Exploring the role of music therapy in the nurturing of personhood in a male psychogeriatic ward

by

KARYN LESLEY STUART

A mini-dissertation submitted in partial fulfilment of the requirements for the degree

MMus: Music Therapy

in the Department of Music at the

UNIVERSITY OF PRETORIA

FACULTY OF HUMANITIES

SUPERVISOR: Mrs ME van Heerden
CO-SUPERVISOR: Prof M Pavlicevic

February 2008

CONTENTS

Acknowledgements

PART 1 – CASE REPORT AND CLINICAL REVIEW

Chapter 1: Background and Context

1.1 Introduction 1
1.2 The psychogeriatrics ward and music therapy 2
1.3 Conclusion 2

Chapter 2: Literature Review

2.1 Introduction 4
2.2 Personhood and person-centred care 4
2.2.1 Definitions and approaches 4
2.2.2 Personhood of the patient 5
2.2.3 Subjectivity, intersubjectivity and personhood 6
2.2.4 Malignant social psychology in relation to personhood 7
2.2.5 Institutionalization 9
2.2.6 I-Thou relationship 9
2.2.7 Personhood of nursing staff/carers 10
2.3 Music therapy with older persons with psychiatric illnesses 12
2.3.1 Inherent music child – Creative music therapy 12
2.3.2 Community music therapy 14
2.3.3 Music therapy and groups 15
2.4 Music therapy and personhood 15
2.5 Conclusion 16

Chapter 3: Clinical Report

3.1 Ethical considerations 18
3.2 Clinical details and general information 18
3.3 Report narrative 19
3.3.1 Overview of group 19
3.3.2 Description of music therapy group process 19

3.4 Selection of clinical work material 22
3.4.1 Pre-selected video excerpts 22
3.4.2 Observation notes 25

PART 2 – CLINICAL WORK ANALYSIS AND INTERPRETATIVE DISCUSSION

Chapter 4: Clinical Work Analysis
4.1 Coding 27
4.1.1 Video excerpts 27
4.1.2 Observation notes 28
4.2 Categorizing 30
4.3 Identifying emerging themes 33
4.3.1 Description of theme 1: Growth of personal worth 34
4.3.2 Description of theme 2: Experience of a changing group and self identity 35
4.3.3 Description of theme 3: Community: Being in social relationship with others 36
4.3.4 Description of theme 4: Musical interplay: Expression through music 37
4.4 Conclusion 38

Chapter 5: Interpretation and Discussion 39
5.1 Interpretation and process 40
5.2 Addressing Question 1, 2 and 3: How does music therapy nurture personhood in an open group on a psychogeriatric ward? How does music therapy nurture the personhood of the patient and staff member? 41
5.2.1 Theme 1: Growth of personal worth 41
5.2.2 Theme 2: Experience of a changing group and self identity 43
5.2.3 Theme 3: Community: Being in social relationship with others 45
5.2.4 Theme 4: Musical Interplay: Expression through music 48
5.3 Addressing question 4: What implications might this have regarding the status and role of staff in music therapy groups? 49
5.4 Conclusion 50

PART 3 – PROPOSED RESEARCH PROJECT

Chapter 6: Proposed Research Methodology
6.1 Introduction 52
6.2 Focus of research and proposed research questions 52

6.3 Research paradigm 53
6.4 Data sources 53
6.4.1 Pre-selected video excerpts 54
6.4.2 Focus group interviews 54
6.4.3 Secondary data source: Observation notes 54
6.5 Preparation of data sources 54
6.5.1 Pre-selected video excerpts 55
6.5.2 Focus group interviews 55
6.5.3 Observation notes 55
6.6 Data analysis 55
6.6.1 Coding 55
6.6.2 Categories 55
6.6.3 Themes 56
6.7 Ethical considerations 56
6.8 Conclusion 57

PART 4 – CONCLUSION OF CLINICAL ENQUIRY

Chapter 7: Conclusion and Recommendations

7.1 The nurturance of personhood in the music therapy group on the male psychogeriatric ward 58
7.2 Limitations and recommendations 59

Bibliography 60

Appendices

Appendix i Informed consent form
Appendix ii Permission letter from institution
Appendix iii Lyrics of traditional songs
Appendix iv Thick descriptions of video excerpts 1 to 3
Appendix v Sample of observation notes
Appendix vi Main text lifted from observation notes
Appendix vii Text and codes of video excerpts 1 to 3
Appendix viii Text and codes of observation notes
Appendix ix Full list of codes
Appendix x Full table of codes, categories and emerging themes

Appendix xi Staff informed consent form
Appendix xii Focus group interview questions

List of Figures and Tables

Table 2.1	Relationship between McCormack's derived concepts of person-centredness and Kitwood's definitions	5
Figure 3.1	Video excerpt 1- layout of group	23
Table 3.2	Sample of main text lifted from observation notes	25
Table 4.1	Sample of coding of video excerpt 1	28
Table 4.2	Sample of coding of observation notes	29
Table 4.3	Sample from full list of codes	29
Table 4.4	Codes in mutually exclusive categories	31
Figure 4.5	Theme 1 with relating categories	34
Figure 4.6	Theme 2 with relating categories	35
Figure 4.7	Theme 3 with relating categories	36
Figure 4.8	Theme 4 with relating categories	37
Figure 5.1	The process of nurturing personhood	40

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

ACKNOWLEDGEMENTS

I would like to thank the following people for their support throughout this process:

My supervisor, Adri van Heerden – thank you for your time, insights and encouragement.

Carol Lotter and the lectures at the Music Therapy Unit – thank you for all the hard work and continued support during those trying months.

My family and friends in Cape Town – thank you for your love and the many prayers.

The patients and staff at the psychogeriatrics ward at Weskoppies hospital – it was a pleasure working with you and getting to know you. Thank you for supporting our music therapy groups.

My 2006/7 classmates who became friends and colleagues – what a journey! Thank you for the tough, interesting, challenging, hilarious times over these two years. Bronwyn, thanks for helping me stay sane!

My Creator and Saviour, God – You are my Rock. Thank You for Your faithfulness.

ABSTRACT

This clinical enquiry, based on clinical work undertaken during an internship, explores the role of music therapy in the nurturing of personhood of persons in a male psychogeriatric ward. The purpose of the enquiry is to draw insights into the role of music therapy in fostering personhood, not only in patients, but nursing staff members, who were included in the weekly music therapy group. The music therapy sessions included a variety of musical activities with many opportunities for performing. Over the course of thirteen sessions, clinical material was selected via purposive sampling, in the form of three video excerpts, and text lifted from observation notes. This material was analyzed using the research methods of coding, categorizing and identifying themes. The emerging themes are opportunities for growth of personal worth; experience of a changing group and self-identity; community: being in social relationship with others; and musical interplay: expression through music. It appears that music therapy indeed played a role in nurturing the personhood of group members, through the affordance of opportunities, and through enablement and empowerment of the individuals and the group. It would seem that including staff in the music therapy groups, developed not only their own personhood, but the personhood of the patient. This may have implications in music therapists' view of the role of the nursing staff member within a music therapy group. Staff may be seen as, not only perfunctory helpers, but as a contributing, equal members of a music therapy group.

KEY WORDS:
Personhood
Malignant social psychology
Institutionalization
Psychogeriatric
Staff inclusion
Enablement and empowerment
Personal worth
Identity
Social relationship
Musical interplay

PART 1

CASE REPORT AND CLINICAL REVIEW

Chapter 1

BACKGROUND AND CONTEXT

"Umuntu Ungumuntu Ngabantu" is a Zulu proverb meaning "A human being becomes human through other human beings."

1.1 Introduction

The idea for this clinical report grew out of an interest in elderly persons suffering from psychiatric illnesses, and four years previous experience as an occupational therapist in an old age residential and rehabilitation setting. During this time, and more recently during my music therapy internship, I witnessed nursing staffs' emotional needs and stress impacting on patient care and quality of life – at times stressed staff treating patients in a manner not responsive or sensitive to the patient's needs. As I observed the relationship between staff and patients, I wondered how the staff could be viewed holistically, as persons with physical, emotional and spiritual needs. When included in a music therapy group, the staff member's role is generally seen as perfunctory – they are there to assist the music therapist. If a change in how we view staff and their own needs could be achieved, I wondered how it would affect the care of the elderly person.

It may be that through inclusion in a music therapy group, a sense of value, self-respect and other emotional needs might be nurtured (channeled, facilitated and guided) in staff as much as it can in patients. These aspects of emotional needs, mentioned above, speak of 'Personhood' – the need to be validated as a human being; to be seen and experienced as a human being. The Zulu proverb written at the beginning of this chapter reflects this sentiment. One becomes human through validation by others. Viewing staff members not just as 'helpers', but as equal, contributing members of the music therapy groups, may validate them, thereby encouraging their 'humanness' together with that of the patient.

Part of my clinical internship took place at the male psychogeriatric ward at Weskoppies Psychiatric Hospital in Pretoria, and this forms the context of this clinical enquiry.

I will now briefly describe this context and music therapy's involvement there.

1.2 The psychogeriatric ward and music therapy

Weskoppies Hospital is situated on a vast piece of land in the centre of Pretoria. There are many wards, including long-term, short-term, closed and open in-patient wards, and an out-patient building. Professional staff members include doctors, psychiatrists, psychologists, occupational therapists and nursing staff, who meet weekly on various wards during ward rounds. The male psychogeriatric ward houses twenty-four elderly patients with varying diagnoses including schizophrenia, dementia, bipolar mood disorder and psychosis. It is a chronic, long-term ward, where patients are all sixty years and older. Staff members present on the ward are generally nursing staff and auxiliary staff.

Music therapy has been practiced in this psychiatric hospital for eight years. Music therapy interns have worked in various wards over that period, including the male and female adult, psychogeriatric and lock-up wards. Individual sessions and open (where anyone is free to attend or not) or closed (select membership) group sessions generally take place once a week with patients over a 4 month period. Every second year, the music therapy interns and some of their patients, present their music to the public at the fund-raising fête held at the hospital. This promotes awareness of music therapy and presents aspects of the work done with patients.

Music therapy ward groups generally do not include staff members. When nursing staff are present in groups, they have usually been asked to help patients to play an instrument or manage disruptive behaviours. In other words, the function of nursing staff member has generally been perfunctory. In approaching my clinical internship, I decided to invite nursing staff members to join the groups and to view them as equal members of the open group. My experiences in co-facilitating this group further fueled my interest.

1.3 Conclusion

My concern for the concept of personhood and the experiences I'd had with staff, both in the past work experiences and in my recent clinical internship, led me to think about how music therapy may nurture personhood in such a context. I became interested in the role that music therapy might play in nurturing elements of personhood in all members (i.e. patients and staff) of an open ward group. Furthermore, I wondered how this may influence the thinking regarding the personhood of staff, and their inclusion in future music therapy groups.

This led me to ask the following:

Main question:

How does music therapy nurture personhood in an open group on a psychogeriatric ward?

Sub-questions:

How does music therapy nurture the personhood of the patient?

How does music therapy nurture the personhood of the staff member?

What implications might this have regarding the status and role of staff in music therapy groups?

The following chapter deals with an overview of the literature regarding this area of interest, namely personhood and music therapy.

Chapter 2

LITERATURE REVIEW

2.1 Introduction

In terms of approaching the questions I've posed surrounding how music therapy can nurture personhood, applicable literature from a variety of sources including books, articles, journals and online journals was collected and read. As the clinical enquiry takes place within a psychogeriatric ward with older men with psychiatric diagnoses, relevant focal topics that this literature review will cover are the concept and theory of personhood with relation to geriatrics and psychiatric patients. This will also include the concepts of malignant social psychology, institutionalization and a short reference to staff and personhood. The review then focuses on music therapy with allusion to the psychogeriatric population, where community music therapy and open group theory will also be mentioned.

2.2 Personhood and person-centered care

2.2.1 Definitions and approaches

The term 'Personhood' or 'person-centeredness' seems multi-faceted and has various descriptions in literature. The word 'person' does not only refer to our biological state but, according to McCormack (2004), it represents our humanness. Existing socio-cultural psychology literature defines personhood as the qualities of 'humanness' in all of us and views personhood as a social concept (Kitwood & Bredin, 1992). People don't live in isolation; we all have a context in which our personhood is manifested (Kitwood, in McCormack, 2004). The Zulu proverb quoted in chapter 1, speaks about how being valued as a 'person' happens through others, and hence the social aspect of this concept of personhood. Kitwood (in McCormack, 2004:33) defines person-centeredness in dementia care as: '… a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust.' Kitwood's descriptions form the basis of the term 'personhood' that I will use during this clinical enquiry and report.

Many authors have approached personhood or person-centered care as relating to the interpersonal relationship between practitioner and patient. Williams and Grant (1998) state that person-centered care necessitates that practitioners learn more about the patient as an individual, and gain a better understanding of the patient's personal meanings, experiences and attitudes. Personhood pays greater attention to the psychological and emotional needs than the

medical model offered in the past (Simpson, 2000). When applying this concept of personhood in the traditional models, Beach (*et al.*, 2005) reports that meaningful relationships or therapeutic partnerships promote personhood of the patient.

2.2.2 Personhood of the patient

Due to the limited literature found regarding personhood within the realm of music therapy, nursing literature was explored, which was found to contain many references to personhood and patient-centered care. Person-centered models of nursing have emerged from the new ways of viewing dementia care through personhood (Kitwood, 1990, 1997; Kitwood & Bredin, 1992). In providing quality care for a patient, personhood moves away from the more traditional medical model towards one where the practitioner (staff member or caregiver) sees behind the 'mask of ageing' (Featherstone & Hepworth, in Clarke *et al.*, 2003: 698), illness or disability (Clarke *et al.*, 2003). This goes beyond caring for people's physical and/or mental needs, to discover more about their experiences, cares, concerns and relationships that are important to them.

McCormack (2004:33-34) argues that four concepts lie within person-centered nursing. The first of these is 'being in relation'. McCormack states that sustaining a patient-staff member relationship nurtures both the patient and staff member. The second concept, 'being in a social world', implies understanding the person's context and social world. The third concept, 'being in place', refers to the context in which care takes place – the institution, systems of decision-making, staff relationships. 'Being with self' is the last core concept and is based on respecting the person's values and how he/she makes sense of what is happening. The application of these concepts leads to a more person-centred approach in nursing and quality care. McCormack linked these concepts with Kitwood's definitions of personhood as demonstrated in table 1 below.

Relationship between McCormack's derived concepts of person-centredness and Kitwood's definitions

Concept	*Link with Kitwood's Definition*
Being in relation	Persons exist in relationships with other persons
Being in a social world	Persons are social beings
Being in place	Persons have a context through which their personhood is articulated
Being with self	Being recognized, respected and trusted as a person impacts on a person's sense of self

Figure 2.1 (McCormack, 2004:33)

Kitwood and Bredin (1992) created a list of twelve indicators of well-being, included below, that draws on the concept of personhood. Although this list refers to people with dementia, there appears to be many similarities with other psychiatric illnesses in general.

- "The assertion of desire or will
- The ability to experience and express a range of emotions
- Initiation of social contact
- Affectional warmth
- Social sensitivity
- Self-respect
- Acceptance of other dementia sufferers
- Humour
- Creativity and self-expression
- Showing evident pleasure
- Helpfulness
- Relaxation" (Kitwood & Bredin, 1992, p. 281-282)

The authors continue by stating that these twelve indicators are an expression of four global states. These states are personal worth, sense of agency, social confidence and hope (Kitwood & Bredin, 1992). It is through relationships that these global states can be achieved. However, in order to form and maintain relationships, a level of 'knowing oneself' and 'knowing another' is required. This 'knowing' can be explained by the concepts of subjectivity and intersubjectivity.

2.2.3 Subjectivity, intersubjectivity and personhood

Subjectivity and intersubjectivity, which are defined below, influence personhood and contribute to the state of well-being. I will therefore mention these concepts in relation to personhood and older persons.

Trevarthen (in Pavlicevic, 1997:105) writes that subjectivity is the "state of being a coordinated subject – to act with purpose in relation to the world outside". Pavlicevic (1997) comments that from birth, there is a sense of subjectivity in our lives. The stimulus of touch, sight, smell and sound is received through our senses, all of which are located in our bodies as infants. This locus of reference, Pavlicevic (1997:105) states, is a "foundation for expressing ourselves, receiving expression from, and coordinating and communicating with another person."

Pavlicevic (1997:109) cites Trevarthen in saying that intersubjectivity is "knowing and interacting with another's internal state." This kind of relating, which begins with the mother-infant relationship, persists throughout our lives. According to Pavlicevic (1997), this relating continues to give us a sense of who we are and how the world is with us.

When we are isolated - physically or psychologically - we lose the sense of who we are and, in turn, lose our subjectivity. In losing who we are, we lose the ability to interact and experience intersubjectivity. In a sense, this marginalization isolates the person, leading to a decrease in 'humanness' and personhood. I will link this with the literature on music therapy later in this chapter (2.3.1). The institutionalized older person with dementia, or any psychiatric disorder, lives in a community and environment that includes other patients and staff members. There is a level of interaction that takes place between these members of the context. As the subjectivity of the older person deteriorates, inter-subjectivity should take over if personhood is to be maintained, according to Kitwood & Bredin (1992). As the psychiatric illness renders the person physically and mentally disorientated, and unable to function independently in terms of activities of daily living, their relationships develop more importance in terms of maintaining their personhood and 'humanness'.

It would seem, therefore, that when facing a psychiatric illness such as dementia or schizophrenia (as many clients within the context of this enquiry are diagnosed with), support of the patient's personhood through person-centred care should be imperative. However, age discrimination and poor standards of care continue to characterize the care that older people often receive (Nolan *et al.*, 2004). In order to further understand the concept of personhood and person-centredness, a brief look into malignant social psychology and its effect on personhood is necessary.

2.2.4 Malignant social psychology in relation to personhood

Within the context of my clinical internship and enquiry, being a psychogeriatric ward, the patients have various psychiatric disorders. They live in a state of daily routine, where they may be deprived of aspects of humanness such as choice, independence and autonomy, due to their disabilities.

Kitwood (1990) discusses malignant social psychology which affects human beings and how we view others. It can be seen as the dynamic interplay between neurological and psycho-social factors which deprives a person with dementia of their personhood (Kitwood & Bredin, 1992). What society stands for and holds in high regard (e.g. Status, power, money) is usually deficient

in a person with any medical diagnosis, not only dementia. Kitwood (1990) called these social pressures 'malignant social psychology', and explains the effects of this diminished personhood using ten aspects of this 'malignancy'. Kitwood's explanation of each is outlined below:

- Treachery: Some form of dishonest representation, trickery or outright deception to get the patient to comply with the caregiver's wishes.
- Disempowerment: Tasks are done for the patient, even though they may be able to complete the task, albeit slowly and clumsily.
- Infantilization: Subtle messages that the patient has a mentality and capability of a young child. This can be in the form of patronizing or condescending behaviour towards patient.
- Intimidation: Patients are made afraid by procedures (e.g. head scans or psychological assessments), which are often carried out in an impersonal way by 'powerful' professionals.
- Labeling: Once a diagnosis is given, a patient is expected to deteriorate and decline, and is treated differently (a self-fulfilling prophecy).
- Stigmatization: This is an aspect of labeling, but carries connotations of exclusion.
- Outpacing: When patients function mentally at a slower rate, caregivers continue to go at their normal pace, failing to establish contact.
- Invalidation: Invalidation occurs when the subjectivity of the person is ignored or overlooked. I.e. ignoring the person's need for reassurance or acceptance.
- Banishment: When the patient becomes 'intolerable' to others, he or she is removed from the human milieu, either physically or psychologically.
- Objectification: The patient is not treated as a person, but rather 'something' to be pushed around, filled, fed, and manipulated.

These are processes that depersonalize older patients (Kitwood, 1990). Although Kitwood relates these aspects of malignant social psychology to dementia care, they may be extended to psychogeriatric patients in general, who are often marginalized and depersonalized due to their diagnoses. According to Kitwood (1990), the above interactions are remarkably common in the lives of the older people who are confused. Each of these aspects of malignant social psychology is in some way damaging to the older person's self esteem and diminishes personhood (Kitwood, 1990). The effects of malignant social psychology occur amid the consequences of institutionalization that may deny individuals in long-term institutions of their former identity.

2.2.5 Institutionalization

According to the Concise Medical Dictionary (1980), institutionalization is a condition produced by long-term residence in an unstimulating, impersonal institution. The individual adapts to the behaviour characteristics of the institution to such as extent that he/she is unable to cope in other environments. The features of institutionalization include apathy, dependence and a lack of personal responsibility.

The presence of malignant social psychology and the ten aspects of malignancy, as described in 2.2.4, only serve to worsen the patient's institutionalized behaviour. In a psychogeriatric ward where patients have been institutionalized for prolonged periods, the sense of apathy and dependence is evident. For example, many experiences of infantilization, outpacing, labeling and disempowerment were witnessed by the music therapy interns on the ward, during the period of enquiry, which aggravated the apathy and dependence of the patients. Music therapy may provide a stimulating experience for the patients as well as encourage relationships between staff and patients, which in turn may assist in nurturing the personhood of all.

Relationships between staff and patients, as well as between family and patients, may be characterized by the social pressures as discussed above. This malignant social psychology exacerbates, and is exacerbated by, the effects of institutionalization. Yet nursing staff, and caregivers in general, can only give person-centered care to others if their own personhood is acknowledged and nurtured (Kitwood and Benson, in Ashburner *et al*., 2004). Nolan *et al.* (in McCormack, 2004:33) states that, in gerontology, the term 'person-centredness':

> "fails to recognize the importance of relationships, as person-centredness focuses (in care literature) on the primary care of the personhood of the patient being cared for, at the expense of those doing the caring."

Due to the scarcity of literature regarding these topics in music therapy, psychology literature has been further consulted. The 'I-Thou' relationship, as developed by Buber, pertains to the development of personhood within patients and nursing staff.

2.2.6 I-Thou relationship

The experiential self (how one experiences oneself) develops from a person's self-concept. It arises from being with others in conditions of equality, mutual attention and mutual respect (Kitwood, 1997). The experiential self is formed and nourished by the 'I-Thou' relationship. Using

this terminology, Buber wrote about the different qualities of relationships. Ansdell (1995) quotes Buber:

> "In particular he brought attention to the difference between what he called 'I-it' relationships in contrast with 'I-Thou' type: between a world to be used and a world to be 'met'. In the former people or things we come into relationship with remain objects to us – to be experienced, used and manipulated… In an 'I-Thou' relationship there is a real meeting within an intimate relationship, the outcome of which is that each side somehow changes the other."
>
> (Buber, in Ansdell, 1995:67).

It is within this I-Thou relating that it becomes possible to develop a responsive way of being with others. This may be related to intersubjectivity. Within an I-Thou relationship, intersubjectivity is encouraged. When a person is subjected to oppression, conflict, rejection and exploitation (and often the ten aspects of malignancy), the experiential self does not develop (Kitwood, 1997). This leads to lack of self development and poor interactions between the person and others.

A good care worker, according to Kitwood (1997), requires a well-developed experiential self, willingness to bear others' burdens and the ability to set aside one's own issues for the sake of another. This ability to maintain I-Thou relationships may result in quality person-centred care. However, this ability is determined by whether or not staff needs are met and whether their experiential self is being developed. The literature has, so far, revealed the vital role of the personhood of the staff member in care of the older person. The concept of staff member personhood will therefore be further explored.

2.2.7 Personhood of nursing staff/carers

The importance of creating positive nurse-patient relationships has recently been acknowledged in an attempt to provide better quality care (Nolan *et al.*, 2004; Clarke *et al.*, 2003; McCormack, 2004; Ashburner *et al.*, 2004). Positive cultures of care for older people are associated with staff who feel well-supported and appreciated (Nolan *et al.*, in Ashburner *et al.*, 2004). There is not enough acknowledgement of the staff's need to feel valued as individuals in order for them to deliver person-centered care (Ashburner *et al.*, 2004).

The rate of burnout amongst professional staff members, such as nurses, is high due to emotional stressors, unsatisfactory working conditions, and feelings of depersonalization (Hilliard, 2006). In a recent study by Weman *et al.* (2004), it was found that registered nurses in

Sweden, working in community care with older persons, experienced lack of time, lack of stimulation, and lack of support which resulted in discontentment.

The use of music therapy for hospice workers has positive effects, in relation to compassion fatigue and team building (Hilliard, 2006). Hilliard (2006) also states that social rewards, psychosocial support and counseling have been associated with lower degrees of burnout among nurses. In the South African context, with its lack of resources, unemployment, high staff to patient ratio, high crime and social pressures, nursing staff face their own psychological and emotional issues, which affect their interaction with patients. As commented on by Kitwood (1997), the caregivers not only deal with their inner conflict – such as facing their own aging and mortality, and dealing with stress from their own families – but with the negative traditions in care practice, and the severe lack of public funding.

The relationship between staff and patients is affected by the emotional state and personhood of both parties. Nolan *et al.* (2004) lead a research study which introduced a 'sense framework' consisting of six senses that account for intersubjective perceptions of care experiences for older persons and staff. This framework "captures the subjective and perceptual dimensions of caring relationships" (Nolan *et al.*, 2004:49). It is underpinned by the belief that all parties involved in caring (the older person, family and carers) should experience "relationships that promote a sense of:

- Security – to feel safe within relationships;
- Belonging – to feel 'part' of things;
- Continuity – to experience links and consistency;
- Purpose – to have personally valuable goal or goals;
- Achievement – to make progress towards a desired goal or goals;
- Significance – to feel that 'you' matter" (Nolan, in Nolan *et al.*, 2004)

Participating staff members commented, in the study, that if staff felt more valued and supported, they would be better able to value and support older people (Nolan *et al.,* 2004). This indicates that staff's personhood may be viewed as important within the relationship between staff and patient. In order to deter interactions characterized by aspects of malignant social psychology, the staff's personhood needs to be accepted and supported.

Participation in time-limited music therapy groups is a "wonderful way for workers to gain such support." (Hilliard, 2006:400). When included in music therapy groups, the role of the staff

member is generally that of an assistant. However, given the above comments, their inclusion may be as valuable to themselves as it is to therapists and the group. There is little literature, internationally and within the South African context, regarding the inclusion of staff members in music therapy groups for their own emotional development and maintenance of their individual personhood. This includes music therapy groups that consist of both staff and patients, or only staff members.

Music therapy may be an effective medium to provide support for patients as well as nursing staff. Yet, little seems to be have been researched regarding the inclusion of staff in music therapy groups for the purposes of enhancing their own personhood. Having addressed the staff's needs and motivation for their participation as equal members of a music therapy group, I focus now on literature regarding music therapy and the psychogeriatric population.

2.3 Music therapy with older persons with psychiatric illnesses

The benefits of music, and music therapy with the psychogeriatric population, are described at length in literature. The upsurge of interest in using the arts within dementia care partly stems from Kitwood's argument for personhood and the concept of person-centred care (Killick & Allan, 1999). Many forms of music therapy, such as improvisational, analytical and receptive music therapy, are being used with psychiatric patients (Wigram *et al.*, 2002). Music therapy nurtures positive aspects in the quality of life (Brotons, 2000; Wood, 2004), such as physicality and motor skills (Wood, 2004), cognition (Lipe, 1995), self-esteem and confidence (Killick & Allan, 1999), socialization and social interaction (Abad, 2002), and can result in an improved mood (Clair, 2000). Music therapy may not address the symptoms of the illness directly, but it appeals to the whole person (Pavlicevic, 1997). I would like to now venture into creative music therapy theory to lay the foundation of music therapy in relation to personhood of patients and staff, as well as development of 'relationship'.

2.3.1 Inherent music child – Creative music therapy

In general, music therapists treat patients holistically, creatively developing a patient-therapist relationship based on the innate 'music child' that lies within everyone. Nordoff and Robbins (1977) state that this inherent healthy 'music child' responds to music almost automatically. Considering that we are intrinsically and physiologically musical beings in the rhythms, tempi and pitches we use in everyday living, it is noted that even in the presence of a disability (physical or neurological), this healthy, innate part of us continues to function.

According to the Nordoff and Robbins approach, creative music therapy focuses on the musical event, and the musical, empathetic, trusting, interpersonal relationship that develops between therapist and client. At its root, musicking[1] is about the creation and performance of relationships (Small, in Ansdell, 2004). This relationship has the potential to bring about intra- and interpersonal changes. It is through this musicking that the therapist and client develop and extend a unique sense of themselves in relation to one another, akin to the mother-infant relationship, which is non-verbal (or pre-verbal for the infant). Through this, the client has the opportunity to be met and matched, attuned to and extended, and to hear themselves within the music the therapist and client are creating. A communicative, expressive relationship is formed, serving to encourage personal growth in the client, to the point where they are able to interact in the world in a healthier way (Turry, in Bruscia, 1998).

Indirectly, this elicits the 'humanness' within the person, especially with client groups that are non-verbal, or have a psychiatric condition (Simpson, 2000), as they are often unable to make their needs known. Taking part in a musical act is of central importance to our humanness (Small, in Amir, 2004). The therapist and client connect and experience intersubjectivity within these musical acts. Within the musical meeting brought about in a music therapy session, client and therapist make contact in the music (Ansdell, 1995). The I-Thou relationship between therapist and client, and also between staff member and patient, may be enhanced by participation in a music therapy group. It can be argued that self-esteem, sense of value, confidence, self respect, and thereby quality of life, can be nurtured in a supportive, containing setting such as a music therapy session. Thus, throughout the relationship that develops in the interplay between the members of a session (individuals or group), intimacy and intersubjectivity are promoted.

However, within an institution and ward such as the psychogeriatrics ward discussed in this enquiry, with both nursing staff and patients involved in a music therapy group, it seems necessary to move away from the more traditional consensus model of music therapy where the aims are directed to the individual. Rather, it appears essential to include the 'community' of the ward, the context, environment and people surrounding the individuals in the ward, in order to cultivate musical community in and between participants.

[1] Musicking is "to take part, in any capacity, in a musical performance, whether by performing, by listening, by rehearsing, or practicing, composing, or by dancing." (Small, in Ansdell, 2004).

2.3.2 Community music therapy

In a country with as rich and diverse cultures as seen in South Africa, a community approach, such as community music therapy, may be beneficial. This would ensure inclusion of persons in the client's community as a method of treating the whole social person. It is not always possible to work with a client as an isolated individual, but rather with people "in context: acknowledging the social and cultural factors of their health" (Ansdell, 2002:16). In the context of this enquiry, the psychogeriatric ward can be viewed as a community, within the wider community of the hospital.

According to Amir (2004:251), community music therapy explores the "universal human need for self-expression and creativity, and addresses cultural and musical identity in order to enhance the quality of life". It aims to generate well-being and potential in individuals, relationships, milieus and communities (Ansdell, 2002). As in the case with personhood, where it is necessary to view the person within his context as a social being, so it is with community music therapy.

In community musicking, staff and residents have the opportunity to become connected in a creative process (Powell, 2004). This potentially leads to a greater understanding and increased quality of life within residential and hospital settings. Hosting such an open music therapy group as part of a music therapy process, assists the group in being therapeutically effective and socially uplifting (Wood *et al*, 2004) and, therefore, develops more of a community atmosphere of caring. Aasgaard (1999:40) states that:

> "Musical activities can create new relationship between the participants in a milieu. When patients and parents make music together with staff, it is likely that the spirit of community is strengthened within the institution".

The view of personhood that Wood (2006) sees in community music therapy is one of interdependent self. In a sense, as humans we are dependant on others to have relationships and experience intersubjectivity. This reminds us of the Zulu proverb, quoted earlier, which says that a human being becomes human through other human beings. Zharinova-Sanderson (2004) writes that through musical activity, people can recognize humanity in others. Furthermore, she asserts that confirming each other's humanity by 'being in music together', can facilitate "the natural processes of connecting, healing and evolving, and in turn can impact upon a person's way of relating to himself and to the people around him" (Zharinova-Sanderson 2004:241). This

may take place within the setting of a group. As the context of this enquiry is a heterogeneous group, attention will be turned to literature regarding groups and music therapy.

2.3.3 Music therapy with groups

To maintain the focal point of this enquiry, which is the nurturing of personhood and not the group process, little information on open group theory has been included. Rather, a brief background on the reasoning and theory of open groups shall be outlined.

In the context of this clinical enquiry, music therapy is held in the setting of an open group to which all patients and nursing staff are invited. Open groups are groups that have no particular or set membership, where attendance is voluntary. Such groups function in long- and short-term therapy (Pavlicevic, 2003), and offer the benefit of socialization with peers. Aspects of 'meeting' and 'connecting' with the client individually within the group still apply as they would in individual music therapy, but the aspect of peer interaction may be included in a group.

Systems Theory (developed by Kurt Lewin) links with Community Music Therapy in that it reflects that group musicking, wherever and whenever, does not take place in a vacuum (Pavlicevic, 2003), just as a person does not exist in isolation. Amir (2004) states that by sharing music with each other, clients (and staff) come to understand themselves and others, and feel less isolated. Thus, there are many benefits of music therapy in the format of an open group. In the South African context there is little published literature regarding music therapy with groups, relating to personhood.

Within group music therapy, the potential lies for personhood to be encouraged. I would like to turn now to music therapy literature specifically relating to personhood, where this potential is further explored.

2.4 Music therapy and personhood

Music therapy may be a powerful way in which persons, with or without pathology, may be themselves, be heard, listened to, and responded to as themselves (Procter, 2004). Within a music therapy group, a community is developed – the therapists, staff and patients join together in making music, each person playing different roles, forming a social network around the individual. Throughout the progression of the sessions, the group may grow socially and emotionally as a community. It is in this kind of context that personhood may be developed.

Research done by Ishazuka (1998) for her masters degree at the Nordoff-Robbins Music Therapy Institute in London, suggests that creative music therapy enables therapists to work with the person as a whole. She relates this to Kitwood's 'person-centred care' and theory of personhood, in terms of recognizing and respecting the humanity of each person. Although her thesis relates to music therapy and personhood, it refers only to the context of dementia care and does not include other diagnoses or nursing staff members.

There appears to be a gap in the literature with regards to the social psychology concept of personhood and music therapy literature (Ansdell, 2002, 2006). There is limited literature on personhood related to work with nursing staff within music therapy, as well as music therapy relating to personhood of the patient or staff member. The majority of the above-mentioned literature in existence originates within a European context. Furthermore, much of the literature discussed above refers to the specific diagnosis of dementia, and does not include other psychiatric illnesses. Little research has been done in South Africa regarding music therapy and the psychogeriatric patient group. There is also a large gap in terms of staff inclusion in groups, as well as patient and staff personhood, in international music therapy literature. For these reasons, this clinical enquiry may form the basis of future research in this area. It would be important to the work of music therapists in South Africa, as it would help develop insights into how music therapy may nurture personhood in staff and patients in a group context.

2.5 Conclusion

In view of the above literature, and gaps within the literature, particularly in South Africa, it would seem that qualitative research of this nature is vital. In music therapy, viewing not only the patient, but also the staff member as a 'person', seems valuable. This clinical enquiry explores the use of music therapy with an open group, consisting of staff and patients in a male psychogeriatric ward, with regards to nurturing personhood among all members. After a review of the available literature, the questions of this enquiry, as posed in chapter 1, remain unchanged:

Main question:

How does music therapy nurture personhood in an open group on a psychogeriatric ward?

Sub-questions:

How does music therapy nurture the personhood of the patient?

How does music therapy nurture the personhood of the staff member?

What implications might this have regarding the status and role of staff in music therapy groups?

The following chapter deals with the case report and selection of clinical material to be explored in order to address these questions.

Chapter 3

CLINICAL REPORT

This chapter includes the ethical considerations, general information regarding the group, and a narrative of the process of this music therapy group. The selection of relevant clinical material, in terms of video excerpts and observation notes, will be discussed in detail.

3.1 Ethical considerations

Prior to the commencement of the music therapy group process, ethical considerations were taken into account. Informed consent (Appendix i) was obtained from the group members. This included their consent to participation, and the audio/video recording of the group. Assent was obtained from patients, and it was explained that they were invited to attend the music therapy group or not, should they so choose. In addition, informed consent from the institution was obtained for the use of video recordings for analysis in this clinical enquiry (Appendix ii).

3.2 Client details and general information

Commencing our clinical internship at this psychogeriatric ward, my co-therapist and I decided to host an open ward group, thus inviting all patients and nursing staff members to participate. Our clinical reasoning regarding this was to be inclusive of patients and staff. There were no specific reasons for the referral of patients to the group. It was discussed with the nursing staff that all patients and staff were invited, and the staff assisted in encouraging all to attend the weekly sessions. When available, the nursing staff members were free to participate in the sessions.

The group consisted of geriatric patients at the psychiatric hospital, all aged sixty years and older, and nursing staff members aged between forty and fifty years. The nursing staff members are African, speaking Sotho and Zulu. The patients are of African, English and Afrikaans cultures, whose home languages include English, Afrikaans, Sotho, Zulu and Tswana. I am a Caucasian female, as is my fellow music therapy intern, and we are of English and Afrikaans cultures respectively. All patients are male, whilst staff members comprise male and female persons.

The diagnoses of the group include a variety of chronic, long term, psychiatric disorders, including dementia (including Alzheimer's disease), schizophrenia, bipolar mood disorder,

behavioural disorders and psychotic disorders. All patients have been admitted to this psychiatric hospital for many years due to the chronic nature of their disorders, and a number of patients having lived in this ward for over twenty years.

The patients, when not involved in the music therapy group, seemed subdued and lethargic. Most of the day was spent sleeping or smoking outside with little social interaction or activity taking place. Interaction between staff and patients seemed perfunctory, with staff tending to daily needs and supervising activities of daily living such as personal care. Patients congregated in the dining room for meals, but generally this was an isolated affair, as there was little verbal exchange between them.

3.3 Report narrative

3.3.1 Overview of group

The sessions were held weekly in the lounge area of the psychogeriatric ward. Participants sat on comfortable chairs, in a large circle. Good ventilation and lighting was ensured to further promote comfort. After a greeting song, a variety of activities were introduced one at a time, including movement to music (dancing and exercises), group singing and improvisational playing of percussive instruments. Instruments used included djembe drums, hand drums, bongos, a triangle, a variety of shakers, and a tambourine. Group members could play an instrument of their choice. Songs included English, Afrikaans, Zulu, and Sotho songs and ranged in style from sixties pop, to folk songs. Members were encouraged to suggest songs for the group to sing. Sessions ended with a greeting song that remained consistent each week to provide a sense of continuity and predictability throughout the process.

Altogether thirteen sessions were held, and six of these sessions were video-taped. The two music therapy interns alternated facilitation of the groups, with the non-facilitating intern in the role of co-therapist. On average, the group consisted of approximately twenty group members, of which at least three were nursing staff members. Sessions were approximately 30-45 minutes in length.

3.3.2 Description of music therapy group process

Initially, the members of the group presented as low in energy, sluggish, slow to attend sessions, and required encouragement to participate musically. Vocally, members participated softly and tentatively, requiring much encouragement to suggest songs. Most members were generally quiet, showed little eye contact, and did not initiate conversations with therapists, staff or each

other. There was little laugher or expression of pleasure. Instrumentally, as a whole, the group played when asked to, and sang when asked to, reflecting an element of compliance prevalent in institutional behaviour. They 'obeyed' the therapist's verbal requests to play or not to play, and demonstrated very little independence, choice or initiative within the music. I'd like to demonstrate this compliant behaviour with a brief vignette.

> After the greeting song during session two I, as facilitating therapist, asked the group for a suggestion of a favourite song that we could sing together. The group members sat in silence. Some looked at me expectantly and others looked down. Even though the members each had instruments, no one was playing. After a brief time, when no one had suggested any songs, I began playing, on guitar, the opening chords for a traditional Afrikaans song, "Die Oukraalliedtjie". The co-therapist and I began singing and for a few seconds, we were the only two singing. Slowly the group joined us in singing the song.
>
> (Appendix iii is a lyric sheet of "Die Oukraalliedtjie")

There were many moments in the initial sessions that the group showed aspects of compliance. They seemed content to follow the therapist's lead, showing little independence or autonomy. As therapists, we experienced ourselves as the distinct leaders of the group, whom all looked to for facilitation and guidance.

After an initial assessment period of approximately three sessions, which revealed a lethargic and indecisive group, the following aims were identified:

Therapeutic Aims –

- To provide opportunity for individual and group self-expression through music.
- To provide enjoyment, fun and celebration.
- To stimulate social interaction between members.
- To promote group development, cohesion and community in the ward.

Over the course of the thirteen weeks, opportunities for 'solo' playing emerged, with individual group members playing an instrument in the centre of the group (usually the snare and cymbal), with other members supporting by singing or clapping along. A change in atmosphere occurred during this phase, where group members began showing an eagerness to attend, improved self awareness and became more aware of others in the group. Members looked at each other as they began singing each others' names in the greeting songs. The validation they felt through

expressing themselves through music may have been a motivating factor. Group members began playing duets in the group, promoting social interaction, showing increased eye contact between therapists and members. It was at this stage that staff members began to participate more actively with patients, often playing alongside patients, watching them, and laughing with them. The staff members added their more active and excitable energy to the group. Musical dynamics (changes in volume, such as loud and soft) in the group were raised and, although the energy remained low at the beginning of sessions, a more energized, stimulating experience could be facilitated with more ease. It is possible that this flexibility in the energy of the group may indicate an increased tolerance to different experiences, such as loud, soft, energized and calm. This may also demonstrate the 'entrainment' quality that music possesses: that group members were moved and motivated to participate in the music, and were 'pulled along' with the music. Instrumentally, the group showed more initiative in reaching for instruments and played with more confidence and alertness. The therapists continued to use musical, verbal and body language cues for the group members to follow, to ensure musical flow and variety. I include a short vignette:

> During session ten, the group was singing, a cappella, a traditional Zulu gospel song "Ga Gona Yo A Tshwanang Le Jesu" while we all stood in a large circle, swaying to the music. The music was legato, soothing and rich in harmony. In order to bring about variety in the musical elements of our singing, I used my hands and body to cue the group to sing louder, softer, faster or slower. The group members were watching me as I took the lead in this activity. A while later, another group member indicated with her body movements that we should sing softer and the group followed her lead.
>
> (Appendix iii is a lyric sheet of "Ga Gona Yo A Tshwanang Le Jesu")

A sense of musical interaction and togetherness seemed to have developed over the group process. The musical elements (dynamics and tempo) stimulated the group's cohesion in that as a group, they responded to the cues. Although I was leading this activity, the group showed greater awareness and interaction. There was a moment of initiative and a shift in roles as another group member took the lead. This group moved from a more individualized and differentiated (isolated) stage, as seen in the initial non-communicative playing, towards a more cohesive stage. Group members supported one another by observing, clapping, and giving verbal encouragement before and after members took their turns. Together, they supported suggestions of songs from various members by singing enthusiastically, thereby adding to a more cohesive experience of the group as a whole. In the last few sessions, certain members

(staff and patients alike) were confident enough to stand up and 'perform' a song in front of the group. Music therapy provided a safe space for self-expression. Humour and enjoyment were evident in the laughing and joking that occurred within sessions. Social interaction took place more frequently between patients and staff, and between patients themselves, in the most recent sessions. This seemed to carry over into the ward, as the singing of the goodbye song would often accompany members as they walked out of the lounge; the singing heard for some time after the session ended.

There were many significant moments highlighted in the music therapy process. These included moments of patients initiating social interaction (conversing) with the therapist and other group members; moments of helpfulness shown by members; independence demonstrated in members selecting their choice of instrument or suggesting songs; moments of laughter and fun in the group; and communicative eye contact held between facilitating therapist and members.

To summarize, the group seemed to move from being tentative, unmotivated, and lethargic to more energetic, lively, alert, and interactive. I will be focusing on three moments in this group process where aspects of personhood were experienced by individuals or the group. Based on the report narrative of the process of this group, clinical material was selected for analysis in order to answer the questions posed for this clinical enquiry. The selection thereof will now be outlined.

3.4 Selection of clinical work material

To reiterate, thirteen music therapy group sessions were held and six of these sessions were video-taped. All sessions included patients and most included staff members. It is from this clinical work that the clinical material was obtained. The material includes three pre-selected video excerpts from the music therapy groups, and information retrieved from the observation notes written after each group session.

3.4.1 Pre-selected video excerpts

Three short video excerpts were chosen from the video material of the groups. This medium was selected for use because film captures visible phenomena objectively and is valuable for discovery and validation (Schurink *et al.*, 1998). The density of data is greater than any other kind of recording, and it is possible to review events as often as necessary (Schurink *et al.*, 1998). Bottorff (in Schurink *et al.*, 1998) further states that video presents an accurate reproduction of events and behaviours. The three video excerpts were chosen through a

process of purposive sampling, for their application to the questions I posed. The excerpts reflected significant moments between group members. Through a process of peer review and group supervision, harmful bias was eliminated, and credibility of the excerpts ensured. It was decided that these video excerpts did, indeed, portray moments of personhood.

As two of the sub-questions I posed dealt with personhood of staff and patients, I ensured that two of the video excerpts portrayed the musical participation of one staff member and one patient respectively. The other excerpt portrays a non-musical moment between two patients. A detailed, thick description of each video excerpt then took place. Describing is the process of putting into words what a person sees or hears from another modality, to preserve and share knowledge (Pavlicevic & Ansdell, 2001). Contextual and musical events in the group were described, as viewed in each excerpt, without interpretation. Supervision and peer review ensured the accuracy of these thick descriptions.

I have included below a diagram and thick description of video excerpt 1.

Video excerpt 1: A helps J to retrieve the djembe drum

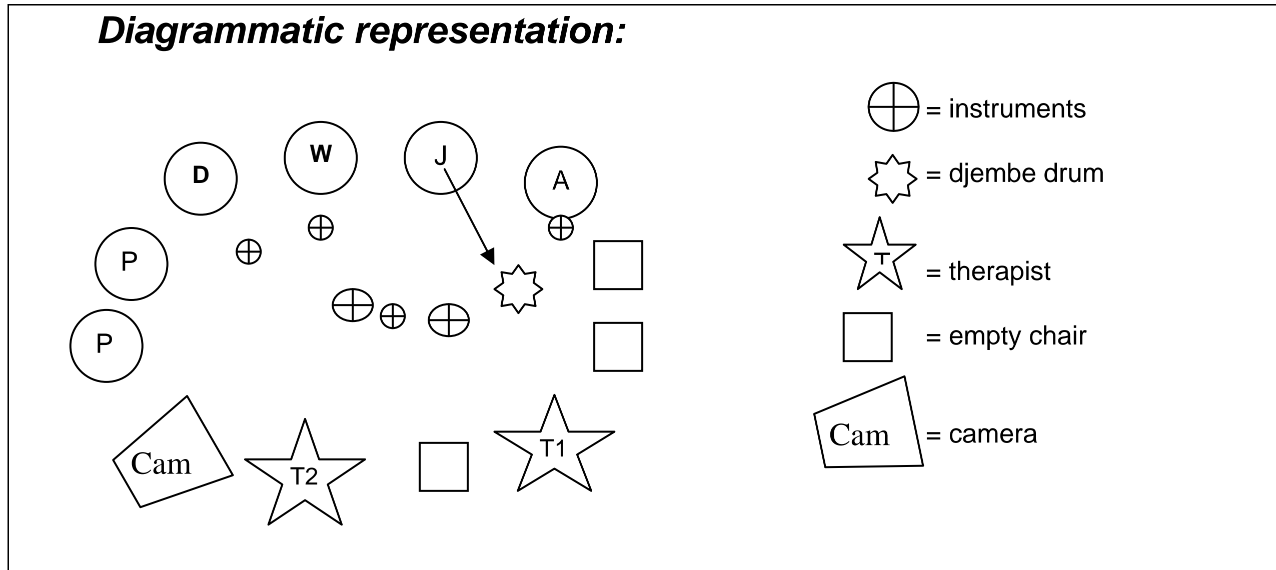


Figure 3.1 Video excerpt 1- layout of group

This diagram does not show all group members. It aims to show the position of relevant members.

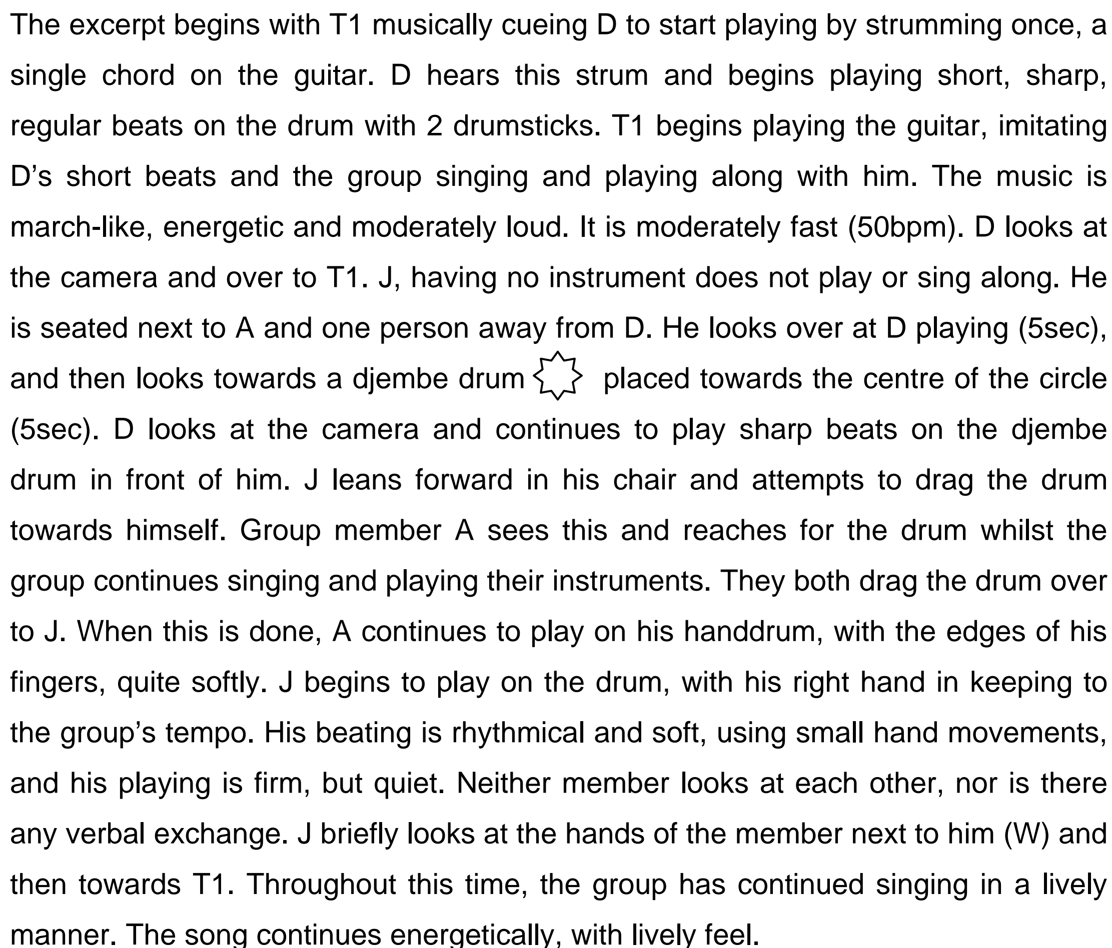
Context:

This fourth music therapy session takes place in the spare lounge on the ward. All patients and nursing staff were invited to participate, however the nursing staff

members were unavailable. The group consists of approximately 15 patients, who are seated, as per usual, on chairs and couches in a circle.

Prior to the excerpt, the therapist is playing the guitar, and group members are playing a variety of percussive instruments, including djembe, bongo and handdrums, and smaller instruments such as shakers. The instrumental song is a Negro Spiritual song, “Oh when the Saints”, that is known to the group. The therapists have initiated a turn-taking activity that involves members standing up and playing the snare drum and cymbal placed in the centre of the circle as a ‘solo’ opportunity. The rest of the group is free to sing and play along with the soloist. The therapists attempt to adapt the group’s song to the speed, volume and tone of the soloist’s playing. J has just had his turn in the middle and is seated without an instrument in front of him. D is holding the two drumsticks, having just been offered a turn to play. He chooses to stay seated and play his djembe drum with the beaters instead of standing in the middle.

Excerpt description:

The excerpt begins with T1 musically cueing D to start playing by strumming once, a single chord on the guitar. D hears this strum and begins playing short, sharp, regular beats on the drum with 2 drumsticks. T1 begins playing the guitar, imitating D’s short beats and the group singing and playing along with him. The music is march-like, energetic and moderately loud. It is moderately fast (50bpm). D looks at the camera and over to T1. J, having no instrument does not play or sing along. He is seated next to A and one person away from D. He looks over at D playing (5sec), and then looks towards a djembe drum  placed towards the centre of the circle (5sec). D looks at the camera and continues to play sharp beats on the djembe drum in front of him. J leans forward in his chair and attempts to drag the drum towards himself. Group member A sees this and reaches for the drum whilst the group continues singing and playing their instruments. They both drag the drum over to J. When this is done, A continues to play on his handdrum, with the edges of his fingers, quite softly. J begins to play on the drum, with his right hand in keeping to the group’s tempo. His beating is rhythmical and soft, using small hand movements, and his playing is firm, but quiet. Neither member looks at each other, nor is there any verbal exchange. J briefly looks at the hands of the member next to him (W) and then towards T1. Throughout this time, the group has continued singing in a lively manner. The song continues energetically, with lively feel.

Please refer to Appendix iv for the full thick descriptions and diagrammatic representations of all three video excerpts. Appendix iii contains the lyrics of “Die Oukraalliedtjie”, “Ga Gona Yo A Tshwanang Le Jesu” and “Oh When the Saints”.

In addition to the three video excerpts, observation notes were included as part of the clinical material.

3.4.2 Observation notes

As part of the requirements of music therapy clinical internship, observation notes (also known as session notes) are written after each individual and group session. These notes include a description of the session plan, the process, as well as interpretations based on the general participation and individual/group dynamics. Such observation notes assist us, as music therapy interns, to discover significant moments in sessions, to identify goals for the group, and to plan for following sessions. Throughout this music therapy process, thirteen observation notes were written (as thirteen sessions were held). Please refer to Appendix v for a sample of a single session’s observation notes.

The use of these observation notes for this clinical enquiry will provide further information to compliment the video excerpts, and will contribute to the analysis of the clinical work. The observation notes form part of the process and development of the music therapy group throughout the thirteen weeks, thus all observation notes were used, to preserve qualitative information. After reading through the observation notes of each session, information and interpretations that described or revealed moments of personhood were lifted out of the main text. This information was placed on a separate document in the format of a table, along with from which session the text originated, ready for analysis.

Session no	Main Text
2	[Afrikaans Traditional Song] initiated by client: All took ownership of this song. 1 black staff member even initiated it again saying, “It’s lekker!”
2	Rich harmony and a sense of connection flowed. The song continued for very long: some staff danced, one even closed his eyes.
2	The African staff (all are African) took ownership of even this ‘white’ Afrikaner song, adding their own African harmony to it.
3	The men enjoyed being greeted by hand – many made eye contact and there were some smiles.

4	There were some moments of personhood that were illuminated in the group: J smiling and chatting to me; R coming up by himself to play the drum and cymbal; K assertively taking instruments without prompting; J taking djembe and A helping him get to it.
5	Gradually the group energy built louder vocal participation and clapping. Staff investment increased markedly when they were also invited and encouraged to 'solo'. Laughter and giggles.

Figure 3.2 Sample of main text lifted from observation notes

Please refer to Appendix vi for the full list of extracted information from the observation notes. This concludes the discussion of the preparation of clinical work materials. The following chapter addresses the analysis of the selected material in detail, including the coding, categorizing and identification of themes.

PART 2

CLINICAL WORK ANALYSIS AND INTERPRETATIVE DISCUSSION

Chapter 4

CLINICAL WORK ANALYSIS

Through the analysis of my clinical work, I aim to explore how music therapy can nurture personhood in an open music therapy group, as well as how the personhood of both patient and nursing staff member may be fostered. In order to analyze the work, I employed the qualitative research methods of coding, categorizing and identifying themes. This chapter describes the process of analysis of the selected clinical material.

After the selection and preparation of the video excerpts and observation notes, as discussed in the previous chapter, this clinical material was ready for analysis. Throughout the analysis, peer review and supervision ensured that credibility was upheld, and negative bias eliminated.

4.1 Coding

Coding is defined as analytic labeling (Pavlicevic & Ansdell, 2001). The coding of the transcripts aims to break up the information into smaller meaningful chunks.

4.1.1 Video excerpts

The thick descriptions of the video excerpts were broken up into discernable segments. Each discernable segment, or chunk of information, was numbered and a code constructed for each. The numbering assisted when it was necessary to refer codes back to the original sentence later in the process. At times, several codes per segment were identified, with all codes remaining relevant to the questions posed. Again, through a process of peer review and supervision, negative bias was eliminated.

The following is a sample of the numbered text and the relating codes from video excerpt 1. Please refer to Appendix vii for the full text and codes of each video excerpt. Note: The main text was numbered from 1.1 with the first number (1) denoting video excerpt 1.

Main Text	Code
(1.9) The therapists attempt to adapt the group's song to the speed, volume and tone of the soloist's playing.	1.9.1 T matching soloist 1.9.2 T adapting to soloist's musical offering 1.9.3 Clinical technique of matching
(1.10) J has just had his turn in the middle and is seated without an instrument in front of him.	1.10.1 'J' no instrument 1.10.2 Choice to not play
(1.11) D is holding the two drumsticks, having just been offered a turn to play.	1.11.1 Offered a turn 1.11.2 Anticipation of musical participation
(1.12) He chooses to stay seated and plays his djembe drum with the beaters instead of standing in the middle.	1.12.1 Choice 1.12.2 Decision-making 1.12.3 Autonomy
(1.13) The excerpt begins with T1 musically cueing D to start playing by strumming once, a single chord on the guitar.	1.13 Musical cue
(1.14) D hears this strum and begins playing short, sharp, regular beats on the drum with 2 drumsticks.	1.14.1 Musical awareness of soloist 1.14.2 Instrumentally active
(1.15) T begins playing the guitar imitating D's short beats and the group singing and playing along with him.	1.15.1 Clinical technique of matching 1.15.2 Group supporting soloist
(1.16) The music is march-like, energetic and moderately loud.	1.16 Loud, energetic march
(1.17) It is moderately fast (50bpm).	1.17 Tempo is moderately fast
(1.18) D looks at the camera and over to the therapist.	1.18.1 Awareness of camera

Table 4.1 Sample of coding of video excerpt 1

4.1.2 Observation notes

The identified sentences, lifted out of the observation notes, were also divided into discernable segments, and each segment was numbered and coded. As in the case of the video excerpts, at times, there were several codes per segment.

Below is a sample of the numbered text and relating codes from the observation notes. Please refer to Appendix viii for the full text and codes of the observation notes.

Main Text	Code
(1) [Traditional Afrikaans Song] initiated by client: All took ownership of this song. (2) One black staff member even initiated it again saying, "It's lekker!"	1.1 Traditional Afrikaans song; 1.2 initiative; 1.3 ownership; 1.4 autonomy; 1.5 investment; 2.1 staff initiative; 2.2 enjoyment; 2.3 exclamation of pleasure
(3) Rich harmony and a sense of connection flowed. (4) The song continued for very long: some staff danced, one even closed his eyes.	3.1 harmony; 3.2 connected; 3.3 togetherness; 4.1 perseverance; 4.2 attention; 4.3 dancing; 4.4 enjoyment; 4.5 absorbed; 4.6 long duration; 4.7 pleasure; 4.8 expression of emotion
(5) The African staff (all are African) took ownership of even this 'white' Afrikaner song, adding their own African harmony to it.	5.1 African; 5.2 ownership; 5.3 cross-cultural; 5.4 song; 5.5 harmony; 5.6 creativity
(6) The men enjoyed being greeted by hand – many made eye contact and there were some smiles.	6.1 enjoyment; 6.2 physical contact; 6.3 eye contact; 6.4 pleasure
(7) There were some moments of personhood that were illuminated in the group: J smiling and chatting to me; (8) R coming up by himself to play the drum and cymbal; K assertively taking instruments without prompting; J taking djembe and A helping him get to it.	7.1 moments of personhood; 7.2 social interaction; 7.3 conversing; 7.4 pleasure; 7.5 autonomy; 7.6 independence; 8.1 initiative of social contact; 8.2 confidence; 8.3 assertiveness; 8.4 eagerness; 8.5 helpfulness; 8.6 sense of others; 8.7 social interaction

Table 4.2 Sample of coding of observation notes

The codes from the video excerpts and the observation notes were then pooled. At this point, duplication of codes appeared, so these were removed and only one of each was retained to avoid repetition (e.g. the code 'initiative' appeared eight times, but only one was retained in the final list of codes). Below is a sample list of some of the final codes retrieved from the clinical material.

Absorbed Active participation Anticipation of musical participation	Acceptance Accompaniment Acknowledgement Awareness of another needing help	African Gospel song Choice Choice of next performer Choice to not play

Attention	Awareness of camera	Communicative eye contact
Clinical decision by T	Awareness of group's tempo	Conversing
Clinical technique of matching	Awareness of others	Cooperation with another
Dancing	Awareness of T	Deep, focused voice
Eagerness	Clapping in support	Energising elements
Group leads	Cohesion	Eye contact/looking at T
Group provides	Connected	Firm singing
Helpers	Cross-cultural	Firm, light melody
Investment	Different experiences	Group laughs with soloist
Involved	Encouragement	Group member suggests song
J not instrumentally active	Enjoyment	Harmony
Leader role	Exclamation of pleasure	Helps group member
Longer duration	Experience others	Known song
Motivation to be part of group	Expression of emotions	Loud, energetic march
Music on ward	Feelings	Loud, rhythmical playing
Musical cue	Fun	Negro Spiritual song
Musical partners	Group alert/aware	No eye contact/verbal exchange
Negotiation	Group clapped	Promote awareness of others
Ownership	Group singing lively	Recognition
Participating	Group supporting soloist	Sense of others
Partnership	Group watching soloist	Social interaction

Table 4.3 Sample from full list of codes

Please refer to Appendix ix for the complete list of codes of the clinical material.

At this point, I noticed that several of the codes were similar in nature, for example 'choice', 'choice of next performer' and 'choice not to play'. I did not collapse these into one code of 'choice' as I felt that in order to answer my questions, this qualitative information may be necessary. I therefore kept these codes as they appeared. The list of codes was then ready to be placed into categories.

4.2 Categorising

According to Pavlicevic and Ansdell (2001), a category is a mutually exclusive 'meaning box', which allows for detailed definition and comparison. The codes identified from the selected material were organized at a higher level, into mutually exclusive categories. The enquiry

questions regarding the role music therapy plays in nurturing personhood, as well as the literature dealt with in chapter 2, informed the selection of categories. Once again, through peer review and supervision, credibility of this process was guaranteed and negative bias reduced.

Each code was placed into a mutually exclusive category as shown below:

Category	Codes	
Sense of agency (The integrated psychological components that effect individual's quality of 'being' and 'doing')	Accomplishment Assertiveness Autonomy Choice Choice of next performer Choice to not play Confidence Creativity Decision-making Free Free to play/sing	Group member suggests song Independence Initiative Initiative of social contact Own choice of song Reaches for drum Spontaneity Staff choice to participate Staff initiative Stand/walk to centre of circle Unique experience
Motivation / investment (The desire to be involved in the group and quality of participation)	Absorbed Attention Eagerness Investment Involved	Longer duration Motivation to be part of group Perseverance Reluctance to leave Staff investment
Musical participation (This describes what the group/individuals participated in)	Instrumentally active Group singing lively Active participation Dancing Group joins in vocally J not instrumentally active No instruments	Participating Percussive instruments Rhythmical body movements Slow to react T playing guitar Vocally active Turn-taking activity
Group awareness and support (The acknowledgement of group members of each other's presence and individual musical	Acceptance Accompaniment Acknowledgement Awareness of another needing help Awareness of camera Awareness of group's tempo	Group clapped Group supporting soloist Group supports through singing Group watching soloist Helpfulness Musical awareness of soloist

contributions)	Awareness of others Awareness of T Brief silence as quiet member sings Clapping in support Cohesion Connected Cross-cultural Different experiences Encouragement Experience others Group alert/aware Group awareness of soloist's energy	Mutuality Offers turn to another Plays bongos in rhythm to soloist Promote awareness of others Recognition Sense of others Support for performance Supportive Supportive atmosphere T adapting to soloist's musical offering Together moving drum Togetherness Tolerance
Group interaction (Any interaction or communication between group members)	Communicative eye contact Conversing Cooperation with another Eye contact/looking at T Helps group member	Interaction between staff and patients No eye contact/verbal exchange Social contact Social interaction Verbal exchange Verbal/social interaction
Roles (The identity or responsibilities that individuals/group take on within the music therapy group)	Anticipation of musical participation Clinical decision by T Clinical technique of matching Group leads Group provides Helpers Leader role Music on ward Musical cue Musical partners	Negotiation Ownership Partnership Staff as equal members Staff roles T clinical intervention T encouraging T encouraging/supporting T leads activity
Expression of emotions (The verbal or body expression of emotion)	Enjoyment Exclamation of pleasure Expression Expression of emotions Feelings Fun Group laughing	Group laughs with soloist Humour Pleasure Self-expression Smiles/laughing Soloist smiling

Musical elements (The quality and variety of elements used in music therapy with this group. It may indicate musical expression)	Aesthetic music African Gospel song Deep, focused voice Definite melody, firm rhythm Dynamics Energetic feel Energetic music Energising elements Firm singing Firm, light melody Harmony Known song Loud, energetic march Loud, rhythmical playing	Moderate march Negro Spiritual song Playful energy Playful, purposeful, strong Purposeful energy Regular, firm shaking of maracas Rhythmical, soft, firm, quiet playing Singing clear, loud Singing harmonies Singing more energetic Slow, strong, loud Soft, strong playing Tempo is moderately fast
Performance of self (The appearance of the opportunity for performing musically in front of the group)	Member playing solo Staff member performed Soloing Offered a turn	Solo opportunity Staff solo opportunity Improvised song Performance
Therapeutic space (The space in which the group functioned)	Musical time Safe musical space Seated in circle on chairs Seated with others	Staff and patients included Therapeutic space Ward lounge

Table 4.4 Codes in mutually exclusive categories.

With the codes placed into mutually exclusive categories, I then identified emerging themes.

4.3 Identifying emerging themes

Upon review of the categories, with reflection on the enquiry questions and literature review, four themes emerged. Most categories led to more than one theme, hence the overlap of some categories between the themes. This seems appropriate, as themes are not mutually exclusive, and more than one theme could be identified with many of the categories.

4.3.1 Description of theme 1: Opportunities for growth of personal worth

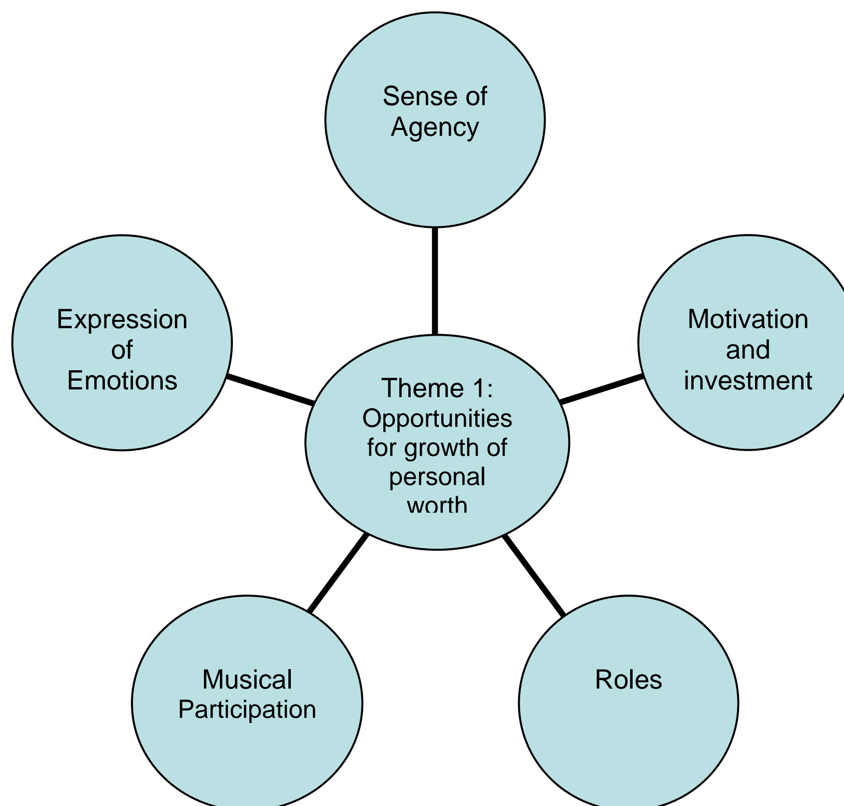


Figure 4.5 Theme 1

Throughout the music therapy group process that took place over the thirteen weeks, growth of personal worth took place. In the context of the psychogeriatric ward, there is little opportunity for promotion of personal worth outside of music therapy. The patients rarely participate in activities that provide them with a sense of agency, mastery or achievement (Sense of agency includes concepts such as confidence, autonomy, independence, initiative). This exacerbates the institutionalized nature of patient's being. Through musical participation and the encouragement of choice, autonomy and independence, a sense of agency developed in individuals and in the group as a whole. Through active musical participation, which included opportunities for performing for their fellow members, the group was provided with opportunities to express emotions and become invested in their group's music. The group members were enabled to experience different roles – drawing on their abilities, rather than their inabilities. They were empowered to become functional members of this group, and their investment in the activities, and the group as a whole, was promoted. Their personal and group self-worth was elicited in a context initially characterized by apathy and disempowerment.

4.3.2 Description of theme 2: Experience of a changing group and self identity

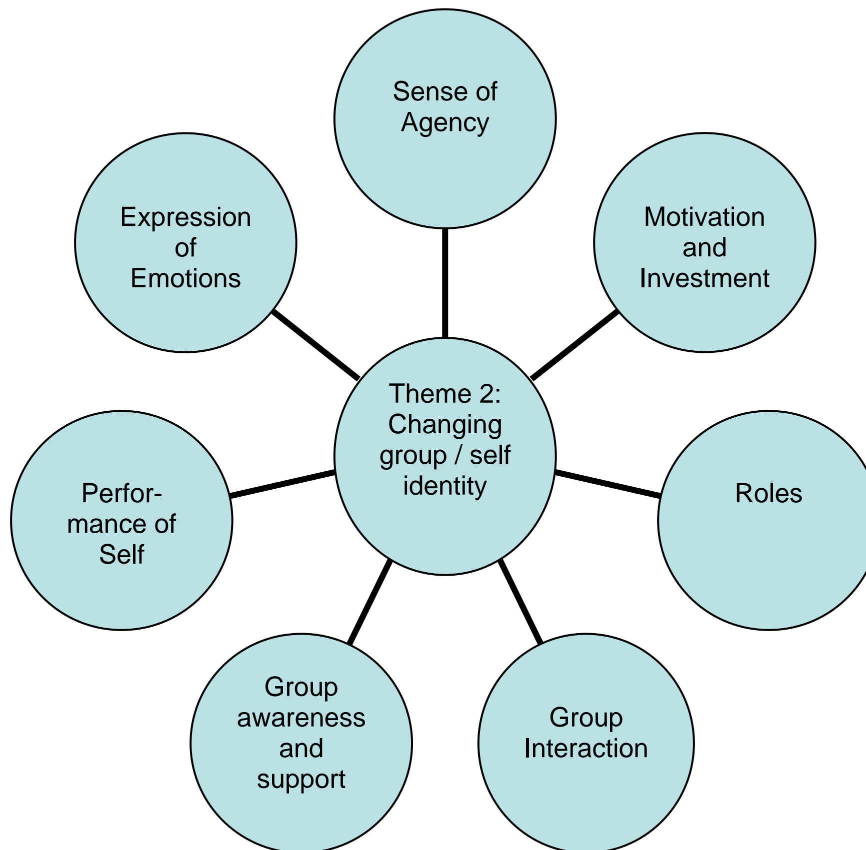


Figure 4.6 Theme 2

As a group of patients, nursing staff and therapists, identities were clearly defined at the beginning of the music therapy process. Leader roles clearly belonged to the therapists, revealing a limited sense of agency in individuals and minimal group interaction. As awareness of self and others grew, members began to support others during their musical performances and share moments of expression of emotions (e.g. laughter). Members gained the confidence to perform and express themselves. Consequently, the roles of individuals changed as they became musicians, performers, partners in music, leaders of activities, decision-makers and communicators. They were no longer 'mentally ill patient' and 'healthy staff member', but members and partners in a musical experience. The identity of the group changed to a more invested, interactive, negotiating group, who were able to manage different roles. This was in contrast to the group atmosphere and dynamics at the start of the music therapy process.

4.3.3 Description of theme 3: Community: Being in social relationship with others

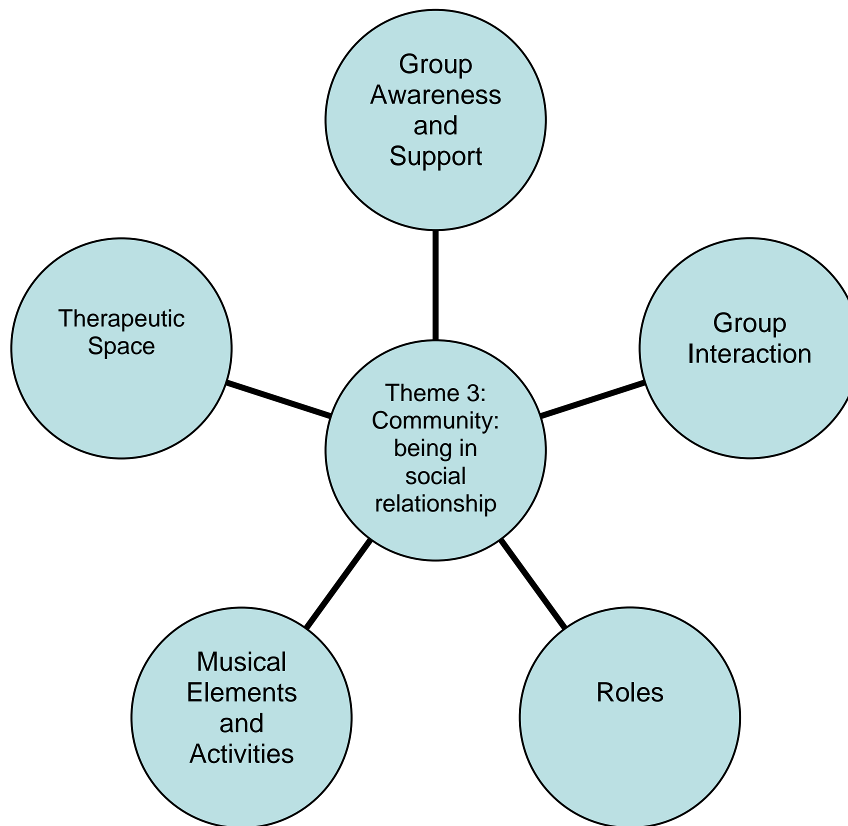


Figure 4.7 Theme 3

The institutionalised behaviour of this client group was largely due to the severely limited opportunities for them to experience mutual, trusting, interpersonal relationships. Although this group is a community in the context of the ward, there was little interaction or relationship in this community. In the therapeutic space, which maintained a supportive atmosphere, group members became aware of and supportive of each other. Through the use of music elements and activities, group members began relationally interacting with each other, whether in the music (e.g. playing a duet) or out of the music (e.g. helping another reach for a drum). These phenomena appeared between staff and patients alike. Thus, as they began interacting in a more social manner with their fellow group members, a perceived sense of community began developing on the ward, hence the emergence of this theme of social relationship.

4.3.4 Description of theme 4: Musical interplay: Expression through music

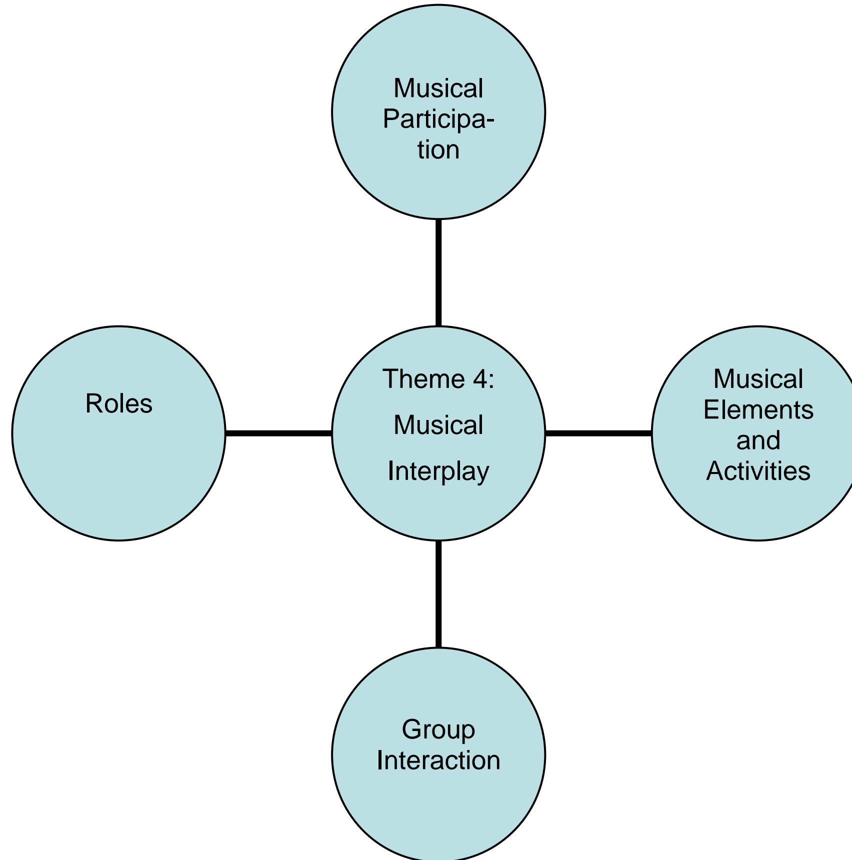


Figure 4.8 Theme 4

It is important to include a musical aspect in the themes relating to the type of music, musical participation and how the musical elements were used. Musical interplay between members in various activities (e.g. turn-taking activities) was facilitated through active participation in music, and through the role of the therapists. Interaction between members took place on a musical level, and transferred to their general group social interaction, as demonstrated by the moments of personhood. This, in turn, affected the roles that members played during the group. Members were able to express themselves through music-making. The development of interaction, different experiences of others and themselves, along with musical expression through musical elements, prompted the emergence of the theme, ‘musical interplay’.

Please refer to Appendix x for a full table of codes, categories and emerging themes.

4.4 Conclusion

The process of analysis of clinical materials, i.e. developing codes, categories and identifying emerging themes, was described in detail in this chapter. Four themes emerged from the analysis of this clinical work. In brief they are:

- Opportunities for growth of personal worth
- Experience of a changing group and self identity
- Community: Being in social relationship with others
- Musical interplay: Expression through music

In the following chapter I return to the questions posed, which arose from my clinical work, and discuss them, referring to literature and the above emerging themes.

Chapter 5

INTERPRETATION AND DISCUSSION

The focus of this clinical enquiry, based on my area of interest, is the exploration of how music therapy nurtures the personhood of members of an open ward music therapy group. In this chapter, the themes that emerged from the analysis of the clinical material will be discussed in relation to the literature gathered and the questions posed.

In the previous chapter, I gave a description of each theme. Now, in order to answer the enquiry question of how music therapy nurtures the personhood of patient and staff member, I decided to present a diagram that may reveal how these moments emerged in therapy, and what led to the moments, or experience, of personhood. Music therapy is a process which occurs over a time period. It seemed that the moments of personhood, or general nurturing of personhood, was a process which relied on various happenings and developments in the group. The flow of the diagram, represents that development (flow) of the group over time. It is also symbolic of the flow in the actual sessions towards the end of the process.

I have incorporated the themes in the discussion of the diagram, and will refer to relevant literature. To reiterate, the four emerging themes are:

- Opportunities for growth of personal worth
- Experience of a changing group and self identity
- Community: Being in social relationship with others
- Musical interplay: Expression through music

5.1 Interpretation and process

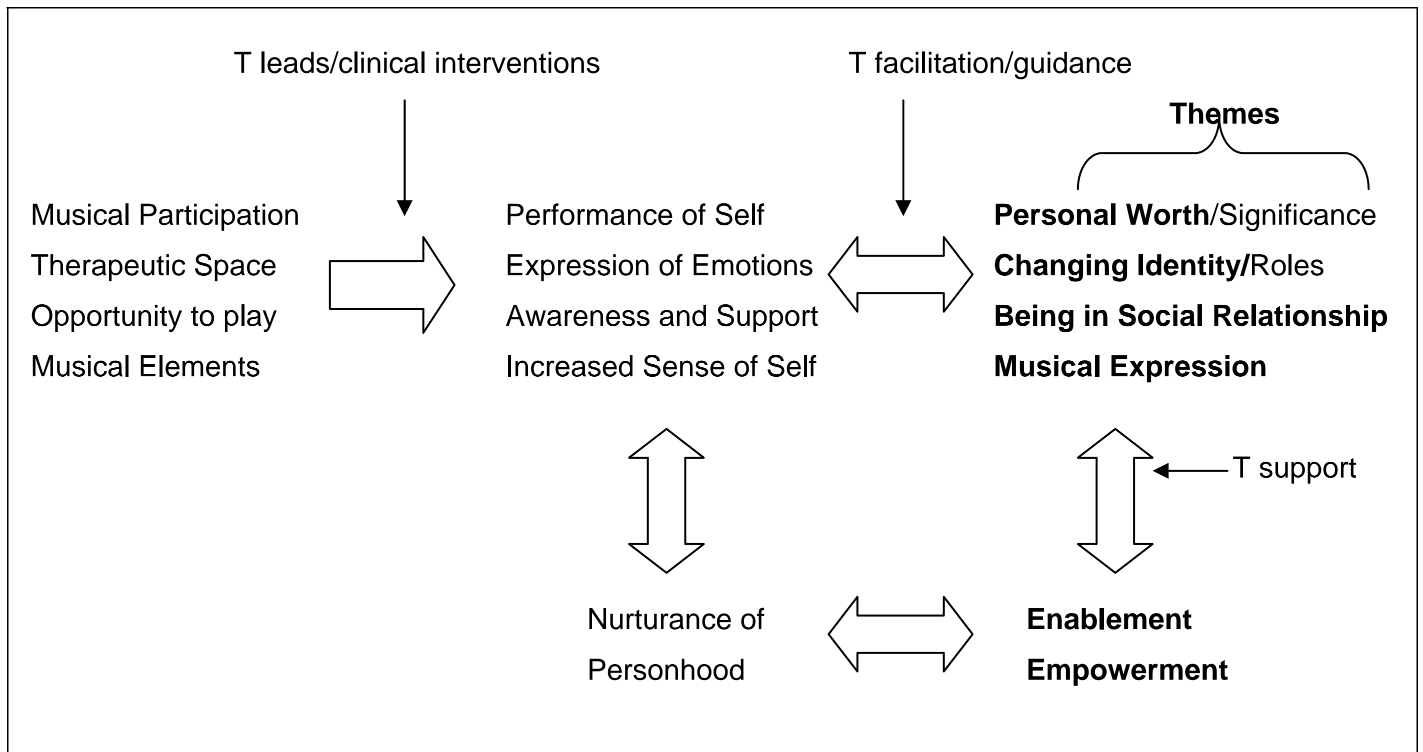


Figure 5.1 The process of nurturing personhood

In exploring how music therapy nurtures personhood, it seemed that the development of the themes took place in a flowing manner over time, beginning with the therapeutic space and the individual's opportunity to be involved in communal musical activity. What music therapy provided, together with the role of the therapist, led to the enablement and empowerment of the individual and group, allowing for the nurturance of personhood. The nurturance of personhood also leads back to increased expression of emotions and awareness, as depicted in the diagram. The themes are interwoven, which indicates that nurturance of personhood is not based on only one aspect, but on the interaction of several experiences and happenings in the group. These happenings/themes do not appear consecutively, but rather simultaneously. They also are not unidirectional, but rather move along the diagram cycle. Although the scope of this clinical analysis was not to explore change over time, it was my clinical observation that many aspects that will be discussed below, occurred over a time period as the group developed during music therapy.

I now address each of the themes in relation to the questions and the diagram above.

5.2 Addressing question 1, 2 and 3: How does music therapy nurture personhood in an open group on a psychogeriatric ward? How does music therapy nurture the personhood of the patient and staff member?

5.2.1 Theme 1: Opportunities for growth of personal worth

In some of the literature gathered regarding psychiatric patients, malignant social psychology and institutionalization (Kitwood, 1990; Kitwood & Bredin, 1992, 1997; Nolan *et al.*, 2004) emphasis is ostensibly placed on the concept of disempowerment. The nature of the group, as described in our initial phase of the music therapy process, complies with the description in literature of typical, institutionalized behaviour. The group was apathetic, dependent on the therapists, and lacked initiative. The clinical report, drawn up from my clinical observations as therapist documented that following:

> Initially, the members of the group presented as low in energy, sluggish, slow to attend sessions, and required encouragement to participate musically. Vocally, members participated softly and tentatively, requiring much encouragement to suggest songs.

Aspects of malignant social psychology were present, especially disempowerment, infantilization and labeling. Patients were expected to be, and labeled, 'unable' and so tasks were performed for them. This kind of treatment of the patients was obvious in the initial music therapy groups. The staff members would often 'command' patients to sing or play, shake their instruments for them, or pass patronizing looks towards us, as therapists, or between themselves, when a patient seemed to respond inappropriately, or not at all. During music therapy sessions, opportunities were created which nurtured the relationship between staff and patients, through music played within the therapeutic space. Opportunities for empowerment were provided, such as performance of self, expression of emotions, and edification of sense of agency. Simultaneously, group awareness and support began to increase, which further stimulated the above-mentioned aspects. Referring back to the clinical report, it was noted that in the third excerpt that there seemed to be more eye contact and group support between members than had been experienced in previous excerpts:

> When B doesn't immediately react, another group member suggests a song for the group to sing. The group is watching this verbal exchange. Suddenly B stands up and with the group watching, walks purposefully to the centre of the circle.

Personal worth, sense of agency, social confidence and hope (based on the expression of the twelve indicators of well-being) are the four global states, according to Kitwood & Bredin (1992). In this music therapy group, we experienced almost all of the twelve indicators of well-being. For example, the helpfulness displayed by person A toward person J in video excerpt 1, and the initiation of conversation (social contact) demonstrated by some patients during the later sessions. The twelve indicators of well-being draw on the concept of personhood. The opportunities for the emergence of well-being grew out of the musical participation, together with the therapist's use of clinical techniques and interventions. The input we provided in our roles as therapists, helped to facilitate the development of sense of self, as well as the support and awareness of others. This provided a context in which group members could perform, be recognized, respected and trusted. This was apparent in the support and encouragement shown to members by their peers. The following is taken from the clinical report (3.3.2):

> Over the course of the thirteen weeks, opportunities for 'solo' playing emerged, with individual group members playing an instrument in the centre of the group (usually the snare and cymbal), with other members supporting by singing or clapping along.

The following excerpt from the clinical report also highlights the support and encouragement between group members, as observed by myself as therapist:

> Group members supported one another by observing, clapping, and giving verbal encouragement before and after members took their turns. Together, they supported suggestions of songs from various members by singing enthusiastically, thereby adding to a more cohesive experience of the group as a whole.

Turning to McCormack's concepts, support and encouragement links with 'being in place' and 'being with self', which leads to a more person-centered approach (McCormack, 2004).

Although literature regarding personhood focuses mainly on those with dementia, in this group, it seemed that all patients required promotion of personal worth and relationship, regardless of their diagnosis. This observation can be extended to the staff members, who also initially showed little motivation, initiative and social confidence. Upon reflection on the staff member's personhood, it became apparent that their personal worth developed over the music therapy process. Group members seemed to be experiencing what Nolan *et al.* (2004) described, in the

senses framework, as relationships that promoted a sense of purpose, continuity, achievement and significance. Members seemed to be recognized, respected and trusted by group members.

This was reflected in how the staff treated those around them. Under the guidance of the therapists, the staff began to wait for, and support patients, rather than 'perform' or 'do' for them. Staff showed more patience and were better able to acknowledge the patients, showing their support, whilst participating with them in music-making. This concurs with Nolan's view in the literature, that staff are better able to support older persons if they, themselves, feel valued and supported (Nolan, *et al.*, 2004). The staff seemed to experience the patients differently, as they witnessed the patients' developing sense of agency and musical abilities. They appeared to be more attuned to the patients' emotional needs of validation and acceptance. This resulted in a decrease in the appearance of aspects of malignant social psychology in the group. The following was clinically observed, as noted in the clinical report (3.3.2):

> It was at this stage that staff members began to participate more actively with patients, often playing alongside patients, watching them, and laughing with them. The staff members added their more active and excitable energy to the group.

It seemed that the staff were seeing past the 'mask of ageing' and psychiatric illness, and experiencing the humanness and abilities of the patient. In turn, the patients witnessed a different aspect of the staff – no longer as 'in charge' decision-makers, but as equal partners in the music-making. Although the scope of this clinical analysis was not to explore change over time, I, as therapist, clinically observed these changes, which were linked to the music therapy process.

5.2.2 Theme 2: Experience of a changing group and self identity

Congruent with the dependent and apathetic institutionalized behaviour sensed initially from the group, we as therapists, experienced the roles of leaders, providers and stimulators. There was a level of compliance from the group, as members 'obeyed' the facilitating therapist's requests for musical participation, and waited for her input as clinically observed by the therapist in the clinical report (3.3.2):

> Instrumentally, as a whole, the group played when asked to, and sang when asked to, reflecting an element of compliance prevalent in institutional behaviour. They 'obeyed' the therapist's verbal requests to play or not to play,

and demonstrated very little independence, choice or initiative within the music.

Due to institutionalization and the effects of malignant social psychology, the sense of self and self-identity may be lost. When the person is marginalized or alienated, there is a decrease in personhood (Kitwood, 1990). In the context of this clinical enquiry, the routine and daily circumstances of the ward do not provide many opportunities for these elderly persons to express emotions or develop a sense of self or others. Institutionalization can often rid the patient of his or her former identity by placing them within the role of the mentally ill, incompetent patient. The ten aspects of malignant social psychology aggravate this condition. As mentioned, many of these aspects were apparent in the group - especially disempowerment, labelling, infantilization and invalidation. These aspects influenced the roles of the members, which were, at first, clearly defined in a hierarchal order as therapist, staff member and patient.

Including nursing staff members in the music therapy group was challenging. On the ward, outside of music therapy, nursing staff are the medicine providers and daily directors of the patients. Initially, they assumed helper roles, rather than group member roles. As personal worth and relationship began developing in the group, so we witnessed a change in the group and self-identity of the members. Within the therapeutic space, as the music therapy sessions progressed, the therapists' role became one of supporter and the members' roles became that of providers and negotiators of their own music-making. This shift in ownership of the group, allowed for the members, both patients and staff, to have more control over their music, to assert themselves and be empowered and enabled. An extract from the third video excerpt demonstrates an individual's empowerment:

> Suddenly B stands up and, with the group watching, walks purposefully to the centre of the circle. He picks of two maracas, one in each hand, and begins singing an African gospel song in a deep, moderately soft (mp-mf), focused, determined voice. At the same time as he starts singing, he shakes the maracas on the strong beat with regular, firm movements. The song has a definite melody, a regular, firm rhythm and a purposeful energy. There was a brief moment of silence from the group, as this normally quiet man begins singing.

B showed a definite sense of agency and motivation to express something of himself for the group. He experienced and expressed a different identity within this moment of personhood. The therapist's role in nurturing this personhood and expression of well-being was imperative. The

clinical decisions, application of music therapy techniques, and the choice of activities (known songs and turn-taking) seemed to play a role in nurturing personhood.

Nolan's sense framework (Nolan *et al.*, 2004) is underpinned by the belief that all parties involved in caring (the older person, family, carers) should experience relationships that promote a sense of belonging. Within the identity of this group, amidst the supportive atmosphere, staff and patients had the opportunity to feel 'part' of things, thereby promoting a sense of belonging. The inclusion of nursing staff members contributed to the community identity of the ward. The use of various traditional cultural songs, e.g. 'Die Oukraalliedtjie' and 'Ga Gona Yo Tshwanang le Jesu', enhanced the development of awareness, tolerance and a group identity. By using traditional songs, we were able to address cultural and musical identity of the group members, in order to enhance the quality of life, as mentioned by Amir (2004).

Thus, the group identity seemed to evolve from isolated, towards cooperative and supportive. Music therapy provided an opportunity for interaction on a variety of levels, including interaction between patients and staff members. Once again, the role of the individual was changing from a tentative onlooker to an active participant, contributor and co-owner of the group music. The sense of belonging and significance was promoted through the relationships built, which positively affected the group identity. Members were enabled and empowered as a group.

5.2.3 Theme 3: Community: Being in social relationship with others

One of the four concepts McCormack (2004) mentions that are key to person-centered nursing, is 'being in relationship'. It is in relationship that many of the twelve indicators of well-being (created by Kitwood and Bredin, 1992) can exist - such as humour, initiation of social contact, helpfulness and social sensitivity. Institutionalization negatively affects these aspects of well-being, which concurs with our initial experience of the atmosphere of the ward and the group. The limited social interaction on the ward interfered with patients' experience of social relationship. Other than perfunctory duties that were performed by staff, there was very little indication of relationship between staff and patients, and between patients themselves.

As Hilliard (2006) mentions, high emotional stressors contribute towards feelings of depersonalization. How staff members enact their roles on the ward is influenced by the working conditions, fatigue and lack of psychosocial support, which have all been linked to burnout (Hilliard, 2006). We noticed that the staff members on the ward generally appeared tired and were, thus, slow to attend to patients. The situation was further exacerbated by the high staff to patient ratio on the ward. It was important for us, as therapists, to work with the patients in their

context as Ansdell (2002) states, acknowledging their social and cultural health factors. In their context, this meant acknowledging the staff as social persons within their environment.

The therapist develops relationships with clients through music. Using clinical techniques such as matching and meeting, the therapist attunes to the person, like a mother attunes to her infant. As mentioned in the literature review (2.3.1), this group had the opportunity to be matched, met and attuned to by the facilitating therapist. A brief extract from video excerpt 2 shows the therapist listening, matching and meeting the member:

> He begins playing loudly, in a complicated rhythm and, after 6 seconds, T1 begins playing, matching his new style. It is the same song, but modulated to D major, louder, stronger and slower.

Through this attunement, the music-making, and the therapeutic space, a foundation is provided upon which a communicative, expressive relationship is formed. This relationship, according to Turry (in Bruscia, 1998), encourages personal growth in a client. As the members musically participated, and the relationship developed between persons in the therapeutic space, many aspects of well-being were demonstrated. Examples of this relationship include patient A helping J reach for a djembe drum in video excerpt 1. In video excerpt 2, we witnessed staff and patients laughing and supporting a staff member as she performs a solo. Video excerpt 3 illustrates a patient's assertiveness, sense of agency and expression of self and emotions, through a song he sings to the group.

Members, once in relationship, began interacting with each other in a healthier way, linking with what Turry (in Bruscia, 1998) states regarding communicative relationships. Group members were experiencing 'being in relation' through music, within the social context of the psychogeriatric ward. 'Being in relation' is imperative for the personhood of both parties, as it provides intersubjective experiences. In congruence with the concepts of subjectivity and intersubjectivity in literature (Pavlicevic, 1997; Kitwood & Bredin, 1992), the group members' subjectivity was enhanced as a sense of self, agency and the expression of emotions developed. Initially the therapists observed the following as mentioned in the clinical report:

> Most members were generally quiet, showed little eye contact, and did not initiate conversations with therapists, staff or each other. There was little laugher or expression of pleasure. They 'obeyed' the therapist's verbal requests to play

> or not to play, and demonstrated very little independence, choice or initiative within the music.

A change was noted as follows in the report (3.3.2):

> In the last few sessions, certain members (staff and patients alike) were confident enough to stand up and 'perform' a song in front of the group. Music therapy provided a safe space for self-expression. Humour and enjoyment were evident in the laughing and joking that occurred within sessions.

Members were thus able to interact in a more mutual manner with others. The therapists, patients and staff members connected, and experienced intersubjectivity, through the musical acts. Through the relationship that developed in music, intimacy and intersubjectivity was promoted. This, in turn, caused a shift from an 'I-It' relationship towards a more 'I-Thou' relationship (Buber, in Ansdell, 1995). The members, who were experiencing being in a musical relationship, became more responsive to each other. An extract from the clinical report narrative indicates the kind of relationship that was developing:

> Group members supported one another by observing, clapping, and giving verbal encouragement before and after members took their turns. Together, they supported suggestions of songs from various members by singing enthusiastically, adding to a more cohesive experience of the group as a whole.

During the music therapy groups, the relationships formed between group members appeared to have promoted a sense of security, continuity, purpose and achievement. This corresponds with Turry (*et al.*, 2004) in the statement that a sense of security is promoted through relationship. Within the secure therapeutic space, members felt sufficiently safe to perform, to express emotions, to freely participate or choose not to.

All group members had opportunity to become connected in a creative process, as facilitated by the therapists. According to Powell (2004), this connection appears in community music therapy approach, aspects of which we adopted in this setting. The sense of support that was experienced in the group, and the transference of musicking to the space outside music therapy, indicated that social and community upliftment took place on this ward. Through musical activity and facilitation from the therapists, interpersonal relationships and a sense of community,

developed. The group was empowered and enabled to be in relationship, therefore personhood was nurtured.

5.2.4 Theme 4: Musical interplay: Expression through music

A therapeutic space was created through the musical participation of all members. The musical relationship formed between therapists and group members, afforded opportunity to experience 'being in relationship' with another (see theme 3). As music therapists, we treat all group members holistically, relying on the emergence of the inherent 'music child', as noted by Nordoff and Robbins (1977). In accordance with the creative music therapy theory of the innate music child, group members were able to participate in musical interaction, even in the presence of mental or psychological disability. The musical activities and events in the group created a musical interpersonal relationship that allowed for expression.

In this psychogeriatric open ward group, it appeared that within the music interplay between members (including therapists), persons become enabled and empowered. In this context, and this group, the nurturing of personhood began with the therapeutic space and the individual's opportunity to be involved in a communal musical activity. The initial phase of the group provided these opportunities, and with the facilitating therapist's guidance, group members began to participate actively. They were free to play how they wanted to; free to choose to express that which they desired to. The use of clinically selected activities, use of variety in musical elements (e.g. tempo, dynamics and timbre) by the therapist, and the opportunity to play, stimulates development of expression of self. The members' use of musical elements and energy in their music, revealed the sharing of enjoyment, creativity and expression of self. These included expressions of energy, variety in dynamics and timbre, and creative rhythmical patterns. They were performing aspects of themselves for the group. An example of this is found in video excerpt 3:

> He picks up two maracas, one in each hand, and begins singing an African gospel song in a deep, moderately soft (mp-mf), focused, determined voice. At the same time as he starts singing, he shakes the maracas on the strong beat with regular, firm movements. The song has a definite melody, a regular, firm rhythm and a purposeful energy.

This group member expressed himself creatively and emotionally as he sang and played. This concurs with Amir's (2004) statement that community music therapy addresses the need for expression and creativity in humans. Taking part in the creative, musical act elicits the

psychiatric patient's 'humanness' (Simpson, 2000). During the group, we observed that elicitation of humanness in how the members began supporting, interacting and musically engaging with one another. This support and encouragement from others further motivated and enabled members to express themselves through their music.

During these moments, as well as musical interactive moments, for example the duet played between members in video excerpt 3, enablement and empowerment was promoted. It was within this musical interplay and musical participation that the moments of personhood emerged.

To reiterate, the scope of this clinical enquiry, was not to explore change over time, however, as clinically observed throughout the group process, changes did appear in individual and group behaviour indicating the emergence of personhood.

5.3 Addressing question 4: What implications might this have regarding the status and role of staff in music therapy groups?

Nursing staff members are an integral part of the community and context in which psychiatric patients live. The ability of nurses to provide person-centered care is affected by their own emotional, physical and psychological needs. The relationship between staff and patients is affected by the emotional state and personhood of both parties. However, in most music therapy groups, when staff members are included, they perform minor, perfunctory roles. In my personal experience both as occupational therapist and music therapy intern, the therapists generally host the group with the patients' needs in mind, often not including the staff as equal, participating members of the group.

In this clinical work, including the staff meant that relationships could be formed, based not on their expected roles, but on the shared music they were making, together with patients and therapists, as equal members of a music therapy group. This is encouraging, as positive nurse-patient relationships assist in rendering better quality care (Nolan *et al.*, 2004; Clarke *et al.*, 2003; McCormack, 2004; Ashburner *et al.*, 2004). This enquiry appears to confirm that acknowledging the nursing staff members' emotional needs, leads to the delivery of person-centered care (Ashburner *et al.*, 2004). In this music therapy open ward group, there appeared to be a more positive relationship between staff, therapists and patients. Staff encouraged, supported and validated the patients during their solo performances, as described in the video excerpts and clinical report:

Social interaction took place more frequently between patients and staff, and between patients themselves, in the most recent sessions.

Staff shared in the laughter and musical interplay in the group. Not only did this interaction provide the staff, themselves, with the opportunities for enablement and empowerment, and ultimately enhance their own personhood, it may have beneficially influenced the patient's personhood as well.

From this clinical enquiry it would seem that, where possible, staff members should be included as equal members of the group with the view that improving their personhood influences their relationships with patients positively. Within a music therapy group, the role of the nursing staff member need not be limited to helper or manager of patients' difficult behaviour. Their role and status may be seen as essential to the group due to the benefits to both themselves and patients. The implications are then, that staff should be included in music therapy groups.

5.4 Conclusion

As depicted in the diagram (5.1), in the context of this enquiry, the emergence and nurturance of personhood occurs while music therapy promoted enablement and empowerment of the individual and group. The enablement and empowerment, in turn, emerged from the promotion of personal worth, social relationship, changes in identity and the musical expression. Musical activities, together with the therapists' facilitation, interventions and clinical skills, guided the process of this group towards promoting aspects of well-being. Inclusion of the nursing staff meant that relationship could be fostered between them and the patients. The staff members were valued for their input, which created opportunity for them to value others. As staff's own personhood grew, they seemed better able to promote the personhood of the patient. Clinical observations by the therapist highlighted the emergence of personhood, by reporting the developments that took place in the group. Although this clinical enquiry did not aim to explore change over time, it was these developments that occurred throughout the group process that may signify the nurturance of personhood.

This would imply that, in the future work on this ward, the role of the nursing staff member in music therapy groups should be reconsidered. It can be recommended that staff be included as equal members in music therapy groups, so as to promote their own personhood, as well as that of the patient. Considering the themes that emerged from this clinical enquiry, I would like to propose that research, within music therapy, be done in the area of staff and patient

personhood, and also the area of person-centered care. The following chapter discusses the methodology for a proposed research project.

PART 3

PROPOSED RESEARCH PROJECT

Chapter 6

METHODOLOGY

6.1 Introduction

It would seem that, due to the limited literature focusing on personhood in music therapy, as well as the insights gained from my clinical enquiry and analysis, South African research in this field would be beneficial. I propose a research project, which will be described in detail in this chapter. I also include the rationale for this research, possible research questions and discuss the methods for data collection and analysis. Furthermore, I address ethical implications for a research project of this nature.

6.2 Focus of research and proposed research questions

I propose that this research project focuses on personhood of any person regardless of diagnosis or whether they are admitted on a long- or short-term ward. Hence, I suggest focusing on how music therapy nurtures personhood of patients and staff on two wards. This would provide opportunity to ascertain how music therapy might nurture personhood in two psychiatric wards. However, due to the unique nature of group development, this research would not aim to compare the process of the two groups; rather it would explore the unique development and nurturance of personhood in each group over a period of time. Group development may be different, depending on the context of each group. I suggest that this project take place over six months to ensure enough time for the potential development of the group process.

I suggest the following research questions:

1. How does music therapy nurture the personhood in an open group on two psychiatric wards over a period of six months?
2. How do the nursing staff members view and experience their inclusion in the music therapy group?

I will now discuss the research paradigm, methods, data collection and analysis that would be employed if this project were to be conducted, in order to answer the suggested research questions. The ethical implications that would need consideration will be discussed afterwards. This research would take place within the context of a weekly music therapy open groups on two psychiatric wards in a state hospital.

6.3 Research paradigm

The proposed research project would be set within the naturalistic paradigm. Aigen (in Wheeler, 1995) defines the naturalistic paradigm as research which is time-and context-bound where the inquiry is value-bound. This qualitative approach is dependent on the researcher-as-participant. The researcher would be fully involved in the group as co-facilitator and fellow member. This proposed project does not aim to prove anything, reach a single truth, or elicit facts regarding the group. Rather, it aims to explore and describe the experiences of personhood within the different groups and across different wards. The qualitative research method of coding, categorizing and identification of themes will be used.

6.4 Data sources

Approximately 24 weekly music therapy open group sessions would be held on the two wards over a period of six months. All of the sessions on the two wards would be video/audio recorded, with permission of the participants and the institution (Appendix i, ii). I will discuss permission and informed consent with ethical considerations further in this chapter.

Each group would be facilitated by a music therapist, together with a co-therapist, who could be any kind of medical professional colleague, e.g. a music therapist, an occupational therapist or a psychologist. Activities used would be at the discretion of the facilitating music therapist according to the needs of the groups, and the goals identified in the assessment phase of the group process. The goals and activities would, therefore, be unique to the group.

It is out of this clinical work on the two wards that data would be obtained. The proposed main data sources would be three pre-selected video excerpts from the music therapy groups on the two wards (a total of six video excerpts), and a focus group interview that would take place with consenting staff members from each ward (a total of two focus group interviews). A variety of data sources, such as these, will ensure triangulation and enhance the credibility of the research process.

6.4.1 Pre-selected video excerpts

As highlighted in section 3.4.1 of the clinical enquiry, video provides for rich and objective data capturing, also allowing for repeated viewing (Schurink *et al.*, 1998). I propose that three short video excerpts be chosen from the video material of the groups on each ward. The video excerpts would be chosen through purposive sampling for their application to the proposed research questions, and their reflection of significant moments of personhood. Through a process of peer review and group supervision, harmful bias may be eliminated, and credibility of the excerpts would be ensured.

6.4.2 Focus group interviews

I propose that focus group interviews be held with a selection of staff members from each ward in the final month of the music therapy. Focus groups generate qualitative data, i.e. words and expressions used by the participants themselves (Schurink *et al.*, 1998). The advantages of focus group interviews are that many can participate at one time, and they are low in cost (Schurink *et al.*, 1998). Although there are no time limits for the interview, the staff members are busy and a group interview may be of shorter duration than individual semi-structured interviews. Participations would be chosen randomly and those that are willing and available would be included in the focus group interview. A maximum of five members is suggested. Consent for participation in the interview would be obtained (Appendix xi). I suggest that open-ended questions be asked during the interview to gain a sense of the staff's experience of the music therapy groups – how they experience themselves and the patients in the group, as well as the music itself (see Appendix xii for a list of proposed questions and an explanation of the rationale for each question). Two focus group interviews would be held in total. A brief description of each interview as experienced by the researcher should be included.

6.4.3 Secondary data source: Observation notes

A secondary data source would be the researcher's observation notes from the groups held. As discussed in section 3.4.2, observation notes are imperative to the clinical work of a music therapist. Throughout this music therapy process, observation notes for each of the twenty-four sessions will be written. As there are two wards, it should stand that a total of forty-eight observation notes will be notated. This contextual and interpretative information would inform the main data sources and ensure triangulation through using a variety of sources.

6.5 Preparation of data sources

At this stage, the process of preparing data for analysis would be commenced.

6.5.1 Pre-selected video excerpts

A thick description of each video excerpt is necessary to describe, in depth, the music and relationship between players during the significant moments. It would include contextual information and a detailed, moment by moment, description of the video excerpt. Thus, six descriptions would be ready for analysis.

6.5.2 Focus group interviews

The two focus group interviews would be transcribed in order to provide a detailed account of the discussion that occurred, and of statements made by staff members from each ward. A description of the interview, as experienced by the researcher, would also be included.

6.5.3 Observation notes

The observation notes would be examined in their entirety. The reason for not restricting the examination of notes to the sessions from which the excerpts are taken is that much qualitative information is contained in these notes, which may otherwise be lost. Moments that depict aspects of personhood in the group will be considered significant moments, and these form part of the qualitative information. A process of peer review and supervision will ensure that these, truly are such moments, and will enhance the credibility of the study. The information gathered from this source will be included as part of the analysis.

All the prepared data sources described above would then be ready for analysis.

6.6 Data analysis

6.6.1 Coding

Coding is defined as analytic labeling (Pavlicevic & Ansdell, 2001). The coding aims to break up information into smaller meaningful chunks. The thick descriptions of the video excerpts, the transcriptions of the focus group interviews, and text lifted from the observation notes would be coded.

6.6.2 Categories

According to Pavlicevic and Ansdell (2001), a category is a mutually exclusive ‘meaning box’, which allows for detailed definition and comparison. All the codes identified will be organized at a higher-level into mutually exclusive categories.

6.6.3 Themes

The categories would then be arranged into recurrent, emerging themes and these themes discussed in relation to the proposed research questions.

6.7 Ethical considerations

The ethical implications within a qualitative research project involve value-boundedness and trustworthiness. This needs to be ensured by means of a systematic and rigorous approach (Aigen, in Wheeler, 1995). Prior to commencing this research project, it is advised to send a proposal to the Medical Ethics Board for approval. In terms of data collection for this proposed research project, informed consent (Appendix i) would need to be obtained from all participants, and/or the appropriate guardian, with regards to video-recording and involvement in research. Written consent from the staff members participating in the focus group interviews, should obtained to ensure informed consent (Appendix x). Confidentiality would have to be ensured through anonymity. Permission from the institution should be obtained, if required (Appendix ii).

To further promote trustworthiness, Aigen (in Wheeler, 1995) suggests that triangulation be applied. This entails the use of a variety of data sources in order to ascertain the accuracy of data. In this research project, this would be ensured through the use of three data sources, namely, video excerpts, focus group interviews, and the use of observation notes. Although subjectivity and bias is generally seen as positive in qualitative research, bias in terms of pre-conceived notions and assumptions is viewed as negative and needs to be avoided. Through peer debriefing and group supervision, this negative bias may be reduced, and the afore-mentioned processes are, therefore, recommended for this project. I would recommend that the therapists allow the groups and participants to unfold spontaneously and naturally within the supportive environment, as indicated by Bruscia (1998).

Yardley (in Smith, 2000) offers three broad principles to assessing the quality of qualitative research. These include sensitivity to context and data; commitment, rigour, coherence and transparency; and impact and importance. Through the data collection, analysis, and the writing up of this hypothetical research project, attempts should be made to maintain clarity, awareness and appropriateness throughout.

6.8 Conclusion

This chapter outlined the methodology that would be employed for the proposed research project. Aspects of the qualitative, naturalistic paradigm, as well as methods, data analysis, and the ethical implications applicable to this proposed research were addressed and clarified.

The following chapter is a conclusion of this clinical enquiry. It includes a summary of the interpretations made, and an outline of the limitations encountered in this enquiry.

PART 4

Conclusion of Clinical Enquiry

Chapter 7

CONCLUSION

In this conclusion, I aim to draw together parts 1 to 3 of this clinical enquiry.

7.1 The nurturance of personhood in the music therapy group on the male psychogeriatric ward

My focus area of interest for this clinical enquiry was the personhood of patients and staff, and how it may be nurtured through music therapy. This was based on my prior experiences of witnessing nursing staff not always being responsive to patients' emotional needs, and noticing how their own emotional needs affected their treatment of the patients. This enquiry, based on clinical work at the male psychogeriatric ward, thus focused on how music therapy could nurture personhood of not only the patients, but the nursing staff members as well. Although the scope of this enquiry was not to explore change over time, the clinical report and the analysis of the clinical work material implied the development of aspects of personhood.

It revealed that, through music therapy, there was growth in personal worth; a change in self and group identity; development of social relationship; and expression through musical interplay. The four emerging themes exemplify that music therapy enabled and empowered group members, which led to the nurturance of personhood of staff and patients. Nurturing personhood of both patients and staff provided opportunities for social relationships to be fostered and a perceived sense of community to be strengthened. Staff members appeared to look past the diagnosis and age of the patient, and treat them with recognition and respect. Both staff and patients' 'humanness' was elicited during this process as their personhood was promoted.

This clinical enquiry illustrates the benefits of staff inclusion and nurturance of staff personhood. In this enquiry, the concept of personhood could be extended to include not only those with dementia, but all psychiatric patients and even nursing staff members. In addressing staff members' emotional needs for validation, significance and acceptance, they may be able to better value the patients. This has implications for how nursing staff members are viewed on

wards where patients receive group music therapy. In order to ensure the personhood and person-centered treatment of patients, music therapists may have to include aspects of staff involvement and personhood in their clinical thinking.

This clinical enquiry is not without limitations. The following section highlights the limitations of this enquiry and outlines recommendations for further study.

7.2 Limitations and recommendations

- Staff opinions were not included in this enquiry. This may have limited the depth of the qualitative information gathered. It would be valuable to obtain the nursing staff members' views, opinions and experiences of being included in such music therapy group, and to gain their input as to whether they, indeed, experience patients, and themselves, differently. It is recommended that staff's opinions be included in future studies.
- Patient opinions were not included in this enquiry. It may also be valuable to gain the patient's comments on their inclusion with staff in such a music therapy group.
- Due to the qualitative nature of this clinical enquiry, it may not be generalized to other wards or music therapy groups. This clinical enquiry focused on this specific context, and the nurturance of personhood with this client and staff group. The emergence of personhood in other wards and groups may be dissimilar, due to the unique nature of the group process and dynamics.
- Due to the limited research done in the field of music therapy and staff/patient personhood, it would be valuable to recommend that qualitative research of this nature be embarked on. Such research would greatly enrich South African music therapy as a discipline, as it would develop insight into this field.

To end, I would like to quote Zharinova-Sanderson (2004):

"Confirming each others' humanity by being in music together, can facilitate the natural processes of connecting, healing and evolving, and in turn can impact upon a person's way of relating to himself and to the people around him."

In other words –

"Umuntu Ungumuntu Ngabantu"

BIBLIOGRAPHY

Aasgaard, T. (1999) 'Music Therapy as milieu in the hospice and paediatric oncology ward.' In: *Music Therapy in Palliative Care: New Voices*, ed. D. Aldridge. London: Jessica Kingsley Publishers.

Abad, V. (2002) 'Reaching the socially isolated person with Alzheimer's Disease though group music therapy – a case report.' *Voices: A World Forum for Music Therapy.* November 2(3). Retrieved May 21, 2006 from http://www.voices.no/mainissues.

Aigen, K (1995) 'Philosophical enquiry'. In: *Music therapy research: Quantitative and Qualitative Perspectives*, ed. B.L. Wheeler. Phoenixville: Barcelona Publishers.

Aigen, K. (1995) 'Principles of qualitative research'. In: *Music Therapy Research: Quantitative and Qualitative perspectives*, ed. B. Wheeler. Phoenixville: Barcelona Publishers.

Amir, D. (2004) 'Community Music Therapy and the challenge of multiculturalism.' In: *Community Music Therapy*, ed. M. Pavlicevic and G. Aldridge. London: Jessica Kingsley Publishers.

Ansdell, G. (1995) *Music for life: Aspects of creative music therapy and adult clients.* London: Jessica Kinsley Publishers.

Ansdell, G. (2002) 'Community Music Therapy and the Winds of Change.' *Voices: A World Forum for Music Therapy*, July 2(2). Retrieved March 5, 2007 from http://www.voices.no/mainissues/voices2(2)ansdell.html.

Ansdell, G. (2006) 'Do we puncture the balloon or let it fly?' *Voices: A World Forum for Music Therapy* [contribution to moderated discussions], November 2006. Retrieved March 5, 2007 from http://www.voices.no/mainissues.

Ashburner, C., Meyer, J., Johnson, B. & Smith, C. (2004) 'Using action research to address loss of personhood in a continuing care setting.' *Illness, Crisis & Loss, 12*(1): 23-37.

Beach, M. & Inui, T. (2005) ‘Relationship-Centered Care: A constructive framework.’ *Journal of General Internal Medicine, 21*(7): 801-811.

Brotons, M. (2000) ‘An overview of the music therapy literature relating to elderly people.’ In: *Music Therapy in Dementia Care*, ed. D. Aldridge. London: Jessica Kingsley Publishers.

Brown, S and Pavlicevic, M (1997) ‘Clinical improvisation in creative music therapy: musical aesthetic and the interpersonal dimension.’ *The Arts in Psychotherapy, Vol 23, No. 5*, 397-405

Bruscia, K (1998) ‘Standards of integrity for qualitative music therapy research.’ *Journal of Music Therapy, XXXV (3)*, 176-200

Clair, A. (2000) ‘The importance of singing with elderly patients.’ In: *Music Therapy in Dementia Care*, ed. D. Aldridge. London: Jessica Kingsley Publishers.

Clarke, A., Hanson, E. & Ross, H. (2003) ‘Seeing the person behind the patient: enhancing the care of older people using a biographical approach.’ *Journal of Clinical Nursing, 12*: 697-706.

Concise Medical Dictionary (1980) Oxford University Press, 337.

Hilliard, R. (2006) ‘The effect of music therapy sessions on compassion fatigue and team building of professional hospice caregivers.’ *The Arts in Psychotherapy, 33*(5): 395-401.

Ishizuka, O. (1998) ‘Between words and music – Creative music therapy as verbal and non-verbal communication with people with dementia.’ Masters Thesis: Nordoff-Robbins Music Therapy Institute, UK.

Killick, J. & Allan, K. (1999) ‘The arts in dementia care: tapping a rich resource.’ *Journal of Dementia Care, July/August*, 35-38.

Kitwood, T. (1990) ‘The dialectics of dementia: with particular reference to Alzheimer’s disease.’ *Ageing and Society, 10*: 177-196

Kitwood, T. & Bredin, K. (1992) ‘Towards a theory of dementia care: personhood and well-being.’ *Ageing and Society, 12*: 269-287.

Kitwood, T. (1997) 'Personhood, dementia and dementia care.' In: *Dementia: Challenges and New Directions*, ed. S. Hunter. London: Jessica Kingsley Publishers.

Lipe, A. (1995) 'The use of music performance talks in the assessment of cognitive functioning amongst older adults with dementia.' *Journal of Music Therapy, 32*(3): 137-151.

McCormack, B. (2004) 'Person-centredness in gerontological nursing: an overview of the literature.' *Journal of Clinical Nursing, 13*(3a): 31-38.

Nolan, R., Davies, S., Brown, J., Keady, J. & Nolan, J. (2004) 'Beyond 'person-centered' care: a vision for gerontological nursing.' *International Journal of Older People Nursing* in association with *Journal of Clinical Nursing, 13(3a)*: 45-53.

Nordoff, P. & Robbins, C. (1977) *Creative Music Therapy.* New York: John Day.

Pavlicevic, M. (1997) *Music Therapy in context: Meaning, Music and Relationship.* London: Jessica Kinsley Publishers.

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

Pavlicevic, M. (2003) *Groups in Music*. London: Jessica Kinsley Publishers.

Powell, H. (2004) 'A Dream Wedding: from community music to music therapy with a community.' In: *Community Music Therapy*, ed. M. Pavlicevic and G. Aldridge. London: Jessica Kingsley Publishers.

Procter, S. (2004) 'Playing politics: Community Music Therapy and the therapeutic redistribution of musical capital for mental health'. In: *Community Music Therapy*, ed. M. Pavlicevic and G. Aldridge. London: Jessica Kingsley Publishers.

Schurink, W.J., Schurink, E.M., Poggenpoel, M (1998) 'Focus group interviewing and audio-visual methodology in qualitative research.' In: *Research at grass roots: a primer for the caring professions*, ed A.S. De Vos. Pretoria: JL van Schaik

Simpson, F. (2000) ‘Creative Music Therapy: a last resort?’ In: *Music Therapy in Dementia Care*, ed. D Aldridge. London: Jessica Kingsley Publishers.

Smith, J (2000) Validity and qualitative psychology. *Validity Trustworthiness.*

Weman, K., Kihlgren, M. & Fagerberg, I. (2004) Older people living in nursing homes or other community care facilities: Registered nurses’ views of their working situation and co-operation with family members. *Journal of Clinical Nursing, 13*: 517-626.

Wigram, T., Pedersen, I. & Bona, L (2002) ‘Music therapy in clinical practice.’ In: *A Comprehensive Guide to Music Therapy: Theory, Clinical Practice, Research and Training.* London: Jessica Kingsley Publishers.

Williams, B. & Grant, G. (1998) ‘Defining ‘People-Conditions’: making the implicit explicit.’ *Health and Social Care in the Community, 6*(2): 84-94.

Wood, S. (2004) ‘Music Therapy: Striking a chord with care home residents.’ *Nursing Older People, 16*(7): 24-26.

Wood, S., Verney, R. & Atkinson, J. (2004) ‘From therapy to community: making music in neurological rehabilitation.’ In: *Community Music Therapy*, ed. M. Pavlicevic and G. Aldridge. London: Jessica Kingsley Publishers.

Wood, S. (2006) Interdependence and emergence: Core concepts in Community Music Therapy? – A response to Thomas Wosch [contribution to moderated discussions] *Voices: A World Forum for Music Therapy*. Retrieved March 5, 2007, from http://www.voices.no/mainissues

Zharinova-Sanderson, O. (2004) ‘Promoting intergration and socio-cultural change: Community Music Therapy with traumatized refugees in Berlin.’ In: *Community Music Therapy*, ed. M. Pavlicevic and G. Aldridge. London: Jessica Kingsley Publishers.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

APPENDIX I

Informed Consent Form of Group Members

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

MUSIC THERAPY PROGRAMME
TEL (012) 420-2614
FAX (012) 420-4351
www.up.ac.za/academic/music/music.html

UNIVERSITY OF PRETORIA
UNIVERSITEIT VAN PRETORIA

PRETORIA 0002 SOUTH AFRICA

Date: ……………………………

MUSIC THERAPY SESSIONS: PERMISSION TO RECORD

I ____, Chief Executive Officer of Weskoppies Hospital, Pretoria, give permission to video tape ____________________ __________________ of Ward ___ in Music Therapy sessions between February and July 2007. These recordings will be used for clinical, research and educational purposes as part of the students' music therapy training. This includes supervision sessions with their clinical supervisors, and as part of their clinical case study presentations for their examinations. I understand that visual and audio recordings of sessions are standard music therapy practice, enabling detailed analysis of the sessions in order to gain clinical direction to ongoing sessions. Privacy and confidentiality is assured, in line with professional ethical practice. At the end of the student's training, these tapes will form part of the training archives and will become the property of the Music Department, University of Pretoria. This material will not be distributed or sold. I understand that I can arrange to view / listen to the recordings should I so wish.

______________________________ Chief Executive Officer, Weskoppies Hospital.

______________________________ NAME: ……………………………., MMus (MT) Student

______________________________Mrs C Lotter, MMus(MT) Training Programme

APPENDIX iii

Lyrics of

"Die Okraliedjie"/ "Ga Gona Yo Twana"/ "Oh When The Saints"

Die Oukraalliedjie

Jy met jou mandolinetjie, ek met my bandolientjie,
Sing ons die Oukraalliedjie saam.
Sing ons van waterstrome, slange in olienhoutbome,
En 'n ribbok wat daar op die randjie staan.
Ons sing, ons speel, van die Oukraal wat ons nooit nie sal verveel.
Jy met jou mandolinetjie, ek met my bandolientjie,
Sing ons die Oukraalliedjie saam.

Ga Gona Yo Tshwanang le Jesu(There's no one like Jesus)

Ga gona yo a tshwanang le Jesu
Ga gona yo a tshwanang le Yesu
Ga gona yo a tshwanang le Jesu
Ga gona yo a tshwanang le Yesu
Ka Batla batla, gotlhe gotlhe
Ka mofumana, Jesu wa ke
Ga gona yo a tshwanang le Jesu

Oh When the Saints

Oh when the saints
Oh when the saints
Oh when the saints go marching in
Oh I want to be in their number
Oh when the saints go marching in

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

APPENDIX iv

Thick description of Video Excerpt 1

Video Excerpt 1: A helps J to reach djembe drum

Diagrammatic representation:

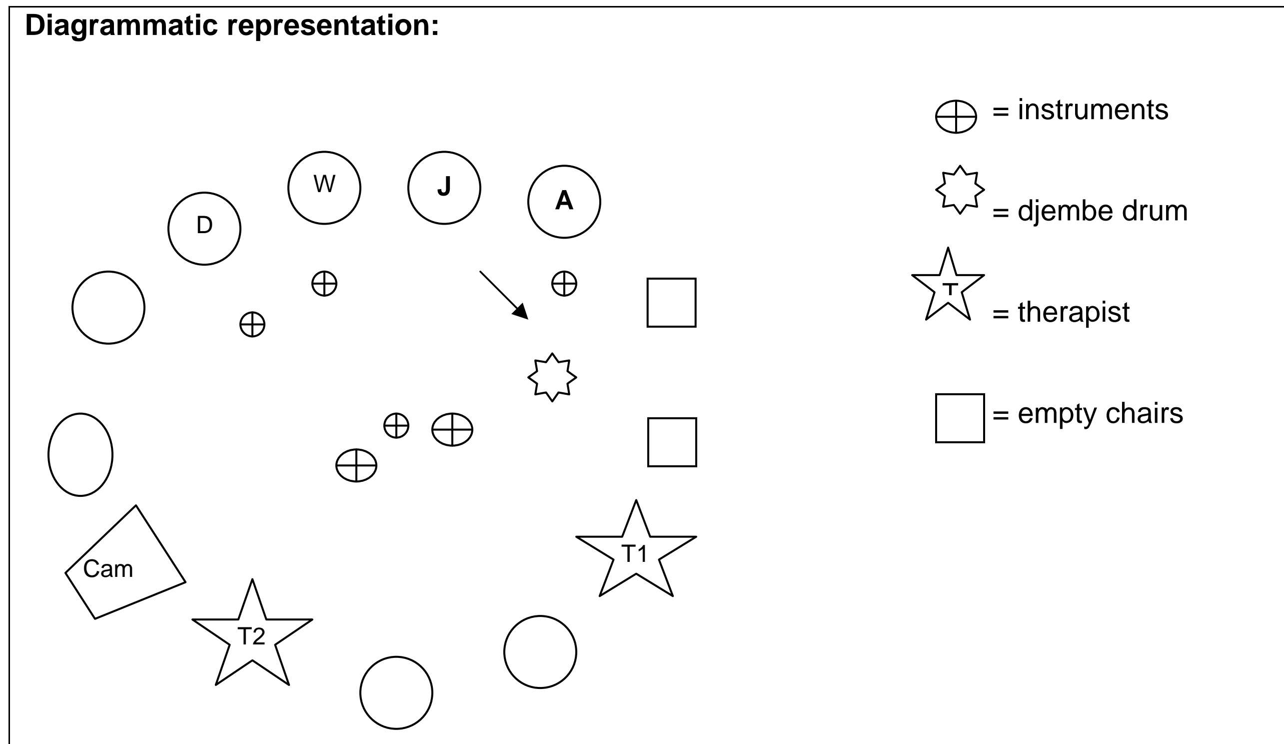


Figure 4.1: video excerpt 1 layout of group

This diagram does not show all group members, it aims to show the position of relevant members.

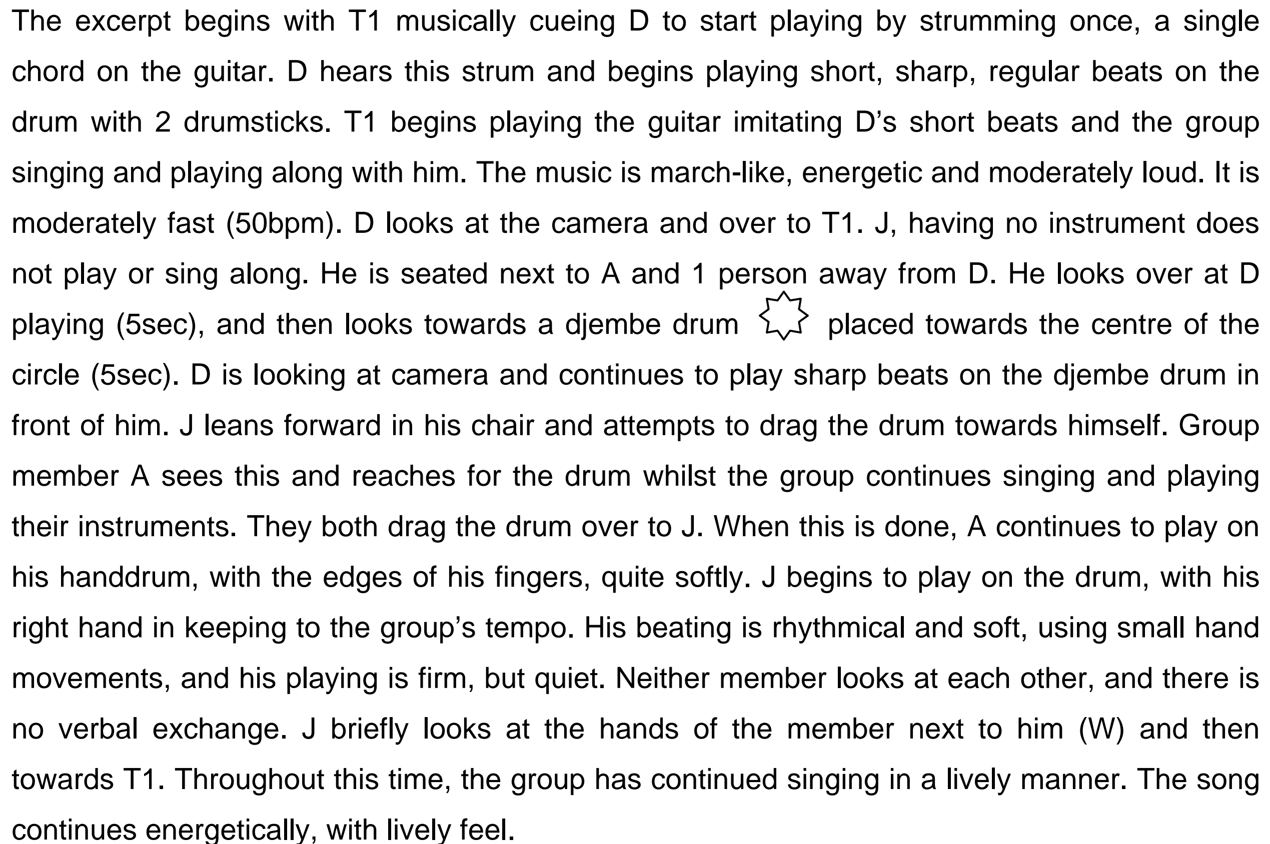
Context:

This music therapy (session 4) takes place in the spare lounge on the ward. All patients and nursing staff were invited to participate, however the nursing staff members were unavailable. The group consists of approximately 15 patients, who are seated as per usual on chairs and couches in a circle.

Prior to the excerpt, the therapist is playing the guitar, and group members are playing a variety of percussive instruments, including djembe, bongo and hand drums, and smaller instruments such as shakers. The instrumental song is a Negro Spiritual song, “Oh when the Saints”, that is known to the group. The therapists have initiated a turn-taking activity that involves members standing up and playing the snare drum and cymbal placed in the centre of the circle as a ‘solo’ opportunity. The rest of the group is free to sing and play along with the soloist. The therapists

attempt to adapt the group's song to the speed, volume and tone of the soloist's playing. J has just had his turn in the middle and is seated without an instrument in front of him. D is holding the two drumsticks, having just been offered a turn to play. He chooses to stay seated and play his djembe drum with the beaters instead of standing in the middle.

Excerpt Description:

The excerpt begins with T1 musically cueing D to start playing by strumming once, a single chord on the guitar. D hears this strum and begins playing short, sharp, regular beats on the drum with 2 drumsticks. T1 begins playing the guitar imitating D's short beats and the group singing and playing along with him. The music is march-like, energetic and moderately loud. It is moderately fast (50bpm). D looks at the camera and over to T1. J, having no instrument does not play or sing along. He is seated next to A and 1 person away from D. He looks over at D playing (5sec), and then looks towards a djembe drum  placed towards the centre of the circle (5sec). D is looking at camera and continues to play sharp beats on the djembe drum in front of him. J leans forward in his chair and attempts to drag the drum towards himself. Group member A sees this and reaches for the drum whilst the group continues singing and playing their instruments. They both drag the drum over to J. When this is done, A continues to play on his handdrum, with the edges of his fingers, quite softly. J begins to play on the drum, with his right hand in keeping to the group's tempo. His beating is rhythmical and soft, using small hand movements, and his playing is firm, but quiet. Neither member looks at each other, and there is no verbal exchange. J briefly looks at the hands of the member next to him (W) and then towards T1. Throughout this time, the group has continued singing in a lively manner. The song continues energetically, with lively feel.

APPENDIX iv (cont.)

Thick description of Video Excerpt 2

Video Excerpt **2**: L soloing, laughing and choosing next soloist, A

Diagrammatic representation:

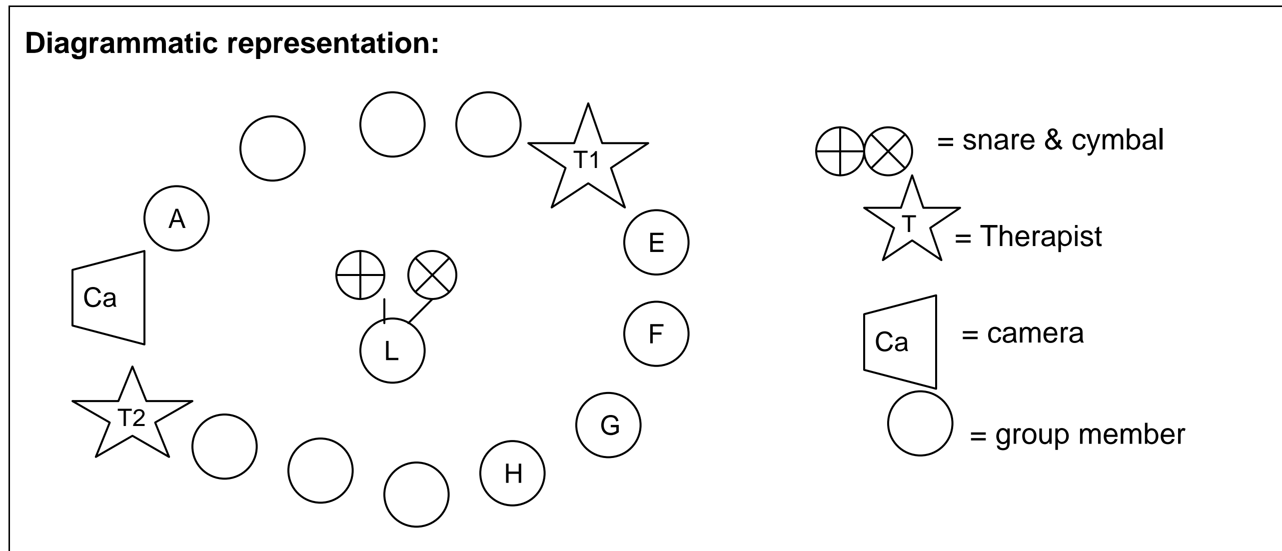


Figure 4.2: video excerpt 2 layout of group

This diagram does not show all group members, it aims to show the position of relevant members.

Context:

During session 5, the group is seated on chairs, in a circle in the ward lounge. The clip is 38 seconds in length. Both nursing staff and patients are members of this group. During this session, the group is participating in a turn-taking activity, where one member is invited to play the drum and cymbal as solo in the middle of the circle. Other group members are encouraged to sing along, but do not have instruments. The reason for this was to promote awareness of others (especially the soloist). Prior to the clip T1 is playing the guitar and the Negro Spiritual song "Oh when the saints" is being sung. No other instruments are being played, as decided by the therapists prior to the session. Staff member L is encouraged to take her turn as soloist.

Excerpt:

The excerpt begins with L standing, playing solo in the middle of the circle, and beating both snare drum and cymbal in a variety of rhythmical ways, using the two drumsticks. The rest of the group is singing along with the well-known song. The energetic music is in the key of E major, march-like with a lilting quality, moderate in tempo (±70bpm). The group members in view of the camera (E, F, G, H) are watching L play and the group can be heard singing along to the song, with harmonies. The singing is firm with a focused, yet almost playful energy. L's turn

ends with a loud smash on the cymbal to emphasize the finale and begins to smile and laugh. The group laughs with the soloist as she ends with a flourish and walks, bent over laughing, towards another group member. Clapping can be heard in support of her playing. Group members watch her closely as she offers the drum sticks to another member. The group continues laughing as she hands the drumsticks to A, who at first refuses, then takes the sticks, stands and walks to the middle of the circle. The group laughs when he comes up to play because he has a smile on his face. He begins playing loudly in a complicated rhythm and after 6 seconds T1 begins playing, matching his new style. It is the same song, but modulated to D major, louder, stronger and slower. His playing is definite, purposeful with only strong, small wrist movements. A looks at T1 as they play, with a small smile on his face. The group sings with more energy as they readily join in.

APPENDIX iv (cont.)

Thick description of Video Excerpt 3

Video Excerpt 3: H leads the group

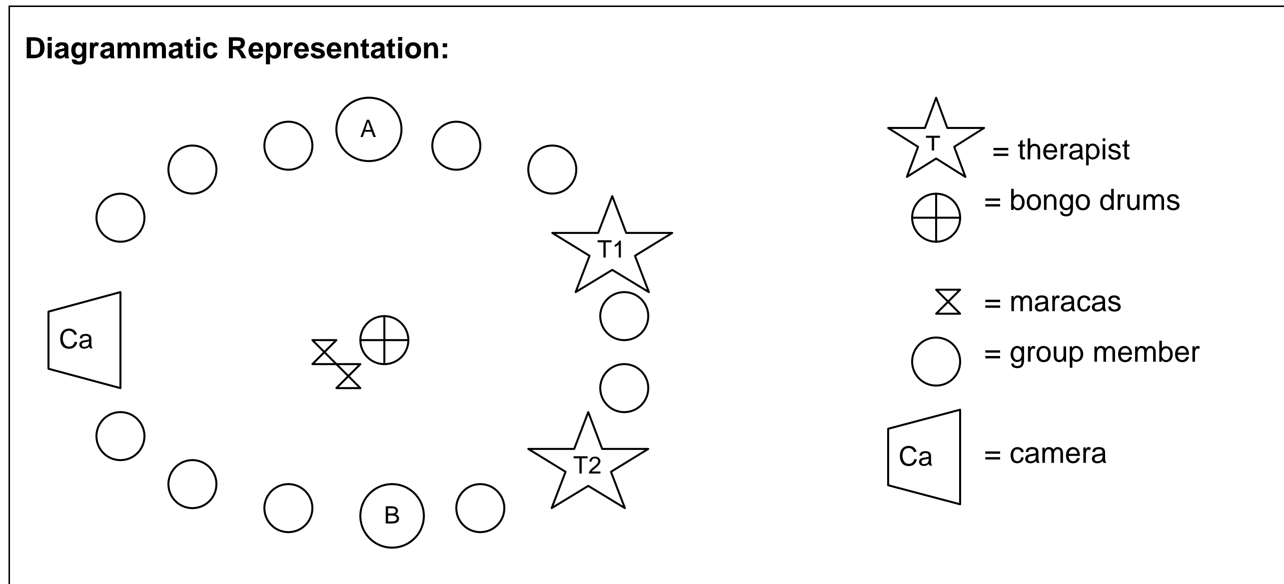


Figure 4.3 Video excerpt 3 layout of group

This diagram does not show all group members, it aims to show the position of relevant members.

Context:

This music therapy session 11 takes place in the ward lounge. Members are seated in a circle of chairs. The group is negotiating who would like to have a turn to perform a song of his/her own song choice in the middle of the circle. Prior to the excerpt, one of the staff members (female) has just sat down, having just performed, a cappella, in a confident, husky voice, a song that she has improvised about us being welcome in the ward. Her song was short, firm with a light melody. She used rhythmic, hand movements to emphasis certain accents in the song. The group clapped and showed support of her performance when she finished.

Excerpt:

The excerpt begins with T2 encouraging B to sing a song of his choice for the group. When B doesn't immediately react, another group member suggests a song for the group to sing. The group is watching this verbal exchange. Suddenly B stands up and with the group watching, walks purposefully to the centre of the circle. He picks of two maracas, one in each hand, and begins singing an African gospel song in a deep, moderately soft (mp-mf), focused, determined voice. At the same time as he starts singing, he shakes the maracas on the strong beat with

regular, firm movements. The song has a definite melody, a regular, firm rhythm and a purposeful energy. There was a brief moment of silence from the group, as this normally quiet man begins singing. The group then almost immediately joins him in singing, a staff member providing a strong harmony against his melody. The singing is moderately loud and clear. A stands up, walks towards the centre of the circle, and stands across from B. He takes the two beaters that T2 is offering him, and begins playing the drum in rhythm to B's singing and playing of the maracas. A's playing is soft, but strong. B looks over at A at various stages during the verse. The phrase ends, and B continues to sing his song.

APPENDIX vi

Full List of Text Extracted from Observation Notes

The following table represents the text lifted from the observation notes and indicates from which session's observation notes they were taken.

From session no.	Main Text
2	[Song] initiated by client: All took ownership of this song. 1 black staff member even initiated it again saying, "It's lekker!"
2	Rich harmony and a sense of connection flowed. The song continued for very long: some staff danced, one even closed his eyes.
2	The African staff (all are African) took ownership of even this 'white' Afrikaner song, adding their own African harmony to it.
3	The men enjoyed being greeted by hand – many made eye contact and there were some smiles.
4	There were some moments of personhood that were illuminated in the group: J smiling and chatting to me; R coming up by himself to play the drum and cymbal; K assertively taking instruments without prompting; J taking djembe and A helping him get to it.
5	Gradually the group energy built louder vocal participation and clapping. Staff investment increased markedly when they were also invited and encouraged to 'solo'. Laughter and giggles.
5	Staff [are] no longer 'helpers' in the group, but active participants.
5	The energising elements were: encouragement, mutual enjoyment, in general the support that the group provided to all the 'soloists'. Patients and carers could experience each other in a different way.
5	Staff and patients humming and singing in the halls. This group created a time and place for staff and patients to experience each other as partners – musical partners, creating something together that is fun, aesthetically pleasing, expressive - all as equals. They provide support and encouragement.
6	It seems that there are more moments of interaction between members and attention given when members are 'soloing'. Staff and patients seem to interact more also. Generally [there is] an atmosphere of acceptance and tolerance.

7	An increase in sustained eye contact and more smiles indicates the effectiveness of greeting each group member on his name, making physical contact to acknowledge his presence.
9	Group members [were] able to negotiate whose turn was next.
9	Two of the members suggested songs and many smiled and actively participated.
10	[…] At the introduction of an African song [by a member]. It was an expression of herself (presenting self in performance) as she sang it while the group accompanied her.
10	[There is more] eye contact, more social interaction with each other. The energy in the group is involved and quite communal.
11	The group is quite supportive of each other.
12	The group is more verbal (greeting with eye contact, smiles, verbal 'hello's/'how are you's) than initially. The groups are also longer in length as attention improves. The group generally is more vocal and instrumentally active. Moments of performance happened with e.g. H leading a song. Lots of humour and laughter, also negotiation of songs (especially with staff!). There were moments of spontaneous clapping after a few songs. There were moments when the group almost 'led' themselves: negotiating songs; using initiative/choice/decision-making. Awareness of others has improved with most singing hello/goodbye to each other using names and eye contact.
12	There is almost a reluctance to leave the musical space once we've said goodbye – we actually have to ask people to leave. I think this says much about the space and group in terms of acceptance, support, enjoyment and accomplishment that group members may feel.

APPENDIX vii

Coding of Video Excerpt 1

Main Text	No.	Code
This music therapy (session 4) takes place in the spare lounge on the ward.	1.1.1 1.1.2	Excerpt from session 4 Lounge
All patients and nursing staff were invited to participate, however the nursing staff members were unavailable.	1.2.1 1.2.2	All invited Staff choice to attend
The group consists of approximately 15 patients, who are seated as per usual on chairs and couches in a circle.	1.3	Seated in circle on chairs
Prior to the excerpt, the therapist is playing the guitar…	1.4	T plays guitar
…and group members are playing a variety of percussive instruments, including djembe, bongo and hand drums, and smaller instruments such as shakers.	1.5.1 1.5.2	Group instrumentally active Percussive instruments
The instrumental song is a Negro Spiritual song, “Oh when the Saints”, that is known to the group.	1.6.1 1.6.2	Negro Spiritual song Known song
The therapists have initiated a turn-taking activity that involves members standing up and playing the snare drum and cymbal placed in the centre of the circle as a ‘solo’ opportunity.	1.7.1 1.7.2 1.7.3	T leads activity Turn-taking activity Solo opportunity
The rest of the group is free to sing and play along with the soloist.	1.8.1 1.8.2	Free to play/sing Group supports soloist
The therapists attempt to adapt the group’s song to the speed, volume and tone of the soloist’s playing.	1.9.1 1.9.2 1.9.3	T matching soloist T adapting to soloist’s musical offering Clinical technique of matching
J has just had his turn in the middle and is seated without an instrument in front of him.	1.10.1 1.10.2	‘J’ no instrument Choice to not play
D is holding the two drumsticks, having just been offered a turn to play.	1.11.1 1.11.2	Offered a turn Anticipation of musical participation
He chooses to stay seated and play his djembe drum with the beaters instead of standing in the middle.	1.12.1 1.12.2 1.12.3	Choice Decision-making Autonomy
The excerpt begins with T1 musically cueing D to start playing by strumming once, a single chord on the guitar.	1.13	Musical cue
‘D’ hears this strum and begins playing short, sharp, regular	1.14.1	Musical awareness of soloist

beats on the drum with 2 drumsticks.	1.14.2	Instrumentally active
'T' begins playing the guitar imitating D's short beats and the group singing and playing along with him.	1.15.1 1.15.2	Clinical technique of matching Group supporting soloist
The music is march-like, energetic and moderately loud.	1.16	Loud, energetic march
It is moderately fast (50bpm).	1.17	Tempo is moderately fast
D looks at the camera and over to the therapist.	1.18.1 1.18.2	Awareness of camera Awareness of therapist
'J', having no instrument does not play or sing along.	1.19.1 1.19.2	'J' not instrumentally active Choice to not participate
He is seated next to 'A' and 1 person away from 'D'.	1.20	Seated with others
He looks over at 'D' playing (5sec), and then looks towards a djembe drum placed towards the centre of the circle (5sec).	1.21.1 1.21.2	Awareness of others Awareness of instruments
'D' is looking at camera and continues to play sharp beats on the djembe drum in front of him.	1.22.1 1.22.2	Awareness of camera Instrumentally active
'J' leans forward in his chair and attempts to drag the drum towards himself.	1.23.1 1.23.2 1.23.3	Reaches for drum Initiative Motivation to be a part of group
Group member 'A' sees this and reaches for the drum while the group continues singing and playing their instruments.	1.24.1 1.24.2	Helps group member Awareness of another needing help
They both drag the drum over to 'J'.	1.25.1 1.25.2	Together moving drum Cooperation with another
When this is done, 'A' continues to play on his handdrum with the edges of his fingers quite softly.	1.26	Instrumentally active
'J' begins to play on the drum, with his right hand in keeping to the group's tempo.	1.27.1 1.27.2	Instrumentally active Awareness of group's tempo
His beating is rhythmical and soft, using small hand movements, and his playing is firm, but quiet.	1.28	Rhythmical, soft, firm, quiet playing
Neither member looks at each other and there is no verbal exchange.	1.29	No eye contact/verbal exchange
'J' briefly looks at the hands of the member next to him ('W') and then towards the therapist.	1.30.1 1.30.2	Awareness of others Awareness of T
Throughout this time, the group has continued singing in a lively manner.	1.31	Group singing lively
The song continues energetically with lively feel.	1.32	Energetic feel

APPENDIX vii (cont.)

Coding of Video Excerpt 2

Main Text	No.	Code
During session 5, the group is seated on chairs, in a circle in the ward lounge.	2.1.1 2.1.2 2.1.3	Session 5 Seated on chairs in circle Lounge
The clip is 38 seconds in length.	2.2	
Both nursing staff and patients are members of this group.	2.3	Staff and patients included
During this session, the group is participating in a turn-taking activity, where one member is invited to play the drum and cymbal as solo in the middle of the circle.	2.4.1 2.4.2 2.4.3	Participating Turn-taking activity Solo opportunity
Other group members are encouraged to sing along, but do not have instruments.	2.5	Group sings along
The reason for this was to promote awareness of others (especially the soloist).	2.6.1 2.6.2	Promote awareness of others Clinical decision by T
The therapist 'T' is playing the guitar and the Negro Spiritual song "Oh when the saints" is being sung.	2.7.1 2.7.2 2.7.3	T playing guitar Negro Spiritual song Vocally active
No other instruments are being played, as decided by the therapists prior to the session.	2.8.1 2.8.2	No instruments Clinical decision by T
Staff member 'L' is encouraged to take her turn as soloist.	2.9.1 2.9.2	Encouragement by T Staff solo opportunity
'L' is standing, playing solo in the middle of the circle, and is beating both snare drum and cymbal in a variety of rhythmical ways, using the two drumsticks.	2.10.1 2.10.2	Member playing solo Musical creativity (staff)
The rest of the group is singing along with the well-known song.	2.11.1 2.11.2	Group singing along Group supporting soloist
The energetic music is in the key of E major, march-like with a lilting quality, moderate in tempo (±70bpm).	2.12.1 2.12.2	Energetic music Moderate march
The group members in view of the camera (E, F, G, H) are watching 'L' play and the group can be heard singing along to the song, with harmonies.	2.13.1 2.13.2	Group watching soloist Singing harmonies
The singing is firm with a focused, yet almost playful energy.	2.14.1 2.14.2	Firm singing Playful energy
'L's turn ends with a loud smash on the cymbal to	2.15.1	Loud playing

emphasize the finale and begins to smile and laugh.	2.15.2 2.15.3	Confidence Smiles/laughs
The group laughs with the soloist as she ends with a flourish and walks, bent over laughing, towards another group member.	2.16.1 2.16.2	Group laughs Accomplishment
Clapping can be heard in support of her playing.	2.17	Clapping in support
Group members watch her closely as she offers the drum sticks to another member.	2.18.1 2.18.2	Group watching soloist Offers turn to member
The group continues laughing as she hands the drumsticks to 'A', who at first refuses, then takes the sticks, stands and walks to the middle of the circle.	2.19.1 2.19.2 2.19.3	Group laughing Awareness of others Choice of next performer
The group laughs when he comes up to play because he has a smile on his face.	2.20.1 2.20.2	Soloist smiling Group laughs with soloist
He begins playing loudly in a complicated rhythm and after 6 seconds 'T' begins playing, matching his new style.	2.21.1 2.21.2	Loud, rhythmical playing T clinical technique of matching
It is the same song, but modulated to D major, louder, stronger and slower.	2.22.1 2.22.2	T clinical intervention Slow, strong, loud
His playing is definite, purposeful with only strong, small wrist movements.	2.23.1 2.23.2	Playing purposeful, strong Confident
'A' looks at 'T' as they play, with a small smile on his face.	2.24.1 2.24.2 2.24.3	Awareness of T Communicative eye contact Enjoyment
The group sings with more energy as they readily join in.	2.25.1 2.25.2 2.25.3	Group support through singing Singing more energetic Group awareness of soloist's energy

APPENDIX vii (cont.)

Coding of Video Excerpt 3

Main Text	No.	Code
This music therapy session 11 takes place in the ward lounge.	3.1.1	Ward lounge
Members are seated in a circle of chairs.	3.2	Seated on chairs
Prior to the excerpt, one of the staff members (female) has just sat down, having just performed, a cappella, in a confident, husky voice, a song that she has improvised about us being welcome in the ward.	3.3.1 3.3.2 3.3.3 3.3.4 3.3.5	Group negotiating Staff member performed Choice Creativity Improvised song
Her song was short, firm with a light melody.	3.4	Firm, light melody
She used rhythmic, hand movements to emphasis certain accents in the song.	3.5.1 3.5.2	Rhythmical body movements Self-expression
The group clapped and showed support of her performance when she finished.	3.6.1 3.6.2	Group clapped Support for performance
The excerpt begins with T2 encouraging B to sing a song of his choice for the group.	3.7.1 3.7.2 3.7.3	T encouraging/supporting Song Choice
When B doesn't immediately react, another group member suggests a song for the group to sing.	3.8.1 3.8.2	Slow to react Group member suggests song
The group is watching this verbal exchange.	3.9.1 3.9.2	Group alert/aware Verbal exchange
Suddenly B stands up and with the group watching, walks purposefully to the centre of the circle.	3.10.1 3.10.2	Stand/walk to centre of circle Confidence
He picks of two maracas, one in each hand, and begins singing an African gospel song in a deep, moderately soft (mp-mf), focused, determined voice.	3.11.1 3.11.2 3.11.3 3.11.4 3.11.5	Instrumentally active Singing African gospel song Own choice of song Deep, focused voice
At the same time as he starts singing, he shakes the maracas on the strong beat with regular, firm movements.	3.12	Regular, firm shaking of maracas
The song has a definite melody, a regular, firm rhythm and a	3.13.1	Definite melody, firm rhythm

purposeful energy.	3.13.2	Purposeful energy
There was a brief moment of silence from the group, as this normally quiet man begins singing.	3.14.1 3.14.2	Brief silence as quiet member sings Awareness
The group then almost immediately joins him in singing, a staff member providing a strong harmony against his melody.	3.15.1 3.15.2	Group joins in vocally Strong harmony
The singing is moderately loud and clear.	3.16	Singing clear, loud
A stands up, walks towards the centre of the circle and stands across from B.	3.17.1 3.17.2	Member walks to centre Initiative
He takes the two beaters that T2 is offering him, and begins playing the drum in rhythm to B's singing and playing of the maracas.	3.18	Plays bongos in rhythm to soloist
A's playing is soft, but strong.	3.19	Soft, strong playing
B looks over at A at various stages during the verse.	3.20	Eye contact/looking at soloist
The phrase ends, and B continues to sing his song.	3.21.1 3.21.2	Continues singing Assertive

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

APPENDIX ix

Full list of codes from video excerpts and observation notes

Absorbed	Longer duration
Acceptance	Loud, energetic march
Accompaniment	Loud, rhythmical playing
Accomplishment	Member playing solo
Acknowledgement	Moderate march
Active participation	Motivation to be part of group
Aesthetic music	Music on ward
African Gospel song	Musical awareness of soloist
Anticipation of musical participation	Musical cue
Assertiveness	Musical partners
Attention	Musical time
Autonomy	Mutuality
Awareness of another needing help	Negotiation
Awareness of camera	Negro Spiritual song
Awareness of group's tempo	No eye contact/verbal exchange
Awareness of others	No instruments
Awareness of T	Offered a turn
Brief silence as quiet member sings	Offers turn to another
Choice	Own choice of song
Choice of next performer	Ownership
Choice to not play	Participating
Clapping in support	Partnership
Clinical decision by T	Percussive instruments
Clinical technique of matching	Performance
Cohesion	Perseverance
Communicative eye contact	Playful energy
Confidence	Playful, purposeful, strong
Connected	Plays bongos in rhythm to soloist
Conversing	Pleasure
Cooperation with another	Promote awareness of others
Creativity	Purposeful energy
Cross-cultural	Reaches for drum
Dancing	Recognition

Decision-making	Regular, firm shaking of maracas
Deep, focused voice	Reluctance to leave
Definite melody, firm rhythm	Rhythmical body movements
Different experiences	Rhythmical, soft, firm, quiet playing
Dynamics	Safe musical space
Eagerness	Seated in circle on chairs
Encouragement	Seated with others
Energetic feel	Self-expression
Energetic music	Sense of others
Energising elements	Singing clear, loud
Enjoyment	Singing harmonies
Exclamation of pleasure	Singing more energetic
Experience others	Slow to react
Expression	Slow, strong, loud
Expression of emotions	Smiles/laughing
Eye contact/looking at T	Social contact
Feelings	Social interaction
Firm singing	Soft, strong playing
Firm, light melody	Solo opportunity
Free	Soloing
Free to play/sing	Soloist smiling
Fun	Spontaneity
Group alert/aware	Staff and patients included
Group awareness of soloist's energy	Staff as equal members
Group clapped	Staff choice to participate
Group joins in vocally	Staff initiative
Group laughing	Staff investment
Group laughs with soloist	Staff member performed
Group leads	Staff roles
Group member suggests song	Staff solo opportunity
Group provides	Stand/walk to centre of circle
Group singing lively	Support for performance
Group supporting soloist	Supportive
Group supports through singing	Supportive atmosphere
Group watching soloist	T adapting to soloist's musical offering
Harmony	T clinical intervention

Helpers	T encouraging
Helpfulness	T encouraging/supporting
Helps group member	T leads activity
Humour	T playing guitar
Improvised song	Tempo is moderately fast
Independence	Therapeutic space
Initiative	Together moving drum
Initiative of social contact	Togetherness
Instrumentally active	Tolerance
Interaction between staff and patients	Turn-taking activity
Investment	Unique experience
Involved	Verbal exchange
J not instrumentally active	Verbal/social interaction
Known song	Vocally active
Leader role	Ward lounge

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

APPENDIX x

Full list of Themes, Categories and Codes

Theme	Category	Codes	
1. Opportunities for growth of personal worth 2. Experience of a changing group and self identity	Sense of Agency	Accomplishment Assertiveness Autonomy Choice Choice of next performer Choice to not play Confidence Creativity Decision-making Free Free to play/sing	Group member suggests song Independence Initiative Initiative of social contact Own choice of song Reaches for drum Spontaneity Staff choice to participate Staff initiative Stand/walk to centre of circle Unique experience
1. Opportunities for growth of personal worth 2. Experience of a changing group and self identity	Motivation / Investment	Absorbed Attention Eagerness Investment Involved	Longer duration Motivation to be part of group Perseverance Reluctance to leave Staff investment
1. Opportunities for growth of personal worth 4. Musical interplay: expression through music	Musical Participation	Instrumentally active Group singing lively Active participation Dancing Group joins in vocally J not instrumentally active	No instruments Participating Percussive instruments Rhythmical body movements Slow to react T playing guitar Vocally active
1. Opportunities for growth of personal worth 2. Experience of a changing group and	Growth of awareness and support	Acceptance Accompaniment Acknowledgement Awareness of another needing help Awareness of camera	Group clapped Group supporting soloist Group supports through singing Group watching soloist Helpfulness Musical awareness of soloist

self identity 3. Community: being in social relationship with others		Awareness of group's tempo Awareness of others Awareness of T Brief silence as quiet member sings Clapping in support Cohesion Connected Cross-cultural Different experiences Encouragement Experience others Group alert/aware Group awareness of soloist's energy	Mutuality Offers turn to another Plays bongos in rhythm to soloist Promote awareness of others Recognition Sense of others Support for performance Supportive Supportive atmosphere T adapting to soloist's musical offering Together moving drum Togetherness Tolerance
1. Opportunities for growth of personal worth 2. Experience of a changing group and self identity 3. Community: being in social relationship with others	Group Interaction	Communicative eye contact Conversing Cooperation with another Eye contact/looking at T Helps group member Interaction between staff and patients	No eye contact/verbal exchange Social contact Social interaction Verbal exchange Verbal/social interaction
2. Experience of a changing group and self identity 3. Community: being in social relationship with others	Roles	Anticipation of musical participation Clinical decision by T Clinical technique of matching Group leads Group provides Helpers Leader role Music on ward Musical cue	Musical partners Negotiation Ownership Partnership Staff as equal members Staff roles T clinical intervention T encouraging T encouraging/supporting T leads activity

1. Opportunities for growth of personal worth 2. Experience of a changing group and self identity	Expression of Emotions	Enjoyment Exclamation of pleasure Expression Expression of emotions Feelings Fun Group laughing	Group laughs with soloist Humour Pleasure Self-expression Smiles/laughing Soloist smiling
1. Opportunities for growth of personal worth 4. Musical interplay: expression through music	Musical expression	Aesthetic music African Gospel song Deep, focused voice Definite melody, firm rhythm Dynamics Energetic feel Energetic music Energising elements Firm singing Firm, light melody Harmony Known song Loud, energetic march Loud, rhythmical playing Moderate march	Negro Spiritual song Playful energy Playful, purposeful, strong Purposeful energy Regular, firm shaking of maracas Rhythmical, soft, firm, quiet playing Singing clear, loud Singing harmonies Singing more energetic Slow, strong, loud Soft, strong playing Tempo is moderately fast Turn-taking activity
1. Opportunities for growth of personal worth 2. Experience of a changing group and self identity 3. Community: being in social relationship with others 4. Musical interplay: expression through	Performance of Self	Member playing solo Staff member performed Soloing Offered a turn Solo opportunity Staff solo opportunity Improvised song Performance	

music		
3. Community: being in social relationship with others 4. Musical interplay: expression through music	Therapeutic Space	Musical time Safe musical space Seated in circle on chairs Seated with others Staff and patients included Therapeutic space Ward lounge

APPENDIX XI

Informed Consent for Focus Group Interview

FACULTY OF HUMANITIES
MUSIC DEPARTMENT

MUSIC THERAPY PROGRAMME
TEL (012) 420-5372 / 5374
FAX (012) 420-4517
www.up.ac.za/academic/music/music.html

UNIVERSITY OF PRETORIA
UNIVERSITEIT VAN PRETORIA
PRETORIA 0002 SOUTH AFRICA

Date: ______________________

MMUS (MUSIC THERAPY) CASE STUDY FOR MINI-DISSERTATION: focus group interview

I, Karyn Stuart (MMus student), am doing my music therapy internship at ward 48 at Weskoppies Hospital. The music therapy sessions that have included both patients and staff have been recorded via audio and video. These recordings will be used for clinical and analysis purposes as part of my clinical internship and case study which forms the basis of my Mini-Dissertation. My Mini-Dissertation is looking at how music therapy can nurture 'personhood' within patients and staff members in a music therapy group.

This focus group interview forms part of my case study, and will be recorded and used as data. This data remains confidential and anonymous to ensure your privacy, in line with professional ethical practice. Your participation in this discussion will help me, and I would greatly appreciate your input.

Your signature on this page will demonstrate your willingness and consent to participate in this discussion.

Thank you very much
Karyn Stuart
MMus (Music Therapy) Student

Name: ____

Signature: _____________________________________

Ward: ______________________

APPENDIX xii

Staff Focus Group Interview Questions

As a warm-up to the proposed questions, it may be appropriate to thank the staff for their participation in the music therapy groups and perhaps for the parts they played, e.g. bringing certain energy to the group or providing harmonies. It is necessary to gain their written informed consent (Appendix xi), remind them of the confidential nature of the interview and of the consent the researcher would have obtained from the institute to record sessions and use material for research (Appendix ii). At this stage placing them at ease about the audio recording of the interview would also be called for.

It would be valuable if the interview facilitator add facets of his or her own experiences of the group or patients before or after related questions so as to place the staff at ease and facilitate discussion.

I propose the following questions be asked, and have provided a reasoning for each below.

1. When you were asked to join in this music therapy group, what did you think about the fact I asked you? I would ask this question to gain an understanding about their reactions, both positive and negative, to being asked to join the music therapy group. It may also function as an easier warm-up question.
2. What did you think about being part of a group with patients? This question may provide information as to how nursing staff might view their roles in relation to patients. Also this may provide qualitative information regarding their thoughts of being included with patients.
3. Why do you think I asked you to join? The answers to this question may reveal information regarding how the staff see their roles in a music therapy group. It may also reveal what they think the therapists expectations of them might be.
4. When you were playing, singing and sometimes dancing, what did you think about it? This question requires staff to think about their feelings/thoughts regarding their musical participation in the group.
5. When you were in the music therapy group with the patients, did you notice anything about them? I would include this question to ascertain whether or not the staff noticed any different behaviour from patients, especially as they see the patients outside of the music therapy group. This question

may lead to a deeper enquiry of the staff's expectations of patients and how these expectations may or may not have been met (e.g. a patient who is expected to be lethargic and slow, who may have reacted musically with energy and vigour).

6. **What did you like about the group?**

The nursing staff members have this opportunity to reveal what they enjoyed about the group. A follow up question may be why they enjoyed certain aspects or activities. This question may also reveal information about what the staff liked about the group as a whole, not necessarily the activities. These questions may reveal information for future music therapy groups, and may help facilitating therapists to include staff more through group activities/aspects they enjoy.

7. **How did you experience the groups?**

This may or may not be necessary to ask, depending on the quality of the answers in question 6. This question does not focus on physical activities, rather it requires thinking about the feeling and experience of the group. This may also provide information on how possibly their personhood might be nurtured, addressing aspects of the research questions.

8. **What did you not like about the group?**

Asking this question, possibly with some encouragement, may provide insight into aspects that staff found uncomfortable or that they disliked. This would be beneficial for planning for future music therapy sessions.

9. **What have you learnt about yourself and each other in the group?**

The answer to this question would be helpful in exploring how music therapy may facilitate growth in staff member's awareness of others (especially patients) in the groups.

10. **Did anything change outside the music therapy groups in your work with the patients?**

It would be beneficial to discover whether music therapy may influence relationships on the ward, or whether staff's thinking regarding patients may be influenced by their experiences in the group process.

11. **Do you have any other thoughts, feelings or questions about the groups?**

As a closing question this would open the floor for the staff to discuss anything that may have not been covered by the proposed questions. It may also provide them with the opportunity to revisit any previous questions or recall anything they may have forgotten to mention previously.