as fixed categories.

For some, the divide was easier to articulate. One teacher likened habilitation to a personal trainer “strengthening and training healthy voices” while comparing rehabilitation to physiotherapy, dependent on medical knowledge and clinical expertise. Others gave more holistic definitions. One described habilitation as “the practice of using the voice in a way that is sustainable, effective, and artistic... across the physical, mental, and emotional realms.” Another referred to rehabilitation as “athletic rebuilding,” *emphasising* the reconditioning required after surgery or illness. These perspectives mirror Behrman, Borczak and Guthrie’s (2008) comparison of habilitation to athletic training and rehabilitation to physiotherapy, while also reflecting Wade’s (2020) argument that recovery should be understood in terms of wider participation and wellbeing, not just restored function.

Figure 17: Quote cloud of description of habilitation and rehabilitation.

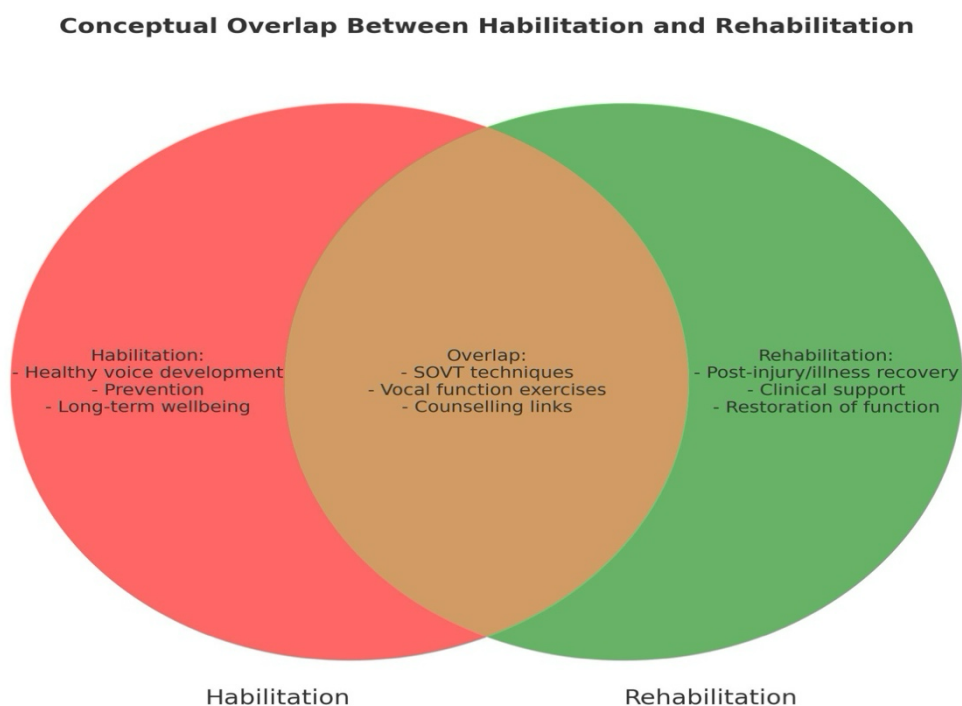


The word cloud, created using WordArt.com, demonstrates the diverse ways in which

participants conceptualised habilitation and rehabilitation. Some drew comparisons with specific practices such as personal training *or* physiotherapy, while others framed it more broadly in terms of building, strengthening, and balancing. These differing perspectives reinforce the overlapping boundaries illustrated in Figure 18, and, in practice, many participants acknowledged that the distinction between the two is often less clearly defined.

Participant 1 explained: “Yes, SOVT techniques and vocal function exercises are used quite often, both for habilitative and rehabilitative care... They’re a big part of yoga and fitness routines too.” Participant 2 echoed this, citing “SOVT and vocal function exercises” as common across both domains. This supports Andrade et al.’s (2014) finding that semi-occluded vocal tract exercises are practical in both prevention and therapy, as well as Kapsner-Smith et al.’s (2015) conclusion that such adaptable methods bridge disciplinary boundaries. To make this overlap clearer, Figure 18 maps the relationship between habilitation and rehabilitation, with shared techniques sitting in the middle where the two areas intersect.

Figure 18: Overlap.



Beyond the technical overlap, some participants also linked these shared practices to wider aspects of wellbeing. Participant 1 further connected these approaches to psychological wellbeing, noting: “When people struggle with anxiety or psychological concerns, these approaches can be integrated into counselling sessions as well.” This reflects Aldridge-Waddon et al.’s (2024) findings that voice difficulties are often intertwined with psychological distress and require holistic, interdisciplinary responses.

Systemic barriers often pushed pedagogues into quasi-rehabilitative roles. One US teacher noted: “Voice rehabilitation with an SLP is usually only covered for 8 weeks... I train students who need consistent training.” Another explained: “One of my students had a vocal injury and it took a year to get in to see someone... I’ll probably have her completely rehabilitated before that time.” These accounts highlight the impact of inequities in access, echoing Behlau, Postma De López and Madazio (2015), who argue that limited clinical provision forces pedagogical professionals to fill gaps in care, sometimes beyond their intended remit. Participant 3 reinforced this point from the clinical side, acknowledging: “I don’t think habilitation and rehabilitation are understood very well at all.”

Ethical concerns were also raised. One SVS warned: “Singing teachers that claim to be rehabilitation specialists should be working in a clinic, period... then, they will learn ethical boundaries.” This underscores Van Houtte et al.’s (2011) warning that pedagogues working without clear referral pathways risk delaying essential treatment. Participant 2 also highlighted blurred boundaries with respiratory physio and gastroenterology: *“We know a lot about reflux and how it could impact the larynx, but we’re not necessarily the right people to be managing the cause.”* Such concerns reflect Achey and He’s (2016) argument that referral procedures and transparent qualifications are essential to avoid undermining safe, ethical care.

Despite these challenges, participants frequently framed their work around broader notions of vocal wellbeing. One respondent described habilitation as “building, strengthening, and balancing the voice so it can function freely, efficiently, and expressively across styles.” Another stressed maintenance: “Assessment and maintenance toward sustainable and healthy voice use to build synergy and redirect vocal performance.” These align with Rosenberg’s (2019) framing of voice care as a resilience-based model, as well as Maxfield and Ragan’s (2021) evidence-based pedagogy model, which integrates artistic and clinical goals to support long-term vocal health.

Looking forward, participants called for more structured support. Participant 1 argued: “Estill, for example, doesn’t always explain how to apply what you’ve learned or what knowledge to use in different situations.” They *suggested “more voice clinics in hospitals specifically for singers and performers,”* along with opportunities for mentorship and shadowing. These proposals echo Radionoff’s (2004) call for structured, competency-based pathways for hybrid professionals like the SVS, and align with Zhou et al.’s (2021) evidence that integrating voice training into clinical settings improves post-surgical outcomes.

Taken together, these accounts suggest that while habilitation and rehabilitation are conceptually distinct, they are practically entangled. Preventative and wellbeing-focused approaches are highly valued, yet systemic inequities and training gaps often compel professionals to cross boundaries. The findings highlight both opportunities for holistic, integrated care and ongoing risks around role legitimacy, ethical clarity, and equitable access.

Theme 5: Service access

Participants described significant variability in how professional voice users access services and navigate referral systems. Healthcare models, financial resources, and awareness among gatekeepers such as GPs or general ENTs shaped these experiences. While some described relatively structured pathways, others highlighted barriers that left singers and

teachers to fill systemic gaps. These findings mirror broader critiques in the literature that specialist voice services remain fragmented and unevenly distributed (Schneider & Sataloff, 2007; Behlau et al., 2015).

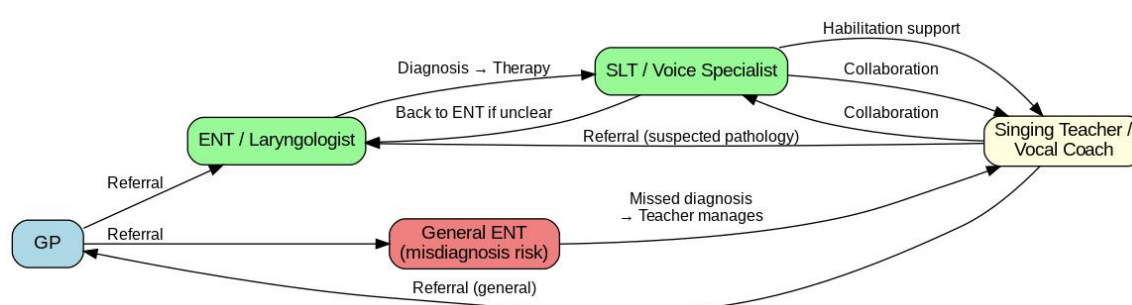
In the UK, certain routes were described as reasonably clear. Participant 3 explained: *“All patients must go through ENT before voice therapy,”* emphasising mandatory pathways designed to rule out underlying pathology. Participant 2 added that onward referral was often necessary: *“If I’m not making progress, I’ll send them back to ENT — sometimes the initial diagnosis is wrong... we quite often pick up a subtle polyp or something that’s been missed.”* They also described referrals to respiratory physio, gastroenterology, and clinical psychology, noting: *“A lot of voice problems are massively linked to underlying psychological issues, whether it be trauma or domestic abuse.”* These reflections demonstrate the complexity of interdisciplinary pathways, supporting Gartner-Schmidt and Rosen’s (2018) argument that optimal care often requires integrated input across medical, psychological, and rehabilitative domains.

At the same time, UK participants highlighted barriers within the system. One SLT reflected: *“In some NHS services you will be sat within an MDT. In others, you won’t be. It just depends what’s commissioned, where, by whom.”* This “postcode lottery” reflects Titze’s (2012) concern that provision for professional voice users is inconsistent, limiting equitable access to specialist services. A singing teacher echoed the issue at primary care level, stating: *“For GPs to understand the referral system to ENTs & Voice Clinics... is important. General ENTs should be more aware of the specific needs of professional voice users and refer them to laryngologists and voice clinics where required.”* Similar concerns appear in Hunter and Johns (2019), who note that inadequate GP and ENT awareness often results in delayed or misdirected care for performers.

By contrast, US-based participants described more systemic obstacles. One singing teacher explained: “Voice rehabilitation with an SLP is usually only covered for 8 weeks or 60 visits max (depending on insurance). As a voice pedagogue with specialised training... I train students who need consistent training.” Another highlighted the impact of long waits: “One of my students had a vocal injury and it took a year to get in to see someone... the appointment’s in 2 more months and I’ll probably have her completely rehabilitated before that time.” An SLT added: “Lots of community ENTs but not laryngologists,” meaning that singers were often misdiagnosed. These accounts echo Carroll and Searce’s (2020) observation that insurance restrictions and the shortage of laryngologists push pedagogues into quasi-clinical roles, raising questions about scope and safety.

Independent teachers also described challenges in deciding when and how to refer. One commented: “For me, with no clinical training, maybe this comes down to me understanding when I need to refer on... I won’t take them on as a client if I suspect they have a clinical pathology.” Another explained: “If hydration or training exercises aren’t making a difference... or if a singer loses their voice suddenly and it doesn’t come back, then I would definitely refer them on to ENT or their doctor.” These accounts highlight both the vigilance of many teachers and the ambiguity they face in the absence of formalised referral frameworks, supporting Loar’s (2020) call for clearer guidelines for when pedagogues should escalate concerns. Figure X shows that referral routes are not always straightforward. Teachers may refer to ENT or GPs; SLTs often work alongside teachers, and cases can loop back to ENT. This highlights how the “ideal” pathway is frequently disrupted and adapted to context.

Figure 19: Referral pathway



When the chain breaks down or professionals work outside their scope, the risk of misdiagnosis increases. This was a recurring concern in both the questionnaire and interviews. An SVS recalled: "I've encountered singers who were told by choir directors or other voice teachers that they had a pathology without having done any evaluation by a medical or other voice professional. This caused a lot of anxiety for the singer." Participant 2, an SLT, also flagged poor ENT referrals: "We still get ENT referrals that are utterly and completely wrong... sometimes it's not spasmodic dysphonia, it's MTD." These challenges reinforce Van Houtte et al.'s (2011) concerns about diagnostic uncertainty and the dangers of non-clinical labelling, which can heighten anxiety and delay appropriate treatment.

Despite these obstacles, participants were hopeful about future improvements. One SLT emphasised the role of professional attitudes: "Communication and willingness to keep an open mind to what others may bring to helping the individual seeking help are key skills in a good voice practitioner." Others advocated for structured referral frameworks and competency-based standards, aligning with the Pan American Vocology Association's (2019) call for nationally recognised referral protocols and shared competencies. Some participants even suggested initiative-taking measures, such as baseline laryngeal examinations for students entering conservatoire training, reflecting Schneider and Sataloff's (2007) proposal that preventative screening could reduce later risks.

Taken together, these findings highlight a system marked by both successes and inequities. Where pathways were clear as in mandatory ENT screening before therapy participants felt supported. Yet variability in provision, inconsistent diagnostic accuracy, and systemic barriers meant that many singers still fell through the cracks. As the literature emphasises, without clearer protocols and more consistent access to laryngologists and interdisciplinary clinics (Goffi-Fynn & Carroll, 2013), professional voice users remain vulnerable to delays, misdiagnosis, and uneven care.

Theme 6: Professional Boundaries

Participants reflected extensively on how they defined and maintained professional boundaries, particularly where pedagogical and clinical roles overlapped. Some described clear strategies. One UK singing teacher explained: “I ensure that I never diagnose, just advise a referral to a clinician.” Participant 1 similarly noted: “If hydration or training exercises aren’t making a difference, or if they lose their voice suddenly and it’s not coming back, or if a situation is ongoing for many weeks without improvement, then I would refer them on to ENT or their doctor.” They stressed the risks of overstepping, particularly with vulnerable individuals: “There might be issues where vulnerable people are being guided by people that aren’t trauma informed... if they continue to work in a situation they’re not fully aware of, rather than referring, it can become an ethical issue.” These examples demonstrate an awareness of limits and reflect Achey and He’s (2016) argument that ethical practice is underpinned by timely referral and recognition of professional scope. Alongside these concerns, participants also pointed to strategies for safe practice, such as humility, clear communication, and timely referral. These examples show that boundaries are managed not only by avoiding risks but by fostering respect and collaboration across disciplines.

Despite this, several participants described situations where boundaries blurred. Participant 2 explained: “The whole ‘should SLTs be working with singers’ crops up really frequently... some think yes, others argue no, that’s the job of the singing teacher.” They added: “Working on breathing is part of working on voice, but if it’s an actual dysfunctional breathing pattern, we don’t necessarily know enough about that... so making sure we’re not to the detriment of what another professional might be doing is really important.” Participant 3 raised similar concerns: “We’d be worried if someone was doing voice therapy without ENT assessment that’s outside of scope.” These reflections resonate with Smith’s (2021)

observation that even when pedagogical and clinical strategies look similar, they are shaped by different competencies and responsibilities, and role creep risks undermining safe, effective care.

Participants also described problematic cases. One teacher recalled: “As an undergraduate and graduate student, I had teachers that tried to work on rehabilitating my MTD in ways that I now believe were outside of their scope of practice.” Another described colleagues diagnosing without evidence: “I have encountered singing teachers diagnosing vocal pathologies without any clinical evidence and continuing to work with them rather than referring.” Similarly, an SVS cautioned: “Singing teachers that claim to be rehabilitation specialists should be working in a clinic, period... then, they will learn ethical boundaries.” Such accounts reflect Van Houtte et al.’s (2011) concerns that blurred practice can delay proper treatment and heighten client anxiety.

Explicit references to ethics were common. An SLT highlighted grey areas in medical crossovers: “We know a lot about reflux and how it could impact the larynx, but we’re not necessarily the right people to be managing the cause of the reflux.” Another warned against shortcuts in training: “Weekend courses in things like laryngeal massage... if untrained teachers start promoting those services, it’s unsafe.” These comments echo Manternach et al.’s (2022) findings that transitions between pedagogical and clinical contexts require ethical safeguards, particularly in relation to legal liability and trauma-informed practice. The different ways participants described handling boundaries are summarised below in Figure 20, which contrasts strategies that support safe practice with the challenges that risk blurring roles.

Figure 20: Boundary Practices in Voice Care

Positive Strategies	Potential Challenges
Referring clients to ENT/SLT when symptoms persist or worsen	Diagnosing vocal pathologies without clinical evidence
Advising clients without stepping into medical roles	Continuing to work with clients instead of referring on
Humility and openness to other professionals' expertise	Taking on quasi-clinical roles beyond training/scope
Clear communication with colleagues across disciplines	Attending short "weekend courses" and applying invasive techniques (e.g., laryngeal massage) without sufficient training
Trauma-informed awareness when supporting vulnerable clients	Ignoring potential safeguarding issues or working without appropriate supervision
Participation in CPD and Clinical Excellence Networks	Promoting unverified or non-evidence-based practices to clients

Alongside risks, participants pointed to strategies for negotiating boundaries. One SVS/SLP encouraged humility: "Be comfortable code switching and remain humble. "There is ALWAYS more to learn." An SLT agreed: "Communication and willingness to keep an open mind to what others may bring... are key skills in a good voice practitioner." These views align with Maxfield and Ragan's (2021) evidence-based voice pedagogy model, which emphasises that shared responsibility across disciplines depends as much on interpersonal respect as on technical expertise.

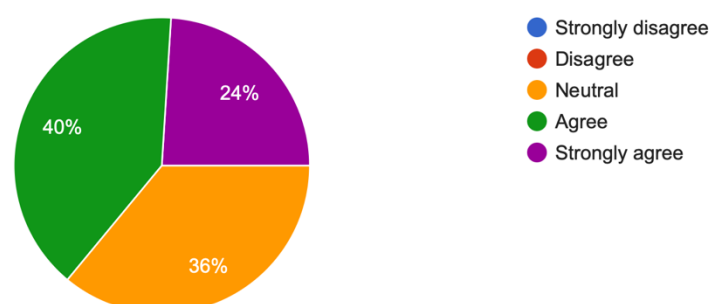
Finally, some participants emphasised the importance of more structural regulation. One SVS/SLP warned: "The cynic in me fears that schools will see this as an opportunity to attract students and collect tuition not to develop a population of individuals with lived experience." Others called for national standards, with one SLT suggesting: "It would be fantastic if the NHS reached a point where there was a standard referral process and consistent practice for voice." Questionnaire responses echoed this view, with most participants supporting more precise regulation and common standards for hybrid or cross-disciplinary roles. Figure 21 shows that 62% of respondents either agreed or strongly

agreed that clearer regulation and shared standards are necessary. In comparison, 28% remained neutral, and only a small minority disagreed. This indicates broad backing for structural guidance, though not complete agreement. The neutral responses may represent uncertainty about how such standards would be practically implemented or concerns that certification schemes might prioritise commercial gain over expertise.

Figure 21: Pie chart on more precise regulation.

Would you support clearer regulation and shared standards for hybrid or cross-disciplinary voice roles?

25 responses



These perspectives reflect Gilman and Carroll's (2023) argument that professional legitimacy in voice care will depend on clear competencies and shared governance but also caution against credential schemes that prioritise commercialisation over expertise.

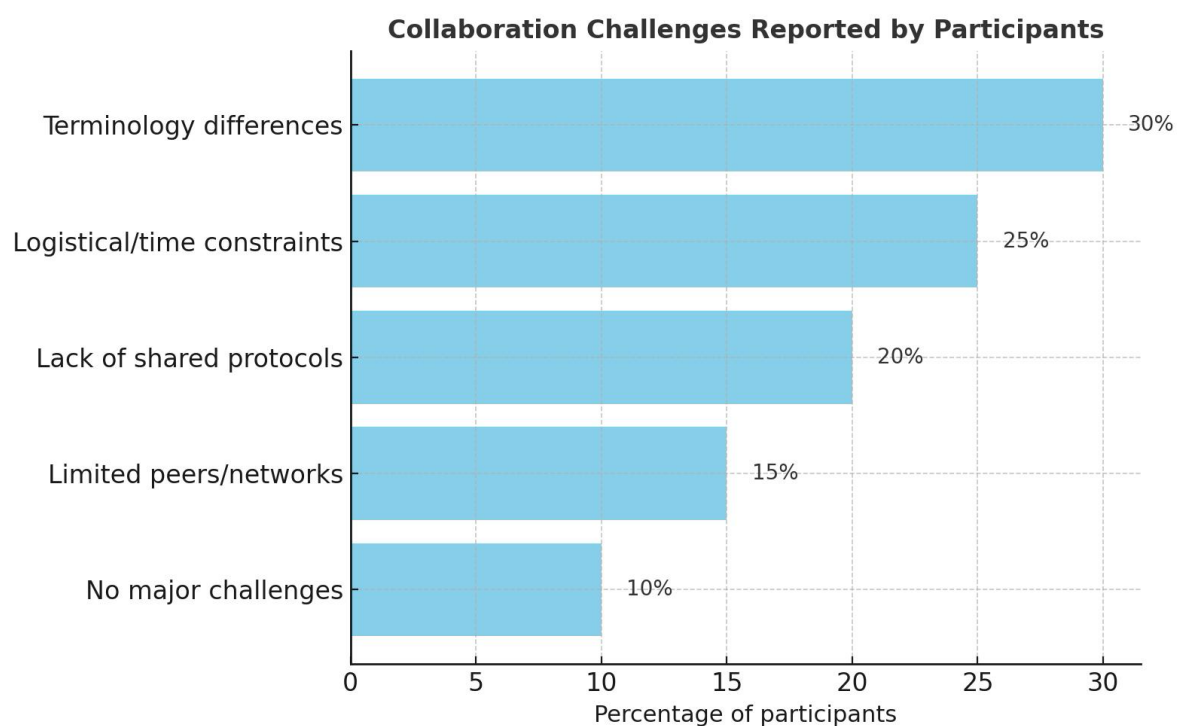
In sum, participants agreed that maintaining scope is essential but described many situations where systemic pressures, client demand, or gaps in training blurred boundaries. These findings support recent literature emphasising that ethics and role clarity are not fixed but continually negotiated (Flock et al., 2023). While humility, communication, and respect were seen as vital strategies for safe practice, there were repeated calls for clearer referral

frameworks, competency-based training, and regulatory oversight to ensure client safety and professional legitimacy. These findings connect directly to the project's aim, showing that professional identity is not static but continually reshaped at the point where habilitation and rehabilitation meet, with boundaries being worked out in practice rather than set in stone

Theme 7: Collaboration challenges

Participants widely recognised collaboration as both a strength and a challenge in voice care. Where it worked well, it provided reassurance for clients and professional growth for practitioners. Where it broke down, it created confusion, delays, and at times ethical risks. Figure 22 shows the most common challenges, including differences in terminology and a lack of shared protocols, followed by logistical and time constraints. Cultural issues such as territorialism were mentioned less frequently, but still shaped how smoothly professionals were able to work together.

Figure 22: Collaboration challenges reported.



These findings reinforce longstanding concerns in the literature that interdisciplinary practice depends as much on communication and trust as on technical expertise (Schneider & Sataloff, 2007; Schriefer, Roy & Smith, 2022).

Participants repeatedly emphasised respect and open communication as the foundation of good teamwork. One experienced singing teacher reflected: “As long as each side is respectful of one another, I think it would be incredibly effective for all involved, most importantly the client.” An SLT echoed this view: “Communication and willingness to keep an open mind to what others may bring to helping the individual seeking help are key skills in a good voice practitioner.” Participant 2 similarly highlighted the importance of tailoring communication to different audiences: “Engineers always want to understand the physics of the voice. Some people benefit more from imagery. You have to meet them at their own level.” For some, multidisciplinary clinics offered the clearest model of successful collaboration. As one SLT explained: “The most successful MDT working that I’ve done has been alongside ENT and that’s just been through being in the same place, working with the same clients, learning from each other and what each role gives to the management of a patient”. This reflects evidence that co-location and shared caseloads help reduce duplication and improve continuity of care (Gartner-Schmidt & Rosen, 2018).

Several participants stressed that collaboration extended beyond formal MDTs. Informal exchanges, such as discussing cases, sharing exercises, or clarifying terminology, were valued for bridging disciplinary divides. One teacher described: “Comparisons of systems and protocols... even a basic informative crossover can be helpful to pass on verbal knowledge and redirection.”

Participant 3 explained how they adapted their style for different backgrounds: “I don’t talk about larynxes I say ‘voice box’ and use touch and imagery so patients can feel what I mean.” They also warned against operating in a “clinical bubble,” where technical jargon can

alienate patients or other professionals. Such strategies resonate with Hillman et al.'s (2023) call for communication models that are flexible and audience-specific.

Despite these strengths, barriers were common. Some described territorialism between pedagogues and clinicians, with one teacher commenting: "There is a great deal of territorialism that is not helpful or earned between voice teachers and clinical practitioners." Others highlighted limited access to certain disciplines. One SLT explained: "Collaboration with clinical psychology is particularly difficult... they are very difficult to get hold of, one of the key groups I'd like to work more closely with, but they're so few and far between."

Terminology also caused problems, with Participant 2 noting: "We still get ENT referrals that are utterly and completely wrong. You must learn what certain consultants mean by certain terms." Another SLT reflected on the impact this has on patient trust: "Patients think the doctors should know what they're doing, and they should but often they don't get the terminology right, and that can cause problems." These accounts echo Rinta and Welch's (2008) findings that inconsistent language undermines interdisciplinary dialogue.

Confidence in collaboration varied across participants. Some admitted feeling underprepared due to limited interdisciplinary training during their education. A US-based singing teacher reflected: "As an undergraduate and graduate student, I had teachers that tried to work on rehabilitating my MTD in ways that I now believe were outside of their scope of practice... I think having interdisciplinary experience in my graduate program would have been helpful."

Others described how confidence developed gradually through experience. An SLT explained: "When I trained 20 years ago, we didn't sit alongside medics. It's better now, but it depends on where your service sits." In contrast, another teacher reported feeling "very

confident” after years of working across habilitation and rehabilitation. These differences echo Loar’s (2020) observation that confidence in interdisciplinary voice care is often built informally rather than systematically embedded in training.

The consequences of collaboration, both good and bad, were most visible in patient outcomes. One SVS recalled: “I’ve encountered singers who were told by choir directors or other voice teachers that they had a pathology without having done any evaluation by a medical or other voice professional. This caused a lot of anxiety for the singer.” Similarly, an SLT reflected: “We still get ENT referrals that are utterly and completely wrong... sometimes it’s not spasmodic dysphonia, it’s MTD.”

Participants also highlighted the emotional weight of communication. Participant 3 noted: “It can be devastating whether it’s just a temporary loss from a cold or a permanent loss through Parkinson’s.” This reinforces Aldridge-Waddon et al.’s (2024) finding that voice disorders are often tied to psychological distress, meaning that how practitioners communicate is as important as what they diagnose.

Taken together, these accounts show that teamwork and communication remain central to effective voice care. When collaboration is grounded in mutual respect, patients feel supported, and recovery is more effective. Where miscommunication, territorialism, or training gaps persist, clients experience unnecessary anxiety and delays. These findings support Gilman, Nix & Hapner’s (2010) argument that integrated collaboration requires not just technical expertise but also humility, shared vocabulary, and an understanding of the psychosocial impact of voice disorders.

Theme 8: Systems

Participants discussed more general systemic concerns in voice care, such as funding, innovation, service design, and regulation. Professional voice users continue to experience uneven and sometimes insufficient provision, even though many acknowledged areas of progress. These results support more general discussions regarding the dispersed and frequently underfunded character of voice services as well as the challenges of policing hybrid occupations in a field that is evolving. (Zeller, 2016; Gilman & Carroll, 2023).

Access to care was shaped by geography and healthcare system design. US participants described long waiting times and restrictive insurance cover, with one explaining: “Voice rehabilitation with an SLP is usually only covered for 8 weeks or 60 visits max (depending on insurance).

As a voice pedagogue with specialised training... I train students who need consistent training.” Another reported: “One of my students had a vocal injury and it took a year to get in to see someone... the appointments in 2 more months and I’ll probably have her completely rehabilitated before that time. “Such accounts support Van Houtte et al. (2011), who argue that systemic inequities force pedagogues into quasi-clinical roles when timely rehabilitation is unavailable.

UK participants described more structured services through the NHS but still noted variability. One SLT stressed: “There needs to be greater clarity around the roles, training and boundaries of other individuals working with professional voice use, given that these are not regulated by professional bodies. The level of knowledge, skill, training and experience of some professionals can be highly variable.” Another emphasised the “postcode lottery” of MDT provision, depending on local commissioning. These experiences echo Loar’s (2020) finding that institutional design strongly determines access to specialised care.

Concerns were raised about unregulated and underqualified practice. One participant criticised “weekend courses” in laryngeal massage, warning that “well-meaning ‘weekend warrior’ types then promote this service to singers with no clinical oversight.” Similarly, another participant expressed caution around diploma-only training routes, noting: “It takes more than a diploma to create expertise... true interdisciplinary study takes time and reps.” Such reflections reinforce warnings in the literature that without stronger regulation, singers may receive inconsistent or unsafe support (Manternach et al., 2022; Fleming et al., 2024).

Participants also worried about misleading role titles, with one noting: “The lines around titles are blurred because we are human... SLTs can also be singers, physios can be singing teachers.” This aligns with Achey & He (2016), who argue that blurred professional identities complicate accountability and safeguarding.

Isolation and geography further shaped access to professional development. A coach explained: “As a coach who works outside of London, it is hard to keep up with developing trends and research in a way that feels useful.” Similarly, one SLT described being “the only voice therapist” in their service and having to “go elsewhere to build competency.” These reflections resonate with Rosenberg (2019), who highlights the uneven availability of CPD and the reliance on networks or conferences to sustain learning.

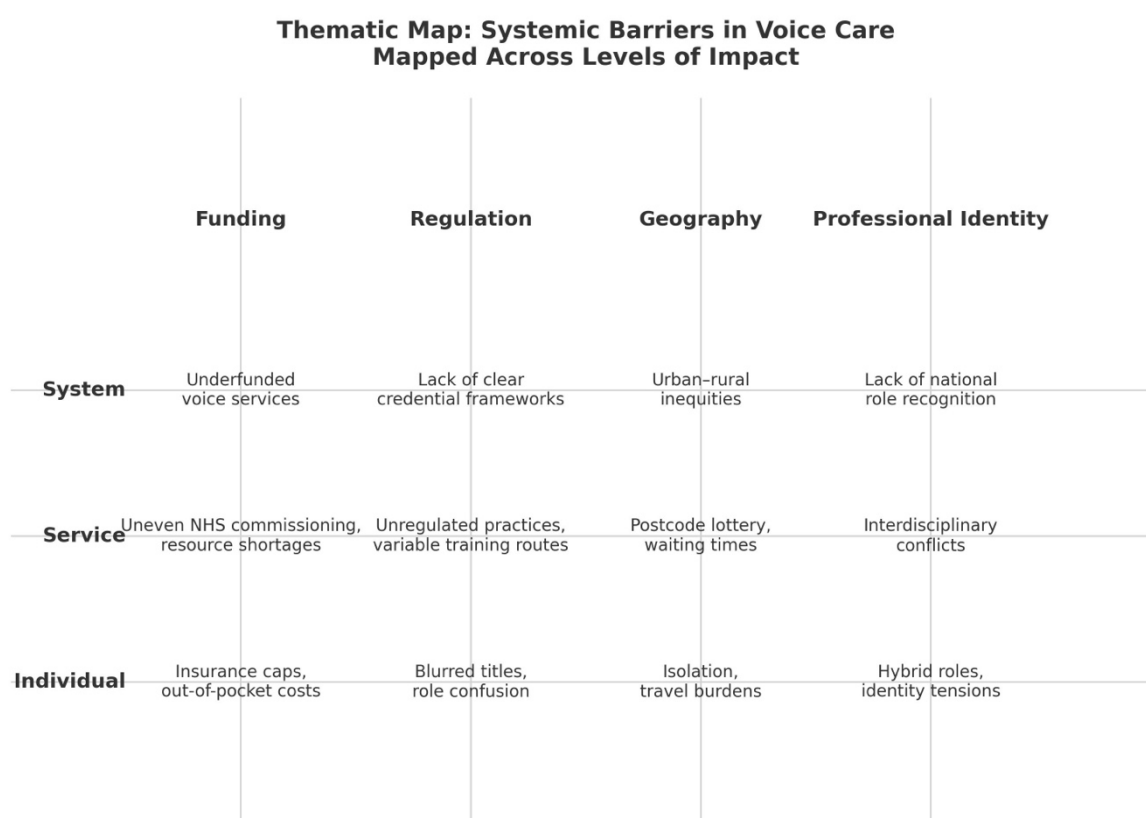
Despite these barriers, participants also saw opportunities for development. Participants recognised possibilities for progress. Several pointed to professional associations like PAVA and the BVA as having an important role in setting future standards. One SVS suggested: “An MA level credential or PG certificate would be nice to see in the future... I would also like to see some kind of para-professional clinical certification so SVSs without a clinical degree could effectively and ethically engage in practitioner-rehabilitation without breaking scope of practice boundaries.” However, others expressed scepticism: “The cynic in me fears that schools will look at this opportunity as a way to attract students and collect tuition not create a population of individuals with lived expertise.” These concerns echo Maxfield and Ragan’s (2021) point that credentialing schemes can become commercialised and exclusionary if they are not firmly based on real expertise.

Participant 2 suggested more structured national frameworks: “It would be amazing if the NHS got to the point where there was a standard referral process and practice for voice, but I think that’s a long way off.” They also argued for streamlined surgical care: “It would be nice to see some structured pre- and post-surgery support for patients with benign voice problems. The research is starting to come, but resourcing it is the issue.”

Participant 3 agreed, emphasising the shortage of voice-trained SLTs and calling for interdisciplinary competencies, drawing on successful models in swallowing disorders. Figure 22 provides a thematic map that demonstrates how participants’ experiences of barriers spanning funding, regulation, geography, and professional identity play out across the individual, service, and system levels.

Across the dataset, participants stressed that individual practitioners cannot solve systemic challenges.

Figure 23: Thematic map of systematic barriers in voice care.



While these barriers highlight the scale of the challenge, participants also pointed towards opportunities for development and innovation, suggesting ways that services and professional structures could evolve to support voice users better.

Many described going “above and beyond” to support clients, but recognised that sustainable improvements depend on investment, regulation, and clearer structures. Proposals included:

- More hospital-based voice clinics tailored to singers and performers.
- Greater recognition of the SVS role within healthcare systems.
- Integration of psychological support into mainstream voice care.
- National competency frameworks to ensure equity across regions.

Interdisciplinary research initiatives aim to develop evidence-based collaborative modes of work. One participant summarised with this: *“Multidisciplinary research!!!!!! We need to look at things together to problem solve and address everyone’s needs with nuance!”* This aligns with Carroll & Searce (2020) and Brown (2025), who argue that the future of voice care lies

not in rigid role divisions, but in shared systems that balance expertise, ethics, and accessibility.

Conclusion and Recommendations

This study aimed to explore how professional roles are negotiated at the intersection of voice habilitation and rehabilitation, with a particular focus on collaboration and ethical practice. Although often regarded as separate fields, the findings show that they frequently overlap in practice. Interviews indicated that collaboration is influenced more by local factors than by formal structures, while training routes remain inconsistent and access to specialists varies. Practitioners from different backgrounds share methods, language, and values, highlighting areas of common ground. The themes identified were closely interconnected: training boosted confidence, confidence affected boundary-setting, and boundaries, in turn, impacted referrals, teamwork, and the overall experiences of voice users. In relation to the project's aims, the study clarified how habilitation and rehabilitation are understood and applied in practice. Participants' perspectives differed depending on their background and workplace, with some emphasising daily practice and others focusing on multidisciplinary collaboration. These accounts highlighted how professional identity is shaped by context. Gaps also emerged, including uneven access to continuing professional development, limited undergraduate preparation, and unclear referral routes. These findings emphasise the need for clearer competencies, shared frameworks, and more accessible interdisciplinary training.

The data revealed instances where professional boundaries become unclear, particularly when shared techniques are applied across different settings or when systemic barriers compel teachers to assume roles like those in clinical practice. Factors that support collaboration include mutual respect, co-location, and open communication, while barriers range from service inequalities and inconsistent terminology to difficulties in accessing psychological support. Ethical concerns are raised, as crossing boundaries could improve

care but also risk delayed diagnosis, role confusion, or causing anxiety for clients. The study does have limitations. The interview sample was small and leaned towards pedagogical perspectives, with possible self-selection bias favouring participants already interested in collaboration. Reliance on self-reported data may mean confidence levels do not always reflect actual competence, and differences in terminology may have shaped responses. My position as an insider researcher also influenced the process, though I worked reflexively to reduce bias. These factors restrict generalisability, but the study still offers valuable insights and highlights areas for further research, particularly larger and more balanced cross-disciplinary studies.

Despite these constraints, the project advances by bringing together perspectives from across voice care and identifying both opportunities and challenges for collaboration. Three priorities emerge: establishing clearer competencies and referral processes, expanding access to training and mentoring, and enhancing psychological support. The recognition and regulation of hybrid roles, such as the Singing Voice Specialist, also need attention, focusing on competence and accountability rather than commercial credentials. On a personal level, this research has broadened my understanding of vocal anatomy, physiology, and pathology, directly supporting my aim of deepening knowledge of both habilitation and rehabilitation. It has prompted greater reflection in my work as both teacher and researcher, strengthening my awareness of scope, referral, and collaborative practice. I have also improved my research skills, from designing interviews to analysing qualitative data, and have situated my work within broader scholarly debates. Engaging with perspectives from pedagogy, speech-language pathology, laryngology, and clinical voice care has expanded my view of interdisciplinary practice.

In conclusion, the study demonstrates that context, rather than fixed definitions, influences boundaries between habilitation and rehabilitation. While this flexibility can foster more comprehensive care, it also introduces ethical and practical challenges. More explicit

guidance, stronger collaboration, and a shared sense of professional responsibility are necessary. The findings indicate that the future of voice care relies less on strict divisions and more on integrated, ethical, and collaborative approaches that best support professional voice users.

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