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EXPERIENCING TIME AND REPETITION: FINDING COMMON GROUND BETWEEN TRADITIONAL AND MODERN MUSIC THERAPY PRACTISES.

Karen Louise de Kock
22273167

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ABSTRACT

This study describes the different experiences of time (duration) and repetition in a cross cultural context and how these influence the evaluation of Music Therapy clients in cross-cultural contexts. Field notes from an overnight Traditional Healing ceremony and video footage and session notes from a group Music Therapy session with female psychiatric patients provided primary data for this qualitative study.

All data was transcribed and coded in order to analyse the nature of both time and repetition in these contexts. The results of the data analysis were compared to Western perceptions of time and repetition and Modern Music Therapy practice in an attempt to identify common ground.

experiences play a role when evaluating clients cross-culturally. The aim was to generate a deeper understanding and awareness of issues that may have to be taken into consideration when evaluating clients. My interest in this topic arose from my observation and participation in an overnight traditional ceremony and clinical work with a group of female patients from different backgrounds in a psychiatric setting. In both instances, culture appeared to play a significant role that I could neither fully understand nor be party to. I realised that attempts to evaluate clients in this context could provide inappropriate results.

I used field notes from the overnight traditional ceremony and a video excerpt and session notes from a group session with female psychiatric patients as primary data sources for this qualitative study. All data was transcribed and coded in order to analyse the nature of both time and repetition in these contexts. The results of the data analysis were compared to Western perceptions of time and repetition and Modern Music Therapy practice in an attempt to identify common ground.

This study is limited by the inaccessibility of first-hand experience of both Traditional Music Therapy and Modern Music Therapy by clients from traditional cultures. Such observations cannot be made by individuals from outside this context.

I found that the aims, processes and practice of Traditional Music Therapy and Modern Music Therapy were far removed from each other and little, if any, commonality in perceptions of time and repetition existed. This however does not invalidate the practice of Modern Music Therapy with clients from traditional societies. What is required, however, is the development of a deeper understanding of the nature, implications and manifestations of traditional cultures in the context of Modern Music Therapy. We can learn from the vitality and inclusivity of African music and the healing role it plays in African societies. The development of a mutual understanding of each others cultures can provide a rewarding experience both for therapist and client.

DEDICATION

"Music is the only bodiless entry into a higher world of knowledge which comprehends mankind, but is not comprehended by it."

Beethoven

I dedicate this study in loving memory of my mother, whose energy, love and strength remains a constant inspiration.

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CHAPTER ONE - INTRODUCTION

The purpose of this study is to explore how differences in cultural experience of time (duration) and repetition in music-making, can be addressed in the clinical process in Modern Music Therapy, which appears to have certain constraints and boundaries. I am seeking to explore how these different experiences are relevant, in a cross-cultural context, which does not seem to have these clear boundaries, when evaluating clients from Traditional societies. This implies that the experiences of time (duration) and repetition in a cross-cultural Modern Music Therapy practise will be examined as well as the experiences of time (duration) and repetition in a Traditional Ceremony. Through describing and comparing these different experiences, I hope to evoke a deeper understanding and awareness when evaluating the duration and repetition of musical activities in Clinical sessions.

1.1. BACKGROUND TO THE STUDY

Modern Music Therapy refers to a set of disciplines that first emerged in Europe and North America during World War 1, and continues to develop and grow, entrenched within a Western world-view (Ruud 1998, Stige 2002a). Traditional Music Therapy refers to music and healing practises that originated in pre-Modern societies and continue to flourish throughout the world whilst not necessarily being named 'Music Therapy' (Gouk 2002, Horden 2002, and Kigunda, in Press).

Music Therapy training in South Africa is based on a Modern Western approach, namely Nordoff-Robbins Improvisational Music Therapy.

Clinical Improvisation forms the core of Improvisational Music Therapy and is an inter-personal communication in which both client and therapist learn about one another through their mutual improvisation (Pavlicevic, 1997).

1.2. CONTEXT OF THE STUDY

During our Masters in Music Therapy Programme, we had the opportunity to observe and participate in an overnight Traditional ceremony of the Pedi Tribe

in Sekhukhune, Limpopo Province. Although the ceremony was not an authentic healing event, it served a useful demonstration of the process and context of Traditional Music Therapy.

8 students and the Head of Training represented the Music Therapy Department of the University of Pretoria. The Music Therapy students were divided into groups of observers and participants. Group roles were alternated during the ceremony. This field trip required a 6 hour return journey and for the majority of the delegation, no sleep for thirty-six hours.

It was in the course of the Music Therapy Group's discussion and analysis of the entire ceremony, that I realised that some of our views and perceptions of the experience could be seen as prejudiced or biased. This was possibly due to ignorance and a lack of access to direct experience of such an event. The overriding perception of the Music Therapy group was that the process went on for too long and that the music became too repetitive.

I compared my personal experiences as a participant and interpretations of events as observer of the Traditional ceremony to my experiences of participation and observations in Clinical work with a group of adult African clients. I considered my experiences of these two forms of Music Therapy. The differences between them was Centered on the following aspects:

(1) the experience of the duration of the process and

(2) the experience of repetitive aspects of the music.

I wondered to what extent my Western perceptions of time (duration) and repetition, influenced my work as Music Therapist with African clients.

I acknowledge that my work in the context of mental illness includes certain pathological aspects that arise as a direct consequence of the illness and institutionalisation, but I wondered if the language of Modern Music Therapy[1]

[1] Music Therapists use the Nordoff–Robbins rating scales as a reference to evaluate clinical sessions (Nordoff & Robbins, 1977). These scales are applicable to Music Therapy with individuals but the concepts embodied in them are often extended to the evaluation of other client populations. I question the significance of words such as: 'perseverative', 'compulsive', 'inflexible' and 'persistently obsesses', which generally have negative and pathological implications.

might be appropriate and flexible enough, in the evaluation of African clients. I began to question whether as Music Therapists, we impose our notions of time (duration) and repetition on cultures that seem to experience and use these aspects differently. As a result of disparities in the perceptions of Modern Music Therapists and those of Traditional societies, Modern Music Therapists may attach pathological meaning to their clients' responses in a clinical environment.

1.3. THE RESEARCH QUESTIONS

The line of questioning above prompted this explorative study. In this study I will address the following questions:

- What are the experiences of time (duration) and repetition in both Modern Music Therapy and Traditional Music Therapy?
- What implications do these distinctive experiences have for the practice of Modern Music Therapy in South Africa?

1.4. CONTENT AND RESEARCH PERSPECTIVE

The purpose of this study is to describe the different experiences of time (duration) and repetition in a cross-cultural context, and to explore how these different experiences play a role when evaluating clients cross-culturally. The aim is to generate a deeper understanding and awareness of issues that may have to be taken into consideration when evaluating clients cross-culturally but not to provide either a definite or answer statistical proof. I therefore approach this study from a qualitative research perspective. I will discuss further reasons for this research paradigm in chapter three.

Literature on cross-cultural Music Therapy in the South African context is limited to the work of a few writers[2]. On a global scale however, the volume of work on cross-cultural Music Therapy has increased in the last decade. I

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[2] Writers include Pavlicevic and Henderson. Pavlicevic is the only writer to specifically address issues of time and duration in this context

have drawn on these resources. I have also drawn from the literature of Ethnomusicology and Systems Theory. A discussion of the relevant literature will be presented in the following chapter in order to provide information applicable to my research questions.

The data gathered from the field trip as well as data from a clinical session, will be transcribed and analysed in order to elicit the most salient points. The data presentation will be followed by an in-depth analysis and discussion which will aim to link the findings of the study to the research questions and attempt to answer these questions.

CHAPTER 2 - LITERATURE REVIEW

2.1. INTRODUCTION

When establishing a relationship with a new client or group, the Music Therapist aims to engage the client or group 'where they are at', meeting them in their own sense of being (Pavlicevic, 1997). Music Therapists thus strive to offer clients an understanding of who they are. This constitutes the initial stage of therapy in which the Music Therapist works to establish a trusting relationship, which together with the mutual music made with the client(s), form the core of Music Therapy. In this initial stage, Music Therapists assess the Music Therapy process and the client's responses. Their assessments are used to formulate clinical aims for their therapeutic interventions. Aims are directed at alleviating possible obstacles in the clients functioning. Through a process of negotiation and clinical intervention, Music Therapists offer the client, or group, a new experience and the chance to reflect upon their current state. The onus rests on the client or group to accept the therapist's intervention. The client's response may be one of either acceptance or avoidance.

In Music Therapy, the therapist and client negotiate a mutual culture. In this cultural space, the therapist and client may learn one another's cultures and create cultural norms (Pavlicevic, 1999). One of the basic clinical features of playing together is that of jointly defining and establishing a mutually comfortable beat. This means that the beat is not imposed by either one or the other player, but negotiated mutually by both players. The joint beat can be seen as a shared universal, underpinning and enabling both players to share the music and to create music jointly (Pavlicevic, 1997).

When a Music Therapist works with and evaluates clients from a culture other than their own, the following questions arise:

- On what criteria and in whose culture do Music Therapists base their observations and perceptions in their assessment of clients?

- When assessing clients in a cross-cultural context, are the Music Therapists experiences and observations bound by the time (duration) and repetition of the clients' responses to their clinical interventions?

It is this line of questioning which led to this explorative study of the role that the experience of time (duration) and repetition plays in Modern Music Therapy, when working cross-culturally.

To facilitate the answering of my research questions, my literature review will discuss time (duration) and repetition in the contexts of both Modern Music Therapy practise and Traditional Music Therapy Practise.

2.2. PERCEPTIONS OF TIME (DURATION)

Bunt (1994) states that all human beings are intimately connected with a range of biological tempi such as heartbeats, walking, thyroid activity, metabolic rate and neural activity. The duration of our heartbeats and our spontaneous preferred tempi seem to fall within a similar range.

Ornstein (in Bunt, 1994) qualifies Bunt's observation by providing a definition that views duration as a mental construct that depends on the amount of information that the human brain needs to process. He attributes longer durations to activities where there is more material to process. Using Ornstein's view, the experience of time appears to be both arbitrary and subjective.

In Western societies, time is perceived to be infinite and spans a range from infinity in the past to a future infinity. This infinite range is partitioned into discrete, regular quanta that subdivide time both backward and forward from a dynamic present. Time units are measured as absolute entities by devices that repeat an elementary unit such as a clock tick (Deutsch, 1999). Western societies attach great importance to adhering to time schedules (Bunt, 1994).

In contrast to Western time, many traditional societies perceive time as variable and cyclical. In African societies, time conforms to this non-linear

view and is based on a continuous, reversible, sliding scale that has circular, or spiral, properties. Time is not quantified and is not measured by any device. Time in essence only exists through reference to natural phenomena such as the passage of the sun and the seasons and particularly by social activity (Deutsch, 1999).

Regardless of any individual perception of time, Blacking (in Byron, 1995) points out that the ordinary daily lives and experiences of all people occur in *actual* time. When our perceptions of 'normal' time are upset, we appreciate the quality rather than the duration of an activity. Music has a particular power to create (and be experienced in) a world of *virtual* time. Blacking quotes Stravinsky who expressed *"Music is given to us with the sole purpose of establishing an order in things, including, and particularly, the co-ordination between* man *and* time*"* (p34). The virtual time of music frees people from the actual time of daily existence, allowing for a greater intensity of experience. The act of creating music may help to generate such experiences.

2.2.1. TIME IN THE MODERN MUSIC THERAPY CONTEXT

In Modern Music Therapy, as in Western societies, clock time is important. Sessions are structured according to a predetermined duration with set starting and ending times. Therapy occurs in a sequence of sessions that take place at set intervals, usually daily or weekly. Audio and video recordings of sessions have specific durations and these are indexed and analysed according to 'real' time. Modern Music Therapists attach meaning and significance to events and responses that occurred at a specific, noted time in the session.

Pavlicevic (2003) proposes a re-evaluation of the time-bound structures of sessions when working with African clients. She points out that thinking in such terms as "the session begins in ten minutes", "the session will last for forty minutes", or "when everyone is there the music will begin" has no place in an African context. Group music does continue despite a constant flow of arrivals and departures. A session's duration is determined by the need for

the music to sound and be sounded completely. There is thus another time altogether, which Pavlicevic refers to as "social-music time".

TIME IN WESTERN MUSIC

In Western music, a time signature is assigned to indicate a meter, the basic *measure* of time, which is separated by placing bar lines on a staff. Music is divided into standard, easily comprehensible units of time, which are marked by tapping or clapping. Western rhythm marks time at an even pace, alternating strong and weak beats, resulting in a recurrent main beat (Chernoff, 1979).

2.2.2. TIME IN THE TRADITIONAL MUSIC THERAPY CONTEXT

In Traditional societies there is no emphasis on adhering to either schedules or clock time as occurs in Western societies. In traditional healing there is no set time allocated for the start or duration of gatherings and activities. The role of music is thus unconstrained by such measures.

In contrast to Western music, *measured* music in African music is based on a sequence of equal temporal pulsations that can be realised as a beat. Thus beat or pulsation is a manifestation of a metronomic sense at the basis of African rhythm: It is not a device for forming groups of two, three, or four beats as in Western classical measure (Chernoff, 1979).

Arom (1991) suggests that the implicit metronomic beat, materialised by Africans themselves, is intrinsic to the music and thus a 'cultural pattern'. Its durations always refer to the implicit beat as the regular reference unit (Deutsch, 1999). Rhythmic patterns appear to have little meaning out of context and a player can often not perform his pattern alone. This is because congruence relations with other players define musical formulas and these cannot be kept in mind without a beat or metric reference (Deutsch, 1999).

Gregory (1997) supports Deutsch's view and suggests that Western practitioners must necessarily develop their own 'metronome sense' in order to appreciate African music. In Western music, the main beats are integral

to and are part of the music. African musicians proceed on the assumption that the audience is mentally supplying these fundamental beats through the use of their 'metronome sense'. They will elaborate their rhythms around this assumed mental beat, often using poly-rhythms, the interplay of two or more simple meters and offbeat melodic accents. The main beat is not stressed musically but exists in the dance and in the minds of the musicians and listeners. African music thus needs to be danced to either physically or mentally, in order to fully appreciate it

2.3. REPETITION IN MODERN MUSIC THERAPY

Repetition is used as a tool in Music Therapy to achieve the aims of eliciting a musical response and to establish an emotional climate or mood.

Eliciting a response serves to engage the client or group in a musical interaction. This helps clients perceive and remember the musical motive.

In establishing an emotional climate, the therapist repeats musical material to both create expectation and to provide predictability to the client. Predictability engenders feelings of comfort, reassurance, stability, and consistency in clients (Bruscia, 1987).

If the music provides enough repetition it can begin to 'make sense' fairly quickly for everyone (Pavlicevic, 2003). A steady pulse, similar phrasing and regular cadential points may thus engender feelings of familiarity and inclusivity by providing enough clues for the client to predict a sequence of events.

Bunt (1994) notes that different rhythms may produce very different emotional responses. These range from the soporific and calming to the highly arousing and ecstatic. Repetitive and steady rhythms produce a hypnotic effect. The minimalist school of composers made much use of repetitions, with the added complexities of very subtle changes and inflection in the rhythm. Such music can sometimes produce a meditative response in the listeners.

2.4. REPETITION IN TRADITIONAL MUSIC THERAPY

With reference to musical performance in a Traditional setting, Blacking (1973) states that the duration and repetitive nature is generally determined by the specific social situation, the number of performers and by their musical ability. There is a direct correlation between the size of the group and the duration of the music.

Diallo and Hall (1989) emphasise this use of musical repetition in traditional music. They draw parallels between musical repetition and other practices such as affirmations and mantra recitation. These are all only effective through prolonged repetition.

As my study focuses on Music Therapy in a group context, I will proceed to literature on Group Music Therapy.

2.5. GROUP MUSIC THERAPY

2.5.1. THE THERAPIST-GROUP RELATIONSHIP

Bunt (1994) proposes that an overall aim of the therapist in Group Music Therapy is to find a musical means of meeting as many of the participants needs as possible, at that particular moment in time. The therapist works as a facilitator, observing how each member of the group copes, listening to the sounds they produce as an indicator of their internal being, observing each member' behaviour in the group, and monitoring the interactions between members of the group (Bunt, 1994).

Apart from the Therapist's role as facilitator, Pavlicevic (2003) suggests further tasks in the group context: To enable, to allow, to lead, to guide, to monitor, to follow, to hold, to sustain and to end.

Group Music Therapy provides an opportunity to support each person's tempo, to make initial contact at that level before moving away from this focal point to explore other rhythmic and temporal experiences. In walking to our own comfortable tempo with music for support, we are learning to synchronise a movement with sound. At such moments, the response

produced occurs in synchrony with the appearance of the stimulus: this is often described as "rhythmic entrainment" (Bunt, 1994)

2.5.2. GROUP MEMBERSHIP

Pavlicevic (2003) defines three types of groups based on the nature of group membership. These are:

- The *closed group* where membership is stable and all members are expected to be present for all sessions.
- An *open group* where clients come and go as they will and there are no expectations from the therapist regarding attendance. There may be totally different people each week, or there may be a mixture of 'old' and 'new' faces.
- The *semi-open* group has a core membership, as well as a fluctuating one. The core group attends regularly while some members attend a few sessions and then leave, some return after an absence, some attend erratically and some attend once-off. In instances of medical or psychiatric settings, this is a useful format since patients may have periods of feeling unwell and not being able to attend, while others appear every week.

Ansdell (1995) observed in his work with a *semi-open group* that a new person could make both the group and the music quite different, but equally there was also a sense of continuity and development. Pavlicevic (2003) cautions that the therapist be alert to the fact that core members might feel resentful if "visitors seem to be getting a bit more of the limelight than the core members feel they deserve".

2.5.3. GROUP AIMS

Bunt (1994) relates Yalom's core 'curative factors' to the aims of group Music Therapy. These include:

Instillation of hope: In Music Therapy there is no right or wrong way to play. Understanding this may decrease the clients' initial fears and anxieties

and increase a sense of curiosity and interest. The permission to explore within a secure and safe setting may provide the necessary springboard for the group.

Universality: A group may start off as a collection of isolated and quiet people, preoccupied with their own problems. Playing together may unite people as they master any difficulties together.

Altruism: Music and group-work can take the focus away from clients' immediate problems. Helpful insights about each other's behaviour can occur, often being more easily accepted from other group members than from the Therapist. Such learning will hopefully be carried over to their interactions outside the session.

Interpersonal learning: Each member can begin to find an individual place in the group and explore ways of feeling increasingly comfortable in relating to others. Members can experience a sense of agency and that they can make a unique contribution to the whole.

Group cohesiveness: Making music can bring people who have previously felt isolated together and provide a sense of group cohesion and a sense of immediate belonging.

2.5.4. REFLECTION AND ASSESSMENT

There could be a number of reasons for a client or group not responding to the therapist's musical offering. Openness is therefore a key requirement of a successful therapeutic relationship, a condition and a prerequisite when therapists assess a client or group (Stige, 2002a)

Roy (1999) suggests "curiosity' as tool for assessing responses in therapy. She states that the therapist needs to be "empty" enough to continue to learn from the client and allow new information to make a difference. As soon as the therapist stops being curious, when a conclusion has been reached and finalised, further dialogues in therapy can become turgid.

Cechin (ibid) in Roy (1999) makes a clear connection between curiosity and neutrality. He talks about "the creation of a state of curiosity in the mind of

the therapist" (p406). By cultivating curiosity, by not pinning one's flag to any single pitch but instead seeking alternative viewpoints, we move towards neutrality. It is a neutrality of "openness", a willingness on the part of the therapist to continue to explore and accept new angles on problems presented.

Bradt (1997) alerts us to the fact that assessment and the viewpoint of the therapist may entail ethical issues. Often, cultural differences in expressing symptoms are not sufficiently taken into consideration when assessing clients' responses. Clients from Traditional cultures, for example, value inter-dependence and social connectedness. These values are often misinterpreted by Modern Therapists for whom healthy behaviour includes independence and an individualistic orientation. Different cultural values, can not only lead to misdiagnosis, but also have an immense impact on the therapeutic process. The client's belief about mental illness, emotional issues, appropriate expressions of emotions and the clients' attitudes toward authority figures can be very different from the therapists' conceptualisation.

2.5.5. CULTURAL AWARENESS IN MUSIC THERAPY

The question arises as to how much the therapist should adapt to the music of the client's culture and to what extent such adaptation effects the authenticity of the therapist's efforts (Bradt, 1997).

Moreno in Bradt (1997) compares the above issue to verbal languages in which a few words can greatly increase the possibility of establishing communication cross-culturally. He proposes that by playing a simple song or basic musical material from the client's culture can open new channels for communication that otherwise would not have been possible.

Pavlicevic (1997), points out that although Music Therapists should be encouraged to familiarise themselves with music of different cultures, it is not possible for them to have direct access to any hidden nuances and symbolism embodied in the music of other cultures. The purpose of familiarising themselves with different world music's is more to familiarise

themselves with the different *energies* embodied in the different types of music, than to produce culture specific music for the client.

Roy (1999:125) echoes this view when she promotes respecting the client's culture but states that *understanding* another culture "may be impractical or even Utopian".

2.5.6. GENERALISATION AND STEREOTYPING

Various sources caution Music therapists against stereotyping clients or cultures:

Stige (2002c) addresses the dangers of overgeneralisations and warns against assumptions that a client will act or respond in a certain manner. He uses African cultures as an example and calls it the "Jambo means 'Hello' in Africa Syndrome". In his article he suggests that there are still Therapists who make unfounded generalisations about their clients' cultures.

Cole (2002) echoes this sentiment when she states that although it is important to understand cultural differences, Music Therapists cannot make assumptions for all persons from a particular culture based on what a book or article tells them is a "cultural norm".

Bradt (1997) states that a wide range of behaviour exists within any group of people. One should therefore be careful to not view individuals in a cultural group as all the same as this is a dangerous course and promotes ill conceived and poor treatment.

Stige (2002b) proposes that, when meeting a new client, the therapist should acknowledge that she or he is unique: different from any other client in some respect, similar to other clients in some respects, and like any other client in other respects. In other words, the client has a personal history, belongs to a cultural group, and is at the same time a human being sharing human nature with any other human being. There is a continuum then, from the individual to the communal to the universal that needs to be studied and which should inform the therapists' work.

2.6. TRADITIONAL MUSIC THERAPY

2.6.1. AFRICAN MUSIC

Music forms an integral part of all activities in the majority of African cultures. These activities include celebration, mourning, working, communication, healing rituals and everyday existence (Blacking, 1976).

Gregory (1997) stresses that to understand African music it must be studied within the context of traditional African life as it is not merely an independent form used for entertainment, but rather an integral part of African culture. He quotes Bebey who states that the main aim of African musicians is to 'express life' in all its aspects through the medium of sound, rather than to create sounds that are pleasing to the ear.

2.6.2. RHYTHM AND DANCE

In African music, dance is either an integral part of ceremonies or is performed for its own enjoyment. Dance is so pervasive in African Traditional Music Therapy that Gregory (1997) notes that it is often difficult to discern the primary activity between music and dance. Arom (1991) goes one step further and describes music in sub-Saharan Africa as being a motor activity, almost inseparable from dance. He comments that hearing music will often give rise to an immediate movement of the body.

Chernoff (1979) points out that rhythm makes dance possible. Rhythm and dance enhance both group cohesion and group energy. He claims that group dance, following the temporal order of music, allows interpersonal interaction through a unity of artistic purpose. He suggests that the performers' facial expressions and body movements communicate messages that enhance both the participants and audiences' understanding of the music.

2.6.3. MUSIC AND HEALING

In Traditional ceremonies, music serves a healing function as it is believed to facilitate communication with the ancestors, spirits, and the Creator. It

serves to harmonise the forces of the visible and the invisible world (Gregory, 1997).

Repeated drum rhythms are particularly important as it is believed they have a calming and stabilizing effect on patients (Gregory, 1997). Drumming may continue for several hours, helping to restore the inner balance of a disturbed individual.

2.6.4. THE TRADITIONAL HEALER

In most Sub-Saharan Traditional African societies, the activities and interventions of ancestors play an important role in the concepts of illness and healing (Bührmann, 1984; Maiello, 1999). Maintaining good relations with the ancestors, whose presence remains constant, is essential for the well-being of an individual or his family. A disturbance in this relationship is seen as a sign that the ancestors are unhappy with the individual and will ultimately result in illness. Healing through a Traditional healer, is seen as essential for reconciliation with the ancestors (Maiello, 1999) and therefore restoring an individual to health.

The Traditional healer, or Sangoma, is a tribe's healer, chief musician and priest. Becoming a healer is not a matter of personal choice but is rather an ancestral calling. This calling may manifest itself through dreams accompanied by long-lasting illness which includes symptoms that would be interpreted as psychotic breakdown in Western cultures (Maiello, 1999). This period of illness is called 'Thwasa' (coming out) and should perhaps be seen as a 'creative illness' as described by Ellenberger in Bührmann (1984). Such 'creative illness' is not restricted to primitive and isolated communities but occurs in western cultures amongst mystics, poets, philosophers and dynamic psychologists and psychiatrists.

Traditional healers are held in high regard because of their ability to exploit the forces of nature and to make contact with the spirit world. They often enhance their charisma by wearing colourful costumes, which cause people to fear, respect and admire them simultaneously. Clients relate to healers

with the same reverence as is accorded to highly respected elders of the client's ethnic group (Vontress, 1991).

2.6.5. TRAINING OF THE TRADITIONAL HEALER

A Sangoma's training begins once the calling is confirmed by an experienced healer. The apprentice moves into the home of his/her mentor. The training is a time consuming process in which apprentices learn about the therapeutic powers of various plants, purification rituals necessary for opening clients to receive messages from ancestors, ritual dancing, diagnosis of illness and performing of ceremonies, amongst others (Maiello, 1999).

2.6.6. ASSESSMENT

In assessing and diagnosing clients, healers use a number of techniques singly or interactively to holistically eliminate or ameliorate factors. Techniques span physical, psychological or spiritual practices. These include dream interpretation, possession dances, sacrifices, and pharmacotherapy among others. The assessment and healing process can become very time consuming as clients and their families may move into the healers' hut or compound for the duration of the treatment. Vontress (1991:245) interviewed a Kenyan woman in the United States who commented: "*Traditional healers take more time with you than Western-trained doctors*".

2.6.7. TRANCE

In addition to the ability to calm and stabilise, repetitive music and dance is often used to induce trance. Trance is a special state of consciousness which usually occurs in the context of prolonged dancing. It may feature a convulsive state, accompanied by cries, trembling, loss of consciousness, and falling (Gregory, 1997). Often, music and dance act together to produce the emotional state favourable to trance. Gregory (1997) states that all kinds of music may produce trance, although there are some frequently recurring characteristics such as repetition, breaks or abrupt changes in rhythm, or a simultaneous accelerando and crescendo. Possession is associated trance

and is regarded as a requirement for communication with ancestors or spirits.

The social environment and context is important in situations where trance and possession are desired. Blacking 1973) describes the possession dance of the Venda people of the Northern Province, and illustrates the importance of both the music and the social environment. Despite the fact that a ceremony may have a number of participants, the only members to achieve trance are those who are designated this role. In this particular case they were required to be members of a cult, dancing in their own homes, which the possessing ancestors and spirits are familiar with. The effectiveness of the music thus depends on the context, but trance ultimately depends upon the music. He cites an occasion where he participated in a ceremony by playing the drums. A senior female participant, expected to achieve trance when the music of her cult group was played, began dancing. She stopped after a few minutes and insisted that another drummer replace him, claiming that Blacking was ruining the effect of the music by 'hurrying' the tempo.

This concludes my discussion of the literature. In the next chapter I address the research methodology that I used in this study.

CHAPTER 3 - RESEARCH METHODOLOGY

3.1. QUALITATIVE RESEARCH

3.1.1. NONPOSITIVIST

> *"Nonpositivists believe that truth and reality exist in the form of multiple, intangible mental constructions which are influenced by individuals and social experiences. Research reveals not whether these constructions are true or real, but whether they are 'more or less informed and/or sophisticated"* (Guba & Lincoln in Wheeler, 1995:66).

For the purposes of this study, I have chosen a qualitative research paradigm based on a non-positivistic worldview. My research does not aim to find a single truth which can be applied to other contexts. The discoveries are bound to the time and context of the inquiry and are meaningful to that specific context rather than any broad generalization.

In this study, I do not consider myself as independent from the participants. As therapist, observer and participant, I am linked to participants through our relationship in which we create our own reality and truth.

3.1.2. THERAPIST AS RESEARCHER AND PARTICIPANT

As therapist, my interaction and involvement with the subjects influences my reasoning and is therefore "constructions of the mind, influenced by subjective experiences" (Bruscia, 1995; Wheeler, 1995). As a result of my involvement with the phenomena under investigation, I become both participant and observer. My subjective involvement, allows for researcher's bias, which is openly acknowledged and viewed as a "resource" rather than a problem in qualitative research (Ansdell & Pavlicevic, 2001).

To control the possibilities of excessive bias and trustworthiness, I will cultivate on-going self-reflection and "clarity of voice" by keeping my personal context and values transparent throughout the study (Bruscia, 1998).

As researcher-and-therapist, I realise that I am, together with my clients, under the spotlight and that my clinical practice will be examined. I am fully prepared and mindful of this as I am interested in the *process* of the phenomena and unconscious issues that may occur *during* the process.

The qualitative paradigm offers a flexible method which can unfold naturally and spontaneously as the study progresses (Bruscia, 1998).

3.1.3. NATURALISTIC SETTING

Qualitative research, involves an *ecological* approach which allows the researcher to study the phenomenon in its natural setting as opposed to a laboratory setting. In this setting, the essential features and meanings are more easily comprehended. The phenomenon and its context, gave me first-hand experience and empathy needed to understand the phenomena from an inside perspective (Wheeler, 1995).

3.1.4. ETHICAL ISSUES

> *"Legally speaking, consent involves three components: 'capacity, information and voluntariness'"* (Drew in Wheeler, 1995:81).

My clinical work is set in a Psychiatric Hospital and informed consent to record the sessions for research purposes was obtained by the Chief Executive Officer of the institution. The institution has assumed legal guardianship of patients as mental disorders have reduced their *capacity* to give personal consent. An example of the consent form is presented in Appendix A.

Information and instructions were carefully informed to the participant's level of understanding. Participation was strictly voluntary and under no circumstances were clients forced to attend or participate.

To ensure confidentiality and anonymity of clients, real names have been changed.

To ensure trustworthiness, materials chosen for this study have been validated by a Peer Supervision panel.

3.2. DATA COLLECTION

My study is based on two sources of data. Data source A is a video excerpt and session notes from a session in my clinical work with female psychiatric clients. Data source B is the salient points from field notes compiled during the Overnight ceremony as discussed in the introduction.

3.2.1. DATA SOURCE A: VIDEO EXCERPT OF GROUP SESSION AND SESSION NOTES

It is standard clinical practice in Music Therapy to record and videotape sessions as these recordings enable the therapist an in depth analysis of proceedings and facilitates the process of clinical ratings. In order to answer my research questions, I have chosen the video excerpt for the following reasons:

- It is taken from a group session with female clients from a culture other than my own.
- I was the therapist in this session and it is therefore a reflection of my experiences within the session.
- There was a marked difference in the level of group participation from previous sessions.
- The session was supervised by the Head of Training of the Music Therapy Department.

3.2.2. DATA SOURCE B: FIELD NOTES FROM AN OVERNIGHT TRADITIONAL CEREMONY

In addition to the information obtained from the video excerpt and session notes from clinical work, I have used the student group's documentation of their experience of the overnight trip. I have chosen the documentation, as it involves *intersubjectivity* which in this context means "a shared subjective

judgement of a phenomenon or event" (Ansdell & Pavlicevic, 2001:181). The written experiences were documented during and after a Traditional African event by our group of Modern Western-trained Music Therapy students, who have a common cultural and perceptual milieu. Our experiences and documentation is an *intersubjective* account of the event.

3.3. DATA PRESENTATION

3.3.1. DATA SOURCE A: VIDEO EXCERPT AND SESSION NOTES

> *"Videotape recording is a way of direct observation in the study of behaviour and human experience as they occur in daily life in a variety of settings and contexts"* (Bottorff in De Vos, 1998:326).

Schurinck, Schurinck and Poggenpoel (1998) alert us to the fact that although video recordings contain a greater density of data than in any other kind of recording, it is not complete. A major advantage of video recording is its capacity for a more thorough and complete analysis but the disadvantage is the absence of contextual data beyond what is recorded (De Vos, 1998). In order to overcome this limitation, I have included a description of the group dynamics and work, followed by a description of the activity as a whole, to provide a context.

To present the video excerpt, any verbal or sung material will be transcribed into text material. The excerpt will be indexed according to a real time base. Any non-verbal interaction will be described alongside the verbal interaction. It is not necessary for the purposes of this study to provide an exact transcription of musical notation as the musical elements will be described verbally.

Indexing will be coded. Codes will be grouped into mutually exclusive categories to establish emerging themes (Robson, 1993). Session notes will be coded and categorised.

3.3.2. DATA SOURCE B: FIELD NOTES FROM AN OVERNIGHT TRADITIONAL CEREMONY

To contextualise the experiences of the group, I will initially offer a description of the proceedings of the ceremony. This will provide a background and context to the group's experiences.

Salient points from the notes will be coded and put into mutually exclusive categories from which emerging themes will be discussed.

CHAPTER 4 - DATA PRESENTATION AND ANALYSIS

4.1. DATA SOURCE A: VIDEO EXCERPT AND SESSION NOTES OF GROUP MUSIC THERAPY

4.1.1. BACKGROUND

The excerpt is taken from a session with a group of female psychiatric patients in Ward 36 at Weskoppies Psychiatric Hospital. The group was a semi-closed group consisting of four core members: Beauty, Rose, Mary and Cherise. The ages of members ranged from 37 to 54 years. All members were diagnosed with Schizophrenia and had previous admissions. At the time of our Therapy, most members had been in the ward for an extended period.

The members were referred for Music Therapy by the Head Nursing Sister for reasons including:

- To provide opportunities for improving focus and awareness.
- To improve levels of participation.
- To create opportunities for self-expression.
- To facilitate interaction between members.

4.1.2. THERAPEUTIC CONTEXT

The sessions were conducted weekly by a therapist and co-therapist. I facilitated 7 of 14 sessions.

In our initial assessment to formulate goals for the Therapy process, we observed that there was a sense of apathy and low energy levels. Members were unable to stay focused and a lot of movement in and out of the group occurred. Members left the group to lie down on the floor, went to the toilet or started taking snuff during sessions.

Our aims were to encourage a greater sense of focus, group cohesion and participation.

To encourage focus, cohesion and participation most activities were structured and predictable. The simplistic structure of activities involved repetition which enabled members to stay focused for extended periods. Within the structured activities there were opportunities for free improvisations.

4.1.3. SESSION CONTEXT

The excerpt is taken from session 9. The duration of the session was 25 minutes. When we went to gather the group, a new patient on the ward, Sophie, approached us asking to attend the session. We decided to include her as she seemed eager to attend. Before we started, two Student nurses came to ask if they too could join the session. We agreed as it would be an opportunity for members of staff to interact with patients and to experience the Music Therapy process. The number of members in this session increased from 4 to 7.

Before the excerpt, we sang a pre-composed greeting song. The duration of the song was longer than usual with the addition of 3 members as each member was greeted individually and given an opportunity to play the tambourine. The energy of the group was increased by the high energy of the three additional members which was evident at the end of the greeting song when the two nurses spontaneously got up and started dancing to which everyone followed.

DESCRIPTION OF TURN TAKING ACTIVITY

I decided to sustain the movement after the greeting song was completed by forming a circle with members following. Nurse 1 continued playing multiples of the beat on the Tambourine. I initiated a Turn-taking activity singing a familiar pre-composed song alternated by prompting a member to occupy the centre of the circle and lead by playing on the Jembe. When each member had had a turn to play, the activity was extended by prompting each

member to initiate a song. The activity ended when I sensed tiredness in members and myself. The duration of the activity was 11 minutes.

4.1.4. DATA ANALYSIS

After indexing the video excerpt according to a real time base, I coded each sentence (See Appendix B). I then segmented the excerpt according to the turn-taking structure of the music. Each turn was analysed as a separate segment to which I assigned codes (see Appendix C), to each member's response in that segment. The coding of each segment was followed by a brief commentary on that segment. Table 4.A below shows an example of this coding:

TABLE 4.A. DATA SEGMENTING AND CODING EXAMPLE

TURN III:	Mary
DURATION:	18 seconds
1.	Key change
2.	Directing
3.	Delayed response, disorientation
4.	Rhythm change
5.	No tempo/metre change
6.	Support
7.	Increased pace
8.	Tambourine, dancing, singing
9.	High energy, dancing, singing
10.	Low energy, distracted
11.	Unfocused, bumping
12.	Initiative, stacking chairs
13.	Movement out
14.	High energy, dancing, singing
COMMENTARY: The direction and metre stays the same. As the group seems to get stuck at one point, members take initiative in removing the chairs from the circle. There is an increased sense of energy although some members still appear to be unfocused and distracted. The dynamic is getting louder as there is increased singing. There is a key change and the tempo is sustained.	

4.1.5. CATEGORISING

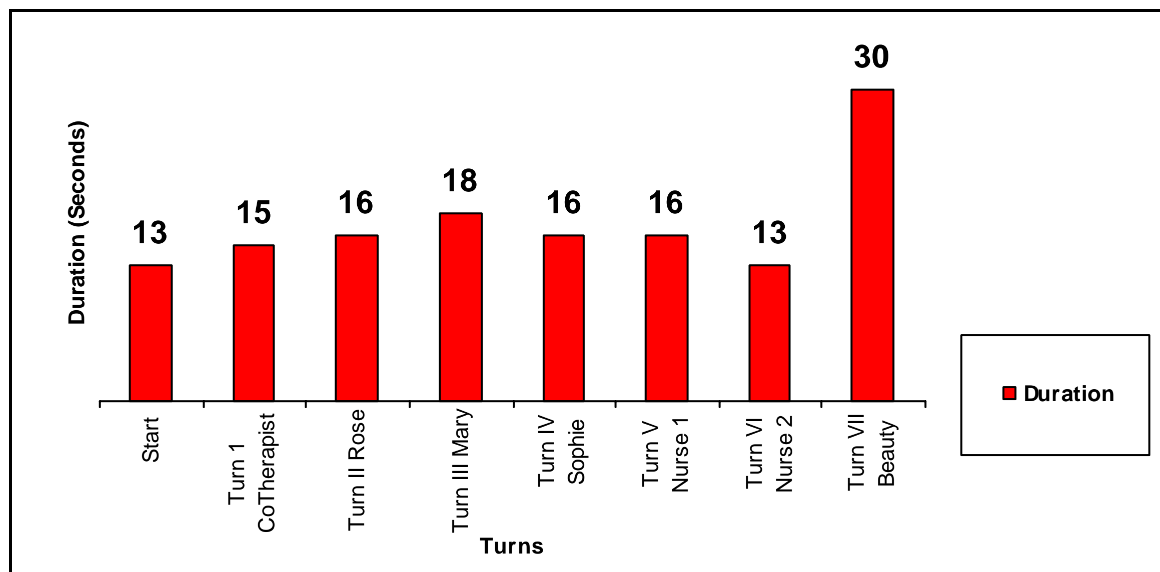
After coding the segments, I clustered the codes derived from the segments into four categories:

Category A	Group participation
Category B	Musical activity
Category C	Group musical Profile
Category D	Group energy Profile

These categories were tabulated. The tables following overleaf present the four categories that emerged from the video segments. The codes that belong to each category are presented alongside the category. Once again, a brief commentary has been written after each category has been presented in order to summarise the presented information.

The duration of each turn is plotted in Figure 4.B. below. Length of turn is correlated to both tempo and group energy and participation. The longer the turn the slower the tempo and the lower the level of group energy and participation. These are illustrated in Figures 4.C. and 4.D. below.

FIGURE 4.B. TURN DURATION



CATEGORY A	CODES
Group Participation	Directing/non directing Following Unsteady Distracted Unfocused Irritation Reprimanding/Authority Focused Obstacles/chairs Delayed response Initiative Initiating Movement out Movement back Obstruction Supported Carried by group Disorientated

COMMENTARY:

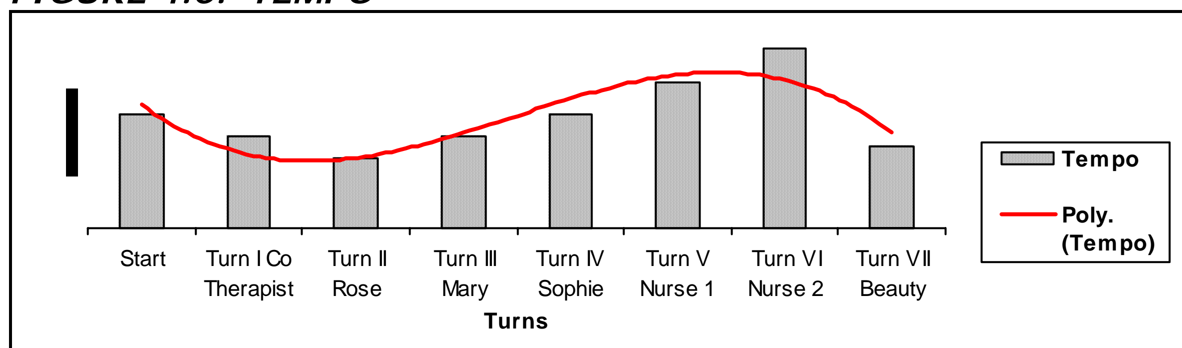
This category illustrates group participation and how members are part of the group. In the Start, Turn I, II and III, there were disparities between focused and unfocused participation. Members showed a mixed response on the disorientation of others. The nurses supported those that became disorientated while some core members became irritated and reprimanded these members. In Turn IV and V there was a build up of increased participation which reached a climax in Turn VI where every member was participating with focus and direction. Although there were clear moments of directing from the therapist in Turn I, II and III, there were also moments of indecision or delay, in which members took initiative by moving to the centre without prompting (Turn IV) which prompted a series of unprompted turns (Turn V and VI). The chairs were an obstacle, resulting in delayed response (Turn I and II). Members took initiative in removing the chairs (Turn III) which resulted in movement in and out of the circle which did not affect the musical flow of the activity. The Nurses exercised their authority in the ward, by guiding members who showed delayed response (Turn II and III) or by reprimanding members who played out of turn (Turn V).

CATEGORY B	CODES
Musical Activity	Anti-clockwise direction Singing Tambourine Arm movement Jumping Clicking fingers Walking pace: slow, increased, varied Jembe Dancing No singing Hip swaying Harmonising Clapping Rhythmic steps
COMMENTARY: This category illustrates member's responses and their actions to make the music happen. As with the previous category, there was initially a disparity between member response (Start, Turn I, II and III) ranging from just walking, to increased body movement and cross-modal response such as singing, clicking fingers, jumping, hip swaying and playing on instruments. As the turns progressed, initiative from some members had the effect on others, whose response became more sustained with increased body movement (Turn IV and V) which reached a climax in Turn VI as all members were responding with increased body movement and singing.	

CATEGORY C	CODES
Group Musical Profile	Tempo Key Rhythm Metre Dynamic
COMMENTARY: This category describes the musical effects of the group's responses. The changes in tempo were a direct result of each member's response and playing of their turn. The tempo in the Start, Turn I, II, III and IV ranged between 118bpm – 126 bpm increasing to 132 bpm in Turn V, reaching a climax to 138bpm in Turn VI. As a result of disorientation in Turn VII, the tempo decreased to 120 bpm. Key changes were directed by the therapist and ranged from E major to C, C-sharp and D major. The metre of 4/4 stayed the same throughout the activity. Changes in rhythm was as a result of each individuals playing on the Jembe ranging from single beats (Turn I) irregular playing (Turn II and VII), multiples of the beat (Turn III) to sustained dotted rhythmic patterns (Turn IV, V and VI). The dynamic level increased as more members started to sing as each turn progressed. The dynamic level moved from mezzo-forte to fortissimo (Turn VI). There was a break in singing in Turn VII due to a delayed response and as a result the dynamic level moved back to mezzo-forte.	

The tempo of each segment is shown graphically below. A fitted polynomial curve shows changes in tempo through the sessions.

FIGURE 4.C. TEMPO



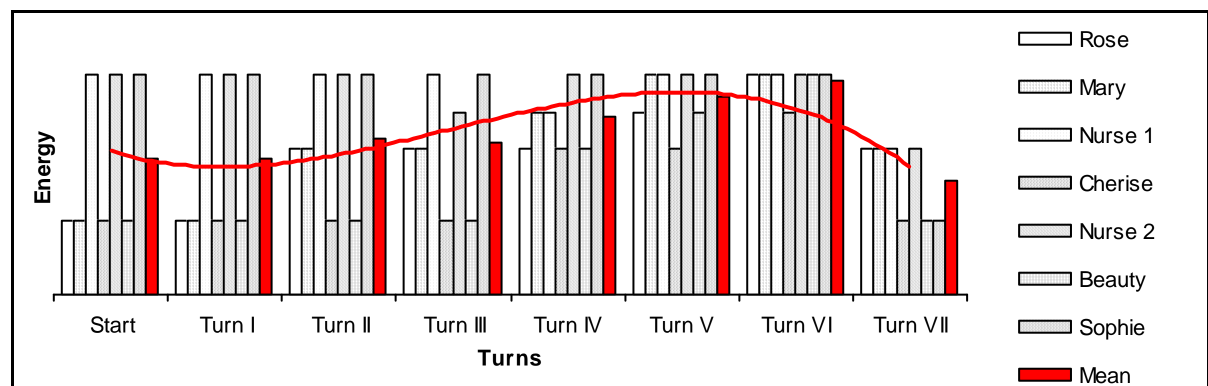
CATEGORY D	CODES
Group energy profile	Low Medium High Unfocused Sudden changes Stuck Flexible Sustained Increased Climax Disrupted

COMMENTARY:

This category illustrates what happened with the group energy as the activity progressed. Initially there was a disparity in members' energy ranging from low to high (Start, Turn I, II and III). Some members participated with unfocused energy as a result of disorientation and distraction while others were more focused. The increased and sustained high energy of others had the effect that there was an overall sense of increased energy in Turn IV and V, which reached a climax in Turn VI with all members participating with sustained medium to high energy. In turn VII the group energy was disrupted and changed suddenly to a loss of focus as a result of delayed response and disorientation from the member whose turn it was.

I then constructed a graph to illustrate the group participation through each of the segments. Numerical values ranging from low (1) to high (3) were assigned to observations of group energy. These allowed for the calculation of mean group energy to allow the plotting of an energy trend line.

FIGURE 4.D. GROUP ENERGY AND PARTICIPATION LEVELS



4.1.6. SESSION NOTES

My session notes are presented in Appendix D. After coding my session notes, I found that there was repetition of data that I had already used in my context and description of the activity. I took the salient codes and re-sorted them under the category of Subjective experience for the purpose of my discussion in Chapter 5.

CATEGORY	CODES
Subjective Experience	Group too large Session too long Spinning effect Loss of control Carried along Limited intervention Questioning Exhaustion

4.2. DATA SOURCE B: FIELD NOTES OF AN OVERNIGHT CEREMONY

4.2.1. DESCRIPTION OF OVERNIGHT CEREMONY

The process started at approximately 6 pm with a visit to the tribe's ancestral graves where we were introduced to the ancestors who would be present in this event. We were then escorted to the house of the Traditional Healer who would be our host for the duration of proceedings. A period of waiting followed while the venue of the Welcoming Ceremony to be prepared. The Welcoming Ceremony started at around 7:30 pm. The delegation was welcomed by various community leaders and we were introduced to the healer who would be conducting the ceremony, and the various persons who had been instrumental in his training. The Welcoming Ceremony was followed by another period of waiting, while food was being prepared. The meal was served at approximately 9 pm. This was followed by a period of waiting as the venue for the musical event was being prepared. The musical event started at approximately 11 pm. and lasted with intervals until 7 am the next morning. As mentioned in paragraph 1.2. the ceremony was not an authentic healing event and took the form of groups of three or four

"patients" entering the circle and dancing to the singing and drumming of observer-participants. The entering of these sub-groups was hierarchical and subject to the seniority within the group. The healer intervened at specific times of the event and was instrumental in shifting the energy of the proceedings. The healer intervened for the last time at 6 am after a build-up of intensity. He performed a dance in which he was in contact with the ancestors and where he received their suggestions and information to divulge to the "possessed" and their families.

4.2.2. DATA ANALYSIS

The student delegation was divided into observers and participants who regrouped every two hours, noting down observations and experiences. Although the group was divided, there was minimal participation from the student group.

As I went through the field notes, I found that they were less extensive than I had originally anticipated. The notes were incoherent in places, possibly as a result of fatigue amongst the observers and the inability to hear each other properly as a result of the loudness of the music.

As there was a lot of repetition, I transcribed the field notes lifting only the relevant ideas to this project. See Appendix E.

I then clustered the codes derived from the field notes, into four categories:

Category E	Subjective experience
Category F	Social experience
Category G	Musical profile
Category H	Healer profile

Categorisation of this data source is presented below.

CATEGORY E	**CODES:**
SUBJECTIVE EXPERIENCE:	1. Monotonous

	2. Detached 3. Sense of timing 4. Irritation 5. Alienated 6. Pretentious 7. Excessive respect 8. Hierarchical 9. Self-conscious 10. Dragging 11. Repetitious 12. Unvaried melodic line 13. No pivot chords 14. No key changes 15. Impatience 16. Time wasted 17. Too long 18. Relief 19. Participation: ambivalence 20. Observing: ambivalence 21. Initial stimulation 22. Overload 23. Altered consciousness 24. Discomfort
COMMENTARY: This category looks at the group's experience as a whole, which is subjective. The overall feeling was that the proceedings carried on for too long and that the music did not have enough variety and was too repetitive which resulted in discomfort, an altered sense of consciousness, tiredness and questioning of the relevance of it all.	

CATEGORY F	**CODES:**
SOCIAL EXPERIENCE	25. Acceptance 26. Supportive 27. Generosity 28. Welcomed 29. Trusted 30. Hierarchical 31. Holding 32. Connected 33. Unburdened 34. Sleep/awake 35. Persevering 36. Carried along 37. Definite ending
COMMENTARY: This category illustrates how the group experienced the social context of the ceremony. The group experienced a sense of communality, inclusion and feeling welcome but with a lost sense of self.	

CATEGORY G	CODES:
MUSICAL PROFILE	38. Key 39. Musical structure 40. Singing 41. Variation 42. Internal structure 43. Lack of understanding 44. Implicit rhythm 45. Descending melodic line 46. Rhythm, organic 47. Cross-rhythms 48. Dance variety 49. Fixed roles 50. Definite leaders 51. Performance structure 52. Drumming directed 53. Hierarchical subgroups 54. Rigid structure 55. Choreographed
COMMENTARY: This category looks at what happened in the music as a product of the ceremony. There were definite roles assigned to drummers, dancers and singers. Although there were discernable musical structures, most of the melodic and rhythmic structures were implicit and not easily understood.	

CATEGORY H	**CODES:**
HEALER PROFILE	56. Leader 57. Magnetism 58. Timing 59. No boundaries 60. Dancer 61. Authority 62. Energises 63. Directing 64. Shifts energy 65. Establishes cohesion 66. Creates suspense 67. Arrival anticipated 68. Presence felt 69. Obedience 70. Increases energy
COMMENTARY: This category looks at the profile of the traditional healer. He has the ultimate power and commands respect and obedience from everyone. He has the authority to intervene at any time and his influence knows no boundaries. There is a sense of timing to his interventions which shifts the energy and effects increased participation from everyone.	

I now conclude the Data Analysis for this study and will discuss the emerging themes from Data source A and B in the following chapter.

CHAPTER 5 - DISCUSSION

The research questions for this study are:

- What are the experiences of time (duration) and repetition in both Modern Music Therapy and Traditional Music Therapy?
- What implications do these distinctive experiences have for the practice of Modern Music Therapy in South Africa?

Discussion of the second question is dependant on and flows from discussion of the first.

5.1. RESEARCH QUESTION I

What are the experiences of time (duration) and repetition in Modern Music Therapy and in African Traditional Ceremonies.

Three themes emerge from the analysis of Data Sources A and B presented in Chapter 4. These are:

- I. Meeting of World Views
- II. Feelings of Un-familiarity and Discomfort
- III. Tolerance, or Intolerance, of Differences

5.1.1. MEETING OF WORLD VIEWS

Pavlicevic (1997) reminds us that Music Therapists offer clients an understanding of who they are. This is achieved by engaging the client or group "where they are at", or meeting them in their own sense of being.

Data source A. shows that the therapist engaged the clients by initiated Turn-taking, moving in an anti-clockwise direction in response to members who started dancing after the Greeting song. This spontaneous dancing illustrates Arom's (1991) description of African music being a motor activity, almost inseparable from dance and that hearing music will often immediately give rise to movement of the body.

Turn-taking was structured as a repetitive activity in which each member was given a chance to respond according to their ability. The activity had an open structure which allowed members to take initiative. The length of this activity was significantly longer than anticipated through the presence of three additional members.

Category A (Group Participation) revealed that core members were initially unable to remain focused, showed signs of disorientation and played in an irregular pulse. This was evidenced in a decrease in tempo and longer durations of each individual turn. Delayed responses and a feeling of stuckness in a slow tempo, prompted the 'new' members to initiate a shift in energy through stable, sustained rhythmic patterns. This change offered support to core members, illustrating Ansdell's (1995) observations on the effects of new members on group dynamics. The tempo of 'new' members turns were significantly faster with shorter durations. The core members started, as each repetition progressed, to participate with increased energy, focus and body movement as they were supported by the 'new' members.

Although the therapist experienced the duration of the music as being too long and repetitive as a product of the group's responses (Category I of Session notes), Category C (Group Musical Profile) reveals that there were significant variations in tempo (118-138bpm), Key (C, C-sharp, D and E Major), Dynamic (Mezzo-forte to Fortissimo) and rhythm although the metre stayed the same throughout. In contrast, Category III (Musical Profile) of the Ceremony revealed little or no variation in key, rhythm, dynamic level or tempo and the structure was set. Unlike the therapy session, the duration of the ceremony was not set.

Fixed roles are assigned in the process of music-making in the Traditional Ceremony as shown in Category III (Musical profile) of Data source B. The dancers create the rhythm and tempo while the drumming sustains or increases the energy level. The roles of drummers and dancers were maintained throughout the ceremony and were not interchangeable.

Category IV (Healer profile) of the Ceremony shows the healer's role as the ultimate leader. His interventions have no boundaries and he alone was able

to alternate between drumming and dancing. His interventions displayed a sense of timing and he could shift the energy of the ceremony at will as a result of his position and obedience to him. There is thus a strong sense of direction and leadership in Traditional music-making. Roles are hierarchical according to members standing in the community.

In contrast, roles for participants in a clinical session are neither fixed nor defined according to social standing or position in the institution. When considering the members response and participation in Category A (Group participation) of the clinical session, one must acknowledge the fact that some members may not feel comfortable playing the drum as this role is restricted in certain communities. The presence of authority figures (Nurse I and II) seemed to have a marked influence on the participation of members in the session. In the light of the hierarchical structure of Traditional societies, it is possible that core members felt coerced into participating. From the graph (Figure 4.D.), it is clear that energy and participation shifted significantly in the turns of the authority figures and reached a climax in the turn of Nurse II (Turn VI). This could also be interpreted as the core members need for a more directive role and leadership. The authority figures possibly felt that the music was getting stuck as core members played in an irregular pulse. This slowed the tempo and they consequently made their presence felt by intervening and shifting the energy which increased participation.

This brings us to the role of the Modern Music Therapist which is to facilitate, observe how each member of the group copes, to listen, and to observe behaviour and interaction in the group (Bunt, 1994). Further tasks are to enable, to allow, to monitor, to guide, to lead, to follow, to hold etc (Pavlicevic, 2003). From the Data it is evident that there were moments where I was uncertain about how to intervene. This resulted in authority figures intervening in a leadership capacity. I found that I was influenced by the presence of authority figures from the same culture as that of the members. I felt that my role as therapist was insignificant. Category I (Subjective Experience) in the Session Notes, reveal feelings of being caught up as participant in the momentum of the activity and that my interventions

were restricted to key changes and selective prompting. This in turn could also be seen as fulfilling the role of facilitator, as opposed to leader, through enabling and following.

It is important to introduce differing world views of illness. In the Western World view, illness resides within a medical model. This is in stark contrast to an African view of illness which is regarded in terms of a Spiritual model. Maiello (1999) reminds us of the important role ancestors play in the concepts of healing and illness. A disturbance in the individual's relationship with their ancestors will result in illness. In this view, it therefore follows that healing can only occur through reconciliation with the ancestors, through the mediation of the Traditional Healer. As a result of Traditional African life being embedded in a collective existence (Maiello, 1999), the healing process requires the co-operation of the community, as the individual does not exist separately from the community.

The function of repetition in this context should be noted. Gregory (1997) points out that repeated rhythms serve to provide a calming and stabilising effect on patients. When used for an extended duration, this has the effect of strengthening a sense of community and connectedness. In contrast, Modern Music Therapists use repetition as a tool to create expectation and to engender feelings of comfort, reassurance and stability in clients through providing a sense of predictability (Bruscia, 1987). In this view, too much repetition negates the aims of providing a varied experience for clients (Pavlicevic, 1997) and is considered symptomatic of pathologies in client populations.

5.1.2. FEELINGS OF UN-FAMILIARITY AND DISCOMFORT

When we look at Category II (Social Experience) of the Traditional Ceremony, which illustrates the Student Group's experience, it is clear that the group noted a sense of support, holding, connectedness and community. Prolonged repetition gave rise to an experience of a lost sense of self. This lost sense of self lead to feelings of discomfort and unfamiliarity with a concept foreign to the Western frame of mind. The Student Groups discomfort and fatigue resulted in some members leaving the proceedings to go to sleep.

When we examine the social context of the Traditional Ceremony, which was communal, open and inclusive and compare this to the private and exclusive context of the Music Therapy session, we must consider the possibility that group members also experienced feelings of discomfort and unfamiliarity. The group was a semi-closed group which by implication excluded others. Although the aim of Group Music Therapy is to experience participation in a group, the size of the group is considerably smaller than groups in Traditional societies. There is thus a focus on each individual's behaviour within the group which does not exist in the Traditional setting. It is difficult to measure the members' expectations and/or experience of Music Therapy, but one wonders how much of their disorientation or unfocused participation in previous sessions, was as a result of their expectations of the Music Therapy process not being met. The focus on individuals within the smaller group might have engendered feelings of discomfort which in previous sessions resulted in members leaving the group. This can be compared to the Student Group's uncertainty about what was expected of them in the Traditional Ceremony (Category E, codes 9, 19 and 20).

Category A (Group Participation) of the clinical session, shows that there was only one movement out from the group, which was as a result of a member removing chairs. Compared to previous sessions, all members stayed within the circle for the duration of the activity. The larger group and the presence of authority figures from the ward, could also contribute to a greater sense of belonging. This category also revealed a greater sense of support and 'being carried' which is more inclusive and communal. This links to Bradt's (1997) comments that clients from traditional cultures value interdependence and social connectedness.

5.1.3. TOLERANCE, OR INTOLERANCE, OF DIFFERENCES

Blacking (1973) states that the duration and repetitive nature of Traditional music is generally determined by the specific social situation, the number of performers and by their musical ability. There is a direct correlation between the size of the group and the repetitive nature of the music.

When we examine Category III (Musical Profile) of the healing ceremony, there was a set structure of turn-taking with three drummers and three dancers, acting as patients, in each turn. Each turn lasted for a significant period accompanied by repeated drum rhythms.

When we look at Category I (Subjective experience) of the Traditional Ceremony, we note that there was an overall intolerance of the duration and repetitive aspects of the music experienced amongst the Modern Music Therapy Group. The relevance of the fixed, repetitive structure was questioned. This could be a result of a lack of understanding and experience of such events. This could also result from Western notions of duration and music which displays more variety and development as the music progresses. In Category III (Musical Profile), the Student group identified variation in the repetition, but stressed that this variation was insufficient according to their Western expectations. The experienced lack of variety lead to irritation, impatience and a sense of time wasted.

When comparing my experience of the Session (Category I, Session notes) to my analysis of the activity, certain disparities emerge. I experienced the activity as too long and repetitive but the data analysis reveals that there was significant variation within the repetition. (See Graphs 4.B. and 4.C.). The variation present did not seem to be sufficient to satisfy my Western perceptions of development and variety as experienced by the group in Category I (Subjective Experience) of the Ceremony.

5.2. RESEARCH QUESTION II

What implications do these distinctive experiences have for the practice of Modern Music Therapy in South Africa?

From the discussion of research question 1 in 5.1 above, it is clear that there are significant differences between Modern Music Therapy practices and Traditional Music Therapy. Music Therapy in South Africa has to take cognisance of these differences as therapy in this area spans both modern and traditional societies. The implications of these differences can be discussed in terms of the three identified themes.

5.2.1. MEETING OF WORLD VIEWS

Individual world views influence both behaviour and experience of others. As Modern Music Therapists may potentially come into contact with individuals and groups from differing cultures, it is important that some awareness of and respect for, clients' culture be cultivated. Although Roy (1999) points out that the goal of understanding of another culture may be utopian, Pavlicevic (1997) advocates familiarisation with the music of different cultures in order to gain an appreciation of the different energies embodied in that music.

MISINTERPRETING BEHAVIOUR AS PATHOLOGY

Bradt (1997) alerts us to the fact that by not being aware of cultural differences in our assessment of client responses, we risk misinterpreting behaviour as pathologies. Our assessments of clients' responses are used to formulate aims for the therapy process and if these assessments are inaccurate, our therapy may be inappropriate.

REACTION TO TIME BOUND EXPERIENCES

Where the Music Therapists perception of time is different to that of the client, a danger exists that the Therapist will become frustrated by the client's perceived lack of timekeeping. Similarly, the client may become frustrated with an insistence to adhere to clock time on the part of the Music Therapist. Pavlicevic's (2003) proposal of a re-evaluation of time-bound structures when working with African clients should be borne in mind and sessions should be planned with sufficient flexibility as to allow the music to 'sound and be sounded completely'.

RESPONSE TO REPETITION

Modern Music Therapists use repetition as a tool to establish an emotional climate and to elicit responses. The use of repetition by Traditional Music Therapists is different and assists in achieving group cohesion and producing a trance-like state. Modern Music Therapy aims to engage the client in the moment and not to alter consciousness. Clients familiar with Traditional Music

Therapy practices may misinterpret repetition in Modern Music Therapy sessions and expect to engage in a prolonged activity.

PROVIDING CLIENTS WITH A DIFFERENT EXPERIENCE

Clients from Traditional societies may be restricted by hierarchies that exist in their society. In such cases, Music Therapy affords a real opportunity for them to gain an experience outside the confines of their restricted social position.

5.2.2. FEELINGS OF UN-FAMILIARITY AND DISCOMFORT

In cross-cultural therapy, Modern Music Therapists will encounter situations where they are unfamiliar with either musical material or client responses. Music Therapists should not allow themselves to feel intimidated in such situations, but rather use the experience to build and strengthen the shared music. Pavlicevic (1999) sees this as an opportunity for the Therapist and Client to learn one another's cultures and create cultural norms within the therapy process.

By being flexible and open to learning from the client's cultural experience, Modern Therapists can be enriched by an appreciation of communality and an inclusive act of music-making.

5.2.3. TOLERANCE, OR INTOLERANCE, OF DIFFERENCES

Music Therapists need to cultivate an appreciation of the cultural differences they will experience in a South African context. At the same time, this should not be limited to the application of a fixed set of stereotypes. Stige (2002) proposes that Therapists should acknowledge the individuality of each client who exists as an entity in a continuum from individual, through the communal to the universal.

CHAPTER 6 - CONCLUSION

The purpose of this study was to describe the different experiences of time (duration) and repetition in a cross cultural context and to explore how these different experiences play a role when evaluating clients cross-culturally. The aim was to generate a deeper understanding and awareness of issues that may have to be taken into consideration when evaluating clients. My interest in this topic arose from my observation and participation in an overnight traditional ceremony and clinical work with a group of female patients from different backgrounds in a psychiatric setting. I realised that attempts to evaluate clients in this context could provide inappropriate results.

I used field notes from the overnight traditional ceremony and a video excerpt and session notes from a group session with female psychiatric patients as primary data sources for this qualitative study. All data was transcribed and coded in order to analyse the nature of both time and repetition in these contexts. The results of the data analysis were compared to Western perceptions of time and repetition and Modern Music Therapy practice in an attempt to identify common ground.

This study is limited by the inaccessibility of first-hand experience of both Traditional Music Therapy and Modern Music Therapy by clients from traditional cultures. Such observations cannot be made by individuals from outside this context.

I found that the aims, processes and practices of Traditional Music Therapy and Modern Music Therapy were far removed from each other and little, if any, commonality in perceptions of time and repetition existed. This however does not invalidate the practice of Modern Music Therapy with clients from traditional societies. What is required, however, is the development of a deeper understanding of the nature, implications and manifestations of traditional cultures in the context of Modern Music Therapy. We can learn from the vitality and inclusivity of African music and the healing role it plays in African societies. The development of a mutual understanding of each others cultures can provide a rewarding experience both for therapist and client.

APPENDIX A – CONSENT FORM

FACULTY OF HUMANITIES
MUSIC DEPARTMENT
TEL (012) 420-2316/3747
FAX (012) 420-2248

MUSIC THERAPY PROGRAMME
TEL (012) 420-2614
FAX (012) 420-4351

UNIVERSITY OF PRETORIA
UNIVERSITEIT VAN PRETORIA
PRETORIA 0002 SOUTH AFRICA

Date: ______________________

MUSIC THERAPY SESSIONS: PERMISSION TO RECORD

I ____, Chief Executive Officer of Weskoppies Hospital, Pretoria, give permission to video tape _______________________________________ of Ward ___ in Music Therapy sessions between January and November 2003 .

These recordings will be used for clinical, research and educational purposes as part of the students' music therapy training. This includes supervision sessions with their clinical supervisors, and as part of their clinical case study presentations for their examinations. I understand that visual and audio recordings of sessions are standard music therapy practice, enabling detailed analysis of the sessions in order to gain clinical direction to ongoing sessions. All efforts to protect patients' privacy and confidentiality will be adhered to, in line with professional ethical practice. At the end of the student's training, these tapes will form part of the training archives and will become the property of the Music Department, University of Pretoria. This material will not be distributed or sold. I understand that I can arrange to view / listen to the recordings should I so wish.

_______________________ Chief Executive Officer, Weskoppies Hospital

_______________________ NAME: ____________________, MMus (MT) Student

_______________________ Clinical Supervisor, MMus(MT) Training Programme

APPENDIX B – INDEXING OF VIDEO EXCERPT

PLACEMENT:	Weskoppies	THERAPIST:	Karen
CLIENT NAME:	Ward 36: Group	CO-THERAPIST:	Carol
SESSION No:	9	DURATION:	25 minutes
DATE:	7/04/03	PAGE No:	1

REAL TIME	INDEXING
11:52:38	**START: Duration: 2 minutes, 13 seconds**
	1. The therapist starts moving in a circle with woman following her in an anti-clockwise direction. (Anti-clockwise direction)
	2. The therapist starts singing Tu-le-le-le x6 (Directing, singing) in
	3. E major (key).
	4. The metre is in 4/4 (4/4 metre) and the
	5. tempo is at 126bpm (Tempo).
	6. Rose is not walking in time to the rest, her pace is slower which results in a gap between her and Nurse I. She holds onto chairs for support (Low energy, varied pace, unsteady).
	7. Nurse I moves in an energetic quick pace playing multiples of the beat on the Tambourine (High energy, quick pace, playing Tambourine).
	8. Mary moves at a slow pace and momentarily looses her balance. (Slow pace, low energy, unsteady).
	9. Nurse II moves with high energy and moves her arms from side to side. (High energy, arm movement).
	10. Sophie dances with high energy jumping from side to side and clicking her fingers.(High energy, jumping, clicking).
	11. Beauty moves at a slow pace, looking around. (Low energy, - distracted)
	12. Cherise moves at a slow pace, bending down to pick something off the floor. (Slow pace, unfocused).
	13. Beauty bumps into her and pushes her forward saying "Go". (bumping, irritation)

REAL TIME	INDEXING
11:52:51	**TURN 1: Duration: 15 seconds** 1. The therapist prompts the co-therapist to the middle. (Directing) 2. She makes her way through the chairs. (obstacle) 3. Her playing is in single beats and the tempo changes to 122 bpm. (playing, tempo change to 122 bpm). 4. Nurse I plays multiples of the beat on the Tambourine, moving with quick steps, singing. (Tambourine, quick pace, singing). 5. Nurse II moves with high energy and starts dancing and singing. (High energy, dancing, singing) 6. Cherise moves in a slow pace, without singing. (Low energy, no singing) 7. Rose walks in a slow pace, still touching a chair here and there without singing. (Low energy, unsteady) 8. Mary walks in a slow pace, without singing. (Slow pace, no singing) 9. Sophie dances, moving her hips energetically, singing. (High energy, dancing, hip swaying, singing). 10. Beauty walks with varying pace, looking around. (Varied pace, distracted) 11. The direction of movement stays the same. (Same direction) 12. The key of E major is sustained. (No key change)

REAL TIME	INDEXING
11:53:06	**TURN II: Duration: 16 seconds** 1. The key, direction and metre stay the same. (Same direction, key, metre) 2. The Therapist prompts Rose to the middle. (Directing) 3. She does not move to the circle immediately (Delayed response) and 4. Nurse I touches her shoulder and moves her forward. (Support) 5. She finds her way through the chairs. (Obstacle) 6. She plays in an irregular pulse. (irregular pulse) 7. The tempo slows down to 118 bpm. (Tempo change, 118 bpm) 8. Mary starts clicking her fingers while walking, without singing. (Clicking, walking, no singing) 9. Cherise walks at an uneven pace without singing. (Varied pace, no singing) 10. Beauty walks with low energy, looking around. (Low energy, unfocused) 11. Sophie dances with high energy, singing. (High energy, dancing, singing) 12. Nurse I continues playing multiples of the beat on the tambourine, dancing and singing. (Tambourine, dancing, singing) 13. Nurse II dances moving her arms and clicking her fingers. (Dancing, high energy, arm movement, singing).

REAL TIME	INDEXING
11:53:22	**TURN III: Duration: 18 seconds** 1. The therapist changes the key to C major. (Key change) 2. The therapist prompts Mary to the middle. (Directing) 3. Rose does not leave the middle when Mary starts playing. (Delayed response, disorientation) 4. Mary's playing is regular and she plays multiples to the beat. (Rhythm change) 5. The tempo remains at 118 bpm and in 4/4 metre. (No tempo, no metre change) 6. Nurse I moves to the inside and touches her Rose's shoulder motioning her to leave the middle. (support) 7. Rose starts walking at a quicker pace, without singing. (increased pace) 8. Nurse I continues playing the tambourine, dancing and singing. (Tambourine, dancing, singing) 9. Nurse II dances with high energy, singing. (High energy, dancing, singing) 10. Beauty walks without much interest, looking around. (Low energy, distracted) 11. Cherise walks without focus and bumps into Sophie. (Unfocused, bumping) 12. Sophie starts stacking the chairs with the help of the co-therapist and Beauty. (Initiative, stacking chairs) 13. Beauty leaves the circle to remove the chairs. (Movement out) 14. Sophie dances energetically while singing. (High energy, dancing, singing)

REAL TIME	INDEXING
11:53:40	**TURN IV: Duration: 16 seconds** 1. The key is still in C major. (no key change) 2. The group starts harmonizing. (harmonizing) 3. Sophie moves to the middle of the circle without prompting. (No prompting, initiative) 4. She plays a dotted rhythmic pattern (Rhythm change) and the 5. tempo increases to 126 bpm.(Tempo increase, 126 bpm) 6. Cherise walks at a faster pace and with increased energy. (increased energy) 7. Nurse II starts clapping, while singing. (clapping, singing) 8. Beauty returns to the circle and walks at a faster pace and starts to dance. (Movement back, increased energy, dancing) 9. Nurse I continues playing multiples of the beat, dancing and singing with high energy. (Sustained playing, dancing, singing) 10. Mary starts walking in a faster pace, singing. (Increased energy, singing).

REAL TIME	INDEXING
11:53:56	**TURN V: Duration: 16 seconds** 1. The Therapist changes the key to C# Major. (Key change) 2. There is a moment of hesitation on prompting from the therapist and (Delayed directing) 3. Nurse I moves to the middle of the circle without prompting. (initiative) 4. Beauty moves to the middle with Nurse I who tells her to go back. (obstruction, reprimanding) 5. Nurse I plays a regular, dotted rhythmic pattern. (sustained rhythm) 6. The tempo increases to 132 bpm. (Increased tempo, 132 bpm) 7. Rose walks , being carried by the movement in the group. (support) 8. Cherise loses direction and moves on the inside of the circle. (Disorientation) 9. Mary walks with increased energy, swaying her hips. (Increased energy, swaying hips) 10. Nurse II dances with a definite step with high energy, singing. (Dance step, sustained high energy, singing) 11. Beauty's energy increases and she dances while singing. (Increased energy, dancing, singing)

REAL TIME	INDEXING
11:54:12	**TURN VI Duration: 13 seconds** 1. Nurse II moves to the middle of the circle without being prompted. (No directing, initiative) 2. She plays the same dotted rhythmic pattern as Nurse I. (Sustained rhythm) 3. The tempo increases to 138 bpm. (Tempo increase, 138 bpm) 4. She moves her body energetically while playing. (Body movement, High energy) 5. The group starts harmonizing in the same key. (No key change, harmonizing) 6. Rose starts clapping and walks with increased energy. (Increased energy, clapping) 7. Mary starts dancing, clapping and singing. (Increased energy, dancing, clapping, singing) 8. Cherise increases her pace, swaying her hips. (Increased energy, hip swaying) 9. Sophie jumps from side to side, clicking her fingers and singing loud. (Jumping, clicking, loud singing) 10. Beauty dances with increased energy, singing. (Increased energy, dancing, singing) 11. Nurse I sustains her energetic dancing and clapping and singing. (Sustained high energy, dancing, clapping, singing).

REAL TIME	INDEXING
11:54:25	**TURN VII: Duration: 30 seconds**
	1. The Therapist changes the key to D major (Key change) and
	2. prompts Beauty to the middle. (Directing)
	3. She does not move to the centre (Delayed response) and is
	4. motioned to the middle by the co-therapist. (support)
	5. There is a moment of confusion as the pace is disturbed. (Disturbed flow)
	6. There is a break in singing. (Break in singing)
	7. Her playing is irregular to the pulse (irregular pulse, stuck) and the
	8. tempo decreases to 126 bpm. (Tempo decrease, 120 bpm).
	9. Rose is walking at a slow pace, which results in Nurse I behind her touching her shoulders motioning her forward. (Low energy, support)
	10. Rose sings for the first time, clapping her hands. (singing, clapping)
	11. Mary is walking at a slow pace with big steps. (slow pace)
	12. Cherise walks with low energy. (Low energy)
	13. Nurse I starts walking at a slow pace, without other body movement. (Decreased energy)
	14. Nurse II clicks her fingers walking at a slow pace. (Clicking, slow pace)
11:54:55	15. Sophie stops dancing and walks in a slow pace, singing. (Decreased energy, singing)
	16. The therapist motions everyone to stop and asks if everyone has had a turn. (Directing, stop)

APPENDIX C – GROUP THERAPY CODING

START:	
DURATION:	13 seconds

1. Anti-clockwise direction
2. Directing, singing
3. Key: E major
4. Metre: 4/4
5. Tempo: 126 bpm.
6. Low energy, varied pace, unsteady
7. High energy, quick pace, playing Tambourine
8. Slow pace, low energy, unsteady
9. High energy, arm movement
10. High energy, jumping, clicking
11. Low energy, distracted, unfocused
12. Slow pace, unfocused
13. Bumping, irritation

COMMENTARY:
There is a disparity in energy ranging from low to high. Pace and movement are varied, ranging from walking, jumping, dancing and clicking fingers. Some members are moving at a focused, quick pace while others are moving at a slow, irregular pace. The uneven pace results in pushing and irritation from some members.

TURN I:	Co-Therapist
DURATION:	15 seconds

1. Directing
2. Obstacle
3. Playing, tempo change to 122bpm
4. Tambourine, quick pace, singing
5. High energy, dancing, singing
6. Low energy, no singing
7. Low energy, unsteady
8. Low energy, slow pace, no singing
9. High energy, dancing, hip swaying, singing
10. Varied pace, distracted
11. Same direction
12. No key change

COMMENTARY:

The direction stays the same with the therapist directing. Chairs are an obstacle which prolongs the duration. The key and metre remains unchanged. Although the tempo and energy increase, there is still a disparity between low energy, slow pace and high energy, quick pace. There is less body movement ranging from walking to dancing with hip-swaying. There is a change in dynamic as a result of increased singing.

TURN II:	Rose
DURATION:	16 seconds

1. Same direction, key, metre
2. Directing
3. Delayed response
4. Support
5. Obstacle - chairs
6. Irregular playing
7. Tempo decrease to 118 bpm
8. Clicking, walking, no singing
9. Varied pace, no singing
10. Low energy, unfocused
11. High energy, dancing, singing
12. Tambourine, dancing, singing
13. Dancing, high energy, arm movement, singing

COMMENTARY:

The direction, metre and key remains the same. The therapist directs initially. A delayed response causes Nurse I takes initiative in prompting. The delayed response affects a decrease in tempo, which prolongs the duration. There is still a disparity in energy and movement ranging from walking to dancing and arm movement.

TURN III:	Mary
DURATION:	18 seconds

1. Key change
2. Directing
3. Delayed response, disorientation
4. Rhythm change
5. No tempo/metre change
6. Support
7. Increased pace
8. Tambourine, dancing, singing
9. High energy, dancing, singing
10. Low energy, distracted
11. Unfocused, bumping
12. Initiative, stacking chairs
13. Movement out
14. High energy, dancing, singing

COMMENTARY:

The direction and metre stays the same. As the group seems to get stuck at one point, members take initiative in removing the chairs from the circle. There is an increased sense of energy although some members still appear to be unfocused and distracted. The dynamic is getting louder as there is increased singing. There is a key change and the tempo is sustained.

TURN IV:	Sophie
DURATION:	16 seconds

1. No key change
2. Harmonising
3. No prompting, initiative
4. Rhythm change
5. Increased tempo at 126 bpm
6. Increased energy
7. Clapping, singing
8. Movement back, increased energy, dancing
9. Sustained playing, dancing, singing
10. Increased pace, singing

COMMENTARY:

The direction, metre and key stays the same. There is no directing as a member takes initiative in moving to the centre. She changes the rhythm to a dotted rhythmic pattern. The tempo increased and as a result, the duration is shorter. There is increased energy and movement from all members. Increased singing and harmonising results in a louder dynamic. Movements range from walking in a quick pace, clapping, and dancing.

TURN V:	Nurse I
DURATION:	16 seconds

1. Key change
2. Delayed directing
3. Initiative
4. Obstruction, reprimanding by member
5. Sustained rhythm, sustained energy
6. Increased tempo at 132bpm
7. Support
8. Disorientation
9. Increased energy, swaying hips
10. Dance step, sustained high energy, singing
11. Increased energy, dancing, singing

COMMENTARY:

The direction and metre stays the same and the therapist changes the key. There is a moment of hesitation in directing and Nurse I takes initiative moving to the centre. Beauty moves to the centre with Nurse I who sends her back. Nurse I sustains a dotted rhythmic pattern and the tempo increases which effects a shorter duration. There is sustained movement and energy from most members while one member moves in a disorientated manner.

TURN VI:	Nurse II
DURATION:	13 seconds

1. No directing, initiative
2. Sustained rhythm
3. Sudden tempo increase to138 bpm
4. Body movement, sustained high energy
5. No key change, harmonising
6. Increased energy, clapping
7. Increased energy, dancing, clapping, singing
8. Increased energy, hip swaying
9. Jumping, clicking, loud singing
10. Increased energy, dancing, singing
11. Sustained high energy, dancing, clapping, singing

COMMENTARY:

The direction, metre and key stays the same. Nurse II takes initiative moving to the centre, without directing. The tempo increases which effects a shorter duration. There is an overall sense of high energy. There is increased movement from all members and harmonizing results in a loud dynamic which reaches a climax as five members are singing and four members are clapping.

TURN VII:	Beauty
DURATION:	30 seconds

1. Key change
2. Directing
3. Delayed response
4. Support
5. Disturbed flow
6. Break in singing
7. Playing, stuck in irregular pulse
8. Tempo decrease to 120 bpm
9. Low energy
10. Singing, clapping
11. Slow pace
12. Low energy
13. Slow pace, decreased body movement
14. Clicking, slow pace
15. Slow pace, walking, singing
16. Directing: End

COMMENTARY:
The direction and metre stayed the same. The therapist directed a key change and prompted Beauty to play. Her delayed response prompted the Co-therapist to direct her to the centre. There is a disruption in flow and a break in singing. There is an overall sense of low energy. The tempo slows down and the dynamic level becomes softer as only 2 members are singing. The therapist directs members to stop and asks if everyone has had a turn.

APPENDIX D – CODED GROUP THERAPY SESSION NOTES

PLACEMENT:	Weskoppies	THERAPIST:	Karen
CLIENT NAME:	Ward 36: Group	CO-THERAPIST:	Carol
SESSION No:	9	DURATION:	25 minutes
DATE:	7/04/03	PAGE No:	1

1.	We had 3 extra members in the group today. (Increased Membership)
2.	All three members had high energy. (Increased energy)
3.	This changed the dynamics of the group significantly, I felt the energy was too high , too soon. (Changed dynamic)
4.	We normally have 4 members and 2 therapists. (Increased membership)
5.	The ratio of energy is normally 4:2, today it was 7:2. (Energy imbalance)
6.	I felt that the extra three members were making the group too big, we were 9 in total. (Too large)
7.	Turn-taking forms an important part of this group as one of our aims are to give members an opportunity for leadership and self-expression. (Aims: Leadership, self-expression)
8.	Turn-taking in today's context just kept on for too long. . (Too long)
9.	It took much longer to give each person a turn. . (Too long)
10.	The idea of forming a circle is normally fine, but today it became too tedious, going round and round. . (Spinning effect)
11.	I felt it was hard to control the activities. . (Loss of control)
12.	I was just swept along by what was happening. . (Carried along)
13.	I felt that the only intervention that I could offer was a change of key. (Limited intervention)
14.	Is this not part of negotiation and allowing? . (Questioning)
15.	I was exhausted after the session. (Exhaustion)

CODING OF SESSION NOTES
1. Increased membership
2. Increased energy
3. Changed dynamic
4. Increased membership
5. Energy disparity
6. Too large
7. Aims: Leadership, self-expression
8. Too long
9. Too long
10. Spinning effect
11. Loss of control
12. Carried along
13. Limited intervention
14. Questioning
15. Exhaustion

APPENDIX E – DATA SEGMENTING OF FIELD NOTES

1.	It went on and on.	Monotonous
2.	What happens to time? Feels stupid wearing a watch.	Detached
3.	Timing: everything happens when it happens.	Timing
4.	Irritation: sitting in bus waiting.	Irritation
5.	Going on and on for us, for them: meant with sincerity (alien for us), our lives are not at this pace.	Alienated
6.	Person with microphone talking as long as possible, long and pretentious.	Pretentious
7.	Too much respect paid to people, foreign concept.	Excessive respect
8.	Different hierarchy than we know.	Hierarchical
9.	Our position experienced as us having to behave, "being on stage.	Self-conscious
10.	Slow pace and concept of time.	Dragging
11.	12:30 am: Same rhythm and tempo on drum all the time.	Repetitious
12.	Same descending melodic line $5^{th}/6^{th}$.	Unvaried melodic line
13.	Pivot chords please.	No pivot chords
14.	Wishing they would change key.	No key changes
15.	2:30 am: Had enough. Want to go home. We've seen the range, why go on.	Impatience
16.	What we really went for only started at midnight.	Time wasted
17.	Speeches went on and on.	Too long
18.	Good to come out.	Relief

19.	Didn't want to join, felt intrusive, but everyone did and it then felt a bit better.	Participation ambivalence
20.	But it also felt silly just to stand and watch.	Observing: ambivalence
21.	Drumming and rhythm initially catching and kept me interested.	Initial stimulation
22.	Later on the repetition irritated me and was much too long.	Overload
23.	Being in another dimension.	Altered consciousness
24.	Taken to edge of personal discomfort.	Discomfort
25.	Enveloped/felt carried, embraced.	Acceptance
26.	Whole community gathering round the "affected person.	Supportive
27.	All people are welcomed and given food.	Generosity
28.	Real sense of being welcomed.	Welcomed
29.	We were invited in their sacred space.	Trusted
30.	Definite roles: Program-coordinator, interpreter, healer, host.	Hierarchical
31.	Woman behind me led me moving, holding my hips.	Holding
32.	Dancing in circle, loose sense of self as all move together.	Connected
33.	Experience of letting go, letting someone else deal with it.	Unburdened
34.	5:55 am: Group split: some slept, some stayed – observed and participated on behalf of everyone.	Sleep/awake
35.	Trance, not very intense and intensity doesn't change much, people just going.	Persevering
36.	Good-bye song/dance felt like being in a sea of moving people.	Carried along

37.	Definite ending ritual, saying good-bye, thanking us.	Definite ending
38.	Pentatonic.	Key
39.	Cyclical.	Musical structure
40.	Chant-like.	Singing
41.	Tone/style sounds the same, but not only one song.	Variation
42.	Accented vocalizations from individuals. Are they random, who made them and why?	Accents
43.	Points that we didn't perceive were clearly indicated as they all moved and changed together.	Internal structure, lack of understanding
44.	The rhythm was part of the texture, it came out of the people there.	Implicit rhythm
45.	Melodies always descending.	Descending melodic line
46.	Feet movements creating the rhythm.	Rhythm, organic
47.	Walking and playing in cross-rhythms, at times the rhythms coincide with walking.	Cross-rhythms
48.	Not always doing same steps.	Dance variety
49.	Specific Roles: drummers and dancers.	Fixed roles
50.	Starting: either someone hums or woman on left started.	Definite leaders
51.	Structure: 3 drummers, everyone singing, locus: 3 dancers.	Fixed structure
52.	Drumming changed, the energy level increased.	Directed drumming
53.	Subgroups determined by order in which you were called to become a healer.	Hierarchical sub-groups

54.	Moment when one lady was praise singing, left drummer began playing, middle drummer looked at her and told her to stop.	Rigid structure
55.	Dancers determine tempo and rhythm to a certain extent.	Choreographed
56.	Simon, grand master, everyone obeyed him.	Healer: leader
57.	Has the presence and the power.	Magnetism
58.	The interpreter said that Simon was waiting until the music/time was right.	Timing
59.	He even drummed at one stage when the woman didn't drum enthusiastically enough.	No boundaries
60.	Simon joined dancers, have a presence about him.	Dancer
61.	Called everyone to dance.	Authority
62.	Energy changed and built up.	Energising
63.	2pm: Group energy flagging:	
	Simon steps in, begins to "drive" the music.	Directing
64.	Takes the energy and shifts it.	Shifts energy
65.	The group's singing intensifies- until the male dancers are cohesive and have "upped" their dancing.	Establishes cohesion
66.	He continues to drive the energy of the group until others rise and join the large circle. Conducts and also stopped the music.	Creates suspense
67.	8am: Four woman who were healers started dancing and "revved up the energy for Simon's arrival.	Arrival anticipated
68.	Simon joined dancers, have a presence about him.	Presence
69.	Called everyone to dance.	Obedience
70.	Energy changed and built up.	Increases energy

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