

**Group music therapy utilising marimba playing for children with  
low self-esteem**

**by**

**Helene Best**

**Student number 12243150**

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## Key terms

Self-esteem

Marimbas

Group Music Therapy

Behavioural Indicators of self-esteem

Two-factor theory of self-esteem

## Abstract

Qualitative research was conducted to explore if, and how, music therapy utilising group marimba playing can facilitate increased self-esteem for children in a small independent school in the Western Cape. The case study involved ten weekly group music therapy sessions as well as a performance session. African marimbas were used in conjunction with other methods of active music making in the group sessions. Excerpts of video recordings were analysed and the Behavioural Indicators of Self-esteem (BIOS) rating scale was completed for each child pre- and post-intervention in order to examine whether music therapy sessions facilitated changes in children's self-esteem that transferred to the classroom situation. The findings from the qualitative analysis of video excerpts indicate that group music therapy intervention utilising marimba playing appeared to facilitate the development of self-esteem. Experiences were provided to increase the participants' sense of worthiness and competence. Results of the BIOS scale could not be statistically analysed due to the small sample size, but the data suggests that the music therapy intervention had an impact that carried over to the classroom situation on participants who were assessed to have *lower* self-esteem before the intervention (compared to others in the sample) as observed in their classroom behaviour.

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## 1. Introduction

### 1.1 Background and context

Before undertaking my postgraduate studies in music therapy, I taught marimba playing to a group of children from various cultural backgrounds in a small school in Northern KwaZulu-Natal. I became aware of the therapeutic potential of playing the marimba in groups after noticing increased self-confidence and increased motivation during and after sessions in children who played in the marimba band.

I often included children in the band who might not have had opportunities to take part in music activities before, or who did not achieve in other school-related activities. These children, in particular, seemed to have flourished in the marimba band, gaining confidence as they became more skilled in playing marimba and performed in front of others. Some developed a sense of responsibility as they took on specific roles and duties in the band. The music seemed to energise and enthuse all of the children and they enjoyed performing. I was curious to further investigate the invigorating moments that we shared in the music and the influence that the group music had on the individuals in the marimba band.

The current study takes place at Privaatskool Tersia Theron. It is a registered private school in Paarl in the Western Cape. At present, there are 40 learners in the school, ranging from grade one to grade 12. The primary school section consists of only 12 children and there are 32 high-school learners. Children from different cultures attend the school and the medium of tuition is Afrikaans. According to the principal, children are often placed at this school when it is found that they do not cope in the large classes in mainstream schools. Some children in the school have been diagnosed with Attention Deficit Disorder and learning difficulties and one child is physically disabled. These problems, according to the principal, have an impact on the learners' self-esteem. The school is geared towards teaching the children in small groups and providing individual attention. This independent school operates from a sub-urban house in Paarl and is not well-resourced in terms of sport or cultural activities as the focus is mainly on the academic development of the learners.

The importance of self-esteem in the psycho-social development of children (Eccles, 1999:35; Mann, Hosman, Schaalma and Devries 2004:357) and an awareness of the potential of group marimba playing served as motivation to conduct this study. In music therapy, anecdotal reports of group marimba playing indicate that it appears to encourage the shaping of identity of youths (Fouche, 2010:77), and that marimba playing helps to build musical skills, resilience and motivation (Fouche, 2010:75). No specific studies on the use of marimbas in music

therapy groups have been conducted in order to get a clearer idea of specifically how group marimba playing may influence self-esteem.

## **1.2 Research aim**

This study aims to explore how group music therapy utilising marimba playing can affirm self-esteem in children. Self-esteem will be assessed by means of observing behaviour that is indicative of levels of self-esteem as according to the Behavioural Indicators of Self-esteem (BIOS) rating scale.

The findings of this study may be useful to music therapy practitioners in terms of how and why music therapy using marimbas specifically may benefit children in relation to self-esteem. The findings may also serve as a motivation for other organisations to consider implementing music therapy utilising group marimba playing with children of this age group.

## **1.3 Research questions**

The main research question guiding this study is, therefore:

Can music therapy utilising group marimba playing facilitate increased self-esteem for children in a small independent school and, if so, how?

The sub-questions are as follows:

Sub-question 1:

How does music therapy utilising marimba playing facilitate opportunities for the development of self-esteem within sessions?

Sub-question 2:

Do music therapy sessions facilitate changes in self-esteem within the children participating in the study that transfer to the classroom situation?

## **1.4 Chapter overview**

In this introduction I have explained the background and context of the present study. The research aims and research questions were stated. In the next chapter a review of literature is provided regarding self-esteem, the development of identity through music, previous studies on the use of music therapy to improve self-esteem, and the therapeutic use of marimbas in groups. Chapter three examines the qualitative research paradigm in which this study was conducted. Methods of data collection and analysis are explained. A detailed account of the process of data analysis is provided in chapter four. The themes that emerged during data

analysis are discussed in the light of the research questions in chapter five. In the last chapter concluding remarks are offered, the limitations of the study are discussed and recommendations are made for future research.

## CHAPTER 2

### Literature Review

#### 2.1 Introduction

In this chapter I will review literature pertaining to self-esteem: the importance of self-esteem from a humanistic perspective, self-esteem in middle to late childhood, and Mruk's (2013) two-factor theory of self-esteem. Following this, literature regarding the role of music in shaping identity will be discussed. I will review previous studies on music therapy and self-esteem and end with a discussion of literature on the therapeutic use of marimbas particularly.

#### 2.2 Self-esteem

Self-esteem is a widely studied topic in social and behavioural sciences. A vast body of literature from many disciplines indicates that high self-esteem is associated with the behaviours, goals and coping mechanisms that facilitate success in school, work and relationships. Several influential authors have suggested that a positive self-esteem is critical to personal and social adjustment (Coopersmith, 1967; Maslow, 1954). These views are supported by recent authors (Eccles, 1999:35; Mann, Hosman, Schaalma and Devries 2004:357). According to MacDonald (1994:19), the most basic task for one's mental, emotional and social health, which begins in infancy and continues until one dies, is the construction of his/her positive self-esteem. Harter (1999:257) points to the role of self-esteem in the adaptive functioning and everyday happiness of the individual. Donnelan, Trzesniewski, Robins, Moffitt and Caspi (2005:333) conducted a study in which it was found that a robust relationship exists between low self-esteem and externalising problems through aggression, antisocial behaviour and delinquency. This relationship held for measures of self-esteem and externalising problems based on self-reports, teacher ratings and parent ratings, and for participants from different nationalities and age groups. According to Baumeister (1990:95), and Jessor, Van den Bos, Vanderryn, Costa and Turbin (1995:924), individuals with low self-esteem are pre-disposed to adopt risk behaviours, such as substance abuse, to cope with or escape from negative feelings associated with low self-esteem. The most common affective correlate of negative self-esteem is depression (Harter, 2012:12) and, in the extreme, depressive reactions associated with negative self-perceptions can result in suicidal thoughts and behaviours (Harter & Marold, 1993:363).

### 2.2.1 Self-esteem from a humanistic perspective

In the following section I will look at self-esteem from a humanistic perspective as this framework relates particularly well to my study. The humanistic perspective focusses on each individual's potential and stresses the importance of growth and self-actualization (Meyer, Moore & Viljoen, 1990:338). This was my therapeutic stance during the music therapy sessions in the study. Self-esteem and self-worth were important considerations in the work of influential humanistic psychologists such as Maslow (1970) and Rogers (1961).

Maslow (1970:37) introduced his concept of a hierarchy of needs, which suggests that people are motivated to fulfil basic needs before moving on to other, more advanced needs.



Fig. 2.1 Maslow's Hierarchy of Needs

He described two versions of self-esteem: one that includes the need for respect from others, status, fame, recognition and appreciation, and another version involving self-respect, confidence, competence, achievement, independence and freedom. When the need for self-esteem is fulfilled, it leads to "feelings of self-confidence, worth, strength, capability and adequacy of being useful and necessary in this world" (Maslow, 1970:45). Thwarting of these needs produces feelings of inferiority, weakness and helplessness which in turn, according to Maslow, gives rise to either basic discouragement or to compensatory or neurotic trends. Maslow emphasised that the most stable and, therefore, healthiest form of self-esteem is based on respect that is earned or deserved and not based on fame or flattery. Hjelle and Ziegler (1981:373) support this by pointing out that self-esteem should not merely be based on the opinion of others, but should rest on real life experience. Self-esteem and love are

conceptualised as instinctive needs according to Maslow's theory and the fulfilment of these is regarded as essential in maintaining health and achieving self-actualization.

Rogers (1961) developed Maslow's ideas further by proposing that the origin of many people's personal difficulties is that they do not consider themselves as valuable or worthy of being loved. He maintained a holistic view of people (an understanding that a person functions as an integrated whole, and that all the different parts of the personality are intricately interwoven) and emphasised the active role that a person plays in the realisation of his/her own potential. According to Rogers (1961:187), the environment only plays a facilitative or inhibitive role in the process of realising the potential of a person. It is rather a person's subjective perception of the world and the person's opinions of him- or herself that determine whether he/she will realise his/her potential.

Many music therapy models that are growth-orientated are founded on humanistic principles (Wigram, Pederson & Bonde, 2002:67). Humanistic psychotherapy is "growth orientated and directed towards mild psychological problems and personal development (self-realisation)" (Wigram *et al.*, 2002:68) and importance is attached to the 'here and now' situation, to the therapeutic relationship, and to the understanding of the client's problems.

### **2.2.2 Self-esteem in middle to late childhood**

Harter (2012:9) explains that the views of theorists such as Maslow are "critical to an understanding of the self" but points out that those theories primarily focus on adulthood. Harter positions herself as coming from a contemporary developmental perspective, as she explores self-development from early childhood to adulthood. She traces the normative stages that define the emergence of many self-processes, including self-esteem. In her view the self is both a cognitive and social construction (Harter, 2012:4). Cognitive determinants illuminate the *developmental features* of self-development whereas social antecedents (child-rearing practices, cultural factors) are more likely to produce *individual differences* in how the self is crafted. Harter (1999:5) describes self-esteem as the "evaluative and affective dimension of the self".

Cognitive development impacts two general characteristics of the self-structure, namely the level of *differentiation* and the *integration* that the individual allows in his/her development of self (Harter, 2012:4). With regard to differentiation, cognitive abilities allow the individual to create self-evaluations that differ across various domains of experience. The older child is able to distinguish between a real or actual self-concept and an ideal self-concept to which he/she aspires. These self-concepts can also be compared to one another. Discrepancies may have consequences with regards to self-esteem: the cognitive realisation that one is not

meeting one's expectations in domains that one deems important, will lower one's overall level of self-esteem (Harter, 2012:64). Cognitive abilities play a role in the *integration* of the self-structure in that they allow the individual to construct higher-order generalisations about the self in the form of trait labels (e.g. maths skills plus science skills equal 'clever'). During middle childhood the individual also develops the ability to construct a concept of his/her worth as a person. This evaluation as an overall opinion of the self is termed global self-esteem (Harter, 2012:4).

Harter (2012:12) describes the developing self as a social construction, and pays particular attention to how socialisation experiences in children's interactions with caregivers, peers, teachers, and in the wider sociocultural context influence the content and valence of self-representations. The child may come to adopt the opinions that significant others are perceived to hold toward him/herself. In a study by Bouchey and Harter (2005) involving 378 Latino and European-American middle school students, it was found that the perceived beliefs and behaviour of adults represent a crucial context that impacts upon the child's self-system and scholastic success. Reflected appraisals of significant adults' beliefs concerning both the importance of and students' competence in maths and science, as well as the perceived support from adults, predicted students' own self-perceived importance, competence, scholastic behaviour and performance in these courses (Harter and Bouchey, 2005:680).

This illustrates the manner in which the construction of self is highly dependent on social interactions with significant others. The child internalises his/her evaluations and comes to view them as his/her own. This can entail either positive evaluations of the self (high self-esteem) or negative opinions of the self (low self-esteem) (Harter, 2012:11). Significant others who are kind and compassionate will provide the nurturance, approval and support that will be mirrored in self-evaluations that are positive. Approval from others is, thus, internalised as acceptance of self. Significant others lacking in responsiveness, approval, encouragement, and nurturance or who are rejecting, punitive or neglectful will cause children to develop negative or tarnished images of self (Harter, 2012:12). In the extreme, according to Harter (2012:13), children subjected to chronic abuse create images of the self as despicable. Harter (2012:68) notes that caregiving practices resulting in very negative perceptions of the self put children at risk for serious forms of depressive pathology. A study conducted by Wild, Fisher & Lombard (2002) with 939 students in grades eight and 11 in a public school in South Africa aimed to disentangle the influence of depression and self-esteem on suicidal behaviour in adolescents. Participants completed questionnaires assessing suicidal ideation and behaviour, depression, and self-esteem with respect to family, peers, school, sports, body-image and global self-worth. Results indicated that depression and low self-esteem within the

family context were independently associated with suicidal ideation and attempts (Wild, Fisher & Lombard, 2002:620).

Harter (2012:12) explains that the evaluations of significant others also provoke strong self-affects in the form of pride and shame. Pride will develop as a result of praise and support for efforts. Shame will develop when a child is criticised for his/her performance and this can be psychologically crippling. These self-affects are defined by a developmental acquisition sequence and emerge during early to mid-childhood. Other affective consequences associated with the valence of self-representation are that those individuals who internalise favourable views of the self are likely to be cheerful and those who have negative self-perceptions may have a greater tendency to be depressed (Harter, 2012:12).

Harter (1983:96) used a hierarchical structure to explain the development of self-esteem. According to this theory, global self-esteem is composed of four dimensions: competence, power, moral worth and acceptance. These dimensions manifest in more specific domains, e.g. scholastic competence, athletic competence, physical appearance, behavioural conduct and peer social acceptance. Harter (2012:23) notes that certain dimensions may be more important than others at different developmental levels, e.g. the dimension of competence begins to play a critical role during middle childhood. These dimensions interact and influence each other as the child advances through subsequent stages. When the child reaches the stage of middle childhood, he/she becomes able to verbalise a concept of his/her overall worth as a person (Harter, 2012:63).

During the stage of middle to late childhood cognitive skills that emerge lead to more accurate but also more negative self-appraisals. These skills include:

- 1) an appreciation for one's negative as well as positive attributes;
- 2) the ability to use social comparison for the purpose of self-evaluation;
- 3) the ability to differentiate real from ideal self-perceptions;
- 4) increases in social perspective-taking skills (Harter, 2012:64).

Harter's developmental approach incorporates the interaction of competence and social support or approval with the processes of cognitive development and social growth. Mruk (1999:169) shared Harter's notion of incorporating both cognitive and affective dimensions of self-esteem and defined self-esteem in terms of two factors, namely competence and worthiness. In the next section I will discuss Mruk's Two-Factor Approach to Self-Esteem.

### 2.2.3 A two-factor model of self-esteem

Mruk’s (1999, 2013) work strongly supports the view of Harter that self-esteem is a developmental phenomenon. He notes that Harter’s multidimensional approach is compatible with a two-factor definition of self-esteem and that the various dimensions of the theory can roughly be divided equally between social factors associated with approval or worth, and behavioural factors associated with competence in various domains of life (Mruk, 1999:169). He also links his definition of self-esteem with the humanistic position through his claim that “self-esteem is understood as consisting of competence, worthiness and the relationship between them, and such a view is consistent with one of the established theoretical perspectives of the field, namely, the humanistic position” (Mruk, 1999:149).

Mruk’s (1999:107) comprehensive review of the major theories in the area of self-esteem has shown that the main definitions of self-esteem fall into two categories: those which primarily focus on self-worth and those which are based upon an individual’s judgement of competence. Mruk developed a model which incorporates these differing perspectives. His two-dimensional model interprets self-esteem as the integrated sum of self-worth and self-competence. This means that for individuals to have positive self-esteem they must be confident both about their sense of self-worth (‘I am a good person, entitled to care and respect from others’) and their sense of competence (‘I am able to meet the challenges I face in life’).

Mruk (1999:150) describes the basic types of self-esteem, based on the two factors of worthiness and competence as explained in the following diagram:

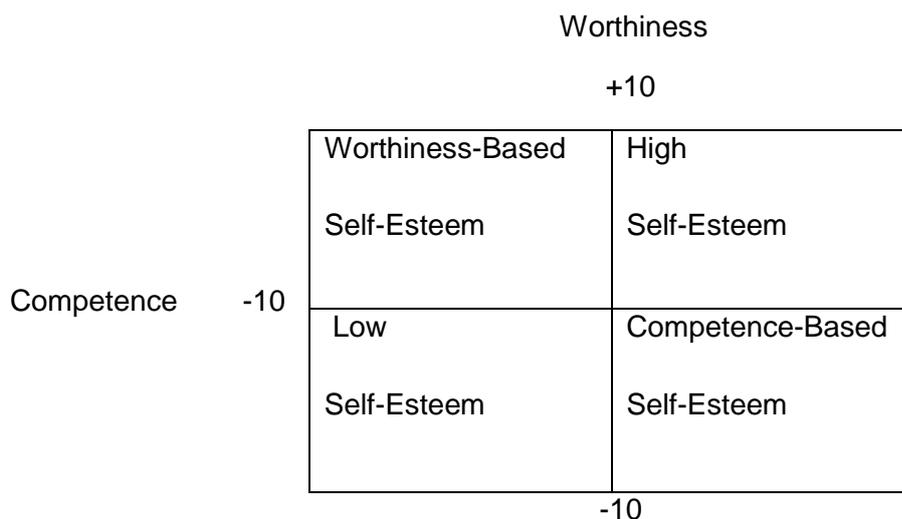


Figure 2.2 Self-Esteem Meaning Matrix with Basic Types of Self-Esteem (Mruk, 1999:152).

Low self-esteem, indicated in the lower left quadrant of the matrix, involves living with both a lack of competence and a lack of worthiness. The combination of reduced coping skills and a “shrunk reservoir of positive self-feeling” (Mruk, 1999:151) could make people vulnerable. Even though low self-esteem ranges in degree, it is usually associated with such things as caution, timidity, lack of initiative, conflict, avoidance, insecurity, anxiety, depression, and so forth (Mruk, 1999:152).

According to the two-factor theory, people with a high self-esteem typically exhibit a positive degree of both competence and worthiness, indicated in the top right-hand quadrant. We would expect people with a high degree of worthiness to feel good about themselves in general, to be relatively open to new experiences, to feel accepted and acceptable, to be pleasant to be around, and so forth. People who are high in competence would also be likely to have the skills that are necessary to succeed in life. Both these sets of characteristics indicate a relationship between self-esteem and happiness, initiative, openness, spontaneity, a secure identity and a general absence of psychopathology (Mruk, 1999:153).

Worthiness-based and competence-based self-esteem indicate types of high self-esteem where one factor is used in an attempt to compensate for deficiencies in the other. These types of self-esteem have been given various names including discrepant, pseudo, defensive, unstable, paradoxical, and fragile self-esteem (Mruk, 1999:154). Worthiness-based self-esteem (indicated in the top left-hand quadrant) involves attempting to make up for the lack of competence in desired domains through a number of mechanisms such as minimising failures, denying shortcomings, surrounding oneself with accepting others, or believing that one merits high self-esteem just because one feels good about oneself as a person.

Individuals with competence-based self-esteem, represented in the bottom right quadrant, attempt to compensate for low feelings of self-worth by focussing on their competence, particularly in domains important to them. They tend to focus outwardly instead of inwardly because competence involves actual manifestations of abilities or successes. Focusing on activities makes it possible to avoid experiencing one’s lack of self-worth, as long as one is nearing success (Mruk, 1999:155).

<p><b>Worthiness-Based Self-Esteem</b></p> <ol style="list-style-type: none"> <li>1. General type: Unstable or fragile self-esteem characterised by a low sense of competence compensated for by focussing on worthiness</li> <li>2. Levels             <ol style="list-style-type: none"> <li>a) Approval seeking: Contingent on approval from others, sensitive to criticism and rejection.</li> <li>b) Narcissistic: Exaggerated sense of worthiness regardless of competence level and reactive to criticism. Vulnerable to defensive acting out.</li> </ol> </li> </ol>	<p><b>High Self-Esteem</b></p> <ol style="list-style-type: none"> <li>1. General type: Relatively stable self-esteem characterised by varying degrees of openness to experience, optimism and lack of defensiveness.</li> <li>2. Levels:             <ol style="list-style-type: none"> <li>a) Medium: Stable sense of adequacy in terms of competence and worthiness, interested in more.</li> <li>b) Authentic: General sense of competence and realistic competence and solid worthiness. Actively concerned with living out positive, intrinsic values.</li> </ol> </li> </ol>
<p><b>Low Self-Esteem</b></p> <ol style="list-style-type: none"> <li>1. General type: Reduced level of self-esteem characterised by a concern to avoid further loss of competence or worthiness.</li> <li>2. Levels             <ol style="list-style-type: none"> <li>a) Negativistic: Generally cautious style of self-regulation, Focusses on protecting current level of self-esteem rather than losing it.</li> <li>b) Classical: Impaired functioning due to a low sense of ability and worth. Vulnerable to depression, giving up.</li> </ol> </li> </ol>	<p><b>Competence-Based Self-Esteem</b></p> <ol style="list-style-type: none"> <li>1. General type: Unstable or fragile self-esteem characterised by low sense of worthiness compensated for by focusing on competence.</li> <li>2. Levels             <ol style="list-style-type: none"> <li>a) Success seeking: Contingent on garnering success or achievements and anxious about and sensitive to failure.</li> <li>b) Antisocial: Exaggerated need for success or power. Vulnerable to aggressive acting out.</li> </ol> </li> </ol>

Figure 2.3 Self-Esteem Meaning Matrix with basic types of Self-Esteem (Mruk, 1999:168)

Mruk (1999:159) identified two different levels or subtypes in each category of self-esteem to indicate the variety of ways in which self-esteem is lived. The first level indicates mild problems of the type and the second level represents clinically significant problems associated with a low sense of competence and worth, or low self-esteem. These levels are summarised in figure 2.2.

This model integrates the cognitive and affective dimensions of self-esteem as well as the two factors of competence and worthiness in order to increase understanding of the concept of self-esteem and to help clinicians and clients to protect and expand the self (Mruk, 2013:163). The model is used in various studies in order to present the findings in an understandable format. A study conducted in a prison in Iowa, USA (Cohen, 2012), for example, measured the changes in perceptions of community members and the prisoner's perceptions of their social competence after a 12-week choral programme. Based on the theory of Mruk – that self-esteem derives from competence and worthiness – the author found that prisoners

develop a sense of worthiness through their relationships with volunteers and a sense of social competence through their successful choral performances, thereby enhancing self-esteem. Miller and Moran (2006:9) argue that Mruk's two-dimensional model provides a conceptual framework for educators to evaluate current practice. According to these authors, focussing only on self-worth is not enough, and the growing awareness of the two-dimensional nature of self-esteem indicates that the creation of a sense of self-worth has to be complemented by a similar emphasis on self-competence.

Mruk (1999:188) suggests that the facilitation of a positive sense of self can be achieved by taking into consideration both factors of competence and worthiness by providing experiences of: (a) personal achievement or successes; (b) acceptance or being valued; (c) evidence of influence or power and (d) virtue or acting on beliefs (doing the right thing).

### **2.3 Identity and music**

In this section, I will discuss literature pertaining to identity and the role of music in shaping identity. In a subjective, phenomenological sense, Ruud (1997:5) refers to identity as a person's consciousness about 'being the same', the experience of continuity, and about being unique from others. Self-esteem plays a role in how children categorise themselves and present themselves to the world. Self-esteem thus has an important role to play in the development of identity. I will now discuss literature regarding this aspect with specific reference to the role of music in developing identity.

According to MacDonald, Hargreaves and Miell (2002:2), the idea of the self as a relatively unchanging core aspect of individuals' personalities, has given way to a more dynamic view of the self as something which is constantly being reconstructed and renegotiated according to experiences, situations and other people with whom we interact in our daily lives. Our identities can be thought of as "complex, hierarchical networks of inter-related constructs: some of these are overarching, superordinate constructs incorporating others which exist at a more subordinate level" (MacDonald *et al.*, 2002:2).

Music is seen as a powerful channel through which people develop their personal and social identities. Music is used to communicate emotions, thoughts, social relationships, political statements and physical expressions. According to MacDonald *et al.* (2002:5), the social functions of music are manifested in three principle ways, namely the management of interpersonal relationships, mood and self-identity. Firstly, people use music to develop interpersonal relationships, for example musical preferences can define which social groups one belongs to and does not belong to. This is particularly evident in the case of adolescents' use of music. Secondly, people use music as a means of regulating their mood. This is

mediated by the immediate social environment in which listening takes place. Thirdly, music can establish or develop a person's sense of identity. Through the concept of 'musical identity', the widespread interactions between music and the individual can be explored.

The foundation of musical self-identity, according to Miell, MacDonald and Hargreaves (2005:6), can be found in the early interactions between infant and parent, termed 'communicative musicality' (Trevarthen, 1999:157). Investigations of talk, singing and other rhythmic games with infants show that features of interactive musicality are displayed in the anticipatory movements and emotions which develop between infants and their caregivers. Early musical identities are based on learning one's own position and role in relation to the reactions and communications of other people, and these are subject to constant development, renegotiation and change. According to Miell *et al.* (2005:7), the development of the musical identities of children have their origin in biological predispositions toward musicality, and are then shaped by the individual groups and social institutions that they encounter in their everyday lives.

An approach to identity which focuses on the social group context is that of 'social identity theory' (Tajfel, 1981:256). Social identity theory (SIT) starts from the assumption that we are all members of social groups. These may be large-scale social groups such as constructed race or gender categories to which people are ascribed, or smaller-scale categories such as peer groups for which membership is usually earned. Individuals have a fundamental motivation to develop and maintain a high level of self-esteem and that is established through identification with groups who have a positive image. People come to see themselves as members of one group (the 'in-group') in comparison with another (the 'out-group') and this categorization instigates a sense of self – a social identity – which guides behaviour. Having a particular social identity means being at one with (or feeling strongly that one belongs to) a certain group, being like others in the group and seeing things from the group's perspective (Tajfel, 1978a:241). For adolescents striving to establish their identities and to increase their self-esteem, identifying with particular genres of music which they rate highly, for instance 'hip hop' or 'rap', and distancing themselves from less valued genres for instance 'pop', allows them to establish favourable social and personal identities (Miell *et al.*, 2005:9).

North and Hargreaves (1999) report on a series of four studies conducted by them, which investigated the function of musical preference as an identifying 'badge' by which adolescents express their own self-concepts and make judgements of others. The first and second studies found that adolescents expect certain characteristics of fans of different musical styles. A statement of musical preference is interpreted by adolescents as implying a range of other characteristics and values (North & Hargreaves, 1999:90). The third study indicated that these

normative expectations lead to perceptions about social consequences for the fans of particular styles: people who like musical styles which are viewed as prestigious by adolescents are also viewed as possessing more socially desirable traits (e.g. being part of the popular group) (North & Hargreaves, 1999:90). The fourth study demonstrated relationships between the normative expectations of the fans of particular musical styles, self-concept, and adolescents' musical preference. There was some evidence that adolescents' preferences (at least for chart pop music) seemed to reflect an attempt to match their self-concept with perceptions of the people who typically listen to that style. Self-esteem mediated this effect: higher levels of self-esteem were associated with adolescents identifying themselves more strongly with a particular musical sub-culture (North & Hargreaves, 1999:90).

Music is viewed as a fundamental channel of communication (MacDonald *et al.*, 2002:1) and it is argued that “it can act as a medium through which people can construct new identities and shift existing ones” (MacDonald *et al.*, 2002:19). Using music as a channel of communication can provide people with a means by which they can share emotions, intentions and meanings (MacDonald *et al.*, 2002:1), and in the process be provided nurturance, approval and support that could be mirrored in self-evaluations that are positive.

#### **2.4 Studies on music therapy and the self-esteem of children and adolescents**

In the following section I will discuss some of the previous studies on music therapy and self-esteem. Most of these studies were done with adolescents within a clinical setting (either psychiatric hospitals or rehabilitation units) and one study was conducted with children from different primary schools in an area in South Korea.

Clendenon-Wallen (1991) conducted a study with adolescents attending a support group at a YWCA (Young Women's Christian Association) Sexual Assault Programme to determine whether music therapy would significantly increase the self-confidence and self-esteem of sexually abused teenagers in a music therapy support group. Singing of songs and song discussions were used as an intervention. Eleven adolescents took part in 12 weekly sessions. All subjects showed positive changes in self-confidence, based on their scores on an adjective checklist. Clendenon-Wallen (1991:79) found that music therapy provided stimulation for discussions and that it increased verbalization, socialization and self-confidence.

Henderson (1983) studied the effects of music therapy (mainly music listening activities) on the awareness of mood in music, group cohesion and self-esteem among 13 hospitalized adolescents diagnosed with adjustment disorder in reaction to adolescence. Participants were randomly assigned to either an experimental or a control group. From pre-test to post-test

significance was not achieved for scores on group cohesion and self-esteem, however, on both measures members of the experimental group improved more than members of the control group as measured by the Coopersmith Self-Esteem Inventory (Henderson, 1983:18). Staff members reported in anecdotal accounts that adolescents in the experimental group displayed increased confidence in school work and in work assignments. Henderson speculates that, had the experimental period for this study been longer, the results might have been more positive.

A case study was conducted by Kivland (1986) to measure the effect of individual music therapy sessions on self-esteem in an adolescent boy with a diagnosis of conduct disorder. The participant in her study was a 12-year old boy admitted to a hospital in Cleveland, Ohio. Self-esteem was measured by frequency of both positive and negative self-statements and the ability to accept positive comments appropriately. Through learning communication techniques and new skills (e.g. playing the piano) the boy displayed increased motivation and made fewer negative self-statements. The author offered several reasons for the observed improvement in self-esteem, such as the supportive therapeutic relationship, an increased sense of self-worth because the therapist spent extra time with him, newly acquired competence that led to increased pride in self, and increased peer acceptance because of his ability to play the piano (Kivland,1986:28). These remarks by the author fit in well with Mruk's two-factor model which suggests that a positive sense of self can be achieved by taking into consideration both factors of competence and worthiness by providing experiences of personal achievement, experiences of acceptance and being valued, and experiences or evidence of influence or power (Mruk, 1999:188).

In a pilot controlled trial Choi, Lee and Lee (2010) investigated the effects of a group music intervention on aggression and self-esteem in children with aggressive behaviour. These children were recruited from primary schools in an area in South Korea. Forty-eight 11 year-old children were randomly assigned to either an experimental group or a control group. The experimental group participated in an active music therapy intervention twice weekly for 15 consecutive weeks. These sessions included the singing of songs, song analysis, making musical instruments, instrumental playing, song drawing and song writing. The control group did not receive any kind of intervention. The outcome measures were Child Behaviour Checklist (Parents), Child Aggression Assessment Inventory (Teachers) and Rosenberg Self-Esteem Scale. After 15 weeks, the experimental group showed significant reduction in aggression and improvement in self-esteem compared with the control group. In this program the use of instruments was structured to involve all of the sensory organs. According to the authors, responses associated with physical movement, relaxation and emotional catharsis

combined with increased self-awareness, self-esteem and pleasure may have enhanced general motivation and quality of life.

Drawing from the above mentioned studies on music therapy and self-esteem, the following aspects seem to have contributed to increased self-esteem:

- a supportive therapeutic relationship with the therapist;
- peer acceptance;
- increased competence in musical skills;
- enhancing the children's general motivation, particularly through the benefits of active music making as demonstrated in the study by Choi *et al.* (2010).

No studies were found on music therapy and self-esteem within the South African context. In South Africa, music therapists often work in environments where group treatment is preferred, particularly in schools and in community-based work. Marimba playing has become a popular activity over recent years as an increasing number of institutions and schools have marimbas and marimba ensembles. In the current study I elected to focus on the playing of this instrument in music therapy sessions. Even though marimbas have been used by music therapists and in music education, and anecdotal reports of enhanced self-esteem were noted (as will be discussed in the next section), no specific studies have been done on the use of marimba playing in a music therapy group to enhance self-esteem.

## **2.5 The use of marimbas in music therapy**

In this overview of literature, I will discuss the DIME (Diversion Into Music Education) programme, and will also look at the 'Music for Life' programme employed by Music Works at Heideveld School in Cape Town. Group marimba playing is used in both of these programmes. The paper by Woodward, Sloth-Nielsen and Mathithi (2007) reports on the DIME programme as a pilot project, and is not a research study. Marimba groups in the 'Music for Life' programme are also not part of a study, but are presented in the form of anecdotal reports. No studies on the use of African marimbas could be found.

DIME, a youth intervention programme, originated in South Africa in 2001. It offered instruction in African marimba and djembes to juvenile offenders (Woodward *et al.* 2007:74). This programme did not take place within a music therapy framework, but rather from an educational and social rehabilitative perspective. Marimba and djembe groups were found to be healthy, enjoyable diversions from crime.

The DIME programme selected African marimbas and djembes for three reasons:

- These instruments form part of the cultural heritage of the children;
- A simple but impressive stage of accomplishment can be achieved in a group setting within a relatively short period, providing the children with a strong sense of accomplishment;
- The act of hitting the marimbas and djembes requires a fair amount of physical exertion that children appear to find both natural and stress relieving (Woodward *et al.*, 2007:75).

Woodward *et al.* (2007:77) described the pilot project. Courts from areas around Khayelitsha referred 14 children aged 16 years and younger who had been in conflict with the law to take part in the project. Community musicians were appointed as teachers of marimba groups and psychology students from the University of Cape Town were appointed as mentors to provide individual support to children enrolled in the project. The teaching strategy focussed on active participation where students were engaged in discovering, performing and improvising on African marimbas. In their experience the children displayed “intense delight and the emergence of a vigorous self-confidence” (Woodward *et al.*, 2007:78). The intricate and complex nature of creating music in a group setting allowed the children to develop in various facets. The individual group members were given the opportunity to move through a variety of roles, “from observer, to participant, to shaper and creator, finding different ways to participate... Identity and self-expression are potent factors within the collective; belonging, coding immigration, assimilation, and globalization are all played out through musical communities” (Woodward *et al.*, 2007:78).

As a microcosm of society, the program provided the children with opportunities to meet peers and develop friendships and, within the group context, children learnt to communicate more effectively, express emotions, manage anger, and resolve conflicts. Musical socialisation through ensemble playing provided opportunities to develop life skills such as sensitive listening to others; sensitive interaction; working towards a common musical goal; co-operation and responsibility towards others. Slobin (1993:60) is quoted by Woodward *et al.* (2007:79) as describing this as a “jointly imagined world that arises from a set of separate strivings temporarily fused at a moment of common musical purpose”. Every note played needs to fit into a musical structure created by the group and listening for the placement of each note thus requires acute attention and co-operation with the actions of others.

The children found marimbas to be a positive experience associated with exhilaration, a sense of mastery, and the discovery of musical aptitude. Making music with links to their cultural heritage contributed to the children’s identity and self-pride. Adolescents not only experienced

an increased sense of self-realisation and self-fulfilment, but also discovered (or re-discovered) an intense enjoyment of music.

Music Works (a non-profit community music therapy project) has been using marimbas for several years in Heideveld as part of their 'Music for Life' project. Fouche (2010:74) reports that drumming circles were first initiated to provide opportunities for the 'troublemakers' to channel their aggressive energy in a constructive way. Three years later, many members of the original drumming group became part of the marimba group. She describes the marimba groups as follows (2010:75):

These (marimba) group members are now able to commit to two practices per week and the boys work hard to perfect complex marimba rhythms, listening intently to one another and to the music. Both the current drumming groups and the marimba group are often asked to perform at community events. The community's sense of pride in these boys inspires them to stay committed. One boy reflected on his experience of briefly joining a gang. He had decided to leave this gang as he now had his marimba group. The younger members in the community look up to these boys – who have subsequently grown into young men – and aspire to also one day be part of a drumming/marimba group. In a world where young people are often expected to get drawn into the criminal activities in the community, the boys in the drumming/marimba group show that they have astounding musical abilities, but more importantly, resilience and a driving force that enables them to be positive role models for the younger children in Heideveld.

The youth programme provides opportunities for young people to work towards acquiring a sense of musical mastery, to develop the habit of self-reflection and self-mastery through participation in music groups, rehearsing and therapeutic workshops ([www.music-therapy.co.za](http://www.music-therapy.co.za)). During this process they are enabled to become agents of change both in their own worlds and in the lives of others with whom they come into contact.

From this literature review, it is clear that marimba playing can successfully be used in a group setting, offering benefits of socialisation and group dynamics. Children and youth find it appealing and are motivated to master complex rhythms thereby increasing their musical competence. There appear to be numerous therapeutic benefits to group marimba playing, but none of these have been specifically researched. The current study attempts to fill a part of that gap in the literature by researching group music therapy utilising marimba playing to enhance self-esteem in children.

## 2.6 Conclusion

This literature review firstly attempted to define self-esteem and then looked at the importance of a healthy self-esteem. This was framed within the perspective of humanistic psychology as this relates well to my stance as therapist. Self-esteem was discussed from a developmental perspective, with specific emphasis on the stage of middle to late childhood. The theories of Harter (2012) emphasise the role of cognitive development on a child's perspective-taking skills and ability to verbalise an overall concept of self-esteem, and the impact that social support has on the self-esteem of a child. The role of music in the shaping of identity was discussed.

Mruk's (1999) two-factor model, which defines self-esteem as a relationship between competence and worthiness, provides a comprehensive approach to self-esteem as it integrates both cognitive and affective dimensions of self-esteem.

An overview of music therapy studies has shown that this form of intervention, particularly active music making, can be used to improve self-esteem in children and adolescents. Mruk's two-factor model seems to fit in well with the findings of previous music therapy studies, as the component of *worthiness* seem to be supported by emphasis the relationship with the therapist and peers within the group, and the component of *competence* is supported by the studies showing that increased competence in musical skills and exposure to active music making contributed to increased self-esteem.

The use of marimbas in music education has indicated potential advantages related to early success being possible on this instrument and feelings of accomplishment experienced by the participants. In music therapy, anecdotal reports of group marimba playing indicate that it appears to encourage the shaping of identity of youths, and that marimba playing helps to build musical skills, resilience and motivation. No specific studies on the use of marimbas in music therapy groups to enhance self-esteem have been found in literature.

The following chapter will discuss the methodology employed in the current study.

## CHAPTER 3

### Methodology

#### 3.1 Introduction

In this chapter I will describe the research paradigm which defines the nature of the enquiry. I will then discuss the research design and methodology, including the description of the sample and how data was collected, prepared and analysed. I will conclude the chapter with ethical considerations.

#### 3.2 Research questions

The research questions guiding this study are as follows:

Main research question:

Can music therapy utilising group marimba playing facilitate increased self-esteem for children in a small independent school and, if so, how?

Sub-question 1:

How does music therapy utilising marimba playing facilitate opportunities for the development of self-esteem within sessions?

Sub-question 2:

Do music therapy sessions facilitate changes in self-esteem within the children participating in the study that transfer to the classroom situation?

#### 3.3 Research paradigm

Research paradigms, according to Terre Blanche, Durrheim and Painter (2006:6) define the nature of the enquiry along three dimensions: *ontology* (which specifies the nature of reality that is to be studied, and what can be known about it); *epistemology* (which specifies the nature of the relationship between the researcher and what can be known); and *methodology* (which specifies how the researcher may go about practically studying whatever they believe can be known). This current study utilised an interpretive paradigm. The ontological foundations of an interpretive paradigm are that the reality consists of people's subjective experiences of the external world (Terre Blanche *et al.*, 2006:6). In this study I tried to explain the subjective meanings that lie behind social action. The epistemological stance of an interpretive perspective is that of an empathic, subjective observer (Terre Blanche *et al.*,

2006:6). The researcher and participants are regarded as being in an intersubjective and interactive relationship.

In this study I made use of primarily qualitative methodology, but I also used quantitative techniques to enrich the findings. According to Wheeler (2005:24), a distinction must be made between using a certain research method, and using research techniques. A technique refers to a specific means of working towards a goal, which may, for example, be collecting data in a particular way. A method is broader, referring to the “qualitative or quantitative method of doing research, and implies adopting the worldview taken by those who embrace that method” (Wheeler, 2005:23). It is possible, thus, to make use of techniques borrowed from the quantitative method whilst not necessarily embracing the positivist paradigm. In this study, the perspective of another discipline was used to generate the quantitative data. By using the findings of other disciplines, we can triangulate to determine the effects of the disciplinary perspective that we have adopted (Terre Blanche *et al.*, 2006:380). The perspective of the school teachers provided more insight into the participants’ behaviour indicative of self-esteem outside of the music therapy situation, thereby attempting to “explain more fully the richness and complexity of human behaviour by studying it from more than one standpoint” (Cohen & Manion, 1986:254). Employing more than one form of data collection and analysis also minimises bias.

In qualitative research, ‘truth’ is not viewed as one undisputable truth, but rather as multiple layers of meaning (Bruscia, 1995:67). The perspectives of the participants were considered important contributions to the various layers of meaning. According to Bruscia, qualitative research has three main characteristics: “It is nonlinear, intensely personal and unavoidably interpersonal” (Bruscia, 1995:391). The process that I followed was indeed nonlinear. This means that an established procedural sequence was not followed, but the research frequently involved responding in an intuitive or holistic way, through inductive modes of reasoning and subjective stances.

Meaning was explored once I become immersed in the data. Data was collected from observations in music therapy sessions using group marimba playing, thus implying a naturalistic setting. Naturalistic research involves collecting data in real-life settings rather than laboratory settings. The context is an important consideration within naturalistic research. Naturalistic inquiry offers a “contextual relevance and richness that is unmatched and it displays a sensitivity to process...” (Guba & Lincoln, 1983:313). It also takes full advantage of the “not inconsiderable power of the human as instrument” (Guba & Lincoln, 1983:313). In this study the researcher actively engaged and interacted with the children as the therapist within the therapeutic setting. Acknowledging my dual role as researcher and therapist, I was

required to conduct the study reflexively, in a non-manipulative, non-controlling way, being open to whatever emerges. Managing subjectivity in a reflexive manner within qualitative research can be experienced more as a resource rather than as a problem (Ansdell & Pavlicevic, 2001:140), as was the case in this study. Being part of the process, I adopted a self-reflexive and critical stance in an attempt to monitor bias.

Reflexivity is an attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process. The background, prior learning, beliefs and values of the researcher will necessarily shape the gathering and analysis of data and the researcher should indicate their research stance from the beginning (Aigen, 2008:257). I demonstrate a self-reflexive stance by providing a transparent account through indicating how the process of meaning-making occurred. During the research process, I kept a reflexive journal where I made regular entries to record the reasons for making methodological decisions, the logistics of the study and to reflect upon what was happening in terms of my own values and interests, as is recommended by Lincoln and Guba (1985:327).

### **3.4 Research design**

The study is designed as a case study as I aimed to obtain rich, detailed information of a particular occurrence, its context and its consequences. A case may refer to any single entity or unit of analysis such as a person, community or a programme (Robson, 1993:146). The case may be considered over a period of time which allows the investigation of change and development within the particular unit (Willig, 2001:75). This case study consisted of a group of primary school children who took part in group music therapy sessions over a period of 10 weeks.

My task as researcher was to produce accurate and comprehensive descriptions of the case, in order to generate new insights into the phenomenon. In case study research, each case is seen as unique and a holistic perspective is taken. The context is of importance and the world is seen as an integrated system where parts cannot be studied in isolation. The group that took part in the study are learners attending a small private school that operates in a suburban house in Paarl. The school caters for children who do not cope either academically or socially in main stream government schools. The participants are Afrikaans speaking and from various cultural backgrounds. In general, they come from middle-income households. Paying attention to the context provided me with richer data and it also served to “establish the boundaries of the case study”, as is recommended by Willig (2001:79). Working ideographic, I was able to focus and explore the particular and unique elements found within this specific case.

Generalisability of case studies is seen as a limitation because the findings in this study is specific to this group and cannot be applied to other, yet unexplored cases in any direct sense. Case studies, though, can be used to develop theory and this means that “case study research can give rise to explanations that can *potentially* apply to new cases” (Willig, 2001:86).

The case study consisted of a group of 12 primary school children, aged between eight and 14 years. The participants had ten group music therapy sessions. In South Africa it is most common for music therapists to run relatively short term interventions of approximately ten sessions in length (Ahmadi, 2010:129; Lotter, 2010:48; Torrance, 2010:26; Wildman, 2010:93). This is largely due to limited resources available for longer term work. It is, therefore, appropriate and extremely important to conduct research that explores what a therapeutic process of this duration can afford clients and how to go about designing an intervention of this nature.

Ten music therapy sessions of an hour each were conducted over the period of ten weeks. I made use of marimba playing, but also incorporated other components such as drumming, singing and dancing as part of the group activities. According to Creswell (2013:47), the research process is emergent for qualitative researchers, which means that the initial plan for research cannot be tightly prescribed and all phases of the process may change or shift after the field was entered to collect data. There were various reasons for including other components. When the process started, most children in the group could not keep a steady beat and struggled to follow simple patterns on the marimba. I, therefore, decided to make use of djembes to help the group members to listen to the group music, find and follow a main beat and to learn play with others. I was able to then gradually increase the level of difficulty. I facilitated the learning of patterns on the marimbas, rhythmical playing and playing as a group. The children started to sing and dance spontaneously and we incorporated this into our group ritual as well.

The sessions consisted of a greeting song, a ‘checking in’ of each member, a drumming circle, some singing, learning and practicing of patterns on marimbas, rehearsing marimba songs, dancing, and at the end of each session, a closing circle with more singing and a chance for ‘items’ (a component that developed later in the process). The groups did not follow a strict sequence of events, and allowed for suggestions from group members. I had to provide a lot of structure and direction within activities and had to adapt as the process unfolded. Creswell states that the key idea behind qualitative research is to learn about the problem or issue from participants and engage in the best practices to obtain that information (2013:47).

After the tenth session, the group had a performance for the parents and family members of all the participants as well as the teachers. They performed the music that they have played during the music therapy group sessions.

### **3.4.1 Sample**

I included all 12 of the children in the primary school section of Tersia Theron Private School. This school was approached for the study for three reasons. Firstly, it is a private school and the process of obtaining permission to do this study was relatively simple. Secondly, a discussion with an educational psychologist from the area and a follow-up conversation with the principal of the school convinced me that the learners attending this school were in need of a therapeutic process where self-esteem could potentially be enhanced. Most children who attend this school have difficulties in some area, for instance, learning difficulties, behavioural problems, Attention Deficit Disorder, emotional problems or socialisation difficulties. One child is physically disabled. These problems, according to the principal, have an impact on their self-esteem. The school is geared towards working with the children in small groups and providing individual attention. This private school, as mentioned, operates from a sub-urban house in Paarl and is not well-resourced in terms of sport or cultural activities as the focus is mainly on the academic development of the learners. The learners would, at the least, benefit from exposure to music and group music making. The third reason is a pragmatic one, in that there were marimbas available at a music school within close vicinity of Tersia Theron Private School.

One participant left the school within a week after we had the first session and the sessions continued with 11 participants. I made use of nonprobability sampling as the selection of participants was not determined by the statistical principle of randomness. All of the children attending this small primary school were chosen to participate so as not to exclude any children from the benefits of a music therapy group. The ages of the children ranged from eight years to 14 years. This age group (middle childhood) was selected because it is at this stage particularly that children are engaged in developing a “healthy sense of industry and a confidence that they can master and control their worlds” (Eccles, 1999:32). Positive experiences where children feel competent within a supportive social and emotional environment may offer them the opportunity to build self-esteem (Eccles, 1999:37).

I explained to the children in age appropriate terms what we were going to do during the music therapy group sessions and it was explained that their participation is voluntary. They understood that if they chose not to participate an alternative activity would be offered to them (art activities with their teacher). Letters were sent home with participants, informing parents/legal guardians of the proposed study and requesting their consent. All of the

participants were excited to take part in the music therapy groups and gave their assent. The sample group was finalised after the completed parent consent forms were received.

The class teachers' participation was also on a voluntary basis. They were asked to complete the BIOS rating scale, which is short questionnaire measuring behavioural indicators of self-esteem within the class situation, on each participating child.

### **3.4.2 Data collection**

Two sources of data were collected: video excerpts of music therapy sessions as well as questionnaires (BIOS rating scales) completed by class teachers before and after music therapy intervention. These methods of data collection will now be discussed.

#### **Data source A: Video excerpts**

Video recordings were made of all the sessions as well as of the performance. The use of video recordings of sessions is common practice in music therapy to analyse the music therapy process and for the purposes of supervision (Oldfield, 2006:177). In qualitative research, according to Bottorff (1994:255), video recordings can be used to identify specific recurring behavioural patterns as units from the flow of the behaviours observed as the researcher watches, listens and asks questions about the recorded events. Bottorff (1994:245) discussed the advantages of using video recordings for data collection as giving 'density' and 'permanence' to the collected data. Verbal and non-verbal behaviour can be observed through video recordings and significant moments can be reviewed as often as necessary.

Two video excerpts were selected from recordings of the music therapy process as well as one video excerpt from the performance by the marimba group at the end of the therapeutic process. Video excerpts were selected with specific emphasis on elements that might suggest changes in self-esteem during group sessions according to the characteristics of self-esteem identified in the BIOS scale (which will be discussed further in the following section). Behaviour observed during music therapy sessions included aspects such as level of confidence (Point 1 of the BIOS scale), range of responses during sessions (Point 4 of the BIOS scale), interaction with others (Point 2; 6; 9; 12 on the BIOS scale), level of satisfaction (Point 3; 8; 13 of the BIOS scale) and interest and involvement in sessions (Point 5 on the BIOS scale). Supervision and peer debriefing were employed in the selection of the three excerpts.

#### **Data source B: BIOS rating scale**

The BIOS (Behavioural Indicators of Self-Esteem) rating scale was completed by the participants' class teacher in order to assess self-esteem outside of the music therapy

situation. By using interdisciplinary triangulation (Terre Blance *et al.*, 2006:380), I was able to obtain information about the participants' behaviour in the school situation. Triangulation was thus employed to study the participants' behaviour from a different standpoint. The questionnaires were completed one week before the music therapy intervention (pre-intervention) and another set after intervention (within a week after the final performance). The class teachers were asked to complete the rating scale for each child participating in the study. Teacher training on the administration of the BIOS scale was done by me, the researcher, and involved a discussion on what self-esteem is, how self-esteem can be measured, and an explanation of each of the thirteen behavioural indicators. Examples of specific behaviours at each point were discussed.

I collected the first set of questionnaires after they were completed. The teachers were not able to visually compare their ratings from the pre-intervention assessment to the post-intervention assessment. The BIOS rating scale was developed by Burnett (1998:107-116) specifically for use by teachers to measure the frequency of behaviours indicating the level of self-esteem. The BIOS scale is used by teachers "to obtain a general picture of student's self-esteem through their behaviour" (Burnett, 1998:112). It was thus possible to get a general idea of if and how the participants' behaviour indicative of self-esteem, changed through the intervention. The questionnaire was translated into Afrikaans and is included as Appendix E.

### **3.4.3 Data preparation**

#### Data source A

Video recordings of music therapy sessions were carefully scrutinised in order to choose the most appropriate excerpts in an attempt to answer the research question. Thick descriptions (Stige, 2002) were written of the video excerpts. A thick description provides a detailed, in-depth description of the excerpt and includes contextual information to provide a richer understanding of the event. The analysis and interpretation of music heard is insufficient and the "meaning of music cannot be understood if isolated from the meaning game it is part of" (Stige, 2002:267). It is not enough to merely give descriptions of what is seen and heard, but description of contexts (situations of use) is needed in order to understand the musical event. A detailed description of the group process and activities was made in order to provide a rich context for the study.

#### Data source B

No preparation was required in terms of data source B.

### 3.4.4 Data analysis

#### Data source A

After the thick descriptions were prepared, I used Ansdell and Pavlicevic's (2001:150) line-by-line coding format to code the data. Coding means breaking up the data in analytical relevant ways (Terre Blanche, Durrheim & Painter, 2006:324). It can be done by marking different sections of the data as being instances of, or relevant to, one or more topics under consideration. Codes were reviewed several times. Codes that could be grouped together were highlighted in the same colour, reviewed again and then grouped under categories. A category is a mutually exclusive 'meaning box' and allows for detailed definition and logical comparison. Arriving at categories is not a simple process and involves playing around with categories, experimenting, revising, re-categorising on the basis of a new idea (Ansdell & Pavlicevic, 2001:153). The three different excerpts were categorised separately in order to compare the data from each excerpt. Categories were reviewed to develop main themes, which in turn were used to address the research question, in combination with the findings obtained from the rating scales.

#### Data source B

The pre- and post-intervention BIOS rating scores of each participant were calculated according to the scoring instructions. The pre- and post-intervention scores of each child were compared to determine whether any improvements in aspects of self-esteem were noted outside of the music therapy situation. This study hopes to provide an indication of whether music therapy, particularly utilising group marimba playing, may offer value in relation to affirming self-esteem. Indications of change between the pre- and post-intervention scores may indicate the need for further study in this area.

The quantitative data collected from the BIOS rating scores is discussed in relation to the themes drawn from the qualitative analysis of the video excerpts.

### 3.5 Research quality

In order to assess whether a piece of research is "rigorous and systematic" (Robson, 1993:402), qualitative researchers have replaced the categories used in quantitative research. Instead of assessing reliability, validity, generalisability and probability, the category of *trustworthiness* is used (Ansdell & Pavlicevic, 2001:203). Within this general category of trustworthiness are the four criteria of credibility, transferability, dependability and confirmability. I will now discuss the trustworthiness of my study by means of these four criteria.

To ensure that this study is credible, I aimed to demonstrate that the subject of inquiry was accurately identified and described. Lincoln and Guba (1985:307) suggest that this should be accomplished through a prolonged period of engagement, providing evidence of persistent observation and through triangulating by using different sources or methods. During the 12 week period, I was able to become well acquainted with the participants, teachers and the context in general and to build trust. Credibility was also pursued through active involvement in the research process and observations before, during and after sessions. The use of video recordings of sessions provided the opportunity to observe behaviour in detail. Triangulation was employed as I used video recordings as well as teacher questionnaires as methods of data collection. Lincoln and Guba (1985:308) suggest peer debriefing as another technique useful in establishing credibility. Supervision and peer debriefing assisted with self-reflection which also contributed to the credibility of the study.

Transferability asks whether the situation and conclusions of the research are transferable to other situations. It is the equivalent of the generalisability criterion of quantitative research (Ansdell & Pavlicevic, 2001:204). I cannot claim that the results of this study are generalisable to apply to other contexts. I have provided detailed information about the research procedure and context though, so that readers will be assisted in establishing conclusions as to whether the findings can be applied within their own contexts (Ansdell & Pavlicevic, 2001:204).

In qualitative research, the process and the rationale should be described in detail in order to show the researcher's systematic procedure because there are no standardised methods for collection or analysis of data (Ansdell & Pavlicevic, 2001:204). I aimed to ensure dependability by describing the entire research process as rationally, systematically and reflexively as possible.

In order to demonstrate that the analysis and findings emerged directly from the data, I meticulously described the process of meaning induction and analysis, rendering it confirmable by readers. I also kept a reflexive journal to continually monitor this process.

### **3.6 Ethical considerations**

The following philosophical principles (Terre Blanche, Durrheim & Painter, 2006:67) informed ethical considerations in my research:

The first principle is that all participants have a right to autonomy and respect for their dignity. Parents of participants were given an information form (see Appendix A) explaining the purpose and process of the study. They had been informed of video recordings that were taken of sessions and were aware that these videos would be analysed. Parents were assured

that participation is voluntary and that all information will be treated confidentially. Information and consent forms were made available in Afrikaans (Appendices A and B) and were given to parents. Assent was obtained from participants and informed consent from parents or guardians of participants was obtained prior to the planned intervention. Consent for recording of video material was obtained from parents or guardians. All information was treated as confidential and the privacy of participants was respected by the researcher at all times. The names of participants have been changed and video clips and personal information have been stored safely. The class teachers were considered participants in the study and their participation was also on a voluntary basis. Informed consent was obtained from the participating teachers (See Appendices C and D).

Data collected will remain in possession of the University of Pretoria and will only be used for educational and academic purposes. Data will be stored for archiving purposes at the University of Pretoria for 15 years.

The principle of nonmaleficence was employed in this study. The research was conducted in such a way that no harm was caused to the participants and they were not wronged in any way. In order not to be labelled as having low self-esteem, all the children in the school were included as participants in the study and no child was referred to as a child with low self-esteem.

The principle of beneficence was followed in that I attempted to maximise the benefits that the research afforded the participants in the study. Participants enjoyed taking part. When the intervention period was completed, I offered to continue with a music therapy group on a weekly basis until the end of the school year, should the principal and participants wish to. The expected beneficial effects to the participants will thus be optimal.

### **3.7 Conclusion**

In this chapter I discussed the research methodology employed in this study. I made use of a qualitative methodology and used quantitative techniques to enrich the data. I described the sample, methods of data collection and how the data was analysed. Considerations regarding the research quality were included. Lastly, the ethical considerations employed in this study were discussed. In the following chapter I explain the process of data analysis and the emergence of themes.

## CHAPTER FOUR

### Data Analysis

#### 4.1 Introduction

In this chapter I describe the process of data analysis that took place in this research study. I provide an overview of the process of data collection and preparation and follow this with how the prepared data was coded. I continue by showing how the codes were grouped into categories and provide a description of the categories. The themes that emerged from these categories are described briefly. This will be followed by a more detailed account in the following chapter.

#### 4.2 Data collection and preparation

Data was collected from two sources, namely video recordings of sessions as well as pre- and post-intervention questionnaires completed by class teachers. I will now briefly discuss the process of data collection and preparation.

##### 4.2.1 Data source A: Video recordings

###### 4.2.1.1 Selection of excerpts for thick description

Ten music therapy sessions of approximately one hour in duration were conducted as well as a performance session at the end of process. The sessions were aimed at affirming the self-esteem of primary school children through the participation in music therapy groups where the participants learnt to play marimba in addition to exploring other instruments. Learning to play specific patterns on the marimba proved rather difficult and very time consuming especially for some of the younger children. The younger children preferred to play percussion instruments, djembes, or to sing and dance. Different components were brought into the groups, such as drumming circles, singing, improvisations, and movement activities as I deemed appropriate, or as spontaneously initiated by group members. The greatest part of the sessions went into learning marimba parts, improving musical skills and playing together as a 'band'. The final session was a performance which friends, family members of participants and teachers attended. All of the sessions and the performance were video recorded.

The video recordings were scrutinised and three excerpts were selected, through supervision, on the basis of showing behaviour indicative of self-esteem, as well as elements that could explain how group music therapy may play a role in affirming self-esteem. The excerpts demonstrate the development that took place during the ten week process.

### Excerpt 1:

This excerpt was taken from session 4 (36:38' – 38:57'). Previously in this session, we had a drumming circle and group improvisations. We then reviewed the marimba patterns learnt the previous week. After practicing the different parts, we started rehearsing the song all together (this is where the excerpt starts).

The excerpt shows the different group members' behaviour during the earlier stages of the process, and demonstrates the group music at the time. Each group member is involved in some way: the older children play marimbas and the younger ones play percussion instruments or express themselves through body movements. The group members all seem to be focussed on their own playing, but do not yet pay attention to the group sound and how their playing contributes to the group sound. The sounds are often scattered as the instruments do not all play in unison. Moments of disorder are evident. The excerpt shows the music therapist's directive approach and the therapeutic support she provides, as well as how the group responds to it.

### Excerpt 2:

This excerpt is taken from session 9 and lasts just under 5 minutes (30:00 – 34:55). Earlier in this session, we had a greeting circle and spoke about the concert. We spent time reviewing and practicing the different marimba parts. The excerpt shows the rehearsal of a song where most members are playing marimba, some drums and S is playing guitar.

The excerpt demonstrates how the group members are, in general, more organised and focussed on their playing, relaxed in their interaction with others and aware of the group music. It shows the music therapist's therapeutic guidance and how the group members respond to it. Increased enthusiasm is noted when their playing improves as they play the song through several times. The group members appear more aware of each other and the music. They seem to play more confidently, and appear to have improved capacity to express themselves creatively in the music through their body movements. Many instances of enthusiasm and excitement are noted.

### Excerpt 3:

This excerpt is taken from the performance session. The group members demonstrated a drumming circle, performed two songs and the last item was a song performed by A. The excerpt is just under 4 minutes long and starts where A is singing the last lines of her song. After the applause, the music therapist asks casually if there is anything else that the children want to do. T spontaneously suggests an item, saying that he would like to 'beat box'. The

music therapist lets him to do his item. T performs his beat boxing, and is well supported by the other group members. They support him musically, playing djembes and moving to the beat. He receives a loud applause. The excerpt shows two more such spontaneous items by R, S and N which demonstrate their confidence in the music, spontaneity, the social support that group members offer each other and the parents' appreciation for their children's attempts.

#### 4.2.1.2 Thick descriptions of video excerpts

After the excerpts were selected, I viewed them a number of times. This was done in order to capture as much information as possible regarding the participants' behaviour that could be indicative of self-esteem. Factors that could possibly have played a role in facilitating self-esteem of the participants, such as the music, social interaction and the role of the therapist (MT) were also investigated. Thick descriptions were written of observations made. Table 4.1 contains an example of a section of thick description 1.

##### Thick description 1

Excerpt 1: From session 4: 36:38' – 38:57'

MT tries to now focus their attention better, by clapping her fingers, arms raised, waiting for eye contact from the children, calling some of their names. They gradually settle down. MT waits for a quiet moment, and says, "kyk hoe mooi kyk julle vir my" in a calm and containing voice as they look at her. She counts to three and as the instrumental music starts, MT looks at her fellow dancer/singer (Er) and they move together. Er dances energetically. They play more in unison, and some are singing along. Most children seem focussed and stay on the beat, and the melody of the song can be heard throughout. K is playing the triangle neatly on the beat. Er dances happily and lightly next to MT, following her lead, and singing along in a clear voice with MT. R does not play along the first time, but sits and only fiddles around with his tambourine with no effort of playing along with the group's music. He looks up at MT now and again. S seems to enjoy playing on the bass drum as his whole body moves in time with the beat and he lifts the beaters high up in the air. T seems rather passive as N holds his hand over T's hand holding the mallet and plays for him. The group plays the song through once and the MT shouts after the last note, "Yes! Weer!", this time in a clear, excited voice and directs them to play it through again, without stopping. MT and E glances at one another and E seems even more excited and now jumps up while dancing her steps.

Table 4.1 Example of thick description of video excerpt 1

Each line of the thick description was numbered to prepare the data for the coding process. Please refer to appendix F for transcripts of thick descriptions.

#### **4.2.2 Data source B: Pre- and post-intervention (BIOS) questionnaires**

The BIOS (Behavioural Indicators of Self-Esteem) Rating Scale was developed by Burnett (1998:107-116) specifically for use by teachers to measure the frequency of behaviours indicating the level of self-esteem. The questionnaire was translated into Afrikaans (please refer to Appendix E) and the teachers were trained (by myself, the researcher) in the administration of the questionnaire. We had a discussion on what self-esteem is, and went through the questionnaire to discuss specific examples of behaviour.

The class teachers were asked to complete the rating scale for each child participating in the study. The questionnaires were completed one week before the music therapy intervention (pre-intervention) and another set after intervention (within a week after the final performance). I collected the first set of questionnaires when it was completed. The teachers could not compare their pre-intervention set of ratings with the post-intervention ratings on the basis of looking at their previous scores.

After I received all the questionnaires (both pre- and post-intervention), I scored each of them according to the scoring instructions on the rating sheet. Each child then had a total BIOS score pre-intervention and a total BIOS score post-intervention. The BIOS score is used to “obtain a general picture of the student’s self-esteem through their behaviour” (Burnett, 1998:112).

When the processes of data collection and preparation were completed, I could continue with coding the data. In the next section I will discuss how this was done.

#### **4.3 Coding the data**

Coding is the process of organising and sorting the data. Ansdell and Pavlicevic (2001:150) propose a form of qualitative coding where labels are given to aspects that are relevant to the research question. Line-by-line coding of data aims to give useful meaning to relevant sections of text. According to Gibbs (2007:50), open coding refers to the process of deriving labels directly from the data. The label (code) is not a mere description of the text, but rather a more general idea/phenomenon. Following is a detailed description of the process of coding of the data.

Thick descriptions of relevant excerpts were placed in a column. Each line was numbered numerically on the left hand side. On the right hand side, a column was created for the coding

of lines. 'TD' refers to 'thick description'. Before coding the thick description, I read it carefully to become aware of the salient concepts. An example of a complete coding document can be viewed under Appendix G. Below is an example of the coding of thick description 3.

Line	Thick description: Excerpt 3	Code
TD3-1	A stands in front of the audience with the MT, who accompanies her on guitar, and sings her song in	A performs with enjoyment
TD3-2	a clear, strong voice. She appears to enjoy her performance and is calm and confident. The other	A confident use of voice
TD3-3	children sit around her on the floor, and play along softly on their djembes, moving to the beat or just	G supportive
TD3-4	listening. Some are mouthing the words of the song with her (R and Er) as they listen to her singing.	G listen intently
TD3-5	They pay attention and look at her kindly as she finishes the song. A and MT make eye contact and	MT supportive
TD3-6	smile when the last chord on the guitar is played and A receives a loud applause from the audience	Audience and member applause
TD3-7	and other group members. She smiles and looks down. The other group members are smiling warmly	Group support
TD3-8	as they clap hands. MT talks to the audience, and points to the fact that A and MT did not have much	MT affirms
TD3-9	practise time, but that they could surely all hear her beautiful voice. MT concludes the concert and then...	MT provides structure

Table 4.2 Example of thick description coding

#### 4.4 Categorising codes

After completing the coding, the next step in the process of data analysis is to organise codes into categories. Ansdell and Pavlicevic describe a category as a "mutually exclusive 'meaning box'" (2001:151). The process of categorisation involves playing around with categories, experiment, revise and recategorise on the basis of a new idea (Ansdell and Pavlicevic, 2001:152).

The process of categorising codes necessitated a global overview of all the codes from the three excerpts. On a separate piece of paper, I played around with codes, trying to group them together. I developed possible categories, looked for overlaps, discarded weak categories and created new categories, as recommended by Ansdell and Pavlicevic (2001:152). I highlighted codes that seem to belong together in the same colour. For example, all moments relating to 'disorder' were highlighted in yellow in all three excerpts. An example of this can be viewed under Appendix G. I became aware of how the frequency of codes shifted from the first excerpt, to the second and then to the third. This gave me an idea of what happened throughout the process and how the codes could be categorised. I then categorised each excerpt separately. The complete table with codes grouped under categories of the three excerpts can be view under Appendix H. The categories, a description of each category and some examples of codes is shown as table 4.3 below.

Category and description	Code examples
<p><b>1. Disorder</b>            Moments of disarray, disorder or chaos during sessions</p>	Lack of musical cohesion Chaotic R withdraws R isolated Group sound falls apart Group disorder N incongruent playing Group sound disjointed Music lacks coherence
<p><b>2. Cohesion</b>            Instances where cohesion or interconnection between members and/or the music was observed</p>	Flow between Er and MT Group members sing along Some group cohesion Energy in group increases Close musical interaction

	<p>T and Ed play in unison</p> <p>Group engaged</p> <p>All group members in unison</p>
<p><b>3. Lack of awareness</b></p> <p>Codes that indicate a lack of awareness of other people or the music</p>	<p>Group not focussed</p> <p>Lack of awareness</p> <p>Group distracted</p> <p>N plays in isolation</p> <p>K loses focus</p>
<p><b>4. Attunement</b></p> <p>Codes that indicate awareness of each other and the music, playing together, attuning to other</p>	<p>Group increased focus</p> <p>K keeping beat</p> <p>A aware of group</p> <p>Er follow beat</p> <p>K follows therapist</p> <p>S sensitively supports T</p> <p>Group members listen intently</p> <p>N attunes finely</p>
<p><b>5. Member support</b></p> <p>Instances where members supported each other in some way</p>	<p>N and T enjoy, make eye contact</p> <p>Spontaneous group social interaction</p> <p>Group supportive</p> <p>D supportive</p> <p>Group gently supportive</p> <p>Member applause</p>
<p><b>6. Uncertainty</b></p>	<p>L hesitant</p>

<p>Instances where behaviour of group members indicated a sense of uncertainty</p>	<p>Music inflexible</p> <p>A hesitant</p> <p>L hesitant</p> <p>K tentative</p>
<p><b>7. Confidence</b></p> <p>Moments where the behaviour of group members indicated self-confidence</p>	<p>K confident participation</p> <p>S shows initiative</p> <p>Group strong use of voice</p> <p>M confident</p> <p>R playful and shows initiative</p>
<p><b>8. Enthusiastic participation</b></p> <p>Instances where behaviour observed indicated enthusiasm and enjoyment of activities</p>	<p>Er sings enthusiastically</p> <p>S enjoyment, big body movements</p> <p>Er excited, big body movements</p> <p>R participates enthusiastically</p> <p>P sings enthusiastically</p> <p>K dances energetically</p> <p>Group excited</p> <p>R relaxed participation</p> <p>High group energy</p> <p>Mutual enjoyment group and MT</p> <p>Group spontaneous</p> <p>T enthusiastic, big body movements</p> <p>Group enjoys music</p>
<p><b>9. Leadership</b></p>	<p>Ed shows leadership</p> <p>A shows leadership</p>

<p>Indicate instances where group members showed signs of leadership</p>	
<p><b>10. Structure and direction</b> Indicate instances where the therapist provided structure and direction during sessions</p>	<p>MT instructs MT directs firmly MT provides clear structure MT guides strongly MT redirects MT focus attention MT sets challenge</p>
<p><b>11. Therapist's support</b> Indicate instances where the therapist provided support, affirmation or encouragement to the members</p>	<p>MT contains MT calmly directive MT offers ideas MT supports dancers MT offers affirmation MT offers positive feedback MT supportive MT supports musically</p>
<p><b>12. Facilitating independence</b> Represent moments where therapist encouraged independence in members</p>	<p>MT facilitates initiative MT lets R play independently MT encourages S MT steps back</p>

Table 4.3 Categories and descriptions with examples of codes

## 4.5 Developing themes

The following themes emerged as I reviewed the categories:

### 4.5.1 Theme one: Client responses

<b>Theme one: Client responses</b>
From disorder to cohesion
From lack of awareness to attunement and support
From uncertainty to confident and enthusiastic self-expression

Theme one ‘client responses’ points to the development of different aspects in the group members’ behaviour and the development of how the members presented from the first excerpt, to the second and to the third. These aspects represent elements indicative of self-esteem, and will be discussed in more detail in the following chapter.

### 4.5.2 Theme two: therapeutic intervention

<b>Theme two: Therapeutic intervention</b>
Structure and direction
Therapist’s support
Facilitating independence

Theme two ‘therapeutic intervention’ describes the music therapist’s ways of interacting with the group members, the practical manner in which I conducted the sessions, how I contained the group, and how these strategies influenced the group process and the group members. This theme provides insight into *how* music therapy seem to influence behaviour indicative of self-esteem.

## 4.6 Conclusion

This chapter provided a description of the process of data analysis that I followed. It has shown how data sources were collected and prepared. Examples of prepared data were provided. I further explained how the process of coding and categorising was applied and provided

descriptions of the categories. I then demonstrated how the two themes emerged from the codes and categories. The themes were briefly described.

In the following chapter the themes that emerged will be discussed in detail in relation to the research questions that guided my study. I will incorporate supportive literature into the discussion.

## CHAPTER 5

### Discussion

In this chapter I attempt to answer the research questions by exploring the findings that emerged from the data analysis. I integrate relevant literature into the discussion. I will first state the research question that guided the study.

Main research question:

Can music therapy utilising group marimba playing facilitate increased self-esteem for children in a small independent school and, if so, how?

Sub-question 1:

How does music therapy utilising marimba playing facilitate opportunities for the development of self-esteem within sessions?

Sub-question 2:

Do music therapy sessions facilitate changes in self-esteem within the children participating in the study that transfer to the classroom situation?

The first sub-question will be discussed in detail by referring to the emergent themes and the second sub-question will be dealt with by discussing the results obtained from the BIOS Rating Scale completed by the teachers.

Maslow (1970:45) described two versions of self-esteem: one that includes the need for respect from others, status, fame, recognition and appreciation, and another version that involves self-respect, confidence, competence, achievement, independence and freedom. Mruk's (1999:107) two-dimensional model conceptualises self-esteem as the integrated sum of self-worth and self-competence. In this chapter's discussion of the themes that emerged from the research I refer to these two dimensions of self-esteem. I discuss how music therapy played a role in affirming the self-worth of participants through therapeutic intervention, recognition, and other social input, as well as how participants' sense of competence was affirmed through active music making in the sessions.

#### 5.1 Theme 1: Client responses

##### 5.1.1 From disorder to cohesion

The first feature that stood out from the data analysis is the shift that took place from disorder in the group in the beginning stages to group cohesion in the later stages. Analysis of the first

excerpt revealed many instances of lack of musical cohesion, members playing in isolation as opposed to playing together, chaos at times, group disorder, and instances where the music was scattered or lacking in coherence. Considering that many of the group members have developmental difficulties, for instance learning difficulties, behavioural problems, Attention Deficit Disorder, emotional problems or socialisation difficulties, it may be understandable that the group was inclined towards disorder. Many group members had a tendency towards the following (as noted and coded throughout the three thick descriptions).

- Poor attention and concentration
- Poor listening
- Hesitancy

When disorder, lack of attention and focus, and poor listening skills are features of one's engagement with others then opportunities for the development of self-esteem may be limited. Negative feedback is typically then received from teachers, parents and peers, and the child may struggle to achieve in different functional areas. According to Kaplan and Sadock (1998:1197) many children with ADHD have secondary depression in reaction to their frustration over failure to learn and their consequent low self-esteem. I aimed to provide more order, structure and experiences of group flow through the music to stimulate participants' attention.

As the process developed, more instances of cohesion were noted. The following is from the second excerpt (session 9) where the group members seemed more attentive to the music and listened intently. Greater interconnection between group members was noted:

The drums are silent during this part of the song and the drum players patiently wait their turn. S is playing on the guitar, incorporating rhythms that he plays percussively on the wooden part of his guitar, with rhythmic strumming on the strings. He plays exactly with the group, following the rhythmic patterns that they play. The members of the group seem to be more aware of the main beat and the group music... (TD 2, lines 10-14).

During the performance session, many instances of group cohesion were noted, and the group members demonstrated sensitive listening, close musical interaction, and enthusiastic co-operation as demonstrated in the following excerpt:

The other group members are quiet, smiling and listening intently to T to try to hear the beat. D moves towards T's wheelchair and sits right next to him, as if to support him. N quickly hears the beat and sensitively supports T on his djembe,

playing the rhythm of T's mouth sounds on his djembe. S and P start to play the same rhythm on their djembes, leaving the strongest, emphasised beat for T to play on his djembe. Shortly, P and E start to play the strong beat along with T. T moves his body to the beat and plays his djembe loudly with his mallet. His wheelchair is moving backwards and forwards as he hits the drum. MT moves to the beat, and supports T's beat by tapping on her guitar, keeping the metre steady. They follow a steady beat and other group members look at him respectfully to follow his beat. R and K also starts to play their djembes in time with the beat, and the energy increases as more people join in (TD 3, lines 14-23).

According to James and Freed (1989:29), group cohesion may be characterised by a high level of group participation, positive mutual feelings amongst members, and strong interpersonal trust between members. Through the structured presentation of music therapy experiences, interpersonal awareness, cooperation and trust can be fostered (1989:28). James and Freed (1989:30) suggest a sequential model for developing group cohesion: 1) goal setting activities which reinforces clients' internal locus of control; 2) individual/parallel activities to develop self- and interpersonal awareness; 3) cooperative group activities to promote interpersonal connection; 4) opportunities for self-disclosure to develop interpersonal trust and 5) group problem-solving activities where individual therapeutic issues are clarified. In the music therapy process described in the current study, opportunities were created through music making activities to develop self- and interpersonal awareness and to promote interpersonal connection. During circle-time they were also offered opportunities for self-disclosure. The group members seemed to become more sensitive towards one another, leading to increased group cohesion and general acceptance of each other.

### **5.1.2 From lack of awareness to attunement and support**

The following feature that emerged from the data analysis was the development that took place in participants from lacking awareness of self, other and the music in the beginning of the process, to attunement and support as observed at the end of the intervention period. Lack of awareness of self and others was observed in sessions during various activities when individuals played concurrently with others, but still in a manner that was isolated. There was often no sense of a shared beat and group members did not seem aware of how their own playing affected the group sound. It resulted in moments of disorder as described in the previous section.

As the process developed, and group members' awareness of the group music and other members were stimulated, they gradually became more mindful of their own contribution to

the group music and attuned to the other group members. During circle time, the group members started to share more personal information, and it was noted how other members listened more intently, and later even offered advice. Eye contact and smiles amongst group members improved, awareness of other members' musical contributions and sensitivity towards others increased. When playing, the group sound was more cohesive as members seemed aware of the main beat and changes in dynamics. In the performance session, musical and emotional support for each other was observed, sensitive listening to each other, and flexibility in response to other group members taking initiative.

Developing an awareness of others or "other-awareness" as described by Asendorpf and Boudonniere, (1993:89), is understood as a cognitive capacity that marks a specific stage in development of empathy. Empathy, in the broad sense, refers to the ability to understand and share the feelings of others. The ability to empathise is important for promoting positive behaviours toward others and facilitating social interactions and relationships (De Wied, Branje & Meeus, 2007:48). Empathy plays an important role in becoming a socially competent person with meaningful social relationships. The music therapy groups seemed to have played a role in facilitating social competence of the group members. In addition to being more attuned to others (and thus being more socially competent), the group members might have felt more accepted by their peers when they were being listened to, which could contribute to the development of a sense of worthiness. The two-dimensional model of Mruk (2013:163) which integrates the cognitive and affective dimensions as well as the two factors of competence and worthiness, can be used to explain how these gains (in competence and self-worth) can be interpreted as gains in self-esteem.

### **5.1.3 From uncertainty to confident and enthusiastic self-expression**

The data analysis further revealed a shift from uncertainty or hesitance observed in the behaviour of participants in earlier sessions to confident and enthusiastic self-expression later in the process. This excerpt from the fourth session shows how uncertainty of the group members was expressed in the music.

The marimbas do not start all together, and the sounds are a little scattered. Some pick up the main beat again, but L and N struggle to play correctly and on the beat. L cannot keep up his pattern on the marimba, looks around hesitantly and plays out of sync. All band members and dancers are concentrating on their own playing and try to follow MT's loud and clear time-keeping efforts (TD 1, lines 27-31).

After this moment in the excerpt, I continued to provide musical direction, guiding the group in an enthusiastic manner. I made sure to support them in their efforts by making eye contact with group members, nodding or smiling.

The group members seemed to grow in enthusiasm and confidence as their competence increased. The following quotation from the fourth session provides an example of this:

A, S and M are playing confidently and enthusiastically as they seem sure of their patterns, and they carry the melody and rhythm brightly (TD 1, lines 39-40).

Many instances of enthusiastic self-expression were noted in all three excerpts, but were generally more evident after participants experienced success (e.g. played in unison), received enthusiastic feedback, or when they seemed to enjoy their participation. It was noted that the members used bigger body movements, sang along uninhibitedly, and danced while playing their instruments. They laughed more in later sessions and more spontaneous social interaction was noted. The level of energy in the group appeared to increase in later sessions.

Confidence seemed to increase as the process developed. As mentioned before, the group members appeared to feel secure and safe in the group and were increasingly more confident to use their initiative and to express themselves in a creative way. Throughout the process, I welcomed their creative contributions and the group also enjoyed and supported spontaneous performances such as A's singing of pop-songs during the drumming circle, L's dancing the 'Leeuloop' and S's playing of the open-tuned guitar. These moments of spontaneous creative expression increased in frequency throughout the process. When I created an opportunity for spontaneous 'items' during the performance event, even though unrehearsed and unplanned, group members were confident to present themselves in front of an audience. This is in line with what Mruk (1999:153) described, namely that a relationship exists between self-esteem and happiness, initiative, openness, spontaneity, a secure identity and a general absence of psychopathology. I will now turn to the themes concerning the therapeutic intervention as this will shed more light on *how* music therapy group intervention facilitated opportunities for the development of self-esteem.

## **5.2 Theme 2: Therapeutic intervention**

### **5.2.1 Structure and direction**

Upon reviewing the three excerpts, I found that I, as the music therapist, provided considerable structure and direction in the first, and even the second, excerpts. A specific ritual in the group was established whereby the group members knew the basic sequence of events in a session. Within specific activities, I used my discretion to decide how much therapeutic guidance to

give, depending on the goal of the activity. Providing structure and direction enabled the group members to become more aware of one another and focus their attention, to be more musically ordered, to experience boundaries, to become enthusiastic, to achieve a goal, and to contribute their own ideas.

The following presents an example from the first excerpt in which the therapist's provision of direction and structure enabled group members to become more aware of one another and to be more focussed:

MT tries to now focus their attention better, by clapping her fingers, arms raised, waiting for eye contact from the children, calling some of their names. They gradually settle down. MT waits for a quiet moment, and says, "kyk hoe mooi kyk julle vir my" in a calm and containing voice as they look at her. She counts to three... (TD 1, lines 13-15).

Many children in this group struggle with attention problems and learning difficulties and it was, therefore, particularly important to help them to become more aware of others and to focus their attention. Establishing a routine of making eye contact, counting and starting together could help them, not only to play more in unison, but to increase their general level of awareness and improve their listening skills.

The provision of direction and structure by the therapist served to guide the group musically. The following is an example from excerpt 1.

All band members and dancers are concentrating on their own playing and try to follow MT's loud and clear time-keeping efforts (TD 1, lines 30-31).

The purpose of guiding the group musically was to help them to play their different parts in unison, to all follow dynamic changes and to follow rhythmic or tempo changes. Immediate feedback in the music was experienced (to facilitate a sense of "this sounds great, I can do this") and this in turn led to greater motivation and experiences of competence.

The therapist's provision of structure and direction helped to set boundaries. Setting boundaries seemed to be important in this group, as some group members tended to want to push the boundaries, or did not appear aware of limits. Knowing the boundaries, and enforcing them, seemed to create a sense of safety for the children. The following is an example from the first excerpt where the therapist clearly set a boundary.

She counts to three, but since the members are not ready and focussed to start, the band does not start in unison. There is no sense of a shared beat and each

person is playing his/her pattern in isolation. Scattered sounds of different instruments are heard. P is still walking towards his instrument, shouts “hey!” and chases S away who is playing on his (P’s) marimba. A, L and S look up from their marimbas and stop playing. MT stops the remaining players and addresses P directly, “P, as ek se is julle reg, dan moet julle by julle instrumente wees”. She tells them to listen to her counting, to prepare themselves so that they can start in unison (TD 1, lines 2-8).

The direction provided by the therapist served to enthuse the group members. The following example is from excerpt two (session 9).

At the end of the song, MT shouts “Whoo!” in praise of their effort and kicks her foot up excitedly. She announces that they will play through both parts of the song now, and the children spontaneously and enthusiastically count with her to three to start (TD 2, lines 27-30).

Within the boundaries of the directions given, group members could feel secure in that they knew exactly what to play. I divided the piece of music up in smaller, more manageable segments that were easier to play. I was able to give them honest, positive feedback. When the music sounded good they experienced success and felt more enthusiastic about taking part.

The use of therapeutic direction served the purpose of setting standards. In order to experience a sense of mastery, the group members needed to know what the standards were. They seemed to have been encouraged to focus more by the therapist’s remark:

MT reminds them of the note names again after the song. She says “Weer ‘n keer, dit was nie goed genoeg nie”.... MT counts to three. They start together and this time... (TD 2, lines 14-18).

Maslow (1970:45) emphasised that the most stable and, therefore, healthiest form of self-esteem is based on respect that is earned or deserved and not based on fame or flattery. Giving empty words of praise, when the group members can hear that their music did not sound harmonious, would not help to build an authentic, positive self-esteem. Helping the group members to know that they deserved respect (e.g. by playing together) seemed to play a greater role in building self-esteem. Hjelle and Ziegler (1981:373) support this by pointing out that self-esteem should not merely be based on the opinion of others, but should rest on real life experience.

The therapist's directions included offering ideas to group members. The group members seemed to feel more secure and willing to take part in activities when they were offered some ideas on what they could do.

...she (MT) invites R and K to get up and to dance along with her and E. She quickly shows them how they can dance. MT tries to keep a moderately fast pace and to maintain a bright, strong energy with her body language (arms in the air, eye contact) and presence ....The dancers (E, R and K) dance and sing energetically, and look at MT regularly to follow her beat. MT makes good eye contact with the dancers and smiles are exchanged (TD 1, lines 44-47; 59-60).

In summary, providing structure and support in this therapeutic situation, served certain important purposes. The group members were led through the process, felt safe and secure and had the opportunity to increase their competence in music. According to Kaplan and Sadock (1998:41), group therapy aimed at refining social skills, as well as increasing self-esteem and a sense of success may be very useful for children with ADHD. An example of a year-long group therapy intervention in a clinical setting for boys with this disorder is described (Kaplan & Sadock, 1998:42). The goals of treatment were to help the boys improve skills in game playing and feeling a sense of mastery with peers. The boys were directed about following instructions, waiting, and paying attention, while being praised for successful cooperation. Kaplan and Sadock (1998:42) are of opinion that this level of structured group therapeutic 'play' is developmentally appropriate for children with ADHD, who benefit from increased ability to participate in any group activities.

In the third excerpt, which was taken from the performance session, I provided much less structure and direction. I found myself able to step back to a more supportive position while some individuals in the group took initiative for items, and other group members supported them in a sensitive manner. It seemed that they felt competent and confident to perform their own items and seemed to feel safe and secure enough to dare.

### **5.2.2 Therapist's support**

The next aspect of therapeutic intervention that emerged as a theme throughout the process was that of therapeutic support. My support, as the music therapist, was communicated verbally through comments such as "julle vorder mooi" (TD 2, line 47); by means of body language or facial expressions such as eye contact, smiles, nods, etc.; and was demonstrated during music making through techniques such as meeting and matching. Meeting and matching refers to a music therapy technique where the therapist attunes to and reflects aspects of the client's tempo, meter, rhythm and pulse, creating a musical context with musical

features that are common to the two players in order to provide a potential space for sharing (Pavlicevic, 2002:3). An example of this would be when individual group members had an opportunity to create rhythmic patterns on the djembes, and I met them musically by matching their rhythms on my djembe.

The following example from excerpt 1 shows different forms of support that were offered to the group. I moved with the group members, made eye contact with them, smiled with them, supported them rhythmically, matched their movements and in the end gave positive feedback in the form of (non-verbal) high-fives. The increase in confidence in the children is evident as their movements became bigger and more secure.

The dancers (E, R and K) dance and sing energetically, and look at MT regularly to follow her beat. MT makes good eye contact with the dancers and smiles are exchanged. They dance using bigger and more secure movements and keep to the beat of the music. At the end of the song, MT turns to the dancers and hands out a high five to each of them (TD 1, lines 59-62).

Therapeutic support links to the concept of containment (Bion, 1962:308). Psychotherapeutically this is built on the notion of the containment provided to an infant by his/her mother (Stern, 1985:221). The mother is able to take in, or contain, her infant's confused feelings and manage them for him/her. The infant senses this containment and is enabled to experience difficult and overwhelming feelings safely. He/she feels secure in that someone is there to make sense of his/her experiences and can then eventually manage them himself/herself. Bion (1962:308) referred to the mother as the "psychic container", a processor of feelings, a figure making sense of chaos. According to Bion (1962:309), the therapist assumes this role with clients in order to contain and transform their unmanageable feelings. Environmental and emotional boundaries provide a sense of containment for the client. In this case, the structure of sessions, structure within the music, together with emotional support, provided by the therapist fulfilled that role.

During the first few sessions, it was noted that the group music was incoherent, at times chaotic, the group members did not focus, there seemed to be low awareness of others and they struggled to play their patterns on the marimbas. Therapeutic support (both emotionally and in the form of provision of direction) seemed to create a sense of safety for the group members. In later sessions (from session 4 onwards), members seemed more willing to share personal issues in the circle, they explored more (trying out new instruments) and seemed to become physically increasingly free as it was observed that their body movements became bigger and they danced more.

Providing support seemed to encourage the group members to take part, to facilitate independence and seemed to energise them. Eventually, the support that they experienced appeared to give them the courage and the confidence to perform in front of others, to take initiative and to be spontaneous. They showed care and gentle support towards each other during the performance, in the same way that the support was modelled to them during the sessions:

MT concludes the concert, and then, on the spur of the moment, asks the children if anyone would like to still do something. T quickly replies “Ekke! Ek wil graag beatbox!” MT encourages him and smiles when she says: “Ja, beat box jy vir ons ‘n bietjie!”...The other group members are quiet, smiling and listening intently to him to try to hear the beat. D moves towards T’s wheelchair and sits right next to him, as if to support him. N quickly hears the beat and sensitively supports T on his djembe, playing the rhythm of T’s mouth sounds on his djembe. S and P start to play the same rhythm on their djembes, leaving the strongest, emphasised beat for T to play on his djembe. Shortly, P and E start to play the strong beat along with T. T moves his body to the beat and plays his djembe loudly with his mallet. His wheelchair is moving backwards and forwards as he hits the drum. MT moves to the beat, and supports T’s beat by tapping on her guitar, keeping the metre steady. They follow a steady beat and other group members look at him respectfully to follow his beat (TD 3, lines 10-22).

In this excerpt, therapeutic support was more subtle as the therapist stepped back and let the children perform more independently, only providing musical support and encouragement. There was also very little therapeutic direction and structure as the group members seemed to feel safe and secure to spontaneously take initiative. This seems to be consistent with Harter’s explanations (2012:12) of the importance of the evaluations of significant others for children in the mid-childhood phase. Strong self-affect in the form of pride develops when praise and support for efforts are provided by significant others (e.g. parents, teachers, and friends).

Therapeutic support seemed to provide containment in this group process. As the process developed, the members appeared to experience a sense of safety which allowed them more freedom, increased their capacity to be aware of others and to take part confidently and enthusiastically.

### 5.2.3 Facilitating independence

The following theme that emerged is how therapeutic intervention facilitated independence in participants and how this, in turn, allowed for freedom for constructive creative expression to develop. After introducing them to the marimbas, I realised that using only marimbas in the group would be unpractical as many participants found the marimba patterns difficult to learn. Different developmental levels, attention problems, co-ordination problems, difficulty with sequencing and poor listening skills complicated matters. I found it challenging to pay individual attention to group members while other group members were waiting (rather impatiently). The children who took part in the study also did not have any previous experience in playing musical instruments and some tended to struggle to control their impulses.

In keeping my therapeutic goal of facilitating self-esteem in mind, I decided to incorporate more components into the music therapy sessions in order to involve more group members constructively at any given moment and to increase the possibilities for them to experience success. Through providing more structure and direction within activities I aimed to improve their skill, facilitate experiences where they receive positive feedback (in the music) and experience group cohesion.

Analysing the excerpts showed how the group members responded to therapeutic intervention as far as creative expression is concerned. In the first excerpt (from session 4) group members tended to follow instructions and responded enthusiastically when they were affirmed, but did not show much initiative. In the second excerpt (from session 9), there were two instances where I left the group members to take their own initiative and play independently. I gave subtle support by making eye contact to affirm their contributions. Group members seemed more certain of what to play by that stage (following marimba patterns, keeping the beat, etc.) and within that structure seemed freer to be creative and use their initiative (e.g. by dancing while playing, singing along and inserting their own extra beats or notes). In the third excerpt, four different group members showed initiative by spontaneously performing their own unrehearsed items. During these performances, other group members supported them spontaneously in creative ways. My role in this instance was simply to be with the group and support them.

Mention should be made of the role of the greeting song/drumming circle, which was a less directive activity, in facilitating creative expression. In our greeting song, an opportunity was given to each group member every week to create their own rhythmic pattern and to play it to the rest of the group. The other group members had the task (with variations) to listen to the rhythmic pattern and then to play with that member. Spontaneous games evolved from this activity and members were very motivated to play creatively. It also led to the creative use of

their voices, spontaneous song creation as well as use of other instruments. Group members were encouraged to express themselves in creative ways and other group members generally enjoyed the contributions.

According to Mruk's (1999:188) two factor theory, people with a high self-esteem typically exhibit a positive degree of both competence and worthiness. In order facilitate self-esteem, I attempted to provide experiences where participants' sense of worthiness and competence could be developed. It appears that the members of the group developed a sense of worthiness through their experiences of feeling accepted and being valued within a safe, contained space. Displaying creativity and using their initiative in a constructive way in the music showed evidence of influence or power which contributed to feeling competent. Experiences of personal achievement when hearing their music making and when performing, also seemed to help to increase their sense of both worthiness and competence.

#### **5.4 Measuring behavioural indicators of self-esteem in the classroom: results from teachers questionnaires**

In order to answer research sub-question two, data obtained from the teacher questionnaires will be summarised and discussed. The questionnaire is attached under appendix E.

Sub-question 2:

Do music therapy sessions facilitate changes in self-esteem within the children participating in the study that transfer to the classroom situation?

#### **BIOS Scale Results:**

Name of group member	Pre-intervention score	Post-intervention score
K:	23	31
E:	36	40
R:	36	38
S:	41	53
M:	43	40
L:	44	43
T:	46	45
Er:	46	46
P:	49	44
N:	51	59
A:	58	58

Table 5.1 BIOS scale results pre-intervention and post-intervention.

1. The names of participants were ordered according to pre-intervention scores: from lowest to highest. The post-intervention score of each participant was then filled in.
2. It was noted that the participants with the lower pre-intervention scores improved the most from pre-intervention to post-intervention. The average improvement of the four lowest scoring was from 34 pre-intervention to 40.5 post- intervention.
3. The scores of the group of participants with higher pre-intervention scores did not change, on average, from pre-intervention to post-intervention. Their average scores were 48 pre-intervention and 48 post-intervention.

The data suggest that the intervention did have an impact that carried over to the classroom situation on participants who were assessed to have *lower self-esteem before the intervention*, as observed in their classroom behaviour.

The data obtained from the BIOS scale results could not be statistically analysed due to the small sample size but the findings indicate that further research with larger sample sizes is necessary.

## 5.5 Summary

The first theme that emerged was the clients' responses throughout the process. The shift that took place from disorder in the group in the beginning stages to group cohesion in the later stages was discussed. The development in participants from, in the beginning of the process, lacking awareness of self, other and the music, to attunement and support as observed at the end of the intervention period was described. The last aspect of the theme regarding the clients' responses was the shift from uncertainty or hesitance in early sessions to confident and enthusiastic self-expression later in the process.

The shifts described in the first theme towards group cohesion, attunement, peer support as well as confidence and enthusiastic self-expression, can be regarded as gains in terms of self-esteem when comparing it to Maslow's (1970:45) explanation of self-esteem. He described two versions of self-esteem: one that include the need for respect from others, status, fame, recognition and appreciation, and another version involving self-respect, confidence, competence, achievement, independence and freedom. The one version of self-esteem concerning social support, seemed to have been enhanced as group members experienced group cohesion, support from peers, and as they developed more awareness of others through their participation in music therapy groups. The other version concerning confidence and competence, appears to have been enriched through this process as indicated through the shift in the group toward confidence and enthusiastic self-expression.

The second theme that emerged from the data was the role that the therapist played in facilitating self-esteem of the participants in the study. Provision of structure and direction in earlier stages of the process in particular and therapeutic support throughout the process, seemed to help the participants to feel valued within a safe, contained space, and created opportunities for participants to improve their sense of competency. Therapeutic intervention further seemed to facilitate independence and freedom for constructive creative expression in participants.

## 5.6 Conclusion

In this discussion I have aimed to show how music therapy groups utilising marimbas can facilitate increased self-esteem in a group of primary school children. Marimbas were not used exclusively in the group as it proved to be rather challenging for especially the younger children and therefore other instruments and components were added.

I have focussed on the themes that emerged for the group as a whole and described the general shifts and developments that were made up by the responses and behaviours of all of the group members. The group as a whole seemed to have benefitted from music therapy group sessions in terms of facilitation of self-esteem. Even though I was concerned with, and followed every participant's progress, it is beyond the scope of this study to discuss in detail how each individual responded to the music therapy groups. The data from teacher's questionnaires (BIOS rating scales) suggest that the music therapy intervention had an impact that carried over to the classroom situation on participants who were assessed to have *lower self-esteem before the intervention* as observed in their classroom behaviour.

In the next chapter, I will conclude with some final thoughts and remarks. Limitations of this study and recommendations for further studies will be included.

## CHAPTER 6

### Conclusion

#### 6.1 Introduction

In this final chapter, I will conclude the research study by summarising the findings and addressing the limitations of the study. I will make recommendations for further possible studies and offer some concluding remarks.

#### 6.2 Findings

In this research project, I aimed to explore if, and how, group music therapy utilising marimba playing can affirm self-esteem in children. I also wanted to find out whether possible changes in self-esteem within the children participating in the study transferred to the classroom situation.

The therapeutic interventions seemed successful in facilitating the development of self-esteem. Experiences were provided to increase the participants' sense of worthiness and competence as suggested by Mruk (1999:188). His two-dimensional model interprets self-esteem as the integrated sum of self-worth and self-competence (Mruk, 1999:150). It appears that the members of the group developed a sense of worthiness through their experiences of feeling accepted and being valued within a safe, contained space. Displaying creativity and using their initiative in a constructive way in the music showed evidence of influence or power which appeared to contribute to experiences of competence. Experiences of personal achievement when hearing their music making and when performing, also seemed to help to increase their sense of both worthiness and competence.

The data obtained from the BIOS scale results suggest that the intervention did have an impact that carried over to the classroom situation on the self-esteem of participants who were assessed to have lower self-esteem before the intervention as observed in their classroom behaviour.

#### 6.3 Limitations and suggestions

Generalisability of this case study can be seen as a limitation because of the small sample size and because it is context-specific. However, according to Van der Riet and Durrheim (2006:92), this situation can also give the researcher the opportunity to examine the participants and context in more depth, which leads to meaningful, detailed and rich descriptions. It then is the reader, not the researcher, who determines what can apply to his/her own context. Stake (2005:455) explains how this transfer of knowledge works: case

study researchers “will, like others, pass along to readers some of their personal meanings of events and relationships--and fail to pass along others. They know that the reader, too, will add and subtract, invent and shape--reconstructing the knowledge in ways that leave it...more likely to be personally useful.”

I recommend a longer music therapy process when utilising marimbas to work towards the enhancement of self-esteem in order to allow participants enough time to become properly skilled in playing the marimba thus increasing their sense of competence. A therapeutic intervention of longer duration may also benefit group members in terms of increasing self-worth. Research into the benefits of such an extended therapeutic process is recommended.

The use of marimbas as primary instruments with this specific population group proved challenging. The older participants (12 to 13 years of age) learnt the patterns faster and had better eye-hand coordination to play accurately whereas the younger children (eight years of age) struggled to remember the sequences and to play smoothly. If the group members are more similar in age, the therapist can use music pieces that are most appropriate for the abilities and preferences of the group members. It may increase the participants' sense of competence when those who find it easy to play are challenged with something more complex, and when those who find it difficult can manage simpler pieces.

The data obtained from the BIOS scale could not be statistically analysed due to the small sample size. The findings indicate that further research with a larger sample size may be fruitful.

#### **6.4 Conclusion**

In this study, I aimed to explore how music therapy utilising group marimba playing could enhance the self-esteem of children attending a small independent school. In this particular school, where many children have learning difficulties, music therapy seems to have played a role in enhancing self-esteem. In many music therapy processes, in a diverse range of contexts, and in individual or group work, the enhancement of a client's self-esteem is often a priority. This study has contributed to understanding the value of music therapy as an intervention in this regard.

## REFERENCES

Ahmadi, M. 2010. Being Alive and Living: A look at music therapy and dementia. In: Pavlicevic, M., Dos Santos, A. & Oosthuizen, H. (Eds.), *Taking Music Seriously* (pp. 67-78). Cape Town: MTCC.

Aigen, K. 2008. An analysis of qualitative music therapy research reports 1987–2006: Articles and book chapters. *The Arts in Psychotherapy* 35(4):251–261.

Ansdell, G. & Pavlicevic, M. 2001. *Beginning Research in the Arts Therapies: A Practical Guide*. London: Jessica Kingsley.

Asendorpf, J.B., Budonniere, P. 1993. Self-awareness and other-awareness: Mirror self-recognition and synchronic imitation among unfamiliar peers. *Developmental Psychology*, 29(1):88-95.

Baumeister, R.F. 1990. Suicide as escape from self. *Psychological Review*, 97: 90-113.

Bion, W. R. 1962. A theory of thinking. *International Journal of Psychoanalysis*. 43:306-310.

Bottorff, J.L. 1994. Using videotaped recordings in qualitative research. In: Morse, J. (ed.) *Critical issues in qualitative research methods*. London: Sage.

Bruscia, K. 1995. The process of doing qualitative research: Part 1: Introduction. In: Wheeler, B. *Music therapy research: Quantitative and qualitative perspectives*. Barcelona: Gilsum.

Burnett, P. C. 1998. Measuring Behavioral Indicators of Self-Esteem in the Classroom. *Journal of Humanistic Education and Development*, 37(2): 107-118.

Choi, A., Lee, M.S., Lee, J. 2010. Group Music Intervention Reduces Aggression and Improves Self-esteem in Children with Highly Aggressive Behavior: A Pilot Controlled Trial. *Evidence-Based Complementary and Alternative Medicine*. 7(2):213-217.

Clendenon-Wallen, J. 1991. The use of music therapy to influence the self-confidence and self-esteem of adolescents who are sexually abused. *Music Therapy Perspectives*, 9:73-81.

Cohen, L. & Manion, L. 1986. *Research Methods in Education*. 2<sup>nd</sup> ed. London: Croom Helm.

Cohen, M. 2012. Harmony within the walls: Perceptions of worthiness and competence in a community prison choir. *International Journal of Music Education*, 30:46.

Cooley, C. H. 1968. The social self: On the meanings of "I". In Gordon, C. & Gergen, K.G. (Eds.), *The self in social interaction* (pp. 87-91). New York: Wiley.

Coopersmith, S. 1967. *The antecedents of self-esteem*. San Francisco: Freeman.

Creswell, J. W. 2013. *Qualitative Inquiry and Research Design*. 3<sup>rd</sup> Edition. CA: Sage.

Crocker, J., Major, B. 1989. Social Stigma and Self-Esteem: The self-protective properties of social stigma. *Psychological Review*, 96: 608-630.

De Wied, M., Branje, S., Meeus, W. H. 2007. Empathy and conflict resolution in friendship relations among adolescents. *Aggressive Behavior* 33: 48-55.

Donnellan, M.B.; Trzesniewski, K.H.; Robins, R.W.; Moffitt, T.E.; Caspi, A. 2005. Low Self-Esteem is related to aggression, antisocial behaviour and delinquency. *Psychological Science*, 16:328.

Eccles, J.C. 1999. The Development of Children Ages 6 to 14. *The Future of Children*, 9(2): 30-45.

Fouche, S. 2010. The Music Therapy Community Clinic. In Pavlicevic, M., Dos Santos, A. & Oosthuizen, H. (Eds.), *Taking Music Seriously* (pp. 67-78). Cape Town: MTCC.

Gibbs, G. R. 2007. *Analysing qualitative data*. London: Sage.

Guba, E.G., Lincoln, Y.S. 1983. *Effective evaluation*. San Francisco, CA: Jossey-Bass

Hargreaves, D.J., North, A.C. 1999. The functions of music in everyday life: redefining the social in music psychology. *Psychology of Music*, 27(1):71-83.

Harter, S. 1983. The development of the self-system. In M. Hetherington (Ed.), *Carmichael's manual of child-psychology: Social and personality development*. New York: Wiley. 275-385.

Harter, S. 1989. Causes, correlates, and the functional role of global self-worth: A life span perspective. In Kolligian, J. and Stenberg, R. (eds.), *Perceptions of competence and incompetence across the life span*. New Haven: Yale University Press.

Harter, S. 1999. *The construction of the self: A developmental perspective*. New York: Guilford.

Harter, S. 2012. *The construction of the self: Developmental and sociocultural foundations*. 2<sup>nd</sup> ed. New York: Guilford.

Harter, S., Bouchey, H. 2005. Reflected appraisals, academic self-perceptions, and math/science performance during early adolescence. *Journal of Educational Psychology*,

97(4):673–686.

Harter, S., Marold, D. 1993. The directionality of the link between self-esteem and affect: beyond causal modelling. In D. Cicchetti & S. L. Toth (Eds.), *Rochester Symposium on Developmental Psychology: Disorders and dysfunctions of the self*. NY:University of Rochester Press.

Henderson, S. 1983. Effects of a music therapy program upon awareness of mood in music, group cohesion, and self-esteem among hospitalized adolescent patients. *Journal of Music Therapy*, 20(1):14-20.

Hjelle, L.A., Ziegler, D.J. 1981. *Personality Theories: basic assumptions, research and applications*. 2<sup>nd</sup> Ed. New York: McGraw-Hill.

James, M.R., Freed, B.S. 1989 A sequential model for developing group cohesion in music therapy. *Music Therapy Perspectives*, 7:28-34.

Jessor, R., Van den Bos, J., Vadderyn, J., Costa, F.M. & Turbin, M.S. 1995. Protective factors in adolescent problem behaviour: Moderator effects and developmental change. *Developmental Psychology*, 31: 923-933.

Johnson, E. 1981. The role of objective and concrete feedback in self-concept treatment of juvenile delinquents in music therapy. *Journal of Music Therapy*, 18:137-147.

Kaplan, H.I., Sadock, B.J. 1998. *Synopsis of Psychiatry*. 8<sup>th</sup> Ed. Philadelphia: Williams and Wilkens.

Kivland, M. 1986. The use of music to increase self-esteem in a conduct disordered adolescent. *Journal of Research in Music Education*, 23: 25-29.

Lincoln, Y.S., Guba, E.G. 1985. *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Lotter, C. 2010. Towards Companionship. In Pavlicevic, M., Dos Santos, A. & Oosthuizen, H. (Eds.), *Taking Music Seriously* (pp. 67-78). Cape Town: MTCC.

Mac Donald, A., Hargreaves, D. & Miell, D. 2002. *Musical Identities*. Oxford: Oxford University Press.

Mac Donald, G. 1994. Self-esteem and the promotion of mental health. In Trent, D. & Reed, C. (Eds.), *Promotion of Mental Health*. Avebury: Aldershot.

Mann, M., Hosman, C., Schaalma, H, Devries, N. 2004. Self-esteem in a broad-spectrum approach for mental health promotion. *Health Education Research*, 19(4):357–372.

Maslow, A. H. 1954. *Motivation and Personality*. New York: Harper.

Maslow, A. H. 1970a. *Motivation and Personality*. 2<sup>nd</sup> Ed. New York: Harper.

Meyer, W. F., Moore, C. & Viljoen, H. 1990. *Persoonlikheidsteoriee - van Freud tot Frankl*. Johannesburg: Lexicon Uitgewers.

Miell, D., MacDonald, R. & Hargreaves, D. 2005. *Musical Communication*. New York: Oxford University Press.

Miller, D.J., Moran, T. 2006. Positive self-worth is not enough: some implications of a two-dimensional model of self-esteem for primary teaching. *Improving Schools*. 9(1):7-16.

Mruk, C. 2013(b). Defining self-esteem as a relationship between competence and worthiness: How a two-factor approach integrates the cognitive and affective dimensions of self-esteem. *Polish Psychological Bulletin*. 44(2):157-164.

Mruk, C. 2013. *Self-esteem and positive psychology: Research, Theory, and Practice (4th Ed)*. New York: Springer.

Mruk, C. 2006. *Self-Esteem: Research, Theory and Practice*. New York: Springer.

Mruk, C. 1999. *Self-Esteem: Research, Theory, and Practice (2nd Ed.)*. New York: Springer.

North, A., Hargreaves, D. 1999. Music and Adolescent Identity, *Music Education Research*, 1(1):75-92.

Oldfield, A. 2006. *Interactive Music Therapy in Child and Family Psychiatry: Clinical Practice, Research and Teaching*. Great Britain: Athenaeum Press.

Pavlicevic, M. 2002. Dynamic Interplay in Clinical Improvisation. *Voices: A world Forum for Music Therapy*. 2(2).

Robins, R., Trzesniewski, K., Donnellan, M. 2012. A Brief Primer on Self-Esteem. *The Prevention Researcher*, 18(2):3-7.

Robson, C. 1993. *Real world research: a resource for social scientists and practitioner-researchers*. Oxford: Blackwell.

Ruud, E. 1997. Music and Identity. *Nordisk Tidsskrift for Musikkterapi*, Vol 6(1): 3-13.

Rogers, C. R. 1961. *On Becoming a Person: A Therapist's View of Psychotherapy*. Boston: Houghton Mifflin.

Rosenberg, M., Schooler, C., Schoenbach, C. & Rosenberg, F. 1995. Global Self-Esteem and Specific Self-Esteem: Different Concepts, Different Outcomes. *American Sociological Review*, 60(1):141-156.

Slobin, M. 1993. *Subcultural Sounds: Micromusics of the West*. CT: Wesleyan University Press.

Stake, R.E. 2005. Quantitative case studies. In N.K. Denzin & Y.S. Lincoln (Eds.). *The Sage handbook of qualitative research* (3rd ed.) 443-466. CA: Sage.

Stern, D.N. 1985. *The Interpersonal World of the Infant. A View from Psychoanalysis and Developmental Psychology*. New York: Basic Books.

Stige, B. 2002. *Culture-Centered Music Therapy*. Gilsum: Barcelona.

Stige, B. 2002b. The relentless roots of community music therapy. *Voices: A world Forum for Music Therapy*, 2(3).

Stige, B. 2006. On a notion of participation in music therapy. *Nordic Journal of Music Therapy*, 15(2):121-128.

Terre Blanche, M., Durrheim, K., & Painter, D. (eds.) 2006. *Research in Practice*. 2<sup>nd</sup> ed. Cape Town: University of Cape Town.

Tjafel, H. 1978a. Differentiation between social groups: Studies in the social psychology of intergroup relations. *European Monographs in Social Psychology*, 14. London: Academic Press.

Tjafel, H. 1981. *Human Groups and Social Categories: Studies in Social Psychology*. Cambridge: Cambridge University Press.

Torrance, K. 2010. Singing our Pain: Song-writing as a therapeutic tool. In Pavlicevic, M., Dos Santos, A. & Oosthuizen, H. (Eds.), *Taking Music Seriously* (pp. 67-78). Cape Town: MTCC.

Trevarthen, C. 1999. Musicality and the Intrinsic Motive Pulse: Evidence from human psychobiology and infant communication. *Special Issue of Musicae Scientiae: Rhythm, Musical Narrative and Origins of Human Communication*, 1:157-213.

Van der Riet, M. & Durrheim, K. 2006. Putting design into practice: writing and evaluating research proposals. In: Terre Blanche, M., Durrheim, K. & Painter, D. (eds.) *Research in practice*. 2nd ed. Cape Town: University of Cape Town.

Wheeler, B. 2005. *Music Therapy Research*. 2<sup>nd</sup> ed. Gilsum: Barcelona.

Wigram, T., Pederson, I. N., Bonde, L. O. 2002. *A Comprehensive Guide to Music Therapy: Theory, Clinical Practice, Research and Training*. London: Jessica Kingsley.

Wild, L., Flisher, A. Lombard, C. 2002. Suicidal ideation and attempts in adolescents: associations with depression and six domains of self-esteem. *Journal of Adolescence*, 27:611-624.

Wildman, C. 2010. Across Beds and Cultures: Music therapy with children in a hospital burns unit. In Pavlicevic, M., Dos Santos, A. & Oosthuizen, H. (Eds.), *Taking Music Seriously* (pp. 67-78). Cape Town: MTCC.

Willig, C. 2001. Case Studies. In: *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham: Open University.

Woodward, S., Sloth-Nielsen, J. & Mathithi, V. 2007. South Africa, the Arts and Youth in Conflict with the Law. *International Journal of Community Music*, 1(1):69-88.

## APPENDIX A: Participant information form

FAKULTEIT GEESTESWETENSAPPE

DEPARTEMENT VAN MUSIEK

TEL (012) 420-2316/3747

FAKS (012) 420-2248



UNIVERSITY OF PRETORIA  
UNIVERSITEIT VAN PRETORIA

PRETORIA 0002 SUID AFRIKA

### Ingeligte Toestemming (vir ouers/voogde van deelnemers)

TITEL VAN DIE STUDIE : Groep musiekterapie met die gebruik van marimbas om eiewaarde in kinders te bevestig.

Geagte \_\_\_\_\_,

In hierdie navorsingsprojek wil ek graag navors hoe groep musiekterapie met die gebruik van marimbas voordelig kan wees vir kinders ten opsigte van die ontwikkeling van hul eiewaarde. Ek beplan om met die laerskoolkinders van Privaatskool Tersia Theron musiekterapie te doen deur marimba groepe aan te bied vir 'n tydperk van tien sessies. Die doel van hierdie studie is om navorsing te doen vir 'n mini-verhandeling wat deel vorm van my meestersgraad in musiekterapie. Ek sal die deelname van u kind in hierdie groepe waardeer.

Die sessies sal opgeneem word op video met die doel om die terapeutiese proses te ontleed en te interpreteer. Die video-opnames sal slegs gebruik word vir die doel van die studie en sal vertroulik gehou word. Die klasonderwyser sal my bystaan deur 'n vraelys aangaande u kind se gedrag in die klaskamer in te vul voor aanvang van die studie en na afloop van die tien sessies.

Deelname aan die studie is vrywillig en u mag op enige stadium versoek dat u kind onttrek word van die groep. Indien u kind van die studie onttrek, sal alle inligting aangaande hom/haar, insluitende die vraelys wat deur die onderwyser voltooi is, vernietig word.

Ek waarborg vertroulikheid daarin dat geen name van deelnemers of enige identifiseerbare inligting van deelnemers gebruik sal word in die geskrewe verhandeling nie. Wanneer die

studie afgehandel is, sal die bevindinge beskikbaar gemaak word in 'n mini-verhandeling en sal ook ingedien word in die vorm van 'n akademiese joernaal-artikel. Data sal vir argiefdoeleindes vir 'n periode van 15 jaar gestoor word by die Universiteit van Pretoria. Sou enige van die gegewens gebruik word vir verdere analise sal formele toestemming van die u as ouer gevra word.

Ek sal die deelname van u kind aan hierdie studie baie waardeer. Indien u gewillig is om u toestemming te gee, vul asseblief die aangehegte toestemmingsvorm in.

Kontak my gerus indien u enige vrae het.

Helene Best

Andeline Dos Santos

Navorser / Student

Toesighouer

Epos: [lientjie.best@gmail.com](mailto:lientjie.best@gmail.com)

Epos: [andelineds@telkomsa.net](mailto:andelineds@telkomsa.net)

Telefoon: 083 375 5333

**APPENDIX B: Participant consent form**

FAKULTEIT GEESTESWETENSKAPPE

DEPARTEMENT VAN MUSIEK

TEL (012) 420-2316/3747

FAX (012) 420-2248



**UNIVERSITY OF PRETORIA  
UNIVERSITEIT VAN PRETORIA**

**PRETORIA 0002 SUID-AFRIKA**

**Deelnemer Toestemmingsvorm**

TITEL VAN DIE STUDIE: Groep musiekterapie met die gebruik van marimbas om eiewaarde in kinders te bevestig.

Ek, \_\_\_\_\_, ouer/wettige voog van \_\_\_\_\_ gee/gee nie my toestemming vir my kind om deel te neem aan die gemelde navorsingsprojek. Ek begryp dat my kind sal deelneem aan marimba musiekterapiesessies en dat die fokus van die navorsing sal wees om te ondersoek watter voordele musiekterapie vir my kind sal he wat betref hul eiewaarde. Ek gee/gee nie my toestemming dat hierdie sessies opgeneem sal word vir die uitsluitlike doel om die terapieproses te beskryf en interpreteer.

Met volle medewete van bogemelde, stem ek in/stem nie in dat my kind deelneem aan die studie op hierdie dag \_\_\_\_\_(dag) van \_\_\_\_\_(maand) van \_\_\_\_\_(jaar).

**BESONDERHEDE VAN DEELNEMER/OUER/WETTIGE VOOG VAN DEELNEMER:**

Naam van deelnemer: \_\_\_\_\_ Handtekening: \_\_\_\_\_

Kontaknommer van deelnemer: \_\_\_\_\_ Datum: \_\_\_\_\_

Ouer/wettige voog van deelnemer: \_\_\_\_\_ Handtekening: \_\_\_\_\_

Verwantskap met deelnemer: \_\_\_\_\_

**NAVORSER EN TOESIGHOUER HANDTEKENINGE:**

Naam van navorser: \_\_\_\_\_

Handtekening van navorser: \_\_\_\_\_

Datum: \_\_\_\_\_

Naam van toesighouer: \_\_\_\_\_

Handtekening van toesighouer: \_\_\_\_\_

Datum: \_\_\_\_\_

## APPENDIX C: Teacher information form

FAKULTEIT GEESTESWETENSAPPE

DEPARTEMENT VAN MUSIEK

TEL (012) 420-2316/3747

FAX (012) 420-2248



UNIVERSITY OF PRETORIA  
UNIVERSITEIT VAN PRETORIA

PRETORIA 0002 SUID-AFRIKA

### Deelnemer (Onderwyser) Inligting

TITEL VAN DIE STUDIE : Groep musiekterapie met die gebruik van marimbas om eiewaarde in kinders te bevestig.

Geagte \_\_\_\_\_

In hierdie navorsingsprojek wil ek graag navors hoe groep musiekterapie met die gebruik van marimbas voordelig kan wees vir kinders ten opsigte van die ontwikkeling van hul eiewaarde. Ek beplan om met die laerskoolkinders van Privaatskool Tersia Theron musiekterapie te doen deur marimba groepe aan te bied vir 'n tydperk van tien sessies. Die doel van hierdie studie is om navorsing te doen vir 'n mini-verhandeling wat deel vorm van my meestersgraad in musiekterapie.

Ek sal dit baie waardeer as u my kan bystaan deur 'n kort vraelys te voltooi vir elke kind wat aan die navorsing deelneem voor aanvang van die studie asook na afloop daarvan. Ek sal u voorsien van riglyne hoe om die BIOS (Behavioural Indicators of Self-Esteem) Skaal te administreer. Die vrae hou verband met hul gedrag in die klaskamer wat moonlik 'n aanduiding kan gee van die kind se eiewaarde. U deelname aan die studie is vrywillig.

Ek waarborg vertroulikheid daarin dat geen name van deelnemers of enige identifiseerbare inligting van deelnemers gebruik sal word in die geskrewe verhandeling nie. Wanneer die studie afgehandel is, sal die bevindinge beskikbaar gemaak word in 'n mini-verhandeling en sal ook ingedien word in die vorm van 'n akademiese joernaal-artikel. Data sal vir argiefdoeleindes vir 'n periode van 15 jaar gestoor word by die Universiteit van Pretoria. Sou enige van die gegewens gebruik word vir verdere analise sal formele toestemming van die u as deelnemer gevra word.

Ek sal u deelname aan hierdie studie baie waardeer. Indien u gewillig is om u toestemming te gee, vul asseblief die aangehegte toestemmingsvorm in.

Kontak my gerus indien u enige vrae het.

Helene Best

Andeline Dos Santos

Navorsers / Student

Toesighouer

Epos: [lientjie.best@gmail.com](mailto:lientjie.best@gmail.com)

Epos: [andelineds@telkomsa.net](mailto:andelineds@telkomsa.net)

Telefoon: 083 375 5333

## Appendix D: Teacher consent form

FAKULTEIT GEESTESWETENSKAPPE

DEPARTEMENT VAN MUSIEK

TEL (012) 420-2316/3747

FAX (012) 420-2248



UNIVERSITY OF PRETORIA  
UNIVERSITEIT VAN PRETORIA

PRETORIA 0002 SUID-AFRIKA

### Onderwyser Toestemmingsvorm

TITEL VAN DIE STUDIE: Groep musiekterapie met die gebruik van marimbas om eiewaarde in kinders te bevestig.

Ek \_\_\_\_\_, onderwyser by Privaatskool Tersia Theron, gee/gee nie hiermee my toestemming om in die navorsing deel te neem. Ek begryp dat my deelname in die studie vrywillig is en dat ek opleiding sal ontvang in die administrasie van die BIOS Skaal. Ek neem voor om die deelnemers te assesser beide voor die intervensie en daarna.

Met volle kennisname van bogemelde, ek stem in/stem nie in om deel te neem aan die studie op hierdie \_\_\_\_\_ (dag) van \_\_\_\_\_ (maand) van \_\_\_\_\_ (jaar).

#### DEELNEMER INLIGTING:

Naam van deelnemer: \_\_\_\_\_ Handtekening: \_\_\_\_\_

Kontaknommer van deelnemer: \_\_\_\_\_ Datum: \_\_\_\_\_

#### NAVORSER EN TOESIGHOUER HANDTEKENINGE:

Naam van navorser: \_\_\_\_\_

Handtekening van navorser: \_\_\_\_\_ Datum: \_\_\_\_\_

Naam van toesighouer: \_\_\_\_\_

Handtekening van toesighouer: \_\_\_\_\_ Datum: \_\_\_\_\_

## Appendix E: Behavioural Indicators of Self-Esteem Rating Scale (BIOS)

## SCALES: BEHAVIOURAL INDICATORS OF SELF-ESTEEM

Burden, R., & Burnett, P.C. (1999). Behavioural Indicators of Self-Esteem (BIOS). In N.Frederickson, & R.J. Camerson (Eds) Psychology in Education Portfolio (pp 11-12). NFER-Nelson: London.

Burnett, P.C. (1998). Measuring behavioural indicators of self-esteem in the classroom. The Journal of Humanistic Education and Development, 37, 107-116.

<b>Student's Name:</b>		<b>Date:</b>	
<b>Teacher:</b>		<b>Grade:</b>	

Please tick the number that best describes the frequency of this student's behaviour over the past two weeks in the school setting.

**1 = Never, 2 = Seldom, 3 = Sometimes, 4 = Often, 5 = Always**

ITEMS	NEVER	SELDOM	SOMETIME	OFTEN	ALWAYS
1. Was confident in what he/she did	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. Was withdrawn from others	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3. Appeared proud of him/herself	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
4. Gave limited responses	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5. Was interested in what was happening	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
6. Was alone and isolated	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
7. Displayed good communication skills	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
8. Lacked satisfaction with own performance	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
9. Interacted well with other children	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
10. Needed constant reassurance	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
11. Displayed leadership qualities	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
12. Was interactive with others	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
13. Appeared happy with him/herself	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

**SCORING INSTRUCTIONS:** Reverse score items 2, 4, 6, 8, 10 (1=5, 2=4, 4=2, 5=1) and add the 13 item scores together to get a total BIOS score.

**BIOS Skaal (Behavioural Indicators of Self-Esteem)**

(Afrikaanse Weergawe)

Burden, R. & Burnett, P.C. 1999. Behavioural Indicators of Self-Esteem (BIOS). In Frederickson, N. & Camerson, R.J. (Eds) Psychology in Education Portfolio (p. 11-12). NFER-Nelson: London

Burnett, P.C. 1998. Measuring behavioural indicators of self-esteem in the classroom. The Journal of Humanistic Education and Development. 37: 107-116

Naam van leerder:	Datum:
Onderwyser:	Graad:

Merk asseblief die nommer wat die frekwensie van die leerder se gedrag in die skool die afgelope twee weke die beste beskryf.

	1=Nooit	2=Selde	3=Soms	4=Gereeld	5=Altyd
ITEMS	NOOIT	SELDE	SOMS	GEREELD	ALTYD
1. Het met selfvertroue opgetree	1	2	3	4	5
2. Het hom/haarself afgesluit van ander	1	2	3	4	5
3. Het trots op hom/haarself voorgekom	1	2	3	4	5
4. Het beperkte reaksies getoon	1	2	3	4	5
5. Was geïnteresseerd in wat om hom/haar gebeur	1	2	3	4	5
6. Was alleen en geïsoleerd	1	2	3	4	5
7. Het goeie kommunikasievaardighede getoon	1	2	3	4	5
8. Was nie tevrede met eie optrede nie	1	2	3	4	5
9. Het goeie interaksie met ander kinders gehad	1	2	3	4	5
10. Benodig konstante bemoediging	1	2	3	4	5
11. Toon leierskapskwaliteite	1	2	3	4	5
12. Was interaktief met ander	1	2	3	4	5
13. Kom gelukkig met hom/haarself voor	1	2	3	4	5

Puntetelling: Ruil die tellings van items 2, 4, 6, 8, 10 (1=5, 2=4, 4=2, 5=1) en bereken die som van die 13 item tellings om die totale BIOS telling te kry.

## Appendix F: Transcript of thick descriptions of video excerpts

### Thick description: Excerpt 1. Session 4b 16:38-18:57

The group is ready to rehearse the song “Amen, Halleluya” as they have each learnt their marimba parts. N is helping T to play the marimba today as T does not know the pattern well. N holds his hand over T’s mallet at times and T goes along with how N is playing. Other marimba players are M, P, L, and A. S plays the bass drum, R and K sit right in front, R has a tambourine and K a triangle. E dances and sings next to MT who stands in front and directs the band.

MT helps N and T with their pattern. She goes back to her position in front to get the rehearsal started, counts to three, but since the members are not ready and focussed to start, the band does not start in unison. There is no sense of a shared beat and each person is playing his/her pattern in isolation. Scattered sounds of different instruments are heard. P is still walking towards his instrument, shouts “hey!” and chases S away who is playing on his (P’s) marimba. A, L and S look up from their marimbas and stop playing. MT stops the remaining players and addresses P directly, “P, as ek se is julle reg, dan moet julle by julle instrumente wees”. She tells them to listen to her counting, to prepare themselves so that they can start in unison. R comes to MT and wants to go out. The band members make use of the opportunity to practice on their own and it sounds rather chaotic in the room while the MT helps R to sit down. She offers him a percussion instrument and demonstrates how and when he should play. R listens, but sits passively and does not play along. MT tries to now focus their attention better, by clapping her fingers, arms raised, waiting for eye contact from the children, calling some of their names. They gradually settle down. MT waits for a quiet moment and says, “kyk hoe mooi kyk julle vir my” in a calm and containing voice as they look at her. She counts to three and as the instrumental music starts, MT looks at her fellow dancer/singer (E) and they move together. E dances energetically. They play more in unison, and some are singing along. Most children seem focussed and stay on the beat, and the melody of the song can be heard throughout. K is playing the triangle neatly on the beat. E dances happily and lightly next to MT, following her lead, and singing along in a clear voice with MT. R does not play along the first time, but sits and only fiddles around with his tambourine with no effort of playing along with the group’s music. He looks up at MT now and again. S seems to enjoy playing on the bass drum as his whole body moves in time with the beat and he lifts the beaters high up in the air. T seems rather passive as N holds his hand over T’s hand holding the mallet and plays for him. The group plays the song through once and the MT shouts after the last note, “Yes! Weer!”, this time in a clear, excited voice and directs them to play it through again, without stopping. MT and E glances at one another and E seems even more excited and now jumps

up while dancing her steps. The marimbas do not start all together, and the sounds are a little scattered. Some pick up the main beat again, but L and N struggle to play correctly and on the beat. L cannot keep up his pattern on the marimba, looks around and plays out of sync. All band members and dancers are concentrating on their own playing and try to follow MT's loud and clear time-keeping efforts. R joins in by first just spinning the one little cymbal of the tambourine in time with the beat, he later hits the tambourine more convincingly, and at the end of the song, he shakes the instrument strongly in the air. K plays the triangle clearly and securely, looking up at MT regularly to keep the beat. MT makes eye contact and smiles with Er, the little dancer/singer next to her and they do some steps together. M is playing confidently, right on the beat and the correct notes, moving his body and tapping his foot on the floor in time with the beat. At the end of the song, MT shouts "weer!" in an excited tone of voice. A turns around and looks at the other group members. They continue to play it through another time. A, S and M are playing confidently and enthusiastically as they seem sure of their patterns, and they carry the melody and rhythm brightly. Both L and N are playing out of time in isolation. L and N do not seem aware of the group music and continue to play what they think are the right notes. The melody and main beat is still heard, but the many loose sounds coming from some marimbas compete with the song's structure. R and K lose focus and play out of time on their percussion instruments and start to fool around with their instruments. MT takes the percussion instruments out of their hands and she invites R and K to get up and to dance along with her and E. She quickly shows them how they can dance. MT tries to keep a moderately fast pace and to maintain a bright, strong energy with her body language (arms in the air, eye contact) and presence, asks the group "is julle reg? Is jy reg, M?". M makes eye contact, nods, says "ja juffrou", and a some excited "whoohoo!" shouts are heard. At the same time N and P throw and swing their mallets in the air excitedly. MT quickly tries to settle them down, with a firm "ah-ah-ah" (meaning 'no' when someone keeps playing before the should) and she focuses their attention to her counting "1...2...3!". Some children spontaneously count along but they don't start together. L, T and N play their rhythms at their own pace and time. P sings along enthusiastically, but does not seem focussed on his marimba pattern. A, M and S sustain the melody on their instruments, but do not show any initiative or much flexibility at this stage. MT and the dancers are singing the melody with them, but the scattered sounds of L, N, T and P mingle and disturb the group sound. N and T enjoy their playing and look at one another and smile. MT does not stop the instrumental players, but lets the song continue. The melody is heard as well as the words of the song, but the harmonies are dissonant as some players are not keeping the beat. The dancers (E, R and K) dance and sing energetically, and look at MT regularly to follow her beat. MT makes good eye contact with the dancers and smiles are exchanged. They dance using bigger and more secure movements and keep to the beat of the music. At the end of the song, MT turns to the

dancers and hands out a high five to each of them. When E hits her hand, MT jokingly shouts “ouch!” and they all laugh.

#### Thick description 2: Session 9b: 11:40-14:35

The group members have each practiced their different parts for the song “Vat jou goed en trek Ferreira” and they are going to play the song together now. The atmosphere is relaxed as some group members are talking, A is looking at the way S is playing the guitar, and some are walking around. L, R and N are practicing their patterns, MT is standing at N’s marimba to help him.

MT asks group members to go to their instruments and get ready. S comes to ask MT to help him with the guitar, and she shows him quickly. The rest of the group members hang around, waiting. Er is talking, and Ed then urges her to stop talking and turn around. MT turns to the group, lifts her arms and asks “Is julle reg?” They answer “Ja juffrou!”. She reminds them of the first note, counts to three and directs them very clearly through the part of the song that they are practicing. All group members seem to focus and pay attention on the music making. R plays randomly on his marimba and MT quickly moves towards him to help him with his pattern. She continues to sing out the note names both groups of marimbas should play, in order to keep them all on track. Er, M and P are playing their part in unison, but the other group (A, L and R) are playing hesitantly and rely on MT’s guidance to play their pattern. The drums are silent during this part of the song and the drum players patiently wait their turn. S is playing on the guitar, incorporating rhythms that he plays percussively on the wooden part of his guitar, with rhythmic strumming on the strings. He plays exactly with the group, following the rhythmic patterns that they play. The members of the group seem to be more aware of the main beat and the group music, but struggle to play all the patterns fluently and scattered sounds are heard. MT reminds them of the note names again after the song. She says “Weer ‘n keer, dit was nie goed genoeg nie”. MT waits for silence, but they keep practicing and do not settle down, until A shouts impatiently “Komaan! Bly nou stil!”. The other group members respond to that, settles down and MT counts to three. They start together and this time, MT leaves R to play independently, and he lets the mallets slide up and down the keys of the marimba. From time to time he hits the keys randomly, swinging the mallets leisurely. The other group members are focussed and play with intention, concentrating to play the patterns correctly. MT let the group practice the part through three times, shouting in between “Mooi P!”, and “OK, again!”. She offers very clear structure and leadership. Group members look up every now and then and listens to her directions. M, E and P play fluently, with no hesitation, make bigger arm movements, move to the beat, and smile as they play. N moves to the beat, and swings his mallets in the air as part of his performance. A and L look down at their

marimbas, focussed, coping with their patterns and playing stronger and using a bigger range of movement. R is playing any notes, but seems to enjoy that, as he plays in a relaxed manner, keeping the beat. At the end of the song, MT shouts “Who!” in praise of their effort and kicks her foot up excitedly. She announces that they will play through both parts of the song now, and the children spontaneously and enthusiastically count with her to three to start. They seem focussed and the drum players are now playing along strongly. MT makes eye contact with Ed and T and nods at them. T and Ed are playing on the beat. K stands in the centre of the band, with seven djembes around him. He stands, moves, turns and plays on the djembes in a dreamy, relaxed way. At times he pats the djembes, moving from one to the other, or rub them on the beat of the music. L does not seem sure of his pattern as he plays hesitantly and often misses his beats. R plays along any random notes and looks up from his marimba as he plays. MT goes to R’s marimba to point to the notes and he then follows her guidance. At the end of the song though, R plays three high ringing notes, right on pitch, to end the piece playfully. A lively, spontaneous discussion follows where the children talk excitedly. More physical movement is seen in the group as E spins around, N and P swing their mallets up in the air. The group members seem relaxed but energised. S continues to play after the song had ended and MT tells him that he should stop playing at the end of the song! The children laugh out loud when MT accidentally uses the wrong name when talking to S. MT just smiles and apologises, and the children also smile. MT mentions to others that P is singing along nicely and encourage the others to do so too. All seem excited and full of energy as mallets are thrown up in the air, and the children dance while MT helps R. K wanders off and MT invites him back to his drums, a little impatiently, and he immediately returns. Group members are now talking, joking and laughing amongst each other. MT struggles a bit to get their attention again, says “shhh” and then mentions, in a softer voice, “julle vorder mooi” and tells the drummers that she likes the way that the drums sounded. Someone is still playing while she speaks and A helps to get everyone quiet. MT explains how the song will be played next, the children seem ready and excited to start. They all count “1...2...3!” and start together (all the children) and some also sing along brightly and unrestrained. A and R are playing a different section, and MT helps R to keep quiet, A quickly catches up with the others. K plays more intentionally, focussed on his djembes, not missing a beat and looking up regularly at the others and MT. He uses big body movements as he moves along from drum to drum. M is focussed on his part and plays along securely, switching his mallet from hand to hand and moving to the beat. R shows initiative by playing his “ping ping ping!” at the end of the song. N shows his enjoyment of the music by swinging his mallets in the air on the beat, and dancing along from time to time. T plays his djembe strongly and spontaneously plays his own beats along the different parts. Ed plays exactly where he was told to play and does not use much initiative in the music. He appears, though, to keep an eye on the younger children around

him. Many group members are singing along uninhibitedly and they all appear to be very much involved in the music and in what they do. P jumps up with every note that he plays in the last phrase of the song. R ends this rehearsal with his signature “ping ping ping!”.

Thick description Excerpt 3 Performance: 21:00-24:58

It is performance night. The group played their two pieces on marimbas and djembes, and the audience, consisting of family members and teachers, applauded their efforts. The concert is drawing to an end, with A delivering the last number. A stands in front of the audience with the MT, who accompanies her on guitar, and sings her song in a clear, strong voice. She appears to enjoy her performance and is calm and confident. The other children sit around her on the floor, and play along softly on their djembes, moving to the beat or just listening. Some are mouthing the words of the song with her (R and E) as they listen to her singing. They pay attention to and look at her kindly as she finishes the song. A and MT make eye contact and smile when the last chord on the guitar is played and A receives a loud applause from the audience and other group members. She smiles and looks down a little shyly, but satisfied. The other group members are smiling warmly as they clap hands. MT talks to the audience, and points to the fact that A and MT did not have much practise time, but that they could surely all hear her beautiful voice. MT concludes the concert, and then, on the spur of the moment, asks the children if anyone would like to still do something. T quickly replies “Ekke! Ek wil graag beat box!”, MT encourages him and smiles when she says: “Ja, beat box jy vir ons ‘n bietjie!” Some laughter is heard, but T immediately starts to produce rhythmic noises with his mouth. These sounds are on a p (piano) dynamic level and everyone present need to be silent in order to hear his performance. The other group members are quiet, smiling and listening intently to try to hear the beat. D moves towards T’s wheelchair and sits right next to him, as if to support him. N quickly hears the beat and sensitively supports T on his djembe, playing the rhythm of T’s mouth sounds on his djembe. S and P start to play the same rhythm on their djembes, leaving the strongest, emphasised beat for T to play on his djembe. Shortly, P and E start to play the strong beat along with T. T moves his body to the beat and plays his djembe loudly with his mallet. His wheelchair is moving backwards and forwards as he hits the drum. MT moves to the beat, and supports T’s beat by tapping on her guitar, keeping the metre steady. They follow a steady beat and other group members look at him respectfully to follow his beat. R and K also starts to play on their djembes in time with the beat, and the energy increases as more people join in. T is playing the djembe enthusiastically, lifting the mallet up high and moving his body along rhythmically. He makes eye contact with the other group members and MT as they play together. The rhythm is uneven at times, but the main beat survives. Excitement and laughter is heard from the audience and spontaneous loud applause and cheering is heard when he finishes. He ends with five quick beats. MT talks and concludes

the concert (again), inviting everyone for some hot chocolate, when R asks if he could also play something. She smiles and nods at him, says “OK!” and he starts to play. He starts to play on his djembe, plays forte and with high energy and establishes a rhythmic pattern after a while. P and T start to play along on their djembes, their energy not as high as R’s and dynamically mezzo forte. K and E join in on their djembes, somewhat tentatively. The beat is steady for a while, but then becomes uneven. MT ends the drumming by saying, “Ah, dankie, R, baie dankie hoor!” and R is applauded for his effort. R smiles broadly as he looks at his mother. During the applause, N and S mention to MT that they would like to also perform a number. MT moves toward them and says “OK!”, as she smiles supportively and nods at them to start. They start their number, N playing the djembe, and S beat boxing rhythmically. There are some noises from the audience and other children, but after a while the background noises die down and a steady rhythmic pattern is heard from the two boys. S and N are sitting together closely listening to each other and improvising. S plays intricate patterns on the djembe, and N’s mouth sounds match the patterns. After a little while, T joins the beat boxing, hitting his djembe with the mallet on the strong beat. The other group members are listening, smiling, as they seem to find N and S’s performance entertaining. L’s fingers move in time with the beat. A moves towards a marimba. T’s wheelchair moves back and forth as he keeps the beat and enjoys the music. More sounds are coming from the side of the audience: laughter, “whoo!”-shouts and after they end their piece with a vocal “pu-pu-chu!”, loud clapping and shouting is heard. S and N get up and smile as they accept the applause.

## Appendix G: Thick description coding document

Thick description Excerpt 3 Performance: 21:00-24:58

It is performance night. The group played their two pieces on marimbas and djembes, and the audience, consisting of family members and teachers, applauded their efforts. The concert is drawing to an end, with A delivering the last number.

TD3-1	A stands in front of the audience with the MT, who accompanies her on guitar, and sings her song in	A performs with enjoyment
TD3-2	a clear, strong voice. She appears to enjoy her performance and is calm and confident. The other	A confident use of voice
TD3-3	children sit around her on the floor, and play along softly on their djembes, moving to the beat or just	G supportive
TD3-4	listening. Some are mouthing the words of the song with her (R and E) as they listen to her singing.	G listen intently
TD3-5	They pay attention and look at her kindly as she finishes the song. A and MT make eye contact and	MT support
TD3-6	smile when the last chord on the guitar is played and A receives a loud applause from the audience	Aud and member applause
TD3-7	and other group members. She smiles and looks down a little shyly, but satisfied. The other group	
TD3-8	members are smiling warmly as they clap hands. MT talks to the audience, and points to the fact	G supportive
TD3-9	that A and MT did not have much practise time, but that they could surely all hear her beautiful voice.	MT affirms
TD3-10	MT concludes the concert, and then, on the spur of the moment, asks the children if anyone would	MT provides structure
TD3-11	like to still do something. T quickly replies "Ekke! Ek wil graag beat box!", MT encourages him and	T spontaneous

TD3-12	smiles when she says: “Ja, beat box jy vir ons ‘n bietjie!” Some laughter is heard, but <b>T immediately</b>	MT facilitates initiative
TD3-13	<b>starts to produce rhythmic noises with his mouth.</b> These sounds are on a p (piano) dynamic level	
TD3-14	and everyone present need to be silent in order to hear his performance. <b>The other group members</b>	G gently supportive
TD3-15	<b>are quiet, smiling and listening intently to him to try to hear the beat. D moves towards T’s wheelchair</b>	G supportive
TD3-16	<b>and sits right next to him, as if to support him. N quickly hears the beat and sensitively supports T</b>	D supportive
TD3-17	<b>on his djembe, playing the rhythm of T’s mouth sounds on his djembe. S and P start to play the same</b>	N shows initiative
TD3-18	<b>rhythm on their djembes,</b> leaving the strongest, emphasised beat for T to play on his djembe. <b>Shortly,</b>	N and S supports T musicl
TD3-19	<b>P and E start to play the strong beat along with T. T moves his body to the beat and plays his djembe</b>	P and E supports,
TD3-20	<b>loudly with his mallet.</b> His wheelchair is moving backwards and forwards as he hits the drum. <b>MT</b>	T enthusiastic
TD3-21	<b>moves to the beat, and supports T’s beat by tapping on her guitar, keeping the metre steady. They</b>	MT supports musically
TD3-22	<b>follow a steady beat and other group members look at him respectfully to follow his beat. R and K</b>	Group supports T
TD3-23	<b>also starts to play on their djembes in time with the beat, and the energy increases as more people</b>	Energy in group increases
TD3-24	<b>join in. T is playing the djembe enthusiastically, lifting the mallet up high and moving his body along</b>	T confident, big body
TD3-25	<b>rhythmically. He makes eye contact with the other group members and MT as they play together.</b>	movements, interact with other group members
TD3-26	<b>The rhythm is uneven at times, but the main beat survives.</b> Excitement and laughter is heard from	Support from audience

TD3-27	the audience and spontaneous loud applause and cheering is heard when he finishes. He ends with	T shows initiative
TD3-28	five quick beats. MT talks and concludes the concert (again), inviting everyone for some hot	MT provides structure
TD3-29	chocolate, when R asks if he could also play something. She smiles and nods at him, says "OK!"	R shows initiative
TD3-30	and he starts to play. He starts to play on his djembe, plays forte and with high energy and	MT supportive
TD3-31	establishes a rhythmic pattern after a while. P and T start to play along on their djembes, their energy	R high energy, R confident
TD3-32	not as high as R's and dynamically mezzo forte. K and E join in on their djembes, somewhat	P support musically,
TD3-33	tentatively. The beat is steady for a while, but then becomes uneven. MT ends the drumming by	T support musically K tentative E tentative, beat uneven
TD3-34	saying, "Ah, dankie, R, baie dankie hoor!" and R is applauded for his effort. R smiles broadly as he	MT affirms, audience applaud, R proud
TD3-35	looks at his mother. During the applause, N and S mention to MT that they would like to	N spontaneous, S spontaneous
TD3-36	also perform a number. MT moves toward them and says "OK!", as she smiles supportively and nods	MT supports, encourages
TD3-37	at them to start. They start their number, N playing the djembe, and S beat boxing rhythmically.	N initiative
TD3-38	There are some noises from the audience and other children, but after a while the background noises	

TD3-39	die down and a steady rhythmic pattern is heard from the two boys. S and N are sitting together	S and N attune finely
TD3-40	closely listening to each other and improvising. S plays intricate patterns on the djembe, and N's	
TD3-41	mouth sounds match the patterns. After a little while, T joins the beat boxing, hitting his djembe with	T musically supportive
TD3-42	the mallet on the strong beat. The other group members are listening, smiling, as they seem to find	G listen, support
TD3-43	N and S's performance entertaining. L's fingers move in time with the beat. A moves towards a	L attunes
TD3-44	marimba. T's wheelchair moves back and forth as he keeps the beat and enjoys the music. More	T enjoys music
TD3-45	sounds are coming from the side of the audience: laughter, "who!"-shouts and after they end their	Audience supportive
TD3-46	piece with a vocal "pu-pu-chu!", loud clapping and shouting is heard. S and N get up and smile as	N receives applause
TD3-47	they accept the applause.	S receives applause

## Appendix H: Codes and categories

### Categories and codes for Excerpt 1

#### 1. Structure and direction:

MT instructs  
MT directs firmly 2x  
MT provides clear structure  
MT directive 2x  
MT strongly directs 3x  
MT guides strongly  
MT redirects

#### 2. Therapist's support

MT calmly directive  
MT contains  
MT offers ideas  
MT sustains energy  
MT supports dancers  
MT encourages dancers  
MT supports musically  
MT recognises efforts  
MT offers affirmation  
MT enthusiastic  
MT affirms 3x

#### 3. Disorder

Lack of musical cohesion 4x  
Chaotic  
R withdraws  
R isolated  
Group sound falls apart

Group disorder  
L incongruent playing  
N incongruent playing  
T incongruent playing  
Group sound disjointed  
Music lacks coherence  
Scattered sounds

#### 4. Cohesion

Flow between Er and MT  
R participates  
Group members sing along

A sustain melody  
M sustain melody  
S sustain melody  
Some group cohesion

#### 5. Lack of awareness

G not focussed  
Lack of awareness  
G distracted  
N plays in isolation  
R loses focus  
K loses focus

#### 6. Attunement

G increased focus 2x  
K keeping beat  
A aware of group  
Er follows MT  
K follows MT  
R follows MT

#### 7. Member support

N and T enjoy, make eye contact

#### 8. Uncertainty

L hesitant  
Inflexibility

#### 9. Confidence

K confident participation  
M confident, follows beat

#### 10. Enthusiastic participation

Er sings energetically  
S enjoys, big body movements  
Er excited, big movements  
M enthusiastic body movements  
A enthusiastic  
M enthusiastic  
S enthusiastic  
P sings enthusiastically  
Er dances energetically  
R dances enthusiastically  
K dances enthusiastically  
Big body movements  
Group spontaneous  
Group excited

#### 11. Compliance

G compliant  
R passive 2x; T passive

## Categories and codes for Excerpt 2

### 1. Structure and direction

MT instructs

MT focus attention

MT clear direction

MT guides musically

MT directs firmly

MT guides 2x

MT sets challenge

### 2. Therapist's support

MT makes eye contact, nods

MT makes eye contact, smiles

MT offers positive feedback (4x)

MT affirms

### 3. Facilitating independence

MT lets R play independently

### 4. Disorder

R plays randomly (2x)

Music scattered

Group does not follow MT

### 5. Cohesion

Er play in unison

P play in unison

M play in unison

Group engaged

Group strong cohesion

T play in unison

Ed play in unison

Group engaged, use voice, body movements

All group members in unison

### 6. Lack of awareness

K loses focus

### 7. Attunement

Patient

MT focus attention and G respond

Group members focus

Listen

S Aware of group music

Group aware of main beat

Group aware of each other

K aware of music

K part of the music

Ed aware of others

### 8. Member support

Group social interaction

### 9. Uncertainty

A hesitant

R hesitant

L hesitant

### 10. Confidence

S shows initiative

M confident

E confident

P confident

A, L play stronger, use bigger movements

Group strong use of voice

M confident

T confident

R shows initiative 2x

R playful and shows initiative

### 11. Enthusiastic participation

M shows enjoyment

E shows enjoyment

P shows enjoyment

R relaxed participation

N big movements, enjoy

Group spontaneous, excited

Big body movements

High group energy

Group spontaneous

Group excited, high energy

N shows enjoyment

P excited, big body movements

Group enthusiastic participation

### 12. Leadership

Ed shows leadership

A shows leadership

## Categories and codes for Excerpt 3

### 1. Structure and direction

MT provides structure

### 2. Therapist's support

MT affirms (3x)

MT supportive (4x)

MT supports musically

MT affirms R

### 3. Facilitating independence

MT facilitates initiative

MT steps back (3x)

MT encourages S

MT encourages N

### 4. Disorder

Beat uneven

### 5. Cohesion

Energy in group increases

Close musical interaction

T interacts with other group members

### 6. Attunement

Group members listen intently (2x)

N support T musically

S sensitively support T

S and N attune finely

L attunes

P supports R musically

T supports R musically

### 7. Member support

Group warmly supportive

Group supportive (4x)

D supportive

Group gently supportive

Audience and member applause (3x)

### 8. Uncertainty

K tentative

Er tentative

### 9. Confidence

A confident use of voice

T shows initiative

N shows initiative

T confident, big body movements

T shows initiative

R shows initiative

R high energy, confident

R proud

N using initiative

S using initiative

### 10. Enthusiastic participation

A performs with enjoyment

T spontaneous

T enthusiastic, big body movements

N spontaneous, enthusiastic

S spontaneous and enthusiastic

T enjoys music