Mini-Dissertation submitted in partial fulfilment of the requirements for the degree of MMus (Music Therapy)

Community music therapy as a resource for persons living with HIV/AIDS

Christine Joubert

28492448

Department of Music

Faculty of Humanities

University of Pretoria

Supervisors:

Ms Andeline Dos Santos

Prof Mercédès Pavlicevic

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ABSTRACT

This study explored community music therapy as a psychosocial resource for persons living with HIV/AIDS at a clinic in Tshwane, South Africa. The role of community music therapy and its implications in South Africa were addressed as a second aim. A review of the literature on HIV/AIDS suggested that Sub-Saharan Africa has the most reported cases of HIV/AIDS and that persons living with HIV/AIDS may experience a lack of psychosocial resources. These psychosocial resources included inter- and intrapersonal attributes, positive mood and feelings of well-being. The data emerged from transcription of audio and video excerpts of community music therapy sessions, which included live music making and informal interviews during sessions at an HIV/AIDS clinic. These excerpts were transcribed as thick descriptions, coded and categorized to answer the research questions. The four categories were discussed as themes and supported community music therapy as a psychosocial resource for persons living with HIV/AIDS. In the broader South African context, community music therapy is a viable, inexpensive and valuable approach to re-establish community and facilitate psychosocial resources for persons living with HIV/AIDS.

Keywords:

Psychosocial resources, resources, HIV/AIDS, South Africa, community music therapy, music therapy, community, roles, music making,

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CHAPTER ONE

INTRODUCTION

As part of my training as a music therapist, I facilitated music therapy sessions for persons living with HIV/AIDS at a clinic in Tshwane, South Africa. The community at the HIV/AIDS clinic includes persons with an HIV/AIDS diagnosis, the staff, volunteers and music therapy students. It is estimated that between 5.8 and 6.2 million South Africans are infected with HIV (Visser & Mundell, 2008: 66). An HIV/AIDS diagnosis may constitute a serious life crisis which may lead a person living with HIV/AIDS to make use of health and coping resources (Visser & Mundell, 2008: 66).

1.1 Background and context

The music therapy project at the clinic was the initiative of a Christian organisation. Three student music therapists conducted sessions once a week at the clinic, two of which were in an enclosed room, and one of which was an outside group session, occurring in the waiting area of the clinic. As most patients attending the clinic only see the doctor every two months, many only attended one music therapy session. The sessions lasted between 40 minutes and an hour and included spontaneous and structured drumming, singing and percussive improvisations and dancing. Anyone was welcome to participate and thus the music therapists facilitated open groups consisting of staff, patients and volunteers. Through the experiences I had had during the music therapy sessions and through observing the people at the clinic my interest was sparked in how community music therapy could be used as a psychosocial resource for persons living with HIV/AIDS.

Music is described as a cultural activity that may be utilized as a health resource (Rolvsjord, Gold & Stige, 2005: 2). It is the belief of the researcher that people may be empowered by being part of a musical community, interacting in "normal" social and cultural ways. Through participating in group music making, people can interact, relax, de-stress and have fun. Drawing on such experiences may have a positive influence on one's attitude towards life, overall well-being and it may even have positive physiological reactions that will further improve health. Such group music making may encourage persons living with HIV/AIDS to take on a positive approach to their illness. Through the work at the clinic, I observed these positive experiences that resulted from music making, and this then prompted my further interest in this research.

Community music therapy is an approach to working musically with people in context and it acknowledges the social and cultural factors of their health, illness, relationships and musics (Ansdell, 2002: 10). Community music therapy resonates with a philosophy of

empowerment; and this fact has been established by quite a few researchers (Procter, 2001; Rolvsjord et al, 2005). Their philosophy of empowerment implies that a person can take charge of his or her life once again and move towards a state of overall wellbeing by being empowered. The proposed study aims to build on this notion by carefully conducting a detailed analysis of excerpts of community music therapy sessions and exploring the perspectives of persons living with HIV/AIDS.

1.2 Definition of terms

Psychosocial resources are defined by Harber, Einev-Cohen and Lang (2008: 296) for the purposes of this study as the following: interpersonal assets (social networks, social support), intra-personal attributes (self-worth, personal control and optimism), belief systems that provide meaning, order and fairness, and transitory affective states (positive mood and feelings of wellbeing).

Community music therapy is a relatively new, yet still debated, concept in the profession of music therapy, and for the purposes of this study, a definition by Ansdell (2002: 10-11) and Stige (2002: 2), will be utilised: community music therapy is a context-based and music-centred approach, thus viewing the activity of music-making as a social and cultural practice and a natural agent of health promotion (Ansdell, 2002: 11).

1.3 Aims

The aim of the study was to investigate how community music therapy might be used as a psychosocial resource for persons living with HIV/AIDS at a clinic in Tshwane, South Africa. The exploration aimed to influence the future of community music therapy at the HIV/AIDS clinic. It also aimed to contribute to informing other community music therapy projects at similar institutions around South Africa.

1.4. Research questions

The study aims to answer the following questions:

- Main research question:
    - How can community music therapy be a psychosocial resource for persons living with HIV/AIDS who attend a clinic in Tshwane?
- Sub-question:
    - What are the implications of this for understanding the role of community music therapy in South Africa?

1.5 Structure and outline of the mini-dissertation

The study aims to discuss community music therapy as a psychosocial resource for persons living with HIV/AIDS. The rest of the study consists of five more chapters. In Chapter Two, literature related to psychosocial resources and HIV/AIDS are discussed. Community music therapy is explored as a possible psychosocial resource. The methods and procedures utilized in this study are discussed in Chapter Three. Chapter Three reflects the design of the study and the procedures followed. Audio and video excerpts are transcribed as thick descriptions in Chapter Four and analysed accordingly. Chapter Five is a discussion of the analysis in relation to the relevant literature researched in order to answer the research questions. In Chapter Six, I provide a conclusion to my findings and suggest a few recommendations for future research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This study examines community music therapy as a psychosocial resource for persons living with HIV/AIDS. From previous research, it has become evident that HIV/AIDS is one of the most complex and mystifying social challenges faced by contemporary society (Visser, Makin & Lehobye, 2006: 42).

Persons living with HIV/AIDS are not only affected on a physical level but also on a psychosocial level. Both physical and psychosocial factors influence overall health. According to Visser, Mundell, De Villiers, Sikkema and Jeffrey (2005: 334), the psychosocial consequences of living with an HIV diagnosis can outweigh the physical effects. Of these psychosocial factors, the stigma and discrimination are well-documented phenomena that hamper the quality of life for persons living with HIV/AIDS in Africa (Genberg, Hlavka, Konda, Maman, Chariyalertsak, Chingono, Mbwambo, Modiba, Van Rooyen & Celentano, 2009; Campbell, Nair, Maimane and Nicholson, 2007; Visser et al., 2005; Skinner & Mfecane, 2004). In addition, lack of social support strongly correlates with the stigma, discrimination and fear (Uwimana & Struthers, 2007; Gaede, Majeke, Modeste, Naidoo, Titus & Uys, 2006; Visser et al., 2005).

This study describes community music therapy as a psychosocial resource for persons living with HIV/AIDS. Community music therapy is a music-centred approach concerned with the context and the culture of a community. In the South African context, community music therapy may offer a viable and inexpensive alternative approach, as it happens where the people are and it reflects everyday activities. This study considers community music therapy in a particular South African community that has been affected by the HIV/AIDS epidemic, and it examines its usefulness in this context.

The following section identifies research concerning psychosocial resources in general, and then explores the literature on psychosocial resources, particularly in the context of HIV/AIDS and the role that such resources might play in combating ill health. This is followed by a discussion on why community music therapy may be considered a psychosocial resource for persons living with HIV/AIDS.

2.2 Psychosocial Resources

American social psychologists, Harber et al (2008: 296) recognize psychosocial resources as the following:

1. Interpersonal assets (social networks, social support),
2. Intra-personal attributes (self-worth, personal control and optimism),
3. Belief systems that provide meaning, order and fairness, and
4. Transitory affective states (positive mood and feelings of wellbeing).

Holahan and Moos (1990 in Harber et al, 2008: 298) state that a central feature of psychosocial resources is that they reduce negative arousal, especially stress. Carels, Baucom, Leone and Rigney (1998: 145) concur with the above, as they refer to psychosocial resources as those resources that include social support (social networks) and coping, in their study of the association between psychosocial factors and psychological symptoms in a HIV-positive sample population.

2.2.1 Psychosocial resources and HIV/AIDS

Sub-Saharan Africa has two-thirds of the total number of people living with HIV/AIDS in the world (Banyini, 2007: 711). Southern Africa continues to be a part of the continent that is worst affected (Banyini, 2007: 711). According to Uwimana and Struthers (2007: 576), HIV/AIDS is a threatening pandemic that has eroded many lives and affected the growth and development of many countries, especially in Southern Africa.

Carels et al. (1998: 146) state that persons living with HIV/AIDS experience psychological stress, as well as life stress, and they identify three psychosocial factors that influence the quality of life of persons living with HIV/AIDS. These factors take into account:

- Life stress that a person experiences;
- The coping behaviours that the affected person engages in; and
- The person's perceived availability of social resources (Carels et al., 1998: 147).

The subjects that Carels et al. (1998: 146) studied included members of an HIV/AIDS community: African-Americans, injecting drug users, heterosexuals and women from poor, demographically diverse areas. The researchers found lower perceived support and greater unsupportive interactions to be associated with greater life stress and coping behaviours (Carels et al., 1998: 160).

Park and Folkman (1997: 424) identified psychosocial resources in the context of HIV/AIDS as:

- Social support,
- The quality of the dyadic relationship,
- The perception of positive meaning in care-giving,
- Spirituality, and
- Optimism.

Park and Folkman (1997: 423) studied the effects of care-giving and bereavement on psychosocial resources of the HIV-negative or HIV-positive partners of men living with HIV/AIDS. Their findings suggest that a diagnosis of HIV/AIDS places significant distress and additional demands on a person's psychosocial resources (Park & Folkman, 1997: 424). This study identified psychosocial resources, although the researchers were mostly concerned about the effects on the *partners* of men living with HIV/AIDS. However, according to the researchers, this is the first study to identify psychosocial resources and how these are affected in care-giving and bereavement.

According to Harber et al. (2008: 296), psychosocial resources strengthen people when they are faced with adversity, and these resources promote their adaptive response to challenges. Harber et al. (2008: 297) studied how psychosocial resources influence the way people, *perceive* negative events. The researchers aimed to evaluate how a person experiences extreme difficulty even with momentary feelings of belonging, support or social acceptance. Findings suggest that psychosocial resources moderate the perception of negative stimuli. Thus, Harber et al. (2008: 297) maintain that people with:

- more social support,
- greater feelings of urgency,
- more robust belief systems and other resources,

will be able to cope better with physical illness, job loss, bereavement, depression and other stressors.

The following section describes the process of stigmatisation as the most devastating psychosocial consequence of HIV/AIDS. Feelings of fear and discrimination are considered to be part of the stigmatisation process.

2.2.2 Stigma as a psychosocial consequence

Stigma is considered to be one of the main reasons why persons do not wish to know their HIV status, do not protect themselves and others from the virus, do not go for treatment and do not care for and support people living with HIV/AIDS (Visser et al., 2006: 43). The process of stigmatisation disempowers the person by highlighting the differences and reducing the stigmatized group or person's social status and sense of self-worth (Skinner & Mfecane, 2004: 158). Health-related stigma is defined by Weiss, Ramakrishna and Somma (2006 in Genberg et al., 2009: 2279) as "a social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation that results from an experience, perception or the reasonable anticipation of an adverse social judgement about a person or a group". A diagnosis of HIV/AIDS is accompanied by the challenges of stigma, discrimination and fear (Visser et al., 2006: 42). Skinner and Mfecane (2004: 158) identify four components of stigma:

1. Labelling differences,
2. Associating human differences with negative attributes,
3. Separating "us" from "them", and
4. Status loss.

In their study, Skinner and Mfecane (2004: 158) suggest that stigma and discrimination play significant roles in the development and maintenance of the HIV/AIDS epidemic. Through analysis of the scientific literature in South Africa between 2001 and 2004, they indicate that stigma undermines personal identity and the capacity to cope with the disease (Skinner & Mfecane, 2004: 160). Kalichman (2004 in Skinner & Mfecane, 2004: 161) states that persons living with HIV often feel isolated, guilty, dirty and full of shame, which is incorporated into their personal identity, and thereby restricts their participation in the activities of life.

In a study in two townships in Tshwane, South Africa, Visser et al. (2005: 334) report that women living with HIV need support to cope with their HIV status, especially when living in a stigmatizing community. Visser et al. (2005: 335) made use of formative evaluations and the process notes of facilitators, as well as the experiences of participants at two township clinics in Tshwane, South Africa. The study aimed to describe the process of developing structured support groups for women with HIV/AIDS. According to previous research, low perceived social support causes significant emotional distress and depression among HIV-positive persons, as reported by an American professor of clinical medicine and epidemiology, W. El-Sadr in 2001, and community psychologist, S.C. Kalichman in 2003 (in

Visser et al., 2005: 335). Visser et al. (2005: 335) added to these findings and concluded that *perceived* social support is more important in the psychological wellbeing of a person than the actual availability of such support. Visser et al. (2005: 335) also report that individuals that are involved in social networks live longer than those with fewer social contacts.

Campbell et al. (2007: 404) agreed that stigma is one of the biggest consequences undermining the prevention and care of persons living with HIV/AIDS. Campbell et al. (2007: 404) conducted a study in response to previous findings that indicated stigma as the leading factor, to undermine the abilities of individuals, their families, and their societies, to protect themselves from HIV and to provide care for those affected by HIV/AIDS. Campbell et al. (2007: 404) attempted to understand the causes of HIV/AIDS-related stigma. Persons from two rural South African communities in Kwazulu-Natal were asked open-ended questions through interviews and focus groups, to elicit understandings of the local response to HIV/AIDS. Findings suggest that various forms of HIV/AIDS-related stigma exist in different settings, such as:

1. in families,
2. with neighbours,
3. with health workers (such as those working in hospitals and clinics),
4. with teachers,
5. from members of religious organisations, and
6. from members of the community.

It is evident from this study that HIV/AIDS-related stigma are present in all factors of daily life. Campbell et al. (2007: 414) recommend that the starting point to facilitate local community responses to stigma should involve the provision of social spaces where people can collectively “work through” their doubts and uncertainties. Further results of their study have indicated that stigmatisation is the most acute in conditions of poverty. In the context of poverty and disempowerment, the researchers report that many persons lack access to resources that might boost their self-esteem (Campbell et al., 2007: 413). These findings are linked to identity theory: when the core of the identity is the categorisation of the self as an occupant of a role, and the incorporation into the self of the meanings and expectations associated with that role and its performance.

2.2.3 Identity theory

Identity theory deals with the components of a structured society, where persons recognize each other and themselves as occupants of roles (Stetts & Burke, 2000: 5). The core of

identity is the categorisation of the self as an occupant of a role and the expectations associated with that role form a set of standards that guide behaviour (Burke, 2001 in Stetts and Burke, 2000: 5). Identity theory encompasses a meaningful relationship between persons and things to incorporate the concept of resources as the central component in identity processes (Freese & Burke, 1994 in Stetts & Burke, 2000: 6). Therefore, identity theories recognize that the individual views himself or herself in terms of the meanings imparted by a structured society.

In the context of HIV/AIDS, a person is labelled as a result of their diagnosis. When a person is labelled, Howard Becker (1963: 80) suggests that the most important consequence is a drastic change in the person's identity. Identity theory further suggests that human beings have the fundamental need for positive self-esteem (Hogg & Abrams, 1988 in Campbell et al., 2007: 413). Persons do not view themselves as being similar to others with whom they interact, but as being different, with their own interests, duties and resources (Stetts & Burke, 2000: 13). The process of socialisation requires persons to acquire social identities with recognisable roles to play.

2.2.4 Roles

Roles are subjective and integral to our personalities and become part of our identities (Billington, Hockley & Strawbridge, 1998: 50). To perform a specific task, the individual must take on a specific role, and each role or task has to be composed of relevant skills, experiences, feelings and attitudes (De Board, 1978: 90). The concept of a role can therefore provide a link between identities and social life. If each role has to function, it must be able to rely on the reciprocity and exchange relation with other roles (Stetts & Burke, 2000: 13). De Board (1978: 90) elaborates further on this when stating that:

"The success of each role, in terms of effectiveness, will depend on the balance and integration maintained between the needs and resources of the individual and the requirements of the external world..."

Different roles require different skills, and so, according to De Board (1978: 91), the ego must implement a management control function, consisting of three elements. Two of these elements in particular are in accord with this present study, as it involves the control of transactions with the environment, and the mobilisation of skills and emotions appropriate for the role performance (De Board, 1978: 91).

Skinner and Mfecane (2004: 161) indicate that fear of discrimination limits the possibilities of seeking out sources of support, such as families and friends. Skinner and Mfecane (2004:

161) therefore imply that the person becomes distanced from his or her community and family, and his or her roles in the community and family are thereby affected.

Personal identity refers to one's own sense of who one is, as described by Billington et al. (1998: 37). Billington et al. (1998: 41) state that the inner core or true self is deeply embedded in the expectations and patterns of culture. However, differing cultures suggest different experiences of personal identity. Culture comprises patterns of belief, values, attitudes, expectations, ways of thinking, feeling, moving and the use of objects. These patterns can be defined as symbolic systems and perhaps exist as structured systems independent of their use by particular persons (Billington et al., 1998: 51). The following discussion briefly aims at culture and ill-health, exploring some cultural responses to disease.

2.2.5 Psychosocial factors of ill-health

Blaxter (2004:15) reports that psychosocial factors of ill-health include stress, unhappiness, and negative life events and are contributing agents of disease. Her social model of health defines health as "salutogenic", a term used by Antonovsky (1979 in Blaxter, 2004: 17) to focus on what facilitates health rather than on what causes or prevents disease. This social model of health incorporates many differences of emphasis, locating biological processes within their social contexts, and considering the person as a whole, rather than as a series of distinct bodily systems (Blaxter, 2004:17). In addition, health is considered to be a positive state, not simply an absence of disease or an "average" condition (Blaxter, 2004: 19). Loustaunau and Sobo (1997: 18) state that health problems in many cultures index social problems, which not only entail physical symptoms but behavioural and emotional problems as well. In an African context, illness is seen as a consequence of transgressing the social order by any member of the family or community (Nzewi, 2002: 2).

The AIDS epidemic seems to threaten the many positive traditional responses to disease prevention in some African cultures (Airhihenbuwa & De Witt Webster, 2004: 5). In the view of Airhihenbuwa and De Witt Webster (2004: 5), culture is understood to be the foundation on which health behaviour in general is expressed and through which health must be defined and understood. Blaxter (2005, in Pavlicevic, 2006: 93) explains health as being able to function in the social world and being integrated within the environment, having a sense of belonging, of usefulness, of neighbourliness, of reciprocity, social support and trust in local institutions. Furthermore, Airhihenbuwa and DeWitt Webster (2004: 4) have mentioned that culture plays a vital role in the health of the individual, the family and the community and that the values of the extended family and community affect the behaviour of the individual.

As a result of stigma, Airhihenbuwa and DeWitt Webster (2004: 5) have provided an example of the sick HIV-infected person who finds himself/herself isolated from his/her family and community. In traditional African cultures, the sick are usually cared for by the family and community. This example reflects how a diagnosis of HIV/AIDS and the process of stigmatisation have changed the way traditional African cultures care for and treat their sick. Airhihenbuwa and DeWitt Webster (2004: 6) recommend that the health behaviour of Africans in general needs to be addressed collectively instead of individually. Their PEN-3 model considers African realities of a culture-based intervention to HIV/AIDS. It includes three categories:

- Cultural identity (including person, neighbourhood, extended family),
- Relationships and expectations (including perceptions, nurtures, enablers) and
- Cultural empowerment (positive, existential, negative).

To enable the PEN-3 model, these three categories and their components are cross examined to determine the point of entry for intervention, or to evaluate health promotion programmes (Airhihenbuwa & DeWitt Webster, 2004: 7).

In summary, psychosocial resources in the context of HIV/AIDS may include:

- Social networking, which refers to interpersonal interaction and participation in community life;
- Personal attributes such as self-worth, optimism, a positive outlook on life; and
- Positive mood and feelings stemming from positive experiences.

For persons living with HIV/AIDS, the availability of these psychosocial resources could improve their quality of life. A diagnosis of HIV/AIDS presents not only with physical difficulties, but also with psychosocial consequences that hinder the quality of life of a person. The psychosocial consequences are caused predominantly by the process of stigmatisation, where the persons with HIV/AIDS are rejected from their social networks, their communities and their families. Persons who face adversity during the process of stigmatisation are typically disempowered, and they often become socially isolated. This affects the person's social identity and thus influences the person's role in his or her community and family life. The stress associated with rejection, as well as the fear of dying, further disables the person's coping mechanisms, as well as intra- and interpersonal attributes. Furthermore, the lack of positive experiences may limit any feelings of hope; and this reduces the quality of life for the person living with HIV/AIDS.

The following section discusses community music therapy as a psychosocial resource for persons living with HIV/AIDS.

2.3 Community music therapy

A new discourse has emerged that challenges traditional boundaries and definitions of music therapy and considers how culture informs the way music therapists look at the needs of their clients (Ruud, 2004: 12). A term for this discourse and field of practice is widely accepted as “community music therapy”.

2.3.1 Music and the environment – a systematic perspective

Ansdell (2004: 66) describes community music therapy as a context-based and music-centred approach. He sees making music as a social and cultural practice, and thus a natural agent of health promotion (Ansdell, 2002: 10). Stige (2002: 28) defines community music therapy as music that brings about change in a community. He proposes that community music therapists work with the context, taking into consideration all the social and cultural factors in the specific environment.

Aasgaard (2004: 148) explains that music promotes health in a specific environment, which in terms of this study, correlates with community music therapy. Stige (in Ansdell, 2002: 13) proposes a systematic perspective to describe community music therapy, by presenting four interlinking layers of context in which community music therapy takes place, and in which the individual is implicated on all levels:

- The immediate *microsystem* of an individual's life
- The mediating *mesosystem* of the individual's communal life
- The social/cultural context of the *exosystem*
- The removed, overlaid cultural/political level of the *macrosystem*

Ruud (2004: 2) is in agreement with Stige, as he suggests that community music therapy negotiates a space between the private and the public domains. He defines community music therapy as the reflexive use of performance-based music therapy within a systematic perspective. According to general systems theory, an open system is continuously in contact with its environment, importing energy, converting, and then exporting the transformed energy back to the environment (De Board, 1978: 88). Rice (1969 in De Board, 1978: 89) made an interesting contribution to this theory when he suggested that an individual can be seen as an open system, where he or she can exist only through a “process of exchange” with his or her environment. In this instance, the system is the individual’s internal world,

comprising his beliefs and expectations. However, the individual exists in an open system with the environment in which he or she lives, continually striving to maintain a balance between his or her own internal needs and the demands of others in the environment. Pavlicevic (2003: 33) states that group musicking cannot happen within a systemic vacuum. She understands systems theory as any group or person as a whole with different but interconnected and interdependent parts (Pavlicevic, 2003: 32).

Kenny (1989 in Woodward, 2004: 4), referring to systems theory, states that the music making group and the environment cannot be seen as two closed systems, and she views the environment as a "resource pool" for therapeutic activity. Woodward (2004: 9) further acknowledges system theory when she states that it is important to work with the environment (the system). When individuals participate in music making they assume different roles: It may be listening, playing an instrument or singing. As different parts of a whole, with particular roles, each participant can be heard, share aesthetic experiences, and be connected with themselves, others and the environment. Thus, as open systems, the individual, the music-making group and the environment, are dependent on the appropriate exchanges taking place between them.

2.3.2 Music, community and personal health

Community music therapy concerns itself with the social and cultural factors of a community (Ansdell, 2002), focusing on the client's needs and health, and enabling individuals and communities to re-establish relations with each other. In a community, such as at an HIV/AIDS clinic, community music therapists realize that ill-health has to be seen in context, as part of social systems such as those mentioned above (Ruud, 2004: 11). Ansdell (2004: 86) suggests that the concept of community in community music therapy is "community in context" and expresses it as "communitas". He explains that through musical communitas, particular possibilities and qualities of social and cultural experience can be motivated and sustained through the "music of everyday life", and could thereby perhaps afford what clients and their communities need (Ansdell, 2004: 86).

2.3.3 Empowerment

Empowerment is a process or mechanism which is used to gain control of a person's own life or situation, or that of a community (Daveson, 2001: 31). This leads to a shift in a person's own feelings, from powerlessness to motivation. The act of music-making in a community music therapy group context facilitates peer support and encourages group participation, as well as enhancing group cohesion (Hunt, 2005: 10). These elements are a

platform on which important group processes occur, and according to music therapist, Meagan Hunt (2005: 11), lead to positive experiences. By acknowledging the social and cultural factors of health, illness, relationships and music (Ansdell, 2002: 10), community music therapy facilitates empowerment. Procter (2001: 5) understands empowerment as focusing on people's ability and potential for wellness with emphasis on the practical and the creative. Daveson (2001: 5) suggests that empowerment is intrinsic to and a consequence of music therapy practice. As a music therapist, Daveson (2001: 6) proposes that for empowerment to exist there must be collaboration. Collaboration requires interaction, which involves the shaping of a response that will depend on the response of the person you are collaborating with (Daveson, 2001: 6). This type of interaction is an integral part of music therapy practice (Daveson, 2001: 6), and thus of community music therapy. Brown (1991 in Daveson, 2001: 6) listed the following action dimensions of empowerment. They are to:

- Affirm people's humanity and uniqueness;
- Link people with resources and hence, to open up greater life opportunities;
- Provide an open space: to give people the opportunity to regain a sense of control over their lives and environment;
- Establish a sense of togetherness and to connect people with each other, encouraging them to work together;
- Legitimise or validate individual or group experiences;
- Develop a heart for justice and compassion, a mind for analysis and hands for skilful, sensitive and disciplined action.

Empowerment in community music therapy puts the emphasis on collaboration and mutual relationships, through participation and self-determination (Rolvsjord, 2006: 5).

2.3.4 Resource-oriented approach

In terms of considering the person as a whole, focusing on what facilitates that person's health, community music therapy utilises a resource-oriented approach. Music therapist, Randi Rolvsjord, terms her way of working, as resource-oriented music therapy and defines it as a contextual approach that embraces the therapeutic context as a source (or resource) for change in the development of the client's health (Rolvsjord, Gold & Stige, 2005: 1). Rolvsjord et al. (2005: 1) have developed a guide for training therapists to become competent in the application of the therapeutic principles of resource-oriented music therapy, specifically in the field of mental health. The client uses the therapeutic context for making important changes in his or her life and therefore mobilizes or activates his or her resources (Rolvsjord et al., 2005: 1).

Community music therapy is a contextual approach and incorporates the resource-oriented approach to focus on the strengths and resources of the client. DeNora (2000 in Ansdell, 2004: 73; Rolvsjord, 2006: 10) describes music as a resource through a twofold process of appropriation and affordance. Affordances are the resources with which music and its musical instruments provide the client (DeNora, 2000 in Ansdell, 2004: 73; Rolvsjord, 2006: 10). Appropriations are how these resources are used (DeNora, 2000 in Ansdell, 2004: 73; Rolvsjord, 2006: 10). Rolvsjord (2006: 7) reports that the attribution of musical meaning to the processes of affordance and appropriation implies an emphasis on the cultural context of music. She further indicates that it is the client that uses music as a health resource, and that the "intervening" music therapist should not have that much power. She suggests that the therapist's primary task is to provide a space for the client, drawing on his or her knowledge to provide "tools" or "methods" that the client can use in order to mobilise his or her own ability for self-healing (Rolvsjord, 2006: 8).

2.3.5 Community music therapy in South Africa

South African music therapists Oosthuizen, Fouche and Torrance (2007: 1) mention that music therapy in South Africa is negotiating a practice that takes into account the continent's musical vibrancy and the contextual understandings of "health" and "illness". Community music therapy is the term used to describe such a practice, and it is a contextual and relevant approach to address the South African people and their health. Dos Santos (2005: 2) interviewed staff members and patients at an HIV/AIDS hospice and orphanage in the light of establishing a community music therapy project. Dos Santos (2005: 2) identifies four themes that emerged from the interviews. The four themes include:

1) Re-establishing community,

2) Offering a safe space,

3) Providing opportunities to give, and

4) Vitality.

The first theme represents a sense of togetherness through music-making. Music making is seen as a safe medium. The second theme is seen as one through which to express and process emotion and feelings. The third theme addresses the concept of performance in community music therapy. A "performance" by the children in the orphanage allowed them to give something of themselves, and not only to be receiving. This enables feelings of contributing to the life of someone else, and so the children make use of their "musical cultural resources" (Zharinova-Sanderson, 2004: 243). Dos Santos (2005: 2) further

maintains that performance is capable of developing community, not only reflecting it. The fourth theme highlights the concept of vitality, when the act of making music celebrates life. This is specifically relevant in an HIV/AIDS community, where persons with HIV/AIDS live with the fear and uncertainty that death holds.

As community music therapy is still a young concept, especially in South Africa, very little research has been done specifically on community music therapy and HIV/AIDS communities. The Music Therapy Community Clinic (MTCC) in South Africa is currently the only organisation in South Africa to specifically work with persons, mostly children, with HIV/AIDS. Therefore, this present study addresses adults' perceptions and experiences, as well as meaningful musical moments with mostly adults participating in the music-making.

In summary, community music therapy is a context-based approach that affects the environment, re-establishes community and empowers the individual. By providing opportunities for music-making in wide open spaces, working with the community and focusing on the client's strengths, community music therapy addresses health in a positive and resource-oriented manner. Community music therapy is a relevant approach when addressing the issue of HIV/AIDS in South Africa. The music-making happens publicly, which facilitates community and a sense of togetherness. Music-making also offers a safe and stable medium in which to share experiences and feelings. Community music therapy focuses on a positive experience and is a reflection of an everyday life activity.

2.4 Conclusion

In conclusion, literature indicates a need for support in the area of psychosocial resources in the context of persons living with HIV/AIDS, as this appears to impact on persons' ability to cope with their illness. The literature review has highlighted studies that reveal how persons living with HIV/AIDS have experienced stigmatisation and a lack of support from their own families, communities and from wider society. Community music therapy can address these psychosocial consequences through facilitating interaction with the environment, re-establishing communities and empowering persons living with HIV/AIDS. In the light of the literature it is important to consider community music therapy as a psychosocial resource for persons living with HIV/AIDS in the context of South Africa. The literature review has highlighted the fact that currently, in the context of South Africa, the necessary psychosocial resources that may enable and empower persons living with HIV/AIDS are lacking. Therefore, community music therapy may be considered a resource, as it is specifically useful to address psychosocial consequences in the South African context.

Chapter 3 outlines the methods and procedures followed in order to address community music therapy as a resource for persons living with HIV/AIDS and to look at its usefulness in the South African context.

CHAPTER THREE

METHODOLOGY

In the following chapter the researcher will present an account of the methodological process used in this study. In order to answer the research questions, the researcher needs to describe the process of the data preparation and analysis.

The study aims to answer the following questions:

- How can community music therapy be a psychosocial resource for persons living with HIV/AIDS who attend a clinic in Tshwane?
- What are the implications of this for understanding the role of community music therapy in South Africa?

3.1 Research design

This study is a qualitative research project. Bruscia (1995: 426) explains qualitative research as a process whereby one human being attempts to understand something about another human being. The researcher is interested in the experiences of persons living with HIV/AIDS through their participation in community music therapy, and so the nature of this project is explorative and descriptive. The study aims to explore community music therapy as a possible psychosocial resource for persons living with HIV/AIDS. In addition, it aims to describe the implications of community music therapy in South Africa. This enables the researcher to gain a "deep but narrow" understanding of human situations, which might or might not be generalisable (Ansdell & Pavlicevic, 2001: 139). Bruscia (1995: 405) states that qualitative research is concerned with particulars that are rooted within a specific context. It is the researcher's view that in this particular context, community music therapy can be utilized as a psychosocial resource by persons living with HIV/AIDS.

Qualitative researchers tend to be concerned with the quality and texture of experiences rather than with the identification of any cause-and-effect relationships (Willig, 2001: 9). Further, the objective of qualitative research is to describe, and also possibly explain, events, but never to predict. Participants' (and researchers') interpretation of events itself must contribute to this process (Willig, 2001: 9).

This research follows a case study design that can be defined as a research strategy to investigate events within their "real-life" context. Qualitative researchers study people within naturally occurring settings, such as the home, schools, hospitals, etc. (Willig, 2001: 9). This is a collective study with several participants, with whom the researcher interacted and

engaged during an internship at the HIV/AIDS clinic, as part of the training as a music therapist. This interaction occurred naturally at this South African clinic, where participants receive diagnosis, medication and counselling.

3.1.1 The setting

Persons attending the HIV/AIDS clinic had an opportunity to participate in community music therapy sessions, often experiencing only one session, due to sessions being offered only once a week on a Monday, and their own infrequent attendance at the clinic. Sessions were held inside an enclosed space, as well as in an open, busy area outside the clinic. Both types of sessions included persons living with HIV/AIDS participating in community music therapy, whether through live music-making, dancing or merely listening to music. The data used in this study include audio and video recordings from sessions conducted in the closed space, as well as from those in the open area. Audio recordings were taken from sessions in both venues and all persons at the clinic were invited to join these sessions. The enclosed sessions also offered opportunities for video recordings depicting spoken exchanges also, as participants would often relate how they felt after a session. The researcher was the co-therapist in these sessions. In the open group sessions, which included staff members, patients and co-therapists, the researcher took on the therapist's role. Verbal exchanges in these sessions featured less and could not be video-recorded due to the lack of privacy in the open area.

Ken Aigen (1993, in Ansdell & Pavlicevic, 2001: 103) suggested that the dual role of therapist and researcher can enhance the research process. He refers to qualities such as insight, intuition, emotional reactions and a capacity for spontaneous analysis that can be helpful to know and sense what needs to be emphasized in the research (Aigen, 1993 in Ansdell & Pavlicevic, 2001: 104).

3.1.2 Participants of the community music therapy sessions

Participants included children, women and men, attending the HIV/AIDS clinic. More women than men attended these sessions. Most patients at the clinic received medication and assessment and left immediately. Participants attending community music therapy sessions would be free to come and go as they pleased, and would often only stay a few minutes and return later, or participate in the later group. In addition, most participants only attended once-off sessions.

3.2 Data collection

Qualitative researchers study spoken and written accounts and records of human experience, using multiple sources of data (Punch, 1998: 174). Two sources were used to obtain the data. The data sources included: audio recordings of musical activities from selected sessions, which incorporated session notes that informed these selected sessions; and video recordings of spoken exchanges after these sessions. In order to obtain a comprehensive view on community music therapy as a psychosocial resource for persons living with HIV/AIDS, the researcher included data that were both observed by the researcher as therapist (i.e. recordings of musical activities in sessions and own session notes) and data as reported by the participants (i.e. recorded discussions after sessions). It is as result of drawing from both these perspectives, musical and verbal observation that the research was designed in this way. This practice of using multiple data sources is termed triangulation. This allows the researcher to view different data sources in order to obtain a holistic picture of the phenomenon (Ansdell & Pavlicevic, 2001: 144; Bruscia, 1995: 408; Robson, 1993: 163). The two data sources allowed the researcher to obtain different information from several different persons (Bruscia, 1995: 408). The chosen excerpts from the audio recordings and session notes enabled the researcher to observe different people participating in community music therapy. The video excerpts allowed for information to be gathered from different participants, as they gave their perspectives on their musical experiences after the sessions. Fig 3.1 depicts the triangulation in data collection.

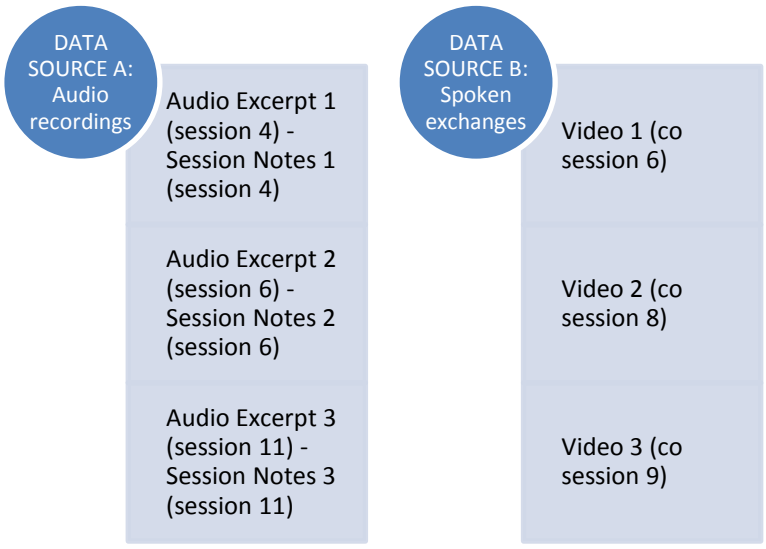

Fig 3.1 Triangulation in data collection

3.2.1 Data source A: audio excerpts and session notes

Three audio excerpts were selected, according to significant moments in the music, as identified by the researcher, as well as through supervision. These were the researcher's subjective identifications of "moments" that occurred during musical activities within the sessions held outside. These "moments" provided insights that were useful in addressing the study's research questions. An advantage of using an audio mode is that it preserves data in their original form (Schurink, Schurink & Poggenpoel, 1998: 329). The audio excerpts were of musical activities occurring outside the clinic, in a busy, open area. Participants included children, women and men of all ages. Each musical activity included different participants so as to obtain a wider base of information. The audio excerpts were transcribed as thick descriptions that allowed the researcher to convey the data as text (Punch, 1998: 192).

Session notes informed the researcher to select meaningful moments that occurred in the music from the audio excerpts mentioned above. They added a richer perspective to the thick descriptions of the audio excerpts and detailed descriptions of what occurred during the music. This is due to the fact that these session notes were written straight after the musical event happened and enabled the researcher to gain a more detailed account of what had happened.

3.2.2 Data source B: verbal reflections during and after sessions (audio and video excerpts)

Many participants engaged in verbal expressions about the music and their feelings during and after the sessions. An enclosed area was used to video record verbal expressions, making it possible to have inter-personal dialogues with others after the sessions. This was an informal way for participants to share their feelings. Through interpersonal dialogues the therapist and the participants could shape the data together as equally qualified sources of information (Bruscia, 1995: 411). Spoken exchanges were selected from three video excerpts and illuminated the participants' perspectives on their experiences of the session. Participants were in a group that included 10 to 15 participants of which most were women. Only one participant attended two of the sessions which were selected. These spoken exchanges were selected by the researcher, as well as through supervision, specifically to address the research questions. Video excerpts of the spoken exchanges were transcribed as text in the form of interviews.

3.3 Data analysis

Regarding data source A, musical improvisations from the audio excerpts were transcribed as thick descriptions. Session notes were examined and added to the thick descriptions of data source A. The spoken exchanges, that is to say the data source B, were transcribed as interviews. The data were then coded. Miles and Huberman (1994, in Coffey & Atkinson, 1996: 27) describe codes as tags or labels used to assign units of meaning to information compiled during a study. This is a means of data simplification or reduction (Coffey & Atkinson, 1996: 29). Strauss (1987 in Coffey & Atkinson, 1996: 31) uses the word "coding" as part of the process of interpretation and analysis. The data were reduced to categories, each consisting of common codes. Emergent categories were explored as themes and discussed in relation to the literature. Fig 3.2 depicts an example of the process of data analysis for data source A1:

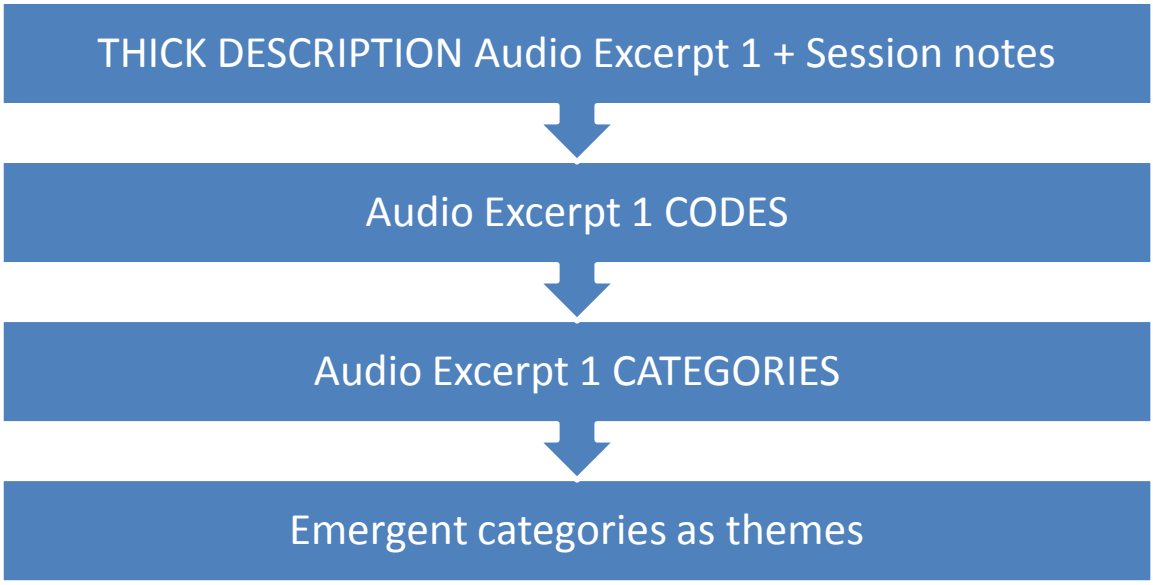

Fig 3.2 Example of data analysis: audio excerpt A1

3.4 Ethical considerations

Ethical considerations included gaining informed consent from the community placement where the researcher worked as a student music therapist (see Appendix I). As part of the training as a music therapist, informed consent forms were sent to this community placement, the HIV/AIDS clinic, before the work had even started. The form included permission to audio and video-record the sessions, and for these recordings of clinical material to be used for research purposes. This consent guaranteed privacy, confidentiality and anonymity for the participants in line with professional ethical practice. Once the work

there had finished, the researcher decided to use the clinical material which had been obtained there as data for this research. Therefore, the analysis of the data is post facto. The researcher ensured the anonymity and confidentiality of the participants by not disclosing any personal information and keeping sensitive material from the public. All names used in the data were changed. The data of this study will be stored at the University of Pretoria for a period of 15 years.

In the following chapter, a detailed account of the process of the data analysis will be presented and will include what the researcher identified as the emerging themes from the analysis procedure.

CHAPTER FOUR

DATA ANALYSIS

This chapter presents the process of data analysis including the transcription of excerpts and the development of codes and categories.

As discussed in Chapter Three, two data sources were selected by the researcher through supervision. The first data source (A) included three audio excerpts of musical improvisations from three different sessions, sessions 4, 6 and 11. These audio excerpts contain significant moments that represent community music therapy as being a psychosocial resource to the participants. Session notes were used to write a richer perspective on the thick descriptions of the three audio excerpts. The second data source (B) consisted of video excerpts, selected from sessions 7, 8 and 9, displaying participants reflecting on their own feelings after participating in community music therapy sessions. These spoken exchanges were not in the participants' first language and the researcher is aware that their choice of words influenced the coding process. However, the words they used were respected by the researcher and were retained.

4.1 Thick descriptions of data source A: audio excerpts of musical improvisations

4.1.1 Thick description of audio excerpt A1

This audio excerpt was taken from the first session held outside on an open cement block. The area was busy, with patients walking to and from the clinic, transport picking up and dropping off patients, staff members finishing their chores and participants joining in the music-making group. A typical community music therapy session included therapists facilitating multiple groups, forming and dispersing at different times as participants joined and left the area. As the final group of this session formed, 40 minutes of improvisation had already taken place. There was a continuous flow of musical improvisation, and so the following group formed: there were 10 people in the group, including 1 small boy, 7 women (staff members and patients) and 3 therapists. The following is an excerpt of the thick description written of audio excerpt A1.

(42:55) A woman in the group shows her enthusiasm by adding her own vocalisation to the music. All the women in the group then initiate their own sound, adding liveliness to the music and the environment. Passers-by clap and cheer as they walk past on their way to the doctor or home. The music is African by its rhythm, and its singing. Vocal phrases are unique to each woman, driven by the repetitiveness of the rhythm, copying and imitating each other's way of singing and playing. The women make eye contact with each other as

each woman shares her musical ideas with the rest of the group. A natural flow of leadership develops in the group.

Table 4.1 Excerpt of the thick description of audio excerpt A1

4.1.2 Thick description of audio excerpt A2

This audio excerpt was taken from session 6. There were approximately 20 people taking part in live musical improvisation, including women, men and children, whilst others were either passing by or were onlookers. The music-making happened in an open, busy area, under a small gazebo and filtered through to where patients were queuing for lunch. Thus, the improvisation could be heard from some distance away. The following is an excerpt of the thick description written of audio excerpt A2.

A group of 20 people gathered under the gazebo. Each member had an instrument on which they kept a steady, ongoing, syncopated rhythm. This rhythm carries the music to the queue, where people are clapping their hands, tapping their feet and some singing along with the therapists. The therapists are singing: Don't worry, be happy" in a call-and-response activity with the queue. Under the gazebo, the rhythm is kept steady by the 5 men who joined the group. The women in the group play the cymbal, shakers, claves, some on djembe drums and others singing and clapping. The music becomes part of the environment, filtering through the outside air. The music is energetic and at a fast tempo.

Table 4.2 Excerpt of the thick description of audio excerpt A2

4.1.3 Thick description of audio excerpt A3

This audio excerpt was taken from the last session, session 11, held outside in an open, busy area, under a gazebo. The therapists brought microphones and amplifiers to set up an area for musical improvisations by the staff members and patients of the HIV/AIDS clinic. The idea of the session was not to provide entertainment to onlookers by terming it a "performance", but rather to encourage participants to let themselves and their music be heard. The group contained mostly women and children, as well as a few men, who contributed to the group, this being the largest here, with approximately 50 people. The session lasted two hours, consisting of continuous musical improvisations. The following is an excerpt of the thick description written of audio excerpt A3.

The therapist starts inviting individual people through gestures to come and play the set of bongos. One young man with a diagnosis of mental health disorder plays first. He plays loudly and rhythmically, but in connection with the group. The old woman that joined the

group first played loudly and confidently, exacerbating the rhythm of the group. The group cheers as she finishes playing. The group repeats the vocal riff until the next one stands up to play.

Table 4.3 Excerpt of the thick description of audio excerpt A3

4.2 Transcription of video excerpts: verbal reflections during and after sessions

Community music therapy sessions included spoken exchanges during which participants could share some of their reflections on their feelings about the music. Video excerpts were taken from these reflections, as they had happened during three sessions, sessions 7, 8 and 9. Participants in the spoken exchanges were mostly women; however a man was present in two of the sessions. The reflections were transcribed as interviews. The following provides an example of this.

CoT*	[Thanks everyone for coming. Thanks for the nice session. I was dancing and jumping and then I was relaxed afterwards.]
P5*	I also like music.
	Music is my comforter
	And I am grateful for everything you have done for us.
	It shows love and
	I am relaxed.
	All the best for you and I hope I can come again, maybe next week.
T*	[Thank you and I hope you come again.]

**CoT= co-therapist P5 = participant whose name has been changed T = therapist*

Table 4.4 Example of transcription of video data: reflections during sessions

4.3 Coding of data source A and B

After the initial data transcription of both data sources A and B had been completed, the researcher tried to provide codes for each sentence in the thick descriptions and the transcripts. This however, seemed to be insufficient, as it produced various codes that are irrelevant to the focus provided by the research questions. This initial coding attempt particularly highlighted the fact that the thick descriptions needed to be reviewed and perhaps befit more relevant detailed descriptions of the chosen excerpts.

The researcher reviewed the thick descriptions and used session notes to add more relevant detail to the text (these are the thick descriptions provided in 4.1). More detailed thick descriptions enabled the therapist to highlight words or phrases that emerged from the text. Meanings emerged from highlighted words and phrases and were constructed as codes. The following is an example of the initial thick description, the initial code, the final thick description (see 4.1) and the final code.

Initial Thick Description	Initial code	Final Thick Description	Final Code
(40:51) After a few seconds, the therapist initiates a short 2 bar vocal phrase after which she pauses for 2 bars. This directs the music into a 4/4 metre, providing structure for the vocal improvisation. The therapist repeats these 4 bars, pausing in the last 2, and the women in the group respond by repeating the first 2 bars in the pause. The therapist's initiation of a pause indicates to the group that it is a call. The women repeat the therapist's vocal riff when she pauses. Short phrases of 1 and 2 bars indicate the "call" whereby the group responds with the same riff.	Therapist initiates vocal phrase Music becomes structured Repetition and response Therapist initiates Group respond Group respond	(40:51) The therapist starts playing loud rhythmic, syncopated beats on the djembe and the members copy her playing with the same intensity and rhythm. The therapist adds a melodic riff above the playing, and the group copies her riff when she pauses. The music sounds lively, rhythmic and at a moderately fast tempo. Their voices are loud and clear as they sing together. The women in the group respond with enthusiasm in their voices and in their playing. (42:55) A woman in the group shows her enthusiasm by adding her own vocalisation to the music. All the women in the group then initiate their own sound, adding liveliness to the music and the environment. Passersby clap and cheer as they walk past on their way to the doctor or home. The music is African by its rhythm, and its singing.	Group support through listening and reflecting Collaboration in music-making Music is continuous and steady Collaborative shift in musical energy Music facilitates positive experiences Group support through listening and reflecting Music becomes alive Group's music influences outsiders to join in Music is

		Vocal phrases are unique to each woman, driven by the repetitiveness of the rhythm, copying and imitating each other's way of singing and playing. The women make eye contact with each other as each woman shares her musical ideas with the rest of the group. A natural flow of leadership develops in the group.	continuous and steady Music support and offers stability Collaboration enables sharing of musical ideas with a natural flow of leadership in the group.

Table 4.5 Example of the coding process

After all of the transcripts and final thick descriptions had been coded, 30 codes emerged from the text. The following is a list of the 30 emerging codes.

Code Nr	**Code**
1	Outside in a hot, busy, public area affected by nature's elements
2	Participants are free to come and go
3	Older woman leads music-making
4	Music provides safety and security
5	Music becomes a collaboration/collaboration in music-making
6	Group support through listening and reflecting
7	Group's music attracts clinic staff
8	Outsiders join in/outsiders influence group's music
9	Collaboration shifts musical energy
10	Collaboration enables sharing and initiating of musical ideas
11	Sharing of leadership
12	Musical initiative is shared by all

Code Nr	Code
13	Music becomes part of the environment
14	Music changes attitudes of authority figure
15	Authority figure praises group
16	Music facilitates/generates positive experience
17	Ownership of music
18	Singing connects participants
19	Music-making connects participants
20	Newcomers lead the group
21	Music generates health – focus on ability
22	Music enables self-confidence/ music empowers participants
23	Positive connection through music enables sustained response
24	Music generates creativity
25	Feeling of togetherness after group sessions
26	Music generates positive attitude/outlook on life/reminder of hope
27	Music comforts
28	Participants are grateful for positive experience
29	Music facilitates community
30	Music facilitates relaxation

Table 4.6 Codes

4.4 Categories

Following coding, the 30 codes were placed into broader categories. Ansdell and Pavlicevic (2001: 151) describe categories as being mutually exclusive and as offering detailed and logical comparisons. Four categories emerged after the grouping of the codes. Due to the small number of categories, these were not further grouped into broader themes. The four categories will be discussed briefly below and will then be explored in more detail in Chapter 5 in an attempt to answer the research questions. Figure 4.1 is a schematic representation of four the categories.

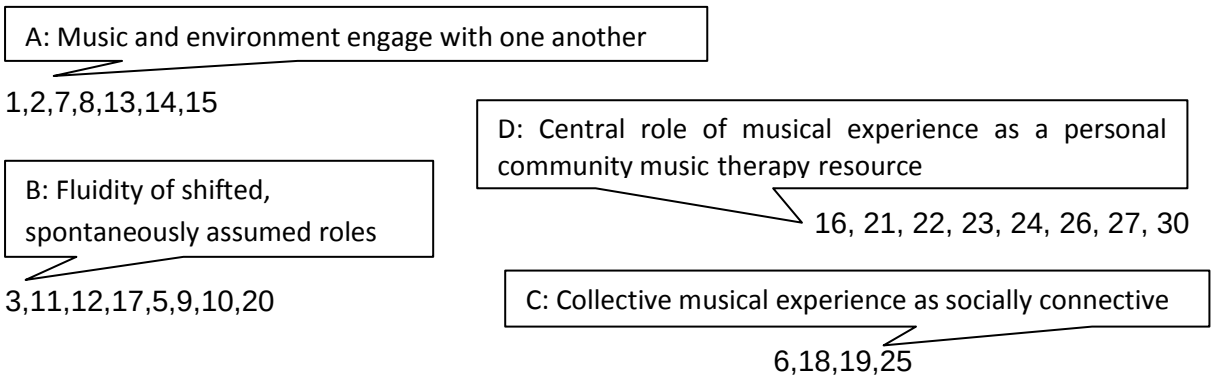

Figure 4.1 Categories and their corresponding code numbers

4.4.1 Category A: Music and environment engage with one another

The music-making did not happen behind closed doors but rather in an open, busy area exposed to nature's elements. The music permeated through the air, attracting persons around and in the clinic. Participants of the musical improvisations were free to come and go. Outsiders influenced the music-making as they walked past, either by cheering, clapping or joining in the musical improvisations. The shared music-making experience attracted an authority figure from the clinic, whose attitude changed as he heard and experienced the patients and staff members engaging in music. This resulted in him praising the participants. Staff members were attracted to the music-making, and as they finished their work, they joined in the improvisation.

4.4.2 Category B: Fluidity of shifted, spontaneously assumed roles

The music-making provided a continuous, steady rhythm which offered stability and security to the participants. On numerous occasions, an older woman led or started a musical improvisation, whereas on other occasions, newcomers were able to lead or influence the music-making. The sharing of leadership is supportive and the following roles within the group provided fluidity to the music, and enabled the participants to fully participate in the musical social experience.

4.4.3 Category C: Collective musical experience as socially connective

Participants in musical improvisation reflected on the act of music-making as an everyday, social, cultural event. Participating in music-making created a feeling of renewed community life. Group support was enabled through turn-taking activities as the group was able to listen to a leader and reflect his/her musical ideas through their own vocalisations and/or instrumental playing. Singing cultural-specific songs or improvised vocal melodies enabled the participants to feel connected to each other as they shared communality through the music, singing songs that were familiar to them and by creating something new together. A

natural flow of leadership during these songs and vocalisations pointed towards a normal everyday experience that might well have been ”lost” without their diagnosis of HIV/AIDS. A shared continuous, energetic rhythm contributed to the feeling of community and evoked feelings of togetherness amongst staff members, patients and therapists alike.

4.4.4 Category D: Central role of musical experience as a personal community music therapy resource

Music-making in an open, public space appeared to facilitate a number of positive experiences. A participant with mental illness due to HIV/AIDS played with powerful determination in front of the group, leading the group. Participation in musical improvisations enabled the participant to be reminded of his/hers ability rather than illness, and therefore generated self-confidence. A shy, hesitant woman influenced a group of 50 people by adding her own musical initiative to the continuous rhythm of the group, by altering their ongoing rhythm. Through the positive contribution that musical improvisation provided, participants in the group could feel creative and powerful and be reminded of being part of a greater whole. Participants reflected on the fact that such jointly created, spontaneous music-making activities facilitated their relaxation. Positive experiences such as these facilitate a positive, healthier outlook on life and act as reminders of hope, despite illness. Furthermore, positive experiences such as these may improve the quality of life of persons living with HIV/AIDS as they facilitated interpersonal interaction and promoted self-confidence.

4.5 Conclusion

This chapter has presented the process of data analysis in detail. In the following chapter, the researcher attempts to answer the research questions based on the above-mentioned categories, which could also be understood as themes. This discussion will be connected to the literature.

CHAPTER FIVE

DISCUSSION

This chapter addresses the two research questions in terms of the four categories. The four categories also act as themes and will therefore be referred to as such. Discussions will be linked to the literature, as reviewed in Chapter Two, as well to the data analysis that was conducted in Chapter Four. The research questions are as follows:

1. How is community music therapy a psychosocial resource for persons living with HIV/AIDS who attend a clinic in Tshwane, South Africa?

2. What are the implications of this for understanding the role of community music therapy in South Africa?

The following is an overview of the categories, now termed themes, with their relevant codes:

Music and the environment engages with one another	**Fluidity of shifted, spontaneously assumed roles**	**Collective musical experience as socially connective**	**Central role of musical experience as a personal community music therapy resource**
- Outside in a hot, busy, public area affected by nature's elements - -	- Older woman leads music-making	- Group support through listening and reflecting	- Music facilitates/generates positive experience
- Participants are free to come and go	- Sharing of leadership	- Singing connects participants	- Music generates health – focus on ability
- Outsiders join in/outsiders influence group's music	- Musical initiative is shared by all	- Music-making connects participants	- Music enables self-confidence/ music empowers participants
- Music becomes part of the environment	- Music becomes a collaboration/collaboration in music-making	- Feeling of togetherness after group sessions	- Positive connection through music enables sustained response
- Music changes attitudes of authority figure	- Collaboration shifts musical energy		- Music generates creativity
- Authority figure praises group	- Collaboration enables sharing and initiating of musical ideas		- Music facilitates relaxation
	- Ownership of music		- Music comforts
	- Newcomers lead the group		- Music generates positive attitude/ outlook on life/ reminder of hope

Figure 5.1: An overview of the categories/themes and their relevant codes

RESEARCH QUESTION 1: COMMUNITY MUSIC THERAPY AS A PSYCHOSOCIAL RESOURCE FOR PERSONS LIVING WITH HIV/AIDS.

5.1 Theme 1: Music and the environment engage with one another – establishing community

Music created during community music therapy sessions appears to have impacted the environment of the clinic, and in turn, allowed for the environment to influence the music. This result is in accordance with the systemic approach that community music therapy entails, as suggested by Stige (in Ansdell, 2002: 10) and Ruud (2004: 2). As a psychosocial resource, these findings suggest that community music therapy could be valuable in the context of a marginalised community (the HIV/AIDS clinic), through the therapists taking into consideration the physical environment and thereby facilitating engagement between people participating in music making and their immediate environment, forming what Ansdell (2004:86) ca;;ed, a circumstantial community.

5.1.1 The environment

The environment at the HIV/AIDS clinic includes persons attending doctor's appointments, counselling sessions, blood testing, and those receiving medicine. By participating in community music therapy in this environment, patients can become participants, engaging with this same environment musically, and pouring their energy into musical activity and transforming it back into the environment. In a systems theory approach (De Board, 1978: 88), any group of people can be a system with interconnected and interdependent parts. Systems theory includes a conceptualization of both open and closed systems. Open systems change and adapt in relation to other systems. The community music therapy group sessions and the environment are open systems, continually interconnecting with each other and exchanging energy. Music and the environment engage with each other by influencing each other, as music-making does not happen inside a systemic vacuum (Pavlicevic, 2003: 33), but rather allows for interrelations with the larger system of the HIV/AIDS clinic.

The HIV/AIDS clinic environment was busy: patients walked to and from doctors' rooms; others waited outside in the waiting area; patients were being transported to and from the bus and taxi ranks; groundsmen went about their daily chores; and volunteers served lunch. The noise of pots and pans and cars driving around contrasted with the human silence: there was little interaction between the patients. Music therapist, Alphe Woodward (2004: 1), describes a similar extended hospital environment as one 'filled with noise pollution, staff busyness, but also the reflected distress of the illnesses it contains'.

Audio excerpts from this study were taken from community music therapy sessions that happened in the centre of this busy-yet-silent environment. The "busyness" of staff, carrying out their daily operations at the clinic contributed to the noise of the clinic environment. However, this busy "noise" contrasted with the human silence, as people in the waiting areas, outside on the cement block or inside the clinic, did not communicate with one another. The human silence in the environment influenced the social networking (i.e. social interaction) of the persons attending the clinic. Social networking has been recognized by Harber et al. (2008: 296) as an interpersonal asset that can be used as a psychosocial resource. To address social networking, community music therapy provided the opportunity for persons living with HIV/AIDS to participate in spontaneous music-making in a public space. The busy environment of the HIV/AIDS clinic was the immediate recipient of the live music-making. Human silence was transferred into energetic, vibrant, fast musical rhythms, as evidenced by the following excerpt (see Appendix A2: 1):

> The music becomes part of the environment, filtering through the outside air. The music is energetic and at a fast tempo.

The vibrant music immediately shifted the energy of the clinic environment. The music transcended into the environment, as more people became participants and started to tap their feet and clap their hands to the fast rhythm. In terms of her environmental approach, Woodward (2004: 9) describes the aesthetic nature of music that allows for a shift from disinterest in, withdrawal from and conflict with the environment towards a shared, conscious aesthetic experience.

5.1.2 Music reflects the health of the environment

As the music filtered through the air, more people became involved in the active music-making by playing an instrument, tapping their feet, singing or listening to the music (see Appendix A2: 1):

> A group of 20 people gathered under the gazebo. Each of the members had an instrument on which they kept a steady, ongoing, syncopated rhythm. This rhythm carries the music to the queue, where people are clapping their hands, tapping their feet and some of them are singing along with the therapists.

The energetic music contributed to the busy environment and reflected the vitality of those creating it. The steady, ongoing rhythms reflected the health and vitality of participants in music, rather than the illness that they carry inside them. Woodward (2004: 1) describes the environment in which a person finds himself or herself as a qualitative and identifiable

personification of health or illness in a system. Where, as before, the noise of the environment was filled with the busyness and the human silence, now the same environment contained energy, vitality and life through the music. As Dos Santos (2005: 2) found in her study at a South African hospice and orphanage, the act of making lively, rhythmic music celebrates life and reflects the vitality of the collaborators. This is specifically relevant in an HIV/AIDS community where persons with HIV/AIDS live with the fear and uncertainty that death holds. Life, energy and enthusiasm are reflected through this music making. This energy, that reflects life, permeated through to others in the queue, in the waiting area and in the clinic itself and more people became involved in the creation of music-making.

5.1.3 Music penetrates psychosocial boundaries

The music, created spontaneously by participants outside in the hot sun, filtered through the air. As the music-making happened in an open, out-door space at the clinic, without physical walls and boundaries, more people were able to hear, listen and/or participate in sessions (see Appendix A2: 1). Wood, Verney and Atkinson (2004: 61) and Pavlicevic (2004: 16) term music "filtering through the air" as the "ripple effect" of music.

"*Music naturally radiates, like dropping a pebble in a pond and seeing the waves of energy spread out in concentric circles*." (Pavlicevic, 2004: 16). The following is a simple demonstration of this ripple effect:

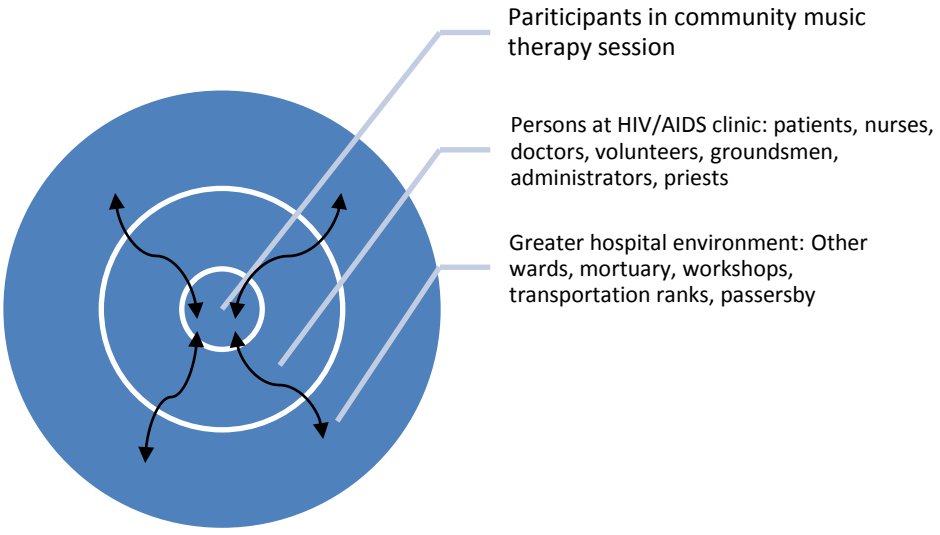

Figure 5.2: The ripple effect of the music at the HIV/AIDS clinic

Interaction with the greater environment was facilitated when music-making happened in a public space as opposed to music-making behind closed doors. Community music therapy allows for a more flexible therapeutic space, with no physical boundaries. A person living

with HIV/AIDS may be limited by psychosocial boundaries of stigma and marginalisation. These boundaries interfere with social participation and engagement with the environment. Music-making in an open, public space with no physical boundaries, perhaps reflects the permeability of music which may have transcended those psychosocial boundaries as the participants share in a collective, musical experience with their immediate environment. Community music therapy happens outside the traditional framework of therapy, which usually occurs behind closed doors. It may well offer new possibilities to the participants. Patients living with HIV/AIDS can become participants, collaborators and creative beings.

5.1.4 Outsiders become part of the music-making community

Onlookers, as part of the immediate environment, became involved in the music by cheering and/or clapping (see Appendix A1: 2):

Passers-by clap and cheer as they walk past (the music-making) on their way to the doctor or home.

An example of specifically experiencing a shift from disinterest to a shared experience (refer to Woodward, 2004: 9 above) was the outside influence from an authority figure at the clinic. From the start of community music therapy at the clinic, he was hesitant to participate in community music therapy sessions. His attitude towards this spontaneously created music-making in an open area remained doubtful. After attending the open sessions outside the clinic, he made the following comment (see Appendix A1: 3):

The priest from the clinic claps his hands after the loud ending, and says: “OK people, the psychiatric ward is on the other end.” All the women laugh. He continues by saying: “A famous programme on English radio is called, “Music while you work”, and I think we can hire you lot to do just that. Marvellous, thank you once again.” The group cheers.

The therapists observed that a remarkable shift occurred in this specific person from the start of the work at the HIV/AIDS clinic to this moment. In his daily work with persons affected by HIV/AIDS, he has most likely encountered the same feelings of withdrawal, social isolation and limited participation in social activities. What he saw on this day is not only a group of women from his clinic: dancing, cheering, singing and playing instruments in an open, public space, but also a reflection on what music can bring to this marginalised community.

5.1.5 Re-integration into the social environment

Music-making happened in the context of the clinic, and formed part of the active environment and vibrancy of everyday life. The therapists were able to take the music-making to where the people were, and work within the context (Stige, 2002: 28). Working with the context included using the open, public space of the clinic, including everyone who was at the clinic at the time, and allowing for spontaneous and free participation as part of people's daily activities. Participants were free to join and leave the music-making (see Appendix A1: 1):

> Most of the people participating in the music play for a few minutes and then leave to carry on with their daily activities.

The HIV/AIDS epidemic threatens everyday life activities by reducing the person's social engagements through the label that the person receives. Persons living with HIV often experience isolation, which may be incorporated into their own personal identity and thereby restrict participation in the activities of life, including communal activities, as Kalichman observed (2004, in Skinner & Mfecane, 2004: 161). Persons living with HIV/AIDS are thus affected on a personal and community level. Community music therapy may provide opportunities where people can have a personal experience (playing an instrument, singing, initiating a specific rhythm, performing a solo) and re-integration into a social environment (playing and singing with others), thereby creating community. Ansdell (2004: 86) explains that through musical communitas, the community in context, particular possibilities and qualities of social and cultural experiences are motivated and sustained through the "music of everyday life" and could perhaps afford what clients and their communities need.

The following is an example of a person's feelings after participating in a community music therapy session (see Appendix V3: 1):

T	Ah! And you?
P5	I am feeling alright.
	Every day I should do this and play.
	Have this! (points to the circle)
T	Every day? Have this?
P5	Ja, Monday I feel alright!
	(group laughter)

**T = therapist P5 = the fifth person who spoke*

From this extract of an informal interview, we see that this person identifies with the music-making as something that she could and should do on an everyday basis. Her gesture of pointing to the circle may be a representation that she should have music, playing with

others and being part of a social environment in her life. The social interaction that she "should" have is perhaps absent in her everyday activities, and through the music and interaction with others in this environment, she can fulfil that need that might be absent in her everyday life.

In summary, community music therapy has facilitated persons with HIV/AIDS to engage with their immediate environment, whilst also impacting on the environment itself. Community music therapy happened in the context of the "musicking" participants and, as Pavlicevic suggested (2004: 45), it worked with the full and complete physical and social realities of the participants. In this setting, the physical reality was HIV/AIDS and the clinic environment was the social reality of isolation. A circumstantial community was created through live music-making, as persons and the environment were able to connect and influence each other.

5.2 Theme 2: Fluidity of shifting spontaneously created roles – reforming identity

Different roles require different skills and, according to the literature, acquiring different skills for specific roles involves the control of transactions with the environment (De Board, 1978: 91). As music and the environment engage with each other, spontaneously created roles shift during such music-making. Within the context of the HIV/AIDS clinic, a staff member assumed the role of "follower", a patient held the role of "leader", and persons who were typically withdrawn, expressed themselves as confident in the midst of the music. Billington et al. (1998: 50) suggested that roles are subjective and integral to our personalities and become part of our identities. Therefore, by assuming different roles during community music therapy sessions, persons with HIV/AIDS could reform their identity, especially after suffering marginalisation due to HIV/AIDS.

5.2.1 Sharing of roles in collaboration

Findings have suggested that staff members, patients and therapists collaborated in a jointly created musical experience, shifting roles during the music. Participants interacted with each other during the music-making, which allowed for the shifting of roles to occur naturally and spontaneously. Through the musical interaction, persons became collaborators or co-participants in the musical experience. Daveson (2001: 6) defines collaboration as the shaping of a response depending on the response of the person with whom one is collaborating. In this next example, staff members join the group of patients and therapists (see Appendix A1: 1):

With the singing, staff members finished with their work in the diner, walked across to the cement block and picked up instruments. There are now ten women, including the three therapists, in the group.

During music-making, staff members, patients and therapists alike took on different roles which included a shift in roles such as: patient became participant, staff member became supporter, and therapist became collaborator. Participants in the following example were able to each share musical ideas that were reflected back to them by the group response. This enabled a natural flow of leadership to occur. The following is an example of shared musical initiatives:

The group jointly creates a melodic structure for their rhythmic playing. The members are musically aware of each other by adding their own rhythmic patterns to the group's music. The woman on the cymbal plays on the off beats, while some of the men in the group add a second vocal, melodic phrase.

By taking the musical initiative, the participants in community music therapy used the creation of their own music as a health resource (Rolvsjord, 2006: 7). In community music therapy sessions, the participants, including the therapists, shared musical ideas that allowed for the roles to shift naturally. The music had a flowing quality and could be sustained through the sharing of the leadership in the group.

5.2.2 Leadership in the music

As revealed in the data, an older woman in the group took on the leading role on numerous occasions. This was always respected by other group members, as was evident in the support they provided her. Skinner and Mfecane (2004: 161) suggest that the roles that persons with HIV/AIDS hold in their family and community life may be affected and cause social isolation and role confusion. Thus, community music therapy may extend these everyday roles during music-making, facilitating the reintegration of persons with HIV/AIDS in the community. The following is an example of an older woman leading the group and her contributing role (see Appendix A1: 1):

The older woman starts singing "hej" on the offbeat. The other women in the group join her in vocalising. The voices grow louder as the musical energy increases. As the group continues with vocalising, the older woman initiates another riff.

Community music therapy allows for women to assume leadership positions, gaining respect from others and impacting on the group's music by initiating and leading. The following

excerpt is an example of two women leading a group from outside the music space, taking on the roles of leaders (see Appendix A2: 2):

> The therapist stops singing in order to gather her voice, and the vocal phrase is continued by two women standing about 5 m away from the gazebo. The therapist stops singing completely and together with the group, follows these two women's lead. They are standing against the wall of the clinic, their participation only recognized now. They carried on singing, leading the group through the song structure. The music continued to be fast-paced, vigorous and rhythmic.

The two women from this excerpt were empowered by taking on a leadership role for a group where they were considered to be "outsiders". They motivated the group to continue with their music-making, by taking over the therapist's leadership. Their role was amplified by the exchange relation they received with the rest of the group. This relates to the research of Stetts and Burke (2000: 13) who stated that if a role should function, it must be able to rely on the reciprocity and exchange relation with other roles. In order for their role as motivators to function, they had to rely on group support. These two women were standing apart from where the actual music-making occurred, yet they still managed to step into the leading role. These two women moved from being less influential to being leaders of the group, and were thus empowered.

Taking ownership of the music was evident when the music stopped momentarily and someone in the group started something new with the rest of the group following enthusiastically. An example of this was when a young woman was invited to play in the middle of the group. She stood up hesitantly and kept eye contact with the therapist (see Appendix A3: 2):

> Still keeping eye contact with the therapist, and smiling broadly, she hits the bongos with determination. She immediately initiates a rest after the first beat of the repetitive syncopated rhythm that the group has been playing for 9 minutes already. The group stopped momentarily, and she plays the next bar on her own.

This example illustrates a young woman's determination to take control of the music, even though she was initially hesitant to play. Taking control in the music, allows for the person to be empowered and perhaps gain an experience of being in control of his or her life. This is in accordance with the concept of resource-oriented music (Rolvsjord, 2006: 7), where, during the process of music making, the focus is on the strengths and abilities of the person rather than on the weaknesses and illness. This young woman may have experienced a sense of control from being hesitant at first, to leading the group's music with determination.

The group changed their music according to hers, whereby she could control what was happening in the music. Being in control also refers to one of the dimensions of empowerment, as mentioned by Brown (1991 in Daveson, 2001: 6): people are "given the opportunity to regain a sense of control over their lives and environment." Her role as a patient with little control over her condition, as withdrawn and hesitant, shifted when she took on the role of leader.

In summary, shifting and shared, spontaneously created roles empower persons participating in community music therapy. Women, who are typically scorned and looked down on for their social vulnerability to HIV/AIDS (Strebel, Crawford, Shefer, Cloete, Henda, Kaufman, Simbayi, Magome, & Kalichman, 2006: 527), had the opportunity to take on leadership positions during the music-making. They earned respect from others, as their musical ideas were reflected through the music of the community music therapy group. The natural flow of leadership roles that occurred, added fluidity to the music, enabling musical initiative to originate from different persons. Those persons who were typically withdrawn took on the role of leader, by taking ownership of the music and experiencing a sense of agency and self-control through the music. The following elaborates on the sense of togetherness which can be thus achieved, by discussing the third theme: music as socially connective.

5.3 Theme 3: The collective musical experience is socially connective – creating a sense of togetherness

Collectively, participants interacted, shared and engaged with others during music-making. Their social isolation was reduced, as they, as a group, supported the soloist, the leader or each other by being collaborators in the music. Traditional responses to illness in many African cultures typically include the family and community involvement of the sick person, by treating the person collectively (Airhihenbuwa & DeWitt Webster, 2004: 5). With the stigma attached to HIV/AIDS, persons with the diagnosis of HIV/AIDS are often left alone, socially isolated from their own families and communities. Through community music therapy, the focus can be placed on creating a socially cohesive experience between persons. After a community music therapy session, a man reflected on his feelings as that of being part of "one family" (see Appendix V3: 3). As a participant, the researcher can reflect on this sense of family, as it was present throughout all the sessions, even when the participants were all strangers to one another.

Community music therapy, in this way, facilitates a collective musical experience as it is a social and cultural practice. As Ansdell (2002: 11) suggests, community music therapy enables communities to re-establish relations with each other. In the circumstantial

community, operating around issues relating to HIV/AIDS, strangers could establish relations with each other by listening to and reflecting back to each other, musical ideas that had originated in collective music-making.

A sense of togetherness was established through collective music-making. Participants in community music therapy sessions were connected through their mutual enjoyment of each other (group laughter), and through collective singing (see Appendix V2: 2). An example of collective singing and enjoyment was evident when a young woman initiated a song, and the rest of the group started playing on their instruments and sang in perfect harmony with her (see Appendix A2: 3):

> With a brief stop in the music, a young woman in the group starts singing. The rest of the group follow immediately. Everyone in the group seems connected to each other, playing together and giving the soloist her chance to sing. Even though she was singing, the music was not led by her, rather by the group playing and singing together.

The group was connected not only through the song, but through being together, sharing a space and making music. The group offered the soloist support and as the song was culturally specific and familiar, the natural flow of voices emerged as a collective musical experience. Referring back to the literature, Hunt (2005: 10) suggests that the act of music-making in a community music therapy group context facilitates peer support and encourages group participation.

In summary, from the social isolation that persons living with HIV/AIDS may experience, music-making has clearly enabled participants to feel connected, giving them an experience of being part of a group. Singing culturally relevant songs during sessions, may have led to participants identifying positively with their own communities and finding something familiar in an unfamiliar environment.

The following theme describes how the individual participant may have experienced community music therapy as a personal, psychosocial resource.

5.4 Theme 4: The central role of musical experience as a personal community music therapy resource

Personal psychosocial factors of ill-health include stress, unhappiness, and negative life events, as reported by Blaxter (2004: 15). The central role of the musical experience in community music therapy sessions facilitated positive experiences, as reflected on by the

participants after the music-making session (see Appendix V1: 1-2). Participants specifically stated that music is their "comforter" and they described music's capacity to help them "relax" and "de-stress". They also expressed the suggestion that they would want to return to future community music therapy sessions.

Personal psychosocial resources mentioned in the literature were referred to during interviews. These resources include intra-personal attributes such as self-worth, optimism, positive moods and feelings of wellbeing (Harber et al., 2008: 296). These are illustrated in the following short excerpt from such an interview (see Appendix V1: 1-2):

P2	It was nice to be here.
	I enjoyed it
	And I will come again.
	I enjoyed it.
P3	I love music because….I love music.
	I can't sing too much […..] reminded all these things will be alright.
T	[Yes, that's very true, hey?]
P4	I really enjoy the music and drums and everything and
	Next time I will be back here.
	Thank you very much.
T	[Thank you very much and thanks for coming.]
CoT	[Thanks everyone for coming. Thanks for the nice session. I was dancing and jumping and then I was relaxed afterwards.]
P5	I also like music.
	Music is my comforter
	And I am grateful for everything you have done for us.
	It shows love and
	I am relaxed.
	All the best for you and I hope I can come again, maybe next week.
T	[Thank you and I hope you come again.]

**T = Therapist; P (number) = person speaking; CoT = Co-therapist*

From the interviews, it is evident that the musical experience helped persons to experience enjoyment, relaxation and have an overall positive experience. It is evident from the participants' reflections that these positive experiences enabled the participants to gain strength from the music-making as they were prepared to face the outside world again (see Appendix V2: 1):

T	And you?
P5	I just want to say thank you.
	I enjoyed it so much.
	I'm prepared to face going out now.
	(Group laughter)

**T = Therapist; P (number) = person speaking;*

Hogg and Abrams (1988, in Campbell et al., 2007: 413) state that human beings have a fundamental need for positive self-esteem, and perhaps even more so when faced with a

stigmatised diagnosis such as HIV/AIDS. The participants reported that the musical experience during community music therapy sessions facilitated positive feelings and generated a positive outlook on life. Participants further indicated that the music was a reminder of hope, which is seldom an emotion that persons with HIV/AIDS experience in the light of their prognosis.

Further, data from the musical improvisations highlighted the ability of persons participating in community music therapy. The following is an excerpt from such moments (see Appendix A3: 2):

> The therapist starts inviting individual people through gestures to come and play the set of bongos. One young man with the diagnosis of a mental health disorder plays first. He plays loud and rhythmically, but in connection also with the group.
>
> The old woman that joined the group first played loudly and confidently, accelerating the rhythm of the group. The group cheers as she finishes playing.

The young man from this excerpt had a diagnosis of a mental health disorder as caused by the final stage of HIV/AIDS. In his life, he might be rejected on a daily basis, discarded because of his mental health and his HIV/AIDS and few might even take notice of him. In this context, he played loudly and rhythmically, and in time with the group. The group supported him and empowered him by giving him the opportunity to lead them. A similar moment occurred when an older woman played in front of the group and received a loud cheer afterwards. Here, music played a central role which focused on the individual person's ability rather than his or her illness, and the musical experience was used as a psychosocial resource.

In summary, theme 1 has explored the interaction between the music and the environment, and how important it is to re-establish that connection, which could then re-establish the feeling of community. Theme 2 described the roles as being shared and roles that shifted during the music-making. This enabled participants to extend their own identity roles through the music, become leaders rather than withdrawn, and further, being empowered through the experience. Theme 3 indicated that through music-making a sense of togetherness was created, re-integrating persons into the social environment and highlighting the social benefits of community music therapy. Theme 4 addressed the central role of the musical experience as it facilitated positive feelings, relaxation and empowerment for the participants. The latter reflects the personal benefits that were gain by each participant.

5.5 RESEARCH QUESTION 2: THE ROLE OF COMMUNITY MUSIC THERAPY IN SOUTH AFRICA

"Sub-Saharan African culture does not separate music from life."

Pavlicevic (1997: 6).

The HIV/AIDS clinic described in this present study is a typical, government institution that most persons living with HIV/AIDS in South Africa make use of. Due to the vast number of persons living with HIV/AIDS in South Africa, community-type interventions are suggested (Freeman, 2004: 143).

As seen above, community music therapy is a psychosocial resource for persons living with HIV/AIDS. Community music therapy is a context-based approach, which consequently entails working with people where they find themselves. Sessions were held where the people were in the environment with which they interacted, largely on a biomedical basis, and where they often found themselves alone, a patient number in the midst of clinical activities.

Healing in an African context often occurs outside closed doors, usually involving the community of the individual receiving the healing. In many African contexts, the individual is considered in relation to others. "Ubuntu" is a word from the Bantu languages of Southern Africa, which, when translated means: "*I exist because I see myself through you*" (Pavlicevic 1997, p. 109). Dos Santos (2005) suggests that group work is the most effective means of addressing people, and as many of their individual needs as possible. Nzewi (2002: 2) explains this further: "*Individual suffering impacts on the wellbeing of many others, and group empathy is compelled in the search for a remedy*". Nzewi (2002: 2) further suggests that the supportive involvement of the community can stimulate the "life energy of the sick". Taking Ubuntu into consideration then, it is appropriate to work with an individual and what he or she is experiencing through group music therapy (Dos Santos, 2005), and particularly community group music therapy. Themes 3 and 4 are therefore specifically relevant within the South African context, as a collective musical experience enables the re-establishment of social connection and individuals reflected on receiving a personal, positive experience.

The music created during the community music therapy sessions was vibrant, energetic and fast. The continuous, steady, energetic rhythm that was created during community music therapy sessions by staff, therapists and patients alike, may be a reflection and the expression of a common cultural musicality that is shared by most cultures in South Africa. Community music therapy entails a grassroots approach to re-establishing cultural

connectivity. Through the continuous, steady beat that the music-making facilitated, the participants were able to make use of their own "cultural musical resources", a term used by Zharinova-Sanderson (2004: 243), therefore simulating the cultural activities of their own communities. The singing of familiar spiritual songs may have assisted participants in identifying with their own cultural music even in a clinical environment where the culture is of a medical nature. Music making is a pleasurable, enjoyable, positive medium that reflects traditional cultural experiences, just as music forms part of everyday life in most South African cultures. Community music therapy is therefore a medium that builds communities in the age of an epidemic that seems to be destroying communities.

In summary, the role of community music therapy in South Africa can be seen as socially connecting people from a marginalised society, such as a HIV/AIDS clinic. The musical experience re-connected people to feel part of a community, and their musical contribution could be valued through the group support.

5.6 Over-arching themes

This study can be concluded by highlighting two over-arching themes, the first being social benefits, which incorporates theme 1 (music and the environment engage with one another – establishing community) and theme 2 (fluidity of shifting spontaneously created roles – reforming identity). The second overarching theme can be conceptualized as personal benefits, which incorporates theme 3 (the collective musical experience is socially connective – creating a sense of togetherness) and theme 4 (the central role of musical experience as a personal community music therapy resource). Personal benefits were gained as individuals were given the opportunity to be the soloist, the leader and the supporter to others in the music. Participants highlighted relaxation, de-stressing and enjoyment as the most important personal benefits. These positive experiences may lead to a healthier, positive outlook on their personal lives and their possible struggle with HIV/AIDS. The study highlights how community music therapy enabled interpersonal interaction when making music with others, including eye contact, instrumental support to a soloist, recognition of another's playing and creating music together in a social space. As this study addresses an alternative medium for intervention for HIV/AIDS, these two over-arching themes are extremely relevant in the South African context.

5.7 Conclusion

This study has examined community music therapy as a psychosocial resource for persons living with HIV/AIDS. The findings suggest that persons living with HIV/AIDS, attending the

HIV/AIDS clinic in Tshwane, could use community music therapy as a psychosocial resource.

Due to living and operating in a marginalised community, such as the HIV/AIDS clinic, community music therapy established a circumstantial community through the music, enabling participants to connect with their environment through their music-making, shifting their energy through the vibrant creation of music. In addition, community music therapy facilitated the environment and the music to engage with each other. The vibrant energy of the music may have been a reflection of health, life and the energy of persons living with HIV/AIDS, rather than of the illness that they carry.

Persons living with HIV/AIDS had the opportunity to reform their identity by assuming different roles through the music. Women and men alike were able to lead, motivate and receive respect through their participation in community music therapy. Patients, staff members and therapists could share leadership of the music, take the musical initiative and become collaborators in the music-making. Persons who were typically hesitant were able to grow in confidence during the music-making experience.

As a socially connecting experience, community music therapy facilitated a sense of togetherness in a marginalised community. Group support, peer support and social interaction were experienced through the spontaneously created music. Community music therapy as a personal psychosocial resource enabled participants to relax, de-stress and gain comfort from the music. The musical experience facilitated the re-establishing of hope, and elicited positive emotions and feelings from the participants.

Community music therapy in South Africa is a viable, valuable, inexpensive and community-based approach that reflects the vibrancy of the South African people. It is a culture-centred intervention that transcends South Africa's many cultural boarders and may make possible the building of new communities. The following chapter will present a broader conclusion, the limitations of the study and some future recommendations for further research on this topic.

CHAPTER SIX

CONCLUSION

My main focus of the study was to discuss how community music therapy can be a psychosocial resource for persons living with HIV/AIDS.

Through the literature, it appears that persons living with HIV/AIDS may experience life in a marginalised society; they may become socially isolated from their communities. This may lead to a loss of identity, negative attitudes towards life and personal stress that is usually associated with these factors. It became apparent through the emerging data that community music therapy may be utilised as a psychosocial resource.

6.1 The findings of the study

6.1.1 Establishing community and facilitating the shifting of roles

Community music therapy facilitated the engagement between the music created by persons participating in live music-making and the clinical environment. This engagement could be understood through the lens of systems theory, where energy is transferred between two open systems, and both systems are influenced by one another. Community is established through this interaction, as participants could reconnect with each other within the context of a musical community. Staff members, patients, groundsmen and therapists alike participated as equal beings, with no stigma or discrimination.

Different roles became apparent through the emerging data. Patients and staff members became leaders through the music, as each person in the music-making took on a leading role. The natural fluidity of leading roles sparked people's individual musical initiative, and participants could experience being creative in the music-making sessions. This creativity that the music-making facilitated was supported by others in the group, and single participants were motivated. Through the music, persons were able to move from having less power to being in control, so experiencing empowerment.

6.1.2 Connective musical experience and musical experiences as a personal psychosocial resource

The fluidity of roles and the establishment of shared leadership facilitated a collective musical experience that created a sense of togetherness amongst the participants. Community music therapy is a social and cultural approach that reflects a communal, collective identity. The music that was created was vibrant, energetic and a reflection of life

amongst those participating in the musical experience. The singing of culturally relevant songs further facilitated group cohesion and reconnected persons to their cultural identity.

People attending community music therapy sessions reflected on their personal feelings after and during these sessions. They suggested that participating in the musical experience during community music therapy sessions facilitated a positive experience, where positive emotions and feelings were elicited. They shared the view that music is a comforter, that it alleviates stress and facilitates relaxation. Feelings of hope for the future were a sign of optimism and indicated a sense of wellbeing. Community music therapy thus contributed to health promotion in this medical setting and could be utilised as a psychosocial resource.

6.1.3 Implications for South Africa

Community music therapy is a viable, valuable, inexpensive and feasible approach that facilitates health promotion in the context of South Africa. Even with medical treatment, the person with HIV/AIDS might still experience a lack of psychosocial support. Community music therapy can offer that support through collective musical experiences, as it is a culture-centred approach that brings people back to their roots: where music-making is part of everyday activities and a medium that transcends South Africa's multi-cultural borders. Participants experienced social benefits through group support and establishing social networks through music. Further, feelings of self-worth, personal control and optimism became clear through interviews with the participants, reflecting the personal benefits that community music therapy could facilitate.

The re-establishing of community and the social reintegration of people into the community through spontaneous music making may provide opportunities for building future communities.

6.2 Limitations of the study and future recommendations

This study discussed community music therapy as a psychosocial resource from the perspective of both the researcher and the participants. During sessions, informal interviews were conducted in most of the participants' second language, English, and difficulties relating to language may therefore have limited the findings. If these informal interviews were conducted in participants' own language, richer data may well have been gathered. For future studies, therefore, it is recommended that more formal interviews be conducted, such as focus groups, to convey a more complete picture of what community music therapy may offer. In addition, these interviews should be conducted in the participants' own language, to allow for deeper personal expression.

Participants attended both outside sessions and sessions in an enclosed room, and only the participants in the enclosed room, had the opportunity to reflect on their experiences. This further limited the richness of the data, as more people participated in the outside sessions and more spontaneous music-making occurred outside. However, it was not possible to obtain formal reflections from participants outside, as there was a continuous flow of participants leaving and joining the music-making during a session. For future studies, reflections from these sessions should be structured to allow for a more comprehensive perspective on these "outdoor" sessions.

Only three informal interviews and three audio excerpts from work at one particular placement were used for data collection. A broader look at community music therapy, using more excerpts or examining work at a range of placements, would contribute further. More in-depth perspectives on understanding community music therapy as a psychosocial resource for persons living with HIV/AIDS could well be forthcoming.

Community music therapy is an approach that could offer persons living with HIV/AIDS a valuable and positive experience with both personal and social benefits, and more studies should focus on aspects of community music therapy and its specific value in South Africa.

6.3 Conclusion

In conclusion, the vast impact of HIV/AIDS on the people living in South Africa is not only on the physical and medical levels, but is also affected by the lack of psychosocial resources. The amount of literature available on examining the lack of resources exceeds the amount of literature available on intervention and solutions. Community music therapy is such an intervention, and may be utilised as a psychosocial resource for persons living with HIV/AIDS. Music-making transcends the cultural borders within the context of South Africa, facilitating engagement with the environment, expanding roles, socially connecting and personally, positively affecting people of all ages and races.

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APPENDIX 11:

THICK DESCRIPTION SESSION 4: AUDIO EXCERPT A1

Thick description
Outside the HIV/AIDS clinic, on a hot sunny morning, three therapists put out a variety of instruments so that people passing by or standing in the cue for lunch can have access to live music making. After approximately 40 minutes, the music had continued through various phases. These phases consisted out of energetic, fast rhythms being played on the djembe drums by people walking past or onlookers waiting in the shade. Most of the people participating in the music play for a few minutes and then leave to carry on with their daily activities. (38:30) An older woman have joined the therapists on the cement block, by pulling an old chair closer, sitting and initiating a slow rhythm on a djembe drum. Five other women join the group, including the three co-therapists, playing on the xylophone, claves, shakers, guitar and djembe drums. The music lack energy but is rhythmic and repetitive and is jointly created. (38:48) The older woman starts singing "hej" on the off beat. The other women in the group join her in vocalising. The voices grow louder as the music's energy is lifted. As the group continues with vocalising, the older woman initiates another riff. With the singing, staff members finished with their work in the diner, walk across to the cement block and picks up instruments. There are now ten women, including the three therapists, in the group. The vocalisations fade out, and the addition of new group members disables the music structure as each member plays their own rhythmic pattern. Here, the music sounds disjointed. (40:51) The therapist starts playing loud rhythmic, syncopated beats on the djembe and the members copy her playing with the same intensity and rhythm. The therapist adds a melodic riff above the playing, and the group copies her riff when she pauses. The music sounds lively, rhythmic and at a moderately fast tempo. Their voices are loud and clear as they sing together. The women in the group respond with enthusiasm in their voices and in their playing.

(42:55) A woman in the group shows her enthusiasm by adding her own vocalisation to the music. All the women in the group then initiate their own sound, adding a liveliness to the music and the environment. Passersby clap and cheer as they walk past on their way to the doctor or home. The music is African by its rhythm, and its singing. Vocal phrases are unique to each woman, driven by the repetitiveness of the rhythm, copying and imitating each other's way of singing and playing. The women make eye contact with each other as each woman share her musical ideas with the rest of the group. A natural flow of leadership develops in the group.

(45:31) The women are connected through their singing as they follow each other's vocalisations. One woman initiates a loud but short vocalisation, and immediately the group copies her. The rhythm drives the music and the voices unite. The woman sustains one note, and this leads to a glissando and an acceleration that resolves in an ending. The priest from the clinic claps his hands after the loud ending, and says: "OK people, the psychiatric ward is on the other end." All the women laugh. He continues in saying: "A famous program on English radio is called, Music while you work, and I think we can hire you lot to do just that. Marvellous, thank you once again." The group cheers.

(46:32) The music continues immediately after the priest spoke, initiated by another member in the group. The tempo is slower than the previous improvisation, but the group sings and plays together rather than one person leading it.

APPENDIX III:

THICK DESCRIPTION OF AUDIO EXCERPT A2: SESSION 6

The music session starts when the therapists carry out the instruments onto the open cement block and pre-recorded South African music is playing on the CD player. It is a busy area where people are cueing for lunch and many patients are arriving to see the doctor, about to leave the clinic or standing along the clinic's wall out of the hot sun, watching the therapists putting the instruments out. Already, there is a long cue outside the diner. A gazebo was constructed on the cement block, 10 m away from the cue to provide some shading from the hot sun. After 19 minutes of different musical phases, stops and starts in the music, a group of 20 people started forming around the gazebo.

THICK DESCRIPTION
A group of 20 people gathered under the gazebo. Each member had an instrument on which they kept a steady, ongoing, syncopated rhythm. This rhythm carries the music to the cue, where people are clapping their hands, tapping their feet and some singing along with the therapists. The therapists are singing: Don't worry be happy" in a call and response activity with the cue. Under the gazebo, the rhythm is kept steady by the 5 men who joined the group. The women in the group play the cymbal, shakers, claves, some on djembe drums and others singing and clapping. The music becomes part of the environment, filtering through the outside air. The music is energetic and at a fast tempo. The therapist returns to the gazebo as the people in the cue goes into the diner to eat lunch. Under the gazebo, the music is still ongoing, and everyone seems excited about the music. The therapist initiates a vocal phrase of thirds in time with the syncopated beat of the group. After this phrase, a call from the therapist indicates faster, rhythmic playing that allows a change in the music. This is repeated and returns to the original vocal phrase. The group jointly creates a melodic structure for their rhythmic playing. The members are musically aware of each other by adding their own rhythmic patterns to the group's music. The woman on the cymbal plays on the off beats while some of the men in the group add a second vocal, melodic phrase.

The therapist stops singing in order to gather her voice, and the vocal phrase is continued by two women standing about 5 m away from the gazebo. The therapist stops singing completely and together with the group, follow these two women's lead. They are standing against the wall of the clinic, their participation only recognized now. They carried on singing, leading the group through the song structure. The music continued to be fast paced, vigorous and rhythmic.

The therapist started singing with the women again, and continued for another few seconds. The therapist started singing slower, indicating a ritardando. The group's music jointly decreased in tempo. The longer, sustained notes in the melody indicated an ending, and on the last note, the group played loud and fast on their instruments, ending in a rumble of instruments. With the acceleration in the music, the group cheered, clapped and laughed as the music ended.
Someone starts another improvisation and everyone in the group play with. The music is fast, with the same syncopated rhythm as before.

With a brief stop in the music, a young woman in the group starts singing. The rest of the group followed immediately. Everyone in the group seemed connected to each other, playing together and giving the soloist her chance to sing. Even though she was singing, the music was not led by her, rather the group playing and singing together.

APPENDIX IV:

THICK DESCRIPTION OF AUDIO EXCERPT A3: SESSION 11

Thick description
The sun was shining warmly by the time we arrived for the last day at the clinic. Instruments were put out on the cement block under the gazebo. An older woman who has attended a few of our sessions is already sitting with her djembe drum and starts playing with enthusiasm. The therapist starts playing on the pennywhistle, and more people, especially women and children, join the music making, picking up various instruments and playing them including djembe drums, shakers, tambourines, claves, boom whackers, xylophone and hand drums. As more people join the music making, a syncopated rhythm in 4/4 metre develops. The rhythm is at a moderately fast tempo, with a strong demanding quality. Its ongoing, repetitive rhythm is characteristic of the culture we have experienced at the clinic. The group members are all playing percussive instruments, including the therapists. A vocal syncopated riff, initiated by the therapist, amplifies the rhythm that is played. Soon, the group joins in on the riff. A set of bongos are placed in the centre of the cement block. With approximately 5 minutes of playing, the therapist walks up to the set of bongos and begins playing on the off beats of the 4/4 metre, to demonstrate playing something different. The group carries on playing their syncopated beat but watches the therapist as she plays. After the therapist played, she returns to the djembe she was playing, and started singing the vocal riff again. The therapist starts inviting individual people through gestures to come and play the set of bongos. One young man with a diagnosis of mental health disorder plays first. He plays loud and rhythmically but in connection with the group.

The old woman that joined the group first played loud and confident, exacerbating the rhythm of the group. The group cheers as she finishes playing. The group repeats the vocal riff until the next one stands up to play.

A woman, who the therapist remembered from a previous session as being shy and introverted, sits opposite the therapist, playing a djembe drum. In the previous session, she refused to play solo, and was hesitant in playing at all. The therapist called her to play on the set of bongos in the middle. She looks at the therapist with slight hesitation, and then she stands up and goes straight to the bongos.

Still keeping eye contact with the therapist, and smiling broadly, she hits the bongos with determination. She immediately initiates a rest after the first beat of the repetitive syncopated rhythm that the group has been playing for 9 minutes already. The group stopped momentarily, and she plays the next bar on her own.

The group starts playing with her, and the music continues in the same syncopated beat.

The energy is lifted even though the rhythm stays the same. A general feeling of enthusiasm is felt. The woman plays for a further 30 seconds, and then goes back to her seat. The group continues the vocal phrase.

More individual persons come to play solos: a woman with a small child plays with loud intensity, and a man standing away from the group, joins in.
The music carried on for an hour after this, all of the group members staying till the end.

APPENDIX V:

INTERVIEWS

INTERVIEWS FROM VIDEO EXCERPT V1

Background

After the music listening activity stopped, where the therapist asked everyone to relax and close their eyes, the therapist asks the participants how they feel and if they could say something about the music. The setting is a closed room and nine people attended the session. 6 Women and two men attended the session.

NAME	INTERVIEW
T	[I think we're finished now, so you must come next week again. I wanted to do another drumming activity, but I think we all feel at ease and relaxed now. Maybe we can just all say goodbye to each other and maybe say one or two sentences about the music.]
P1	About the music? It was alright.
T	[It was alright?]
P1	Ja, it was alright. Whenever I play music, I feel excited.
T	[Thank you for coming. I'm very glad about that. Thank you, N. Thank you to everyone. I hope I will see you next week or….we are here every Monday until May, so we will see you soon.]
FB	[Till May?]
T	[End of May.]

NAME	INTERVIEW
FB	[(pulls sad face)]
ALL	[(laughing)]
P2	It was nice to be here.
	I enjoyed it
	And I will come again.
	I enjoyed it.
P3	I love music because….I love music.
	I can't sing too much[…..] reminded all these things will be alright.
T	[Yes, that's very true, hey?]
P4	I really enjoy the music and drums and everything and
	Next time I will be back here.
	Thank you very much.
T	[Thank you very much and thanks for coming.]
CoT	[Thanks everyone for coming. Thanks for the nice session. I was dancing and jumping and then I was relaxed afterwards.]
P5	I also like music.
	Music is my comforter
	And I am grateful for everything you have done for us.
	It shows love and
	I am relaxed.
	All the best for you and I hope I can come again, maybe next week.
T	[Thank you, and I hope you come again.]

INTERVIEW FROM VIDEO EXCERPT V2

Background

This interview took place in a closed room, from session 6. These spoken exchanges were held after a free improvisation involving singing and playing on different instruments. 10 People attended this session, including the three therapists'. Most of the participants were women, and one man joined the music session during the second last activity.

NAME	INTERVIEW
T	Tell me, how, how did you ….did you enjoy it, how did you feel?
P4	Oooh, I wish we can do this everyday.
	(group laughter)
P1	It was nice.
T	Was it nice? And you? Did you enjoy it?
P1	[Uhm]
P2	Ja…..
P1	I like when we dance….
	(group laughter)
T	And for you?
P3	I enjoyed it.
T	Was it the music or the singing?
P3	The singing and everything.
CoT	I just like being here.
T	And you? You said you'll come everyday?

NAME	INTERVIEW
P4	Ja!
	(Group laughter)
T	And you?
P5	I just want to say thank you.
	I enjoyed it so much.
	I'm prepared to going out now.
	(Group laughter)
P6	It was nice.
	I am de-stressed.
	(plays her drum)
T	And sir, I am so sorry, but you can join the next session outside. What did you think when you came in? Did you hear us from outside?
P7	Ja, I heard the noise and the drums so I just wanted to see for myself.
T	Good, but you must come to the next session.
P7	It was nice
	, I enjoy the beat and us singing all together
T	Yes, you have a very strong voice.
	(Group laughter)

INTERVIEW FROM VIDEO EXCERPT V3

Background

These spoken exchanges happened after a music listening and relaxation exercise where everyone was asked to close their eyes and relax. There were ten people in the group, including the three therapists. One man joined the session during an improvisation activity before the music listening.

NAME	INTERVIEW
T	Ok, now before you go, I just want to know how everyone is feeling cause when I, before the session started, I was abit stressed and now I am relieved and relaxed and stress-free. Uhm, I think, in a way, the drumming helped to get my frustrations out there. Would you like to share something?
P1	(shakes head and smiles)
T	To say how you feel now?
P1	No, I am feeling good now.
T	Did you enjoy this?
P1	Yes (smiles)
T	That's good. Thanks for being here. And you? Would you like to translate for her.
P4	(translating the question)
P2	(speaking in her own language)
P4	She is feeling very happy.
T	Sharp! And you?
P3	[……]

NAME	INTERVIEW
	(laughs)
P4	I am feeling good
	And relieved.
	I was stressed and
	This (points to the drums) makes me always happy
	Always when I come here, I am happy.
	I am really happy and
	Can go now go home.
T	Ah! And you?
P5	I am feeling alright.
	Everyday I should do this and play.
	Have this! (points to the circle)
T	Everyday? Have this?
P5	Ja, Monday I feel alright!
	(group laughter)
T	And you sir? Being the only man, did it bother you?
P6	Nah, I feel like we are one family.
T	Ah, a family.
P6	And relaxed.
T	Did the music, did you hear the music and then did you come?
P6	Ja, I heard the music outside.
T	Well, I am glad you are here.

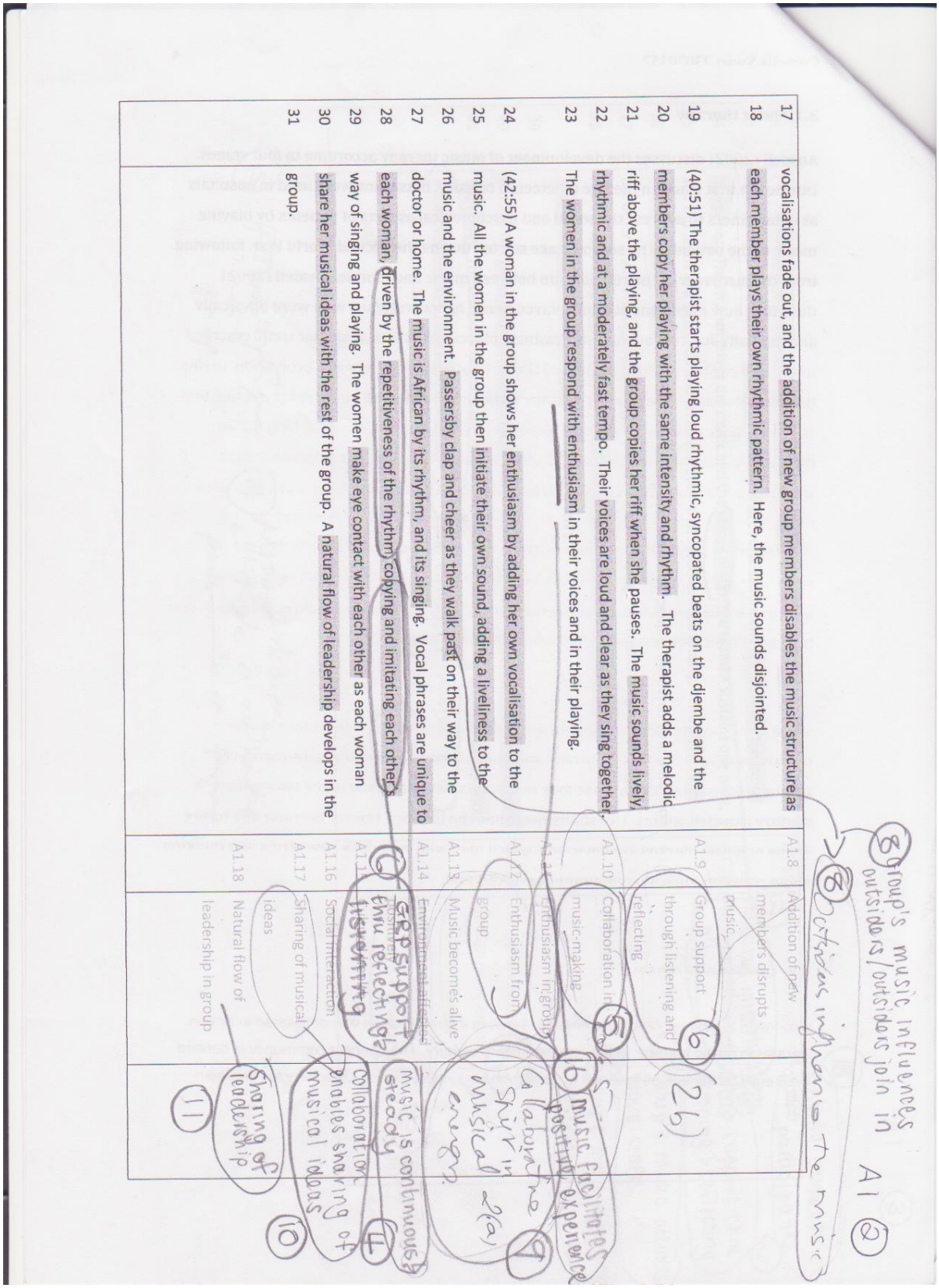
NAME	INTERVIEW
P7	I hope you can….. everytime come here.
	I will be very happy,
	And I am very happy.
T	Thank you everyone.
	(group claps and cheers)

APPENDIX V1:
Coding of Audio Excerpt A1

THICK DESCRIPTION SESSION 4

Line nr	Thick description	Code Nr	code	notes
1	Outside the HIV/AIDS clinic, on a hot sunny morning, three therapists put out a variety of	A1.1	Live music-making outside in busy area.	
2	instruments so that people passing by or standing in the cue for lunch can have access to live			
3	music making. After approximately 40 minutes, the music had continued through various			
4	phases. These phases consisted out of energetic, fast rhythms being played on the djembe	A1.2	Music stems over phases	
5	drums by people walking past or onlookers waiting in the shade. Most of the people			
6	participating in the music play for a few minutes and then leave to carry on with their daily	A1.3	Participants are free to come and go.	
7	activities.			
8	(38:30) An older woman have joined the therapists on the cement block, by pulling an old chair	A1.4	Older woman leads the group music	
9	closer, sitting and initiating a slow rhythm on a djembe drum. Five other women join the group,			
10	including the three co-therapists, playing on the xylophone, claves, shakers, guitar and djembe	A1.5	Music's repetitive but creatively created	
11	drums. The music lack energy but is rhythmic and repetitive and is jointly created.			
12	(38:48) The older woman starts singing "hej" on the off beat. The other women in the group	A1.6	Women respect older woman by following her music	
13	join her in vocalising. The voices grow louder as the music's energy is lifted. As the group			
14	continues with vocalising, the older woman initiates another riff. With the singing, staff	A1.7	MA's energy lifted with celebration	
15	members finished with their work in the diner, walk across to the cement block and picks up			
16	instruments. There are now ten women, including the three therapists, in the group. The			

APPENDIX V1:
Coding of Audio Excerpt A1



vocalisations fade out, and the addition of new group members disables the music structure as each member plays their own rhythmic pattern. Here, the music sounds disjointed.

(40:51) The therapist starts playing loud rhythmic, syncopated beats on the djembe and the members copy her playing with the same intensity and rhythm. The therapist adds a melodic riff above the playing, and the group copies her riff when she pauses. The music sounds lively, rhythmic and at a moderately fast tempo. Their voices are loud and clear as they sing together. The women in the group respond with enthusiasm in their voices and in their playing.

(42:55) A woman in the group shows her enthusiasm by adding her own vocalisation to the music. All the women in the group then initiate their own sound, adding a liveliness to the music and the environment. Passersby clap and cheer as they walk past on their way to the doctor or home. The music is African by its rhythm, and its singing. Vocal phrases are unique to each woman, driven by the repetitiveness of the rhythm copying and imitating each other's way of singing and playing. The women make eye contact with each other as each woman share her musical ideas with the rest of the group. A natural flow of leadership develops in the group.

A1.8 Addition of new members disrupts music

A1.9 Group support through listening and reflecting

A1.10 Collaboration in music-making

A1.11 Enthusiasm in group

A1.12 Enthusiasm from group

A1.13 Music becomes alive

A1.14 Environment affected

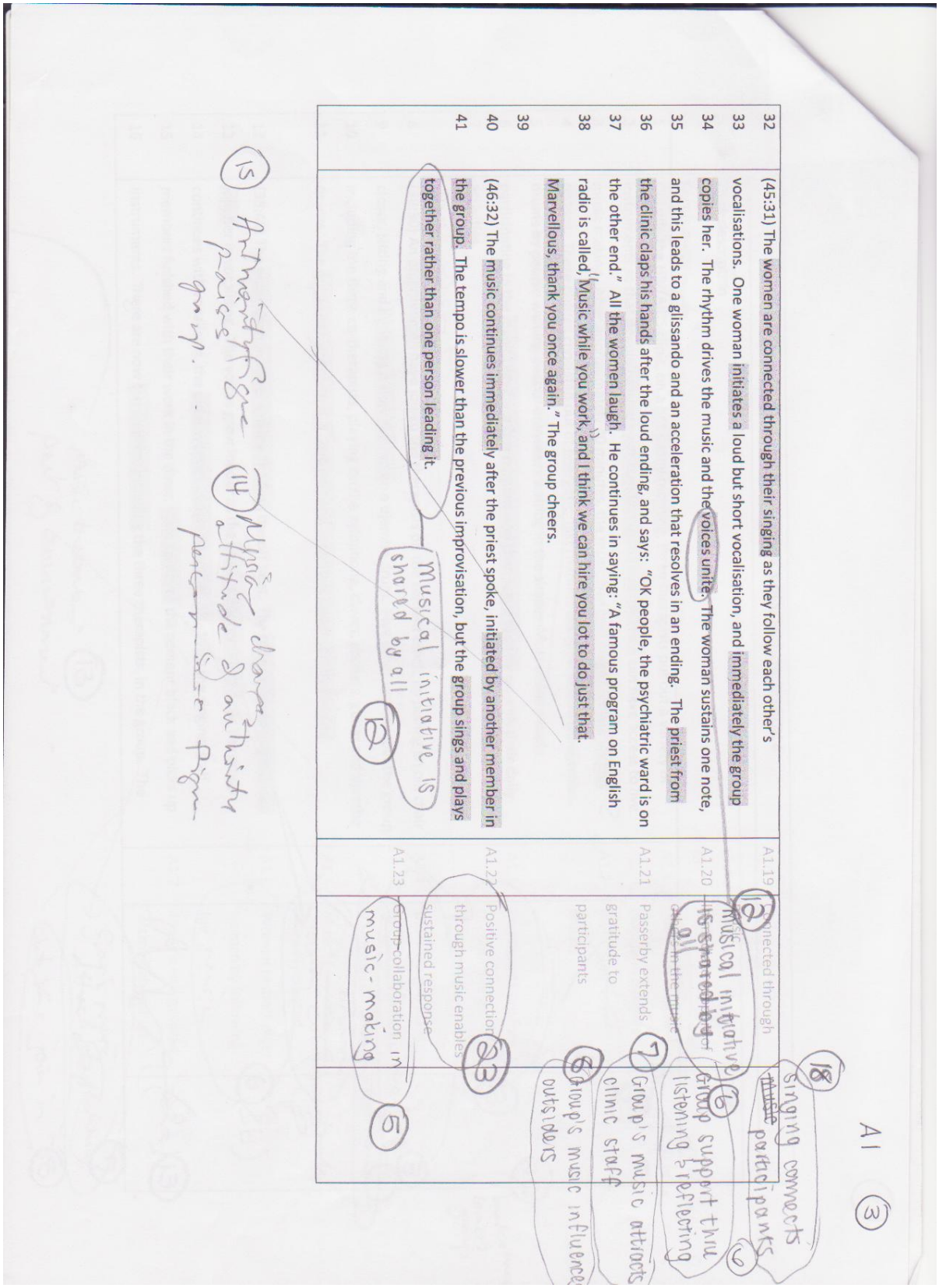
A1.15 Social interaction

A1.16 Social interaction

A1.17 Sharing of musical ideas

A1.18 Natural flow of leadership in group

APPENDIX V1:
Coding of Audio Excerpt A1



(45:31) The women are connected through their singing as they follow each other's vocalisations. One woman initiates a loud but short vocalisation, and immediately the group copies her. The rhythm drives the music and the voices unite. The woman sustains one note, and this leads to a glissando and an acceleration that resolves in an ending. The priest from the clinic claps his hands after the loud ending, and says: "OK people, the psychiatric ward is on the other end." All the women laugh. He continues in saying: "A famous program on English radio is called 'Music while you work,' and I think we can hire you lot to do just that. Marvellous, thank you once again." The group cheers.

(46:32) The music continues immediately after the priest spoke, initiated by another member in the group. The tempo is slower than the previous improvisation, but the group sings and plays together rather than one person leading it.

A1.19 Connected through musical initiative

A1.20 Group support thru listening & reflecting

A1.21 Passerby extends gratitude to participants

A1.22 Positive connection through music enables sustained response

A1.23 Group collaboration in music-making

A1

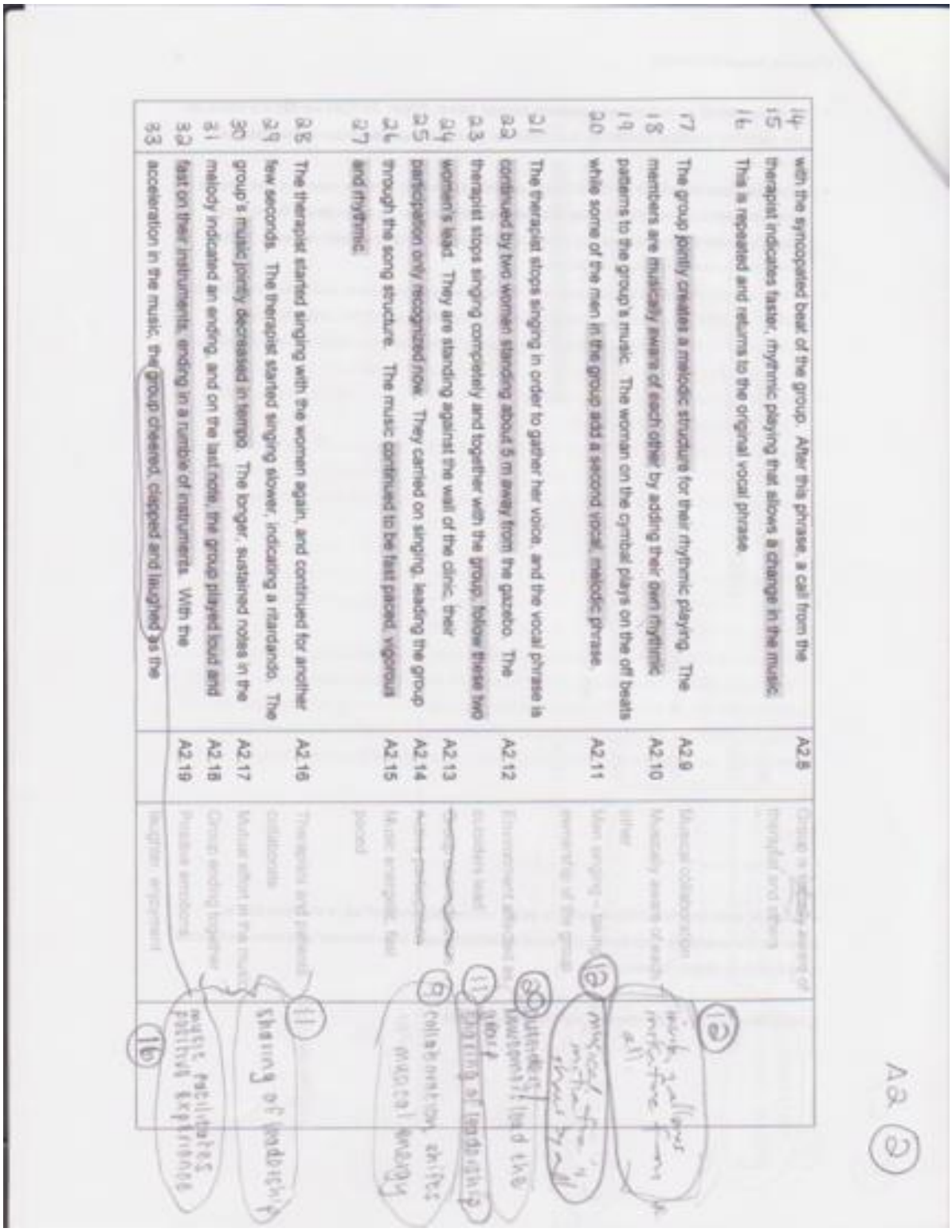
APPENDIX V11:
Coding of Audio Excerpt A2

A2 session 6

The music session starts when the therapists carry out the instruments onto the open cement block and pre-recorded South African music is playing on the CD player. It is a busy area where people are cueing for lunch and many patients are arriving to see the doctor, about to leave the clinic or standing along the clinic's wall out of the hot sun, watching the therapists putting the instruments out. Already, there is a long cue outside the diner. A gazebo was constructed on the cement block, 10 m away from the cue to provide some shading from the hot sun. After 19 minutes of different musical phases, stops and starts in the music, a group of 20 people started forming around the gazebo.

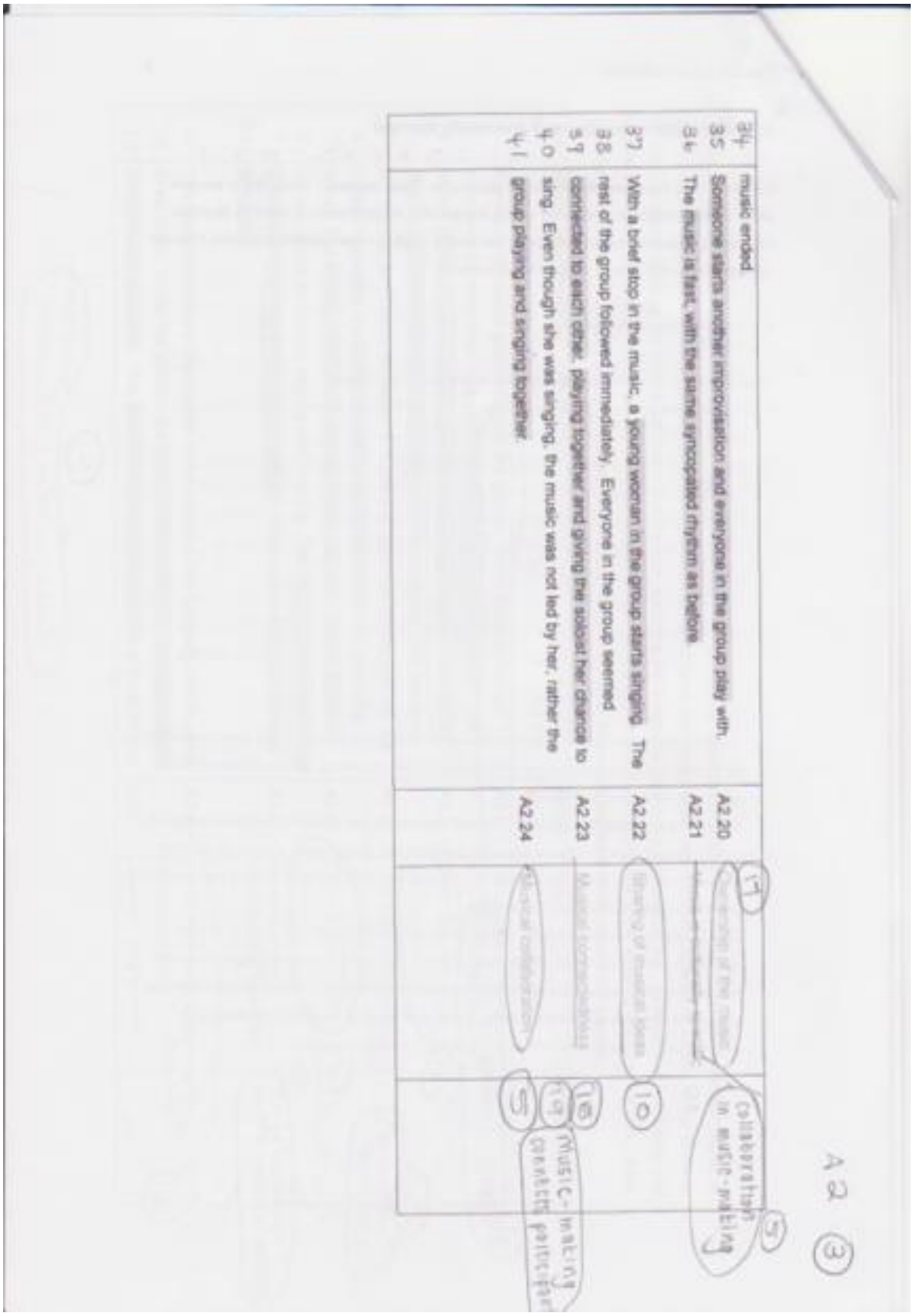
LINE NR	THICK DESCRIPTION	CODE NR	code	NOTES
1	A group of 20 people gathered under the gazebo. Each member had an	A2.1	Ownership playing own music culturally specific	
2	instrument on which they kept a steady, ongoing, syncopated rhythm. This			
3	rhythm carries the music to the cue, where people are clapping their hands,	A2.2	Music carries through	
4	tapping their feet and some singing along with the therapists. The therapists		environment	
5	are singing: Don't worry be happy" in a call and response activity with the cue.	A2.3	Men leading the group.	
6	Under the gazebo, the rhythm is kept steady by the 5 men who joined the		cultural norms	
7	group. The women in the group play the cymbal, shakers, claves, some on	A2.4	Music is part of environment	
8	djembe drums and others singing and clapping. The music becomes part of the			
9	environment, filtering through the outside air. The music is energetic and at a	A2.5	Music is energetic	
10	fast tempo.			
11	The therapist returns to the gazebo as the people in the cue goes into the diner	A2.6	Music continuing, ~~facilitates~~ positive feelings	
12	to eat lunch. Under the gazebo, the music is still ongoing, and everyone seems			
13	excited about the music. The therapist initiates a vocal phrase of thirds in time	A2.7		

APPENDIX V11:
Coding of Audio Excerpt A2



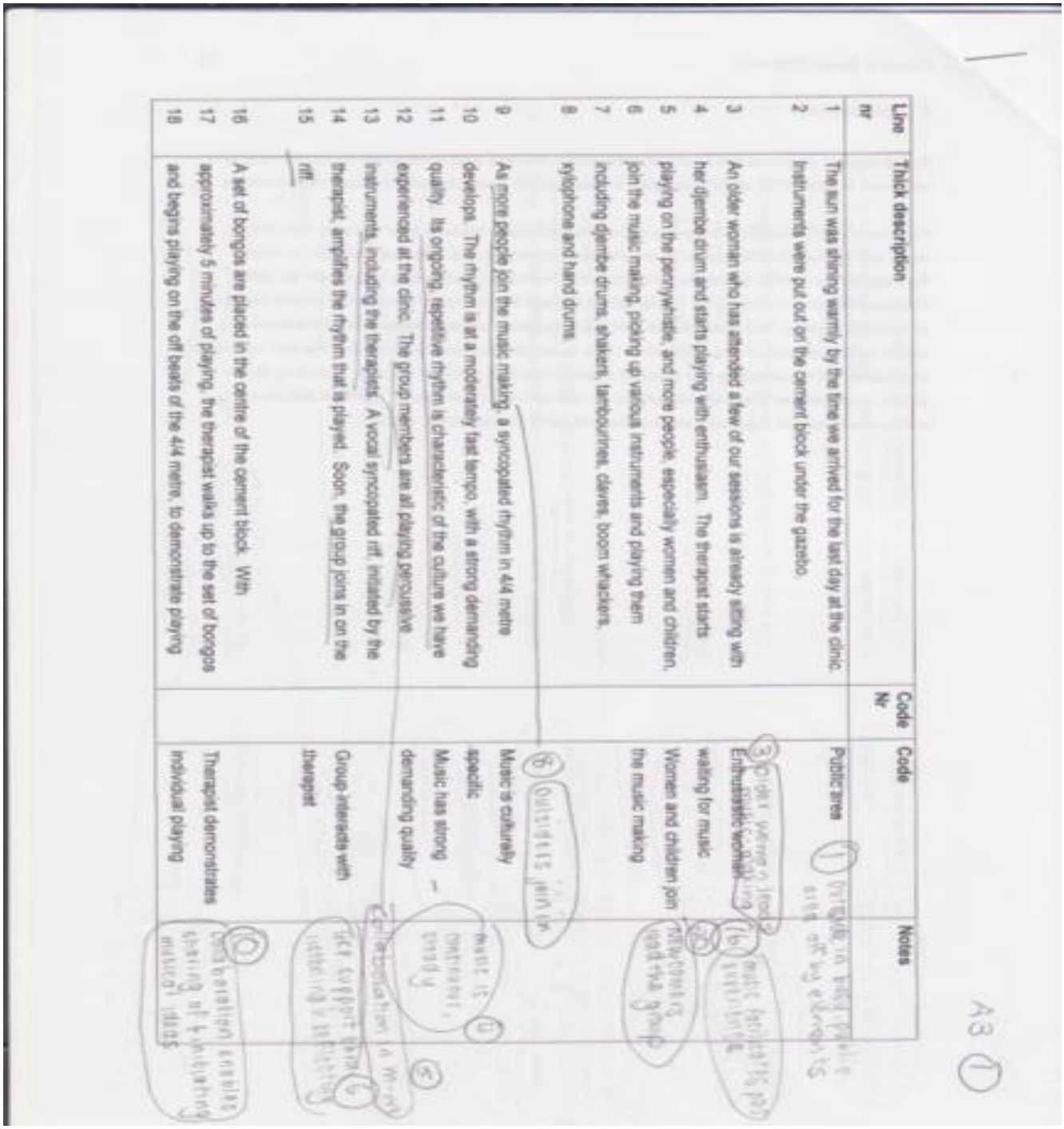
14	with the syncopated beat of the group. After this phrase, a call from the	A2.8	
15	therapist indicates faster, rhythmic playing that allows a change in the music.		
16	This is repeated and returns to the original vocal phrase.		
17	The group jointly creates a melodic structure for their rhythmic playing. The	A2.9	
18	members are musically aware of each other by adding their own rhythmic	A2.10	
19	patterns to the group's music. The woman on the cymbal plays on the off beats		
20	while some of the men in the group add a second vocal, melodic phrase.	A2.11	
21	The therapist stops singing in order to gather her voice, and the vocal phrase is		
22	continued by two women standing about 5 m away from the gazebo. The	A2.12	
23	therapist stops singing completely and together with the group, follow these two		
24	women's lead. They are standing against the wall of the clinic, their	A2.13	
25	participation only recognized now. They carried on singing, leading the group	A2.14	
26	through the song structure. The music continued to be fast paced, vigorous	A2.15	
27	and rhythmic.		
28	The therapist started singing with the women again, and continued for another	A2.16	
29	few seconds. The therapist started singing slower, indicating a ritardando. The		
30	group's music jointly decreased in tempo. The longer, sustained notes in the	A2.17	
31	melody indicated an ending, and on the last note, the group played loud and	A2.18	
32	fast on their instruments, ending in a rumble of instruments. With the	A2.19	
33	acceleration in the music, the group cheered, clapped and laughed as the		

APPENDIX V11:
Coding of Audio Excerpt A2



APPENDIX V11:
Coding of Audio Excerpt A2

APPENDIX VIII:
Coding of Audio Excerpt A3

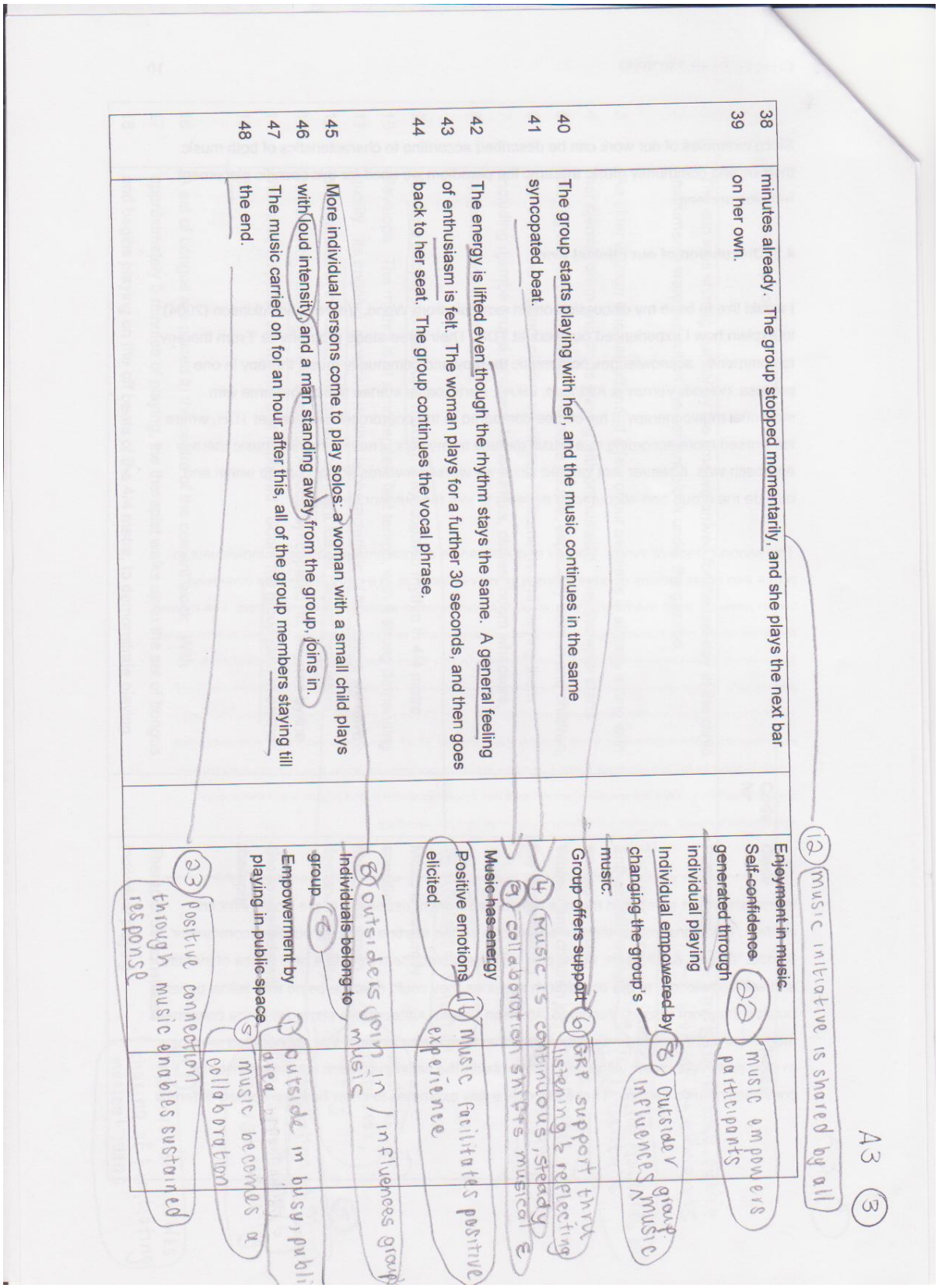


Line nr	Thick description	Code Nr	Code	Notes
1	The sun was shining warmly by the time we arrived for the last day at the clinic.		Public area	
2	Instruments were put out on the cement block under the gazebo.			
3	An older woman who has attended a few of our sessions is already sitting with		Enthusiastic women	
4	her djembe drum and starts playing with enthusiasm. The therapist starts		waiting for music	
5	playing on the pennywhistle, and more people, especially women and children,		Women and children join	
6	join the music making, picking up various instruments and playing them		the music making	
7	including djembe drums, shakers, tambourines, claves, boom whackers,			
8	xylophone and hand drums.			
9	As more people join the music making, a syncopated rhythm in 4/4 metre		Music is culturally	
10	develops. The rhythm is at a moderately fast tempo, with a strong demanding		specific	
11	quality. Its ongoing, repetitive rhythm is characteristic of the culture we have		Music has strong	
12	experienced at the clinic. The group members are all playing percussive		demanding quality	
13	instruments, including the therapists. A vocal syncopated riff, initiated by the			
14	therapist, amplifies the rhythm that is played. Soon, the group joins in on the		Group interacts with	
15	riff.		therapist	
16	A set of bongos are placed in the centre of the cement block. With		Therapist demonstrates	
17	approximately 5 minutes of playing, the therapist walks up to the set of bongos		individual playing	
18	and begins playing on the off beats of the 4/4 metre, to demonstrate playing			

APPENDIX VIII:
Coding of Audio Excerpt A3

19	something different. The group carries on playing their syncopated beat but	Group interacts with therapist	GRP support through listening & reflecting
20	watches the therapist as she plays. After the therapist played, she returns to		
21	the djembe she was playing, and started singing the vocal riff again.	Individual participants invited to play	Music empowers participants
22	The therapist starts inviting individual people through gestures to come and		
23	play the set of bongos. One young man with a diagnosis of mental health	Ability is recognized in music in spite of illness	Music generates health
24	disorder plays first. He plays loud and rhythmically but in connection with the		
25	group. due to HIV/AIDS-	Group offers support	
26	The old woman that joined the group first played loud and confident,		older woman leads music-making
27	exacerbating the rhythm of the group. The group cheers as she finishes	Music elicits positive emotions	Takes ownership of the music
28	playing. The group repeats the vocal riff until the next one stands up to play.		
29	A woman, who the therapist remembered from a previous session as being shy	Music enables creativity, self-confidence	Music generates creativity
30	and introverted, sits opposite the therapist, playing a djembe drum. In the		
31	previous session, she refused to play solo, and was hesitant in playing at all.		
32	The therapist called her to play on the set of bongos in the middle. She looks at		Music empowers participants
33	the therapist with slight hesitation, and then she stands up and goes straight to		
34	the bongos.		
		Empowerment through social support	Music facilitates positive experience
35	Still keeping eye contact with the therapist, and smiling broadly, she hits the		
36	bongos with determination. She immediately initiates a rest after the first beat	Interaction with others	GRP support
37	of the repetitive syncopated rhythm that the group has been playing for 9		ownership of music

APPENDIX VIII:
Coding of Audio Excerpt A3



38 39	minutes already. The group stopped momentarily, and she plays the next bar on her own.		
40 41	The group starts playing with her, and the music continues in the same syncopated beat.		
42 43 44	The energy is lifted even though the rhythm stays the same. A general feeling of enthusiasm is felt. The woman plays for a further 30 seconds, and then goes back to her seat. The group continues the vocal phrase.		
45 46 47 48	More individual persons come to play solos: a woman with a small child plays with loud intensity and a man standing away from the group, joins in. The music carried on for an hour after this, all of the group members staying till the end.		

Informed Consent

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
www.up.ac.za/academic/music/music.html

UNIVERSITY OF PRETORIA
UNIVERSITEIT VAN PRETORIA

PRETORIA 0002 SOUTH AFRICA

Date: ……

MUSIC THERAPY SESSIONS: PERMISSION FOR ATTENDANCE AND TO RECORD

I give permission for----------to receive music therapy sessions with students enrolled in the Masters of Music Therapy Degree Programme of the University of Pretoria from_____ to ___ __ 2009. I understand that the patient has the personal choice to attend music therapy sessions and may withdraw at any stage.
I also grant permission for sessions to be recorded onto video and/or tape. I understand that 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. Privacy and confidentiality are assured, 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.

_____ Representative: Hospi-Vision

_____ NAME: ……., MMus (MT) Student

_____ Mrs C Lotter MMUS (Music Therapy)Training Programme