The affordances of group music therapy for caregivers' well-being in a Child and Youth Care Centre

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Declaration

I declare that this dissertation is my own original work. Where secondary material is used, this has been carefully acknowledged and referenced in accordance with university requirements.

I understand what plagiarism is and am aware of university policy and implication in this regard.

Abstract

Caregivers in a Child and Youth Care Centre face several challenges that might lead to poor well-being. The well-being of the caregivers can impact the quality of care they offer and their relationship with they care for. Psychosocial support through group music therapy can play a role in improving the well-being of caregivers. This study explores caregivers' subjective perception and experience of group music therapy on their well-being and the ability to perform daily tasks.

Using a case study design, data was collected in the form of semi-structured pre- and post-interviews, as well as video recordings from the group music therapy sessions attended by ten participants. The data was then coded and analysed thematically. Five themes for both the pre- and post-interview sessions were generated. The pre-interview themes focus on caregivers' calling, roles, responsibilities, professional interactions and challenges. The post-interview themes cover caregivers' experiences of processes, relationships, caregiving challenges, perceived value and benefits of music therapy, transfer of musical and facilitation skills, as well as release, reflection, and catharsis. Caregiver workload and schedules made it challenging to schedule group sessions, but they nevertheless experienced group music therapy as supportive on personal and professional grounds.

Keywords: Affordances, Caregivers, Child and Youth Care Centres, Music Therapy, Well-being, Relationship

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1. Introduction

1.1 Background and Context

In a discussion by music therapists Pavlicevic and Ansdell (2004), the term "ripple effect" is used as a metaphor to describe the impact of music therapy as a force working "outwards'" from the individual towards the community that "can also bring the community in" (p.16). This study explores how music therapy, focusing specifically on caregiver well-being, can impact the character of a children's home – starting with a small circle of caregivers and expanding through their influence over the children that they attend to daily.

My interest in caregiver well-being evolved while I was writing a literature review for my honours research report on music therapeutic caregiving. The report suggested that active music making, for example caregiver singing, has a positive impact on the caregiver-patient relationship. A key factor influencing the relationship between the caregiver and the person being cared for is the individual well-being of both the caregiver and the person being cared for (Baker et al., 2012). Since the field of music therapy in children's homes has not been much explored (MacLean, 2018), and less so music therapy as a support for caregivers within such contexts, I chose caregivers in a children's home as the focus of my study. The specific music therapy approach informing this study is Community Music Therapy (CoMT), discussed in section 2.7.1

In South Africa, children's homes fall under the broader category of Child and Youth Care Centres (CYCCs). Caregivers form the backbone of CYCCs in providing various forms of support for the young people in their care. According to Omidire et al. (2015), the well-being of vulnerable children is affected by the caregiving responsibility, and it is, therefore, necessary for the caregiver's well-being to be

nurtured and supported. Considering this, I suggest that supporting the well-being of the caregiver through a music therapy intervention may create the foundation for a ripple effect within the broader context of the children's home.

1.2 Rationale (Research Problem)

Caregivers in various contexts, including children's homes, carry a large responsibility. Caregivers can find the caregiving tasks challenging; thus, as indicated in the literature, they sometimes report feelings of stress, burnout, depression, incompetence, and poor overall well-being (Allday et al., 2020; Omidire et al., 2015). These factors influence the caregivers' abilities to perform daily tasks and, as a result, both the children being taken care of and the constituting relationship are negatively affected (Omidire et al., 2015).

This suggests that there is a need for caregiver support because the ripple effect of caregiver well-being influences the children in their care (Omidire et al., 2015).

1.3 Aim

Using a case study design, this study aimed to investigate the role of group music therapy in supporting caregiver well-being in a Child and Youth Care Centre.

1.4 Research Questions

1.4.1 Main research question:

How do caregivers in a children's home experience group music therapy?

1.4.2 Secondary research question:

What are caregivers' experiences or perceptions of well-being over the course of group music therapy?

2. Literature Review

In this section, I review the literature and discuss topics relevant to my study. This includes an explanation of well-being, descriptions of CYCCs, the caregivers' roles and responsibilities within the context of CYCCs, adverse childhood experiences and the development of children in CYCCs, attachment, community music therapy (CoMT), and a definition of the term "affordances".

2.1 Well-Being

The concept of well-being is complex to define since many factors need to be taken into consideration. According to Dodge (2012), stable well-being comprises individuals' psychological, social, and physical resources. Dodge further indicated that these resources are necessary in order to manage psychological, social, and/or physical challenges. Dodge used the analogy of a see-saw to illustrate the balance between resources on the one side and challenges on the other: "When individuals have more challenges than resources, the seesaw dips, along with their well-being, and vice-versa" (p. 230). In other words, well-being is seen by the author as "the balance point" between the resources an individual has and the challenges the individual is required to navigate (p. 230). In comparison, according to Simons and Baldwin (2021), well-being should rather not be described as being "absent" or "present", since well-being "may always be present, but to a greater or lesser extent" (p. 985).

Well-being is described by other researchers in different ways and is often used interchangeably with the terms "happiness and life satisfaction" (Simons & Baldwin, 2021). Bericat (2013), for example, referred to socioemotional well-being as a relatively stable emotional state. Bericat stated that this emotional state is evaluated

by an individual by looking at their social interactions. In comparison, Simons and Baldwin (2021) explained that, while the measurement of well-being might be done by the individual, well-being is a “passive noun” so that responsibility for the state of well-being is more external (p. 986). Meanwhile, Wright et al. (2015) offered a broader definition of psychosocial well-being as the ability to work effectively, successfully manage relationships, demonstrate self-care and impulse control, live responsibly, and enjoy personal life satisfaction.

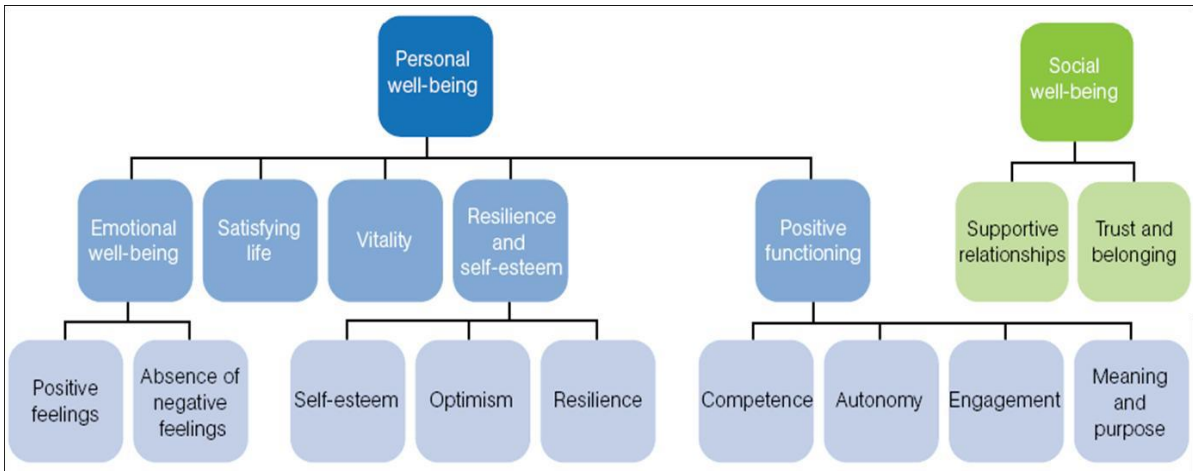
Simons and Baldwin (2021) stated ten areas identified by the UK Office for National Statistics, following a debate held in 2010, as determinants of well-being. It is important to note that the authors made it clear that these are not the components of well-being but its determinants, as they lead to either an increase or a decrease in well-being rather than being the parts that combine to create the state of well-being. These specific areas are “the natural environment, personal well-being, our relationships, health, what we do, where we live, personal finance, the economy, education and skills, and governance” (Office for National Statistics, 2011, as quoted in Simons & Baldwin, 2021, “Determinants versus components of wellbeing” section).

Michaelson et al. (2009), examined various levels and contributors to the concept of well-being in their New Economics Foundation report on the proposed National Accounts of Well-Being. Figure 1 represents the hierarchical structure presented in an “example national accounts framework” to measure well-being (p. 21). According to this “indicator structure”, well-being is first divided into two main categories – personal well-being and social well-being, and then further subdivided into other categories (p. 21). In the National Accounts of Well-Being Framework, Michaelson et al. describe well-being as a “dynamic process that gives people a sense of how their lives are going, through the interaction between their circumstances,

activities and psychological resources or 'mental capital'" (p. 18). Well-being, in this context, "is more than life satisfaction" (p. 18); it includes "personal and social dimensions", as well as "feelings, functioning and psychological resources" (p.19).

Figure 1

Example National Accounts Framework from the National Accounts of Well-Being



For this study therefore, the individual psychological, social, and physical resources; environment; health, and challenges will all be considered as influencers of the caregivers' well-being.

2.2 Child and Youth Care Centres

A CYCC is described by the Children's Act (2005) as "a facility that provides residential care to more than six children outside of the child's family environment in accordance with a residential program suited for the children in the facility" (Jamieson, 2013, p. 67).

The "Circle of Courage" (Brendtro et al., 2002, as cited in Chimange & Bond, 2020) is a model that has been adopted by the South African welfare system. The "Circle of Courage" informs CYCCs' service delivery to the children. It upholds the principles of the indigenous child-rearing philosophy of First Nation people which

places respect for the child as a core value within childcare. The four principles of the "Circle of Courage" are belonging, mastery, independence, and generosity (Chimange & Bond, 2020, p. 1). This suggests that it is the responsibility of CYCCs to ensure that the four pillars of the "Circle of Courage" are implemented and upheld as a means of providing holistic child-centred care and service to the children.

2.3. Children in Children's Homes

2.3.1 Adverse Childhood Experiences

Children in care centres have faced numerous challenges referred to as "adverse childhood experiences" (Chimange & Bond, 2020). These include trauma; emotional, physical and sexual abuse; poverty; exposure to substance abuse; physical neglect; abandonment; witnessing domestic violence; exposure to criminal behaviour; peer-to-peer violence, and bullying (Anda et al., 2010; Chimange & Bond, 2020). These experiences can have a profound and lasting effect on children, and they can become more inclined to engage in unhealthy and risky behaviours, revictimization, and violence (Anda et al., 2010).

2.3.2 Children's Development

Although children's homes standardly provide sufficient physical and basic resources for the children in their care, there can be challenges in terms of the quality and quantity of caregiving (Tottenham et al., 2010). Accordingly, McCall et al. (2019) suggested that caregiver interaction influenced the cognitive, social-emotional, and physical development of children. Research concerning the influence of caregiver interaction on childhood development is grounded in the attachment theory of Bowlby (1958, as cited in Bettmann et al., 2015). This attachment theory describing the

importance and effects of relationships between children and caregivers will be discussed in section 2.5.

According to MacLean (2018), children growing up in orphanages have a greater chance of being socioemotionally and psychosocially underdeveloped. MacLean also reported that, in some cases, cognitive stimulation is neglected due to a lack of one-on-one care and interaction. Similarly, McCall et al. (2019) found that it was common for children to experience chronic stress or to withdraw and isolate themselves. Further, these researchers identified not only that there was often a delay in children's physical growth as well as cognitive and behavioural development as a result, but also that the evidence suggested that children in institutions performed poorly with regard to cognitive functioning, language development, motor development, and personal-social behaviour. Likewise, Bettmann et al. (2015) raised the likelihood of emotional problems arising when a child had been institutionalised from infancy. They concluded that such negative effects of social and emotional neglect could then manifest as a condition called "psychosocial dwarfism" (p. 71).

McCall et al. (2019) reported that in a study focusing on improving the institutional environment, quality caregiver-child interactions resulted in measurable positive differences in the children's cognitive and behavioural scores. This positive effect was ascribed to the quality of caregiver interaction when variables such as nutrition, safety, and medical care were controlled. The findings indicated that the intervention of cognitive and sensory stimulation, alongside caregiver sensitivity combined with caregiver consistency, resulted in better social-emotional development.

The previous paragraphs in this section demonstrated that caregiver-child interactions influence the children's development. When caregivers have enough

personal resources to provide optimal quality care, the ripple effect therefore reaches the children.

2.3.3 Resilience

Resilience is defined by Southwick et al. (2014) as the ability to adapt in the face of challenging circumstances, such as traumatic experiences, stress, poverty or homelessness; it can also mean to function healthily after experiencing adversity. To be resilient does not necessarily mean that a person is not set back by circumstances; instead, it refers to the ability and decision of a person to use lessons from adverse experiences as a resource in the future. Furthermore, resilience is described as "the capacity of a dynamic system to adapt successfully to disturbances", and also as "a process to harness resources to sustain well-being" (p. 5).

It is well acknowledged that resilience is not only influenced by internal factors and individual traits such as the ability to solve problems, be optimistic, and be autonomous, but it is also influenced by external factors (Heard-Garris et al., 2018). Southwick et al. (2014) found that "[i]nteractions with other human beings, available resources, specific cultures and religions, organizations, communities, and societies" could influence a person's response to stress and trauma (p. 3). These authors similarly observed that "[m]astery motivation", the delight of interacting successfully with the environment, was another element that drove and taught resilience (p. 7). Southwick et al. further noted that determinants of resilience for children included "a healthy attachment relationship and good caregiving, emotion regulation skills, self-awareness and the capacity to visualise the future, and a mastery motivation system that drives the individual to learn, grow and adapt to their environment" (p. 11). Beneficially, these determinants of resilience are also linked to the four pillars of the

"Circle of Courage" model – belonging, mastery, independence, and generosity (Chimange & Bond, 2020, p. 1) – as discussed earlier.

Harms et al. (2018) found that resilience and personal resources for responding to adversity are related. Determinants for resilience include a combination of interacting systems comprising individual factors: biological underpinnings or genes (psychological and neurobiological), social aspects (social relationships, emotional support, empathy), environmental factors (opportunities and support systems), and community factors (institutional, ecological, and infrastructure capacities) (Harms et al., 2018; Southwick et al., 2014). Harms et. al. further noted that these interacting systems, known as protective factors, are effective when combined, holding the potential to nurture and support resilience. Likewise, another protective factor they identified was resilience as a process, which refers to how individuals cope with hardship, and the individuals' patterns of well-being.

Southwick et al. (2014) pointed out that although children in children's homes should be provided with the necessary support to learn and develop resilience, it is important to acknowledge both the internal and external factors contributing to resilience. The authors highlighted that personal characteristics such as autonomy, optimism, and problem-solving abilities can be a resource for the cultivation of resilience, and that this resilience can also influence the reciprocal caregiver-child relationship as a child's optimism and autonomy can positively influence the caregiver . Southwick et al. also noted that when caregivers' relationships with the children provided emotional security and protection, these can contribute to the external factors influencing the children's resilience.

The psychosocial and socioemotional well-being of caregivers are therefore important to ensure that they can provide, to the best of their abilities, safety for and

optimal support to the children because these can contribute to the development of resilience. Likewise, when children can develop resilience, strengthen inner resources, find a way to express themselves, and develop healthy relationships, the caregivers' tasks may be more manageable thus, once more, creating the potential for the ripple effect of caregiver-child reciprocity.

2.4 Resilience and Well-Being

Harms et al. (2018) found that resilience and well-being are fundamentally related to such an extent that, despite the relationship between resilience and well-being being complex, instruments used to measure well-being are sometimes used to determine resilience. Likewise, studies by these authors revealed that positive emotions and higher levels of well-being can lead to resilience, successfully arguing that flexible thinking, adaptive coping, and the maintaining of social relationships are promoted by positive emotions. Other literature has similarly suggested a correlation between well-being and resilience through confidence in new situations, goal setting, positive self-esteem and self-image, and avoidance of self-blame (Michaelson et al., 2009).

2.5 Attachment

The attachment theory of Bowlby (1958, as cited in Bettmann et al., 2015) stresses the importance of the relationship between caregiver and infant. Children without secure relationships with their primary caregivers can show the prevalence of delayed development, behavioural problems, and lower cognitive functioning (Moullin et al., 2014). Thus, from a young age, a person's socioemotional and psychosocial well-being and development should be nurtured because these affect their "ability to connect with others and function in the world" (MacLean, 2018, p. 6).

Secure attachment allows children to explore, build self-confidence, regulate and manage their own emotions, and build good relationships (Moullin et al., 2014). When children do not develop secure attachments, there is a danger of them having problems with developing self-regulating strategies (MacLean, 2018). Bowlby (1958, as cited in Bettmann et al., 2015), stressed the importance of a good relationship in childhood experiences when he argued that “healthy attachment relationships with primary caregivers serve[d] as the bedrock for children's developing relational patterns” (p. 71). Other research findings reported by Thompson (2015) supported this and found that when children have secure relationships, they are more likely to be better equipped for emotion regulation and to have a positive self-concept.

However, Thompson (2015) argued that attachment during infancy is not the only predictor of a child’s development, personality formation, and relationships in later life stages. Rather, the author proposed that a child’s internal working model can adapt and change later in life through exposure to new relational experiences (p. 350). As Thompson explained, “young children also internalize conceptions of themselves from early relational experiences that form the basis for developing a self-concept and other self-referential beliefs” (p. 350). However, the author concluded, the internal working models constituting a child’s relational understanding can change and earlier representations of relational experiences can be altered through new modes of understanding.

Thompson (2015) also looked at key relationships during various stages of the child’s development. In toddlerhood, the author reported that the growth of an autonomous self was important, while in pre-school, peer relationships were important. In middle childhood, in comparison, “successful adaptation to school, [and] coordinating friendship and group membership” played a vital role, while in

adolescence, identity and self-reflection were important (p. 351). Thompson found that the child's development was clearly influenced by inner resources, peer interactions, and relationships. When young children developed supportive relationships, they were able to easier master challenges later in life because they had been able to develop internal resources on which they could rely.

It is, therefore, important to acknowledge the importance of attachment in infancy; but the fact that other social and personal factors at older stages also influence the child's development should not be overlooked. Children can develop resilience and flourish as an adult despite adverse childhood experiences. Still, it is important to note that caregivers can serve as a determinant for growing resilience through healthy relationships (Southwick et al., 2014).

2.6 Caregivers

2.6.1 Roles and Responsibilities of Caregivers

Omidire et al. (2015) stated that caregivers in children's homes are responsible for fulfilling basic needs such as food, hygienic maintenance, and clothing. The authors further suggested that, apart from that, the caregivers' fundamental roles also included nurturing and supporting the children: they were responsible for the children's "personal, social, educational and vocational development" (p. 121).

According to Bettmann et al. (2015), children need caregiver receptivity where the caregiver attends to signals by responding to verbal and nonverbal cues of the children. As Bettmann et al. further stated, it is the responsibility of the caregiver to react appropriately to the needs of the child and to build a trusting relationship through attention, love, compassion, empathy, time, and security. The authors also argued that

caregivers should comfort the children through physical affection such as cuddling and holding the child.

2.6.2. Caregiver Health

Although caregiving can be satisfying, it comes with several challenges. Two challenging areas identified by McCall et al. (2019) were the long hours of work with a high caregiver-child ratio, and the strenuous caregiving tasks. Not surprisingly, caregivers in a variety of situations reported feelings of stress, burnout, fatigue, and incompetence (Batt-Rawden & Stedje, 2020; Gottell et al., 2003, 2009). Similarly, Quiroga and Hamilton-Giachritsis (2016) reported that caregivers in large orphanages expressed having “high levels of stress, anxiety, depression, and job dissatisfaction”, and that these feelings complicated their tasks (p. 2). With a heavier burden, there was therefore the risk of a decline in the physical and mental health of caregivers that would additionally affect those being cared for (Kidman & Thurman, 2014). Likewise, behavioural problems and self-harming tendencies in older children seemed to be a challenge for caregivers (Quiroga & Hamilton-Giachritsis, 2016). Unfortunately, since some caregivers performed their tasks on a rotational basis, it appeared as if they viewed their tasks only “as those of paid employees” (Omidire et al., 2015, p. 115), and lacked a sense of warmth, compassion, and emotional nurturing in performing their tasks. As a result, the children’s social and emotional needs may not always have been adequately met.

Omidire et al. (2015) further suggested that, in some cases, caregivers had not received the necessary training. Consequently, the authors stated that caregivers in children’s homes likely experienced stress due to a lack of knowledge about their rights, the rights of the children, as well as about the supporting services and facilities

for the children. Omidire et al. thus concluded that the lack of such knowledge could have resulted in confusion, distress, and feelings of demoralisation which, in turn, could have had an impact on caregiver performance. Caregivers also reported the absence of a support system for staff, since their daily experiences and difficulties were generally overlooked because the institutions were mostly child-centred. However, according to Omidire et al., a contributing source of frustration was the fact that “caregivers [did] not possess sufficient skills to implement disciplinary measures” so they struggled with this aspect of caregiving (p. 122). As a result, the caregivers often had feelings of dissatisfaction and low self-esteem.

While the challenging aspects of caregiving are acknowledged, there are also many positive aspects of caregiving. “Satisfaction can be seen as a coping resource or therapeutic intervention to help caregivers focus on the positive aspects of what they do” (Cohen et al., 2002, p. 187). Caregiver satisfaction can be classified into three groups: “satisfaction deriving mainly from interpersonal dynamic between carer and cared-for persons; satisfaction deriving primarily from the intrapersonal or intrapsychic orientation of the carer and satisfaction deriving mainly from a desire to promote a positive or avoid a negative outcome for the care recipient” (Cohen et al., 2002, p. 184). In this context, caregiver esteem or self-esteem was a contributor to intrapersonal satisfaction evolving through caregiving (Hunt, 2003). Likewise, caregivers reported positive intrapsychic and interpsychic aspects of caregiving from companionship, fulfilment, a sense of duty, finding meaning, and enjoyment (Cohen et al., 2002).

Caregivers in smaller residential homes tended to have a more positive overall experience (Quiroga & Hamilton-Giachritsis, 2016). According to Omidire et al. (2015), caregivers had a deep love for the children and provided care to the best of their

abilities regardless of challenges they may have faced. Similarly, in the study by Quiroga & Hamilton-Giachritsis (2016), caregivers reported a positive experience, and they found joy and a rewarding experience in their jobs. These researchers pointed out that caregivers also reflected on personal and affectional bonds, emotional involvement, and engagement with the children while the children, in return, expressed their love and trust towards the caregivers. Overall, the caregivers strove to create a family-like environment with routines, structures, and different tasks allocated to the children (Omidire et al., 2015).

Developing such emotional bonds was sometimes complex. When caregivers cared for vulnerable children by assuming a maternal role, they faced emotional difficulties, grief, and loss when the child was adopted (Quiroga & Hamilton-Giachritsis, 2016). The caregivers experienced mixed feelings of happiness when the child was placed in a family, while simultaneously worrying about the future of the child or sad about the child's leaving (Quiroga & Hamilton-Giachritsis, 2016).

This section indicated that some caregivers work with investment and commitment while others seem to not have the same care ethic. It is, however, notable that caregiving presents various social, emotional, and physical challenges, and such challenges can affect well-being as well as occupational performance. On the other hand, caregiving can also result in satisfaction. This, in turn, influences the care recipient and the constituent relationship. It is therefore important to acknowledge both positive and negative factors of caregiving as they impact upon caregiver well-being.

2.7 Music Therapy

According to Ansdell (2014), every human being is born with an innate or core musicality. Innate musicality allows the individual to respond to others and engage in

the world (Pavlicevic & Ansdell, 2009). Music is a valuable therapeutic tool and a provider of support in various situations because of the reflective, exploratory, and transcendent nature thereof (Wilson, 2014). Kenneth E. Bruscia (2014) defines music therapy as

> a reflexive process wherein the therapist helps the client to optimize the client's health, using various facets of music experience and the relationships formed through them as the impetus for change. As defined here, music therapy is the professional practice component of the discipline, which informs and is informed by theory and research. (p. 36)

In a study conducted by Lucanne Magill, (2009), caregivers reported that music therapy sessions brought about feelings such as joy, hope, a sense of connection, and empowerment. Another theme reflected by the caregivers in Magill's study who participated in music therapy was that "music is love", and that the verbal, nonverbal, and musical communications in sessions were love-filled (p. 37). Magill also noted that the love-filled experience in music inspired motivation, support, love, and engagement amongst the caregivers outside the sessions as well. Furthermore, Magill stated that music therapy increased the caregivers' awareness of their own feelings and helped them to connect to others who were in similar situations. Song writing, as a therapeutic intervention on the other hand, supported the participants in gaining a sense of mastery, and improved both their confidence and self-esteem (Baker et al., 2008). It provided a platform for the participants to externalise their thoughts and emotions, to tell their stories, and to gain insight into their feelings (Baker et al., 2008).

In a study conducted by Hillard (2006) focusing on the effect of music therapy sessions on compassion fatigue and team building, professional hospice caregivers (comprising of nurses, social workers, and chaplains) who participated in the study

reported significant improvements in team building. Team building is regarded as important since healthy relationships in an "interdisciplinary palliative care team allows for a forum for problem solving, opportunities for personal and professional growth and development, and shared burden and personal support" (p. 395). Dvorak & Dvorak (2011) examined the effect of participation in music therapy support groups for cancer patients and caregivers. The study revealed high levels of satisfaction with the support group, and the benefits of participating in the sessions included improved mood, stress reduction, provision of support, improved communication, and learning new skills. The three most enjoyable therapeutic interventions reported by the participants were playing instruments, relaxing with music, and listening to music.

2.7.1 Community Music Therapy

CoMT – an interdisciplinary field of study and practice – is difficult to define since the concept is multifaceted and complex (Stige & Aaro, 2012). It is described as "a different thing for different people in different places" (Pavlicevic & Ansdell, 2004, p. 17). In other words, "CoMT is being developed in various ways in relation to a range of local contexts, cultures, and social situations" (Stige & Aaro, 2012, p. 17). The work of CoMT refers to the addressing of issues related to culture, community, and society, as well as personal or individual issues, within the specific context (Pavlicevic & Ansdell, 2004). CoMT practice therefore employs social and ecological perspectives on music and health and explores "health-promoting connections between individuals and various communities" (Stige & Aaro, 2012, p. 3).

Central to CoMT is Christopher Small's term "musicking", which suggests that music is "an activity that we take part in" rather than it being an object (Stige & Aaro, 2012, p. 3). From this perspective, music is not only regarded as an art to be

appreciated, but it provides opportunities for various modes of participation such as singing, playing an instrument, or listening to songs. One of the key principles that have formed a part of the identity of CoMT is the "acknowledgement of the value of human connectedness" (Stige & Aaro, 2012, p. 3). CoMT has therefore been attentive to and aware of the various modes of connections related to a person, including their culture, personal relationships, and the context in which music therapy has taken place (Stige & Aaro, 2012). Although CoMT is difficult to define, seven qualities and characteristics of CoMT are used to describe the typical nature thereof. These qualities form the acronym PREPARE and refer to the following characteristics: "participatory, resource-oriented, ecological, performative, activist, reflective, ethics-driven" (Stige & Aaro, 2012, p. 19).

Although the music therapy intervention proposed for this study will only involve the caregivers, the principles of CoMT, where the caregiver is understood from a holistic, ecological perspective, will be implemented. The therapeutic process will therefore be informed by the context, culture, social relations, and personal connections of the caregivers.

2.8 Affordances

Affordance include two aspects – the environment and the observer – and is described by Gibson (1977) as something that is offered, provided, or furnished for someone or something. According to Pavlicevic and Ansdell (2004), "an affordance stands in relation to a possible use by somebody" (p. 73). According to DeNora (2007), "objects do not cause actions or the ways to which they are oriented" (p. 276). Rather, objects "present structuring properties that enable and or constrain action, and through their access and use" (p. 276). For DeNora, this has meant that the way in which we

have actively engaged with the objects has manifested their opportunities. Thus, the affordance of musical participation is related to the manner in which the music has been appropriated. Krueger (2011) has explained that “affordances [have] open[ed] up a shared world in which people can do things, including construct and coordinate their experiences both individually and collectively” (p. 4). As Pavlicevic & Ansdell (2004) have noted, musical affordances are the resources that music provides, including “moods, messages, energy levels, [and] actions” (p. 73). For these authors, musical affordances draw from the unique properties of music, but they are dependent on the particular situations in which they are used.

Group music therapy with the caregivers might afford a space which includes both individual and collective experiences. The caregivers might find personal meaning through music therapy, and it may contribute to enhanced relationships between the caregivers. I used the term “affordances” since music therapy can provide or offer a variety of possibilities for the caregiver. These offerings are still to be explored according to the needs of the caregivers.

2.9 Conclusion

This literature review explored topics relevant to the study including well-being, CYCCs, children in CCYCs, attachment, the caregivers’ roles and responsibilities, CoMT, and affordances. The literature on children in CCYCs indicated that internal as well as external factors contributed to the children’s physical and emotional development and resilience. Caregivers’ roles, responsibilities and well-being were discussed in terms of both positive and negative contributions. CoMT was explained through its principles and qualities, indicating why it is an appropriate model to implement in children’s homes in order to initiate the ripple effect. And finally,

affordances were explained and shown to refer to what music therapy offers the caregivers and what are manifested by the participation of caregivers, according to their needs.

3. Methodology

In this section, I describe the interpretivist paradigm, qualitative approach, and case study design used in this study. I also discuss data preparation, collection, and analysis, as well as research quality and ethical considerations concerning this research study.

3.1 Paradigm

The paradigm used is interpretivism. A paradigm includes both the epistemology in effect, referring to the way knowledge is gained and perceived, and the ontology which concerns the view on reality. The epistemology of interpretivism relies on the interpretation and understanding of meanings that "humans attach to their actions" (O'Reilly, 2012, p. 119). Through the lens of interpretivism, individuals are viewed "as actors in the social world", and their lived worldview is regarded as substantial knowledge for the research (O'Reilly, 2012, p. 119). The essence of using an interpretivist paradigm is in its emphasis on "the importance of interpretations of human meaning" (Bakker, 2012, p. 487). The ontology is therefore relativistic, whereby reality is constructed intersubjectively through meanings and understandings within both the situation and the context.

3.2 Approach: Qualitative Research

This research is qualitative by nature. According to Flick (2009), "qualitative research is of specific relevance to the study of social relations" (p. 12). Qualitative research explores the interpretation and meanings of individual experiences and of how people construct their world (Merriam & Tisdell, 2016). Merriam named four characteristics that describe the nature of qualitative research: "the focus is on the process, understanding, and meaning; the researcher is the primary instrument of data

collection and analysis; the process is inductive, and the product is richly descriptive" (p. 14). The researcher in a qualitative study focuses on "insight, discovery, and interpretation" rather than on hypothesis testing (Merriam, 2009, p. 42). This study explains the caregiver's experience of the music therapy process through rich descriptions.

3.3 Design

This study is based on a case study design. Merriam (2009) stated that "[a] case study is an in-depth description and analysis of a bounded system" (p. 40). The author further explained that a "bounded system" referred to the fact that either a particular group or a person, in a specific context, was being studied (p. 40). Merriam also indicated that the characteristics of a qualitative case study included "being particularistic, descriptive, and heuristic" (p. 43). This means that a particular situation is a focus: a "thick" and complete description of the entity is being investigated holistically. The study can then either result in the discovery of new meaning, or the reader's experience can be confirmed or extended. Thus, detailed information about the context is discussed.

Thomas and Myers (2017) offered another definition which said that a "case study concerns an understanding of how and why something may have happened" (p. 7), which means that it is flexible and adaptable according to the participants' reality and experiences. The authors further expressed the opinion that it is the responsibility of the researcher or the case inquirer to ensure that no specificity of the case is lost when refracting or interpreting the data.

In essence, case studies provide a platform for the researcher to "make connections between another's experience and our own, seeing links, having insights

from the noticed connections" (Thomas & Myers, 2017, p. 14). Therefore, the value of a case study lies in the fact that knowledge or theory can be built through the compilation of evidence from different cases.

3.4 Sampling

The sampling approach used for this research study was volunteer sampling. Volunteer sampling, or convenience sampling, is a method whereby potential participants volunteer to participate in a study. This particular children's home were chosen because it is a well-known organisation in the community where I have been involved and volunteering to spend time with the children for some time. There are eight residential units on the campus of the children's home. All caregivers working at the residential units, as well as the relief caregivers, were invited to participate in the study. In total, 12 caregivers were invited to participate in the process and 10 caregivers volunteered to participate. The process consisted of semi-structured pre-interviews, attending the music therapy sessions, and semi-structured post-interviews.

3.5 Data Collection

Two data sources were used for data collection: semi-structured interviews and video excerpts from the music therapy process. For the first data source, semi-structured interviews were conducted with each participant before and after the music therapy process. A semi-structured interview is also known as a narrative or in-depth interview and is commonly used in qualitative health research (Green & Thorogood, 2004). The researcher sets an agenda and determines topics and content that should be covered through the interview (Green & Thorogood, 2004). In these semi-structured interviews, open-ended questions were asked. This allowed the interviewees to give rich information, to elaborate as they wished, and to take the interview in a new but

related direction (Cook, 2012) (see Appendices C and D). The pre- and post-interviews were approximately 30 minutes in duration and took place in a venue on the facility. The focus of the pre-interview was to get to know the caregivers and how they perceived their career. I found it necessary to develop a full picture of the caregivers' current experiences in and of their working environment and career in order to understand the multiple factors contributing to and influencing their well-being. In comparison, the post-interview focused on the caregivers' experiences of the music therapy process and how these affected each of them personally and professionally.

The second data source comprised video recordings from the group music therapy sessions. The sessions were video recorded for the purpose of transcription and analysis. Excerpts from these sessions were selected to support the emerging themes from the qualitative analysis. The excerpts were selected in consultation with the supervisor of the study. Video recordings allowed the researcher to review and reinterpret the data from different perspectives. Non-verbal cues and interactions which may have been missed during the live sessions were captured and, in such a way, created a thorough completion of the context (Wang & Lien, 2013).

The structure and components of the music therapy sessions were informed by the semi-structured interviews as well as by the emerging therapeutic process of the group music therapy proceedings. Both active and receptive music therapy techniques were employed and typically involved an opening check-in which provided a sense of the caregivers' feelings and needs. This guided the content and development of each session. Music therapy techniques used included music-centred relaxation, drumming, movement, instrumental and vocal improvisation, music listening with drawing or clay work, free-writing, and verbal reflection. Time was allocated in the sessions for the caregivers to engage with self-care by choosing an activity or process

of their preference such as listening to music, drawing, writing, clay work, instrumental improvisation, or relaxing.

Initially, the participants were invited to attend one 45-minute group therapy session per week for eight weeks. In order to accommodate caregiver shifts, two music therapy groups per week were offered, where each participant attended the session most suitable to their shift schedule. Due to the caregivers' busy schedules, 23 sessions were offered over a period of nine weeks, but only 10 sessions were conducted according to the availability of the caregivers. Two of these sessions were individual sessions since other caregivers were not available to attend those time slots. To accommodate the caregivers' limited time schedule, it was agreed by the participants attending the session that some of the sessions would be only 30 minutes in duration.

Below is an outline of the sessions:

Session 1:

- Express how you feel through sound and movement. Group copy
- In circle: bounce balls of different colours to a colleague.

  When the music stops, respond to ques.

  Yellow: Interesting fact about self

  Pink: Compliment person next to you

- Drumming:

Introduction and exploration

Group improvisation

- Relaxing and "me-time":

Participants choose to listen/draw/clay

Session 2

- Express how you feel through sound and movement. Group copy
- In circle: bounce balls of different colours to a colleague.

  When the music stops, respond to ques.

  Yellow: Interesting fact about self

  Pink: Compliment person next to you

- Free writing:

Write for 7 minutes on prompt without stopping. Read through and circle what stands out.

Prompts: When I think of challenges I…

Strengths/resource in my life…

- Draw a mandala while listening to music
- "Take away" verbal reflection of process

Session 3 (Individual)

- Imitation of feelings on drum
- Listen to participants' suggested songs
- Sing participants' suggested song with piano accompaniment
- Verbal discussion of song and meaning
- Closing thoughts

Session 4

- Verbal check in

- Listening and relaxing: Body scan, rain stick sound, therapist singing, listening to recorded music
- Reflection: Options of verbal discussion, clay, or drawing

Session 5

- Relaxation and body scan
- Listen to the music and draw as a response to music
- Verbal reflection of process

Session 6

- Verbal check in – what do you need today?
- Drawing: Use different types of music as inspiration to draw
- Sharing, reflection, and discussion

Session 7 (individual)

- Relaxation and body scan
- Listen to music and draw
- Verbal reflection
- Improvisation
- Relax

Session 8

- How are you? Express on drum
- Drumming improvisation + added voice
- Instrumental exploration with pre-recorded music
- Concluding comments and reflection

Session 9

- Verbal check in
- Relaxing movements with scarfs to pre-recorded music
- Conclusion

Session 10

- Check in and set intention for the session
- Drumming
- Ball activity to pre-recorded music
- Concluding and reflection

3.6 Data Preparation

Data preparation is the process of preparing raw data in a format that makes it easier to analyse. Transcription is a technique that was used in this study to prepare data for analysis. To transcribe means to transform oral language to written language in order for further analysis to take place (Kvale, 2011). In this case, audio recordings of the semi-structured pre- and post-interviews were transcribed verbatim through the use of the online software Temi[1] . After the pre-and post-interviews were transcribed, the data from each set of the interviews were organized in two Excel worksheets for the pre-and post-interview data, respectively. The video excerpts from the music therapy sessions were transcribed as thick descriptions.

[1] https://www.temi.com/

3.7 Analysis

To analyse the data is the first step towards interpreting the data. In this study the data were analysed using thematic analysis – also known as coding (Merriam, 2009).

Braun and Clarke (2006) provide a six-phase guide which served as a guideline for the process of analysis. The semi-structured interviews and video excerpts were thematically analysed with separate sets of themes emerging from the respective analyses. This is further discussed in Chapter 4.

3.8 Ethical Considerations

This study is built upon four philosophical principles of ethical considerations. These principles are autonomy and respect, non-maleficence, beneficence, and justice (Artal & Rubenfeld, 2017).

Autonomy and respect include informed consent where the participant is made aware of the details of the study, agrees to participate, and grants permission for the researcher to use the data as part of the study. The participants were informed about the study through an information document and, upon agreeing to participate, each participant signed an informed consent letter (see Appendices A and B). The participants were also made aware that they were free to withdraw from the process at any given time, without consequences. In addition, a permission letter from the CCYC at which the research was conducted had already been obtained (see Appendix F).

The principle of non-maleficence means that no harm is done to the participants during the study. It was implemented through the principles of confidentiality and informed consent.

Beneficence means that the study aims to provide a beneficial experience to the participants and their best interests are kept at heart. To adhere to this principle, the participants' preferences and input were valued in the sessions whereby they were allowed to actively participate in the choice of music and processes for the sessions. The participants' choices to attend or not to attend the sessions were also respected.

The final principle, justice, refers to fair and equal treatment of each participant which was upheld throughout the course of the study (Green & Thorogood, 2004).

In the event of a caregiver requiring additional support as a result of the music therapy sessions, provision was made through the social work department at the CYCC.

The participants' names were changed within the study to ensure confidentiality and that access to personal information was limited to the researcher and the researcher's supervisor. The data is being securely stored at the University of Pretoria for a period of 10 years in a password encrypted folder. In accordance with HPCSA regulations, all ethical considerations with regard to confidentiality were adhered to concerning participation in group music therapy.

3.9 Research Quality

Research quality is dependent on the concepts of trustworthiness, transferability, dependability, and confirmability.

Hays and Singh (2012) consider trustworthiness or credibility as the "believability" of a study and an important criterion to for determining whether or not the conclusions make sense (p. 200). Transferability, in comparison**,** is also known as "naturalistic generalizability" in quantitative research and refers to the aspects and details of a study (including participants, settings, and time frame) that can help others

to determine whether the findings are applicable in their context (p. 200). The third aspect, dependability, “refers to the consistency of study results over time” and by different researchers – meaning that if this study were to be replicated by a different researcher, the results should be similar to those of the first study. Finally, confirmability, or authenticity is the genuine reflection of data without interference from the researcher – meaning that the researcher took a neutral stance in analysing the data without adding personal opinions.

This study was conducted within a multicultural environment, with participants from different ethnic and cultural backgrounds, and of different genders. The respective homes accommodated between 10 and 15 children, and the caregivers involved took care of children differing in ages from infancy until the age of 18 years.

In the socially constructed nature of research, it is important to acknowledge that it is impossible to achieve complete objectivity and neutrality since values of the researcher as well as the participant are integral parts of the study. As a researcher, it was important for me to engage in reflexivity. Through reflexivity, the contextual intersecting relationships (e.g., race, socio-economic status, age, cultural background) between myself and the participants were described in order to deepen the understanding of the work and to increase the credibility of the findings (Dodgson, 2019). As the similarities and differences between myself and the participants became evident, this might have helped to bring any unconscious bias that existed to light (Dodgson, 2019).

Through reflexivity, I was able to acknowledge personal “biases” and consider how insights and understanding of the data were informed by my own reactions (Willig, 2008, p. 18). Reflexivity was practiced by making journal entries and writing down personal feelings throughout the process. From reading studies involving caregivers,

I was initially surprised by how many caregivers had a passion for their work and loved the ones they cared for. This raised my awareness of an underlying assumption I had that the work might have been a burden for the caregivers. Getting to know the participants through the interviews, I learnt that, for many of them, the work is both a passion and a calling. I became aware of the cultural differences regarding caregiving and family structures. In the white and Westernised culture, it is considered to be more of a sacrifice to leave one's family and take care of children which are not your own. In comparison, in the traditional and black cultures, it is not strange for one member of the family (for example, a grandmother) to look after many children in the village or of the family. Therefore, they do not regard it as a sacrifice to leave their own children and husbands at home in order to take care of other children.

Throughout the process, I jotted down personal notes and feelings right before or just after sessions. This helped me to become aware of my perspective on and feelings about the process, my personal experiences, and my perception of the process and participants. This is further described in Chapter 5.

3.10 Conclusion

This chapter discussed the research methodology and reported on the steps followed in the research process. The following chapter describes the analysis of the two data sources.

4. Analysis

4.1 Introduction

In this chapter, I provide a detailed description of the process followed to analyse the data. I adapted and used the six-phase thematic analysis guide suggested by Braun and Clarke (2006). It is important to note that the stages were revisited throughout the process. Chapter 5 will present a discussion of the findings of the analytical process.

4.2 Steps in the Analysis of the Interview Data

I followed the same analytical procedure for the pre- and post-interviews. Each step of the process is illustrated with examples from both interview sessions, i.e., pre-interview data and post-interview data, as shown below.

4.2.1 Becoming Familiar with the Transcribed Data

I made use of an online software, Temi, to help me with data preparation in transcribing the pre- and post-interviews. As I read through the transcribed texts, I listened to the audio recording of the interview to check for the accuracy of the transcription. Table 1 below presents the transcript of the pre-interview with participant P2, while Table 2 shows the post-interview transcript with participant P9.

Table 1

Transcript of the Pre-Interview with Participant P2

Speaker	Time Marker	Transcript
Therapist	05:42	What led you to pursue the caregiving career?
P2:	05:53	<laugh> it's not something I, I, I, I planned to do, um, I was, I was, I was doing engineering in

		2009, so I, I, I lost interest in it. And then I did not tell my parents cause they wanted me to work as my, my brother, my older brother is is a mining engineer. So, they wanted me to go that path. So now I, I didn't tell them that I, I am dropping out. So, I, I heard of child and youth care program that was running in Gariepdam. So I went, I went for it, uh, during the, the training, uh, we get to interact with the community. And then that is where, uh, I found comfort and I, I, I fell in love with the job.
Therapist:	07:12	Sho. It's interesting how the paths go in the end? Like you didn't think you were in up here?
P2:	07:22	I didn't think, yeah. I'll end up here because, um, on 2012, after our training, after the graduations, I, I, I left, I left the field and did hospitality.
Therapist:	07:36	Okay.
P2:	07:37	Yeah. That was all total different field. So, 2020, I just felt like, let me go back to social work.
Therapist:	07:52	Mm-hmm <affirmative>
P2:	07:53	So I came here and I was absorbed.
Therapist:	08:08	So, um, for how long exactly. Then, have you been a caregiver
P2:	08:15	Beside the training? I came here 2020 October as a relief worker. Until last year [2021], August. I got permanent job here August.

Table 2

Transcript of the Post-Interview with Participant P9

Speaker	Time Marker	Transcript
Therapist:	02:28	Would you say that the music therapy supports you in your role as a house mom?
P9:	02:33	Yes.
Therapist:	02:35	And how so?
P9:	02:37	Well, I think it just gives you, it's a fun way to relax. Um, and, and like, music is always there. <laugh>. Mm that's one thing I like, it's like, music's always there. Like I remember with the drum as well. It's like, you just learn different ways of just being,
Therapist:	03:14	In the interviews before we start with the sessions, I asked you about some of the challenges that you

		have and that you face as a caregiver. Now, would you say that the music therapy affected these challenges in any way?
P9:	03:29	Yes, I think it does because it, it takes you out of, you know, the space that you are in the whole time. Cause you're in such a stressful space, like 24/7 almost. So that takes you out of that space and it just breaks a little bit.

4.2.2 Organizing the Data

After reviewing all the interviews, the questions and responses were transferred to an Excel workbook with separate spreadsheets for the pre-and post-interview data. The spreadsheets were set up as shown in Tables 3 and 4 below:

Table 3

Format for Organising Interview Data and Codes

	Q 1 or R1	**Code 1**	**Q 2 or R2**	**Code 2**	**Q 3 or R3**	**Code 3**

Therapist or Participant	Question from Therapist or Relevant response from participant		Question from Therapist or Relevant response from participant		Question from Therapist or Relevant response from participant	

Note: Questions (Q) and Responses (R)

Questions from the therapist and the responses of each participant pertaining to the same question were entered into the respective question/response column, with an open column allocated for coding to the right of the question/response column. Organizing the data in this way helped me to familiarise myself with the data. Table 4 below is an example of the completed pre-interview question and response data from a participant.

Table 4

Pre-Interview Questions (Q) and Responses (R) of Therapist (T) and Participant P5

	Q 1	**Code 1**	**Q 2**	**Code2**	**Q 3**	**Code 3**
T	What led you to pursue a caregiving career?		For how long have you been a caregiver?		How long have you been working at the children's home?	
	R 1		**R 2**		**R 3**	
P5	My background, I was raised by		I started by voluntarily		Since 2020	.

	my mom and stepfather, so my stepdad, he was abusing me. So I told myself when I grew up, I have to, I have to make change because it cannot make so much change. Maybe take, if you make one child, you do the best. So I told myself, I want to do a change to the community.		working as an on the church. Then after three years, then I went to study childcare, child and youth care. Then 2014 had done child institutional care work. I started working since 2003 till now.			

4.2.3 Generate Initial Codes

The verbatim phrases and statements from the interviews were assigned codes that captured the essence or attributes of the data (Saldanah, 2009). The critical words and phrases that determined the assignment of a code are shown in bold type in the transcripts in Tables 5 and 6. These codes were placed in a column next to the original verbatim script as illustrated below. Some parts of the interview were more detailed, and in those instances, more than one code was assigned to a single sentence. The codes were reviewed to ensure that the essential elements of the raw data were captured therein. The codes were given labels which reflected the participants' numbers, the question numbers, and letters representing the critical words or phrases.

Table 5

Level One Coding of Participant P1's Pre-Interviews

Participant	Q 1. What led you to pursue a caregiving career?	Code 1
P1	I think this really have to do with the **love** for the children and bringing a **change** in someone, you know, because with me, when I want a change, when I made a **difference** in someone's life, then I can sleep well. Like, so yeah, it's the love for you and you have to give everything you, cause it's very challenging being here. Yeah. It's more like, again, more like more like **calling**, you know? Cause if, if you only here for money, then you not gonna survive. You not gonna make it. Cause there, like I said, there are a lot of challenges. You, you may say you wanna guide them this way and only one that will listen. So, if you have that love, if you have that **passion,** if you have that thing inside of you, then you're not gonna say, okay, I give up, you know, you have to be **persistent.** You have to be **resilient**.	P1Q1A Caregivers' love for the children. P1Q1B Making a change in someone's life. P1Q1C Making a difference. P1Q1D Views job as a calling. P1Q1E Having a passion to make a change will prevent early resignation. P1Q1F Resilience and persistency is necessary to foster change in the children.

Table 6

Level One Coding of Participant P1's Post-Interviews

Participant	Q1. Can you tell me, what was your experience of participating in group music therapy?	Code 1
P1	<laugh> what I experienced there is I think each and everyone, we have about **different** experience, but what I, what I experienced is that, while we were busy. At first, we did that was that you had to play the drum however you	P1PQ1A Everyone's experience was different. P1PQ1B Going through the motion and reflecting while drumming.

	want to. So what I experienced is that first, when you busy playing, it closing your eyes, like **going through the motion**, it gives you time to **reflect** back on what happened, you know, and at time, first of you can everything. So it gets too heavy or too difficult, like too much for you. Then you pray, the **emotions gets high**. Then time the emotion you calm down.	P1PQ1C Emotions calm down after a while. P1PQ1D Humming was calming. P1PQ1E Letting go of all the tension and worries. P1PQ1F Feeling strong emotions while musicking

4.2.4 Level Two Coding

Following step one, all the codes with similar labels were grouped together in another table format. The codes related to each other were then assigned new labels and thus formed the level two coding process. This is illustrated in Tables 7 and 8 below.

Table 7

Level Two Coding of Pre-Interviews With Several Participants

New level two codes	**Caregiving as a calling**	**Parental role**	**Making a change**
Previous level one codes	P7Q1C Caregiving is a calling. P1Q1D Views job as calling. P1Q1B Caregiving is a calling. P6Q10B Caregiver made for this career. P6Q4C Living dream. P9Q6A Privilege to be caregiver.	P4Q1D Parental-like care. P7Q6A Parental like role. P7Q6B Regard and treat children as her own. P6Q6A Caregiving viewed as a parental role. P6Q6D Hands on parental role.	P1Q1B Making a change in someone's life. P5Q1B Want to make a change in the community P106A Make a change. P1Q8E Bring a change in the children's' lives makes job worth it.

		P1Q1A Caregiving means to be a mother to the children. 1Q1C Treat the children as own. P1Q1D Caregiver take on parental duties.	P2Q6A Caregiving is to be a life changer. P1Q8E Bring a change in the children's' lives.

Table 8

Level Two Coding of Post-Interviews With Several Participants

New level two codes	**Space for reflection and new perspectives**	**Sharing feelings**	**Caregiver's emotional state after therapy**
Previous level one codes	P2PQ1K Clear decision making when mind is eased. P2PQ1J Mind becomes at ease during drumming P2PQ1C Music therapy distract mind from things. P9PQ7B Sessions helpful to get clarity. P2PQ1H Different perspective on things when feeling calm. P9PQ6C Provided time to think. P9PQ6D Help to figure things out. P5PQ8E Centring thoughts in music therapy.	P1PQ3B Sometimes difficult to share feelings. P9PQ8C Opportunities provided to open up. P9PQ8D Good to open up. P6PQ6C Afraid to share challenges. P5PQ4B Caregiving challenges causes heart to feel heavy	P1PQ3H Friendly and approachable to children after session. P5PQ3G Become you again through music therapy. P1PQ7E Tolerate more after session. P1PQ3I Caregiver is more tolerant after session. P1PQ8B Music therapy brings back inner peace. P8PQ4C Caregiver set example for children to calm down. P8PQ4D Calmly confront children after therapy

4.2.5 Name and Define the Themes

Themes were identified by organising and grouping level two codes. This is described below for both pre- and post-interviews, then illustrated in Tables 9 and 10.

4.2.5.1 Themes that Emerged From the Pre-Interviews.

a) Route to caregiving

The road leading to the job as a caregiver at this children's home had been unique for each participant. Some had more experience in caregiving than others. Overall, the working environment was described as nice, and the caregivers felt confident to confide in the manager regarding both personal and care-related matters.

b) Caregiving as a calling

For these participants, caregiving was something they loved, and their job was viewed as a calling. Through their occupation, they made a difference in the children's' lives and it gave them a sense of purpose and fulfilment.

c) Roles and responsibility of caregivers

The caregivers took on different roles – including being parent-like, being a role model, serving as a protector, taking care of the children's needs and disciplining them.

d) Aspects relating to colleagues

The caregivers regarded healthy collegial relationships as important. Collegial cohesion and support assisted them in their jobs, and they, therefore, regarded collegial ethos as necessary. Conflicts arose due to differences between the caregivers, but they were managed in such a way as to prevent harm.

e) Caregiver challenges and coping

Caregivers faced different challenges including building relationships with the children and dealing with behavioural aspects of the children. The caregivers had unique methods of coping, but they did not prioritise self-care.

Table 9

Themes That Emerged From Pre-Interviews and the Associated Level Two Codes

Theme	Route to caregiving	Caregiving as a calling	Roles and responsibility of caregivers	Aspects relating to colleagues	Caregiver challenges and coping
Level two codes	Previous work experience	Caregiving yields sense of purpose/ fulfilment	Parent-like role	Conflict management with colleagues	Caregiver-child relationship challenges
	Route to caregiving job	Perceived attributes of caregiving	Protecting role	Collegial ethos	Behaviour of children
	Experience of working environment	Making a difference	Caregiver as role model	Healthy collegial relations	Trust-related challenges with children
		Love for the children	Disciplinary aspects	Collegial cohesion	Caregiver challenges
		Sound caregiver-child connections	Children's perceived needs	Collegial support	Self-care engagement
		Caregiving as calling			Relationship with music

4.2.5.2 Themes Emerging From the Post-Interviews.

a) Experiences of relationships and process

The caregivers had varied experiences of the process of music therapy. The process not only impacted them personally, but also played a role in their relationships with their colleagues and the children in their care.

b) Challenges and pressures of caregiving

Challenges the caregivers faced often surfaced in the therapy sessions. The challenges resulted in experiences of difficult emotions which were sometimes expressed in harmful ways towards the children. Participating in music therapy supported the caregivers in processing and expressing these emotions. They often left the session with new courage to face the challenges.

c) Perceived value and benefits of music therapy

Overall, the caregivers found the sessions helpful and enjoyable. More sessions were requested as they perceived the sessions as having a positive impact on their health.

d) Release, reflection, and catharsis

Caregivers reported that their music therapy helped to assist them with stress reduction and provided a valuable space in which to express themselves. The therapy offered them a space to escape and allowed them time to reflect on their personal as well as job-related experiences.

e) Transfer of musical and facilitation skills

Since the caregivers found the therapy helpful for them, they believed some of the techniques might have also been helpful to implement with the children. Hence the request for caregiver workshops where they would receive brief training on skills to possibly implement in their homes.

Table 10

Themes That Emerged From Post-Interviews and the Associated Level Two Codes

Themes	Experiences of relation-ships and process	Challenges and pressures of caregiving	Perceived value and benefits of music therapy	Release, reflection and catharsis	Transfer of musical and facilitation skills
Level two codes	Unique personal experience of music therapy	Overwhelmed by pressures associated with workload	Music therapy experienced as helpful	Stress reduction through music therapy	Need for caregiver workshop
	Expectation and experience of therapy	Children's challenging behaviour and the impact thereof	Request for more sessions	Music therapy space for escape	Transfer and implementation of skills
	Learning experiences in music therapy		Appreciation of sessions	Experiences of catharsis	Perceived potential of music therapy with children
	Experiences of personal and professional support		Enjoyment of music therapy	Space for reflection and new perspectives	Caregivers' personal appropriation of music
	Parental role		Value of individual sessions as compared to group sessions	Sharing feelings	
	Caregivers' experience of facilitator		Supporting caregivers in managing challenges	Opportunities for expression	

	Strengthen-ing collegial relationship		Perceived benefits of movement	Expression of difficult emotions when feeling overwhelm-ed	
	Mediating conflict between colleagues		Effects of humming		
			Positive impact on caregivers' health		

4.2.6 Discussing the Findings

The final step of the process is to discuss the themes. The discussion will be presented in Chapter 5.

4.3 Video Excerpts

Video excerpts supporting the themes from the post-interviews were selected conjointly under supervision. I familiarised myself with the sessions by taking notes immediately after the session and by watching the video. Significant moments in the sessions were mentioned and aided in the process to find excerpts supporting the themes. The excerpts were chosen when it showed a clear illustration of the theme in a short time span either in the dialogue or during musical participation. These excerpts were transcribed using thick descriptions. The transcripts are shown in the left column of Table 11 below, and key features of the thick descriptions are listed in the right-hand column.

Table 11

Thick Description of a Video Excerpt

Theme: Challenges and pressures of caregiving Group 1: P7 and P10; Session 2 Clip: 12 minutes in the session	**Key features**
Participants P7 and P10 attend the session. During the opening ritual, we pass a yellow and a pink ball to each other with the song "When Africa smiles"[2] playing through a speaker. We accompany the passing of the ball with animated sounds to support the action. When the music stops, the person with the pink ball must compliment the person to their left. The person with the yellow ball must say what is bothering them. This prompt was suggested by the group.	
As the balls are passed around, the participants are focused and frequent moments of laughter.	Trusting relationships to share The need for sharing
Twelve minutes into the session the music stops with P7 holding the yellow ball. She holds the ball under her right arm while she explains that she is not happy because she woke up with John screaming "eeeeehh, Tannie hulle boelie my" (Mam, they are bullying me). She imitates his pitch and volume. She then sighs and say in a despondent tone "Sien? Ja". (See? Yes.) Participant R throws the ball from one hand to the other as she explains that he is one of the children from Welkom's children's home who stays with them over long weekends. "Oehf, ja, John* is a	Carer not happy Difficult morning Child screaming

[2] Louw, J. (2021) When Africa Smiles

challenge". Participant P10, now holding the ball in her right hand and hanging it next to her leg, is upset when she elaborates that John called her kids "swart baboons" (black baboons) She pauses to allow the words to sink in. Participant R holds her ball against her chest, shaking it up and down as if she is nodding to show her empathy and understanding. P10 continues to quote John: "Swart baboon, Tannie, hulle maak my MAAAL" (Black baboons, Mam, they are driving me craaaazy)".	Caring for children other than those in their homes – bigger workload Child described as a challenge Carer upset over racism from children Colleagues show empathy

What follows in Table 12 below is a brief description of the five video excerpts relating to the themes emerging from the post-interviews.

Table 12

Themes, Brief Descriptions and the Corresponding Key Features From Video Excerpts of the Post-Interviews

Theme	**Brief description**	**Corresponding key features**
a) Experiences of relationships and process	Video excerpt 1 -The group is seated in a circle, each holding a drum. As part of the process, P4 shares good news from a call she had just received. The group applaud her and celebrate with her by means of the drums.	• Getting to know colleagues • Process flows with one activity inspiring and leading to the other • Space created through music therapy to build relationships • Learning experience

		• Phone always nearby, always on duty • Celebrating through musical elements • Relating to the joy of a permanent job
b) Challenges and pressures of caregiving	Video excerpt 2 - P7 and P10 each hold a ball. Using the prompt of the colour of the ball she is holding, P10 explains a situation in her house during the morning that was a challenge to her.	• Trusting relationships to share • The need for sharing • Caregiver challenges • Caring for children other than those in their homes – bigger workload • Colleagues show empathy • Strong carer reactions to racism
c) Perceived value and benefits of music therapy	Video excerpt 3 - At the end of the session, as the participants are packing up and leaving, P9 thanks me for the session. She states that she needed the session, and her mood has changed completely.	• Finding session helpful • Positive change of mood • Appreciation of session • Social interaction after session

d) Release, reflection, and catharsis	Video excerpt 4 -Three participants are doing a drumming improvisation. I join in the drumming improvisation and hums a melody over the drums.	• Searching for clarity and peace • Giving up due to overwhelm • Processing thoughts while drumming • Emotional expression on drums • Group disconnected • Outlet of emotions through sound • Change in body language, mood and atmosphere • Relief after externalising feelings
e) Transfer of musical and facilitation skills	Video excerpt 5 - The participants take ownership of the space as they curiously explore with various instruments to the beat of a Sotho hymn. P2 picks up the guitar and asks for guidance. The participants later engage in spontaneous dancing towards each other.	• Exploring with instruments • Curious about guitar • Interpersonal connection • Spontaneous social dancing • Extension of activity • Experimenting with music therapy technique at home • Children responding positive to

		applied technique

4.4 Conclusion

This chapter illustrated the process followed to analyse the data. It briefly described the themes emerging from the pre- and post-interviews, and the video excerpts corresponding to these themes. In the next chapter, the analysed data from the interviews and video excerpts will be discussed.

5. Discussion

5.1 Introduction

The main research question and the secondary question guiding this study are:

Main: How do caregivers in a children's home experience group music therapy?

Secondary: What are caregivers' experiences or perceptions of well-being over the course of group music therapy?

In this chapter I will provide a discussion of the findings in relation to the research questions and the relevant literature. This discussion will include stating and explaining the emerging themes derived from the pre- and post-interviews, with reference to the video excerpts that also illustrate the post-interview themes.

5.2 Caregivers' perspectives, roles, and relationships (pre-interview themes informing the music therapy sessions)

This section discusses the themes emerging from the pre-interviews with reference to the reviewed literature. I integrate verbatim statements from the caregivers to support the theme being discussed and engage in reflexivity by including personal reflection notes captured through the process. Pre-interviews were important in my study as they provided insight into the caregivers' views of their jobs and how these informed and influenced the state of the caregivers' well-being. Additionally, the pre-interviews informed the structure and choice of processes for the music therapy sessions.

5.2.1 Theme 1 Route to Caregiving

Seven out of the ten caregivers in the study had previous experience in caregiving before working at this CYCC. This was either in the form of community caregiving, being involved at church, taking care of elders, working at another youth care centre, or caring for children in the family. Many of the caregivers had not initially planned to be fulltime caregivers. Factors such as unemployment and the opportunity for training as a CYCW paved the way to becoming a fulltime caregiver. For P1, P4, and P7, the work of caregiving was described as a calling, and that was the reason why they ended up as caregivers. P7 said, “I think this really is a calling because the first time I applied I got the job”. Caregiving as a calling will be further discussed in theme 2. For P6, P9, and P10, they felt spiritual guidance or the “obedience to a higher power” led them to their jobs. P9 said, “It was not my plan, but it came across my road; the Lord led me here. And I have to be obedient and listen.”

Although caregiving was not necessarily the first choice of career for P2, P6, P9, and P10, they were happy with how things turned out. P10 explained, “I initially wanted to do social work because I always loved children. I want to give love and attention and care for the children”. Caregiver P2 stated in his interview, “It was not something I planned to do. I lost interest in engineering and decided to go for a child and youth care program which I heard of. During the training, we got to interact with the community and there I found comfort and fell in love with the job”.

To be “in love with the job” speaks much about that caregiver’s perception and experience of his career. The fact that he loves his job might even have affected and enhanced his well-being. According to the hierarchical diagram of the National Accounts of Well-Being (Michaelson et al., 2009), one of the aspects relating to personal well-being is “positive functioning” (p. 21) and two factors – namely “meaning”

and “purpose”, specifically contribute to “positive functioning” (Michaelson et al., 2009, p.21). These same aspects of “positive functioning”, “meaning”, and “purpose”, also seem evident in how some of the caregivers described their experiences of their work as caregivers, suggesting that the caregiver’s jobs might be a factor contributing positively to their personal well-being.

I reflected on the participants’ routes to caregiving in terms of how these appeared both to influence the views they held of their jobs and to contribute to their individual sense of well-being. In my reflective notes, I described the compassion I experienced toward the caregivers. I could relate to those who described that “the road led me here although I did not initially plan to follow this career”. The feeling of compassion from a researcher’s and a therapist’s perspective served as a motivation to support the carers through the music therapy process.

Doing further reflection on the pre-interviews in order to prepare for the sessions, I also felt inspired by P5. I can describe her as someone who was resilient based on the definition of resilience by Southwick et al. (2014). These authors stated that resilience is linked to the ability of a person to use lessons from adverse experiences as a resource in the future. In the case of P5 who came from an abusive background, she wanted “to do a change to the community” and either help other children escape similar situations or provide support to children experiencing unfavourable situations. Southwick et al. (2014) put forward the link between resilience and well-being, stating that the successful adaptation to disturbances and challenges develops resilience through which persons “harness resources to sustain well-being” (p. 5).

The current working environment was described by P1 as “nice” (P1Q7F). Several caregivers had a positive view of the manager and he was recounted as “approachable” and “supportive” by P5 (P5Q8C). Thus, this gave the caregivers confidence to discuss challenges with him or seek advice from him (P1Q7D). As P1 said, “I feel like we don't get enough rest, but I'm really happy to see that our manager is now aware of that”. This is in contrast to the findings by Omidire et al. (2015) which indicated a lack of staff support due to the child-centred focus of institutions.

My cognitive bias regarding caregivers’ jobs was challenged throughout these interviews. I initially held the belief that caregivers were unsatisfied with their jobs, that they worked as caregivers out of necessity, and that their job experience might be described more as strenuous and unfavourable. I was therefore surprised by the overall positive job experience reported, the caregivers’ passion for the work, and love for the children in their care. Further reflection, however, brought more complexities to light. It might therefore be the case that some of the carers did not disclose all their feelings about the management and the environment to me, and that they might not have truly experienced it as positively as I gathered from the interviews. It could also be that there was possibly scepticism about trusting me and uncertainty about what I would have done with the information.

Since well-being is a combination of an individual’s psychological, social, and physical resources (Dodge et al. 2012), it was important for me to understand the caregivers' perspectives on the working environment and how it contributed to their well-being, in order to determine whether they regarded it (the working-environment) as a resource or a challenge to their well-being. I also believe their route to caregiving played a role in their current job view, as it included previous experiences and a personal way of relating and assigning meaning to the work of caregiving.

5.2.2 Theme 2 – Caregiving as a Calling

When I asked P1 what had led her to pursue a caregiving career, she explained: “It's more like a calling, you know? Cause if, if you only here for money, then you not gonna survive.” Later in the interview, she described her experience of working in a children’s home: “I enjoy being here. I don't regret it. I love being there even though there are those difficult ones that swear at me; they taught us that we don't have to take it personal.” Describing caregiving as a “calling” (P7Q1C, P1Q1D, P6Q10B), speaks much to its seriousness, the light in which the caregivers regard their jobs and what the jobs mean to them. For the caregivers, living their calling through their jobs might result in them feeling a sense of purpose, fulfilment, and satisfaction. This correlates with the National Accounts of Well-Being’s hierarchical indicator structure (Michaelson et al., 2009) which explains that a sense of purpose contributes to “personal well-being” and thus suggests that the caregivers’ jobs contribute positively to their well-being (p.21).

Living their calling and receiving a sense of purpose and fulfilment in return might be reasons why caregivers are dedicated to their jobs. As P2 said, “it's like being at home. It doesn't feel like you are at work. Because this is the daily household duties that you do for your own kids. It's just that, this larger amount. Like a big family. It doesn’t feel like a job, actually.” Being a caregiver was regarded as a privilege (P9Q6A), and the drive behind the work was the love for the children (P1Q1A, P10Q4A). P8 stated that, “I do it for the children because I love them. They need love and respect and they have suffered a lot.” Caregiving was regarded by the caregivers in this study as an opportunity to make a change in the community and in someone’s life; to make a difference (P9Q6B, P4Q6A, P5Q8E). P2 further said, “it means a lot to be a life changer to give somebody something that they did not have or did not have

access [to].” Cohen et al. (2002) explained that one of the factors leading to caregiver satisfaction is derived from a desire to promote positive outcomes for the care recipient . They also stated that caregiver satisfaction is viewed as “a coping resource” (p. 184). This means that when caregivers face challenges they can draw from their experiences of satisfaction and implement these as a resource for coping during difficult times. Therefore, practicing caregiving as a calling and making a positive contribution in children’s lives also contributes to positive aspects of personal well-being.

Cohen et al. (2002) additionally described positive interpersonal dynamics between the caregiver and children as a strong promoter of caregiver satisfaction. According to these authors, caregiver satisfaction is important because it is linked to well-being. Satisfaction, they found, helps caregivers to focus on the positive aspects of what they do and therefore serves as a coping resource. As Cohen et al. discovered, “[c]aregivers who reported more positive feelings were less likely to report depression, burden or poor health” (p. 187). Positive feelings mentioned by the caregivers in Cohen et al.'s study include companionship, a sense of fulfilment/rewarding and enjoyment.

According to Sironi (2019), “individual perceptions of well-being and happiness are starkly affected by job satisfaction, because of the centrality of work to individuals” (as quoted in the “Job satisfaction and optimal well-being” section). More specifically, Sironi (2019) described affective satisfaction as a feature that refers to a person’s emotions about the job. This is supported by findings by the author regarding the causal relationship between job satisfaction and optimal well-being, where the latter is comprised of both subjective well-being (dealing with pleasure, comfort, and enjoyment) and psychosocial well-being (dealing with happiness as the product of

interpersonal relationships). In another study, Spector (1997, as cited in Sironi, 2019) defined job satisfaction as "[t]he degree of contentment a person feels regarding his or her job and the sense of accomplishment he or she gets from doing it" (as quoted in Sironi 2019, “Job satisfaction and optimal well-being” section). Job satisfaction can likewise contribute to the caregivers’ overall well-being as it can provide support, motivation, and resources to the caregivers, and give rise to positive emotions even in challenging situations.

Therefore, I argue that through living their calling as caregivers and having job satisfaction goes hand in hand. Both these aspects might contribute positively to the caregivers’ well-being.

5.2.3 Theme 3 - Roles and Responsibility of Caregivers

The caregivers in the role of “house mom” or “house dad” do not only attend to the basic needs of the children such as cooking and running the household, but they also make themselves available to develop relationships with the children. From the way in which caregivers in this study described their care and love towards the children, it seemed that they readily worked beyond the call of duty (P2Q26F). P2 stated, “You get attached and you end up going extra mile for the kids.” Qualities and values such as “passion, honesty, humbleness, unconditional love, patience, being approachable and having a forgiving heart” were the standards to which the caregivers executed their jobs (P7Q4C, P2Q5C, P1Q1F, P8Q1B). Unfortunately, these were not often present at the biological parents’ houses (P10). The children looked up to the caregivers and they modelled for them life values such as the “principle to give rather than receive” (P10Q8B).

The caregivers in the study were sensitive to the children's backgrounds, recognising that they had "suffered and need[ed] love and respect", as well as psychosocial support (P8Q1B, P10Q8A). P8 mentioned some of the behavioural challenges presented by the children, such as swearing, but she always sought to understand the reason behind the behaviour. P8 further said, "[these] children here are not 100% good. But I support them. They come and talk to me but other times they do not want to talk. Other times they swear at me, and I feel bad. But I know why they do this." Understanding the situation from the child's perspective made her more tolerant and able to build the carer-child relationship with patience and compassion.

From the caregivers' descriptions, I was able to observe a strong emotional involvement in the caregiver-child relationship. P1 said, "caregiving means to be a mother to the children." P10 mentioned that she not only guided them religiously, but she also tucked them in at night and they called her "Mother." Being in the role of a mother or father, the caregivers were also protectors or guardians, a place of comfort, motivator, supporter, and a safe haven (P1Q5D, P7Q5C, P5Q6A, P2Q6G). As P2 said, "Once you accept that they are under your care, they are yours. Then it comes natural that you protect them. You care for them." The children looked up to the caregivers, regarded them as role models, and had the confidence to approach the caregivers to seek advice (P4Q6B, P2Q6D). P4 also explained, "I can advise them with other things, you see. So, our relationship is very good. They even say that, you know, Tannie at least we know that we have a role model in the house."

A good and trusting relationship between the caregivers and the children was regarded as "necessary" and "important" by the caregivers (P1Q10A, P7Q4E), and it highlighted their commitment towards the children. It is evident from the aforementioned examples that, in addition to meeting the children's fundamental

requirements, carers also fulfil the responsibility of offering psychosocial and emotional support.

The parental role often goes hand in hand with disciplinary aspects. As P8 stated “[s]ome of the older children do not want to do the chores. But then I also have a strategy and say I will take your cell phone. I will also take their TV away and in this way the strategy helps with discipline.” It was also sometimes necessary to discipline the children when they had conflicts with each other. Where the children did not always want to adhere to the rules, this could have led to conflict between the caregiver and children. P4 referred to a challenge she faced regarding discipline when she started at the house: “So they will say, I want to go and smoke. I said, no, I'm not gonna allow you to go smoke then, uh, six o'clock we must lock the door. So they are not used to that because their house mother was not there. They were doing everything that they want. So at least it was challenging until they come to me saying “Tannie, we are so glad for everything.” The challenges faced by caregivers will be further described in theme five.

The caregivers, therefore, carry the responsibility of the multi-faceted role of parent, role model, protector, and carer of basic needs. The emotional involvement of the caregivers in smaller residential homes and the role they fulfil in the children’s’ lives might, on the other hand, cause a more “positive overall experience” as indicated in a study by Quiroga and Hamilton-Giachritsis (2016, p. 16).

5.2.4 Theme 4 - Aspects Relating to Colleagues

To understand a fuller picture of the caregivers involved in the study, one of the questions in the pre-interview investigated the relationship between colleagues within the working environment. Their feedback gave me insight into their socioemotional or

social well-being. Collegial relationships can become a resource for the caregivers as these contribute to social wellbeing which, according to Bericat (2013), is determined by meaningful interactions and can lead to a sense of belonging. In comparison, psychosocial well-being is described by Wright et al. (2015) as the ability to work effectively, and manage successful relationships, self-care, impulse control, living responsibly, and personal life satisfaction. These descriptions of types of social well-being are supported by the National Accounts of Well-Being's framework which depicts "supportive relationships" and "trust and belonging" are two of the building blocks of "social well-being" (Michaelson et al., 2009, p. 21).

In general, the caregivers described collegial relationships in a positive manner in the study. There were, however, some moments of conflict and instances where caregivers differed from each other in terms of attitude and vision (P5Q7B). P5 said, "My relationship with some is very good. Some is not because of our attitude. Sometimes our attitude is not the same. Our vision is not the same. That's why the conflict." Despite these challenges, the caregivers preferred to work through conflicts or solve them rather than to hold a grudge (P1Q7C). P7 felt that holding a grudge made one sick and it was like "holding a stone in your heart". A high collegial ethos was maintained, as they "[did] not gossip because it is harmful and has a negative impact" (P7, P8, P5). Respect amongst colleagues was valued and they were also aware that the children were observant of how the colleagues treated each other (P8Q11B). The caregivers provided support to each other, gave advice, and made time for their collegial friends (P5, P2). P2 said, "So amongst us we can solve our own problems. And having colleagues that understands it, it helps as well. Okay. I can go to any one of them. They will make time." P6 was delighted when she shared her story of the support she received from her colleagues and the manager in the process of

obtaining her license. This not only helped her professionally but also affected her personal life, as she can now drive independently. Teamwork was viewed as important and was encouraged by the institution through teambuilding workshops and collegial outings now and then (P5, P10). In a study with teachers, conducted by Pogodzinski (2013), it was found that both formal relationships, for example mentoring, and informal collegial relationships serve as key sources of support in assisting novice teachers in navigating their responsibilities. I sense that the same might be applicable in this context, and that the supervision the caregivers receive as well as the relationships with their colleagues provide the necessary support for the challenges they face through being a possible resource for social wellbeing.

P9 and P10 reflected on the lack of social support they experienced and expressed their need thereof. This referred to collegial social support, as well as social support in general. For P9 and P10, this applied to a lesser extent to the level of "social well-being" present in their lives which, according to the National Accounts of Well-Being's indicator structure (Michaelson et al., 2009) is supported by supportive relationships as well as trust and belonging. Likewise, Bialowolska et al. (2020) found in a study that an improved social connection in life can result from feeling close to people at work. And, Rumen (2017, cited in Bialowolska et al., 2020), wrote that "workplace friendships contribute to human flourishing" (p. 7). Furthermore, Bialowolska et al. (2020) also stated that "it is natural that social relationships from work can spread (spill-over) into the life domain, while relationships from life are confined in the life domain." (p. 8). It is important not to underestimate the importance of healthy collegial relationships, as it can influence the social well-being of the caregiver in their work, and even have an impact on the caregiver's personal life as well.

According to Dodge et al. (2012,) “stable wellbeing is when individuals have the psychological, social, and physical resources they need to meet a particular psychological, social and/or physical challenge” (p. 230). The abovementioned theme of collegial relations describes a possible social resource for the caregivers, but the challenging aspects of caregiving and the need for more personal family time might need to be attended to.

5.2.5 Theme 5 - Caregiver Challenges and Coping

P9 reflected on caregiving as “physically and emotionally the most difficult job”. One of the greatest challenges the caregivers faced was the children’s behaviour. P2 mentioned the children presented with “disrespect, swearing, fighting, bullying”. Although the caregivers were taught not to take the swearing personally, it was sometimes hurtful. P5 said, “It's very challenging. Cause sometimes it's painful. You will love them and taking care of them in the end”. Originally, P4 started working in a home where the children “were doing things the way they want[ed]”. Then, when she implemented rules and structure, the children were initially unhappy about it; this influenced their relationship negatively. P3 said the children “have a lot of anger, they break windows, and they steal”. These first-hand experiences of the children correlate with the writings of Anda et al. (2010) who describes challenging behaviour exerted by children coming from adverse childhood experiences. According to Holtzhausen, and Campbell (2020), there is a correlation between deviant behaviour and adverse childhood experiences. According to Holtzhausen and Campbell (2020) this confirms and aligns with other studies that “adverse experiences during childhood can impact a child’s behavioural development, often contributing to the development of more anti-social behaviours” (p. 35).

I have personally been involved with the children at some of the houses and experienced the dynamics between the children in a home. Some of the children are well-behaved and well-mannered while others behave disrespectfully or are rude towards the other children or adults. I developed an admiration and respect for the carers as I observed the “resilien[ce] and persisten[ce]” that P1 described as being necessary in managing these dynamics.

In doing their best to create a family environment at the children’s home, the caregivers’ relationships with their own families are often affected as they “have limited time to engage with [their] own children”. Most of the caregivers’ homes are not situated in the same town as their job and they need to travel far distances to get there. When they are at home, they need to sleep and rest before going back to work. As P6 said, “if it's not them at home, then I have to be with my own children because I'm only there for two days. Then when I come back here, they also need that. So, it is quite challenging.” This correlates with findings by Quiroga and Hamilton-Giachritsis (2016)), who mention that the caregiver family-work conflict, due to emotional involvement and exhaustion, is often “to the detriment of their own children” (p. 16).

According to Dozier et al. (2001), “foster infants’ attachment security was concordant with foster mothers’ state of mind at levels similar to that seen among biologically intact dyads” (p. 1474). As they stated, “[a]ttachment state of mind” describes “the way in which adults process thoughts and feelings regarding their own attachment experiences” (p. 1486). The authors further explained that when adults have autonomous states of mind, they value attachment and “are coherent in processing their own attachment experiences” (p. 1468). Then, when children are placed with autonomous caregivers, these children often form secure attachments. Dozier, et al. also described non-autonomous states of mind as a state when adults

"are not coherent in their processing of attachment-related experiences" (p. 1468). As such, disorganised attachment was found among children placed with adults with non-autonomous states of mind. Furthermore, the authors stated that "despite experiences of inadequate care, disruptions in care, or both, young children placed with nurturing caregivers were often able to develop trusting, secure attachments" (1475).

Moullin et al. (2014) similarly reported that secure attachment is beneficial for the children as it can help them to build self-confidence, regulate and manage their own emotions, and build good relationships. The caregivers described that with the older children, it takes time and patience to build a trusting relationship. Some children are sceptical about confidentiality and "do not want to open up" to the house parent. Once trust is built, the caregivers and children might develop a healthy bond.

Healthy caregiver-child relationships come with advantages, but also disadvantages. The carers long for the children when they are not with them (P5Q5B, P10Q5D) and even on off days, the caregivers think and worry about the children at the CYCC. Although there are relief workers taking care of the children when the primary caregivers have off days, the primary caregivers still want to be hands-on with the children (P1, P3). The primary caregivers were learning to trust the relief workers' competency to care, to the best of their ability, for the children in the absence of the house parent (P3). Worrying about the children on off days might mean that the caregivers did not get all the necessary rest before taking on the next shift. It might also mean that the children longed for the primary caregiver when they were on leave.

Other challenges caregivers in the study faced included managing personal challenges in order to be fully present to the children at work. It was especially difficult for caregivers to find a balance between having a personal life, spending time with their own children during their off time, and the caregiving job (P6, P7). P5 and P7

stated that they put personal conflicts and issues aside on behalf of the children, and disengaged from personal matters at work (P5Q11C, P7Q4D). P5 described an incident where she was having a conflict with her husband:

> "Then I came here. Then I told myself when I started entering the entrance, I have to keep that to that gate. But is not helpful for it is there. So, it's not easy. So sometimes you, you just pretend, you just pretend everything is okay, but it's not okay".

P8 agreed and said, "You need to leave your personal things at the gate. The children are clever. They can see when I am not good."

The caregivers have little to no time for self-care engagement. P10 said her off time was used "to catch up on work admin" (P10Q11B). P3 stated that "most of the time you think of the kids more than yourself". Although self-care is regarded as "important for both the caregiver and the children's behalf" by the caregivers (P5Q11B, P3Q11A, P1Q7E), they barely made time for self-care. P5 shared that "it is very important to have self-care to take it, to think of, especially when you work with children. Cause if you are emotional, it is not good. You can't work with the children." Ways of coping mentioned by the caregivers included listening to gospel music, crying, eating chocolate, going out with friends, and shopping. However, the caregivers admitted that self-care engagement does not happen as often as it should. P1 said, "sometimes you even forget that I also need time for myself only. I don't, I can't, I can't really say I take time for myself like I need to".

5.3 Exploring the affordances of music therapy

It became evident in the pre-interviews that the caregivers need time for self-care, as well as a space where they can debrief and process emotions. I, thus,

structured the sessions in such a way that it offered space for relaxation, fun, personal expression, social interaction. For this, I conducted post-interviews to gather insight of the process as experienced by the participants.

5.4 Experiences in music therapy: Feedback from post-interview themes

In this section, I will discuss the five themes emerging from the post-interview analysis, and will do so in relation to the research questions namely:

How do caregivers in a children's home experience group music therapy? and

What are caregivers' experiences or perceptions of well-being over the course of group music therapy?

The post-interviews served to gather information and feedback from the caregivers as a response to the music therapy sessions. The video excerpts selected from the sessions were used to support the themes emerging from the post-interviews. For thick descriptions of the excerpts, see attachment – Thick video transcriptions.

5.4.1 Theme 1 - Experiences of Relationships and Process

All the caregivers had unique personal experiences of the music therapy process. P6 stated that her expectation and experience of therapy differed, and that her perception of music therapy was "wrong". Having the idea that we would mostly sing, she learned that there were many different ways of expressing herself, and she regarded the expression through different musical mediums as helpful. P3 also perceived some parts of the therapy process as a learning experience as he was "amazed that you can use the drums for different sounds".

Although collegial relationships were described as "good" in the pre-interviews, the feedback from the post-interviews highlighted the fact that music therapy aided the

strengthening of collegial relationships. Caregivers participated in groups with colleagues they otherwise did not regularly interact with, and in doing so they got to know each other better (P6PQ5A). Existing relationship bonds were enhanced, and new relational bonds were formed in and out of the therapy sessions (P2PQ4C). As P2 reflected,

> "[i]n the working environment, you will be like grouped, you know, you will talk to this one and you don't normally visit that one or talk to that one, but the music therapy or in this session, we are bound to, to be a team and we have one thing to talk about; like we discuss the session when we go out. So it create, um, more of a relationship with your, with your colleagues that you, you never had. So we are in the same group, now we are discussing the session when we go out so it's like a new relationship because the discussion will be the session, but after, when the discussion goes deep, then you, this is where you tell the other one, your experience, then she will share the experience."

Social interactions and positive relational bonds contribute to socioemotional well-being, a term described by Bericat (2013) as the evaluation of the emotional state by an individual through looking at social interactions. Group music therapy specifically allowed for both social interactions and opportunities for social resources to be built. P9 explained that "[i]n the group you can laugh and have fun with your colleagues, but you also see that they also go through the same things that you go through". Through social interaction, fun, and relating, the caregivers experienced a sense of teambuilding (P2PQ4B, P9PQ1C, P3PQC). However, collegial relationships outside of music therapy also influenced participant attendance of sessions. P5 explained that before coming to a session, she asked her friends if they were also attending. This might shed light as to why it was difficult to schedule group sessions, as it may have

been due to participants preferring to attend the sessions with their colleagues in a timeslot convenient to all of them.

Music therapy acted as a catalyst for conflict processing and restoring relationships (P4PQ2A). A music improvisation allowed the participants a space in which to reflect, process their thoughts, and express their emotions. As a result of that particular session, caregivers were able to resolve conflict among themselves. P4 stated that “So at least after that, we w[ere] able to talk out our feelings cause of this, that session” (P4PQ1C). As therapist-researcher, I experienced this session as challenging and felt a sense of disconnection and discomfort in the music. During a drumming improvisation, I perceived the participants as being disconnected from each other and caught up in their individual worlds, with only brief moments of synchrony between each other. Within the session, I was unaware of what the individual participants were feeling or thinking. Following my instinct, I did not invite verbal reflections after the improvisation, but allowed the group members to reflect in silence before ending the session. It was only in the post-interviews that I learned of the group’s experience of conflict resolution within that session. There was conflict between P1, P2, and P5 that I was unaware of, and they carried it with them into the session. P1 explained that,

> “us three, we are like a tie and we always together, like you saw us, but something happened, I don't know, I wasn't there. And then there was this gap, you know, but through the session, she managed to see the void between the two of them”.

P1 experienced that the music therapy “brought the two colleagues together”, resulting in the two participants apologising to one another after the session. P5, battling with the conflict, reflected as follows:

> "after that you saw us, we were staying there. Then I was telling them the thing that was happen in my mind when I was, uh, relaxing in that song that you were humming. Then that make me to realize that I need to fix this, because of who we are, colleagues, we can't live like we are now, we are strangers".

Through the music, P5 realised that "If I can take out what is inside of me, at least it is gonna fix everything".

Therefore, music therapy allowed for strengthening of relationships which might contribute to social well-being through supportive relationships, trust and belonging.

5.4.2 Theme 2 - Challenges and Pressures of Caregiving

As indicated during the pre-interview themes, the caregivers have a demanding workload; they have "many things on their plate" professionally and personally, and they are required to assume multiple roles and responsibilities (P2PQ1B). As previously mentioned, it was difficult to schedule group sessions since the participants' schedules were already very full. The participants arrived at the sessions feeling tired and "heavy-hearted" (P6PQ1I), and sometimes did not want to attend the session (P2PQ2C). According to P6, the caregivers tended to "give until [our] resources are depleted". Although Theme 1 in the pre-interviews reflects mostly positive experiences of caregiving and the working environment, the post-interviews revealed feelings of "tiredness", a "heavy heart" and "depleted resources" which highlighted the pressure of the environment. These factors can influence the caregivers in their evaluation of personal well-being, or more specifically, their emotional well-being that falls under the sub-category of personal well-being, as described by the National Accounts of Well-Being's indicator structure diagram (Michaelson et al., 2009).

I appreciated the honesty of the participant sharing the fact that he sometimes did not want to attend the session (P2). I did not take it personally as I understood that caregivers have too little time on their hands and that they would rather have rested than attended another session. However, I was wondering how the sessions could have been structured and adapted to make them more enjoyable and worth the caregivers' time. One of the participants' suggestions when I questioned them about their need and expectation for the following session was to engage more in active music making – especially drumming. I thus included it in the planning for the next session, and I facilitated the session according to the groups' presentation, emotional and physical capacity on the day, and engagement in the session.

One of the caregivers suggested that such support sessions should be offered at another facility, as she struggled to switch off while still on the premises of the home (P6PQ8A). This would have been challenging to achieve weekly, since the caregivers' schedules did not allow for much travelling time to a different facility. A weekend getaway was also suggested by one of the caregivers. This could have been feasible, but it also needed to be considered that the caregivers might have preferred to spend their off weekends at home with their own families, instead of sacrificing another weekend due to work.

P5 managed to focus and switch her mind off in the sessions. It was only in the sessions and through the music that P5 realised she has been neglecting "me-time". She explained,

> "I remember the session when you used the drums. Uh, I think, when I did that drums, I become emotional cause it remind me the way to think of myself cause I don't have time for myself. So that time I was sitting there alone with that was very emotional. When the session ended, I was emotional. You know, when

> you sit there, you think of yourself. Because don't have time of sitting and thinking alone. Because when, when I go home, I think of my, husband and my own children and I'm here thinking about children I am working with, you know, so that time of sitting alone, using your hands, you know, think really helps a lot".

In other words, the session evoked strong emotions in her, and the therapy space offered her opportunities to process the emotions. The music allowed her time to focus on herself instead of having thoughts occupied with work and family-related things (P5PQ2B). de Witte et al. (2020) described in their study how active and receptive techniques used in music therapy could influence physiological arousal such as heart rate, modulate brain structures involved in emotional processing, increase emotional valence (felt happiness), and provide distraction from unpleasant feelings and thoughts.

Some of the challenges experienced and described by the caregivers in the pre-interview themes were brought to the table in the music therapy session. As described in the video excerpt supporting the theme of challenges, a child's difficult behaviour and racist comment was one of the things bothering the caregiver. Bringing it to the session allowed the caregiver to share her challenge and express her feelings regarding it. A colleague related to her and provided understanding and support regarding the issue. The aspect of supporting caregivers in managing their challenges is further discussed under the theme of "perceived value and benefits of music therapy".

5.4.3 Theme 3 - Perceived Value and Benefits of Music Therapy

Despite the struggle to arrange sessions due to the caregivers' busy schedules, music therapy and especially active music making was described as "helpful" (P4PQ2B, P5PQ2D). The sessions helped the participants "physically, emotionally, and mentally". P5 described it as a way of "helping heaviness in the heart" (P5PQ4C). P7 found that music therapy supported her health as she reduced her high-blood pressure medication after receiving music therapy. P8 and P6 described how music helped to release back pain, gave power, and recharged their strength and energy.

The music therapy sessions, as well as the ways in which they were facilitated, were appreciated by the caregivers (P9, P7, P3, P5, P6). The participants requested more sessions and suggested that sessions should be done more often or continued at least once a month (P7, P4, P2, P8).

According to P1, P2, P3, P5, and P9, the music therapy sessions offered support for the challenges mentioned in the pre-interviews and they felt ready to face their challenges and problems after therapy. This might link to the fact that the caregivers' emotional states changed during therapy because it "[brought] back their inner peace", helped them to "tolerate more" and made them more "friendly and approachable" after the session. During musicking strong emotions were felt and discharged through active music making, and participants report feeling "different, happy, better, and relieved" after a session (P1, P6, P5, P2, P8). This refers to a change in the carers' emotional state as a result of music therapy.

Movement in the sessions helped P8 with confidence and tiredness, and she particularly enjoyed this part of the session as she would not have previously described herself as musical. Another noteworthy technique was therapist humming

during a drumming improvisation; the participants described it as “calming, causing emotional response, touched and moved the soul, and relaxing” (P1, P2, P5).

As mentioned in Chapter 3, two of the sessions were individual sessions as none of the other caregivers were available during those time slots. P3 and P9 described both the individual and the group sessions as helpful. They particularly found value in “deeper individual work”, while the group sessions offered more opportunities for relational experiences between colleagues (P9PQ1D, P3PQ1D).

5.4.4 Theme 4 - Release, Reflection, and Catharsis

The challenges experienced by the caregivers as described in the pre-interviews caused feelings of being overwhelmed and stressed. Caregivers often entered the session feeling “tired”, “having lots to of things to do”, and “stressed”. Music therapy not only afforded benefits such as enjoyment and support for challenges as described in another theme, but also helped with stress reduction, created a space for escape, offered opportunities for expression, and allowed space for reflection and new perspectives to form. This is ascribed to the fact that the caregivers’ “mind became at ease during drumming”, “music therapy provided time to think”, and it helped with “centring thoughts in music therapy” (P2, P5, P9).

P3, P5, P6, P7 and P8 explained in the post-interviews that the music and drumming helped them with stress relief and stress management. The participants reflected on music therapy as a space to “let go”, “vent”, “offload”, “resolve”, “[feel] lighter”, and “release” (P1, P2 P7, P4, P6). This can be due to either the expression of feelings and emotions in music, or the experience of escaping to an “imaginative space” in music (P1, P9, P7). P2PQ2D shared in the interview that he was planning to resign his job when the music therapy session was done. The session allowed him

to vent, and he decided against his initial decision. He described it as follows, “sometimes we act emotional in the moment, but it is all wrong decisions” (P2PQ2F). In other words, the music therapy supported the caregiver in clear decision making as a result of processing and releasing emotions.

Improvisation allowed the caregivers to express themselves freely and in many different ways. It was a platform for creativity, play, and exploration, which allowed opportunities for different ways of being. Personal problems were voiced in therapy, and the value for self-expression was experienced by the participants (P4, P6, P5, P2, P7, P9).

Guiding the participants into relaxation affected me as well, as I also had many things on my plate during the time of data collection. Although I was still holding the space, the relaxing music and breathing techniques affected me, allowing me to perceive the calming changes in my body. There were times when I felt heavy after a session, as if I was now carrying the participants’ burdens and challenges with me. In times like these, I engaged in self-care techniques such as jogging and spending time in nature to process my thoughts and feelings.

5.4.5 Theme 5 - Transfer of Musical and Facilitation Skills

The effectiveness of the sessions and the help they offered the caregivers inspired them to implement some of the therapeutic tools on a basic level in their everyday life and in their roles as caregivers. After the therapy sessions, they engaged with music on personal levels through listening more to music as a form of emotional support and release. P7, P9, and P2 described music as “medicine”, “reliable” and “a punching bag”. They would listen to music meeting their emotional state, or they would sing along with the volume turned loud as a form of expression. The caregivers also

implemented playing music for the children or doing movement activities with children to music as a result of an intervention we did in the session. As P7 explained, “this morning also, when I'm taking the kids to school, I was playing the music the whole way” in order to create a joyful atmosphere on their way to school.

P2 already listened to music, but he especially found the active music making helpful to release some of his emotional energy. He said,

> “I can use music to calm myself down. Uh, even if I can't play any instrument, but, um, the sound just to, I can take my problems and put it into music. Then it, it helps. I tell myself that, um, I would listen to the radio or, or, or listen to music on my phone, but, uh, it's different than playing something yourself. Yeah, because the energy takes the energy out. So after that you feel like, okay. It's like punching your punching bag”.

Inspired by his personal experience, P2 then used his creativity and adapted a music therapy technique at his residential unit which he found helpful for himself. He encouraged the boys in his house to use the tables or a bucket as an alternative for a drum for emotional expression and anger displacement. His observation was that the boys were calmer after the activity.

As a result of their experiences in music therapy the caregivers saw the need for workshops to learn music or facilitation skills to implement at their caregiving homes. These suggestions made me very excited. I want to empower caregivers and make their lives easier when I am not available. However, I acknowledge that it should be handled with intense care and the suggestion might receive lots of critiques. The idea is not to train caregivers as music therapists, but rather to briefly introduce some skills to them and to create an awareness of the sensitivity in which they should

implement them. If music is an available resource for caregivers to use, I would love to see them applying it in the most useful way for the benefit of both themselves and the children.

Here I can see the ripple effect (Pavlicevic and Ansdell, 2004) actively wanting to happen from inside out and outside inwards. When the caregivers were able to apply techniques that supported them in their roles to help and support the children, the children in themselves had the opportunity to adopt new coping strategies and mechanisms, form better relational bonds, and as a result lighten the burden of the caregivers.

5.5 Conclusion

This chapter presented a discussion of the findings from the data analysis. The themes from the pre-and post-interviews, supported by the key characteristics of the video excerpts, were discussed with reference to the research questions and relevant literature.

6. Conclusion

The present study explored the affordances of group music therapy for caregivers' well-being in a Child and Youth Care Centre. I conclude with a summary of the findings, limitations, recommendations for future research in the area of music therapy with caregivers in South Africa, and the implication for practice.

6.1 Summary of findings

From the analysis of the caregivers' pre-interviews, the themes found were route to caregiving; caregiving as a calling; roles and responsibility of caregivers; aspects relating to colleagues; and caregiver challenges and coping. The pre-interviews informed the planning, structure, and processes of the music therapy session.

In comparison, the themes revealed through the post-interview analysis of the caregivers' responses were experiences of processes and relationships; challenges and pressures of caregiving; perceived value and benefits of music therapy; release, reflection, and catharsis, as well as transfer of musical and facilitation skills.

A number of factors contribute to the caregivers' well-being, including psychological, social, and physical resources; the working environment; health; and finally, the challenges they face. The music therapy processes afforded opportunities for caregiver support, addressing psychological and social needs. This was regarded as valuable by the caregivers and inspired them to use some of the tools in their respective homes to aid them in their job and challenges.

6.2 Limitations

The research conducted was with a small sample in one site. The obstacles encountered during the research process such as the caregiver workload and schedules which made it challenging to plan and conduct sessions, may have hindered the findings.

I took on the dual role as both a researcher and a therapist and it could mean that, although I asked the participants to answer the interview questions as honestly as possible, they felt the need to answer the questions in a specific way.

6.3 Recommendations for further research

This study contributes to the understanding of the value of music therapy for caregivers, and specifically the affording of support for their well-being. Future studies might focus or enlarge upon the implementation of music therapy in multiple children's homes and in other caregiver contexts as well – for instance, for caregivers in old age homes. Studies could also explore the possibility of group music therapy sessions with both the children and the caregivers, and the implications thereof.

6.4 Implications for practice

As caregivers might be burdened with overloaded schedules, the organisation of regular sessions might be challenging. I suggest logistical implications such as planning group sessions well in advance on a less frequent basis – for example once a month. If possible, the sessions should be conducted in a venue other than the facility, since that may be preferable to some of the caregivers, allowing them to switch their minds off from their responsibilities.

The planning and preparation to use both active and receptive techniques with the caregivers are recommended due to the fact to accommodate the preferences of the different participants as well as to be able to meet the needs presented in a given session. Although the pre-interviews provided some information regarding the caregivers' personal music experiences and preferences, I think further discussion and exploration of their musical preferences should be implemented in the sessions. More space should be provided for the caregivers to voice their needs and to have an input in the sessions. I found that the caregivers are initially shy to participate in active music making, and care should be taken to allow them to be comfortable and engage more in spontaneous music making.

It might be valuable to think about implementing practical workshops for caregivers in which they can learn to apply basic skills adapted from the field of music therapy. The idea is that those skills can be transferred by the caregivers to the workplace and in their personal lives for self-management. This may include teaching them songs, guide them in creating playlists for different scenarios (for example with the aim of motivation, relaxation, stress management, playtime), and using music-centred activities and games for supporting relationships in their respective homes. In the instance where the scheduling of workshops is not possible, I would suggest to allocate time in the therapy session to focus specifically on some of these aspects and skills according to the caregivers' needs which they can transfer into their daily lives.

6.5 Conclusion

From the findings, I conclude that the metaphor of the "ripple effect" as described by Pavlicevic and Ansdell (2004, p.16), is applicable when looking at caregiver well-being. As the post-interview themes revealed, the effects of music therapy experienced in the

sessions supported the caregivers in facing face challenges and managing situations. As a result, it worked “outwards’” from the caregiver towards their colleagues and the children, and it brought “the community in” Pavlicevic and Ansdell (2004, p.16).

Reference List

Allday, R.A., Newell, J.M., & Sukovskyy, Y. (2020). Burnout, compassion fatigue and professional resilience in caregivers of children with disabilities in Ukraine. *European Journal of Social Work*, *23*(1), 4-17, DOI: 10.1080/13691457.2018.1499611

Anda, R. F., Butchart, A., Felitti, V. J., & Brown, D. W. (2010). Building a framework for global surveillance of the public health implications of adverse childhood experiences. *American Journal of Preventive Medicine*, *39*(1), 93-98. https://doi.org/10.1016/j.amepre.2010.03.015

Ansdell, G. (2014). *How music helps in music therapy and everyday life.* Ashgate Publishing.

Artal, R. & Rubenfeld, S. (2017). Ethical issues in research. *Best Practice & Research in Clinical Obstetrics and Gynaecology*, *43*, 107-114. http://doi/10.1016/j.bpobgyn.2016.12.006.

Baker, F. A., Grocke, D., & Pachana, N. A. (2012). Connecting through music: A study of a spousal caregiver-directed music intervention designed to prolong fulfilling relationships in couples where one person has dementia*. Australian Journal of Music Therapy, 23, 4-21.*

Baker, F. Wigram, T., Stott, D. & McFerran, K. (2008). Therapeutic songwriting in music therapy. *Nordic Journal of Music Therapy*, *17*(2),105-123. https://doi.org/10.1080/08098130809478203

Bakker, J. I. (2012). Interpretivism. In A. J. Mills, G. Durepos, E. Wiebe, (Eds.), *Encyclopedia of case study research* (pp. 487-493). SAGE Publications. http://dx.doi.org/10.4135/9781412957397

Batt-Rawden, K. B., & Stedje, K. (2020). Singing as a health-promoting activity in elderly care: A qualitative, longitudinal study in Norway. *Journal of Research in Nursing, 25(5),* 404-418.

Bericat, E. (2013). The socioemotional well-being index (SEWBI): Theoretical framework and empirical operationalization. *Social Indicators Research, 119*(2), 599-626.

Bettmann, J. E., Mortensen, J. M., & Akuoko, K.O. (2015). Orphanage caregivers' perceptions of children's emotional needs. *Children and Youth Services Review, 49*, 71-79.

Bialowolska, P., Sacco, P. L., Van der Weele, T. J., & McNeely, E. (2020). Well-being in life and well-being at work: Which comes first? Evidence from a longitudinal study. *Frontiers in Public Health,8*. https://doi.org/10.3389/fpubh.2020.00103

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Bruscia, K. E. (2014). *Defining music therapy.* Barcelona Publishers.

Chimange, M., & Bond, S. (2020). Strategies used by child and youth care workers in to develop belonging and foster healthy attachments with young people in care in child and youth care centers in Tshwane, South Africa. *Children and Youth Services Review, 118,* (3). https://doi.org/10.1016/j.childyouth.2020.105373

Cohen, C. A., Colantonio, A., & Vernich, L. (2002). Positive aspects of caregiving: rounding out the caregiver experience. *International Journal of Geriatric Psychiatry*,*17*(2), 184-188. http://doi. 10.1002/gps.561.

Cook, K. E. (2012). In-Depth Interview. In L. M. Given, (Ed.), *The SAGE encyclopedia of qualitative research methods* (pp. 423-424). SAGE Publications. http://dx.doi.org/10.4135/9781412963909

DeNora, T. (2007). Health and music in everyday life. *Psyke & Logos*, 271-287.

de Witte, M., Lindelauf, E., Moonen, X., Stams, G. J., van Hooren, S. (2020). Music therapy interventions for stress reduction in adults with mild intellectual disabilities: Perspectives from clinical practice. *Frontiers in Psychology, 11*, 1-15. http://doi. 10.3389/fpsyg.2020.572549

Dodge, R., Daly, A., Huyton, J., & Sanders, L. (2012). The challenge of defining wellbeing. *International Journal of Wellbeing*, *2*(3), 222-235. https://doi.org/10.5502/ijw.v2i3.4

Dodgson, J. E (2019). Reflexivity in qualitative research. *Journal of Human Lactation 35*(2)*,* 220-222. https://doi.org/10.1177/0890334419830990

Dozier, M., Stovall, K. C., Albus, K. E., & Bates, B. (2001). Attachment for infants in foster care: The role of caregiver state of mind. *Child Development*, *72*(5), 1467-1477.

Dvorak, A. L., & Dvorak, A. L. (2011). Music therapy support groups for cancer patients and caregivers [University of Iowa]. https://doi.org/10.17077/etd.3zbutejcFlick, U. (2009). *An Introduction to qualitative research*. SAGE Publications.

Gibson, J. (1977). Theory of affordances. In R. Shaw & J. Bransford, *Perceiving, acting, and knowing: Toward an ecological psychology* (pp. 67-82). Lawrence Erlbaum Associates.

Gill, S. I. (2020). Qualitative sampling methods. *Journal of Human Lactation 36*(4), 579-581. https://doi-org.uplib.idm.oclc.org/10.1177/0890334420949218

Gotell, E., Brown, S. & Ekman, S. (2002). Caregiver singing and background music in dementia care. *Western Journal of Nursing Research, 24*(2), 195-216.

Gotell, E., Brown, S. & Ekman, S. (2009). The Influence of caregiver singing and backgound music on vocally expressed emotions and moods in dementia care: A qualitative analysis. *International Journal of Nursing Studies, 46*, 422-430.

Green, J., & Thorogood, N. (2004). Responsibilities, ethics, and values. In J. Green & N. Thorogood, *Qualitative methods for health research* (pp. 51-76). SAGE Publications.

Harms, P. D., Brady, L., Wood, D., & Silard, A. (2018*).* Resilience and well-being*.* In E. Diener, S. Oishi, & L. Tay (Eds.), *Handbook of well-being* (pp. 1-12)*.* DEF Publishers.

Hays, D. & Singh, A. (2012). Maximizing trustworthiness. In D. Hays & A. Singh, *Qualitative inquiry in clinical and educational settings* (pp. 190–218). The Guilford Press.

Heard-Garris, N., Davis, M. M., Szilagyi, M., & Kan, K. (2018). Childhood adversity and parent perceptions of child resilience. *BMC Pediatrics*, *18*(1), 204. http://doi:10.1186/s12887-018-1170-3

Hilliard, R.E. (2006). The effect of music therapy sessions on compassion fatigue and team building of professional hospice caregivers. *The Arts in Psychotherapy (33),* 395-401. https://doi.org/10.1016/j.aip.2006.06.002

Holtzhausen, L., & Campbell, E. (2021). Adverse childhood experiences as a risk factor for antisocial behaviour among young adults in the Western Cape, South Africa. *Acta Criminologica: African Journal of Criminology & Victimology 34*(1), 24-47.

Hunt, C. K. (2003). Concepts in caregiver research. *Journal of Nursing Scholarship*, *35(*1), 27-32.

Jamieson, L. (2013). *Children's Act guide for child and youth care workers*. Children's Institute, University of Cape Town.

Kidman, R., & Thurman, T.R. (2014). Caregiver burden among adults caring for orphaned children in rural South Africa. *Vulnerable Children and Youth Studies, 9*(3)*,* 234-246. http://doi:10.1080/17450128.2013.871379

Kvale, S. (2011). Transcribing interviews. In *Doing Interviews* (pp. 93-100). SAGE Publications. https://doi.org/10.4135/9781849208963

Krueger, J. W. (2011). Doing things with music. *Phenomenology and the Cognitive Sciences, 10,* 1-22.

Maclean, J. (2018). *Breaking barriers: Using music to create community in orphanages*. [Lesley University] Expressive Therapies Capstone Theses.

Magill, L. (2009). The meaning of the music: The role of music in palliative care music therapy as perceived by bereaved caregivers of advanced cancer patients. *American Journal of Hospice & Palliative Medicine*, *26*(9), 33-39.

McCall, R. B., Groark, C. J., Hawk, B. N., Julian, M. M., Merz, E. C., Rosas, J. M., Muhamedrahimov, R. J., Palmov, O. I., & Nikiforova, N. V. (2019). Early caregiver–child interaction and children's development: Lessons from the St. Petersburg-USA orphanage intervention research project. *Clinical Child and Family Psychology Review, 22*(2), 208-224. http://doi.10.1007/s10567-018-0270-9

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation*. Jossey-Bass.

Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research: A guide to design and implementation*. Jossey-Bass.

Michaelson J., Abdallah, S., Steuer, N., Thompson, S., Marks, N., Aked, J., Cordon, C., & Potts, R. (2009). *National accounts of well-being: Bringing real wealth onto the balance sheet.* New Economics Foundation. https://www.researchgate.net/publication/47529285_National_Accounts_of_Well-Being_Bringing_Real_Wealth_onto_the_Balance_Sheet

Moullin, S., Waldfogel, J., & Washbrook, L. (2014). *Baby bonds: Parenting, attachment and a secure base for children*. Sutton Trust.

Omidire, M. F., AnnaMosia, D., & Mampane, M. R. (2015). Perceptions of the roles and responsibilities of caregivers in children's homes in South Africa. *Revista de Asistenja Sociala, 2,* 113-126.

O'Reilly, K. (2012) Interpretivism. In *Key concepts in ethnography* (pp. 119-124). SAGE Publications. https://doi.org/10.4135/978144626830

Pavlicevic, M. & Ansdell, G. 2004. *Community Music Therapy.* Jessica Kingsley.

Pavlicevic, M. & Ansdell, G. (2009). Between communicative musicality and collaborative musicing: A perspective from community music therapy. In M. Stephen & C. Trevarthen, *Communicative musicality* (pp. 357-376). Oxford.

Pogodzinski, B. (2013). Collegial support and novice teachers' perceptions of working conditions. *Journal of Educational Change*, *15*(4). DOI:10.1007/s10833-013-9221-x

Quiroga, M, G., & Hamilton-Giachritsis, C. (2016). "Getting involved": A thematic analysis of caregivers' perspectives in Chilean residential children's homes. *Journal of Social and Personal Relationships*, *34*(3), 1 - 20. DOI:10.1177/0265407516637838

Saldanah, J. (2009). *The coding manual for qualitative researchers.* SAGE Publications.

Simons, G., & Baldwin, D. S. (2021). A critical review of the definition of 'wellbeing' for doctors and their patients in a post Covid-19 era. *International Journal of Social Psychiatry, 67(8)*, 984-991.

Sironi, E. (2019). Job satisfaction as a determinant of employees' optimal well-being in an instrumental variable approach. *Quality & Quantity, 53,* 1721-1742. https://doi.org/10.1007/s11135-019-00835-3

Southwick, S. M., Bonanno, G. A., Masten, A. S., Panter-Brick, C., & Yehuda, R. (2014). Resilience definitions, theory, and challenges: interdisciplinary perspectives, *European Journal of Psychotraumatology, 5*. http://doi:10.3402/ejpt.v5.25338

Stige, B., & Aaro, L. E. (2012). *Invitation to community music therapy.* Taylor & Francis.

Thomas, G., & Myers, K. (2017). What is case study? In G. Thomas & K. Myers, *The anatomy of the case study* (pp. 5-16). SAGE Publications.

Thompson, R. (2015). Early attachment and later development: Familiar questions, new answers. In: J. Cassidy & P. R. Shaver, *Handbook of attachment* (p. 348-365). Guilford.

Tottenham, N., Hare, T. A., Quinn, B. T., McCarry, T. W., Nurse, M., Gilhooly, T., Millner, A., Galvan, A., Davidson, M. C., Eigsti, I., Thomas, K. M., Freed, P. J., Booma, E. S., Gunnar, M. R., Altemus, M., Aronson, J., & Casey, B. J. (2010). Prolonged institutional rearing is associated with atypically large amygdala volume and difficulties in emotion regulation. *Developmental Science, 13*(1), 46-61.

Wang, T. & Lien, Y. (2013). The power of using video data. *Quality and Quantity*, *47*, 2933–2941. https://doi.org/10.1007/s11135-012-9717-0

Willig, C. (2008). *Introducing qualitative research in psychology*. Open University Press.

Wilson, S. H. (2014). *Music therapy support groups for family caregivers of individuals residing in long-term care facilities: A survey of music therapists and interviews with current family caregivers* [Unpublished master's thesis]. Appalachian State University. URL: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://libres.uncg.edu/ir/asu/f/Wilson,%20Stephen_2014_Thesis.pdf

Wright, A.G.C., Calabrese, W.R., Rudick, M.M., Yam, W.H., Zelazny, K., Williams, T.F., Rottermanm, J.H., & Simms, L.J. (2015). Stability of the \dsm-5 section iii pathological personality traits and their longitudinal associations with

psychosocial functioning in personality disordered individuals. *Journal of Abnormal Psychology 124*(1), 199-207.

APPENDIX A: Letter of information

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

School of the Arts
MUSIC THERAPY

Letter of information

Research topic: The affordances of group music therapy for the caregivers' well-being in a Child and Youth Care Centre

Dear Participant

My name is Nadia Smith. I am a student at the University of Pretoria, and I am currently enrolled for a master's degree in Music Therapy. I am conducting a research study on the possible value of running group music therapy sessions for caregivers in a children's home.

What will be expected of you?

The research will run over a period of eight weeks, during which you will take part in one 45-minute group music therapy session per week. You have the option to attend one of two sessions per week depending on your work shift.. Your participation will also involve a semi-structured interview before taking part in the eight-week group music therapy process and another semi-structured interview after

the eight-week sessions. The interviews will take approximately 30 minutes in a venue within the facility to be confirmed**.** The interviews as well as the music therapy sessions will be video recorded. No one except me and my research supervisor will see the video recordings, and although the results of the data will be published in a dissertation, all information will be treated with confidentiality and your identity will not be revealed. Pseudonyms will be used in the written document and transcripts. In accordance with HPCSA regulations all ethical considerations with regard to confidentiality will be adhered to concerning participation in group music therapy.

Risks and benefits:

By participating in the research, you will contribute to the understanding of the value of group music therapy for caregivers' support in a children's home. Participation in the study is completely voluntary and you are free to withdraw at any time. There are no risks or direct benefits in participating in this project. If you decide to withdraw there will be no negative consequences to you, nor will you need to explain your reason. You are encouraged to ask any questions you might have about the study.

Who will have access to the results of the study?

The research will be conducted by myself as principal researcher, and my supervisor. It will be used for academic purposes only. The data will be archived at the university's Department of Music for a minimum of 15 years in a password encrypted folder. If any other researchers would like to use this data during this time they may only do so with your consent.

Provision of psychosocial support:

Should further psychosocial support be required as a result of participating in the music therapy sessions this can be arranged through the social work department at the facility.

Approval:

The study will only begin after ethical approval has been obtained from the Research Ethics Committee of the Faculty of Humanities, University of Pretoria.

Please feel free to contact me or my supervisor if you require more information about the study.

Kinds regards

(Signature of student required) (Signature of supervisor)

Nadia Smith **Name of supervisor:**

Carol Lotter

smith.nadia79@gmail.com **Supervisor email address:**

0718949764

carol.lotter@up.ac.za

APPENDIX B: Letter of informed consent

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

School of the Arts
MUSIC THERAPY

LETTER OF INFORMED CONSENT: REPLY SLIP

Full name: _____

Research topic: The affordances of group music therapy for caregiver's well-being in a Child and Youth Care Centre

I hereby give my consent to participate in the aforementioned research project and acknowledge that the data may be used in current and future research. I confirm that I understand what is required of me in the research project. I am aware that I may withdraw from the study at any time, should I wish to do so.

Signature of participant Date

Signature of student/principle researcher

APPENDIX C: Interview schedule before music therapy sessions

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UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

School of the Arts
MUSIC THERAPY

Thank you for participating in the study. I would like to assure you that the information is confidential and no records will reflect your name. I would also like to inform you that a video recording is being made of this interview. If you are comfortable with that, then we can begin.

1. What led you to pursue a caregiving career?
2. For how long have you been a caregiver?
3. How long have you been working at the children's home?
4. What led you to moving around to another place?
5. What were some of the highlights you experienced as a caregiver?
6. Could you describe to me what it means for you to be a caregiver?
7. How would you describe your relationship with your colleagues?

8. How do you experience working in a children's home?
9. Are there any specific challenges to working in a children's home, and if so, would you describe them?
10. What can you tell me about your relationship with the children?
11. How would you describe your engagement with self-care?
12. Is there anything else you would like to add?

APPENDIX D: Interview schedule after music therapy sessions

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UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

School of the Arts
MUSIC THERAPY

Thank you for participating in the study. I would like to assure you that the information is confidential and no records will reflect your name. I would also like to inform you that a video recording is being made of this interview. If you are comfortable with that, then we can begin.

1. Can you tell me, what was your experience of participating in group music therapy?
2. Were there any moments that stood out for you in the music therapy sessions? If so, could you describe them?
3. Did the music therapy support you in your role as a caregiver? If so, how?
4. (When applicable) Reflecting on the challenges that you mentioned in the previous interview, would you say that

music therapy affected these challenges? If so, in which ways?

5. Did group music therapy affect the relationships with your colleagues? How so?
6. Did participating in group music therapy provide support to you? If so, in which ways?
7. What did the sessions mean for you personally?
8. Is there anything you would like to add?

APPENDIX E: Request for permission letter from the director

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

School of the Arts
MUSIC THERAPY

Director Residential Childcare Information

Research topic: The affordances of group music therapy for the caregivers' wellbeing in a Child and Youth Care Centre

Dear Ms Maree

I am conducting a research study on the possible value of running group Music Therapy sessions for caregivers in a children's home. The research will run over a period of eight weeks, whereby the caregivers will take part in one 45-minute group Music Therapy session per week. Two group music therapy sessions per week will be offered over the eight-week period in order to accommodate the rotating shifts of the caregivers. Each caregiver will, however, be required to attend only one group music therapy session per week. Participation in the study will also involve a semi-structured interview before taking part in the eight-week group Music Therapy process and another semi-structured interview after the eight-week group Music Therapy sessions.

All the interviews, as well as the Music Therapy sessions need to be video recorded for analysis. The data will be archived at the department of music for a minimum of 15 years. No one except me and my research supervisor will see the video recordings, and although the results of the data will be published in a dissertation all information will be treated with confidentiality and the participants' identity will not be revealed. Pseudonyms in the written document and transcripts will be used to ensure anonymity as well as privacy.

It is ethically essential that participation in the study is completely voluntary. Participants may withdraw from the study at any point without owing anyone an explanation. Each study volunteer will be given an informed consent form to read and sign.

Contact details are supplied below. Please feel free to approach me should you have any questions. Your decision to allow caregivers to participate will be greatly valued and appreciated.

Researcher: Nadia Smith

0718949764

smith.nadia79@gmail.com

APPENDIX F: Permission letter from the Director

Engo
Child & Youth Care • Kinder-& Jeugsorg

Ons Kinder- en Jeugsorgsentrum

3 March 2022

Dear Nadia

Masters in Music Therapy: Research Dissertation

I hereby grant permission for you to use Our Child and Youth Care Centre's facilities, and source participants for your research "The affordance of group music therapy for the caregivers' wellbeing in a Child and Youth Care Centre".

Yours sincerely

Christa Maree
Director: Residential Child Care

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Skep hoop in die lewens van kinders