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

Group music therapy in a paediatric oncology ward: Working with a wide open group in a wide open space

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October 2007

ABSTRACT

This mini-dissertation is structured as a clinical inquiry based on a detailed analysis of music therapy work with a wide open group at Kalafong Hospital's paediatric oncology ward. The focus of this inquiry is to characterise 'working moments' within a wide open group music therapy context, that appears to be impacted by noise levels, group structures, and a generally busy and unpredictable physical environment. In addition, this clinical inquiry identifies clinical skills employed during 'working moments' with a wide open group.

Research methods of description, coding, categorising and theme identification are applied in the analysis of three video excerpts and corresponding sessions' session notes. The chosen excerpts are based on a working definition of 'working moments'.

The findings of this clinical inquiry suggest that characteristics of wide open groups include the following: Breaking social isolation and Shifting from illness to health. It furthermore identifies the roles and tasks of the therapist in a wide open music therapy group.

This mini-dissertation also includes a proposed research project that stems directly from the clinical inquiry.

KEYWORDS: Group music therapy, Paediatric oncology, 'Working moments', Effective group therapy, Wide open group, Clinical skills, Hospitalisation, Social isolation, Illness and health.

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ACKNOWLEDGEMENTS

I would like to thank the following:

Kobie, Mercédès and Carol for your guidance, insight and support

The patients and parents at Kalafong Hospital's paediatric oncology ward for your enthusiasm amidst difficult times

The staff at the ward eight, especially Dr. Reynders and Sister Patricia for your encouragement and positive feedback

My friends of the MMus music therapy class - your energetic and optimistic spirit is amazing

Thinus for your unshakeable love and support – I love and appreciate you with all my heart

Annette for your encouragement over a hundred cups of tea

My parents for always believing in me and laying the foundation

God for knowing in Your infinite wisdom, that this is the road I have to travel and for giving me the strength in doing so

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TABLE OF CONTENTS

Abstract

Acknowledgements

PART ONE - CASE REPORT AND CRITICAL REVIEW

Chapter One	Background and Context	1
	1.1 Introduction	1
	1.2 Aim of Clinical Inquiry	3
	1.3 Mini-Dissertation Layout	3
Chapter Two	Literature Review	4
	2.1 Group Therapy	4
	2.1.1 Effective group therapy: Defining working moments	4
	2.1.2 Music therapy and group work	8
	2.1.3 The roles and tasks of the therapist in group work	11
	2.1.4 Group phases	13
	2.2 Music Therapy in a Paediatric Oncology Ward	15
	2.2.1 Hospitalisation	15
	2.2.2 Group music therapy in a hospital setting	15
	2.2.3 Aims of group music therapy in a hospital setting	16
Chapter Three	Group Report and Observation Notes	18
	3.1 Group Details and General Information	18
	3.2 Group Report Narrative	19
	3.2.1 Why use and open group or wide open group format?	19
	3.2.2 Reasons for referral	19
	3.2.3 Therapeutic aims	20
	3.2.4 The music therapy process	20
	3.3 Zooming in on the Clinical Description	24
	3.3.1 Sources of clinical material	24
	3.3.2 Selection of clinical material	24
	3.3.3 Description	25
	3.3.4 Clinical material	25

3.3.5 Example of session notes: Session three 33

PART TWO - SAMPLE OF DATA ANALYSIS AND INTERPRETATIVE DISCUSSION

Chapter four Analysis of clinical material 34
4.1 Coding 34
4.2 Categorising 36
4.2.1 Category one: The therapist's clinical skills 37
4.2.2 Category two: Engagement and participation of the therapist and the group 39
4.2.3 Category three: Shifting roles 41
4.2.4 Category four: Encouragement and support of the therapist and the group 42
4.2.5 Category five: Aspects of group energy 44
4.2.6 Category six: Group cohesion development 45
4.2.7 Category seven: Difficulties in managing the group 46
4.3 Emerging Themes 46
4.3.1 Theme one: Breaking social isolation 47
4.3.2 Theme two: The therapist's roles and tasks 49
4.3.3 Theme three: Shifting from illness to health 51
Chapter five Interpretation and discussion
5.1 Addressing the Focus of my Clinical Inquiry: Characterising Working Moments in a Wide Open Group 53
5.1.1 Theme one: Breaking social isolation 53
5.1.2 Theme three: Shifting from illness to health 57
5.2 Addressing the Focus of my Clinical Inquiry: Clinical Skills Employed during Working Moments in a Wide Open Group 59
5.2.1 Theme two: The therapist's roles and tasks 59

PART THREE: PROPOSED RESEARCH PROJECT

Chapter six Proposed Research Project 63
6.1 Introduction 63
6.2 Research Questions 63

6.3	Research Paradigm	64
	6.3.1 Qualitative research paradigm	64
	6.3.2 Naturalistic inquiry	64
	6.3.3 Researcher as instrument	64
	6.3.4 Personal bias	65
6.4	Data Collection and Preparation	65
	6.4.1 Primary data source: Video excerpts	65
	6.4.2 Secondary data source: Session notes	66
	6.4.3 Description	66
6.5	Data Analysis	67
	6.5.1 Coding	67
	6.5.2 Categorising	67
	6.5.3 Themes and interpretation	67
6.6	Ethical Considerations	67

PART FOUR: CONCLUSION

Chapter seven	Conclusion	69
7.1	Summary of the Clinical Inquiry	69
7.2	Summary and Conclusion of Findings	70
7.3	Limitations of the Clinical Inquiry	72

REFERENCES 73

APPENDICES

Appendix I	Consent form	76
Appendix II	Consent from the institution	77
Appendix III:A	Session notes: Session three	78
Appendix III:B	Session notes: Session five	79
Appendix III:C	Session notes: Session eight	80
Appendix IV	List of all codes	81
Appendix V	Categories, sub-categories and codes	84

FIGURES

Figure 2.1	Diagram of group interaction	11
Figure 3.1	Lyrics of greeting song	21
Figure 3.2	Diagram of seating arrangement: Session: Three	26

Figure 3.3	Diagram of seating arrangement: Session: Five	28
Figure 3.4	Diagram of seating arrangement: Session: Eight	31
Figure 3.5	Session notes: Session three	33
Figure 4.1	Coding extract from video excerpt description: Session three	34
Figure 4.2	Table of all codes	35
Figure 4.3	Diagram of category one with sub-categories	37
Figure 4.4	Diagram of category two with sub-categories	39
Figure 4.5	Diagram of category three with sub-categories	41
Figure 4.6	Diagram of category four with sub-categories	42
Figure 4.7	Diagram of category five with sub-categories	44
Figure 4.8	Table of theme one with relevant categories and sub-categories	47
Figure 4.9	Table of theme two with relevant categories and sub-categories	49
Figure 4.10	Table of theme three with relevant categories and sub-categories	51

PART ONE – CHAPTER ONE

BACKGROUND AND CONTEXT

1.1 Introduction

This detailed analysis of clinical work emanated from my experience of working as a music therapy student with an open group at Kalafong Hospital's Paediatric Oncology Ward.

Kalafong is a public sector hospital situated twelve kilometres west from the city centre of Pretoria, next to Atteridgeville. In conjunction with the University of Pretoria, the facility also serves as a training centre for students from various medical and related fields of study, e.g. medical students, students of physiotherapy, occupational therapy, social work, pharmacology, dietetics, music therapy etc. In order to contextualise the environment in which my work as a music therapy student was conducted, I would first like to elucidate Kalafong Hospital in the context of the South African health care system.

South Africa's health care system consists of a large public sector and a smaller private sector. Health care services varies from basic primary health care, offered free of charge by the Government, to highly specialised health services available in the private sector for those who can afford it. Only eighteen percent of the population are members of medical aid schemes as a result of which most people are unable to afford care in the private sector (SouthAfrica.info, no date). The public sector is currently inundated with patients and severe shortages in staff, financing, equipment and facilities are experienced.

The 'traditional' view of a therapeutic space is that of a private, quiet room which luxury is usually not achievable in the public health sector. The reality of practising music therapy in this context is that there is usually no exclusive space available for private sessions. Consequently, sessions often take place in any available open space, such as wards. This corresponds with my experience of working at Kalafong Hospital.

Keeping in mind that not just any available space at the ward would be a private one and that the number of group members was going to be unpredictable, an open group structure seemed to be the most appropriate format in this particular context. With an open group there are no expectations regarding attendance and group members can come and go as

they please (Pavlicevic 2003). It also allows patients, who have few opportunities to exercise autonomy, to have a choice as to whether or not they attend the group (Pavlicevic 2003).

Weekly music therapy group sessions were held at the Paediatric Oncology ward in one of four open areas, each of which leads directly onto a corridor lined with consultation rooms and single bedrooms. Two walls of the ward areas were lined with beds, some of which were occupied with patients who were physically too weak to move around. For the group sessions, a circle of chairs was placed between the two rows of beds, but the group was not only confined to members in the circle. Parents and staff sometimes joined the group from outside the perimeter of the circle and bedridden patients were also included in group activities. Ages of group members ranged from babies to toddlers, young children to adolescents and adults. The size of the group varied between fifteen and twenty-five members, with only a few core members (three to four) who attended each week. Within each weekly session the size of the group fluctuated: children were fetched for treatment, staff members joined for moments between tasks and parents and curious bystanders came and went.

As a student therapist I often found it very difficult to work with this specific client group in this specific context. The first of these difficulties stems from the absence of a specifically allocated therapeutic space. Weekly negotiations were necessary to attain an appropriate available space. Ideally the quietest section of the ward was to be used, but I also had to take into account whether there were very ill children that could be disturbed, ward rounds that needed to be conducted, cleaners who had to perform their duties etc. Furthermore the continuous movement of people through the group and the fluctuation of group members seemed to intrude upon the traditional sense of privacy and consistency in a therapeutic group space. Due to the mere size of the groups, I found it very difficult to manage instruments, model expectations, validate each group member, monitor relational developments and sustain the groups' music. This was further complicated by the fact that the groups comprised of a wide range of ages and ethnic backgrounds.

This degree of group heterogeneity, the fluctuating attendance and membership as well as the open space where people constantly move through, have made me question which clinical skills I need require in order to achieve optimal group music therapy work within this particular context. For the purposes of this clinical inquiry, I call optimal group work 'working moments', and will construct a working definition from existing literature of moments in music therapy that seem to contribute to therapeutic effectiveness in what I choose to call 'wide open' groups.

1.2 Aim of Clinical Inquiry

The aim of this clinical inquiry is to characterise 'working moments' within a wide open group music therapy context, that appears to be impacted by noise levels, group structures, and a generally busy and unpredictable physical environment. In addition, this clinical analysis aims to identify clinical skills employed during 'working moments' with a wide open group.

1.3 Mini-Dissertation Layout

This mini-dissertation consists of four parts. Part one is a case report based on clinical work and a critical review of relevant literature. Part two consists of an analysis and interpretative discussion of clinical material. Part three stems from the analysis and discussion of my clinical work and is framed as a proposed research project. This mini-dissertation is brought to a close with part four: the conclusion.

PART ONE – CHAPTER TWO

LITERATURE REVIEW

In this chapter, I discuss some of the literature relevant to this study. The literature review is divided into two sections: The first section involves theory relating to group therapy and more specifically selected theory on group work which informs my work with the music therapy group at Kalafong Hospital. The second section involves aspects of music therapy in hospital settings. These aspects include the effects of hospitalisation on children, the benefits of music therapy as intervention and the needs and aims of music therapy groups with hospitalised children.

2.1 Group Therapy

2.1.1 Effective group therapy: Defining working moments

According to psychotherapist Irvin Yalom (1995:1) "therapeutic change is an enormously complex process that occurs through an intricate interplay of human experiences". He refers to these human experiences as "therapeutic factors" and is of the opinion that they constitute the basis of an effective approach to group therapy. Bunt (1994), a music therapist, refers to Yalom's (1995) therapeutic factors as being specific to group work, regardless of the particular therapeutic methods and the therapist's personal style.

Yalom (1995) placed the therapeutic factors into eleven main categories. I will now briefly discuss each of these categories.

Instillation of hope

"The instillation and maintenance of hope is crucial in any psychotherapy" (Yalom 1995:4). According to Yalom (1995), hope is required to keep patients in therapy so that other therapeutic factors may take effect. To achieve this, the therapist must do whatever he/she can to increase patients' confidence in the group, for instance by reinforcing positive expectations of the group. Furthermore, it also seems vitally important that the therapist believes in him/herself and in the efficacy of the group (Yalom 1995).

Universality

Many patients enter therapy with the thought that they alone have certain problems. To an extent this is true, since patients each have a unique constellation of life stresses. Some patients experience an extreme sense of social isolation and accordingly, have a heightened sense of uniqueness which leads to difficulties in experiencing intimacy. This notion of 'being alone' hampers the patient to use opportunities to 'confide in' and ultimately be validated and accepted by others (Yalom 1995). Yalom (1995:6) adds that "in the therapy group, especially in the early stages, the disconfirmation of a patient's feelings of uniqueness is a powerful source of relief".

Imparting of information

Under the general therapeutic factor *imparting of information*, Yalom (1995) includes didactic instruction as well as advice given by the therapist or patients. Keeping in mind that the Kalafong music therapy group rarely exchanged advice, I will focus on didactic instruction. Didactic instruction refers to explicit education of the group to transfer practical information, to structure the group and to explain certain processes. Often such instructions function as the initial binding force in the group, until other therapeutic factors become operative. Yalom (1995) also mentions that explanation and clarification function as effective therapeutic agents in their own right. Human beings seek explanations of phenomena that cause uncertainty. Finding explanations render feelings of control (Yalom 1995).

Altruism

"In therapy groups, patients receive through giving, not only as part of the reciprocal giving-receiving sequence but also from the intrinsic act of giving" (Yalom 1995:12). Patients with serious illnesses are often demoralised and may possess a sense of having little or nothing of value to offer others. Having the experience of finding that they can be of importance to others is refreshing and boosts self-esteem (Yalom 1995). Patients are also enormously helpful to one another in the group therapeutic process. They offer support and reassurance to one another and allow their fellow patients to grow as a result of facilitative, sustaining relationships (Yalom 1995).

The corrective recapitulation of the primary family group

The therapy group resembles a family in many aspects: There are authority/parental figures, peer siblings, strong emotions, intimacy as well as hostile and competitive feelings. It is inevitable that members will interact with leaders and other members in modes reminiscent of the way they interacted with parents and siblings. What is important when thinking of similarities between a family and a therapy group, is that fixed roles must be constantly explored and challenged, and ground rules for investigating relationships and testing new behaviour must be constantly encouraged (Yalom 1995).

Development of socialising techniques

"Social learning – the development of basic social skills – is a therapeutic factor that operates in all therapy groups, although the nature of the skills taught and the explicitness of the process vary greatly depending on the type of group therapy" (Yalom 1995:15). The development of social skills can help patients form healthy social relationships.

Imitative behaviour

According to Yalom (1995) there is considerable evidence that group therapists also influence the communicational patterns in their groups by modelling certain behaviours. Imitative behaviour generally plays an important role in group stages where members need to identify with 'another'. He describes imitative behaviour as a medium for "trying on" bits and pieces of other people and then discarding them if they do not "fit". "This process may have a solid therapeutic impact; finding out what we are not is progress toward finding out what we are" (Yalom 1995:16).

Interpersonal learning

Interpersonal learning is a broad and complex therapeutic factor. In the process of defining interpersonal learning, Yalom (1995) places much emphasis on the importance of interpersonal relationships. He mentions that from whatever perspective we study human society, we are at all times obliged to consider the human being in the matrix of his/her interpersonal relationships. It is furthermore mentioned that humans 'crave' response from their environments (the matrix they function in) and that under varying conditions this 'craving' may be expressed as a desire for contact, for recognition and acceptance, for approval, for esteem or for mastery. The result of the environment's response to a person is

that the individual develops a concept of the self. Since individuals develop their self-concepts based on the appraisals of significant others, the group process can assist group members to construct new/more positive self-regard, based on positive responses from significant others in the group (Yalom 1995). The therapeutic impact of interpersonal learning then lies in the potential of a therapeutic group environment to fulfil the human 'craving' for response, and to construct or alter members' self regard.

Group cohesiveness

Yalom (1995:48) defines cohesiveness as "the attractiveness of a group for its members". It refers to the condition of members feeling warmth and comfort in the group, feeling they belong, valuing the group and feeling that they are valued and unconditionally accepted and supported by other members. Yalom (1995) states that cohesiveness is not fixed, but instead fluctuate greatly during the course of the group. The importance of group cohesiveness lies in the fact that "cohesiveness is necessary for other group therapeutic factors to operate" (Yalom 1995:49).

Catharsis

Catharsis is about the client being able to vent and explore feelings and gain relief from having expressed them (Yalom 1995). Being able to express feelings is not always enough though; at times the experience of intense emotions does not lead to change. This therapeutic factor is only helpful within the context of a supportive group (Yalom 1995).

Existential factors

Yalom's (1995) final category refers to issues such as responsibility, basic isolation, contingency, the capriciousness of existence, the recognition of our mortality and the ensuing consequences for the conduct of our lives. These factors all point to our fundamental apartness. Yalom (1995) explains the double meaning of *apartness* as: "We are separate, lonely, *apart from* but also *a part of"* (Yalom 1995:101). This implies that even though we are lonely, it is comforting to be with others. An awareness of these existential factors is seen as one of the most curative therapeutic mechanisms (Yalom 1995).

Yalom's (1995) therapeutic factors inform my understanding of events or approaches that make group therapy effective. For the purposes of this study, a "working moment" is defined as a moment during which one or more of the therapeutic factors, as discussed above, are present.

2.1.2 Music therapy and group work

Music therapy offers a form of communication, through joint activity, active listening and performing. It resembles the communicative act without the use or need for words (Aldridge 1996). A further, more comprehensive definition of music therapy is the following: "Music therapy provides a framework in which a mutual relationship is set up between client and therapist. The growing relationship enables changes to occur, both in the condition of the client and in the form that the therapy takes… By using music creatively in a clinical setting, the therapist seeks to establish interaction, a shared musical experience leading to pursuit of therapeutic goals. These goals are determined by the therapist's understanding of the client's pathology and personal needs" (Association of Professional Music Therapists (APMT) definition in Bunt & Hoskyns 2002:10). This definition is also applicable to group music therapy.

Tom Plach (1996:3) defines group music therapy as "the use of music or musical activities as a stimulus for promoting new behaviours and exploring predetermined individual or group goals in a group setting". The therapeutic direction of my work with the Kalafong music therapy group was strongly guided by specific group goals.

2.1.2.1 Open groups

Pavlicevic (2003) discusses how different kinds of groups foster different kinds of musical and personal interactions. The different kinds of groups she mentions are closed groups, semi-open groups and open groups. She describes open groups as follows: "An open group means that people come and go as they will, and there are no expectations from you with regards to attendance. You may have totally different people each week, or you may have a mixture of 'old' and 'new' faces" (Pavlicevic 2003:53).

The description of an open group classifies the group members as 'old' and 'new' faces, where the Kalafong groups consisted of the 'classic' open group as well as 'temporary' members (family of patients, visitors and staff). The membership of these subgroups

fluctuates within a single therapy session, implying that the boundary between the therapy group and the people on the ward was highly permeable. For the purposes of this study, I define this extended open group as a *wide open group*.

2.1.2.2 Systems Theory

A theory that seems relevant to wide-open groups is the Systems Theory. A system is defined as "a whole composed of parts in orderly arrangement according to some scheme of plan. According to Systems Theory, "groups function as systems within systems which are interconnected – they continually exchange energy, and change and adapt to each other" (De Board 1978:88). A wide open group can be compared to an 'open' system which is continually in contact with its environment, importing energy, converting and exporting the transformed energy back to the environment (De Board 1978).

According to Systems theory, the open system's effectiveness depends on the maintenance of balance between itself and the environment. The theory also stresses the importance of the boundary in an open system, for it becomes obvious that it is the exchanges at the boundary, both import and export, enables an open system to maintain a dynamic equilibrium (De Board 1978). Due to a highly permeable boundary between a wide open group and its environment, difficulty in maintenance of dynamic equilibrium may be experienced.

2.1.2.3 Environmental approaches

According to Woodward (2004) it is not possible to remove the group from the environment polluted with sound (for instance noise, resident distress, staff business, television and telephone). It is essential to work with, rather than against the environment. Woodward (2004) suggests following an "environmental attitude" in the planning of treatment where participants in music therapy groups have the opportunity to share aesthetic experiences, allowing group members to be heard in their own environment and connecting group members with the 'self', others and the environment through the act of listening (Woodward 2004). An environmental attitude allows people outside the group to experience beauty ín the environment. Music making does not exist within a sound proof vacuum and it can thus enhance the environment in which it sounds. This attitude also gives disempowered members within the system a 'voice'. Group members who are disempowered in one way or another have the opportunity in a group to exercise choice and act as an autonomous

individual. Lastly, this attitude allows people in the system to experience listening in new ways. Viewing listening as a 'sacred' connection between 'self', 'other' and environment, allows people in the system to become quietly involved in the group in stead of only witnessing the group. Considering this, it is clear that the group and the environment cannot be seen as two closed systems and that it is possible to view the immediate environment of a group as a "resource pool" for therapeutic activity (Kenny 1989, in Woodward 2004:4).

Aasgaard (1999:34) states that a healthy environment fosters "self-growth and creativity, regardless of age or physical condition". As a music therapist, he focuses on the importance of establishing and nurturing a 'music environment' within institutions (specifically in cancer care) (Aasgaard 1999). Usually music therapists focus on specific individuals or group work and often seem to neglect working towards having a positive effect on the environment. Aasgaard (1999) proposes that music therapists who work in hospital settings should follow an approach called music environmental therapy. According to this approach the individual patient is not overlooked, but the focus of interventions is extended to encompass all present in a defined milieu (Aasgaard 1999). Wide-open groups have the capacity to include as many group members as possible, and even though there are no clearly delineated boundaries between the groups and their environments, this format may be the way to achieve an optimal group experience for all involved.

Aasgaard (2004) also discusses community music therapy in a paediatric hospital setting. He states that community music therapy strives to give patients a voice and bring people together to perform and enjoy music, not as an alternative to the medical treatment, but as natural agent of health promotion (Aasgaard 2004). It is from Aasgaard's (2004) writings on practicing music therapy in the 'open spaces' of the hospital's common rooms, play rooms, entrance halls or corridors that I borrowed and adapted the term 'open spaces' for this inquiry's title.

In some ways, working in wide open spaces also resembles the establishment of twentieth century music therapy. The profession of music therapy began to develop during World War I when music was used in Veterans Administration Hospitals as an intervention to address traumatic war injuries (University Hospitals of Cleveland 2005). Community musicians of all types, both amateur and professional, went to the Veterans hospitals around America to make music for and with the thousands of veterans (American Music Therapy Association 2004). Veterans passively and actively engaged in music activities that focused on relieving pain perception. Numerous doctors and nurses witnessed the effect music had on veterans' psychological, physiological, cognitive, and emotional state. Since then, colleges and

universities developed programs to train musicians how to use music for therapeutic purposes (University Hospitals of Cleveland 2005).

2.1.3 The roles and tasks of the therapist in group work

In understanding the roles and tasks of a group therapist, let us consider the therapeutic factors outlined earlier (see 2.1.1, p.4-7). In Yalom's words: "Who provides support, universality, interpersonal feedback, learning, opportunities for altruism, and hope? Obviously, the other members of the group! Thus to a large extent, it is the group that is the agent of change" (Yalom 1985:115).

This is a crucial difference between the basic roles of an individual therapist and a group therapist. According to Yalom (1985), it is "the group members who, in their interaction, set into motion the many therapeutic factors, then it is the group therapist's task to create a group culture maximally conducive to effective group interaction" (Yalom 1985:116). In order for a therapeutic group to function optimally, the members must interact freely. The pathways of interaction should appear like the first rather that the second diagram, in which "communication is primarily to or through the therapist" (Yalom 1985:116).

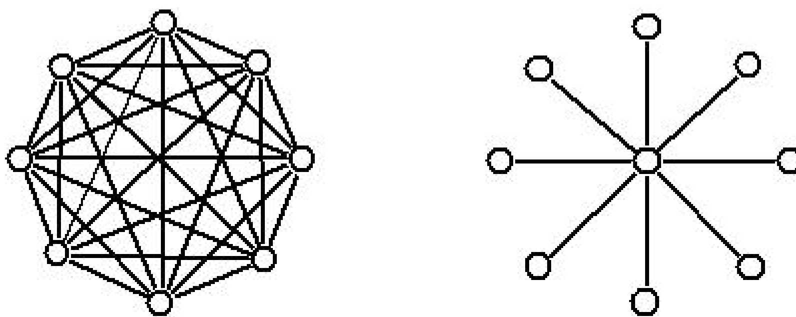

Figure 2.1 Diagrams of group interaction (Yalom 1985:116)

One the basis of the above mentioned differences between the basic roles of the individual and group therapist, I would now like to refer to more specific roles of the group therapist. Pavlicevic (2003) describes the roles of a group leader (in the case of a therapy group, the therapist) as follows: "Providing for the group in terms of a physical space, the session times, the music; providing instruments at times, as well as providing for the musical and social experience". Yalom (1985) refers to these tasks of the therapist as "The creation and maintenance of the group" (Yalom 1985:113). Once the group is a "physical reality", the

therapist focuses on shaping the group into a therapeutic social system (Yalom 1985:115). Yalom (1985:115) refers to this as "culture building". The leader's/therapist's role then includes: Negotiating group norms, keeping track of group 'progress' or 'developments'; monitoring the overall quality and level of group and individual 'energy' levels; and ensuring and facilitating optimal group functioning (Pavlicevic 2003).

The group may not be aware that the leader's/therapist's roles and tasks are part of the 'work' he/she does in the group (Pavlicevic 2003). Pavlicevic (2003:89-90) gives some suggestions as to how the group leader's/therapist's tasks might be described:

- To enable – individual and collective creativity to emerge; to foster musical and human relationships
- To allow – for richness, individuality, community, for music to sound
- To monitor – what is happening in music, within persons and between them
- To guide – and support. Guiding means being attentive to the moment, and accompanying persons in music, in their personal and collective group experience
- To facilitate – not only in the sense of making 'smoother' – but at times to make simple interventions in order to help the music or the group event to shift in whichever way it needs to
- To lead – at times the therapist needs to be the leader. Providing music, setting the tempo, rhythm, melody and gathering the group at the same time
- To follow – this means allowing for others to try out roles of leading, initiating musical activities, and taking cues from them
- To sustain – when the group music is flowing, you may be needed to sustain the energy in order to continue the momentum
- To end – at times groups are not moving towards ending, either within the music, or in terms of allowing your work together to end. It is important that the group leader/therapist listens to the group's 'readiness' to end
- To hold – The presence of the group leader/therapist can be one that creates and sustains a sense of rich collective *musicking*[1] with its accompanying feelings and personal experiences. Music therapists speak of 'holding' the group and group space: allowing experience to be felt in a way that feels 'safe' for the group. One way to create feelings of emotional and relational 'safety' is through negotiating and respecting group norms

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[1] The word 'musicking' is from Christopher Small's book of that name, and explains that rather than think of music as an object or product that exists separately from us as human beings, 'musicking' denotes that we are engaged in music, with music and through music – whether we listen, play, hum, dance or imagine it in our minds (Pavlicevic 2003:17).

I would now like to focus on the therapist's task of establishing group norms. According to Yalom (1985:119), the therapist fulfils the role of the group leader and that "the leader is the initial seat of influence in the group and is looked to by the members for direction". This view of the therapist by the group, allows the therapist to assume two basic roles: Technical expert and model setting participant (Yalom 1985). In each of these roles the therapist helps to shape the norms of the group. When assuming the role of technical expert, the therapist deliberately employs a variety of techniques to move the group in a direction considered therapeutic (Yalom 1985). Techniques range from explicit instructions and suggestions to subtle reinforcing techniques. The leader can also shape norms by setting an example of group behaviour (Yalom 1985). By offering a model of group behaviour such as musical and personal support and acknowledgement, members are offered opportunities to experience self confidence, enjoyment and a collective musical and personal experience (Pavlicevic 2003).

A further role of the group leader/therapist, according to Pavlicevic (2003: 89), is "to listen from a particular stance, and to signal to the group your intentions, requests and demands. Each of your signals has degrees of energy and clarity: at times a quick look will do, while at others, your entire body signals what you want". Apart from monitoring musical activities and how these emerge and develop; how each child participates or not; the quality of the engagement, cooperation, awareness of others, responsiveness to others, it is as important that the group leader/therapist is also aware of what is not happening in a group (Pavlicevic 2003).

What we can gather from all the above information is that the role of the group music therapist is multi-faceted and that it constantly shifts.

In the next sub-section, I briefly discuss some aspects of group phases

2.1.4 Group phases

In working with a group, it is useful to be informed of the work of psychologists and group analysts who have identified group processes and phases that groups generally experience. Foulkes, Bion, Nitsun and Tuckman have written extensively about groups from psychoanalytic perspectives (Pavlicevic 2003). I would firstly like to focus on Tuckman's model of Group Phases as one way of thinking about group processes.

Pavlicevic (2003) alerts us to the following: "Nothing in (any aspect of) group work (or life, for that matter) is as organised and predictable as a linear sequence of phases or processes. In other words, Phase One is not necessarily followed by Phases Two and Three; neither does process 'a' mean 'such and such'" (Pavlicevic 2003:215). She continues to say that it may in some ways, be more useful to think of phases and processes as representing various aspects of group events (Pavlicevic 2003).

Tuckman's Group Phases may be a useful model to help the therapist reflect on his/her work, rather than using it as a model on which to 'plan' or 'execute' work (Pavlicevic 2003). Tuckman's four phases of group life are the following: Norming, storming, forming and performing (MacKenzie & Livesley 1983, Pavlicevic 2003). During the norming phase, group members identify what they have in common, in the storming phase they identify how different they are from one another, in the forming phase they come together once again with a more realistic and balanced understanding of one another, and in the performing phase the group functions as a whole, aware of similarities and differences, and performing its tasks (Pavlicevic 2003).

An awareness and understanding of each of these phases can, for example, help the therapist to manage and contain a fractious and difficult group without feeling like a 'bad' therapist. If the therapist is aware of the fact that such group behaviour is consistent with Tuckman's second phase (storming), it can have a positive impact on the quality of the group work and trusting relationships in the group (Pavlicevic 2003).

Another perspective on group processes that I found to be helpful in thinking about my work with a wide open group, is aspects of Nitsun's view of early group dynamics (Nitsun 1989). He states that members arrive in a state of anxious anticipation at the outset of a group and that there is a "groping for contact, energized by the positive intentions with which participants have come" (Nitsun 1989:251). The positive hopes are quickly replaced by the reality of being in the group. In stead of a cohesive unit it is a fragmentary collection of individuals and what is aroused is anxiety rather than a pleasant merging. Soon, early fear of hostile attack has to be faced (Nitsun 1989). According to Nitsun (1989:251), "most people join a group with the expectation and hope of being able to reveal and understand disturbing aspects of their inner lives, but this is accompanied by a fear of exposure. This fear may continue throughout the group's life, but it tends to be most acute at the start". To group members, exposure means risk and the greatest risk is of being attacked (Nitsun 1989).

Aspects of this view concur with the wide open group, due to its fluctuating membership.

I would now like to return to the process of identifying and characterising 'working moments' in music therapy with a wide open group in a hospital setting. In this regard it may be helpful to understand the effects of hospitalisation on children.

2.2 Music Therapy in a Paediatric Oncology Ward

2.2.1 Hospitalisation

Hospitalised children are exposed to a number of stressors. Stressors are related to how the child experiences the hospital environment, separation from parents, interacting with strangers, experiences and expectations concerning painful or uncomfortable procedures, and separation from peer group and siblings in routine daily events (Melamed 1992 in Aasgaard, 1999). Children's parents, who need to come to terms with the diagnosis of their child, are often unable to provide the support that the child needs (Dunn 1999).

Creating a socially stimulating but secure environment is a challenge for institutions where patients and families are experiencing an extremely insecure and unpredictable time of life, as is often the case in paediatric oncology wards (Aasgaard 1999). The next section gives an overview of how patients and their families can benefit from music therapy in a paediatric oncology setting.

2.2.2 Group music therapy in a hospital setting

The benefits of music therapy with hospitalised patients and their families are well documented (Aasgaard 1999, 2004, Aldridge 1996, Pavlicevic 1999, Turry 1999).

Hospitalisation often leads to emotional confusion in young children. Music therapy offers a medium to express feelings that cannot be expressed in words. Both positive and negative emotions can be expressed, relaxation and pain control can be promoted, healthy body parts can be emphasised, and opportunities to make choices and exert some control over their environment are offered. Music therapy also offers opportunities for engagement and creative participation. Perceptions and feelings of helplessness resulting from physical, psychological, emotional or spiritual states may be brought to awareness and improved (Dunn 1999:62).

Attending group music therapy on the ward can help the child (patient) to see other children dealing with the hospital experience in a positive way and provide moral support by being with others in a similar circumstance. Parent participation can reduce tension by having fun and laughing. Parents interact with their children and often seem to appreciate the child's creative engagement in the music (Dunn 1999:63). Dunn (1999) adds that music is a familiar and prominent part of childhood that can even benefit children who are not actively involved in music making due to severe fatigue or illness. Children seem temporarily happy with watching the music therapist or other children and adults 'in action'. The familiarity of instruments, songs or activities provides the children with a source of security in a strange setting (Dunn 1999). Music is furthermore important for hospitalised children, since it may be associated with positive experiences. It is easily accessible (physically, psychologically and socially) and is easily controlled by people of all ages (Dunn 1999). Music in a hospital adds something pleasurable to an environment that at times may be experienced as unpleasant, unfamiliar or frightening. Aasgaard (2004:161) articulates why music in a hospital ward plays an important role: "To expect or to experience something nice adds pleasurable moments to our lives"

These pleasurable moments can also be experienced by the music therapist. Brigitte Schwarting (2005:110), a music therapist working in a paediatric oncology unit, states: "It is a most wonderful and satisfying experience to tidy up after a music therapy group session which has gone well". According to her, the group has 'gone well' when every member of the group participated and had been given space to make themselves heard and when the session had an organic flow of stimulating/invigorating and relaxing/contemplative energy.

2.2.3 Aims of group music therapy in a hospital setting

In general, aims for group music therapy are determined according to the needs of the group. Examples of aims for a music therapy group are to develop/enhance/sustain social skills, cognitive skills, listening skills, musical and communication skills (Pavlicevic 2003:92-93), improving the environment around the group and tending to emotional needs (Aasgaard 1999:34). These aims may also be appropriate for a wide open group.

Within a wide open group, group members, temporary members and the therapist all have different expectations and needs. Patients have the need to play, stressed parents need to see their ill children socialise and have fun, overworked staff need a place to relax and the therapist has a need to see these needs attended to (These are randomly selected examples

from my own experience). According to Aasgaard (1999), the focus of music therapy intervention in such a setting needs to be extended at times to include the maximum number of people.

Seen in the light of the discussion above, the general aims for wide open groups in paediatric oncology settings may include the following:

- To provide group members with emotional and social support
- To provide group members with opportunities to express feelings that cannot be expressed in words
- To aid group members in relaxation and pain control
- To engage group members in creative participation; and
- To provide group members with opportunities to exercise autonomy and gain some control in their environment

In conclusion, I was unable to find specific literature on wide-open groups as defined in this study. It also seems that there is a general scarcity of information relating to open groups and appropriate clinical techniques that can contribute to the success of such groups. It appears that an understanding of the contexts of the wide open groups may prove to be helpful in successfully managing such groups.

PART ONE – CHAPTER THREE

CLIENT REPORT AND OBSERVATION NOTES

This chapter gives an overall portrayal of the wide open music therapy group I conducted at Kalafong Hospital's Paediatric Oncology ward as a student therapist. It also gives an account of how clinical material was selected for the purposes of my clinical inquiry.

This clinical inquiry is based on work that I have done at Kalafong Hospital as part of my clinical training as a music therapist. Ethical issues that were taken into consideration are: Confidentiality and anonymity, informed consent, protection of participant's rights and accurate documentation of video recordings (Ansdell & Pavlicevic 2001; Schurink et al. 1998). It is standard practice for music therapists to record music therapy sessions for in-depth analysis of the musical material and to facilitate clinical ratings (Schurink et al. 1998). Informed consent for conducting music therapy and the video recording of music therapy sessions was obtained from parents/guardians of patients who attended music therapy (see Appendix I, p.76). In addition to this, consent to write this case report for the purposes of a mini-dissertation, was obtained from Kalafong Hospital (see Appendix II, p.77)

3.1 Group Details and General Information

The weekly open music therapy group sessions at Kalafong's Paediatric Oncology ward were held between February and May 2007. A total of thirteen half-hour sessions were conducted. The Group consisted of members who had been diagnosed with different permutations of childhood cancers, with varying degrees of functional impairment, influencing levels of energy. Ages of group members ranged from a few months to fourteen years. In addition to the 'patient'- members, staff, family and visitors joined the group intermittedly. A further factor that contributed to the diverse nature of this group was the miscellany of ethnic backgrounds. I was not conversant with the most commonly understood language (Northern-Sotho) and sessions were mainly conducted in English. Whenever important information needed to be conveyed to the group, the assistance of a translator (staff member) was employed.

From week to week the group size fluctuated between fifteen and twenty-five members, with only a few core members. The group size also fluctuated within sessions, since children were fetched for, or brought back from treatment. In general, this population group received long

term treatment and were therefore hospitalised for extended periods of time. Some of the patients' primary caregivers stayed with them at the hospital, while many of the children received few or no visitors for the entire duration of hospitalisation.

3.2 Group Report Narrative

3.2.1 Why use an open group or wide open group format?

The foremost reason for conducting a wide open group was due to the lack of a private therapeutic space. It was furthermore not possible to move very ill or bedridden patients and thus more practical to conduct the group sessions on the ward. In the context of the Paediatric Oncology ward, the number of children who attended music therapy was unpredictable – depending on who was in the ward and who was being admitted or discharged. Following an open group format afforded patients, who had been at the hospital for a few weeks, the opportunity to form a core group of members. The core members became familiar with the structure of the sessions in terms of length, frequency, musical material, the instruments and the therapist (Pavlicevic 2003). This sense of familiarity among core members made it easier for new members to join the group at any time. Furthermore, the open group format also allowed patients the exercise of choice whether they wanted to join the group or not. For children with limited opportunities to exert choice, this seemed important. A further characteristic of open groups is that its members can come and go as they will or need to. During music therapy sessions, group members at times had to leave for treatment or return to the group after treatment. As I already mentioned, the group took place in a non-private, open space on the ward. Although the group was physically clearly delineated (the circle of chairs), the group's boundaries were also permeable. The group was visible and audible to others, but also temporarily joined by others such as parents, staff and visitors (Pavlicevic 2003). Due to the notion of the group having permeable boundaries, I extended the idea of an open group to view this group as a wide-open group which included temporary and peripheral group members.

3.2.2 Reasons for referral

There were no specific reasons for referral of patients to the wide open music therapy group. What became apparent though, was that the parents of many of the patients were incapable to support their children emotionally. Because of socio-economic circumstances, many

parents who work and/or live far away could not visit their children regularly. Furthermore, many parents were struggling emotionally to come to terms with their child's illness.

Typically, children in an oncology ward are confronted, and need to deal with an array of physical and emotional trauma and losses, including: Loss of family support, loss of a normal daily social environment, loss of ability (children often loose limbs, bodily capabilities and experience loss of energy and motivation) as well as loss of control over the environment (they have to adhere to ward routines, invasive treatment etc.). Patients often witness fellow patients' death on the ward and are forced to face their own mortality. In addition, they experience regular or continuous physical pain.

In the Kalafong ward setting children often wandered around listlessly and bored. In their daily routine they have few opportunities to play, be creative and spontaneous, or have fun.

It is clear that these children have overwhelming needs. Often it is not possible to address these needs adequately, which can potentially result in withdrawal and social isolation.

Since the groups' membership did not rely on referrals and functioned as a wide open group, children, family members and staff were invited to join the group on a weekly basis.

3.2.3 Therapeutic aims

Throughout the music therapy process we worked towards the following aims:

- To provide group members with emotional and social support
- To engage group members in creative participation
- To provide group members with opportunities to exercise autonomy and gain some control over their environment
- To provide group members with opportunities to express feelings which cannot be expressed in words

3.2.4 The music therapy process

Each week's session started with a hallo-song and ended with a goodbye-song. The familiarity of the greeting-songs provided some form of continuity in this fluctuating group. Group members' names were also used in these songs to validate their presence. An example of one of the greeting songs is shown in figure 3.1 (p.21).

Hallo, good morning, sawubona, dumelang
Hallo, good morning, sawubona, dumelang

We sing hallo to _________, hallo to _________,
hallo to _________, we sing hallo, hallo.

Figure 3.1 Lyrics of greeting song

Between the two greeting songs the sessions consisted of a variety of activities. These activities included instrumental playing, movement, vocal work, musical games or music listening. An example of instrumental playing is where each member had a turn to choose an instrument, which they then played, accompanied by myself on the guitar and with the group's vocal input. The music is adapted to each individual member's style of playing.

Three stages can be identified in the therapeutic process:

3.2.4.1 Stage one: Sessions one and two

The first stage was characterised by a general feeling of disorganisation. Due to the large, heterogeneous and ultimately variable nature of the group, I found it quite challenging to manage instruments, arrange seating and provide the group with appropriate activities. Group members played quite roughly with instruments, had difficulty waiting for turns, and had difficulty choosing instruments without arguing with one another. Parents of group members joined the group on its periphery but did not seem keen to actively take part in the group. Their presence created an atmosphere of a group 'performance' which I found to be detrimental to the group's development. During this stage the group strongly relied on me as group leader and soul provider of ideas. Even though most of the group members appeared to be attentive, their vocal, instrumental and movement participation was tentative and reluctant. Amongst group members there seemed to be little awareness and interaction. At the commencement of sessions, the group energy was generally low and the groups required much time and effort to be elevated. This kind of reaction was not unusual in this context. Most of the group members were seriously ill and/or tired due to treatment and members needed time to get accustomed to me and the manner in which the group functions.

3.2.4.2 Stage two: Sessions three to seven

In some ways session three still resembled the first phase of our group. Group members argued over instruments and seemed to have difficulty listening to others and waiting for turns resulting in disorganisation. It was during this session though, that some of the teenaged members showed initiative for the first time. The focus of the group shifted from me to the teenagers, who sustained a clear, steady rhythmic pattern on the djembe drums. In that moment group roles started shifting – the therapist no longer carried sole responsibility for the music. This phenomenon continued in the following sessions. During this phase, the group also seemed to become more easily excited. Higher energy levels were more spontaneously reached and this attracted interest from peripheral members. Staff and parents got involved in the group and often encouraged the children or showed enjoyment of the group's energy. By this time greeting songs and other familiar activities were well know and the group participated with more confidence.

Due to the limitations of verbal communication between the group members and myself (language disparity), I reverted to using much clearer body cues along with very simple verbal instructions. This proved to be very helpful in managing and directing the group. An interesting pattern that started to emerge, was that the older and more experienced group members started assisting new members and acted as 'disciplinarians' when group members did not comply with group norms. Even though it appeared to be subtle actions, it signified that members were starting to take responsibility in the group.

Session five marked another significant shift in the group. Up to this session, I still felt that the boundaries around instrument use was not yet clear enough. Group members still displayed difficulties in waiting for turns and choosing instruments. During this session, a significant amount of time was spent to re-establish boundaries during an activity where I introduced the instruments one-by-one to the group. This was done through clear body cues and very short, clear verbal instructions. The group was encouraged to watch and listen carefully in order to wait before choosing and playing instruments. During the course of the next few sessions, the group showed an increased tolerance for waiting and they handled instruments more carefully. Other aspects that emerged during this time were imitation (the group imitating my body cues or rhythmic patterns on instruments), moments where the group shared a common pulse, and increased eye contact between members. These aspects point to further development of group awareness.

3.2.4.3 Stage three: Sessions eight to thirteen

In the last stage it became apparent that more individual members took initiative, suggesting songs and adding musical and movement ideas. This was illustrated in session eight, prior to which a regular member requested a song to be sung, and who then displayed the ability to comfortably lead the group in learning the song. Roles seemed to shift more easily between group members and the group felt more spontaneous in general. In session ten, a new dimension of the group emerged briefly: Amongst the teenagers' responses were more boisterous and challenging replies to my invitations. This I interpreted as being indicative of the development of autonomy appropriate to their age.

During this stage, I strongly encouraged interpersonal contact amongst group members to facilitate possible transfer into the ward where the group members could provide peer support to one another. Signs of support within the group started appearing. The group began to assist members with impairments (for example, visual impairment) to take part in group activities, whereas shy members were encouraged to play during individual turns. They also expressed their support by waiting for turns and listening to each other's playing.

It is important to mention that the developments I discussed did not develop or progress consistently over time. This can be attributed to the highly fluctuating nature of this group. Even though the group did appear to 'relapse' at times, I found that the consistency of a few core members, the consistency of time, place, therapist and some of the musical material and activities, provided the group process with a degree of continuity which allowed the process to develop.

Once the needs of the group were identified (see 3.2.2, p.19), I was able to formulate group music therapy goals (see 3.2.3, p.20) in order to address these particular needs. To some degree, most of the goals were achieved. The group was able to provide emotional and social support to its individual members, members were provided with opportunities to participate creatively in group activities, members were able to exercise autonomy (through choice) and gain some form of control over their environment. Although the group provided opportunities for members to express feelings that cannot be expressed in words, emotional expression were only seen on a few occasions.

3.3 Zooming in on the Clinical Description

3.3.1 Sources of clinical material

3.3.1.1 Audio/video recording of music therapy sessions

Video recordings capture the groups in their natural setting and allow documentation of non-verbal behaviour and communication that may have been overlooked by the therapist/researcher during the original sessions. According to Schurink et al. (1998), video recordings make it possible to review events in a variety of ways and allow more thorough and complete analysis of sessions. The limitation of using video recordings for analysis is that there is an absence of contextual information beyond what is recorded (Schurink et al. 1998) and it is for this reason that session notes could be included as a secondary source of clinical material.

3.3.1.2 Session notes

Detailed descriptions from session notes place the video excerpts in context and provide material for richer and more accurate descriptions of the chosen video excerpts. Additional information from session notes include events in and around the group which cannot be seen on video recordings and feelings or observations from the therapist as noted directly after the session (see example of session notes in 3.3.5, p.33).

3.3.2 Selection of clinical material

For the purposes of my clinical analysis, I selected three video excerpts and the corresponding sessions' session notes from my work with the Kalafong wide open group. Selection took place as follows:

Issues of triangulation were addressed in various ways: Possible biases were addressed through discussion of excerpt selection with my supervisors and during peer group debriefing. The excerpts were chosen based on a working definition of 'working moments', while the definition was based on literature findings concerning effective therapy (see definition in 2.1.1, p.8.). Each of the selected excerpts illustrates 'working moments' selected from different sessions and shows different types of activities. The selection of diverse clips

further fulfils the requirements for triangulation, since it provides information from different groups and different activities and thus provides different perspectives.

3.3.3 Description

The first phase of my clinical analysis is the description of selected clinical material. Description translates into words what has been observed or identified in another modality (in the case of this clinical analysis, the video excerpts). Session notes are a secondary source of clinical information and inform the descriptions of video excerpts. The purpose of describing is to preserve and share knowledge so that individual perceptions can be integrated into the larger framework of a story or theory (Ansdell & Pavlicevic 2001). This part of the clinical analysis does not include personal feelings or reactions to the clinical information and only aims to describe the setting, the people and events that have taken place (Robson 1993).

3.3.4 Clinical material

3.3.4.1 Excerpt one: Session three

The first selected excerpt is from session three (two minutes long, ten minutes into the session) and involves a movement activity. I selected the clip because it illustrates some elements of the therapeutic factors “altruism” and “corrective recapitulation of the primary family group” (see 2.1.1, p.5-6).

The group session took place in an open section on the ward closest to the ward entrance. The circle of small blue chairs on which the children sat was situated in the corner of a wall and a waist high divider to ensure minimal movement of staff, visitors and other patients through the group. Twenty-three children attended this session. Most of the group members are visible in the video, since the supervisor handled the camera. At the beginning of the session, I experienced the overall energy of the group as low, but expectant.

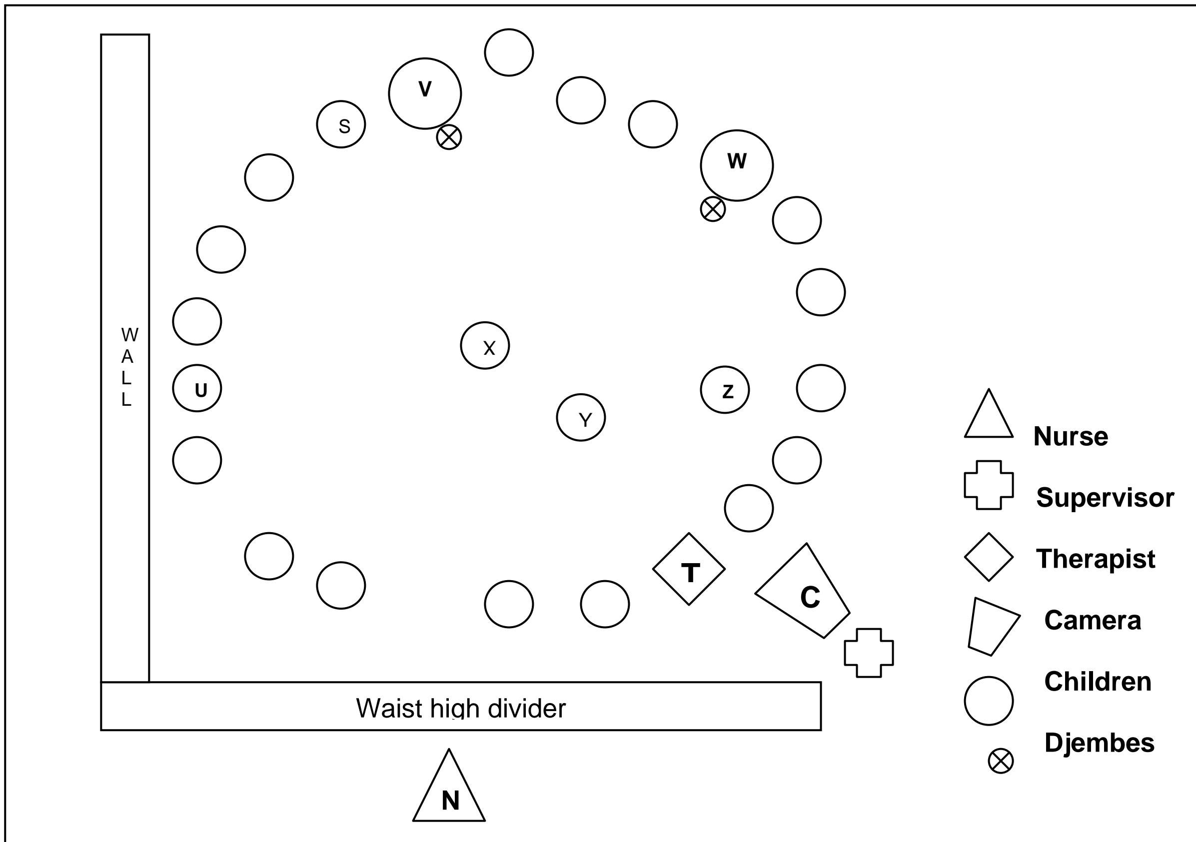

Figure 3.2 Diagram of seating arrangement: Session three

Moments before the excerpt starts, while I was putting away my guitar, two of the older boys in the group (boy V and boy W) fetched the djembe drums that were outside the circle. They returned to their chairs and boy W started playing on his drum. Three of the younger boys (boy X, Y and Z) spontaneously got up from their chairs and started moving to the beat of the drum.

At the beginning of the excerpt, boy W plays a moderately loud, steady, repeated and rhythmically quite complex pattern of about seventy beats per minute on the djembe. The other boy with a drum, boy V, quietly sits with the drum between his legs, watching the therapist closely. Boy X danced to the middle of the circle with energetic movements, while boy Y and Z danced closer to the circle's rim in a similar energetic fashion. All three of the dancing boys' bodies are turned towards the therapist while she in turn, leans slightly forward towards them and moves her body to the beat of the drum-playing. Although many of the group members in the circle seem to be low in energy and quite still, they attentively watch the dancers.

Then the therapist starts clapping crotchet beats to the drum-rhythm. Some of the group members (of which only girl U is visible in the video) join the therapist by also clapping or tapping to the beat. The overall energy of the music seems to increase slightly. At this moment boy Y and Z both move closer to the circle centre. At first all three of the dancing boys are turned towards the therapist, but they gradually turn around to face- and make eye contact with other group members. While boy V still sits quietly with the djembe, boy S leans towards him and whispers something.

Boy V joins boy W's rhythmic pattern by playing firm, moderately loud crotchet beats. Quick glances are exchanged between boy V and boy W. Group members direct their attention towards the two drummers.

In the background a mechanical "beep", from an unknown source can be heard on a B-flat. The therapist introduces her voice, with a B-major dominant-tonic "a-heee" and a downward slide at the end. In the meantime, a staff-nurse joins the group on its periphery clapping hands on the crotchet beats. She, somewhat tentatively, replies to the therapist's vocal call by imitating the "a-heee" sound on the same pitch. Upon hearing the nurse participate vocally, the dancers look at her and faint smiles can be seen from boy Y and Z. The therapist again repeats the "a-heee" motive and this time the nurse answers somewhat louder, on an off-beat with a lower pitched "hey". For a third time the therapist repeats the "a-heee" motive, while the nurse joins her at the end of the phrase, on the same pitch. The nurse then adds her off-beat "hey" motive again and the therapist answers her with a similar "hey". For the last time the nurse and therapist exchange "heys" and then the nurse laughs generously. As the therapist and nurse's dialogue unfolds, the dancers' movements become more animated. Throughout the excerpt other group members attentively watch the drummers and dancers and at times, some of them clap or tap to the beat of the drums.

Boy X draws the therapist's attention with a short, clear vocal sound, while making eye contact and smiling for a moment. He shows her a new movement, lifting his hands up in the air and swinging them from side to side. The therapist imitates this movement until he diverts his attention away from her. The therapist continues moving her body and clapping to the music.

3.3.4.2 Excerpt two: Session five

The second excerpt is from session five (one minute and fifty seconds long, twenty minutes into the session) and is a non-musical excerpt. This excerpt was selected based on the fact that up to this session, the group experienced difficulty in adhering to group norms concerning the use of instruments. They often argued over instruments and had difficulty waiting for turns. The excerpt illustrates elements of the therapeutic factors “imparting of information”, “development of socialising techniques” and “imitative behaviour” (see 2.1.1, p.5-6).

The group session took place in the open section of the ward between two rows of beds, closest to the ward entrance. Twenty children attended the session; two mothers joined the group on its periphery and some staff members briefly took part by encouraging the children. In general the children seemed quite energetic and eager to take part in the group.

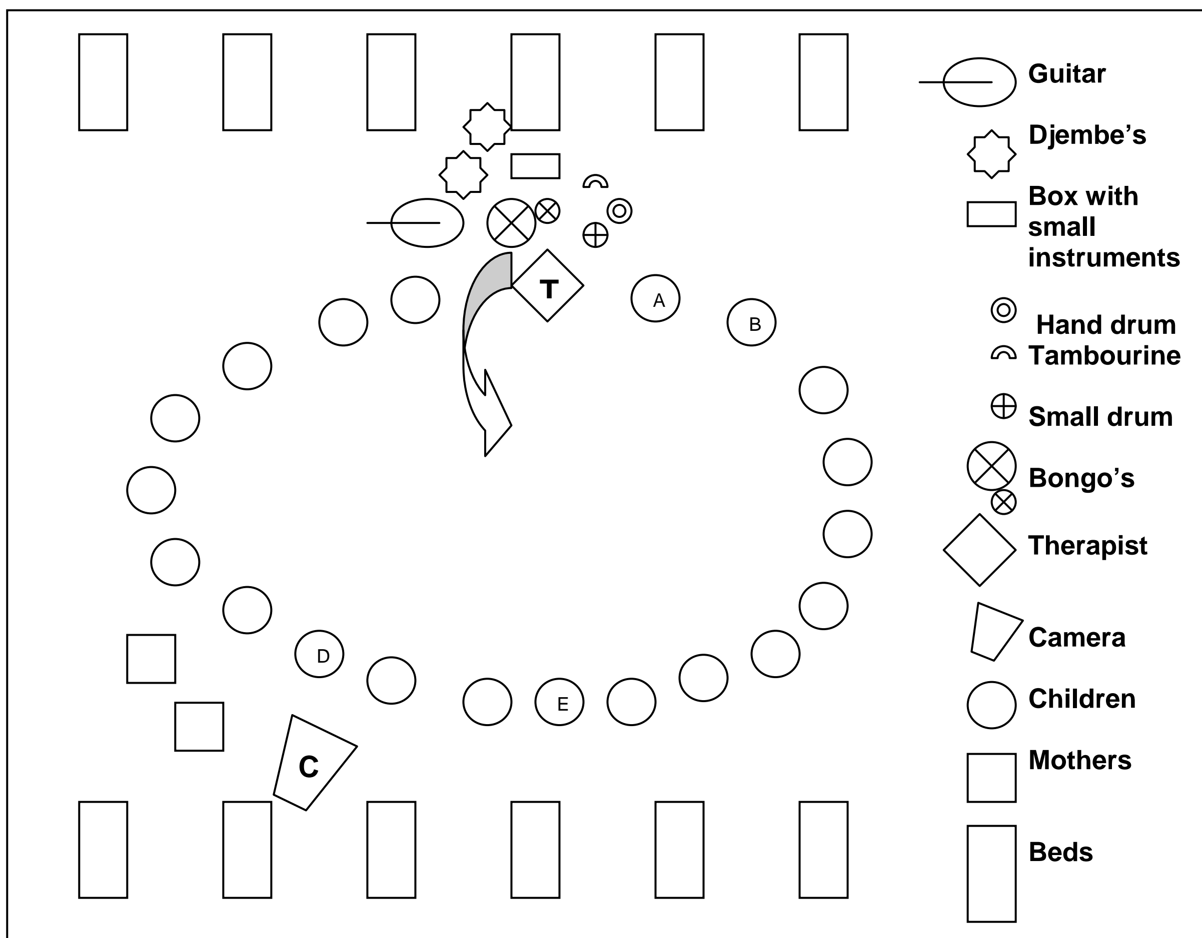

Figure 3.3 Diagram of seating arrangement: Session five

The excerpt starts where the therapist introduces the instruments to the group. By leaning forward (in a seated position) and pointing to the floor with both hands, she indicates to the group where the instruments are going to be packed out. Two girls next to the therapist, girl A and B, imitate her actions. The therapist moves her gaze through the whole group and simultaneously asks the group in quite a serious tone of voice, not to touch the instruments. The verbal request of “no touch” is accompanied by hand movements, index fingers pointed, moving from side to side. Some of the other children join the two girls in echoing the verbal instructions of the therapist and imitating her actions. Then the therapist puts her one index finger in front of her lips. Most of the children either attentively watch what she is doing or copy her actions. A sense of anticipation is present in the group.

Still with her finger in front of her lips, the therapist turns around to pick up a bongo drum behind her. While the other children quietly watch the therapist, boy D excitedly jumps up and shouts out “me, me, me”. The therapist turns towards him, leans closer and makes eye contact with him, still keeping her finger in front of her lips. He immediately sits down again with his finger on his lips. The therapist then places the drum in the middle of the circle. Boy D jumps up again to get to the drum, but the therapist gives him a fleeting look while stretching out both her arms, moving her upper body so as to glance over all group members and moving her index fingers from side to side, clearly saying “No, no” and “no touch”. Again some of the group members imitate the therapist’s actions and echo her words. When the therapist puts her finger to her lips, one of the older boys, boy E, quieten the chattering of the group with a firm and clear “shhh”.

When the children are settled down, the therapist turns around to pick up a small drum. Upon bringing the drum to the circle centre, she still keeps her one arm and a pointed finger stretched out. The group members focus on the therapist and there is a growing sense of anticipation amongst them. In a similar fashion to the drum, the therapist also places a tambourine in the circle centre. When boy D jumps up again, the therapist asks him to sit down, using his name. Other group members can be seen leaning forward in the chairs, still focused on the therapist.

As the therapist turns around again to take hold of the hand drum, she asks the group what the name of the instrument is. One of the group members spontaneously calls out “hand drum”. Some of the children lean forward to pick up the drum, but the therapist reminds them with hand gestures and short verbal “no, no’s”, that for the time being the instruments stay in the middle of the circle. The group members compliantly draw back their hands. The same

happens when the therapist shows the children the box with small instruments. When the children don't jump up or reach for instruments, the therapist smiles.

Next, the therapist puts two djembe drums in the middle of the circle. While she is busy, the group members expectantly watch her, but none of the children jump up or reach for the instruments. The last instrument the therapist introduces to the group is the guitar. When reaching for the guitar, the therapist asks the group what instrument it is. One of the mothers on the circles periphery answers: "A guitar".

3.3.4.3 Excerpt three: Session eight

The last excerpt is from session eight (two minutes long, fifteen minutes into the session) and shows an activity where the group participated vocally. The excerpt contains elements of the therapeutic factor "interpersonal learning" (see 2.1.1, p.6).

The group session took place in one of the mid-sections of the ward. The small blue chairs on which the children sat were placed in an oval shape to fit every one in between the two rows of beds that lined this section of the ward. In the clip, only eleven of the twenty children attending are visible. Before the session, girl X asked the therapist whether the group could sing Si Sinyoni, a Zulu song about a bird that she knows. This specific group member is one of the children who was out of the camera's view. During the course of the session, four or five of the patients' mothers also joined the group on its periphery. The overall energy of the group seems low.

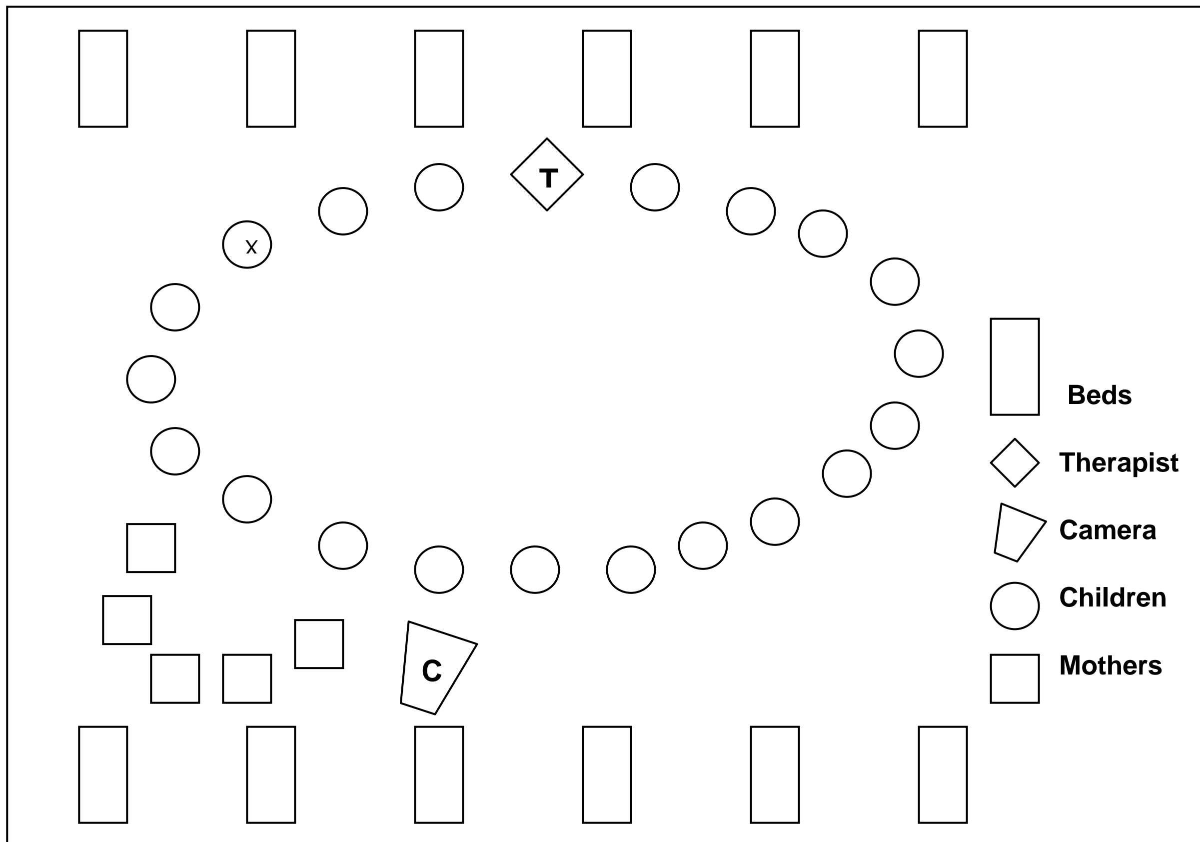

Figure 3.4 Diagram of seating arrangement: Session eight

The excerpt starts where the therapist begins to introduce a new activity, but interrupts herself when noticing a little bird flying through the ward. She verbally draws the group's attention to the bird and points in its direction. Most of the group members' gaze turns to where the therapist points at. The therapist then resumes introducing a new activity, but rather than continuing with her original idea, she suggests to the group a Zulu song about a bird. This is the song that girl X proposed to the therapist before the session commenced. Some of the group members smile.

The therapist begins to sing the 4/4 metre song in B major in a moderate tempo (about 55 beats per minute) while pronouncing the words clearly and leading the melody. She also initiates hand and body movements which reflect the meaning of the words. "Si Sinyoni thina si sinyoni', which means "we see the bird flying", is repeated twice with flapping hand movements. Then follows "Siya thala, siya suga" which means: "we're sitting down, we're standing up". This is accompanied by actions where the upper body is pushed towards the knees and then pushed away from the knees. Initially the children sing along to the song only tentatively and imitate the actions. Apart from the therapist, only one other group

member's voice can be heard above the rest of the group – it is the voice of Girl X. The therapist sings slightly slower and pauses for a brief moment before the movements change from 'flapping' to 'sitting down'. After repeating the song several times, the dynamic level of the group's singing increases slightly and movements become more confident. The therapist continuously looks around and purposely makes eye-contact with group members. Most of the group members watch closely, listen to and imitate the therapist.

The therapist asks the group whether she sings the song correctly. Then girl X, spontaneously starts singing the song once more in a confident, moderately loud voice. The therapist and the other group members attentively look at her while she sings alone. The therapist thanks the girl (using her name) for singing the song to the group and compliments her on how well she knows the song. She then asks girl X to sing the song once more.

Girl X starts singing the song again, this time much louder. By holding her hand to her ear, the therapist indicates to the other group members to listen to girl X's singing, while most members watch her closely. In a seated position, the therapist is slightly turned towards girl X and makes regular eye contact with her.

While girl X continues singing, the therapist turns towards the group. Upon inhalation she lifts her hands and leads the group in joining girl X in singing. The group's singing is on a higher dynamic level and movements are livelier. In general, the energy seems higher than before. The therapist constantly shifts her gaze between group members, while energetically performing the movements which accompany the song. She also audibly taps the rhythm of the song with her feet. Group members who do not participate in singing or movement, quietly observe the activity surrounding them. With a clear *ritardando*[2] in her voice, the therapist indicates the ending of the song and the group ends together.

[2] *Ritardando* is an Italian musical term for 'gradually slower'.

3.3.5 Example of session notes: Session three

Client/Group: Wide open group	**Placement:** Kalafong	**Date:** 19.02.2007	**Session:** 3

Session plan	Greeting song	Movement	Instruments	Songs	Good bye
Other ideas Copy game Body percuss.	We sing hallo, good morning, sawubona, dumela. (D major)	If you like music and you know it… (Melody of If you're happy)	With Avulekile Amasongo	In the jungle (D major to E major)	Good bye everyone

I experienced much difficulty to manage this session. 23 Children were present at this supervised session. Many of the children seemed tired and listless and the overall energy of the group felt low. During the greeting song I accompanied the group on the guitar. One of the group members took hold of a djembe drum outside the circle and then all wanted to play. After the greeting I placed the djembe outside the circle behind me. Two of the teenaged boys showed an interest in the djembe drums and fetched it from where the 2 drums stood. The 2 boys negotiated a rhythm between them and 3 of the smaller children started dancing in the centre of the circle. Members in the circle watched the drummers and dancers with interest and some clapped/tapped to the beat. The lively drumming and dancing attracted interest from staff. A staff nurse encouraged the dancers from the circles periphery with clapping and vocal sounds. An instrumental activity which followed also seemed difficult to manage. Deciding who plays which instrument sparked some arguments amongst group members. All playing together most of the time drowns out quiet members or members with less noisy instruments. Most members sing along to the known goodbye song.

In retrospect I felt that such large groups need clearly structured activities and clear boundaries concerning the use of instruments. The moment where I felt the group 'came together' was when the predictable and sustained drum accompaniment allowed younger members to get up and dance if they were so inclined. The reaction of the staff member seems to have stemmed from the group's increased energy. Her reaction also seemed to be a form of encouragement to the group. The function of the older boys in the drum/dance activity seemed to be that of musical support to the youngsters. They also took on musical responsibility. I wondered how the staff nurse's experience of more 'healthy' and playful children impacts on the staff/patient relationship.

Figure 3.5 Session notes: Session three

The session notes from session five and eight are included in Appendix III: B and C (p.79-80)

PART TWO – CHAPTER FOUR

ANALYSIS OF CLINICAL MATERIAL

In this chapter I present and describe the stages of analysis of clinical material. The research methods of coding, categorising and theme identification will be employed for this purpose.

4.1 Coding

The aim of coding is to "break up the data [in this case the descriptions of three video excerpts and correlating session notes] into meaningful chunks so that comparison and other analytic procedures are possible" (Ansdell & Pavlicevic 2001:150). Each numbered 'chunk' of clinical material (both the video excerpt descriptions and session notes) was labelled with a code that describes the essence of the observation. The line numbers indicate whether the main text (and thus the codes) is derived from video material (V) or session notes (S), and includes a reference to the session number (e.g. V3 is video material from session three). Figure 4.1 below contains examples of codes based on the descriptions (main text) of video excerpt one, session three. A complete set of codes are available in Appendix IV (p.81).

Line no	**Main text**	**Codes** Th - Therapist Te - Teenager Gr - Group M – Member
V3.1	The circle of small blue chairs on which the children sat was situated in the corner of a wall and a waist high divider to ensure minimal movement of staff, visitors and other patients through the group	V3.1.1 Wall-divider corner may decrease physical disturbance
V3.2	Twenty-three children attended this session	V3.2.1 Gr 03 - 23 Ms
V3.3	At the beginning of the session, I experienced the overall energy of the group as being low, but expectant	V3.3.1 Gr energy low; expectant
V3.4	Moments before the excerpt starts, while I was putting away my guitar, two of the older boys in the group (boy V and boy W) fetched the djembe drums	V3.4.1 Tes' initiative – fetch djembes
V3.5	They returned to their chairs and boy W started playing on his drum	V3.5.1 Te's initiative – plays on the drum
V3.6	Three of the younger boys (boy X, Y and Z) spontaneously got up from their chairs and started moving to the beat of the drum	V3.6.1 Younger children initiative - spontaneous dancing
V3.7	At the beginning of the excerpt, boy W plays a moderately loud, steady, repeated and rhythmically quite complex pattern of about seventy beats per minute on the djembe	V3.7.1 Te plays drum in clear, stable manner V3.7.2 Te plays complex drum pattern
V3.8	The other boy with a drum, boy V, quietly sits with the drum between his legs, watching the therapist closely	V3.8.1 Te wary to start, looking for Th's support
V3.9	Boy X dances to the middle of the circle with	V3.9.1 Dancer in mid-circle energetic

	energetic movements while boy Y and Z dance closer to the circle's rim in a similar energetic fashion	V3.9.2 Drum rhythm energising
V1.10	All three of the dancing boys' bodies are turned towards the therapist while she in turn, leans slightly forward towards them and moves her body to the beat of the drum-playing	V1.10.1 Young children initially dancing for Th V1.10.2 Th validates dancers by leaning forward, moving body

Figure 4.1 Coding extract from video excerpt description: Session 3

After the above mentioned process, the final list of codes was compiled (see figure 4.2 below).

Th - Therapist Te - Teenager Gr - Group M - Member		
Th leads song Roles shifting – Th cues Gr to join Role shifts – M leads, Th learns Th invites Gr's assistance M knows song well, sings it to Th Th values Gr's opinion Te M reinforce Th instructions to Gr Tes support each other Tes work together Ms imitate – Th body cues + words Gr imitate – Th Gr focuses on Th Individual M is focus of Gr attention Tes take responsibility, support Gr Core Ms take musical responsibility Core Ms' responsibility aids Th Th gives M musical responsibility Gr attention shifts to Tes with musical responsibility Tes' initiative – negotiate rhythm Te's initiative – playing djembe Tes' initiative – fetch djembes Th initiative – vocals and movement Th introduce – new vocal material Th initiative – new movement M initiative – new movement M's initiative – dancing in circle M's initiative – requests song prior to session M's initiative – propose song Gr energy – low Gr energy low, expectant Increased Gr energy Gr energetic + eager Dancer in circle energetic Energy increase with clapping Drum rhythm energising Gr energy higher after individual M's inspiration Gr energy attract peripheral Ms – staff Nurses involvement attracted by higher Gr energy Transfer of Gr energy into the ward Th clearly indicates end by *ritardando* Th clearly shows Gr new movements	Systematic instrument introduction creates Gr anticipation Th deliberately builds Gr anticipation Th's actions creates Gr anticipation Th extends Gr anticipation Th sets clear boundaries regarding instruments Th verbally/bodily reminds Gr of boundaries Gr learns boundaries due to Th's repeated reminders Th verbally addresses M unable to wait Th adapts session plan Th flexible when opportunity arises Th aware of environment Wall-divider corner may decrease physical disturbance Th allows environmental sounds to serve as musical 'ideas' Th encourages Gr's awareness of environment Th links M's request to environmental activity Ms argue over instruments and turns Noisy instrumental playing drowns out quiet Ms Ms cannot wait for turn causing disorganisation Large Gr needs clear structure and boundaries Th puts instruments out of immediate reach of Gr Th systematically introduce instruments Loss of attention at the end of long rhythmical activity Variety of activities stimulate Gr on multiple levels Ballgame required alertness from Ms Rhythmical activities stimulate cognitive functions Gr enjoys random ballgame with pre recorded music Gr enjoys known song	Tes' djembe playing – clear, repeated Known song facilitates participation Known song engage whole Gr Choruses engage whole Gr Gr continuity enhanced by repeated activities and core Ms Imitation builds Gr musical vocabulary Movements are simple Th uses ritardando and fermata to prepare Gr for change Ms motivating each other verbally Nurse encourages Gr Nurse encourages dancers through vocal sounds and body movements Te supports Th Th shows support to individual M through body language Gr validates individual M Individual M more confident Gr supports – dancers gain confidence Individual M's input inspires Gr Te wary to start, looking for Th's support Tes provide musical support for younger children Possible impact on staff-patient relationship Nurse experience healthy side of patients Some Ms passively engaged Some Ms actively engaged Individual M expresses need to engage with Th Young children initially dancing for Th Th's question invites spontaneous engagement Th invites verbal interaction Th engages Ms with eye contact Vocal communication and eye contact between individual M and Th Increased eye contact between Ms Greater awareness between Ms

Th verbal instructions short + clear Th's body movements reflect text Th clearly indicates with body cues when the Gr should join individual M Th uses body cues to show M to wait Th body cues expresses instructions Th verbal instructions supported by body cues Th validates nurse through imitation Th validates dancers by leaning forward, moving body Th validating Ms initiative through imitation Th validates Gr's adherence to boundaries Names in greeting song validate individuals Th validates individual M	Random nature of game creates anticipation M requests song prior to session Working moments experienced as shared pulse, eye contact, attention, listening Th encourages Gr to listen to individual M Gr cohesion experienced during Tes' djembe playing + young children dancing Gr experience mutual ending Th vocally accompany dancers and rhythm section Th supports Gr rhythmically Th supports through clapping Clapping motivates shy dancers Th repeats vocal motive to engage nurse Songs repeats Repetition allows Gr to become familiar and more confident	Th makes eye contact and models Th makes eye contact with Ms to invite engagement Gr's engagement initially tentative Ms participate by clapping or tapping Gr recognises nurse's participation Nurse enjoys participation Nurse becomes temporary M by clapping Nurse's vocal engagement initially tentative Nurse vocally imitates Th Nurse's engagement animates Gr Nurse responds to Th's vocal imitation Peripheral Ms willing to engage Brief staff participation Focus of Gr an active Ms Gr attentive

Figure 4.2 Table of all codes

4.2 Categorising

The next step in my clinical analysis was arranging codes into categories. Ansdell and Pavlicevic (2001:151) describe categories as mutually exclusive "boxes of meaning". This means that related codes were grouped together in categories linking to the focus of my clinical inquiry (See Appendix V, p.84) for the complete set of categories, sub-categories and codes).

After studying the codes in detail, seven categories (some of which have sub-categories), were identified. Although it was not my intention at the outset of the analysis to utilise sub-categories, it became apparent that arranging material in categories and sub-categories, allowed me to cluster the filtered information into a more manageable and clear structure. Categories were sorted, beginning with the largest category (thus the category with the highest number of codes). I will now describe each category with examples of appropriate codes in brackets.

4.2.1 Category one: The therapist's clinical skills

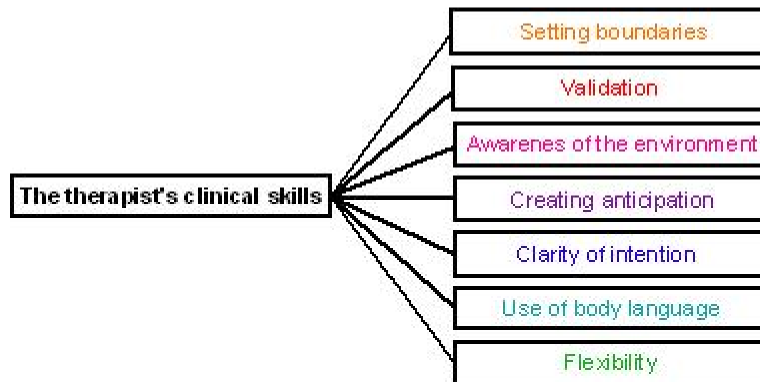

Figure 4.3 Diagram of category one with sub-categories

This category involved a total of forty-three codes.

The therapist's clinical skills are divided into sub-categories as shown in Figure 4.3. Certain skills were applied by the therapist in order to facilitate the group process. In the context of a session, these skills are often used simultaneously and cannot realistically be separated in practice. Some of the categories therefore overlap to some extent, although main categories are mutually exclusive.

4.2.1.1 Setting boundaries (total of nine codes)

Setting boundaries emerged as the most prominent clinical skill of the therapist. Due to the size of the group and the difficulties the group members experienced in choosing instruments and waiting for turns, the therapist soon realised the importance of clear boundaries concerning these issues (e.g. Large group needs clear structure and boundaries; Therapist sets clear boundaries regarding instruments). Without clear boundaries, the group would not have been able to function effectively. The therapist used simple language and body cues to establish boundaries and remind group members of boundaries (e.g. Therapist verbally addresses member unable to wait; Therapist verbally/bodily reminds group of boundaries). Practical measures also aided the therapist in maintaining boundaries (e.g. Therapist puts instruments out of immediate reach of group; Therapist systematically introduce instruments).

4.2.1.2 Validation (total of nine codes)

Clinical information indicated that Validation is also one of the most prevalent clinical skills. Validation allows group members to feel welcome, valued and appreciated. The therapist validated different group members in a variety of ways, namely through musical imitation (e.g. Therapist validates member's initiative through imitation), body language (e.g. Therapist validates dancers by leaning forward, moving body) and through the use of members' names in musical activities (e.g. Names in greeting songs validate individuals). The therapist also validated 'desired' behaviour in an effort to enhance and develop such behaviour (e.g. Therapist validates group's adherence to boundaries).

4.2.1.3 Awareness of the environment (total of seven codes)

This clinical skill refers to the therapist's attentiveness and responsiveness to the group's environment (e.g. Therapist links member's request to environmental activity; Therapist allows environmental sounds to serve as musical 'ideas'). Interesting or extra-ordinary happenings in the environment can be used to focus the group's attention and to encourage group members' appreciation of their environment. This skill also pertains to the physical placement of the group. The therapist attempted to create a therapeutic space with the least possible physical disturbance (Wall-divider corner may decrease physical disturbance).

4.2.1.4 Creating anticipation (total of six codes)

It seemed that the therapist used specific techniques to create and extend group anticipation. The rationale was to capture and preserve the group's attention, which essentially established group engagement. Ways in which this was achieved was through the use of musical elements like tempo changes and pauses (e.g. Therapist uses *ritardando* and *fermata*[3] to prepare group for change), incorporating random turns during musical activities (e.g. Random nature of activity creates anticipation) and through systematic introduction of instruments (e.g. Systematic instrument introduction creates group anticipation). The therapist introduced instruments one-by-one, placing it in the centre of the circle. The group became progressively excited, anticipating the instrumental activity which followed.

[3] *Fermata* is an Italian musical term meaning to "rest" and hold the note longer than usual.

4.2.1.5 Clarity of intention (total of five codes)

As the facilitator of the group, the therapist needed to be easily understood by the group. Since there was a language barrier between the therapist and the group, she had to find clear/simple ways of setting boundaries, expressing expectations and guiding the group. The therapist expressed herself through simple, short sentences (e.g. Therapist's verbal instructions short and clear) and used clear musical and bodily cues to guide musical and movement activities (e.g. Therapist clearly indicates end by *ritardando*; Therapist clearly shows group new movements).

4.2.1.6 Use of body language (total of five codes)

This sub-category is related to the above mentioned sub-category, Clarity of intention involves the therapist's use of body language as a means of expression. The therapist used body language to enhance her verbal and vocal expressions (e.g. Therapist's body movements reflect text; Therapist's verbal instructions supported by body cues), to lead the group in music (e.g. Therapist clearly indicates with body cues when the group should join individual) and to remind group members of boundaries (e.g. Therapist uses body cues to show M to wait).

4.2.1.7 Flexibility (total of two codes)

A small, but significant sub-category that emerged from the clinical information is Flexibility. In order for the therapist to guide the group through the therapeutic process, it was sometimes necessary to adapt the session plan and musical material (e.g. Therapist adapts session plan; Therapist flexible when opportunity arises). This allowed the therapist to work "in the moment" with the group. "Working in the moment" increases the relevance of therapeutic work in relation to the group and the context at the time.

4.2.2 Category two: Engagement and participation of the therapist and the group

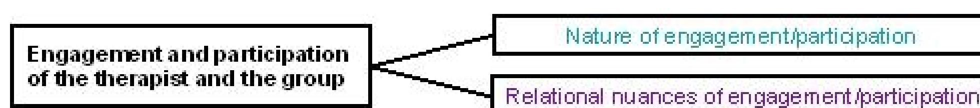

Figure 4.4 Diagram of category two with sub-categories

This category involved a total of thirty-seven codes.

Engagement and participation of the therapist and the group can be divided into two sub-categories: Nature of engagement/participation and Relational nuances of engagement/participation. Engagement and participation were grouped together, as they are closely related. Without participation, (whether active or passive) group members would not have had the opportunity to become engaged in the group process.

4.2.2.1 Nature of engagement/participation (total of thirty codes)

Codes from the first sub-category indicate that some members were actively engaged and some passively engaged in the group (e.g. Some members passively engaged; Some members actively engaged). Passive participation was visible in quiet members who attentively watched and made eye contact with the therapist and other group members. One of the reasons why some members participated passively, was because they were too ill or weak to actively participate in instrumental playing, singing and/or dancing/movement activities. Passive participation was accepted in the group, since the experience of group activity and music may have been as beneficial for passive members as it was for active members. The codes also indicate the presence of brief engagement of peripheral members (e.g. Nurse becomes temporary member by clapping) and ways in which the therapist invited peripheral members' participation (e.g. Therapist repeats vocal motive to engage nurse). What also becomes clear is that engagement and participation were evident in a number of ways, such as being attentive and focused, making eye contact, playing and moving together and by showing enjoyment (e.g. Focus of group on active members; Group attentive; Therapist makes eye contact with members to invite engagement; Members participate by clapping/tapping; Group enjoys random ball-game; group enjoys known song). The last matter arising from the first sub-category, concerns the facilitation of participation. Here the therapist played a considerable role by inviting and facilitating participation especially during the early sessions (e.g. Therapist makes eye contact and models; Therapist invites verbal interaction). A further contributing factor to the facilitation of engagement and participation was the repetition of musical material, such as the greeting songs. Repetition within the music also allowed group members to become familiar with and participate in musical activities (e.g. Known song facilitates participation; choruses engage whole group).

4.2.2.2 Relational nuances of engagement/participation (total of seven codes)

Codes from the second sub-category illustrate some of the relational dynamics which emerged during moments of engagement/participation. At times, especially during our early sessions, individual members expressed the need to engage with the therapist, rather than with other group members (e.g. Individual member expresses need to engage with therapist; Young children initially dancing for therapist). Peripheral members' musical engagement were noted and reacted upon by the group (e.g. Group recognises nurse's participation). In turn, peripheral members expressed enjoyment in engaging with the group (e.g. Nurse enjoys participation).

4.2.3 Category three: Shifting roles

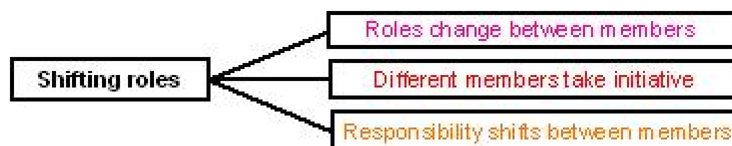

Figure 4.5 Diagram of category three with sub-categories

This category involved a total of thirty-one codes.

4.2.3.1 Roles change between members (total of fourteen codes)

This category contains codes that indicate role changes amongst members. At times the therapist led the group, as director and teacher while the group followed, carefully watching and imitating the therapist. She also facilitated subtle role shifts by inviting the group's assistance and learning from them (e.g. Therapist leads song; Member leads, Therapist learns). At times individual members, in particular teenagers, assumed leadership roles by musically leading the group and supporting the role of the therapist (e.g. Teenaged member reinforces therapist's instructions).

4.2.3.2 Different members take initiative (total of twelve codes)

Codes from this sub-category also indicate that different group members took initiative. The therapist's initiative included the introduction of new vocal or musical material, and body

movements. The teenagers in the group were the first of the group members to show initiative. They fetched djembe drums and negotiated a rhythm amongst each other to support the group's dancers. As the group progressed, more group members started taking initiative, suggesting songs they like and adding their own ideas in movement activities (e.g. Therapist's initiative – new movement; Teenagers' initiative – fetch djembes; Teenager's initiative – negotiate rhythm; Member's initiative – propose song).

4.2.3.3 Responsibility shifts between members (total of five codes)

This sub-category contains codes that illustrate responsibility shifts amongst group members. It becomes apparent that it was not only the therapist who carried responsibility for the group's music. At times she handed responsibility to individual members, such as the member who wanted to teach the group a song (e.g. Therapist gives member musical responsibility). The teenagers took on the responsibility of supporting the group musically when they provided the group with a clear, repeated drum rhythm to which some of the group members danced. The teenagers and some of the core members' responsibility aided the therapist in her task, since she no longer bore the sole responsibility for the group's music (e.g. Teenagers take responsibility to support group; Core members take musical responsibility, Core members' responsibility aids therapist).

Responsibility and initiative is usually associated with group leaders. For this reason it can be assumed that shifts in responsibility and initiative in the group indicates a shift of leadership and thus, roles. In term of the group process, exploration of different roles in the group allows group members to investigate new relationships and test new behaviour (Yalom 1995). This aids them in their experience of being stronger and more autonomous.

4.2.4 Category four: Encouragement and support of the therapist and the group

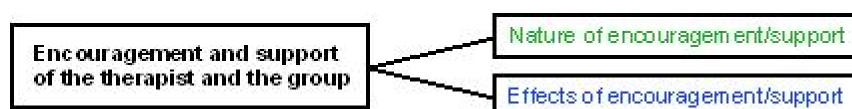

Figure 4.6 Diagram of category four with sub-categories

This category involved a total of twenty codes.

4.2.4.1 Nature of encouragement/support (total of fourteen codes)

Encouragement and support of the therapist and the group illustrates members of the group's encouragement and support to one other. Members encouraged quiet or shy members verbally to take part, whereas the teenagers supported one another in playing together. The teenagers also musically supported the younger children's dancing, and this in turn, supported the therapist's efforts to support the group (e.g. Members motivating each other verbally; Teenagers support each other; Teenagers provide musical support for younger children; Teenagers support therapist). Peripheral members' support to the group was expressed through vocal sounds and body movements in the character of the group's music and movements (e.g. Nurse encourages dancers through vocal sounds and body movements). The therapist's support to individual members and the group was visible through her body language (turning her body towards a member), her vocal and rhythmical accompaniment (singing, clapping, tapping) of group members' actions. She also alerted group members to listen to individual members, showing her support of the member's actions (e.g. Therapist shows support to individual member through body language; Therapist vocally accompanies dancers and rhythm section; Therapist supports group rhythmically; Therapist supports through clapping; Therapist shows support to individual member through body language).

4.2.4.2 Effects of encouragement/support (total of six codes)

The last sub-category in this category involves the effects encouragement and support had on group members. The support of the group, the peripheral members and the therapist encouraged and motivated group members to take part in the group activities with more confidence (e.g. Individual more confident; Group supports – dancers gain confidence; clapping motivates shy dancers). Another facet of support was seen in an individual member's self-assured actions which inspired the group to sing with more confidence (e.g. Individual member's input inspires group). The effect of support in the group may also have submerged into the relationships between patients and between patients and staff in the ward environment (e.g. Possible impact on staff-patient relationship).

4.2.5 Category five: Aspects of group energy

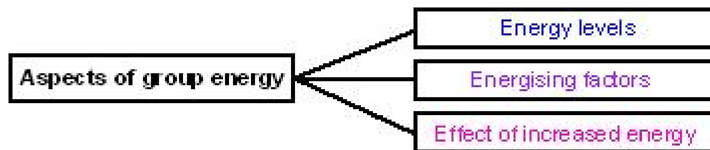

Figure 4.7 Diagram of category five with sub-categories

This category involved a total of fifteen codes.

Aspects of group energy refer to energy levels the group presented, factors that contributed to higher energy and the effect that increased energy had in the group.

4.2.5.1 Energy levels (total of six codes)

In general, the groups' energy levels seemed to be lower at the beginning of sessions and increasing during the course of sessions (e.g. Group energy – low, expectant; Increased Group energy; Group energetic and eager). The groups' low energy seemed to be directly related to the members' illnesses.

4.2.5.2 Energising factors (total of five codes)

Gathering from the clinical information, it became apparent that specific energising factors contributed to the change in energy levels. The groups' energy seemed to increase when the group or the therapist clapped to the beat of the music. A distinct increase in energy was also noticeable when drum beats were added to the groups' music. It seems that extra definition of the group rhythm increased the group's energy (e.g. Energy increases with clapping; Drum rhythm energising). When an individual group member taught a song to the group, the group's energy also increased, possibly due to the group's experience of her confidence (e.g. Group energy higher after individual member's inspiration). The last energising factor was engagement of peripheral members. Staff involvement appeared to motivate the group to participate with even more vitality – showing her what they are capable of (e.g. Nurse's engagement animates group).

4.2.5.3 Effects of increased energy (total of four codes)

The last sub-category illustrates the effects of the group's increased energy. From the codes in the sub-category it becomes apparent that peripheral members joined the group at times when the group's energy was relatively high (e.g. Group energy attract peripheral members – staff; Nurse's involvement attracted by higher group energy). The higher group energy was also transferred into the ward during and after sessions. Group members often left the group while still singing, carrying some of the group energy with them after the group had ended (e.g. Transfer of group energy into the ward).

4.2.6 Category six: Group cohesion development

This category involved a total of six codes.

Group cohesion development refers to ways in which the group had the opportunity to experience cohesion. Repetition and continuity in the group played an important part in the development of group cohesion. Repetition of session material (greeting songs, recurring choruses in a song and repeated activities) allowed members to become familiar with group activities so that they could participate with confidence. Since core members were already familiar with some of the session material, they could sustain activities, while new members became familiar and grew more confident. Confident participation creates feelings of belonging and group members could thus develop a sense of belonging in the group, which resulted in an experience of cohesion (e.g. Repetition allows group to become familiar and more confident; Group continuity enhanced by repeated activities and core members). In the music, cohesion was experience during moments when the group experienced moving or ending together (e.g. Group experience mutual ending; Group cohesion experienced during teenagers' djembe playing and young children dancing). This category also includes visible signs of group cohesion development, such as increased eye contact between members and between members and the therapist, as well as increased awareness between group members. Awareness became increased when members started waiting for turns and listened more readily to one another playing (e.g. Increased eye contact between Ms; Greater awareness between Ms).

4.2.7 Category seven: Difficulties in managing the group

This category involved a total of five codes.

Difficulties in managing the group developed as a separate category from my own observation and experiences of group behaviour, which obstructed optimal therapeutic functioning of the group. Difficulties encountered can be attributed to the size of the group and at times, the lack of clear boundaries. Boundaries on instrument choice and turns were not yet clearly established in the early sessions of the group. Older and stronger members usually entered into arguments over who plays on the larger instruments (e.g. Ms argue over instruments and turns). This resulted in one of the parties not getting to play the instrument they wanted, leading to half-hearted participation or withdrawal. Members also had difficulty in waiting for turns which consequently led to disorganised noise in which quieter members could not be heard (e.g. Noisy instrumental playing drowns out quiet members). Disorganisation deprived some members from exercising their choice of instrument and therefore did not get the opportunity to play and be validated by the group. The last difficulty that became apparent can also be attributed to the size of the group. Activities often lasted quite long when each group member was given a turn to play alone. It became apparent that the group members lose focus/interest when activities carried on for too long (e.g. Loss of attention at the end of a long activity).

In the next section of my clinical analysis, I introduce the themes that emerged from my clinical material.

4.3 Emerging Themes

The last phase of the clinical analysis is the identification of themes. Themes are units of meaning that include multiple categories (Ansdell & Pavlicevic 2001). After studying the categories and sub-categories in depth, three themes emerged. I will now describe each theme in the context of the categories, sub-categories and codes. In Chapter five, I will discuss the themes in relation to the focus of my clinical inquiry and the literature findings.

4.3.1 Theme one: Breaking social isolation

Theme One	Categories	Sub-categories
Breaking social isolation	Engagement and participation of the therapist and the group	Nature of engagement and participation
		Relational nuances of engagement and participation
	Shifting roles	Roles change between members
		Different members take initiative
		Responsibility shifts between members
	Encouragement and support of the therapist and the group	Nature of encouragement and support
		Effects of encouragement and support
	Development of group cohesion	(No sub-categories)

Figure 4.8 Table of theme one with relevant categories and sub-categories

Five of the seven categories pertain to this theme.

Many of the parents of the patients were incapable of supporting their children emotionally. Reasons for this may include socio-economic circumstances (parents live far away and struggle to afford travelling expenses and/or parents needed to continue working), whereas another contributing factor might be the emotional difficulties they personally experienced in coming to terms with their child's condition. Children in the oncology ward typically dealt with physical and emotional trauma and losses (loss of ability, loss of control over their environment etc.). They may have witnessed fellow patients' deaths and face their own mortality. In addition to this they also may have experienced regular or continues physical pain. Having been afforded few or any opportunities to play and have fun on the ward, often caused the children to wander around bored and listlessly.

Whether it be for some, or a combination of the factors mentioned above, it became clear that these children had multiple needs. Since it was not always possible to address all of these needs adequately, this may have resulted in patients becoming withdrawn and socially isolated.

In group music therapy, the issue of social isolation was addressed in various ways. The therapist extended musical, bodily and verbal invitations to members to participate and engage in group activities. Members had the option to participate in any way they felt capable of or preferred, whether it be by actively singing along, dancing or playing, or quietly observing these activities. Simply being part of a group gave group members the opportunity to experience a 'social self'. This 'being part of' also refers to members' feelings of warmth and comfort in the group. Experiencing 'being part of' allowed group members to develop

feelings of belonging and being valued and unconditionally accepted by others. These experiences are not only relevant, but vital in the development of group cohesion.

Social isolation was also diminished by the group members' experience and expression of encouragement and support towards one another. The therapist supported group members musically, by accompanying them vocally (singing) and rhythmically (clapping or tapping to the beat). The therapist furthermore expressed encouragement and support verbally (inviting to members to participate and acknowledging their participation) and with body language (leaning towards members and making eye contact with them), leading to further involvement. Members also began supporting and encouraging one another by means of verbal encouragement of shy members to participate in musical activities, an also by encouraging and supporting one another musically. Musical support was seen in the teenagers' actions when rhythmically accompanying younger children dancing. The participation of staff members also played a significant part in diminishing social isolation. They encouraged group members from the periphery of the group, which signalled their interest and concern for the patients. In this way, members could feel valued and appreciated.

Shifting of roles also signified reduced social isolation. Examples of these role changes are: The teenagers assisting the therapist in group management (reinforcing instructions and boundaries), teenagers initiating an activity and taking responsibility for the group's music (teenagers drumming with dancers), individual member accepting the therapist's invitation to teach a song to the group and group members taking initiative in suggesting songs or movements.

Group members started taking responsibility and initiative, implying that they actively made the choice to take control of their environment in stead of remaining isolated in an environment where they usually experienced limited opportunities to exercise autonomy.

4.3.2 Theme two: The therapist's roles and tasks

Theme two	Categories	Sub-categories
The therapist's roles and tasks	The therapist's clinical skills	Validation
		Setting boundaries
		Awareness of the environment
		Creating anticipation
		Clarity of intention
		Use of body language
		Flexibility
	Shifting roles	Roles change between members
		Different members take initiative
		Responsibility shifts between members
	Difficulties in managing the group	(No sub-categories)

Figure 4.9 Table of theme two with relevant categories and sub-categories

The therapist's task to facilitate the group process was informed by the categories Clinical skills, Shifting roles and Difficulties in managing the group. Analysis revealed that particular skills were relevant in facilitating the process of the wide open group. These skills include validation, setting boundaries, awareness of the environment, creating anticipation, expressing clarity of intention, use of body language and flexibility.

The therapist's actions of validation were intended to acknowledge members' contributions to the group. This was done in a number of ways, such as imitation of a member's idea and by turning her gaze and leaning towards a member. The therapist furthermore used group members' names to acknowledge their presence and commended them on adhering to group norms.

The therapist's motivation for setting boundaries was to create a safe space that is conducive to therapeutic change. By setting clear boundaries in terms of instrument use and turns, each member was afforded the opportunity to come to his/her right. The therapist continually reminded members of boundaries to ensure that new group members also become familiar with it. Some practical measures, for example putting instruments out of direct reach of members and not handing out all instruments at once, allowed the therapist to maintain boundaries.

The therapist's awareness of the environment allowed her to adapt to the environment and utilise it to the group's advantage. For each session, the therapist identified the quietest and least busy section of the ward to conduct the group in. This minimised physical disturbance and promoted the group's focus on happenings within the group. Since the group did not function within a private space, the therapist made an effort to use environmental sounds as

musical ideas (creating music of which the tonal centre is similar to the pitch of mechanical sounds) and to promote group members' awareness of interesting happenings within their environment (as in the example where the therapist drew the group's attention to a little bird inside the ward and then singing a song about a little bird).

Anticipation was created by the therapist in order to capture and hold the group's interest in group activities. This was achieved through systematic instrument introduction (see explanation in 4.2.1.4), random turns in musical activities, and by using *ritardandi* and *fermata* in the music. With these techniques, the therapist captivated group members' attention and created moments where they needed to wait for 'something' to happen.

In working with such a large group with the added difficulty of a language barrier, the therapist needed to unambiguously express expectations and instructions. Simple language and clear body movements allowed group members to understand and follow the therapist. In the music, the therapist also made her intentions known by making clear *ritardandi* and *fermata.* The ways in which the therapist used body language further enhanced the meaning of her verbal expressions, intentions and instructions to the group.

Flexibility of the therapist refers to the adaptation of sessions to achieve maximum relevance to the group and its environment. In order to work effectively towards group goals, the therapist planned group sessions. These session plans were guidelines from which the therapist departed from time to time to meet the needs of the group at specific moments.

The creation of a therapeutic group was also enhanced by shifting of roles within the group. In group therapy, it is the group that is the agent of change (Yalom 1985). For this reason the therapist allowed other group members to take on the role of group leader. This allowed the group to interact more freely as roles developed spontaneously, without having to channel all communication, whether musical or verbal, through the therapist. In the maintenance of a therapeutic group, it was also necessary for the therapist to deal with difficulties in group management. Difficulties the group experienced mainly included choosing instruments and waiting for turns in musical activities. These difficulties necessitated the therapist to regularly remind group members of boundaries and verbally disciplining members who did not adhere to the boundaries.

4.3.3 Theme three: Shifting from illness to health

Theme three	Categories	Sub-categories
Shifting from illness to health	Shifting roles	Role changes between members
		Different members take initiative
		Responsibility shifts between members
	Engagement and participation of the therapist and the group	Nature of engagement and participation
		Relational nuances of engagement and participation
	Encouragement and support of the therapist and the group	Nature of encouragement and support
		Effects of encouragement and support
	Aspects of group energy	Energy levels
		Energising factors
		Effect of increased energy

Figure 4.10 Table of theme three with relevant categories and sub-categories

Music therapy provided group members with opportunities to experience and express their healthy and able sides. Being able to take on roles other than that of patient, such as leader or supporter, allowed group members to feel capable, purposeful and experience autonomy. An example of this was seen when some of the teenagers in the group initiated a drum sequence, thus actively taking on musical responsibility. The example illustrates how the teenagers took control over their situation at the time. As a result of their actions, some of the younger group members initiated dancing in the centre of the circle, thus following the example of the teenagers to exercise autonomy. It became apparent that the 'ill' roles of these group members shifted to 'healthy' roles – the teenagers became supporters and providers, while the younger children became performers and followers.

Illness deprived some of the children of the physical energy to play and have fun. Adding to this, children had few opportunities on the ward to be creative and express themselves. Since the group did not demand active participation from its members as a requisite, weak/tired members could still join the group and experience moments of playfulness, engaging with other group members through eye contact and listening. Through engagement and participation in the group, members were given the opportunity to play and have fun or simply experience the healthy expressions of fellow group members.

Encouragement and support ties in with role shifts within the group. As a consequence of their illness, group members might have felt unable of giving or that they are of no worth to others. In the group they had opportunities to fulfil the role of supporters or leaders which contributed to their sense of purpose and self-worth. Examples of this were evident in the way in which group members encouraged one another to play (verbally), and in the way in which they supported one another musically (see the example of the teenagers rhythmically

supporting and sustaining the group with their drumming, p.26-27). Being of value to someone else gave members the opportunity to feel able, capable, purposeful and valuable again.

Low energy levels of the group could be attributed to the illnesses of the group members. Due to the experience of physical pain and exhaustion due to treatment, some members were unable to contribute to the achievement of higher levels of group energy. During the course of the group sessions however, energy levels of the group generally appeared to increase. This trend can be attributed to certain energising factors, such as clapping, drum rhythms, the engagement of peripheral members, and the inspiration of the autonomous actions of an individual group member. Creating an energetic atmosphere in the group, allowed weak members to experience a level of energy associated with healthy children and other members to experience an element of health in themselves. Increased group energy attracted some staff members to the group. Seeing the patients in another light possibly impacted on their relationships outside the therapy group. The image of a more ‘able’ patient could have assisted staff to approach the children as able and autonomous individuals.

After identifying three themes, I would like to return to the focus of my clinical inquiry in the next chapter. I will attempt to discuss the focus of my clinical inquiry, drawing from the analysis of the clinical information and contextualising it in the Literature review.

PART TWO – CHAPTER FIVE

INTERPRETATION AND DISCUSSION

The following chapter consists of an interpretation and discussion of the focus of my clinical inquiry in view of the themes that have emerged through the process of clinical analysis. References to theory presented in the literature review and some personal insights from my experience of working at Kalafong Hospital's Paediatric Oncology ward as a music therapy student, is also included in the discussion.

As mentioned previously, my clinical inquiry consists of two parts (see 1.2, p.3):

Part One: The focus of this clinical analysis is to characterise 'working moments' within a wide open group music therapy context.

Part Two: In addition, this clinical inquiry aims to identify clinical skills employed during 'working moments' with a wide open group.

5.1 Addressing the Focus of my Clinical Inquiry: Characterising Working Moments in a Wide Open Group

The main focus of this clinical inquiry is to ascertain what happens during working moments within a wide open music therapy group. The detailed analysis of such moments can inform future work with similar groups. As the enquiry progressed, it became clear that in spite of working in a less 'ideal' therapeutic environment (in terms of the traditional view of a private therapeutic space and a mostly consistent membership), the group members and the ward-environment still gained benefit from group music therapy on a variety of levels.

In addressing Part One of my clinical inquiry, I now proceed to discuss Themes One and Three (Breaking social isolation and shifting from illness to health).

5.1.1 Theme one: Breaking social isolation

A prominent and quite extensive characteristic of the working moments I studied, was **Breaking isolation**. As discussed earlier (in 3.2.2, p.19-20), it is clear that children in an oncology ward experience trauma and losses on multiple levels (physical and emotional

trauma, loss of family support, loss of normal daily environment, loss of abilities and loss of control over their environment and their own fate). From my work at the hospital it became apparent that it is not always possible to support these children sufficiently and that this lack of support, in some cases, leads to **social isolation**. Yalom (1995) proposes that another cause of social isolation is that patients enter group therapy with the thought that they alone have certain problems. By attending group music therapy some of the above mentioned needs could be addressed and helped the children to see other children dealing with similar problems (cancer related illness) and in that way experience a sense of *Universality* (see 2.1.1, p.5). According to Yalom (1995) the disconfirmation of a patient's feelings of uniqueness is a powerful source of relief which contributes to therapeutic effectiveness.

During some of the group sessions, isolated behaviour was manifested in limited awareness and interaction between group members. In contrast to this, working moments in the wide open music therapy group were characterised by group **engagement and participation**. Individual members could experience being part of a social network of people who communicated through joint activity, active listening and performing (Aldridge 1996). It was clear that it could not be expected of all members of this group to be active participants at all times. Their illnesses and the effect of invasive treatment caused group members to experience different levels of physical impairment and/or fatigue.

All members' presence was acknowledged and by witnessing group interaction, being a form of involvement, even passive participants could experience the warmth and comfort of the group. This, according to Yalom's (1995), refers to the experience of **group cohesion**. The feeling that they belonged to the group and that the group valued and unconditionally accepted them, links with the human 'craving' for response from others (Yalom 1995, see 2.1.1, p.7). Humans desire contact, recognition, acceptance and approval and, by obtaining these, become part of a social network of people (thus breaking isolation). One of the functions of the group was to satisfy these human 'cravings' by means of providing contact, recognition, acceptance and approval through musical interaction, or as Bunt (1994) calls it "interaction through sounds". These human 'cravings' were expressed in the group interactions in the following ways: If members offered musical ideas, these ideas were recognised and implemented in the group's music, the group was encouraged to listen to each member playing and to wait for turns while others were playing, and to be attentive and respectful while doing so. Group cohesion was furthermore enhanced in musical interaction through the experience of a shared group pulse and mutual endings. Repeated use of musical material (e.g. greeting songs and returning choruses within musical activities) and the presence of core members also allowed the group to experience moments of group

cohesion. Core members' familiarity with the group structures and musical material, allowed for sustenance of activities during which new members were provided time to get used to the group and its music and thus, create a sense of comfort and belonging. Confident participation of core members also alleviated new members' uncertainty, since the group's focus was on confident participants.

One of the early characteristics of the group was a lack of initiative (see 3.2.4.1, p.21). This necessitated me to carry sole responsibility for the group's music and I felt at the time that it hampered the group's therapeutic development. Possible reasons for this may have been that members were unfamiliar with and uncertain of the group set-up, the music/activities and me. Over the course of our sessions though, group members gradually started to show **initiative** (see 3.2.4.3, p.23). This may have been due to the fact that they had a better idea of what to expect of the group.

Initiative and autonomy is closely related. A group member who made the choice of initiating something exercised autonomy. This purposeful act allowed the child to gain temporary control over his/her immediate environment. The group also allowed group members the "freedom of choice-making" (Bunt 1994:28) in order to express themselves as autonomous individuals. Group members could choose instruments, songs, and movements. They also had a choice whether they wanted to attend the group or not, and when they wanted to leave the group.

For the moment I would like to return briefly to the notion of initiative. The fact that different members took initiative indicated **role shifts** within the group. Role shifts became apparent where group members took on the **responsibility** to support other group members and myself. This was clearly demonstrated in the clinical material of session three (See 3.3.4.1, p.26-27), where the teenaged members took on the role of 'music providers' of the group by supporting younger members with a clear predictable drum pattern on the djembe drums. Through this, they were allowed to experience the feeling of being of importance to others. This corresponds with Yalom's (1995) description of the therapeutic factor *Altruism* (see 2.1.1, p.5). In Yalom's explanation of *Altruism* (1995), he refers to the fact that group members are enormously helpful to one another in the group therapeutic process. They offer **support** and reassurance to one another and allow their fellow group members to grow as a result of facilitative, sustaining relationships (Yalom 1995). Another pattern of support emerged during the group process – the teenagers often supported me in practising my tasks as therapist. It appeared that they assumed more responsibility in the group in order to compensate for the difficulties I experienced in managing the group. An example of this was

seen in session five (see 3.3.4.2, p.29) where a teenaged member 'disciplined' younger group members who did not comply with group norms.

Encouragement and support emerged as a prominent theme in working moments. It diminished social isolation in the group in the following way: Group members could support each other in music through listening, body movements, vocalisation and rhythms. Support and encouragement from the group reassured members that they were heard and appreciated by the group. Initially I often had to model supportive behaviour, but as the group progressed, members started to support one another more spontaneously. Another noticeable evolvement of group support materialised in the participation of peripheral members. These members usually were parents or staff members. From the clinical material I studied, staff involvement was usually brief and included singing, body movement and verbal encouragement directed at the group. The positive response group members received from peripheral members, motivated shy members to become more active and boosted group members' confidence. This behaviour is in accordance with Yalom's (1995) therapeutic factor, *Interpersonal learning* (see 2.1.1, p.6). Something seemingly insignificant such as a response (e.g. the therapist's vocal "a-hee" in response to a staff member's participation [see 3.3.4.1, p.27]) may have helped individuals develop their self-concepts, which, according to Yalom (1995) is based on the appraisals of significant others. This notion also corresponds with the human 'craving' for response from their environments. A further contributing factor brought about by the appraisals of significant others within the group process, is that it can assist group members to construct a new or more positive self-regard based on positive responses (Yalom 1995). Since the staff members fulfilled the role of caregivers in the hospital ward, they could be viewed as significant others of the patients for the duration of their hospitalisation. Positive feedback from staff thus played an important role in the shaping of patients' self-regard at the time. The staff-patient relationship will be explored in further detail below (see 5.1.2, p.58).

From the clinical information, it is clear that group members supported each other in various ways. Fostering such relational patterns within music, may have provided group members with the skills to support each other outside the music therapy group.

In concluding this discussion of Breaking social isolation, I proceed to deal with Yalom's last factor, namely *Existential factors* (see 2.1.1, p.7). What I found to be relevant regarding these *Existential factors* is the realisation of basic isolation. This refers to our fundamental apartness as human beings. Yalom (1995) explains *apartness* as having a double meaning: "We are separate, lonely, *apart from* but also *a part of*" (Yalom 1995:101). Within the context

of our music therapy group at Kalafong, this implies that even though patients might have been lonely, being with the group had the potential of comforting them.

5.1.2 Theme three: Shifting from illness to health

This theme is also discussed as one of the characteristics of working moments in the wide open music therapy group at Kalafong Hospital's Paediatric Oncology ward.

Group music therapy focuses on the healthy and able parts of group members. Since illness often demoralises patients and leave them with a sense of having little or nothing of value to offer others (Yalom 1995), one of the departure points of music therapy is to emphasise healthy body parts and to create opportunities for group members to change this 'ill' view of the self to one of 'health' and 'ability'. This means that in music therapy, members were given opportunities to develop the feeling that they have something of value to offer others. This process was facilitated through **engagement and participation** in musical activities. Individual members' initiatives and ideas were acknowledged by the group by means of utilising these ideas in the development of musical activities. A further manifestation of shifting from illness to health in group engagement and participation was the children's expressions of enjoyment. Playing and having fun is a natural occurrence in the every day life of children, but having been ill deprived the group members,not only of opportunities thereto, but also of the energy to engage in such experiences. According to Dunn (1999), participation in 'fun' activities can reduce tension. Although fun and laughter is beneficial for participants, it also reduced tension in parents (seeing a 'healthy' reaction from their ill child) and gave very ill children the chance to experience 'health' in their fellow group members.

Illness is usually associated with low levels of **energy**. This was evident on the ward and throughout all of our sessions. On the ward patients often wandered around listlessly, with nothing to do. Boredom seemed to play a distinct role in the overall energy of the ward environment. Patients often sat around passively with little or nothing to do and it is for this reason that one of the aims for the group was to offer opportunities for creative participation and enjoyment (see 3.2.3, p.20). Although the group usually seemed expectant at the beginnings of sessions, energy levels were generally low and difficult to elevate (see 3.2.4.1, p.21). Later during the process the group seemed to become more easily excited and higher energy levels seemed to be reached more spontaneously (see 3.2.4.2, p.22)). A possible explanation for the increase in energy might have been that the group grew accustomed to, and knew what to expect from our sessions and anticipated enjoyable moments. The music

furthermore contributed to higher levels of energy. Lively drum patters, and increases in tempo and dynamic levels seemed to stimulate the group energy. Elevated levels of group energy were not limited to the time and space of the group - members often left the group while still singing and staff members reported experiencing increased levels of activity on the ward after sessions.

I would now like to return to the notion of **engagement and participation**. Higher energy in the group sparked curiosity and attracted interest from peripheral members (staff), whom, through brief interest and participation, encouraged the group to reach even higher levels of energy. Staff members actively participated by clapping, singing and by doing so **encouraged and supported** the children. Seeing group members interacting and enjoying activities would have given quite a different image of the sick, helpless patients that they usually work with. These experiences were possibly uplifting and satisfying to witness. Over a period of time patients often become incapacitated by the role of "the sick child, the sick brother/sister or, the sick friend". In the music therapy group, staff and group members had the opportunity to see each other in a different light – staff became part of the patients' support networks and patients fulfilled the roles of performers. It can thus be said that new relational patterns started developing within the music therapy group. Transfer of these patterns to the ward environment may have enhanced the patients' support networks and addressed their need for support.

Returning to the concept of patients as 'performers': to perform, implies wilful expression of capabilities and can thus be viewed as an expression of health. The **role shift** from patient to performer, allowed children to experience different facets of themselves (capable of enjoyment, leadership, interaction, etc). This also links to Yalom's (1995) therapeutic factor *Corrective recapitulation of the primary family group.* This means that, in order for a group to function optimally therapeutically, fixed roles must be explored and challenged, and new relationships and behaviour must be investigated and encouraged (see 2.1.1, p.6). Role shifts in the group took place during moments where group members expressed autonomy and took initiative/responsibility. As noted earlier, these instances of initiating behaviour were usually associated with the leader of the group. The experience of leadership boosted members' self confidence and thus the experience of health. Another embodiment of 'health' in the group's behaviour was noted when older and more experienced group members started assisting new members and acted as 'disciplinarians' when members did not comply with group norms (see 3.2.4.2, p.22).

I would like to conclude this section by emphasising that music therapy strives to bring people together to enjoy music, not as an alternative to medical treatment, but as a natural agent of health promotion (Aasgaard 2004).

In addressing Part Two of my clinical inquiry, I would now like to discuss Theme Two.

5.2 Addressing the Focus of my Clinical Inquiry: Clinical Skills Employed during Working Moments in a Wide Open Group

5.2.1 Theme two: The therapist's roles and tasks

In general, my role as group therapist consisted of keeping track of group progress and developments, monitoring the overall quality and level of group and individual energy levels, and ensuring and facilitating optimal group functioning (Pavlicevic 2003). The therapeutic factors of *universality, interpersonal feedback, learning, altruism and the installation of hope* (see 2.1.1, p. 4-6) were mainly provided by group members (see the discussion of group characteristics above). This implied that the group itself was the agent of change (Yalom 1985) and that I was not solely responsible for changes in the group. As therapist I offered opportunities for group members to experience self confidence, enjoyment and a collective musical and personal experience (Pavlicevic 2003). I will now discuss my roles and tasks as wide open group music therapist against the background of the clinical material.

Unlike individual therapy, the therapist is not the agent of change in group music therapy (Yalom 1985). The therapist's task is to create a group "that is maximally conducive to effective group interaction" (Yalom 1985:116). In order to allow this, I needed to be the group leader at times. This required from me to provide music, set the tempo, rhythm, melody and gather the group at the same time. During the first phase of the group, this was most often the case (see 3.2.4.1, p.21). Group members did not yet have the confidence to suggest ideas and they strongly relied on me as 'group leader' to also be the 'provider'. As the group started developing, more members started taking initiative (see 3.2.4.1, p.22). Not being the 'sole provider' allowed me to **shift** out of my **role** as leader and become a follower. This, in turn, gave members the opportunity to try out roles of leading and initiating musical activities. Taking musical cues from other members, allowed leading members to experience a sense of agency.

A further skill is which is required by a therapist in the present context, is the ability to **set boundaries**. I realised early on during the group process that such a large group needs clear boundaries. This realisation emanated from the **difficulties** I experienced in the **management** of such a large group. Arguments ensued between members over instruments and others experienced difficulty waiting for turns. This predicament often caused weaker and younger members of the group to be left with smaller instruments (see 4.2.1.1, p.37). During musical activities, one of the aims was to allow each member to be heard. Ideally weaker and younger members should have had the opportunity to be amplified with the help of bigger/louder instruments. Difficulties were minimised through the implementation of several deliberate techniques (Yalom 1995). An example of this was to give explicit instructions regarding the choice of instruments (for example, only letting small groups of children choose instruments simultaneously and putting instruments out of immediate reach of group members). This links with Pavlicevic's (2003) description of a therapist's task of 'holding' a group. It means that the therapist allows group members to experience emotional and relational 'safety' in the group by means of negotiating and respecting group norms (Pavlicevic 2003). In our group at Kalafong abiding norms, such as waiting for turns and listening to others while they play, were continuously encouraged and reinforced through my verbal and bodily reminders. The predictability and reaffirmation of the group boundaries/norms allowed group members to exercise choice and be heard.

The significant desire of 'Being heard' was discussed above in 5.1.1 (p.54) as the human 'craving' for contact, recognition, acceptance, approval, esteem, and mastery (Yalom 1995). These basic human needs were met through the clinical skill of **validation**. Recognising a group member's presence, initiative, participation, adherence to boundaries etc, through music (use of musical ideas; names in greeting songs) verbal responses (verbalising positive behaviour), and body language (making eye contact, leaning towards) expressed the confirmation that I valued and unconditionally accepted each group member. My task as therapist also included allowing group members to experience warmth and comfort, and a sense of belonging in the group. This concurs with Yalom's (1995) description of *Group cohesiveness* (see 2.1.1, p.7). An example of an experience of group cohesion was during the group activity I described from session three (see 3.3.4.1, p.25-27). The teenagers in the group initiated this activity by playing a rhythmic pattern on the djembe drums. I allowed the activity to comfortably develop to a stage where the group (according to my example), supported each other, creating a sense of warmth and 'togetherness'. In this case I contributed to the development of group cohesion by modelling desired group behaviour (Pavlicevic 2003).

Modelling was one of the techniques I applied to signal intentions, requests and demands to the group (Pavlicevic 2003). The importance of this technique was further highlighted by the language barrier in the group. In order for me to give sufficient guidance to the group, it was necessary for my intentions to have been clear. One of the ways in which this was achieved was through the use of very simple language, supported by clear **body language.** In order for the group to be guided musically, I also needed to make my musical **intentions clear** (clarity of intention). From the clinical information it becomes apparent that I clearly prepared the group for changes and endings through gradual tempo reductions (*ritardando)* and pauses (*fermata*). Clarity of intention also refers to the simple manner in which practical information regarding the group structure and processes were conveyed, whether musically, verbally or bodily (see *Imparting of information*, p.5) (Yalom 1995). An example of this could be seen in session five where I gradually introduced instruments to the group in order to explain boundaries concerning the use of instruments (see 3.3.4.2, p.29-30). Knowing what to expect from the group, relieved some of the possible uncertainties associated with unknown group procedures, thus creating safety in the group.

A clinical skill that was especially evident in the clinical material from session five (see 3.3.4.2, p.29-30) was **creation of anticipation**. Anticipation in the group seemed to be the hope of something pleasant or interesting to follow. It captured the group's attention and by doing so, engaged members in the group process. The example from session five is from an activity where I (for reasons of instrument management) systematically introduced a wide variety of instruments to the group. The group could hardly contain their excitement, looking forward to playing with the instruments. My deliberate efforts to sustain the group's focus and attention created a sense of group cohesion. In the music, anticipation was created through unexpected pauses and tempo changes. These changes stimulated members' awareness and enhanced their engagement in the group. The nature of musical games also contributed to anticipation in the group – an example of this was a ball-game we used in session eight (see Appendix III:C, p.80). Group members had random turns to bounce the ball from person to person which required of them to be alert and attentive in anticipating their turns.

After the detailed analysis of my clinical material, I now come to the discussion of the last two clinical skills I identified, being **Awareness of the environment** and **Flexibility.** Since the wide open group was conducted in the wide open spaces of the Paediatric Oncology ward, I was required to be particularly considerate of the environment. Although it was not always possible, I tried to place the group in areas where environmental disturbances would be least invasive. An example of this was session three's placement of the group in the corner between one of the walls and a waist-high divider. The situation in which the group

functioned resembled many elements from the Systems Theory of groups (De Board 1978). The group functioned as a system within a system which was interconnected. The two systems continually exchanged energy and changed and adapted to each other (see the discussion of energy in 5.1.2, p.57). In a setting like this, Woodward (2004) advises the music therapist to work with rather than against the environment. The potential disturbance of environmental sounds and activity were utilised by the therapist, allowing these to serve as musical ideas within the group (see 3.3.4.1, p.27 and 3.3.4.3, p.31). According to 'traditional' views of the therapeutic space, the intermittent presence of staff members may have been viewed as an intrusion of the group's privacy. However, in the case of the Kalafong group, the presences of staff members were ironically identified as a positive, constructive characteristic during 'working moments'.

From my experience in working with the wide open group at Kalafong Hospital, I learnt that thorough planning for sessions contributed to the level of comfort with which I conducted sessions. It became apparent from the clinical information that **flexibility** within the planned session structures was important in keeping group activities relevant and appropriate to the group and the environment. Session plans were adapted according to cues from the group, but also according to happenings in the environment (as in the example of session eight - see 3.3.4.3, p.31).

My final conclusion and summary of the clinical information follows in Chapter Seven (p.69).

PART THREE – CHAPTER SIX

PROPOSED RESEARCH PROJECT

In the following part of my mini-dissertation, I propose possible research questions and describe the methodological process of a possible research project. This proposed research project stems directly from my clinical analysis and discussion. An account of how data would be collected, prepared and analysed is discussed and ethical considerations are included.

6.1 Introduction

What became apparent from my clinical analysis is that very limited literature is available concerning wide open groups. The outcome of this proposed research study might be useful to music therapists who work in a context similar to that of Kalafong's Paediatric Oncology ward. The findings of this study may also have implications for music therapy training in South Africa, since it seems that students have minimal exposure to the facilitation of wide open groups during the two year training, and yet therapy in 'wide open' spaces seem to be the norm in terms of public sector hospitals and many other institutions. The proposed research study might add to a body of theory on wide open groups.

6.2 Research Questions

The main question would be:

- What are the characteristics of 'working moments' in a 'wide open' group?

The sub-questions would be:

- Which clinical skills can be identified during 'working moments' in a 'wide open' group?
- How does the wide open space influence the wide open group?
- How can environmental 'disturbances' be used to facilitate group processes?
- What are the differences and commonalities of characteristics and clinical skills in 'working moments' of wide open groups and regular open groups and individual music therapy?

6.3 Research Paradigm

The proposed research study in the context of public sector hospitals would take the form of a naturalistic enquiry within a qualitative research paradigm.

6.3.1 Qualitative research paradigm

Forinash and Lee (1998), cited in Ansdell and Pavlicevic (2001: 134-135), define qualitative research as follows:

> "Qualitative research has an emergent focus or design, in which the research methodology evolves, rather than having a present structure or method, thus allowing the process to determine the direction of the investigation. This particular concept is appealing to many music therapists because of the parallel emergent focus found in the creative process. In qualitative research the aim is not to produce predictive generalisations, but rather a more concentrated and in-depth application of the findings. Results generated are context bound."

For the proposed study a qualitative research perspective is most appropriate as the aim would not be to arrive at a single truth. It would rather be an explorative process which produces a description of 'working moments' in music therapy with wide open groups at public sector hospitals.

6.3.2 Naturalistic inquiry

The proposed study would focus on the identification of clinical skills present in moments when wide open music therapy groups at two different public sector hospitals 'work'. The inquiry will thus be concerned with studying events and interactions in their naturally occurring setting or context (Aigen 1995).

6.3.3 Researcher as instrument

Since data will be collected from clinical work, the researcher will become the instrument through which data is collected. Aigen (1995) explains this concept of "researcher-as-instrument" as the researcher's whole self serving as a tool for data gathering and analysis.

He furthermore states that the insight and flexibility of the human being is the most appropriate tool in studying human interactions (Aigen 1995). It is ultimately the open-mindedness, insight and thoroughness of the researcher that ensures the production of interesting and useful findings (Aigen 1995).

6.3.4 Personal bias

The researcher will fulfil both the roles of therapist and researcher and it would be impossible for him/her to detach him/herself as researcher from the research process. The researcher will thus be susceptible to biasing factors. The issue of bias will be acknowledged as both problematic and enriching to the proposed study. According to Ansdell and Pavlicevic (2001), bias can be dealt with through the acknowledgement thereof, regular supervision and peer debriefing, as well as data triangulation. Continuous supervision and peer debriefing will allow the researcher to pose questions regarding substantive, methodological, ethical or any other matters. Through this process the researcher's self-awareness will be increased. Data triangulation ascertains the accuracy of data (Aigen 1995). This means that the researcher will be able to verify his/her own impressions and minimise biasing factors that may negatively influence the trustworthiness of the study. Details concerning supervision, peer debriefing and data triangulation are discussed below in 6.4.1.

6.4 Data Collection and Preparation

The proposed study would be based on two sources of data. The primary data source would consist of video excerpts taken from work with the wide open music therapy groups at two different public sector hospitals. The secondary source of data would consist of session notes selected from work with the same groups. Data selection and preparation are discussed in more detail below.

6.4.1 Primary data source: Video excerpts

Data triangulation would be addressed as follows: Possible biases would be addressed through discussion of excerpt selection during peer group debriefing. The chosen excerpts would be based on a working definition of 'working moments'. In turn, the definition would be based on literature findings concerning effective therapy (see definition in 2.1.1, p.8). Each of the selected clips would illustrate 'working moments' selected from different sessions and

different types of activities. The selection of different clips would further fulfil the requirements for triangulation, since it would provide information from different groups and different activities and thus provide the researcher with different perspectives.

Music therapy sessions are usually video taped (see ethical considerations in 6.6, p.67). It is standard practice for music therapists to record (audio and/or video) music therapy sessions for in-depth analysis of the musical material and moreover to facilitate clinical ratings. Recordings capture the groups in their natural setting and allow documentation of non-verbal behaviour and communication that may have been overlooked by the therapist/researcher during the original sessions. According to Schurink et al. (1998), video recordings make it possible to review events in a variety of ways and allow more thorough and complete analysis of sessions. The limitation of using video recordings for analysis is that there is an absence of contextual data beyond what is recorded (Schurink et al. 1998) and it is for this reason that session notes could be included as a secondary data source.

6.4.2 Secondary data source: Session notes

Detailed descriptions from session notes would place the video excerpts in context and provide material for richer and more accurate descriptions of the chosen video excerpts. Additional information from session notes would include events in and around the group which cannot be captured on video recordings.

6.4.3 Description

The first phase of data analysis would be the description of data. Description translates into words what has been observed or identified in another modality (in the case of this proposed study - the video excerpts). Session notes would be a secondary data source and would inform the descriptions of video excerpts. The purpose of describing is to preserve and share knowledge so that individual perceptions can be integrated into the larger framework of a story or theory (Ansdell & Pavlicevic 2001). This part of the research process does not include personal feelings or reactions to the research tasks (Bruscia 1995) and only aims to describe the setting, the people and events that have taken place (Robson 1993).

6.5 Data Analysis

After the data is prepared, the following phases of data analysis would follow: Coding, categorising and identification of emerging themes.

6.5.1 Coding

Coding is a technical term for analytic labelling (Ansdell & Pavlicevic 2001). Codes are 'labels' given to chunks of data, it assigns meaning to the pieces of data and allows comparison and other analytic procedures (Ansdell & Pavlicevic 2001). In the proposed study, codes would be attached to chunks of data of the descriptions done during the data preparation phase. In the next phase codes would be used to categorise data.

6.5.2 Categorising

Ansdell and Pavlicevic (2001:151) describe categories as mutually exclusive "boxes of meaning". Codes are grouped together in categories or general topics which relate to research questions. This process allows detailed definition and logical comparison of codes (Ansdell & Pavlicevic 2001). From the categories, themes would start to emerge.

6.5.3 Themes and interpretation

Themes are units of meaning that include multiple categories. Moving towards themes allows the next stage of the process: interpreting (Ansdell & Pavlicevic 2001). This would be the last phase of the proposed research study where themes would allow the researcher to elicit meaning from a situation and lead him/her to a level of understanding the phenomena-in-context (Ansdell & Pavlicevic 2001).

6.6 Ethical Considerations

The proposed study would be based on ongoing music therapy work, rather than being implemented especially for this proposed study. Ethical issues that need to be considered are: Confidentiality and anonymity, informed consent, protection of participants' rights and accurate documentation of video recordings (Ansdell & Pavlicevic 2001; Schurink et al.

1998). Informed consent will need to be obtained from patients or parents/guardians of patients taking part in group music therapy; consent will be required from the institutions to conduct the research and a protocol will need to be submitted to the Ethics Board of the Faculty of Medicine. All information surrounding the results of the proposed research study would be safely kept at the University of Pretoria or similar institution and would not be open for viewing by the general public.

PART FOUR – CHAPTER SEVEN

CONCLUSION

7.1 Summary of the Clinical Inquiry

The aim of this clinical inquiry was to characterise ‘working moments’ within a wide open group music therapy context, that appears to be impacted by noise levels, group structures, and a generally busy and unpredictable physical environment. In addition, this clinical inquiry aimed to identify clinical skills employed during ‘working moments’ with a wide open group.

My interest in this matter emanated from my experience of working as a music therapy student with a wide open group at Kalafong Hospital’s Paediatric Oncology Ward. I realised that working in such a context may require the application of specific therapeutic skills.

As far as I am aware there is no published literature specifically on wide-open groups as defined in this clinical inquiry. It also seems that there is a general scarcity of information relating to open groups and appropriate clinical techniques that can contribute to the success of such groups. The literature review included the following topics:

- Yalom’s (1995) therapeutic factors as a basis of an effective approach to group therapy
- Open groups in music therapy
- The Systems Theory
- Environmental approaches
- The roles and tasks of the group therapist
- Group phases
- Hospitalisation
- Group music therapy in a hospital setting
- Aims of group music therapy in a hospital setting

The clinical material I selected for the purposes of my clinical inquiry was three video excerpts and corresponding session notes from work that I have done with the wide open group at Kalafong Hospital’s Paediatric Oncology ward. The chosen excerpts were based on a working definition of ‘working moments’. The clinical material was described, coded and categorised in order to identify the characteristics and clinical skills present during ‘working

moments'. Based on the categories, three themes emerged, around which the focus of my clinical inquiry revolves. The themes are: Breaking social isolation, Shifting from illness to health, and Roles and tasks of the therapist.

7.2 Summary and Conclusion of Findings

Analysis of clinical material revealed characteristics of wide open groups. These were described under two broad themes, namely: Breaking of social isolation and Shifting from illness to health. The diminution of social isolation could be seen in moments where group members were either actively or passively involved in the social act of *musicking* in moments of group cohesion where group members could experience a sense of 'moving' together in music, and in moments where group members were valued and acknowledged by each other/the therapist/staff members. Social isolation was further diminished during moments when role shifts took place. Members took on roles that involved musical initiative and responsibility which indicated members' increased sense of autonomy.

Shifts from illness to health were also seen in moments where role shifts took place. Members assumed more autonomous roles, such as leaders/supporters in contrast to being 'patients'. Healthy expressions of playfulness and group support were noticeable in the group's engagement and participation in group activities. The last characteristic of working moments was increased levels of group energy. More energetic (and thus healthy) actions of group members at times attracted peripheral members, whose encouragement reaffirmed members' performance expression of their healthy sides.

Clinical skills that were identified were described in terms of the therapist's roles and tasks. These included the following: Validation by means of imitation (musical ideas and movements) , using members' names, and making eye contact, setting boundaries regarding instrument use and waiting for turns (verbally and through body language), and awareness of the environment (creating a space for the group where they are minimally disturbed, using environmental disturbances as musical material to complement rather that contradict the environment, and making group members aware of interesting happenings in their environment). Further clinical skills that were identified are creation and maintenance of anticipation (focusing the group and creating excitement) achieved by the therapist's use of clear body language, clarity of intention (therapists clear expressions of expectations in music and body language) and flexibility (adapting session plans and activities to achieve maximum relevance of the music and activities to the group and its environment). The

therapist also facilitated role shifts (allowing group members to experience autonomy) and managed group difficulties concerning the choice of instruments and waiting for turns. Maintenance of boundaries in the group was achieved by the therapist's regular reminders and firm management of members who did not adhere to these boundaries.

An element of group work which did not emerge clearly from the 'working moments', is emotional needs of members. According to Yalom's (1995) therapeutic factors, *catharsis* is about the group members being able to vent and explore feelings and gain relief from having expressed them (see 2.1.1, p.7). He adds that the expression of feelings is not always enough and that this therapeutic factor is only helpful within the context of a supportive/cohesive group. The relative lack of moments in which the group vented and explored feelings, may be attributed to a number of reasons: The lack of privacy and the constant fluctuation of membership in the wide open group, the relatively short duration of the group process (the group had only thirteen sessions) and the group's focus on healthy aspects of its members. Furthermore, the group, might still have been in an early phase of group development. Nitsun (1989:251) describes early group phases in terms of "early group dynamics", where "group members are in a state of anxious anticipation". The anxiety in the early group phases was possibly amplified by pre-existing anxiety due to the losses group members were being confronted with as a consequence of their health condition. Even though the group members probably experienced a need for emotional relief, they were possibly not ready to deal with the emotional intensity of their circumstances yet.

All of the clinical skills I identified and discussed in this clinical inquiry are appropriate for both individual and group music therapists. This made me question whether appropriate clinical skills for wide open groups differ from appropriate clinical skills in the facilitation of open groups, semi-open groups and individual therapy. From the clinical information analysed and interpreted in this clinical inquiry, it became apparent that the therapist, in working with wide open groups, applies skills similar to the skills applied in open groups, semi-open groups and individual therapy. What emerged was that the wide open group therapist needs to lay emphasis on standard clinical skills, namely:

- Having a more acute awareness of the group environment
- Utilising environmental happenings to the advantage of the group
- Setting clear boundaries. This seemed more important than ever in order to avoid the detrimental effects of disorganisation on the therapeutic process.

7.3 Limitations of the Clinical Inquiry

I am aware that an inquiry of this nature focuses on a minute part of work in this area and can hardly be generalised. It is hoped though, that the outcome of this clinical inquiry will be useful to Music Therapists in South Africa (or elsewhere), who work in contexts similar to Kalafong's Paediatric Oncology ward.

Further research might add to a body of theory on wide open groups.

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APPENDIX I

FACULTY OF HUMANITIES
MUSIC DEPARTMENT

MUSIC THERAPY PROGRAMME
TEL (012) 420-2614
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www.up.ac.za/academic/music/music.html

Date: ___________________________

UNIVERSITY OF PRETORIA
UNIVERSITEIT VAN PRETORIA

PRETORIA 0002 SOUTH AFRICA

MUSIC THERAPY SESSIONS: PERMISSION FOR ATTENDANCE AND TO RECORD

I, _________________________________, give my permission for ______________________ to receive music therapy sessions with Ms A. Pollard, enrolled in the Master of Music Therapy Degree Program of the University of Pretoria (UP), at Kalafong Hospital. I also grant permission for sessions to be recorded onto video and/or audio tape. I understand that this recording will be used only for clinical and educational purposes, as part of the music therapy students' training, for supervision purposes with their supervisors, and as part of their clinical case study presentations for their mini-dissertations and examinations. Visual and audio recording during music therapy sessions is standard practice and is used to clinically analyze sessions and in turn to give direction to the ongoing therapy process. Privacy, anonymity and confidentiality will be adhered to, in line with standard clinical practice.
I understand that ___________________________________ may withdraw from music therapy sessions should he/ she so choose.

At the end of the students' training, tapes will form part of the training archives and will become the property of the Music Department, University of Pretoria. Upon request, tapes may be listened to/viewed by parents.

____________________________________ Name and relationship to child

____________________________________ MMus (Music Therapy) Student

_________________________________ Dr Elise van Rooyen, Kalafong Hospital

____________________________________ Clinical Supervisor, Music Therapy Training Programme

APPENDIX II

Enquiry: Prof. M. Kruger
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Faculty of Medicine
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Mrs. Carol Lotter
MMus (Music Therapy), UP
Music Therapy Training Programme
Music Department
Pretoria
0002

14 August 2007

Dear Mrs. Lotter

RE: ANJA POLLARD – MUSIC THERAPY CASE STUDY

Herewith I give permission to Ms. Anja Pollard to write her case study for her MMus (Music Therapy mini dissertation using the open group of children she worked with in the paediatric oncology ward.

The following is the names of the group she worked with:

N. M.	P. M.	(For the sake of anonymity, only first letters of group members' names and surnames are included here)
I. M.	G. B.	
M. S.	S. M.	
S. S.	V. T.	
G. M.	B. M.	
P. R.	H. N.	
T. M.	T. M.	
M. S.	K. S.	
V. R.	P. M.	
L. M.	M. M.	

I would like to see the dissertation for the following reasons:

1. To see that there is no harm to the patient
2. For my own learning curve in music therapy

Looking forward to reading the dissertation.

Yours sincerely

PROF. M KRUGER:
MMed Paed (Pretoria) MPhil Applied Ethics (Stellenbosch) PhD (Leuven)
HEAD: PAEDIATRIC DEPARTMENT
KALAFONG HOSPITAL AND
UNIVERSITY OF PRETORIA

APPENDIX III:A

SESSION NOTES: SESSION THREE

Client/Group: Wide open group	**Placement:** Kalafong	**Date:** 19.02.2007	**Session:** 3

Session plan	Greeting song	Movement	Instruments	Songs	Goodbye
Other ideas Copy game Body percuss.	We sing hallo, good morning, sawubona, dumela. (D major)	If you like music and you know it… (Melody of If you're happy)	With Avulekile Amasongo	In the junge	Good bye everyone (D major to E major)

I experienced much difficulty to manage this session. 23 Children were present at this supervised session. Many of the children seemed tired and listless and the overall energy of the group felt low. During the greeting song I accompanied the group on the guitar. One of the group members took hold of a djembe drum outside the circle and then all wanted to play. After the greeting I placed the djembe outside the circle behind me. Two of the teenaged boys showed an interest in the djembe drums and fetched it from where the 2 drums stood. The 2 boys negotiated a rhythm between them and 3 of the smaller children started dancing in the centre of the circle. Members in the circle watched the drummers and dancers with interest and some clapped/tapped to the beat. The lively drumming and dancing attracted interest from staff. A staff nurse encouraged the dancers from the circles periphery with clapping and vocal sounds. An instrumental activity which followed also seemed difficult to manage. Deciding who plays which instrument sparked some arguments amongst group members. All playing together most of the time drowns out quiet members or members with less noisy instruments. Most members sing along to the known goodbye song.

In retrospect I felt that such large groups need clearly structured activities and clear boundaries concerning the use of instruments. The moment where I felt the group 'came together' was when the predictable and sustained drum accompaniment allowed younger members to get up and dance if they were so inclined. The reaction of the staff member seems to have stemmed from the group's increased energy. Her reaction also seemed to be a form of encouragement to the group. The function of the older boys in the drum/dance activity seemed to be that of musical support to the youngsters. They also took on musical responsibility. I wondered how the staff nurse's experience of more 'healthy' and playful children impacts on the staff/patient relationship.

APPENDIX III:B

SESSION NOTES: SESSION FIVE

Client/Group: Wide open group	**Placement:** Kalafong	**Date:** 05.03.2007	**Session:** 5

Session plan	Greeting song	Movement	Instruments	Songs	Goodbye
Other ideas Song writing Vocab building	Hallo, good morning, sawubona, dumela (D major)	Hands up high, touch the sky, get 'em up	On the floor introduce one by one	In the jungle Halleluja hosanna	Good bye everyone (D major to E major)

During the course of this session I consciously set clearer boundaries with the use of instruments. Previously instrument management was quite difficult due to the size and instrumental preferences of the group. The greeting song allowed each group member to be greeted on his/her name to acknowledge their presence and make them feel welcome. One of the staff nurses joined the group on its periphery and encouraged the children to sing louder. The group reacted on her input, but I question whether they were motivated or only compliant. Most of the children participated in the movement activity where the therapist took the lead and the group copied her actions and vocal sounds. Vocal work included ascending and descending slides which accompanied body movements. The instrumental activity was kicked off by the T, doing an introduction of all the instruments. Instruments were, one-by-one, placed in the centre of the circle. Some group members seemed to experience difficulty with impulse control/waiting. In general there was a sense of anticipation and excitement amongst the group. Small groups of children had turns to choose instruments and play with the verses of "In the jungle". Choruses served as familiar points of reference where the whole group could sing/clap. Most of the children sang along to the known goodbye-song. Some of the children leave the group still singing our goodbye-song.

I felt more relaxed during the session, possibly due to the fact that I was well prepared. The presence of core members also spreads some of the musical responsibility of the group, making it easier to introduce known activities. Known activities and the core members provide some sense of continuity in the group process. At this stage copy-activities works well and can serve as a spring board for building the group's musical vocabulary. What I perceive as working moments are the following: Common group pulse, eye contact between members and members and T, focused attention and listening.

APPENDIX III:C

SESSION NOTES: SESSION EIGHT

Client/Group: Wide open group	**Placement:** Kalafong	**Date:** 26.03.2007	**Session:** 8

Session plan	Greeting song	Movement	Instruments	Songs	Goodbye
Other ideas Music listening Ball game	Hallo, good morning, sawubona, dumela (D major)	Everybody do this, just me/ do that just like…	Oh we can play on the instruments and this is the music to it	In the jungle Vocal rhythm "smarties" "marshmallows" etc.	Goodbye everyone

Most of the group members seemed familiar with the greeting song and sang along to it. The returning chorus allowed group members to stay engaged between personal greetings in the verses. In general the group energy seemed quite low. During the chorus's the children clapped along to their singing and this seemed to heighten the energy of the group. Upon the therapist's request for a song, one of the group members proposed that we sing "In the Jungle". Before the session one of the core members requested a song about a little bird During the session a bird flew through the ward and when the therapist notices it, she draws the group's attention to the bird. This seemed to be the perfect opportunity to introduce the group members' proposed song. Therapist gives the group member an opportunity to show the group how the song should be sung. After the member's solo the group sang with more energy. The therapist introduced an activity where small groups of children needed to clap a rhythmic pattern accompanied by a word with the same rhythmic pattern. We then combined the patterns to see how well each group could stick to their own pattern. The group enjoyed the activity where an inflatable ball was randomly bounced around the group while energetic pre-recorded music played. The therapist saw to it that all members had a chance to catch and throw the ball. The ball-game created a sense of anticipation in the group. After the greeting song, some members and parents could be heard singing the greeting as they left the group.

Combination of rhythmic patterns required cognitive focus from group members. Some of the members lost interest towards the end of the activity. Children needed to be alert if they wanted to catch the ball. A wide variety of activities seems to provide maximum stimulation for the group on a variety of levels: musical, interpersonal, physical, cognitive. The 'effectiveness' of the ball-game highlights the importance and the need for these children to play freely.

APPENDIX IV

LIST OF ALL CODES

S3.1.1 Th has difficulty in managing large Gr S3.2.1 Sess 03 23 M's S3.3.1 Gr energy low/listless S3.4.1 Guitar accompaniment for greeting S3.5.1 Te's initiative – playing djembe S3.5.2 Ms cannot wait for turn causing disorganisation S3.6.1 Th puts instrument out of immediate reach of Gr S3.7.1 Tes' initiative – fetch djembe's S3.8.1 Tes' initiative – negotiate rhythmic djembe pattern S3.8.2 Tes' rhythm is energetic, regular and sustained S3.8.3 Younger children's initiative - dancing in circle centre S3.9.1 Some circle Ms passively engaged S3.9.2 Some circle Ms actively engaged S3.10.1 Gr's energy attract peripheral Ms – staff S3.11.1 Nurse encourages dancers through vocal sounds and body movements S3.12.1 Difficulty in managing large Gr – instruments S3.13.1 Ms argue over instruments and turns S3.14.1 Noisy instrumental playing drowns out quiet Ms S3.15.1 Known song allows vocal participation S3.16.1 Such a large Gr needs clear structure and boundaries S3.17.1 Gr cohesion experienced during Tes' djembe playing with young children dancing S3.17.2 Tes' djembe playing – clear, repeated S3.18.1 Nurse's involvement attracted by higher Gr energy S3.19.1 Nurse encourages Gr S3.20.1 Tes provided musical support for younger children S3.21.1 Tes taking responsibility to support Gr S3.22.1 Nurse experiences 'healthy' side of otherwise ill children S3.22.2 Possible impact on staff-patient relationship S5.1.1 Th sets clear boundaries concerning instrument use	S5.4.1 Nurse encourages Gr to perform S5.5.1 Gr complies to nurse's encouragement S5.6.1 Th initiates - movement/vocal sounds S5.6.2 Gr imitates Th S5.7.1 Th initiates - free vocal sounds with body movement S5.8.1 Th systematically introduce instruments S5.9.1 Th introduces instruments one at a time S5.9.2 Th deliberately builds Gr anticipation S5.9.3 Th establishes boundaries S5.10.1 Ms have difficulty waiting S5.11.1 Systematic instrument introduction creates Gr anticipation S5.11.2 Systematic instrument introduction creates excitement S5.12.1 Clearer boundaries in terms of instrument use S5.13.1 Choruses engage whole Gr S5.14.1 Known song engages whole Gr S5.15.1 Transfer of group energy into the ward S5.16.1 Session preparation allows Th to relax more S5.17.1 Core Ms take musical responsibility S5.17.2 Core Ms' responsibility aids Th S5.18.1 Gr continuity enhanced by repeated activities and core Ms S5.19.1 Imitation builds Gr's musical vocabulary S5.20.1 Working moments experienced as shared pulse, eye contact, attention, listening S8.1.1 Known song facilitates participation S8.2.1 Choruses engage Gr S8.3.1 Low Gr energy S8.4.1 Clapping during chorus increases energy S8.5.1 M's initiative - propose song S8.6.1 M's initiative prior to session – requests song S8.7.1 Th aware of environment S8.7.2 Th encourages Gr's awareness of activity in environment S8.8.1 Th links M's request to environmental activity S8.9.1 Th validates individual M

S5.2.1 Management of instruments difficult without clear boundaries of instruments and turns S5.3.1 Names in greeting song validates individuals S8.12.1 Challenging Gr's listening and rhythmical skills S8.13.1 Gr enjoys random ball-game with pre-recorded music S8.14.1 Th validates each M S8.15.1 Random nature of game creates anticipation S8.16.1 Transfer of Gr energy into the ward S8.17.1 Rhythmical activity stimulates cognitive functions S8.18.1 Loss of attention at end of long rhythmical activity S8.19.1 Ball game required alertness from Ms S8.20.1 Variety of activities stimulates Gr on multiple levels S8.21.1 Ms need to play freely V3.1.1 Wall-divider corner may decrease physical disturbance V3.2.1 Gr 03 - 23 Ms V3.3.1 Gr energy low; expectant V3.4.1 Tes' initiative – fetch djembes V3.5.1 Te's initiative – plays on the drum V3.6.1 Younger children initiative – spontaneous dancing V3.7.1 Te plays drum in clear, stable manner V3.7.2 Te plays complex drum pattern V3.8.1 Te wary to start, looking for Th's support V3.9.1 Dancer in mid-circle energetic V3.9.2 Drum rhythm energising V3.10.1 Young children initially dancing for Th V3.10.2 Th validates dancers by leaning forward, moving body V3.11.1 Ms with low energy passively engaged V3.12.1 Th supports through clapping V3.13.1 Circle members participate by clapping/tapping V3.14.1 Energy increase with clapping V3.15.1 Clapping motivates 'shy' dancers V3.16.1 Gr supports - dancers gain confidence V3.16.2 Increased eye contact between Ms V3.17.1 Ms motivating each other verbally V3.18.1 Tes supporting each other V3.18.2 Tes play clear drum rhythm V3.19.1 Tes working together V3.19.2 Tes making eye contact	S8.10.1 Individual M's input 'inspires' Gr S8.11.1 Th work on listening and rhythmical skills V3.22.1 Th vocally accompany dancers and rhythm section V3.22.2 Th introduce new vocal material V3.22.3 Th allows environmental sounds to serve as musical 'ideas' V3.23.1 Nurse becomes temporary M by clapping V3.24.1 Nurse vocally imitates T V3.24.2 Nurse's vocal engagement initially tentative V3.25.1 Gr recognises nurse's participation V3.26.1 Th repeats vocal motive to engage nurse V3.27.1 Nurse responds to Th's vocal imitation V3.28.1 Th validates nurse through imitation V3.29.1 Nurse enjoyed participation V3.30.1 Nurse's engagement animates the Gr V3.31.1 Focus of Gr on active members V3.31.2 Passive members also engaged V3.32.1 Individual M expresses the need to engage with Th V3.32.2 Vocal communication and eye contact between individual and Th V3.33.1 M initiates – new movement V3.34.1 Th validating M's initiative through imitation V3.35.1 T supports Gr rhythmically V5.1.1 Gr 05 20 children V5.1.2 Gr 05 2 mothers on Gr's periphery V5.1.3 Gr 05 brief staff participation V5.2.1 Gr energetic and eager V5.3.1 Th introduces instruments V5.4.1 Th indicates instruments' positions through clear body cues V5.5.1 Two Ms imitate Th's body cues V5.6.1 Th engages Ms with eye contact V5.6.2 Th's verbal instructions short/clear V5.6.3 Th sets clear boundaries regarding instruments V5.7.1 Th's verbal instructions supported by body cues V5.8.1 Gr imitates - Th's verbal instructions and movements V5.9.1 Th's body cues expresses her instructions V5.10.1 Gr actively (imitation) and passively engaged V5.10.2 Th's actions create Gr anticipation V5.11.1 Th extends Gr anticipation

V3.20.1 Gr's attention shifts to Tes with musical responsibility
V3.20.2 Greater awareness between Ms
V3.21.1 Th aware of environment
V5.14.1 Th instructions clear
V5.14.2 M obeys Th and imitates body cues
V5.15.1 Th extends Gr's anticipation
V5.16.1 Th verbally/bodily reminds Gr of boundaries
V5.17.1 Ms imitate Th's body cues and words
V5.18.1 Te M reinforce Th instructions to Gr
V5.18.2 Te supports Th
V5.19.1 Th introduces new instrument
V5.20.2 Th extends Gr anticipation
V5.21.1 Gr focuses on Th
V5.22.1 Th extends Gr anticipation
V5.23.1 Th verbally addresses M unable to wait
V5.24.1 Gr anticipation visible in body language
V5.25.1 Th invites verbal interaction
V5.26.1 Th's question invites spontaneous engagement from Gr
V5.27.1 Th verbally/bodily reminds Gr of boundaries
V5.28.1 Gr understands and adheres to boundaries
V5.29.1 Gr learns boundaries due to Th's repeated reminders
V5.30.1 Th validates Gr's adherence to boundaries
V5.31.1 Th introduces wide variety of instruments to Gr
V5.32.1 Gr engaged
V5.32.2 Gr learned to adhere to boundaries
V5.33.1 Th invites verbal engagement
V5.34.1 Peripheral Ms willing to engage
V5.2.1 M requests song prior to session
V5.3.1 5 Peripheral Ms present
V5.4.1 Gr energy – low
V5.5.2 Th flexible when opportunity arises
V5.5.3 Th aware of Gr environment
V5.6.1 Th encourages Gr's awareness of environment
V5.7.1 Gr attentive
V5.8.1 Th links M's request to environmental activity
V5.8.2 Th adapts session plan
V5.9.1 Th validates individual M
V5.10.1 Gr enjoys known song
V5.11.1 Th leads song
V5.12.1 Th initiates – body movements
V5.12.2 Th's body movements reflect text

V5.12.1 M displays difficulty waiting
V5.13.1 Th uses body cues to show M to wait
V8.13.1 Th repeats song
V8.14.1 Th clearly shows Gr new movements
V8.15.1 Movements are simple
V8.16.1 Gr's engagement initially tentative
V8.17.1 Th aware of individual M
V8.18.1 Th uses ritardando and fermata to prepare Gr for change
V8.19.1 Repetition allows Gr to become familiar and more confident
V8.20.1 Th makes eye contact with Ms to invite engagement
V8.21.1 Gr attentive
V8.22.1 Th values Gr's opinion
V8.22.2 Th invites Gr's assistance
V8.23.1 M who knows song well sings it to Th
V8.25.2 Role shift - M leads and teaches Th
V8.24.1 Gr validates individual M
V8.25.1 Th validates individual M
V8.25.2 Role shift – M leads, Th learns
V8.26.1 Song repeated
V8.26.2 T gives M musical responsibility
V8.27.1 Individual M more confident
V8.28.1 Th validates individual M
V8.28.2 Th encourage Gr to listen to individual M
V8.29.1 Individual M is focus of Gr's attention
V8.30.1 Th shows support to individual M through body language
V8.31.1 Roles shifting -T cues Gr to join
V8.32.1 Th clearly indicates with body cues when the Gr should join individual M
V8.33.1 Gr's energy higher after individual M's inspiration
V8.34.1 Increased Gr energy
V8.35.1 Th makes eye contact and models
V8.36.1 Th provides rhythmic support to the music
V8.37.1 Some Ms passively engaged
V8.38.1 Th clearly indicates end by ritardando
V8.38.2 Gr experiences mutual ending

APPENDIX V

CATEGORIES, SUB CATEGORIES AND CODES

CATEGORY ONE	SUB CATEGORIES	CODES
The therapist's clinical skills	Validation	• Th validates nurse through imitation • Th validates dancers by leaning forward, moving body • Th validates Ms's initiative through imitation • Th validates Gr's adherence to boundaries • Names in greeting song validates individuals • Th validates individual M x4
	Setting boundaries	• Large Gr needs clear structure and boundaries x2 • Th sets clear boundaries regarding instruments x2 • Th verbally/bodily reminds Gr of boundaries • Gr learns boundaries due to Th's repeated reminders • Th verbally addresses M unable to wait • Th puts instruments out of immediate reach of Gr • Th systematically introduce instruments
	Awareness of the environment	• Th aware of environment x2 • Wall-divider corner may decrease physical disturbance • Th allows environmental sounds to serve as musical 'ideas' • Th encourages Gr's awareness of environment x2 • Th links M's request to environmental activity
	Creating anticipation	• Systematic instrument introduction creates Gr anticipation • Th deliberately build Gr anticipation • Th's actions creates Gr anticipation • Th extends Gr anticipation • Th uses ritardando and fermata to prepare Gr for change • Random nature of activity creates anticipation
	Clarity of intention	• Th clearly shows Gr new movements • Th's verbal instructions short + clear x2 • Movements are simple • Th clearly indicates end by ritardando
	Use of body language	• Th's body movements reflect text • Th clearly indicates with body cues when the Gr should join individual • Th uses body cues to show M to wait • Th's body cues expresses instructions • Th's verbal instructions supported by body cues
	Flexibility	• Th adapts session plan • Th flexible when opportunity arises

CATEGORY TWO	SUB CATEGORIES	CODES
Engagement and participation of the therapist and the group	Nature of engagement/participation	• Some Ms passively engaged x3 • Some Ms actively engaged x2 • Th invites verbal interaction • Th engages Ms with eye contact • Vocal communication and eye contact between individual M and Th • Th makes eye contact and models • Th makes eye contact with Ms to invite engagement • Gr's engagement initially tentative • Ms participate by clapping or tapping • Nurse becomes temporary M by clapping • Nurse's vocal engagement initially tentative • Nurse vocally imitates Th • Focus of Gr on active Ms • Gr attentive • Variety of activities stimulates Gr on multiple levels • Ballgame required alertness from Ms • Rhythmical activities stimulates cognitive functions • Gr enjoys random ballgame with pre-recorded music • Gr enjoys known song • Th repeats vocal motive to engage nurse • Known song facilitates participation x2 • Working moments experienced as shared pulse, eye contact, attention, listening • Th's question invites spontaneous engagement • Known song engage whole Gr • Choruses engage whole Gr x2
	Relational nuances of engagement/ participation	• Individual M expresses need to engage with Th • Young children initially dancing for Th • Gr recognises nurse's participation • Nurse enjoys participation • Nurse responds to Th's vocal imitation • Peripheral Ms willing to engage • Brief staff participation • Possible impact on staff-patient relationship • Nurse experience healthy side of patients

CATEGORY THREE	SUB CATEGORIES	CODES
Shifting roles	Roles change between members	• Th leads song • Roles shifting – Th cues Gr to join • Role shift – M leads, Th learns • Th invites Gr's assistance • M knows song well, sings it to Th • Th values Gr's opinion • Te M reinforce Th instructions to Gr • Tes work together • Ms imitate – Th body cues + words x3 • Gr imitate – Th • Gr focuses on Th • Individual M is focus of Gr attention
	Different members take initiative	• Tes' initiative – negotiate rhythm • Te's initiative – playing djembe • Tes' initiative – fetch djembes • Th's initiative – vocals and movement x2 • Th's introduce – new vocal material • Th's initiative – new movement • M's initiative – new movement • Ms' initiative – dancing in circle • M's initiative – requests song prior to session • M's initiative – propose song • M requests song prior to session
	Responsibility shifts between members	• Tes take responsibility, support Gr • Core Ms take musical responsibility • Core Ms' responsibility aids Th • Th gives M musical responsibility • Gr attention shifts to Tes with musical responsibility

CATEGORY FOUR	SUB CATEGORIES	CODES
Encouragement and support of the therapist and the group	Nature of encouragement/support	• Ms motivating each other verbally • Nurse encourages Gr • Nurse encourages dancers through vocal sounds and body movements • Te supports Th • Tes support each other • Th shows support to individual M through body language • Te weary to start, looking for Th's support • Tes provide musical support for younger children • Gr validates individual M • Th encourages Gr to listen to individual M • Th vocally accompany dancers and rhythm section • Th supports Gr rhythmically x2 • Th supports through clapping
	Effects of encouragement/support	• Individual M more confident • Gr supports – dancers gain confidence • Clapping motivates shy dancers • Individual M's input inspires Gr

CATEGORY FIVE	SUB CATEGORIES	CODES
Aspects of group energy	Energy levels	• Gr energy – low x2 • Gr energy low, expectant • Increased Gr energy • Gr energetic + eager • Dancer in circle energetic
	Energising factors	• Energy increase with clapping x2 • Drum rhythm energising • Gr energy higher after individual M's inspiration • Nurse's engagement animates Gr
	Effect of increased energy	• Gr energy attract peripheral Ms – staff • Nurse's involvement attracted by higher Gr energy • Transfer of Gr energy into the ward x2

CATEGORY SIX	SUB CATEGORIES	CODES
Group cohesion development		• Repetition allows Gr to become familiar and more confident • Gr continuity enhanced by repeated activities and core Ms • Gr cohesion experienced during Tes' jembe playing + young children dancing • Gr experience mutual ending • Increased eye contact between Ms • Greater awareness between Ms

CATEGORY SEVEN	SUB CATEGORIES	CODES
Difficulties in managing the group		• Ms argue over instruments and turns • Noisy instrumental playing drowns out quiet Ms • Ms cannot wait for turn causing disorganisation x2 • Loss of attention at the end of long rhythmical activity