

Name and surname: Leigh-Ann Burger

Physical and postal address: 17 Zebra Crescent, Eldoraigue, Centurion, 0157

Cell phone number: 076 669 85 09

Email: leighannburger1@gmail.com

Student number: 12059955



UNIVERSITEIT VAN PRETORIA  
UNIVERSITY OF PRETORIA  
YUNIBESITHI YA PRETORIA

Research dissertation in partial fulfilment of the requirements for the degree  
MMus (Music Therapy)

**Music therapy groups for adolescents in oncology inpatient wards:  
The affordances of vocal improvisation for the  
expression of social resilience**

Leigh-Ann Burger

12059955

Department of Music

Faculty of Humanities

University of Pretoria

Supervisor:

Helen Oosthuizen

Co-supervisor:

Andeline dos Santos

Date: October 2017

## Abstract

This dissertation is a qualitative study of how vocal improvisation within music therapy groups may afford the construction of social resilience for in-patient adolescents in oncology wards. The study was conducted at the Pediatric Oncology Unit at the Steve Biko Academic Hospital in Pretoria. The case study involved six daily group music therapy sessions, with four to eight participants. The primary music therapy technique was vocal improvisation to assess how the participants perform themselves as resilient (or not). Excerpts of video recordings were analyzed through Gee's (2005) suggestion for discourse analysis. Session notes were written as an additional data source to contextualize the excerpts. Through discourse analysis, four primary discourses were identified: participant as patient, participant as adolescent, cultural adolescent, and participant as Hip-hop musician. These enabled the participants to explore their performance of selves in various ways. It was concluded that vocal improvisation in group music therapy enabled the expression of lack of resilience, as it received those feeling less resilient and provided them with safety and containment. It also offered the participants a means of instant coping within the various discourses that were identified. Vocal improvisation in this context also afforded the participants a space to adapt to their challenges as they explored various types of participation by learning from past experiences/ways of being, and adjust accordingly. Finally, the participants could transform through the changing relationships within the group itself, and how these social changes offered a social environment that afforded the resilience of the whole group.

### Key Terms:

Vocal improvisation

Group music therapy

Social resilience

Adolescent

Paediatric oncology

Culture

Hip-hop

## **Acknowledgements**

First and foremost, I would like to honour God for including music therapy in His plan for me and those I work with. The past seven years serve as a testimony of Your grace and faithfulness to me. Thank You for the fire You placed in my heart to help others through music and relationship, just as You have helped me all my life.

Then, to my father, Harry Collins, who has sacrificed most of his future to secure mine. Thank you for believing in me, even when I forget to believe in myself. I aspire to be a parent of your stature one day.

My loving husband, Fires Burger, you are my rock and comfort; my mountain in the storms. Thank you for accepting this journey with me. Some said that getting married during masters is unthinkable. Well, not having you as my husband during this time is unimaginable. I could not have done this without you.

To my supervisor, Helen Oosthuizen, I am so honoured to have gone through this with you. You are inspiring and so wise. Not only have you guided me through the work, but you managed to encourage a deeper love for working with youth. Thank you.

To Carol Lotter and Andeline dos Santos, you have been the best mentors that I could've ever dreamt of having, even before Masters. You are always warm, direct and know just how to say what I need to hear/learn the most. You will always remain what I aspire to be.

Finally, to each participant and staff member at the Steve Biko Paediatric Oncology Unit, thank you for your gracious hospitality and enthusiasm for this project.

## Contents

|  |    |
|--|----|
| 1. Introduction.....   | iv |
| 1.1. Background and context.....   | 1  |
| 1.2. Aim.....  | 2  |
| 1.3. Research question .....   | 2  |
| 1.4. Dissertation outline summary .....  | 2  |
| 2. Literature Review .....   | 3  |
| 2.1. Needs of adolescents diagnosed with cancer.....                                   | 3  |
| 2.2. Social resilience .....   | 5  |
| 2.3. Adolescents and music.....  | 9  |
| 2.4. The social affordances of using the voice and improvisation in music .....        | 10 |
| 2.5. Adolescents in group music therapy .....  | 14 |
| 2.6. Arts and music therapy interventions for inpatient paediatric oncology wards..... | 16 |
| 2.7. Conclusion .....  | 19 |
| 3. Methodology.....  | 20 |
| 3.1. Research paradigm .....   | 20 |
| 3.2. Research design .....   | 21 |
| 3.2. Participants .....  | 22 |
| 3.3. Data collection.....  | 22 |
| 3.4. Data preparation.....   | 23 |
| 3.5. Analysis.....   | 24 |
| 3.6. Research quality.....   | 26 |
| 3.7. Ethical Considerations.....   | 27 |
| 4. Data Analysis .....   | 29 |
| 4.1. Introduction .....  | 29 |
| 4.2. Participants .....  | 29 |

|      |   |    |
|------|---|----|
| 4.3. | Overview of the Music Therapy sessions.....                               | 29 |
| 4.4. | Selection of excerpts .....   | 34 |
| 4.5. | Thick descriptions and session notes .....                                | 35 |
| 4.6. | Recognising Discourses in the data.....                                   | 38 |
| 4.7. | Exploring resilience within the context of the identified Discourses..... | 44 |
| 4.8. | Conclusion .....  | 47 |
| 5.   | Discussion.....   | 48 |
| 5.1. | Introduction .....  | 48 |
| 5.2. | The “sick patient” Discourse .....  | 48 |
| 5.3. | Discourse of being a teenager.....  | 53 |
| 5.1. | Participant as Hip-hop musician .....                                     | 59 |
| 5.2. | Explorative space .....   | 65 |
| 5.3. | Conclusion .....  | 69 |
| 6.   | Conclusion .....  | 71 |
| 6.1  | Introduction .....  | 71 |
| 6.1. | Summary of findings.....  | 71 |
| 6.2. | Limitations.....  | 72 |
| 6.3. | Recommendations for future studies .....                                  | 73 |
| 6.4  | Conclusion .....  | 73 |
|      | REFERENCES.....   | 74 |

## Appendixes

|   |   |     |
|---|---|-----|
| A | Guardian information and consent form.....                    | 82  |
| B | Participant information and assent form.....                  | 84  |
| C | Institution consent forms.....                                | 86  |
| D | Thick descriptions of video excerpts with session notes.....  | 88  |
| E | Grouping of discourses and characteristics of resilience..... | 101 |
| F | Figures and Scores.....                                       | 106 |

## List of Tables

|      |   |    |
|------|---|----|
| 2.1. | Characteristics of Resilience as per Literature Review.....   | 8  |
| 2.2. | List of the main effects of vocal improvisation as per Sauv  (2004:129-130)....   | 11 |
| 3.1. | Summary of selection criteria.....  | 23 |
| 4.1. | Group music therapy session ideas for Pediatric Oncology Inpatients.....  | 30 |
| 4.2. | Selected excerpts.....  | 32 |
| 4.3. | Example of a transcribed video excerpt.....   | 36 |
| 4.4. | Example of a transcribed video excerpt outlined with session notes.....   | 36 |
| 4.5. | Example of an analyzed thick description.....   | 39 |
| 4.6. | Highlighted thick descriptions.....   | 40 |
| 4.7. | Discourses relating to the adolescents.....   | 40 |
| 4.8. | Performative expressions of the music therapist and discourses/Discourses<br>that are drawn upon .....                    | 42 |
| 4.9. | Example of organizing characteristics of resilience and lower resilience within<br>the Discourse of the Sick Patient..... | 45 |

## List of Figures

|      |   |    |
|------|---|----|
| 2.1. | Summary of the three dimensions of social resilience.....   | 7  |
| 2.2. | Themes indicating benefits of choir singing in cancer care .....  | 18 |
| 3.1. | Forms of participation as a repertoire of possibilities.....  | 26 |
| 4.1. | The interaction between the constructs  | 44 |
| 5.1. | Primary characteristics of resilience and lower resilience that were present<br>whilst participants engaged in the Discourse of being a sick patient..... | 49 |
| 5.2. | Lyrics of a verse from "Don't Cry" .....  | 52 |

|      |   |    |
|------|---|----|
| 5.3. | The primary characteristics of resilience that were present whilst participants engaged in the Discourse of being a teenager.....     | 54 |
| 5.4. | K's Lyrics.....   | 61 |
| 5.5. | Primary characteristics of resilience that were present whilst participants engaged in the Discourse of being a Hip-hop musician..... | 65 |
| 5.6. | Primary characteristics of resilience that were present whilst participants engaged in the explorative space.....                     | 66 |

#### List of Scores

|      |  |    |
|------|--|----|
| 4.1. | Call and Response beat S1-2.....             | 31 |
| 4.2. | Don't Cry.....                               | 32 |
| 4.3. | Friends, Friends, Everywhere.....            | 34 |
| 5.1. | TL's Vocal Improvisation.....                | 57 |
| 5.2. | An excerpt from the Improvisational rap..... | 64 |



## 1. Introduction

### 1.1. Background and context

During my first year of training in music therapy I had the privilege of building relationships with adolescents who had been diagnosed with cancer and were hospitalised at the Steve Biko hospital in Pretoria. Relationships (between me and them, as well as with each other) seemed very difficult for these hospitalised adolescents to initiate and maintain. Isolation is a common struggle for adolescents with cancer. This is often due to, for example, removal from their home context, feeling ill, and having little contact with peers (Albritton, 2003:2594).

When I observed how both children and adolescents in oncology wards interacted with others, it struck me how they seemed to lack motivation and joy. I noticed that this struggle may be increased for adolescents (between 11 and 18 years of age) at a time when social relationships form a crucial part of their identity development (Evans, 1997:179).

'Adolescence' has been defined and redefined for several years. In Western cultures, adolescence is considered a physical maturation stage wherein the individual intensely explores their identity (Louw & Louw, 2007:347). Through this process they experience a need for socialization and becoming more autonomous. Cognitively, their reasoning becomes more scientific, abstract and relativistic. However, the case might not be the same regarding non-Western cultures. In such cultures, the adolescent is brought up in a context wherein collectivism/interdependence is emphasized: "the interests of the group are more important than mine" (Louw & Louw, 2007:318). In addition, physical maturation, and moving into the adulthood stage, is demarcated by initiation rites, such as circumcision.

When considering what it means to be a South African adolescent, one discovers multiple facets embedded within this Discourse. Norris et al. (2008:51-69) conducted a study that investigated how Coloured, White and Black South African adolescents identify themselves in different ways within post-Apartheid South Africa. They stated that South African-ness is an umbrella identity, wherein individuals identify themselves according to aspects such as race, occupation, etc. that may overlap with that of other groups. They found that youth identifying as Black generally defined themselves as part of a collective culture (either by language, religion, or ethnicity), and had a strong sense of South African national identity. Contrastingly, youth identifying as White reported

a weaker national identity, and based their identities on age and gender groups. According to Norris et al. (2008:51-69), the 2003 South African Social Attitudes Survey (SASAS) confirmed that dual identities exist among Black South Africans, who tended to show both a strong national and group identity. However, dual identities did not emerge among the White, Coloured and Indian participants. Why this is the case is an interesting topic for future research.

According to Glavovic, Scheyvens and Overton (2003:291) adolescents who are ill need to develop social resilience to “absorb change”. In this study, social resilience includes three aspects as stipulated by Keck and Sakdapolrak (2013:14): social learning, participative decision-making, and processes of collective transformation. Keck and Sakdapolrak explain that social resilience is a dynamic process wherein uncertainty, crisis and change is considered normal as opposed to exceptional. In addition to socialization and building resilience, identity development is important as well.

## **1.2. Aim**

The aim of this study is to investigate how vocal improvisation within music therapy groups may afford the expression of social resilience for in-patient adolescents in an oncology ward.

## **1.3. Research question**

The research question is:

How does vocal improvisation in music therapy groups afford the expression of social resilience for adolescents in oncology in-patient wards?

## **1.4. Dissertation outline summary**

The following chapter will provide an overview of existing literature regarding the research question, as well as identify possible areas needing more research. The third chapter (methodology) will contextualize the paradigm and methodology of this study. It will also explain the sampling, data preparation, collection and analysis. This chapter also includes ethical considerations involved in this study. The fourth chapter (data analysis) will provide an in-depth illustration of the steps taken to conduct the research, as well as how it was critically examined. The fifth chapter (discussion) will elaborate on the findings in this study. The final chapter will conclude the study, as well as mention the limitations and recommendations for future research.

## **2. Literature Review**

In this section I will discuss and compare the existing literature on the social implications and needs of adolescents diagnosed with cancer; existing social interventions for in-patients in paediatric oncology wards; and the social affordances of using the voice in music. Finally this section will provide literature documenting the affordances of music therapy for adolescents, particularly within the context of oncology.

### **2.1. Needs of adolescents diagnosed with cancer**

Common forms of cancer that adolescents may be diagnosed with include lymphomas (22%), sarcomas (16%), leukaemia (12%), brain tumours (9%), testicular cancer (9%), female genital tumours (7%), thyroid cancer (8%) and melanoma (7%) (Pentheroudakis & Pavlidis, 2005:181-188). The treatment procedures that these adolescents must undergo include chemotherapy, radiation therapy, immunotherapy, hormonal therapy, and targeted therapy to mention only a few (De Santis, Lin, Mariotto, Siegel, Stein, Kramer, Alteri, Robbins, & Jemal, 2014:254). Due to frequent visits to hospitals and clinics, as well as frequent hospitalisations, the adolescents and their family's daily routines and social roles are disrupted (Seitz, Besier & Goldbeck, 2009:683).

Regarding their external or contextual challenges, adolescents with cancer struggle with unfamiliar environments, loss of control, immobility, physiological discomfort, and isolation (Ayson, 2008:1; Daykin, McClean & Bunt, 2007:355). Adolescents may be isolated as they stay in a children's ward. They are older than the children around them and need different stimulation, but are also too young to interact with adults from other wards. Staying for a long period may result in them experiencing disruption of personal relationships due to not being able to build new or maintain existing relationships at school, at the hospital or within their families (Clark et al., 2011:665). Their family, peer and intimate relationships may also be negatively influenced due to stigmatization of being an 'ill' individual. Additional stressors such as their dependence on others and financial demands placed on support systems can further impact relationships (Ayson, 2008:1; Daykin et al. 2007:355; Jones, Jones, Parker-Raley, & Barczyk, 2011:1033).

According to Paal (2010:160), adolescents suffering from cancer often experience controversial feelings about the concept of cancer. They may avoid using the word cancer, and instead refer to it through euphemisms, or as "it" or "that". Paal (2010:160) explains that "this ideology restricts word use and sets boundaries on individual self-expression." However, Greaves (2001:3) states

that it is often difficult to accurately define cancer, even from a biological point of view: “the illness we call cancer has extraordinarily diverse features including its causation, underlying pathology, clinical symptoms, therapeutic response, and outcome or chance of cure. In a sense, every patient’s cancer is unique, which is part of the difficulty”.

According to Featherman (2016:137), “the ways in which we talk and think about disability might be, perhaps paradoxically, revealed in how we commonly conceptualize understanding. Arguably one of our most pervasive metaphors is the concept that knowing is seeing.” Grue (2015:52-90) who also writes about the Discourse of illness and disabilities, stating that the Discourse of disability has been centered around what is considered as ‘normal’, and has overlapped with those of other marginalized social groups, for example, people with cancer. Disability/illness was a form of economic and political oppression enacted on people whose bodies did not conform to the needs of industrial capitalism (Grue, 2015:51-74). Grue (2015:52, 99) further refers to the hierarchical power in the medical field, as well as “the totalizing potential of medicine to identify disability with illness.” Grue argues that in focusing too narrowly on reducing illness to problem-solution arguments, one misses what it means to be ill in contemporary societies. Illness and disability has been used as an identity marker that continues to marginalize and oppress those within particular social groups. Understanding how these Discourses have developed, as well as the tensions among them, might empower these social groups.

The Discourse of cancer has several implications for individuals diagnosed with it. Paal (2010:168) states that even when treatment is successful, dealing with the consequences of a culturally set stigma can be more distressing than dealing with the bodily experience and physical suffering associated with cancer. Paal (2010:168) further states that,

The popular image of cancer is closely connected with death and dying, and thus, often at the societal level, people with cancer are treated as ‘fading’. This particular image of cancer influences expectations of the cancer patient’s behavior.

People often expect those diagnosed to start acting and looking differently than those who are “normal”. According to societal expectations, they are often even excluded from daily activities, due to being expected to behave like dying people. Paal (2010:187-188) further explains that:

Conclusions, as well as (mis)judgements, are made according to each individual's understanding as outlined by culture bound ideas relating to the particular situation. If the sufferer acts 'unnaturally', by not following cultural norms appropriate for cancer patients, 'normal people' feel threatened. Sometimes the popular image of cancer affects behavior so intensely that some people still do not hesitate to break their social connections with those who have cancer.

Adolescents tend to form their identities through social comparison. During their stays in the hospital they may form relationships with their peers, and yet these relationships might not be sustainable beyond their stay at the hospital. Further, absence from their home communities (in addition to the experience of being ill) can impact how their identities are constructed within their relationships beyond the hospital community. Thus, being diagnosed with cancer may impact how they construct their identities and self-image within relationships with others (Young, Sproeber, Groschwitz, Preiss & Plener, 2014:137).

Adolescents in this context may experience complications in identity and self-image formation, loss of expression, anxiety, depression, shame, denial, and guilt (Ayson, 2008:1; Daykin et al., 2007:355). These could further impact their ability to form relationships. According to Seitz et al. (2009:683), adolescents with cancer "have to deal with dual stressors: having a life-threatening diagnosis and its associated invasive treatment, in addition to the challenge of the developmental transition from childhood to adulthood".

## **2.2. Social resilience**

To cope adequately with these challenges, adolescents need to be able to develop social resilience. According to Haase, Kintner and Robb (2014:2), "since 2001, increased research has enhanced our understanding of resilience, which is now primarily considered from a systems perspective, examined through multilevel analysis, and focused on understanding dynamics of how individuals adapt and change." Through analysing various qualitative and quantitative studies, they have found evidence that individual protective factors of positive coping, optimism, hope, spirituality, and purpose in life afford better psychosocial adjustment. This concurs with the aspects of resilience as stipulated by Keck and Sakdapolrak (2013:10-11), as each of these protective factors either aim at restoring the current level of well-being, or ensuring well-being for

the future.

Also, through an ecological systems perspective, Keck and Sakdapolrak (2013:14) argue that social resilience contributes new ways of thinking about and understanding vulnerable groups under stress. They explain that central aspects of social resilience are social learning (through observation, modelling and imitation), participative decision-making, and processes of collective transformation; and that social resilience is a dynamic process wherein uncertainty, crisis and change is considered normal as opposed to exceptional. If social resilience is developed, individuals may be better equipped to cope with the stressors they are faced with (Keck & Sakdapolrak, 2013:14; Scheyvens & Overton, 2003:291).

Social resilience is a relational concept that involves three dimensions embedded within a social milieu (Keck & Sakdapolrak, 2013:5): coping capacities (the ability to cope with all kinds of difficulties); adaptive capacities (the ability to learn from past experiences and to adjust to future daily life social challenges); and transformative capacities (“[the] ability to craft sets of institutions that foster individual welfare and sustainable societal robustness towards future crises”). These are further explained as follows (Keck & Sakdapolrak, 2013:10-11) and are then summarised in figure 2.1:

- 1) Coping capacities refer to the “re-active” (Obrist, 2010:289) means people resort to when dealing with immediate challenges, using resources that are instantly available to restore the current level of well-being.
- 2) Adaptive capacities refer to the “pro-active” (Obrist, 2010:289) means people use to not only learn from past experiences, but to also anticipate future risks and adjust accordingly.
- 3) Transformative capacities refer to the “participative capacities” (Voss, 2008:39–56; Lorenz, 2010) people use to “participate in decision-making processes and to craft institutions that both improve their individual welfare and foster societal robustness toward future crises” (Keck & Sakdapolrak, 2013:10-11).

|                         | Coping capacities                          | Adaptive capacities           | Transformative capacities                    |
|-------------------------|--|-------------------------------|--|
| <b>Response to risk</b> | ex-post                                    | ex-ante                       | ex-ante                                      |
| <b>Temporal scope</b>   | short-term                                 | long-term                     | long-term                                    |
| <b>Degree of change</b> | low, status quo                            | medium, incremental change    | high, radical change                         |
| <b>Outcome</b>          | restoration of present level of well-being | security of future well-being | enhancement of present and future well-being |

*Figure 2.1. Summary of the three dimensions of social resilience. Source: Keck & Sakdapolrak (2013:10) based on Voss (2008), Lorenz (2010), Obrist et al. (2010), Béné et al. (2012), Keck (2012).*

A method was designed by Haase, Kintner and Robb (2014:1) to increase the understanding of how resilience is influenced by positive health factors such as social integration, courageous coping and derived meaning. This method, called the Resilience in Illness Model (RIM), considers two main risk factors, namely illness-related distress and defensive coping.

When writing about hospitalised adolescents, McFerran (2010:65) states, “the chronically ill teen may be coping extremely well under the circumstances.” In this context, resilience refers to how the adolescent responds to their circumstances. It also involves insight, self-management and an experience of ‘happiness’ even if this may not correspond with that of a physically healthy adolescent (McFerran, 2010:65). It involves a social environment that fosters positive and/or healthy responses to adversity.

However, according to Biswas-Diener and Kashdan (2013:online), always appearing happy impairs one’s ability to adjust to external changes, when being flexible would be more advantageous. For example, people attempting to always express themselves as ‘happy people’ are often optimistic resulting in attending to symptoms or treatment guidelines too lightly. They suggest that one should face negative emotions with the same intention as seeking happiness. Negative emotions refer to facing the disappointments in life ‘head on’, and, for instance, to use feelings of anger to stand up for yourself, or to use feelings of guilt as motivation for changing one’s behavior. They state that this shift between positive and negative feelings according to situational demands is known as psychological flexibility. In addition to this pre-requisite for well-being, Biswas-Diener and Kashdan (2013:online) consider happiness, occasional sadness, a sense of purpose, playfulness, autonomy, mastery, and belonging within a matrix. This challenges

the idea of 'happiness' itself being a characteristic of resilience. Table 2.1 offers a summary of the various characteristics of resilience referred to thus far:

|   |  |
|---|--|
| Keck & Sakdapolrak (2013:14)            | <ul style="list-style-type: none"> <li>• Social learning</li> <li>• Participative decision-making</li> <li>• Processes of collective transformation</li> <li>• Coping capacity</li> <li>• Adaptive capacity</li> <li>• Transformative capacity</li> </ul>  |
| Killian, 2004; Snyder & Lopez, 2002     | <ul style="list-style-type: none"> <li>• Good cognitive abilities and problem-solving skills</li> <li>• Positive outlook on life (hopefulness)</li> <li>• Talents valued by self and society</li> <li>• Good sense of humor</li> <li>• General appeal or attractiveness to other</li> <li>• Sense of self-efficacy and positive self-esteem</li> <li>• Sense of control over one's own life</li> <li>• Achievement orientated</li> <li>• Ability to experience and express a wide range of emotions in a regulatory manner</li> <li>• Ability to empathize and consider situations from another's perspective</li> </ul> |
| Haase, Kintner, Monahan, & Robb, (2014) | <ul style="list-style-type: none"> <li>• Hope</li> <li>• Purpose in life</li> <li>• Optimism</li> </ul>  |
| McFerran (2010:65)                      | <ul style="list-style-type: none"> <li>• Insight</li> <li>• Self-management</li> <li>• An experience of 'happiness' that may not correspond with that of a physically healthy adolescent</li> </ul>  |

*Table 2.1. Characteristics of Resilience*



Albritton and Bleyer (2003:2591) state that adolescents, as well as their parents, benefit in a pediatric hospital from a socially supportive culture wherein the adolescents can experience group therapies and have more visits from family and friends. Some hospitals in the United States and in Britain have designated adolescent oncology wards to optimally meet the needs of different age groups (Albritton & Bleyer, 2003:2592). Programs on offer for them are considered as support systems that include age-specific treatment plans, nursing care, peer companionship, and recreation therapy. Some hospitals offer education for family and friends so that patients are not stigmatized or treated differently (Woodgate, 2010:122-123). These supportive environments enable collective coping, adaptive and transformative capacities. It is particularly important to consider the role that music therapy could play in a context where such supportive environments are unavailable.

### **2.3. Adolescents and music**

Due to the social nature of music and its importance for many adolescents, this may be a helpful tool within interventions for inpatient adolescents with cancer. According to Saarikallio and Erkkilä (2007:104), adolescents use music to alleviate boredom, pass time, distract themselves from stress, and to relieve tension. In addition, music is considered a resource for personal renewal and recovery. Rap music in music therapy, for example, offers young people opportunities to use their voices along with their favourite artists or spontaneously create their own raps as a means of expressing and performing their identities (Hadley & Yancy, 2012:278).

Adolescents often build their identities, in part, in relation to the music they listen to as their music preferences express their belonging to certain groups (North & Hargreaves, 1999:91). According to Adz (2012:8), many youth in South Africa favor house music and hip-hop as the themes often freely expressed in the music relate to relevant social issues. Kwaito is another popular style that appeals to South African youth. Kwaito is a form of dance music that originates from informal settlements and includes languages and slang familiar to the youth who listen to it (Seidman, 2009:74).

Keck and Sakdapolrak (2013:13) indicate that social resilience is enhanced through a sense of belonging and self-concept, and identifying with certain styles of music can foster this. Social isolation can be addressed within music therapy interventions (Schwantes, McKinney & Hannibal, 2014:120). This can be done through, for example, sharing music. When adolescents share their

music with others, they are sharing parts of their social identity. When others respond to or associate with this music, it can build social resilience within these relationships. This may apply not only to listening to music, but also to participation in music-making/singing alone or as a group, as will be discussed further in the following section.

In a study done by McFerran and Saarikallio (2014:89-97), it was found that music is not always helpful to use when adolescents do not feel well/happy. They emphasize the importance of adolescents having to take responsibility for how they appropriate music, instead of depending on music for its power. It is also important to note that even though music can be helpful in drawing adolescents together, it might also exclude those with different musical preferences. This may be counterintuitive as within a stressful hospital environment, music would be more effectively used as a tool to unite, rather than divide.

#### **2.4. The social affordances of using the voice and improvisation in music**

Singing can offer various affordances. In a study by Clift, Hanox, Morrison and Bärbel (2007:201) choral singing with adults with low psychological wellbeing enhanced their endurance and enabled them to develop better social relationships. Other benefits included social support, regular commitment, cognitive stimulation, positive affect and focused attention.

In a study conducted by Dingle, Brander, Ballantyne and Baker (2012:405), adults with chronic mental health problems, physical disabilities and/or intellectual disability indicated that group singing helped the participants to form a new and valued group identity. They were impacted personally regarding their self-perception and emotional regulation; and they experienced social connectedness. In addition, Scherer (1995:235), states that the voice is a particularly powerful means of self-expression, which may assist in building resilience.

The Canadian Association of Music Therapy's website describes improvisation as follows:

Improvising offers a creative, nonverbal means of expressing feelings. It helps the therapist to establish a bond of trust with a person and serves as a useful assessment technique. Through vocal, instrumental, and movement improvisation a person interacts with another and explores feelings which are difficult to express verbally. Improvising offers an opportunity to make choices and deal with structure in a creative way.

Sauvé (2004) conducted a research study involving the therapeutic effects of vocal improvisation. She defines vocal improvisation as free vocalization within a context of self-awareness (Sauvé, 2004:ii). Her study drew from the experiences of practitioners who participated in a vocal improvisation workshop. She concluded that vocal improvisation facilitated mainly relationship with others, the inner-self, and within a spiritual relationship. Table 2.2 indicates the main affordances of vocal improvisation for the participants in her study.

Singing together could include repertoire familiar to the participants or free improvisation. Improvisation can be contained within song frameworks or can be freely played. These forms of improvisation may be valuable for those who struggle to verbally express themselves due to emotional, cognitive and/or physical limitations (Sauvé, 2004:77-90), especially in groups. When considering the non-verbal functions of the voice, one finds that the voice is part of “gestural language”, holding multiple meanings at once. In addition, the non-verbal nature of vocal improvisation can create a sense of safety for the individual (Sauvé, 2004:26). Due to the wide range of non-verbal expression possible through vocal improvisation, it can evoke feelings of vulnerability. Singing in front of others might increase this sense of vulnerability due to it often being intimidating for the singer.

However, despite feeling vulnerable when singing in front of others, McMillan (1999:265-267) points out that risk-taking and musical relationships between musicians are important factors within the development of the distinct identity of improvising musicians. Even deviations or so-called ‘mistakes’ from a pre-determined format during improvisation may lead to desirable development within the vocalists. This may aid the development of social resiliency as it fosters an ability to adjust or adapt to challenges within a social context (Keck & Sakdapolrak, 2013:5).

|                           |  |
|---------------------------|--|
| WELL-BEING                | <ul style="list-style-type: none"> <li>• well-being (x4)</li> <li>• clarity</li> <li>• centered (x3)</li> <li>• calm</li> <li>• grounded (x2)</li> <li>• grounded in my voice</li> </ul>   |
| CONNECTION TO SELF        | <ul style="list-style-type: none"> <li>• emotional communion</li> <li>• re-connecting with myself</li> <li>• connection to breath and body</li> <li>• contact with emotions</li> </ul>   |
| RESOLUTION                | <ul style="list-style-type: none"> <li>• to process important issues</li> <li>• tool to face and transform emotions</li> <li>• cleansing</li> <li>• balance</li> <li>• release</li> <li>• release of terror</li> <li>• crying</li> <li>• safety, security</li> <li>• loosen and sometimes release ancient stuck bits from my cells</li> <li>• healing</li> </ul> |
| CONNECTION TO ENVIRONMENT | <ul style="list-style-type: none"> <li>• environmental communion</li> <li>• connectedness to the other participants</li> <li>• connectedness to universe</li> <li>• flow with other people's voices and presence</li> </ul>  |
| FUN                       | <ul style="list-style-type: none"> <li>• joy</li> <li>• enjoying the surprises</li> </ul>  |
| FLOW                      | <ul style="list-style-type: none"> <li>• flow</li> <li>• awareness in the moment</li> <li>• being in the present moment</li> <li>• opening (x2)</li> <li>• elation</li> </ul>  |
| BEAUTY AND LOVE           | <ul style="list-style-type: none"> <li>• sheer beauty (x3)</li> <li>• pure love (x2)</li> <li>• happiness</li> <li>• inspiration</li> </ul>  |
| CONNECTION TO SPIRIT      | <ul style="list-style-type: none"> <li>• sourceful communion</li> <li>• Life force</li> <li>• enlivening</li> <li>• help with meditation</li> <li>• spirit energy</li> <li>• calling</li> </ul>  |

Table 2.2. List of the main effects of vocal improvisation as identified by Sauv  (2004:129-130)

According to Sauv  (2004:29-30), vocal improvisation creates a space wherein singers can explore new ways of being and relating to others through being playful. Through singing freely rather than rigidly, one can be guided playfully to experiment with various sounds in relation to the self and others, with playfulness creating a safe container for this free exploration to occur. In Sauv 's (2004:137) study, relationships were developed within the improvisation group that differed from regular social relationships. She explains that:

As singing together in this context entails the sharing of one's being with others, it appears to bring about a vulnerability which makes the process very intimate. Group members thus report meeting each other on a spirit level, where this is acceptance of everyone. The elements of comfort and safety seem to enable this process. In addition, as the singers merge their voices together, they report experiencing a sense of unity and of oneness that might be explained in terms of entrainment. The relationships born from group singing thus seem to be ones of sharing, of vulnerability, of acceptance, of safety and of unity.

Hadley and Yancy (2012) looked at the significance of rap music as a therapeutic tool with adolescents in general, as well as in oncology and paediatric medical contexts. Rap music is a way for youth to express themselves where rapping serves as a 'metaphoric mic' through which youth can express themselves in difficult circumstances such as unemployment and poverty. Hadley and Yancy (2010:xxv) state that "rap became a medium through which youth described and interpreted the existential density of lived urban spaces and thereby were able to achieve an important level of transcendence, though without denial." Youth gain an opportunity to express their identities and lived experiences by rapping as a form of 'story telling'.

In an article about Hip-hop Discourse within the context of music therapy, Viega (2015:1-2), states that,

Hip Hop offers a multidimensional theoretical perspective for music therapy theory that views the ability of its artistic elements to transform and produce spirit, enabling individuals and communities to move from a location of marginalization to that of an empowered, collective voice.

Viega (2010:6-7) further explains that Hip-hop features themes of assuming personal

responsibility, resilience, and endurance through times of stress and oppression. Authenticity is an important social construct in the Hip-hop Discourse as it refers to the “ability to voice your lived internal and external experience in a truthful and genuine manner” (Viega, 2010:6-7). This involves the act of “being real” within one’s racial, class, and cultural experiences and expression by accepting it as part of oneself (Hodgman, 2013:402). In addition, being real in this way might lead to transformation through self-knowledge and commitment to self-improvement (KRS-One, 2009).

Even though adolescents who listen to hip hop may not be experiencing the direct oppression and circumstances of the artist, they are exposed to and engage in the meanings and Discourses behind the lyrics. In addition, adolescents in hospital are experiencing adversities that they might relate to in hip hop lyrics.

## **2.5. Adolescents in group music therapy**

Although vocal work with adolescents was discussed in the previous section, here additional literature on adolescents in group music therapy more generally will be explored. Some goals in group music therapy with adolescents experiencing illness may include: emotional expression; discussing “feelings in relation to their experience of living with a deteriorating illness” (McFerran, 2010:150); expressing their identities; and listening to and respecting the musical contributions of the other group members. Aldridge (1995:103-109) also states that vocal or instrumental improvisation fosters a sense of purpose as well as counters feelings of isolation and abandonment in music therapy with adolescents. These are important qualities in developing social resiliency.

Adolescents in oncology wards may experience a lack of safety and a absence of control as they undergo invasive procedures. In this hospital context, where other medical staff may be perceived as mostly concerned with their physical health, music therapy can provide a space for psychosocial support wherein the adolescents may feel safe enough to express themselves and their emotions. According to Aldridge (2003:18), through improvisation (including vocal improvisation) the therapist offers the client an opportunity “to be remade anew in the moment to assert an identity that is aesthetic, in the context of another person, [and] to be separate yet not abandoned, in an activity invested with that vital quality of hope.”

Co-creating songs based on known styles in therapy can be particularly useful in building

relationships with the adolescents as well as helping them to feel comfortable. This is due to the associations they may have with the songs (McFerran, 2010:87). These associations may communicate a sense of hope or familiarity to the adolescents staying in oncology wards. It is also valuable to use songs as an entry point into a group improvisation. It is important that the therapist prepare for diversity in taste as this can be both valuable and unavoidable (McFerran, 2010:88).

Some genres that have been used in music therapy with adolescents include, rap and hip-hop (Hadley & Yancy, 2012) (as discussed in the previous section) and rock (Tervo, 2005). According to Tervo (2005:1-3), "rock music is used as a defense against archaic impulses which belong to the regressive tendencies of adolescence." He further states that lyrics may be more important for girls than for boys, however, in the rap and hip-hop culture, it might have changed.

In her doctoral dissertation on the experience of group music therapy for six bereaved adolescents, Skewes (2001:i) found that vocal and instrumental improvising with other adolescents in music offered them opportunities for both freedom and control. According to Skewes (2001:18-19), "the group's improvised material showed increasing levels of musical cohesion, which was reflected in the development of the musical property of rhythm and through the changing leadership strategies employed by the group leader". When challenging the proposed musical material of the leader, the adolescent is taking control over their behaviour in response to adversities (such as changing the disliked material proposed by the leader) (McFerran, 2010:65). This is a means of developing their social resilience.

## **2.6.Arts and music therapy interventions for inpatient paediatric oncology wards**

Arts therapies have been shown to be valuable psychosocial interventions for oncology patients regarding the enhancement of psychological wellbeing, spirituality and emotional expression (Puig, Lee, Goodwin, & Sherrard, 2006:218). The influence of music therapy in hospital wards has been researched widely. Of 140 articles reviewed by McFerran (2010:28-29), she found that 31% of music therapy for adolescent clients occurs in paediatric hospitals. In a study investigating adolescents receiving cancer treatment at a hospital in the UK, Molassiotis and Cubbin (2004:50) note how music therapy can be used as a treatment for adolescents with chronic illness due to it promoting confidence, well-being, management of symptoms, and coping mechanisms.

According to Aldridge (2003:17-25), in oncology wards creative expression, such as improvisation, helps patients deal with “loss, relief of suffering, restoration of identity, empowerment, and [finding] meaning in challenging situations”.

In a commentary on McFerran’s book: *Adolescents, Music and Music Therapy*, Bunt and Stige (2014:109) note that many music therapists set clinical goals of self-understanding and relationships with others. However, they state that ‘enhancing resilience’ is only occasionally mentioned as a goal in the music therapy literature: “in the broader literature on adolescent development, music has consistently been identified as a resource for coping, so McFerran suggests that this aspect might be more significant than music therapists have considered so far” (Bunt & Stige, 2014:109).

According to Pasiali (2012:50), more research is required regarding music therapy and social resilience. However, Haase and Robb (2014:909) conducted a study involving music therapy interventions with adolescents undergoing high-risk cancer treatments. The intervention was designed to improve resilience within the participants. The interventions included song-writing and creating a music video that proposed to create an awareness and understanding of their perspectives, treatments and dreams amongst family and friends. According to Haase and Robb (2014:online),

...several protective factors helped [them to] be resilient in the face of cancer treatments, including spiritual beliefs and practices; having a strong family environment characterized by adaptability, cohesion and positive communication; and feeling socially connected and supported by friends and health care providers.

While this study explored how the individual’s resilience was aided through interventions such as song-writing and creating a music video, my study is filling another gap by looking specifically at the use of the voice in improvisation, within a group context.

Tervo (2001:79-91) conducted a study examining his work over 20 years. The study was on the influence of group music therapy with adolescents in psychiatric hospital wards. A multiplicity of musical experiences (such as instrument and vocal work, as well as improvisation and pre-composed songs) were included. Results indicated that music, especially rock music (in the context of these studies), gave adolescents an opportunity for expression (for example, of feelings



of anger, rage, grief, longing and psychological disintegration); being in contact with and sharing experiences among themselves; and experiencing closeness and isolation. Music-based approaches may particularly appeal to adolescents due to their social affordances.

Reagon et al. (2017:1) state that “Cancer survival rates have improved dramatically over recent years, however, health-related quality of life for many patients, survivors and their families remains low even after successful treatment”. Thus, these authors included observations and interviews that explored the effects of participation in community choirs on health-related quality of life for individuals who are diagnosed with cancer, survivors and others affected by cancer (family, friends, etc.). Participants were asked to complete the Hospital Anxiety and Depression Scale at the start and end of the six-month study. Results indicated that participating in the choir improved vitality, overall mental health and anxiety in those diagnosed with cancer. For non-patients, participation improved anxiety. Figure 2.2 illustrates the themes derived from the data.

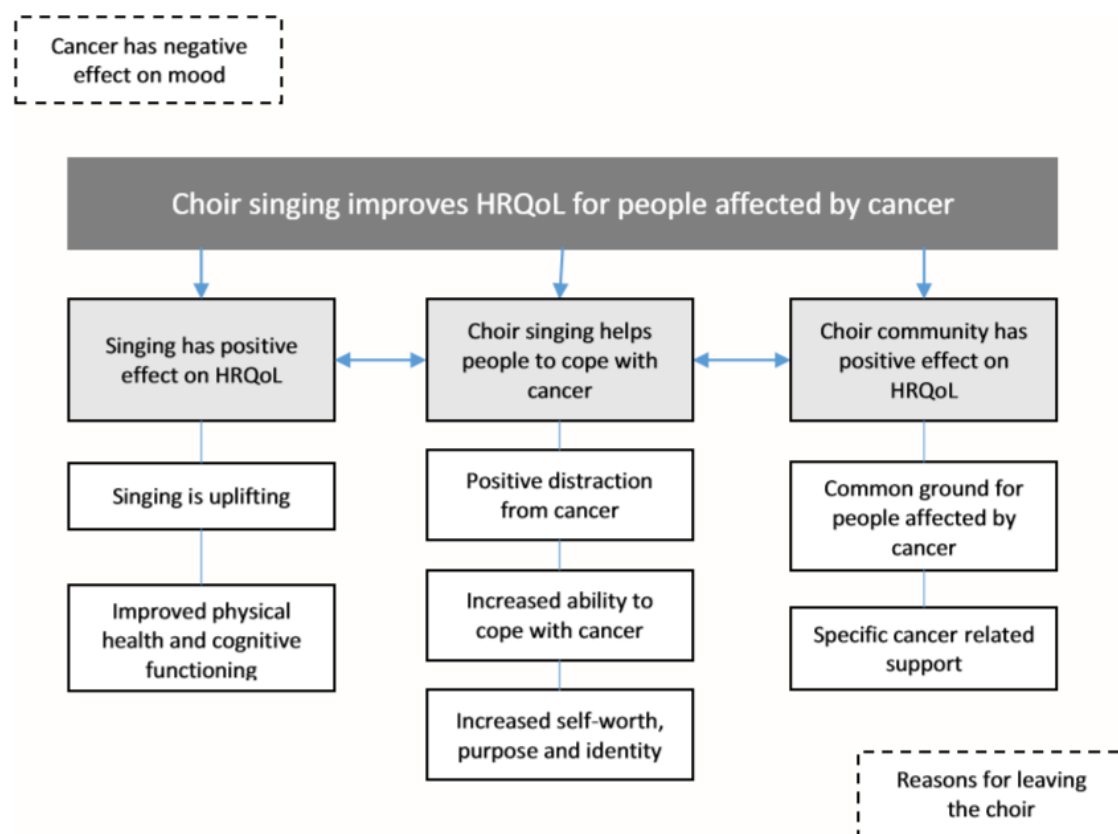


Figure 2.2. Themes indicating benefits of choir singing in cancer care (Reagon et al.,2017:3).

Reagon et al. (2017:1) further state that “participants experienced the choirs as both an uplifting musical activity and a supportive community group. The results support the provision of a spectrum of support options to meet the different needs and preferences of people affected by cancer”.

In another recent study, Clements-Cortes interviewed eighty music therapists working in the context of cancer and palliative care to assess their perceptions of singing and vocal interventions within this context. Clements-Cortes (2017:online) found that using the voice in music therapy interventions influenced the following themes: offering a contained space where patients could connect with others and themselves, where their anxiety was lessened, freeing their voice within, letting go of things that hinders them, and finally, to explore their identities. Clements-Cortes (2017:online) also discovered that individuals in cancer and palliative care enjoyed using their voices for relaxation. Goals of therapy mostly included: self-expression, mood improvement, and creating a feeling of togetherness between individuals receiving palliative care and their family. She concluded that, “music therapists use singing to address the physical, emotional, social, and spiritual goals of patients, and described singing interventions as accessible and effective. Further research is recommended to examine intervention efficacy and identify factors responsible that contribute to clinical benefit” (Clements-Cortes, 2017: online).

## **2.7. Conclusion**

After reviewing the literature, I would argue that the importance of the current research is twofold. Firstly, additional research is required that focusses on the use of voice as a specific technique within music therapy with adolescents because the use of voice affords a variety of experiences and expressions. Secondly, studying the affordances of vocal improvisation for social resilience of adolescents is important because using the voice in improvisation offers a platform to express oneself as more or less resilient.

### **3. Methodology**

In the following section I explain the methodological processes used to address the research question. These include the research paradigm, the preparation of the data, how the data were analyzed, and finally, the ethical considerations involved in this study.

#### **3.1. Research paradigm**

##### **3.1.1. Ontological and epistemological foundations**

This study was located within a postmodern ontology (Gray, 2004:38). Within this ontology, research is not approached as describing a generalizable 'reality' of the world, but rather as one of many possible representations of the social world and how meanings are produced therein. These representations are fluid and moving, as opposed to static. This study focused on how adolescents in an oncology ward respond to musical experiences by performing themselves as resilient. According to Gray (2004:28), the focus of a postmodern ontology lies in "how the social world becomes represented, and how meanings are produced." A postmodern stance was considered for this study as the goal was not to determine a single set of linear answers to the research question. Rather, it was to explore the various possibilities of how and why the participants constructed and performed themselves as resilient (or as less resilient) in this social context.

The social constructionist epistemology of this study was based on the notion that knowledge is produced and reproduced in context rather than being inherited/absolute (Burr, 2003:4). Individuals formulate meaning through language and social interaction as experience is mediated culturally, historically and linguistically (Willig, 2013:7). Thus, I attempted to explore how the participants constructed themselves as resilient (or less resilient) within a group/social context.

According to Starks and Trinidad (2007:1372-1380), "language both mediates and constructs our understanding of reality. It also defines the social roles that are available to individuals and serves as the primary means through which they enact their identities." The way that language functions to construct reality is understood in social constructionism through the notion of discourse (Burr, 1995:182). While social constructionism often focusses on how meaning is constructed through language, Gee (2005) offers a way in which to understand how the construction and performance of meaning also takes place through non-verbal process. This will be discussed further in section

3.5 on data analysis.

Gee (2005:7) differentiates between two approaches to 'discourse': the first, discourse (lower case 'd') which he refers to as "language-in-use" and secondly, Discourse (upper case 'D') that includes other aspects of communicating, such as our emotions, actions, how we interact with others, our clothing, etc. This relates to the concept of performance of self. Regarding the Discourse of the self as performance, Gergen (2011:113) states: "One's utterances are essentially performative in function. That is, in the very saying of something, one is also performing an action within a relationship. As performance, more than the felicitous use of words is required."

### 3.1.2. Research methodology

Because of the ontological and epistemological foundations of this study, qualitative research was, therefore, used. Qualitative research is defined by Bruscia (1998:186) as, "the study of interaction and interexperience, as it seeks to explicate the various gaps and bridges that exist between human beings and which make it possible to understand one another's behavior and experience." According to Hancock (1998:2), qualitative research involves the opinions, experiences and feelings of individuals producing subjective data. Other defining features of qualitative research include the research being subjective, holistic, descriptive, naturalistic and inductive (Halkier, 2010:71-73; Hancock, 1998:2).

I selected qualitative methodology as the most suitable for this research study as social resilience is constructed within interpersonal spaces and demands. As a qualitative researcher, I sought to understand how the participants formed themselves as resilient individuals (or individuals who may construct themselves as less resilient) through social practices and processes, as well as to discover possible barriers and facilitators of change within these processes (Starks & Trinidad, 2007:1372).

## **3.2 Research design**

A single case study design was used as I aimed to explore one group of participants in-depth over a period of time (Hancock, 1998:6). According to Simons (2009:21), a "case study is an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, program or system in a 'real life' context." This study is designed in relation to the multiple representations of how meaning is created in postmodernism, as well as investigating

the several possible Discourses present within one context.

I conducted six daily 45 to 55-minute music therapy sessions in the playroom situated within the paediatric oncology ward of the Steve Biko hospital in Pretoria. The sessions involved various music therapy techniques that included vocal improvisation and the use of instruments. The instruments were used either as an accompaniment for the vocal improvisation or to act as a safeguard for the participants who may have felt too exposed at first. Other techniques that were used were group song-writing, and free-style rapping.

### **3.2. Participants**

The sample was selected purposively. Latham (2007:9) explains a purposive sample as “selecting a sample based on your own knowledge of the population, its elements, and the nature of your research aims. That is the population is non-randomly selected based on a particular characteristic. Music therapy sessions were held with an open group. All inpatients at the paediatric oncology wards in the Steve Biko hospital between the ages of 13 and 18 were invited to participate, if their parents had signed a consent form and they had signed an assent form. Adolescents participated in sessions with the possibility of withdrawing or simply observing if they were feeling ill or not able to participate. This occurred once, when a participant was feeling too ill to attend, he did not attend a few sessions. He joined again after a few sessions.

The group included eight participants per session and this enabled the collection of in-depth data. There was never an instance where someone within this age bracket was excluded from the group, as there were never more than eight adolescents present.

Not all group members were fluent in English, however, the groups were conducted in English as I am not fluent in the participants' home languages. This might have impacted the group by limiting the participant's understanding of the process, and their ability to express themselves and reflect during discussions. The group members were generally from either a Xhosa or Pedi background. Fortunately, due to some members being proficient in English, they were invited to help one another with translations. This was rarely necessary as all members understood English well enough for sessions to occur smoothly.

### **3.3. Data collection**

The main source of data collection was video recordings of the musical and other non-verbal

interactions. Each session was video recorded from beginning to end, capturing all data. Session notes were written as a supplementary data source. These were used to offer context to the interpretations of the video data.

As researcher, I was also involved in the music therapy process as a participant-observer. Robson (1993:159) notes the importance of being reflexive and acknowledging one's dual role within research. I was actively involved in the music therapy process by facilitating the direction of the music, as well as the interactions between members. I also often took on a non-directive role when one of the members indicated initiative and leadership.

Sessions were video-recorded in a static manner with a view of all participants. A disadvantage of video recording sessions is that the presence of the device may influence how the participants behaved or perceive the situation (Sparrman, 2005:243-244). I managed this through positioning the device out of sight as far as possible. By video-recording the sessions, I could capture data during musical, verbal and non-verbal interactions.

### 3.4. Data preparation

Selection criteria were used to guide the systematic choice of excerpts. These are presented in table 3.1:

| Selection   | Exclusion  |
|---|--|
| One from each session   | No more than one from any session                    |
| Includes vocal improvisation  | Does not include vocal improvisation                 |
| Clear recording – more clarity in discerning individual contributions | Unclear recording – [video] contaminated in some way |

*Table 3.1. Summary of Selection or Exclusion Criteria*

Using these criteria, I identified six excerpts. When reviewing the full videos, I made notes of which sections included vocal improvisations where clear interactions could be observed between the participants. These moments made up a short list of excerpts. During supervision, we reviewed the short list and decided to take one excerpt per session as it ensured the data included observations of each participant regardless of irregular attendance. Thus, observations included different contextual details such as group membership. As the researcher my selection of data

may have been biased towards excerpts that best supported my desired findings. Choosing excerpts along with a supervisor served to address this bias.

I then wrote thick descriptions of those excerpts including both musical and non-verbal interactions. According to Geertz (1973:3), thick descriptions are means of describing human behavior, as well as its context, so that the behavior becomes meaningful to an outsider. Due to the session notes including a brief outline of what happened both before and after each excerpt, I included these notes within the thick descriptions, to provide the reader with the context of the excerpts. These notes were not analyzed as separate sources of data.

### **3.5. Analysis**

Due to this study being conducted within a social constructionist frame, discourse analysis was used. Often discourse analysis focusses entirely on verbal language. However, there are many approaches to discourse analysis that focus on a range of non-verbal phenomena as well (for example, images (Ryan, 2004)). In the current study, the focus lay on interactional processes largely facilitated through music. This is also more effective in this study, due to the barrier that may be presented through working with people from different language groups. Language difficulties may have influenced how the participants understood activities, and thus how they understood what was expected of them. This study draws on the approach of Gee (2005). Gee provides a theoretical foundation to justify the exploration of music through discourse analysis. He states the following:

We continually and actively build and rebuild our worlds not just through language, but through language used in tandem with actions, interactions, non-linguistic symbol systems, objects, tools, technologies, and distinctive ways of thinking, valuing, feeling, and believing. Sometimes what we build is quite similar to what we have built before; sometimes it is not. But language-in-action is always and everywhere an active building process (Gee, 2005:11).

Gee (2005) considers language and these other ways of being as active tools through which we build seven areas of our realities: significance, activities, identities, relationships, politics, connections, and sign systems and knowledge. Gee's (2005:20-28) 'tools of inquiry' refer to "ways of looking at language-in-use that will help us study how the building tasks are carried out and

with what social and political consequences.” These tools are as follows:

**Situated identities:** using varieties of language for different purposes in different settings to convey a particular identity.

**Discourses:** how we use other forms of communicating our identities that do not involve the spoken language, for example, our clothing, way of thinking, acting, etc.

**Intertextuality:** when the language we use makes a cross-reference to another text or someone else’s words, such as quotes, for example.

**Conversations:** the language we use often refers to other broader texts, such as themes, motifs or debates, that influences how what we say is interpreted by through the social group it is related to (Gee, 2005:21).

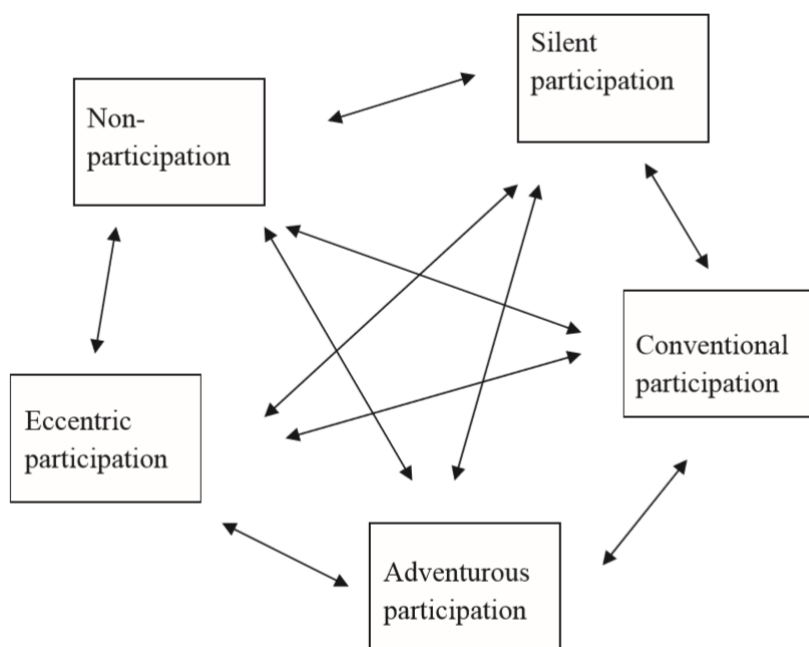
Situated identity is particularly important in this study. Gee (2005:13) states: “What I mean by a ‘who’ is a socially-situated identity, the ‘kind of person’ one is seeking to be and enact here and now. What I mean by a ‘what’ is a socially-situated activity that the utterance helps to constitute.” This is relevant in this study as the concern lay on how participants enacted social resilience as a socially-situated identity and performed themselves as having resilience as part of socially-situated identities.

As discussed earlier, Gee differentiates between two approaches to ‘discourse’: discourse (lower case ‘d’) referring to “language-in-use” (Gee, 2005:7), and secondly, Discourse (upper case ‘D’) including other aspects such as emotion, action, interaction, clothing, etc. With these concepts in mind, I began to carefully read the text whilst noting any phrases that indicated discourses and Discourses, including “actions, interactions, non-linguistic symbol systems, objects, tools, technologies, and distinctive ways of thinking, valuing, feeling, and believing” as proposed by Gee (2005:11).

The questions I asked myself whilst reading each section of meaning in the text were: “what is happening here”, “who is performing themselves as ‘who’ here?”, and “who is interacting with who, and how?”. These questions were based on Gee’s (2005:10) building tasks that explore how the participants might be constructing their realities through their activities, identities, significance, relationships, connections, politics and signs.



In addition to drawing on the work of Gee (2005), I also used Stige's (2010) participation styles as a reference to describe and identify various ways of performing within a group. Stige (2010:32) indicates five forms of participation styles/roles through observing bodily co-presence, mutual focus of attention, barrier to outsiders, and shared mood in a music therapy workshop. These include non-participation (not being there), silent participation (being there), conventional participation (joining in), adventurous participation (standing out), and eccentric participation (going across). These styles of participation are not discrete, and can move from the one to the other. The five forms of participation are not linear, but rather represent a repertoire of possibilities as illustrated in figure 3.1:



*Figure 3.1. Forms of participation as a repertoire of possibilities*

Stige (2010:132) explains that transformation occurs as a participant moves from one style of participation to the next, possibly suggesting a form of personal responsibility that is taken up to undergo this transition. In addition, the adventurous and eccentric styles are characterized as influencing the transformation of the situation, as well as the whole group. Thus, Stige's (2010:132) styles of self-representation within music therapy groups were used in this study to explore how socially situated identities can transform, as transformation is a key aspect in social resilience as proposed by Keck and Sakdapolrak (2013:14).

Practically, therefore, when analyzing the thick descriptions, I created a table in which the text from the thick descriptions was included on the left and three additional columns were then added on the right of this. The first was for initial analytic notes, the second was for notes to be written as specific discourses/Discourses were recognized in the text, and in the last column I wrote notes that specifically related to characteristics of resilience that were being performed.

### **3.6. Research quality**

As researcher, I needed to carefully take steps to ensure the trustworthiness of the research. The following strategies were used to increase the trustworthiness of this study: transferability, confirmability and dependability.

Transferability refers to the extent that a study's findings can be applied beyond the context in which the study was conducted. The goal is for the findings of this study to be useful for consideration by other therapists within similar contexts. This is achieved through detailed descriptions of the context (Malterud, 2001:484). Lincoln and Guba (1985:316) state that thick descriptions need to include the "widest possible range of information" for transfer to occur and conclusions to be reached. In attempting to afford transferability, several thick descriptions were written to provide as much information as possible. Confirmability considers how the researcher relates the findings to existing literature (Shenton, 2004:72). This was accomplished in chapter two and will be discussed further in chapter five.

According to Ruby (1980:153), reflexivity refers to the "assessment of the influence of the investigator's own background, perceptions, and interests on the qualitative research process". This includes the influence of the researcher's personal history on the research process. In this study, I was aware of my influence on the data, and I managed this by setting and maintaining clear boundaries. In addition, I discussed my perceptions with my supervisor on a regular basis. According to Aigen (2008: 307), peer support groups and clinical supervision assist in developing reflexivity as both therapist and researcher. According to Stige, Malterud, and Midtgarde (2009:1507), reflexivity is "about articulating questions tacitly underlying and motivating research, and of evaluating their legitimacy and relevance."

Dependability is also necessary to ensure the quality of research. This refers to how consistent the research process is over time (Williams, 2011:online). This was ensured through rigorous supervision as my supervisor examined the research process step-by-step. Peer examination is

considered by Krefting (1991:219) as a means of ensuring dependability in qualitative research. Member checking might have been valuable in this study however, this context makes it rather difficult to achieve. During peer examination, one investigates how careful the researcher was in conceptualizing the study, collecting the data, interpreting the findings and reporting results. In this study, this enabled the research process to be critically reviewed on a regular basis.

### **3.7. Ethical Considerations**

As this was a vulnerable group, I was very careful in ensuring that the research followed strict ethical procedures. Permission to conduct the research was obtained from the Steve Biko Academic Hospital (see appendix C). Participants and their guardians were thoroughly informed through verbal and written information of all the ethical implications of the study prior to signing consent and assent (see appendixes A and B). Thus, before engaging in any sessions, the participants and their guardians were informed of the process, and implications for their participation. The information included the fact that they were free to withdraw from the study at any time, at which point any data pertaining to them would be destroyed, and that the sessions would be video and audio recorded. There was no pressure to participate each week. The forms were given to them in person by me. Thus, they could ask any further questions they might have had.

In this study, all participants' rights to privacy, confidentiality were protected. No background information through which a participant might be identified was included. Participants' involvement, contributions and progress in the study was kept private. Confidentiality was ensured by not using the participants' names in any documentation and by keeping their identities secret (Willig, 2013:82). Confidentiality was upheld through guaranteeing that all transcriptions, documents, and video excerpts were only seen by the researcher and research supervisor. As a student, I followed ethical guidelines to ensure my competence to carry out the research, including receiving adequate clinical supervision.

## **4. Data Analysis**

### **4.1. Introduction**

In the following chapter, a brief outline will be provided of the music therapy session planning, and what occurred in each session. This is to contextualize the data. I will then be illustrating step-by-step how I collected and analyzed the data and what the findings were.

### **4.2. Participants**

In total, seven adolescents, between the ages of 12 and 16 years, participated. Their names were abbreviated to ensure confidentiality.

AZ, aged 14 years, was the only female present. She attended five of the six sessions. The one she missed was due to an outing. She always actively participated and was often shy to sing alone. TL, aged 15 years, attended four of the sessions. He mostly presented as quiet and resistive to participate in the music, but was always fully engaged. O, aged 12 years, only attended the first two sessions before being discharged. He was confident and enthusiastic about the process. TH and W, both aged 12, attended five of the six sessions. They are best friends. TH missed the first session due to later admission, and W missed the second session due to feeling ill. KH, aged 13 years, was very ill during the first few weeks. He attended the first and final sessions. TA, aged 16 years, only attended the second session as he came to the ward for check-ups. While all group members had cancer, I was not aware of the specific diagnoses of all participants. The ones I was aware of included rhabdomyosarcoma, retinoblastoma and leukemia.

### **4.3. Overview of the Music Therapy sessions**

During each session, there were at least two participants. The attendance of each session was as follows (with the total number of participants offered in brackets): session one (5), session 2 (5), session 3 (4), session 4 (2), session 5 (3), session 6 (5).

Due to music therapy involving an improvisational, client-centered approach, a variety of techniques were planned for the sessions and these were specified and refined during the sessions. The session plans are presented in table 4.1.

| Title                                     | Description  | Tools to bring                             |
|---|--|--|
| Greeting ritual                           | Drumming<br>Pre-composed beat<br>Includes each participant stating their names, and other facts/sounds/faces.      | Minimum of 8 drums                         |
| Sharing own music                         | Discuss what music they like<br>Use a song to move/play to   | Speakers<br>Internet (YouTube)             |
| Lyric analysis & improvisation            | Based on what they have shared.<br>Can take the chorus and<br>Improvise verses.                                    | Printed lyrics<br>Stationary               |
| Drumming & structured vocal improvisation | All members keep basic beat whilst vocal turn-taking or call and response (each gets turn to lead vocally).        | Drums                                      |
| Free vocal improvisation                  | Groups finds own tonal structure and moves freely & leave space for rapping.                                       | n/a  |
| Structured vocal improvisation            | Structured chorus with free improv in verses (individual or group).  | Drum/back-track/no instrumental grounding. |
| Verbal reflections                        | Causal discussions about how the session was; how it felt singing in front of others; etc. To be done at any time. | n/a  |

*Table 4.1. Group music therapy session ideas for pediatric oncology inpatients*

During sessions with a larger group, focus was placed on overall group interaction through turn-

taking, offering leadership roles, and creating opportunities for individual creativity that could be affirmed by group members. During sessions with two or three members, more in-depth work was done, such as song-writing, rapping, and challenging the individuals within the group context. The following is brief outline of what occurred in each session.

Session 1 (TL, W, O, K, AZ):

During the pre-music space, the participants sat in a circle. There was almost no interaction or eye-contact amongst them. The session started with a drumming ice-breaker: we all chanted the word “shaboya” (an imaginary word) rhythmically as we played. This served as a chorus. The verses consisted of everyone saying something about themselves within a recurring pause in the drumming. This space was created by the rest of the group, who played the same beat to offer a rhythmic container (see score 4.1).

## Call and response beat S1-2



*Score 4.1. Call and response beat S1-2*

This developed into a vocal call-and-response, wherein each participant was invited to make a vocal sound that was echoed by the rest of the group. This was extended into making a sound and movement. After this, the session included a conversation about what music each participant likes. The session concluded by collaboratively writing the first part of our weekly greeting song.

Session 2 (TA, TH, O, AZ, TL):

This session began as the previous session did. After the greeting exercise, the group engaged in a “build-a-beat” groove. In other words, one person started with a beat on his drum, and each group member was invited to add a beat of his/her own, until the group reached a full groove which continued for a while. This developed into a call and response wherein each member had

an opportunity to play a beat to be imitated by the others.

The rest of the session consisted of “fill-in-the-blank” song writing. The chorus was written by the group. Each member was invited to write one line about what they would like to tell someone in their current situation. They asked for an example. At that moment, a baby was crying in the ward next-door. I asked them what they would like to tell that baby who was crying, possibly due to physical discomfort due her diagnosis. The following chorus emerged, as illustrated in score 4.2:

**Don't Cry**  
Fill-in-the-blank Song Writing TA, TH, O, AZ, TL



Don't cry don't, don't cry, ev-rything's go-na be fine (don't cry) Don't cry, you'll go home

4 when you feel bet-ter (don't cry) Don't cry don't, don't cry,

6 ev-rything's go-na be fine (don't cry) Be strong, be, be strong, it's - gon-na be fine.

*Score 4.2. Don't Cry*

The verses were based on their individual completion of sentences written on pieces of paper that were handed to them:

The hospital \_\_\_\_\_.

The doctors \_\_\_\_\_.

My body \_\_\_\_\_.

I feel \_\_\_\_\_.

See appendix F (“Don’t Cry”) for the verses written by each participant. The chorus was sung and the verses were read as a pre-recorded rap instrumental played over the sound-system. The session ended with a few minutes of the group collaborating in writing the greeting song.

Session 3 (TL, AZ, TH, W):

The session began with the greeting song (written by the group) that adapted to the “goodbye song” and altered the words to “hello”. During this session, we mostly engaged in vocal turn-taking, either using lyrics about things we like, or improvised melodies. This developed into an improvisation with minimal structure. This session ended with the group continuing to collaboratively write the greeting song for ending sessions.

Session 4 (TH, W):

This session was held on a Saturday and most participants were at home for the weekend. TH and W attended. Once again, the session started with the greeting song. We rapped free-style. TH and W also took turns improvising vocally as I accompanied them on the guitar. This session included listening to one of W’s favorite songs by Chris Brown, “Don’t judge me” (see appendix F for the lyrics). We danced to the song as TH rapped his own improvised lyrics over the recording. The session concluded with the greeting song.

Session 5 (TH, W, AZ):

The session started with the greeting song. During this session, we engaged mostly in improvisation, either vocally or instrumentally. The improvisations often included enjoyment in turn-taking and call and response. The group members were creative and occasionally laughed together. The session ended with a verbal reflection and the greeting song.

Session 6 (TH, W, AZ, KH):

For the final session, we engaged in song writing with a theme suggested by TH and W: “friends”. Each member wrote their own lyrics for the verses (no guidance was given). The chorus was developed collaboratively and is included in score 4.3:



## Friends, Friends, Everywhere

TH, W, AZ, KH



### *Score 4.3. Friends, Friends, Everywhere*

This was rapped and sung over a pre-recorded rap accompaniment. Towards the end of the session, each member rapped and improvised questions to any of the other members, who responded with rapping.

#### **4.4. Selection of excerpts**

The video recording of each session was carefully examined in its entirety with my supervisor. Excerpts to be selected needed to illustrate moments wherein some of the participants offered material that could be directly explored in relation to the topic of the study. In other words, excerpts were required to display how vocal improvisation in music therapy groups may afford the expression of social resilience according to how “resilience” is discursively constructed in this study including the features of coping, adapting and transforming (as described in chapter one, section four). As the methodological approach rests on social constructionism and the data would be analyzed through discourse analysis, of concern was how these participants were drawing on and/or resisting certain discourses/Discourses within their performances of resilience (or less resilience). Excerpts were selected that contained demonstrations of this. Table 4.2. presents a summary of the six excerpts that were selected. One excerpt per session was selected.

| Session | Time of the point in the session that the excerpt begins | Description   |
|---------|--|---|
| 1       | 32:40  | KH was invited to lead the call but hesitated. O intervened by taking his place.<br><br>What is happening in the music in these examples? E.g. genre / style of the music. When I get to the hip hop Discourse below it would have been useful to have already read that there was some hip hop present in the music that was happening. Otherwise I might think “where did hip hop come from”? |
| 2       | 10:00  | We engaged in build-a-beat; most members were tentative.  |
| 3       | 11:40  | Group vocally improvised together.  |
| 4       | 32:00  | TH challenged therapist within music. The intervention results in emotional release.  |
| 5       | 7:00   | Vocal call and response; TH was shy than usual.   |
| 6       | 25:30  | Group members rap individually using their own lyrics. This developed into spontaneous question-and-answer lyrics.  |

*Table 4.2. Selected excerpts*

#### **4.5. Thick descriptions and session notes**

After selecting the six excerpts thick descriptions were written for each. Table 4.3 illustrates an example of a thick description. For all the thick descriptions, please refer to appendix D.

| Thick description: session 1, paragraph 2  |
|--|
| <p>After a few calls, I looked at K, and tilted my head towards him with a smile and raised eyebrows, inviting him to lead the calls. The group continued with the pattern. K smiled, played the pattern, and shook his head slightly. As he shook his head, O, sitting at the other side of the circle, jumped in with a clear, high pitched syncopated sound. TL smiled at him and turned his posture towards him. W looked at K, with a slight smile, but K was looking at O (his face was not visible). After four calls that were softly responded to by the group, the</p> |

drumming became slightly “dissynchronized”. O chuckled softly and stopped calling. The group members (GM) also looked around at each other, and sometimes at him during his calls.

*Table 4.3. Example of a transcribed video excerpt*

As shown in table 4.3, I noted the behaviors of group members, such as K smiling and shaking his head, as well as interactions between the group members, such as when they looked at each other. Each thick description was read through a number of times to gain an overall understanding. The thick descriptions were then separated into paragraphs that indicated a particular event. The above excerpt is an example of this, as the paragraph starts with K being invited to lead, and ends with O’s turn (who intervened on K’s behalf). These paragraphs were referred to as meaning moments. Reference will be made to these as follows: ‘thick description, session (number), paragraph (number)’, for example, ‘thick description, session one, paragraph three’.

As mentioned, session notes were also written for each session and were used to contextualize each excerpt by being included at the beginning and end of each thick description. These have been included in appendix D. Table 4.4 illustrates a shortened example of a transcribed video excerpt accompanied by session notes.

**SESSION NOTES:**

The room was a room for isolated patients. The room was unoccupied. The walls were bright green with animals and plants painted on the them. One half of the room was filled with two beds squeezed next to each other. The other side of the room contained six chairs in a circle, and 6 drums in front of each chair.

**Pre-music space:** five participants are present, four male and one female. All of them are between 13 and 15 years of age. TL, the oldest of the group, had a beanie on his head, but wore a t-shirt. He had a drip machine attached to him. His posture was up-straight. Next to him was KH, also having a machine attached to him. He was very quiet, and had a slight hunched over posture. AZ, the only female in the group, was dressed warmly. She did not

have a machine. W was the youngest. He has impaired vision and often faced his head towards the roof when engaging with others. Sitting between him and TL, was O fiddling with a drum, and had a machine. Little, if any interaction between the participants. Therapist gets equipment ready. Participants sit in the circle and look at each other.

**Greeting song:** I introduced everyone through their name tags and everyone listened attentively. I then began to teach the greeting song. We all started with the chorus, “shaboya, sha-sha, shaboya, ah-yeah!”. This alternates with verses wherein each member gets a chance to say their name, hometown and play a beat, as everyone else responds with “Yeah!”. I had to frequently encourage the “yeah”-responses. Each member spoke very softly. O gave a more complex beat, whereas TL seemed very hesitant. His turn was, however, interrupted by a nurse needing to check his fluids. I then did a very brief call-and-response with him, wherein I played a short beat to be responded to by him. He engaged by responding with similar beats to hers. During the chorus, I added more complex rhythms to her playing, and AZ attempted those rhythms, but was a bit unsteady. She continued to play.

This excerpt is taken from the activity following the greeting song. During this, the GM were playing on a common pulse, but with various rhythmic patterns each. Then, without anyone saying something, a new common pattern emerged from everyone’s various individual patterns. It was repeated several times. The pattern included a space of silence wherein each member was invited to improvise a beat, and then later, a vocal call. The group would respond by imitating the individual call in the following space. Everyone sat against the back of the chairs, but in an upright, engaged posture (not slouching).

EXCERPT:

As the group continues the pattern, I initiated vocal calls. I invited the group with hand gestures to respond. The group initially responds out of time and softly. K and TL does not respond vocally, but are playing the pattern on their drums. O, W and AZ smile and respond audibly. The second call has a facial invitation from me (a smile and raised eyebrows) that was met louder than the first call. I made calls that were two beats in duration, and simple in rhythmic structure. It was mostly vowels, such as, “ah-yeah”, “e-e-e-e” and “ah-ye-e”. In

response to the fourth sound made by me, TL looked away from the group, smiled, and responded to the call with the group.

After a few calls, I looked at K, and tilted my head towards him with a smile and raised eyebrows, inviting him to lead the calls. The group continued with the pattern. K smiled, played the pattern, and shook his head slightly. As he shook his head, O, sitting at the other side of the circle, jumped in with a clear, high pitched syncopated sound. K smiled at him and turned his posture towards him. W looked at K, with a slight smile, but K was looking at O (his face was not visible). After four calls that were softly responded to by the group, the drumming became slightly “dissynchronized”. O chuckled softly and stopped calling. The GM also looked around at each other, and sometimes at him during his calls.

...

#### SESSION NOTES:

Toward the end of the session, I asked the group how they say “goodbye” in their language. Most said, “sanibonani”. I then played the guitar and verbally invited the group to think about how we can sing that to greet each other. After long silences, and looking at each other, O softly sang a line. I asked him to sing it louder. The group smiled and sang it when I asked everyone to repeat what he sang. This became the hook of the song. TL seemed as if he wanted to say something, by opening his mouth, then keeping quiet. I invited him to share, but he shook his and smiled. I then asked him to think of a word that we can use the following day. He nodded.

*Table 4.4. Example of a transcribed video excerpt accompanied by session notes*

#### **4.6. Recognising Discourses in the data**

As mentioned in chapter three, a table was created wherein the thick description text was included in the left-hand column and three additional columns were then included on the right of this. Within these columns I wrote initial analytic notes (while reflecting on Gee’s (2005) guidelines and also bearing Stige’s (2010) participation styles in mind); I then concentrated specifically on recognizing Discourses; and I then identified possible characteristics of resilience. A short example is provided in table 4.5:

| Thick description paragraph (session 2, par. 3)   | Initial notes                            | Recognizing Discourses  | Characteristics of resilience |
|---|--|---|-------------------------------|
| I invited O to lead the calls. He took a while to look up at the roof, smile, and then give a very soft, low pitched call. I asked him to sing louder, and he did. His calls were very rhythmic and monotone. The other GM did not look at him at all. I then invited everyone to copy O. TA then glanced at O with a blank expression. | O leads tentatively; directive therapist | O: participant as emerging musician; therapist as facilitator | O: risk-taking, adaptable     |

Table 4.5. Example of an analyzed thick description

After I had completed this table for all the thick descriptions I then reviewed the table as a whole to further reflect on the discourses/Discourses that may have been present in this process. I began to highlight discourses/Discourses that were prominent across the text by using different colors. As the work was mostly non-verbal and interactional, Discourses, rather than discourses, became the focus. In appendix D the full table is included with all the colored highlights.

The following table provides an excerpt from the highlighted thick descriptions. Colors that were used were yellow (Hip-hop musician), grey (therapist), green (explorative space), pink (sick patient Discourse), and blue (Discourse of being a teenager). See appendix D, session five for full data.

I asked W to join in, and he said “e-e” with his face still cover, and hoodie over his head. Az sang what I was singing, and TH began to clap his hands I a repeated rhythmic pattern (ta-ta-taa), that I matched with the guitar’s strumming. He then began to whistle short notes in the key of the guitar.

W: withdrawn; Az: imitates therapist; TH: creative variations

W: client as withdrawn adolescent patient; Az: client as complaint musician; TH: client as musician/hip-hop musician

W: resistive, withdrawn; Az: dependent, compliant; TH: creative, explorative, self-esteem

I began to sing more varied sounds, such as, “weeee-wooo-waaah”, etc. Az softly sang similar and slightly different sounds. TH began making animal sounds like roars. Az laughed and waved her index finger at TH. He looked at her and smiled. The strumming pattern changed to more percussive (muting every 4th beat). TH placed his head on his arm. W then made a very soft, but long “aaaaahh” sound, slightly off-key. I then said, “well done, W!”. He smiled and kept quiet.

Az: explores different sounds independently, initiates direct contact with TH; TH: creative sounds; W: participant

Az: client as musician; TH: client as hip-hop musician; W: client as compliant musician/ tired patient

Az: compliant, explorative, increasingly confident; TH: creative, allows contact humour; W: compliant, resumes engagement/ includes self, tired

I started to play the guitar very softly. TH looked around at me. I asked everyone to move in closer. He looked at me blankly. I then indicated with my hands how he should move. He came in bit by bit. Everyone was sitting closer to the centre of the group, and leaned in. I then asked everyone to close their eyes. TH leaned back on his chair, and closed his eyes. I then said, "we will be making sounds together, as loud as we can." TH then lifted his arms in the air, gave one loud clap and made a loud, long, and low-pitched sound on "uuuuuh". I then matched him. Az giggled and joined me with long sounds. As I went louder, TH gave one loud shout, "aaaagh!" and clapped again. Az went louder with me and then laughed again. W sat with his face in his hands, resting on his legs. It is unclear of what he did vocally. TH leaned back and placed his hands over his face.

TH: is creative and engaged; W: façade of disengagement; Az: laughed and followed therapist

TH: client as hip-hop musician; W: client as withdrawn patient; Az: client as compliant musician

TH: creative, expressive in regulatory manner, humour; W: withdrawn, inward; Az: "happiness" compliant

*Table 4.6. Highlighted thick descriptions*

Discourses that were identified in the data will firstly be presented. This will be followed by a discussion of the identification of performances of resilience in the context of these broader Discourses.

The following Discourses were identified, as presented in table 4.7:

| Discourses recognized          | Brief description  |
|--------------------------------|--|
| <b>Sick patient (pink)</b>     | This refers to when the participants performed themselves as "ill", in relation to constructions of self within the medical Discourse. The medical Discourse uses language in a way that deems the individual to be a physical entity that is socially reduced to a prognosis (Grue, 2016:51-58).  |
| <b>Being a teenager (blue)</b> | This refers to when the participants performed themselves as teenagers as described by Louw and Louw (2007:347). This features personality, physical, emotional and social stages of development of individuals transitioning from childhood to adulthood. This also includes how the participants challenged boundaries and resisted certain forms of participation. This is one particular construction of being a teenager. |

|   |  |
|---|--|
| <p><b>Hip-hop musician (yellow)</b></p> | <p>This refers to when a participant confidently introduced new material, challenged leadership by establishing a new musical center, or by challenging the group coherence is by interfering with existing structures and material. Within Hip-hop Discourse, engaging in such moments may indicate freedom from oppressive roles through taking personal responsibility within the moment (Viega, 2015:1).</p> |
|---|--|

*Table 4.7. Discourses relating to the adolescents*

An addition to these three Discourses important contextual information was present as well. This included the explorative use of the music therapy process where the participants could “try out” engaging with different Discourses (colored green in appendix D), as well as the role of the therapist (colored grey in appendix D).

### **An explorative space (green)**

Not only did the participants enact socially situated activities and identities in relation to the particular Discourses mentioned in table 4.7, they also used music therapy as a space in which to explore shifting possibilities for performance. This explorative space was used as an “in-between” the Discourses space. While expressing different possibilities of performing themselves, the participants largely performed themselves in relation to Stige’s (2010) participation styles. Firstly, they explored performing a conventional participation style (2010: 130-131). Here they expressed greater compliance by imitating or synchronizing with the group. Young people identifying with this role often perform as expected, with occasional “personal embellishment” (Stige, 2010:130). In this study, members were compliant and self-conscious, yet they were fully engaged and active in the group, choosing to participate.

In addition, the participants also occasionally expressed aspects of Stige’s adventurous participation style. Here musical embellishments were not expressed as expected by the socially constructed conventions of the music we were creating, and participants deviated by introducing new material. According to Stige (2010: 130) this “could be described as a divergence that requires considerable active adjustment by the other people present in the social-musical



situation”.

The reason that this data was not incorporated within a formulation of a Discourse was that when a participant engaged in these explorative enactments, it was as if they presented themselves in a space “in-between” the Discourses listed in table 4.7. From the dominant position of one of those Discourses they then also indicated moments of exploring other ways of performing socially-situated activities and socially-situated identities within musicking.

For example, TL initially performed himself as a sick patient, but as he engaged more in music-making, he began to transition more towards the teenager Discourse, whilst still indicating moments of being a sick patient. This example indicates how TL engaged in the explorative space by moving in-between the discourses listed in table 4.7.

#### **Discourses drawn upon by the music therapist (grey)**

In analyzing the data, two particular performative expressions were identified in relation to myself as the music therapist. Table 4.8 indicates these two, namely directive music therapist and music therapist as facilitator. The table offers a brief description of each, including the discourses/Discourses that are drawn upon within them.

| Performative expressions of the music therapist | Brief description  |
|---|--|
| Directive music therapist                       | I often performed myself as a directive therapist, particularly when the participants engaged primarily with a ‘sick patient’ Discourse. Within these moments, I aimed at creating a sense of safety in the space. By being directive, I drew on a hierarchical Discourse of ‘therapist-knows-best’. This could be considered as situated within a biomedical discourse and enacted a behavioral focus at times. |
| Music therapist as facilitator                  | When the participants mostly engaged in the explorative space and teenager and hip-hop Discourses, I performed myself as a facilitator by facilitating roles, changing the direction of the  |

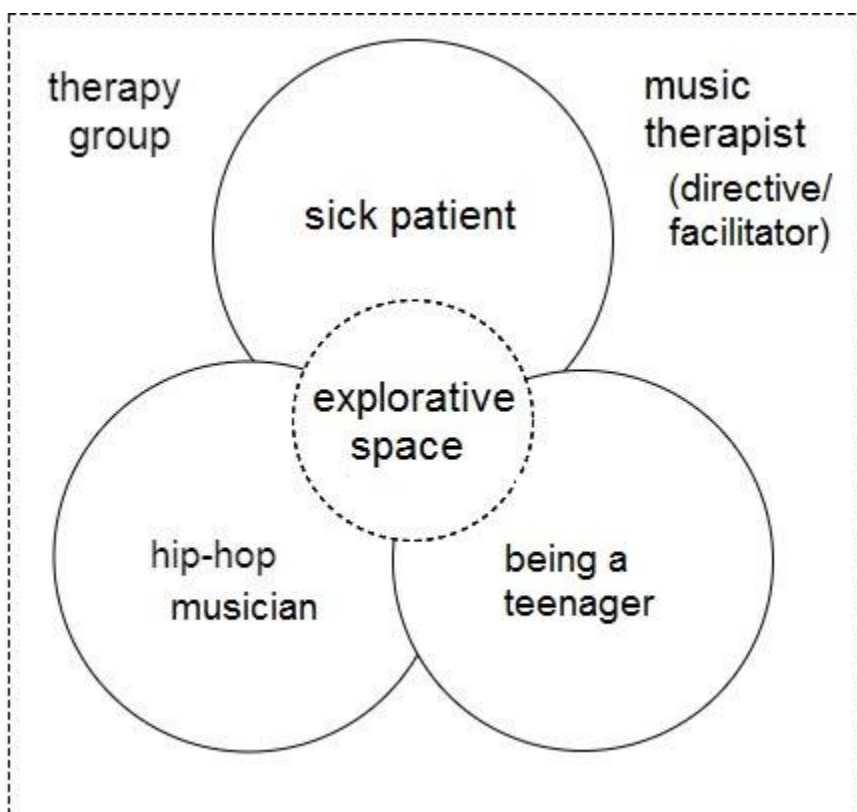
|  |  |
|--|--|
|  | <p>musical material, challenging participants within the music, etc. Even though this might indicate being directive, the facilitation aimed at enabling individuals to take responsibility in the music. During these moments, the participants took more initiative, and indicated more independence and creativity. By choosing to facilitate a music therapy group in a more client-centered, non-directive, improvisational manner I drew in these times on a more humanistic Discourse as well as a discourse of empowerment (this will be discussed further in the discussion chapter).</p> |
|--|--|

*Table 4.8 Performative expressions of the music therapist and discourses/Discourses that are drawn upon*

### **Bringing it all together**

The Discourses mentioned in table 4.7 were explored in relation to Gee's (2005:20-29) approach for identifying Discourses using his tools of inquiry. He states that these are particularly relevant to how individuals construct their identities and activities they engage with, as well as identifying the identities and activities of others. When regarding the tools of inquiry, one looks at *who* is doing *what* (Gee, 2005:22). This entails how an individual presents himself or herself as a certain kind of person in different kinds of circumstances. 'Whos' can be multiple and are not separated from the 'whats'. Gee (2005:23) states that "you are *who* you are partly through *what* you are doing and *what* you are doing is partly recognized for *what* it is by *who* is doing it."

Figure 4.1 presents a diagrammatic representation of the Discourses recognized in the text as enacted in the music therapy group process; the explorative space in which the participants tried out various ways of performing within the various Discourses; as well as the roles of the music therapist.



*Figure 4.1. The interaction between the constructs*

The three circles in figure 4.1 with solid borders are the primary Discourses that are all interlinked. Participants moved between these in various ways, and engaged in more than one at once. Here, the participants were free to explore various Discursive presentations of self.

#### **4.7. Exploring resilience within the context of the identified Discourses**

In the current study, the construction of resilience explained in section 2.4 was founded on literature by Keck and Sakdapolrak (2013:14), Killian (2004), Snyder and Lopez (2002), Haase, Kintner, Monahan, and Robb (2014), and McFerran (2010:65). The characteristics of resilience identified included coping; adapting and transforming; self-confidence; humor; a wide range of emotional expression in a regulatory manner; social learning; participative decision-making; processes of collective transformation; good cognitive abilities and problem-solving skills; hopefulness; talents valued by self and society; a sense of humor; a sense of self-efficacy and positive self-esteem; a sense of control over one's own life; being achievement orientated; having

the ability to empathize and consider situations from another’s perspective; having purpose in life; optimism; insight; self-management; and an experience of ‘happiness’ that may not correspond with that of a physically healthy adolescent.

Tables were created within which resilience was considered in relation to each of the Discourses recognized in the data. A table was created for each discourse. The initials of each participant were listed in the column on the left and the music therapy session numbers were listed across the top row. The notes from the initial full table with the notes, discourses and resilience rows that related to the characteristics of resilience and lower resilience as enacted by each participant were then included into this new table. Table 4.9 shows an example of this. It is a section of the table created for the Discourse of “sick patient” and shows the notes on resilience that were included for the first three sessions for each of the participants. The full tables for each of the Discourses and the explorative space are included in appendix E.

| Sick Patient |                              |  |                              |  |                              |                                       |
|--------------|------------------------------|--|------------------------------|--|------------------------------|---------------------------------------|
| Session:     | S1                           |  | S2                           |  | S3                           |                                       |
|              | characteristic of resilience | potential lack of resilience   | characteristic of resilience | potential lack of resilience   | characteristic of resilience | potential lack of resilience          |
| TL           |                              | limited range of emotional expression, withdrawal from challenge, poor communication, no risk-taking, blunted affect | self-orientated control      | low self-esteem, not achievement orientated, blunted affect, low self-efficacy | somewhat playful             | tired, blunted affect, low confidence |
| AZ           |                              |  |                              |  |                              |                                       |
| TH           |                              |  | asserts control              | Unhappy  |                              |                                       |
| W            | open communication           | no risk-taking, low confidence   |                              |  |                              |                                       |

|        |  |                                   |                        |                              |  |  |
|--------|--|-----------------------------------|------------------------|------------------------------|--|--|
| O      |  |                                   |                        |                              |  |  |
| TA     |  |                                   |                        |                              |  |  |
| K      |  | low confidence,<br>no risk-taking |                        |                              |  |  |
| GROUP: |  | compliant                         | enjoyment,<br>cohesive | tentative, no<br>risk-taking |  |  |

*Table 4.9. Example of organizing characteristics of resilience and lower resilience within the Discourse of the Sick Patient*

As the research question sought to explore how vocal improvisation in music therapy groups afforded the expression of social resilience in adolescents in oncology inpatient wards, these tables enable us to see how each participant could perform themselves with varying degrees of resilience, whilst engaging in the recognized Discourses and the explorative space. The following is a summary of how each participant expressed themselves as resilient in the Discourses:

Within the Discourse, or socially situated identity, of sick patient, TL expressed resilience by taking control over his situation (refusing certain roles). He also struggled to perform a resilient self as he often expressed a blunted affect and withdrawal. As the music therapy process developed, he performed risk-taking and humor as characteristics of resilience by exploring aspects of the other Discourses within the explorative space.

O attended two sessions, wherein he took initiative and expressed creativity and happiness. Overall, he performed himself as a Hip-hop musician. W began the music therapy process by performing compliance, commitment and engagement. As the process developed, though, he became more withdrawn, and often refused leadership roles, moving from the explorative space towards being a sick patient.

TH entered the process as “a resistive, noncompliant and challenging teenager”. Throughout our process, he ventured towards being a Hip-hop musician who took on a leadership role. Az presented herself consistently within the explorative space as she was primarily compliant, but often explored different ways of making music. KH, who attended the first and the last session, performed himself in contrasting ways. In the first session, he presented himself as a sick patient,

but during the final session he engaged as a Hip-hop musician. These will be discussed further in the following chapter.

#### **4.8. Conclusion**

This chapter gave an overview of the music therapy process that was conducted. It then illustrated a step-by-step process of how data were prepared and analyzed according to Gee's (2005) Discourse analysis and Stige's (2010) participation styles. Discourses were identified and the relationships between these and the aspects of resilience that were performed by the participants were explored. This was in order to examine the question of how engaging in vocal improvisation could afford resilience for adolescents diagnosed with cancer. The following chapter will provide a discussion about these Discourses and how the participants performed themselves through various forms of resilience within the music therapy process.

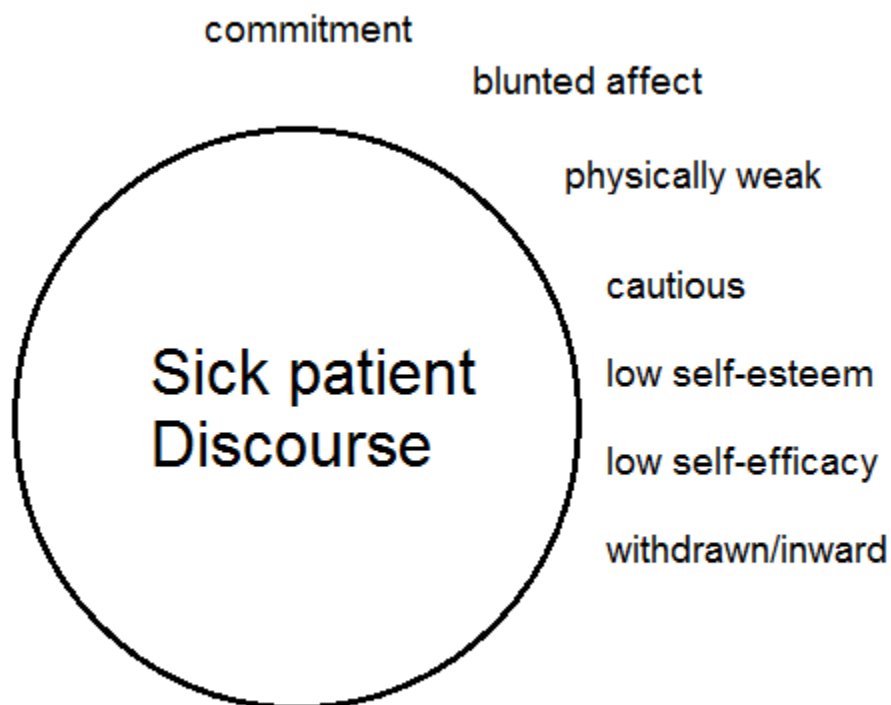
## **5. Discussion**

### **5.1. Introduction**

This section explores the various Discourses that have been identified through the data analysis. Each will be described, including examples of how the participants expressed aspects of resilience within each Discourse. The participation of the therapist will also be mentioned throughout. These facets of discussion contribute to the overarching aim of examining how vocal improvisation in music therapy may afford the expression of resilience by adolescents. This is considered within their context of the Discourses that they are engaging in.

### **5.2. The “sick patient” Discourse**

According to Grue (2015:51), in medical discourse illness has been used as an identity marker that continues to marginalize and oppress those within particular social groups, such as those diagnosed with cancer (Grue, 2015:51). Stigmatization and marginalization contribute to individuals suffering from cancer often experiencing constricting feelings about the illness, as “it restricts word use and sets boundaries on individual self-expression” (Paal, 2010:160). In addition to being treated according to their prognosis, individuals diagnosed with cancer also experience physiological discomfort, as well as potentially feeling powerless, defeated, hopeless, having a smaller range of emotional expression, feeling anxious, depressed, and so on (Ayson, 2008:1; Daykin et al., 2007:355). These experiences might be heightened through stigmatization, and vice versa. In the current study, it was found that when engaging in this Discourse, the participants could still express aspects of resilience such as commitment, while also expressing blunted affect, physiological weakness, withdrawal, caution, and having low self-confidence and self-efficacy, as illustrated in figure 5.1:



*Figure 5.1. Primary characteristics of resilience and lower resilience that were present whilst participants engaged in the Discourse of being a sick patient*

In this study, Stige's (2010:130-131) silent participation style seemed to adequately describe the participation of group members when engaging in this Discourse. They expressed powerlessness and a limited range of emotional expression. This participation style occurred when members indicated being present psychologically (for example, by seeming to understand the instructions) and socially (by making eye-contact with their peers), but did not take part in any conventional way, such as joining in during music-making when invited. They often seemed to be listening and watching through their body language and posture and at times engaged in mimicking. It is important to note that the possible reasons for participating in this way might be based on being physically exhausted or in pain (Esposito, 2014:1179), or having the attitude of an "ill" self perhaps linked to a sense of passivity.

Over the first few sessions TL, for example, performed himself through blunted affect, withdrawal, and potential low self-esteem and self-efficacy (see appendix D, session one, paragraph five).



One can argue that he was physically able to participate on the drums, as he did during other occasions. Perhaps he felt too self-conscious to lead the group using his voice, as improvising vocally can bring about feelings of vulnerability, as explained by Sauv  (2004:1-49). Features such as blunted affect and low confidence contrast the definition of resilience by Sauv  (2004:77-90).

Importantly, in addition there were also moments of greater resilience expressed. TL was also possibly willing to engage musically (as he was present and kept returning to the sessions). TL indicated commitment to the process, despite possible challenges that it levied on him to use his voice. Similar patterns were observed with other participants, such as W and AZ, who attended the sessions with commitment. These participants performed some resilience through accessing coping capacities when dealing with immediate challenges, using resources (the music therapy sessions) that were available. This concurs with Keck and Sakdapolrak's (2013:10-11) framing of resilience as the use of resources for the restoring of well-being.

In addition, when each of the participants were invited to take on a vocal leadership role, they communicated that they did not want to participate. They may not have felt able to participate (reaffirming a sense of powerlessness) or this could be viewed as assertion of a sense of control (the choice not to participate) in the face of having very little control over other aspects of their lives. For example, TL was asked to take leadership, but refused the invitation, as illustrated in the fifth paragraph of the thick description written for the excerpt drawn from session one:

I invited TL to lead the vocal call. He looked at me blankly as he continued to play the pattern with the rest of the group. I then verbally invited him, but he continued to stare at me. I smiled and said, "that's fine".

I propose that being able to 'not do what was asked', and being told it was acceptable to make this choice offered TL a means to take control to some degree.

As the sessions progressed, some of the participants seemed to experience a transition in how they performed themselves within the context of the Discourse of "sick patient" from enacting less to more resilience. For example, TL indicated minimal resilience during the first session (as already discussed). As the sessions progressed, however, he could exert control in the moment, and then express an emotion by smiling, laughing and using his voice more expressively to show

happiness. McFerran (2010:65), referred to happiness despite one's illness as being resilient. This can be seen in thick description, session one, paragraph three: "TL's playing was now very soft, with small irregular hand movements. He was looking down at his hands smiling as he responded [vocally]." This might suggest that through beginning to use his voice, TL experienced some pleasure.

W appeared to show lower levels of resilience as the sessions progressed. During the first few sessions, he presented as a participant who was enthusiastic, a risk-taker, and as 'happy' (see appendix E). However, as music therapy progressed, he began to enact being withdrawn and inward focused. An example of this was identified in the second paragraph of the thick description written for the excerpt drawn from session five:

W sat bent over with his hands over half his face, and elbows resting on his knees. He mostly had a blunted expression...

A limited or blunted range of emotions can be a sign of lower resilience (Sauvé, 2004:77-90). Or, this might suggest that he could experience being resilient *within* the Discourse of being a sick and stigmatized teenager. The participants generally responded to the medical team's questions regarding how they were feeling by using words such as "fine", "good" or "better". During session two, in our fill-in-the-blank song-writing, TL wrote the following lyrics:

The hospital hospital is so nice because <sup>helping me</sup>  
 The doctors doctors ~~keep~~ help ME  
 My body M body is good  
 I feel Feel well

Figure 5.2. Lyrics of a verse from "Don't Cry"

One might conclude that TL (and the other participants who often responded in this way) might have been feeling well. However, when considering their physical, social and emotional circumstances, it is hard not to wonder whether they have learned that this is the expected response and are conforming to it. They may have learned how to 'speak patient'. As mentioned before, illness and disability have been used as identity markers that continue to marginalize and oppress those within those social groups (Grue, 2015:52-99). This might also be reflective of the limited English vocabulary young people could draw from that may have influenced how they were able to describe their feelings.

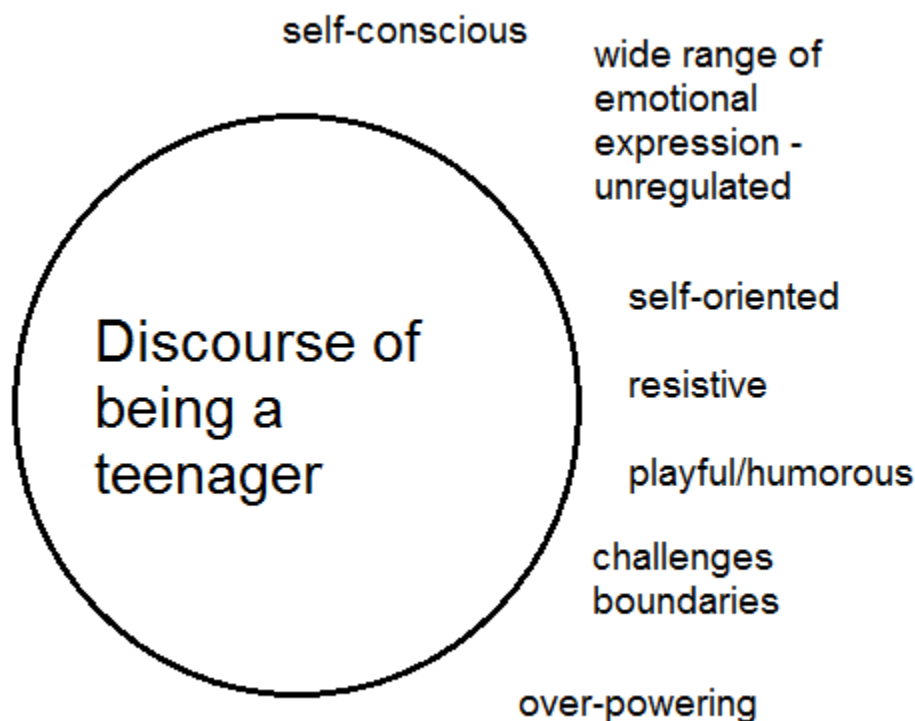
During the beginning of our process, W engaged in musicking by being creative and playful. As our process progressed, he responded each time he was invited to sing, even when he did not seem to want to participate in this way (indicating this by sighing). Towards the end of the process he declined to do so. This was not due to feeling sicker, as indicated by his medical records for those mornings. In W's case, the music therapy group, in which he could 'practice' expressing

himself in various ways, might have provided him a space wherein he did not have to conform as he does outside of sessions, but instead perform himself as he needs to or wants to in the moment. According to Sauv  (2004:25-26), vocal improvisation can serve as a vehicle for change and growth. W's vocal participation in the first few sessions (playful and creative and then reluctantly conforming) seemed to have contributed to him expressing various inner states such as resistance, fearfulness and playfulness.

A final aspect to consider in this Discourse, is how I, as the music therapist, influenced the expression of resilience. My role as the music therapist was to intervene through, for example, facilitating roles, changing the direction of the musical material, or challenging participants within the music in order to achieve a sense of safety, or to challenge the participants to try out various ways being. During the analysis of this Discourse, I noticed that my role was primarily focused on being directive. As most of the participants generally seemed tentative and self-conscious I often intervened by encouraging their engagement. Music therapy is a constructed discourse (Ansdell, 2002:1) that is formed in many ways, one of them being a strengths-based approach. Thus, instead of seeing the participants as powerless and ill individuals within the biomedical discourse, I often invited them into new and challenging means of engagement. This might have afforded them a sense of agency as I provided them with safety and security in this therapy space.

### **5.3. Discourse of being a teenager**

According to Louw and Louw (2012:306) behavior that is commonly expressed by adolescents includes testing boundaries, being 'awkward' and self-conscious, being self-focused and egocentric, challenging authority, experimenting with various roles, identity confusion, engaging in questioning, idealism, and argumentativeness. This is only one particular construction of adolescence (a largely Western one), however, some of these features were expressed by the participants in this music therapy group. The primary characteristics of resilience that were present whilst participants engaged in this Discourse of being a teenager are illustrated in figure 5.3.



*Figure 5.3. The primary characteristics of resilience that were present whilst participants engaged in the Discourse of being a teenager.*

Some of these features are recognized as aspects of resilience by authors on social resilience (table 2.1). This includes being playful/humorous (Killian, 2004; Snyder & Lopez, 2002). However, others may not be stipulated as such by these authors, but imply a contradiction thereof. For example, an unregulated, wide range of emotional expression may be considered less resilience than a wide range of regulated emotional expression (Killian, 2004; Snyder & Lopez, 2002); self-orientated may be considered less resilient than engaging in a process of collective decision-making or transformation (Keck & Sakdapolrak, 2013:14); and over-powering others may be seen as less resilient than having empathy towards others (Killian, 2004; Snyder & Lopez, 2002). In this study compliance was included within this Discourse as it seemed as if being self-conscious might have resulted in compliant behavior at times versus being confident (Killian, 2004; Snyder & Lopez, 2002). Being resistive and challenging boundaries do not necessarily imply more or less resilience as it depends on the context of the behavior. For example, lower resilience may be indicated when resistance and challenging occurs at the cost of another's experience (Killian

(2004) argues that this shows low empathy); or it may indicate exerting control over one's life (Killian, 2004; Snyder & Lopez, 2002).

In the data, AZ was often compliant. One potential explanation for this could be that she was the only female in the group. As Strebelt et al. (2006:517-518) argue, men are considered to have more power and status than women in South Africa. This might suggest an increased self-consciousness for women and, thus, more safety in being compliant. For instance, when AZ was invited to lead the group vocally the following transpired (thick description, session one, paragraph one):

Az chose the microphone. I invited Az to lead the call and response, as I just did. She smiled, chuckled and asked, "anything?". The boys were fiddling with their instruments. She used a melody I just did, but added words, "I like netball, I like pizza." She then stopped and smiled. The boys did not look at her, or respond vocally. They were still busy with their instruments. I responded to her vocally.

Here one might see how she performed herself as compliant (as she repeated my melodic material), willing, creative (as she extended the material by adding her own English words that she felt comfortable with), self-conscious and as a risk-taker, simultaneously. The boys in the group ignored her contributions by not responding to her calls, perhaps reinforcing gender-roles. She continued regardless, performing robustness despite the response of the boys. This contrasts how she resisted taking on roles like these at other times due to being self-conscious. Sauv e (2004:9-18) states that vocal improvisation serves as a means for expressing the authentic self. Sauv e's (2004:9-18) work is not situated within a social constructionist view. In this study, one can argue that this vocal improvisation is offering AZ an alternative means of self-expression, as opposed to expressing the core self.

Improvisational vocalizations may not be constrained by the same restrictions that instrumental playing entails (an individual might struggle to find the right instrument or sound to express what they want to, or they may lack the skills to play an instrument according to how they imagine they would like the music to sound). Vocal improvisation allows singers, such as AZ, to express themselves in various ways through intuitive sounds such as laughing, sighing, shouting, and so on. AZ was encouraged to simply make a small sound or say a word to express how she would like to perform herself. Perhaps participating in a music therapy group provided her with a sense

of safety to explore various socially situated identities, including those that challenged her adolescent self-consciousness and perceived gender role.

In the previous section, TL was described as predominantly performing himself as a sick patient during the first few sessions. However, TL gradually moved towards performing more as a teenager than as a patient (as detailed in appendix E). During sessions one and two, TL performed himself through several moments of potential lower resilience. These include blunted affect, withdrawal and cautiousness within the Discourse of being sick patient. Towards session three, TL indicated less moments of lower resilience within the Discourse of being a sick patient, and more moments of having more resilience (such as playfulness) and lower resilience (such as self-consciousness) within the Discourse of being a teenager.

In sessions one and two, TL would resist taking on leadership roles through looking at me with blunted affect. However, in session three, TL introduced humor by first smiling, taking the microphone from me, and then passing it on to the next member in order to avoid taking on the leadership role. The group responded with laughter at his humorous avoidance of his turn. According to Sauv  (2004:29-30), vocal improvisation creates a space wherein singers can explore new ways of being and relating to others through being playful.

Score 5.1 provides a musical example of TL's first response after accepting the leadership role during session three. Here, he sang an improvised melodic phrase as I accompanied him on the guitar. The rest of the group responded by imitating/echoing his material.

### TL's Vocal Improvisation

The musical score is written in treble clef with a key signature of three sharps (F#, C#, G#) and a 4/4 time signature. The melody consists of quarter and eighth notes. The lyrics are written below the notes, with group echoes indicated in parentheses.

Staff 1: E A E A E A E A  
 TL: li li li li li (Group echoes) TL: li li li (Group echoes)

Staff 2: 5 E A E A E A E A (pause)  
 TL: tra la la la (Group echoes) TL: tra la la la (Group echoes) TL: lu - lu

### *Score 5.1. TL's Vocal Improvisation*

After an extended pause when invited to lead vocally, TL began to sing: it was fast and out of tempo (during the first bar), but he adjusted his tempo and continued to sing. According to McMillan (1999:265-267), deviations or so called 'mistakes' from a pre-determined format during improvisation may lead to desirable development within the vocalists. While these tempo adjustments could be considered from a variety of perspectives (for example, neurological (Han, Kleifgen, Martin & Zarling, 2011:1), they can be considered in relation to resilience in that musical adjustments reflect interpersonal adjustments (Pavlicevic, 2004:3-19) and, hence, potentially the development of social resiliency as it fosters an ability to adjust or adapt to challenges within a social context (Keck & Sakdapolrak, 2013:5). In addition, the group echoing his contributions may have affirmed him in this interaction. Overall, even though there were moments when TL expressed less resilience, those moments were more grounded on him being resistive, yet in control, as opposed to appearing emotionally blunted and powerless. Also, although he expressed self-consciousness, he still managed to begin expressing his emotions more openly by smiling and introducing humor after finally taking on a vocal leadership role.

TH only attended from the second session. During the first few sessions that he attended, he was very resistive. There were a few sessions wherein TH indirectly challenged me as the music therapist. I then matched him, and this developed into a shouting and drumming crescendo between us. These moments ended with extreme emotional expressions, followed by sighs of relief and laughter from the others in the group. For example, during sessions three and four, the following scenario occurred (for the full text, refer to appendix D, session three):

I then invited Az to give the microphone to TH. As she handed it to him, all GM smiled. He looked at me blankly. I then said, as I played the same repetitive guitar progression, "go lalala or something." He responded with "aaaaih", whilst leaning back on his chair, swinging it, and looking down to his side, smiling. I then asked him to hold the mic for me. He sat up straight and held it upwards for himself. I sang, "la-la-lalala". He looked at me with wide eyes, and responded with a blunt, witty and loud, "laaah!". He then laughed with the other GM. I then imitated him and the quality he did it with. He sat back in his chair, holding the mic with both hands close to his face. He repeated the same sound for three consecutive calls.



As I matched him, he repeated it, pushing his head swiftly forward, and beginning to shout his call. I continued to match him. The repetitions became much faster, louder and accented. AZ and W played their shaker and tambourine faster and louder as they smiled at what was happening between TH and me. TL watched us, with a blunted affect, lightly tapping his drum. TH and I grew gradually louder and faster with our turn-taking on “la”. After a few moments, we reached a very loud and fast climax, and stopped as TH started laughing loudly. The rest of the GM laughed as well.

During these moments, TH initially indicated lower resilience by having no or very little self-regulation, asserting control at the expense of the group’s experience, and by overpowering others. Having little control over one’s life, as well as having a limited range of self-expression, are common experiences within individuals diagnosed with cancer (Ayson, 2008:1; Daykin, McClean & Bunt, 2007:355). The voice is a particularly powerful means of self-expression, as well as a means of exerting control over one’s vocal utterances (Scherer, 1995:235), which may assist in building resilience. In this example, TH could use his voice to shout in relation to me, as I did it with him. According to Sauv  (2004:137), when improvising vocally with others, sometimes...

...singers merge their voices together, they report experiencing a sense of unity and of oneness that might be explained in terms of entrainment. The relationships born from group singing thus seem to be ones of sharing, of vulnerability, of acceptance, of safety and of unity.

As the therapist, I could take on an affirming role. I could match him, and let him feel as if he could be contained, despite his unregulated and more extreme emotional expression. In this sense, my support within the music therapy group space enabled his sense of being contained, and thus his resilience.

In addition, singing and vocalizing with others may afford individuals social support, regular commitment through motivation to attend sessions, positive affect and focused attention (Clift et al., 2007:201). As the music therapist, I matched and extended TH’s vocal sounds and included them as part of the musical interaction, incorporating them within the musical frame provided for this activity. According to Dingle et al. (2012:405), group singing may assist in forming a new and valued group identity as it can impact the individual’s self-perception, emotional regulation, and

experience of social connectedness. This may be the case with TH.

One must note, however, that TH's "outbursts" were mostly not in the interest of the group. He often interrupted the turns of others, and was generally disruptive when the rest of the group was cohesive. One may speculate that he probably wanted attention or had difficulty with impulse control. His behavior could indicate a lack of resilience as he did not engage in participative decision-making (engaging in this is one of the features of resilience (Keck & Sakdapolrak, 2013:14)) and did not indicate the ability to empathize and consider situations from another's perspective (being able to do so is also a feature of resilience (Killian, 2004; Snyder & Lopez, 2002)).

As a music therapist, I could treat TH and TL as individuals able to make choices, whilst still providing them with an enjoyable experience, instead of treating them as stigmatized and powerless adolescents. This afforded them the opportunity to explore different experiences of being resilient teenagers a times – immediately, and in later sessions.

### **5.1. Participant as Hip-hop musician**

When a participant confidently introduced new vocal material, their participation style was considered as Stige's eccentric style (2010:130-131). Through this style, leadership is challenged by the establishment of a new musical center, or the group coherence is challenged by an individual interfering with existing structures and material. I suggest that this participation style could be considered in relation to a hip hop Discourse. By showcasing their own unique style participants indicated freedom from oppressive roles through taking personal responsibility within the moment. Viega (2015:1) states that engaging in Hip-Hop enables individuals to transition from marginalization and oppression to empowerment.

Three participants in this study performed themselves in this manner: O, TH and K (see appendix E). During the first session, K was invited to lead the group in a hip hop vocal call and response. He responded by looking at me with blunted affect, resisting the invitation. O, sitting at the other side of the circle, intervened by starting to sing his own call to be responded to by the group. O indicated self-efficacy, initiative, spontaneity, problem solving, and empathy when he intervened on the behalf of his fellow group member, K (thick description, session one, paragraph two):

After a few calls, I looked at K, and tilted my head towards him with a smile and

raised eyebrows, inviting him to lead the calls (in the Hip-hop style). The group continued with the pattern. K smiled, played the pattern, and shook his head slightly. As he shook his head, O, sitting at the other side of the circle, jumped in with a clear, high pitched syncopated sound. K smiled at him and turned his posture towards him.

According to Viega (2015:1), when engaging in a hip hop Discourse, one is encouraged to take personal responsibility for one's life or situations. In this example, O took personal responsibility for the sake of his peer, as he immediately looked at K, and nodded at him directly afterwards. O connected with K. As Clements-Cortes (2017: online) notes, vocal interventions within cancer care are valuable as they offer a contained space where patients can connect with others and themselves. O's motivation may have been informed by empathy towards K, as he considered the situation from K's perspective. This is considered a characteristic of resilience by Killian (2004:1), and Snyder and Lopez (2002:1).

K only came back to attend the sixth session, as he was too ill to attend the others. During the sixth session, the group engaged in song-writing with the theme "Friends in the hospital". This song was accompanied by a hip hop instrumental backtrack that was played on the sound system. Initially, K was very quiet and withdrawn in the group. This can be understood, as the other members had been bonding for the past few weeks, and he was new to this established group. K told me that he did not have any friends in the hospital. I invited him to write that down in his verse. He seemed to understand English very well but might have struggled when having to write his ideas down, perhaps as he struggled to spell words or felt self-conscious about his ability to write in English. I then asked him to write about his friends at home in the next part of his verse:

I don't have friends in hospital

I feel lonely

I have friends at home

I feel happy when i'm with them

Figure 5.4. K's lyrics

Finally, when each improvised their verses through rapping, I facilitated K's role by encouraging him to rap his verse in any way that he felt comfortable with – even just by reading it. K then began to rap with what is referred to as 'swag' in a Hip-hop Discourse. This is slang/street language for

'cool' (Chen, 2011:online). He used his hands to accentuate certain syncopated beats in his lyrics. He also included phrases such as, "ah-yeah" that is also situated within street language (the linguistic code of Hip-hop). Engaging in this music-making provided him an opportunity to connect with peers, whilst freely expressing himself as a confident adolescent, with a sense of control and agency through the free use of his voice. According to Hadley and Yancy (2012), rap music is a way for youth to vocally express themselves through a "metaphoric mic" in difficult circumstances. They are able to "tell stories" about their lived experiences, and thus, express their identities. In addition, young people who are familiar with hip hop may look up to affiliated artists, and thus, being able to tell their "stories" within this genre may be affirming for them through this identification.

In Sauv e's (2004:137) study, relationships were developed within the improvisation group that were different than other social relationships in the participants' lives. When engaging in group vocal improvisation, one can experience a deep sense of connectedness, within oneself and others. One becomes vulnerable, and this acceptance of vulnerable expressions can assist in achieving therapeutic goals. One has the permission to "express one's truth in the presence of others or becoming unified with the group itself could also be therapeutic" (Sauv e, 2004:138). The social context that K experienced in the current study may, therefore, have provided him with an opportunity to experience social resilience.

In another example, TH initially performed himself as being aggressive and resistive in his contributions. According to Viega (2013:338), behaviors within a Discourse of hip hop can be reframed within the music therapy space. In this study, TH's aggressive and resistive behaviors could be reframed as being creative, expressive and being a leader within the context of the music. Through expressing possible anger and frustration, but being able to reframe this "resistance" and "aggression" as being cool and influential in the group, he could construct himself differently. According to Hadley and Yancy (2010), hip hop artists can model expressing anger, or other difficult emotions and life experiences through rapping. Young people, such as TH, who admire these accomplished artists can imitate these expressions in the music therapy space. This might suggest that identifying with such artists include feelings of being 'accomplished' themselves. This is significant, as most aspects of TH's environment are tightly controlled, not allowing room for such behavior. Being afforded an opportunity to express himself like this, might have further offered him the space to transform these forms of self-expression into qualities of,

for example, leadership. Performing himself within this Discourse appeared to help him to contain and direct his anger and frustration. For example, whereas his apparent 'outbursts' often excluded other group members from the moment, he intentionally attempted to re-include W (thick description, session four, paragraphs two to three):

I then changed the drum and vocal beat from the recurring beat to a count-down beat. TH stopped with me. He then laughed very loudly and reached out for a high-five with me. W's head was looking down towards the floor as he smiled broadly and scratched his head. After TH gave me a high-five, he touched W's head. As W looked up, I reached out to high-five him as well and he gave one back gently. W then looked at TH and gave him a harder and faster high-five, almost like a snap.

Keck and Sakdapolrak (2013:10-11) described transformative resilience as, "participating in decision-making processes" as well as "improving [one's] individual welfare and foster[ing] societal robustness toward future crises." One can argue that during the moments of "bursting out", TH might have been unable to regulate himself, or he was just expressing himself differently in different situations. Skewes (2001:i) found that vocal and instrumental improvisation with other adolescents in music offered them opportunities for both freedom and control as challenging the leader's musical material can develop the adolescent's social resilience. In addition, she states that resilience involves "mood and behavioral self-management in response to adversity", instead of avoiding stressful situations (McFerran, 2010:65). In the context of pediatric oncology, the term adversity may refer to having little control over one's body; loss of expression; and so on, as described by Ayson (2008:1) and Daykin et al. (2007:355). TH might have expressed these experiences of adversity through these "outbursts". Using his voice in conjunction with mine in these moments provided him the opportunity to practice regulating his emotions, as in a study conducted by Dingle, Brander, Ballantyne and Baker (2012:405). Group singing assists in learning to regulate one's emotions, in addition to providing a particularly powerful means of self-expression as argued by Scherer (1995:235). Regulated emotional expression is considered a characteristic of social resilience.

When considering collective transformation (that forms part of the definition of transformative resilience by Keck and Sakdapolrak (2010:10)), one notices that the excerpt above also involved W. During the past few sessions, W had been indicating moments of withdrawal and blunted affect

(see appendix E). Perhaps, as TH showed more resilience through his increasing confidence, W also felt able to slowly try other ways of being by re-including himself in the group interaction.

Finally, TH took initiative and suggested that for the final song-writing session we should include asking each other questions through rapping (vocal improvisation – see score 5.2.). This might have indicated a desire to interact and connect with others, instead of overpowering them. Through participating in vocal improvisation within the group, TH built a relationship with W, as he referred to him as his best friend (see appendix F, session six). As noted by Sauv  (2004:20-32), relationships formed within group vocal improvisation often include sharing and unity. After expressing himself in a contained space, TH could allow himself and others to participate in a more mutually interactive way. TH seemed to be more able to transform (from over-powering the group to actively re-including those who have been withdrawn) in a collective space as his vocal questions invited participation from others.

As the music therapist, I engaged as a facilitator, as someone who was open to giving the group members a space to explore different expressions of themselves. I stepped back from being directive (which I had done with the intention of creating safety), and allowed room for the participants to direct the music (resulting in, for example, TH’s suggestion to rap dialogues, as seen in score 5.2.). They could engage in a flexible space that allowed inspiration and authenticity, not forcing conformity within any particular Discourse.

## Improvisational Rap

TH, Az, W and TH

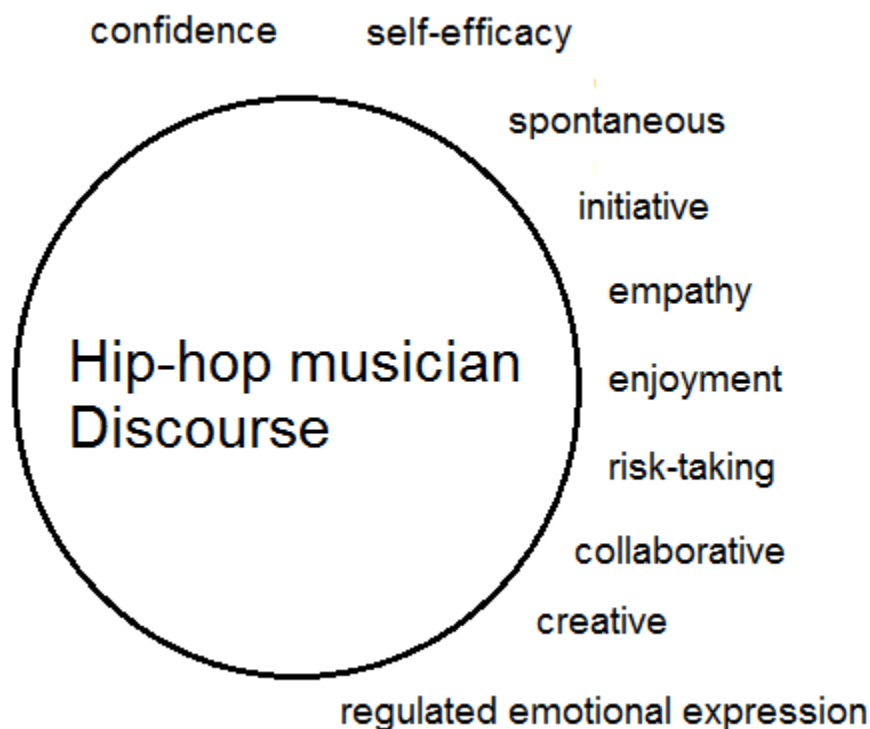
K:T-H, T - H, where do you come from? TH:I, I, I come from Mp-u-malan - ga

5  
TH:Hey, man, what is your fa - vou - rite food? K:I like chi - cken - li - cken.

Score 5.2. An excerpt from the *Improvisational Rap*

Engaging within a hip hop Discourse, young people can explore various aspects of themselves. Clements-Cortes (2017:online) found that using the voice in music therapy interventions influenced connection, identity, and freeing the voice within. The latter links to being “authentic” according to a Hip-hop Discourse as it relates to the “ability to voice your lived internal and external experience in a truthful and genuine manner” (Viega, 2010:6-7).

In this study, the primary characteristics of resilience that were noted as the participants engaged with this Discourse are illustrated in figure 5.5.



*Figure 5.5. Primary characteristics of resilience that were present whilst participants engaged in the Discourse of being a Hip-hop musician*

## **5.2. Explorative space**

As before mentioned, the explorative space refers to how the participants could try out various ways of being through musicking. In this space, participants could explore their identities and activities (as proposed by Gee (2005:11)), through trying out different ways of being. The

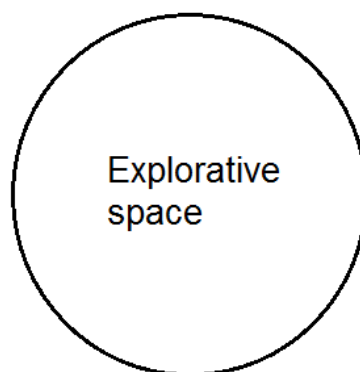


participants might have been performing their identities mainly from one Discourse, but were also exploring alternatives. For example, TH, who was strongly situated within an adolescent Discourse, began to explore himself as a Hip-hop musician. This explorative space is an “in-between Discourses” space wherein participants could explore various aspects of the Discourses at once. Music therapy could offer an opportunity to “try out” different expressions of self, perhaps through trying different forms of musical participation, according to Stige’s (2010:1) types of participation styles. To briefly review, Stige’s participation styles include non-participation (‘not being there’), silent participation (‘being there’), conventional participation (‘joining in’), adventurous participation (‘standing out’), and eccentric participation (going across). These styles of participation are not discrete, and an individual can move from the one to the other (even in a non-linear manner) (Stige, 2010:1).

In this in-between/explorative space, the participants tried out a variety of ways of performing themselves as resilient, or as one with lower resilience. Within this space, a wider variety of characteristics of resilience were present, as illustrated in figure 5.6:

more resilience

self-efficacy  
 sense of control  
 risk-taking  
 achievement orientated  
 enjoyment  
 empathy  
 supportive  
 humour  
 wide range of emotional  
 expression  
 creative



lower resilience

little self-regulation  
 tentative/ cautious  
 self-conscious  
 lower self-efficacy  
 resistive  
 dependent

*Figure 5.6. Primary characteristics of resilience that were present whilst participants engaged in the explorative space*

As before mentioned, through most of the process W tended to participate through being compliant. And yet, in the music therapy process he began to express a wider variety of emotions, such as sadness. The safety and containment of the group might have encouraged W to try out

expressing feelings of powerlessness (as seen in his gradual withdrawal from the musicking), sadness (as seen in his facial expressions whilst others were laughing) and a low self-esteem, (despite the fact that he was not getting physically sicker, as he performed himself in the Discourse of a patient). Choosing to identify with the Discourse of being a patient at the end of the process indicates feelings of support and being enabled in the group (as TH re-included him with a high-five). Thus, the increasing social resilience of the group might have provided him with the space to be vulnerable. According to Biswas-Diener and Kashdan (2013: online), it is often necessary to value 'negative emotions' just as much as 'positive emotions', such as happiness. W allowed himself to shift between positive and negative feelings according to his situational demands and this may indicate psychological flexibility. Biswas-Diener and Kashdan (2013:online) consider this aspect of resilience to be essential for well-being.

K attended the first and last sessions. During the first session, he declined the opportunity to lead the group vocally. However, when I intervened by directing the group to play the grounding beat softer, he accepted the role (thick description, session one, paragraph five):

I then invited K again (who refused the first time). He scratched his head as if contemplating. I then leaned inward towards to my drum and went "shhhhh". The rest of the group played slightly softer. K then softly called vocally in a low voice. The rest of the group softly responded. After calling four times he leaned his head downwards, smiled, stroked his drum with a flat hand, and said, "eish". The rest of the group imitated that sound and movement and some chuckled in response to it.

Within this space, K could experience both feeling powerless and unsafe to share his voice, and then, being able to lead the group and having a voice. Perhaps having me creating an intentional space for him to be heard, might have encouraged him to take a risk. This is considered an aspect of resilience by Clements-Cortes (2017:online). He was moving from identifying himself solely within Discourses such as being an ill patient or self-conscious musician to being an emerging musician.

Finally, some of the participants engaged in more adventurous participative moments according to Stige's (2010:130-131) conceptualization of this term. This participation style is like the conventional participation style, but stands out more as embellishments may deviate from the norm through the introduction of new material. According to Stige (2010:130), "it could be

described as a divergence that requires considerable active adjustment by the other people present in the social-musical situation.”

According to Sauv  (2004:29-30), vocal improvisation creates a space wherein singers can explore new ways of being and relating to others, through being playful. Through singing freely, one can be guided to experiment with various sounds in relation to the self and others, with playfulness creating a safe container for this free exploration to occur. This could be seen within the data during moments wherein AZ ventured away from being just complaint, to also trying out new ways of being (see appendix E). She introduced new material, as opposed to imitating others. She also took initiative and indicated moments of agency (thick description, session five, paragraphs three to five):

I began “ooooe” sounds that were atonal. AZ looked at the roof and tried to softly sing similar notes (softly). I then began to sing more varied sounds, such as, “weeee-wooo-waaah”, etc. AZ softly sang similar and slightly different sounds.

This could also be seen in the following example (thick description, session six, paragraph two):

...passed the mic to AZ. She began to softly speak-rap over the mic by repeating some words and fitting them into the phrase. She said that she likes netball.

At first glance, it might not seem as if she was creative or taking initiative. However, in the context of her contributions (in sessions one to six), this is a meaningful shift as she had not deviated from the group’s music before. Here, she risks individual creativity by introducing material that is her own, even though it is soft. Due to this occurring within moments wherein the whole group improvised at once, she found safety in the collective risk-taking of all members, thus exploring new ways of expressing herself vocally. Within these moments, she could express herself as confident and creative, thus, more resilient than in the previous sessions. The group also enabled expression. As the group seemed to become more confident, able and resilient, she was offered a space to explore different Discourses, moving from a self-conscious female adolescent (as discussed in section 5.3. reference to gender roles) to trying out being a musician.

Even though TH seemed to have limited regulation of his emotions, he did manage to express a wide range of emotions. He managed to express some intense feelings he might have not been able to express otherwise. According to Clements-Cortes (2017:online), using the voice in music

therapy can afford the individual feelings of being contained in the space, as well as letting go. This might have been the case with TH. Perhaps his capacity for mutual interaction with others transformed, as he could participate in decision-making processes and foster societal robustness (Keck & Sakdapolrak, 2013:10-11).

### **5.3. Conclusion**

This chapter has described the identified Discourses and how the participants could perform themselves in various ways within these. Members who primarily identified within the Discourse of being a sick patient, and having no voice/ loss of expression (by having no psycho-social support during their stay) according to Ayson (2008:1), were invited to use their voices in front of their peers. This provided the opportunity to refuse the invitation, thus having a voice. Even though they often presented as less resilient, they were afforded safety and agency, despite their illness. In addition, all members also indicated a sense of control and resilience through coping (the capacity of dealing with immediate challenges as described by Keck and Sakdapolrak (2010:131)) as they were committed to the process, despite not participating in a conventional manner.

Within a Discourse of being a teenager, members could express and explore their identities whilst using their voices. TH used his voice to challenge boundaries, as well as to express his anger and frustrations through “outbursts”. TL could identify with being a sick patient or a resistive teenager (as in Louw and Louw’s (2012: 306-326) conventional construction of being a teenager), to taking control and ownership over his vocal contributions in the space, thus indicating resilience. When he did use his voice, he was able to transform his blunted affect to that of humor and smiling within the group. Thus, while enacting and performing the Discourse of being a teenager and sick patient within music therapy, they were regarded as young people able to make choices and explore their identities.

Those who identified primarily with a Hip-hop Discourse (as described by Viega (2015:1)), could let go of oppressive roles and stigmas, and take personal responsibility for their actions, whilst using their voices. K could take his feelings of isolation and communicate them to his peers through rapping, thus connecting with them despite his feelings of loneliness. O could intervene vocally on behalf of his peer, K, thus choosing empathy and connection (by nodding at K warmly directly after the interaction). Finally, after vocally expressing his wide range of emotions at the

cost of the group, TH could later also experience himself as a leader who took responsibility of the group by taking initiative and including those who are withdrawn, encouraging a space of sharing and unity (Sauvé, 20014:20-43).

In addition to the Discourses within which the participants expressed themselves, the music therapy group provided them a space wherein they could explore moving between the Discourses recognized in this study. This occurred within an explorative space. Stige's (2010:131) different possibilities for participation was used to look at how each participant behaved within the group, and how they moved between the various ways of participating. It was discovered that the participants indicated a wider variety of performance of resilience whilst engaging in this space. For example, W could let go of his façade of being "fine" and using his voice compliantly, and began to express himself as a sad and withdrawn patient. This indicates potential resilience, as he allowed himself to feel unhappy emotions and to express these to others. According to Biswas-Diener and Kashdan (2013: online), expression of happiness is not necessarily healthy in certain situations.

The use of voice within these various Discourses allowed the participants to explore and express different aspects of resilience. This was not limited to a particular Discourse, as participants could perform themselves as resilient in each Discourse. In addition, even though a participant may have identified themselves as situated mostly with one Discourse, through the creativity, flexibility, and resource orientation of music therapy, they were still afforded the opportunity to explore themselves through other Discourses.

## 6. Conclusion

### 6.1 Introduction

In this chapter I will be providing a summary of the findings of this study. In addition, I will discuss limitations that occurred, as well as recommendations for future studies.

#### 6.1. Summary of findings

In review, social resilience is a relational concept that involves three dimensions embedded within a social milieu (Keck & Sakdapolrak, 2013:5): coping capacities (the ability to cope with all kinds of difficulties); adaptive capacities (the ability to learn from past experiences and to adjust to future daily life social challenges); and transformative capacities (“[the] ability to craft sets of institutions that foster individual welfare and sustainable societal robustness towards future crises”).

During this research study, it was found that firstly, music therapy affirms, supports and enables a space for young people to express their perceived lack of resilience. Thus, they were afforded an opportunity for safety and agency, despite their illness or perceived lack of resilience. Secondly, music therapy offers spaces where adolescents can explore alternatives, such as exploring ways to adapt and transform. Group members could experience transitions from being complaint towards taking risks. Thirdly, music therapy could motivate, foster and enable performance of resilience even in a context that often tests and challenges the resilience of young people. Group members could transform their feelings of resistance and aggression toward having empathy for fellow members.

Thus, participating in group music therapy sessions, that focused primarily on vocal improvisation, the participants were able to cope with immediate challenges, specifically within the Discourses of being patients and adolescents. They could adapt by exploring various ways of performing themselves as they moved between Discourses; by learning “the ability to learn from past experiences and to adjust to future daily life social challenges”.

Adolescents are in transition from childhood to adulthood (Louw & Louw, 2007:347). Even when ill, one is transitioning between “am I getting better, am I not?” This music therapy space wherein they could use their voice spontaneously, provided them the opportunity to transition between various forms of selves – to transform. Thus, they could transform into individuals with the ability

to foster individual welfare and sustainable societal robustness towards future crises.

To revise the research question: How does vocal improvisation in music therapy groups afford the expression of social resilience for adolescents in oncology in-patient wards?

To conclude, vocal improvisation in group music therapy enabled the expression of lack of resilience, as it received those feeling less resilient and provided them with safety and containment. It also offered the participants a means of immediate coping within the various Discourses that were identified, as they could express their emotions, and aspects of self. Coping involves “using resources that are instantly available to restore the current level of well-being” (Keck & Sakdapolrak, 2013:10-11). Vocal improvisation in this context also afforded the participants a space to adapt to their challenges as they explored various types of participation (Stige, 2010). In this space, they could learn from past experiences/ways of being, and adjust accordingly to future risks. Finally, the participants could transform through the changing relationships within the group itself, and how these social changes offered a social environment that afforded the resilience of the whole group.

## **6.2. Limitations**

Firstly, language may have limited the interaction between the participants and me. Not all group members were fluent in English, however, the groups were conducted in English as I am not fluent in their home languages. The group members were generally from either a Xhosa or Pedi background. Fortunately, due to some members being proficient in English, group members were invited to help one another with translations. This was rarely necessary as all members understood English well enough for sessions to occur smoothly.

In addition, my identity as a white, female therapist with young, black participants, might have introduced power dynamics. This may have further prevented the group members' depth of reflection and performance of resilience.

The research was conducted within six consecutive days, as opposed to one session per week. This was done in an attempt to avoid, yet still include, changing membership. This was also due to the nature of the treatment processes at the hospital. As a result, long-term involvement with the group members was not possible. The duration of the study influenced how long the participants had to explore and embody the various Discourses. It is proposed that if the study

was longer, that more time would have been available for the participants to express themselves as Hip hop musicians, for example. Participants mainly engaged with this discourse towards the end of the process, not providing enough time to determine whether they would have continued engaging as Hip hop musicians.

### **6.3. Recommendations for future studies**

Further investigation may be helpful to gain deeper insights into how vocal improvisation in music therapy groups can afford the resilience of adolescents diagnosed with cancer. The duration of the study could be longer as this might enable the relevant findings to be deepened. It is also recommended that the therapist-researcher in future studies attempt to work with participants of similar culture, for reasons discussed in the limitations sections. Finally, this study only looked at moments of vocal improvisation. However, moments of significance occurred during instrumental improvisation as well. It is recommended that further investigation is done on the affordances of instrumental improvisation on the social resilience of adolescents diagnosed with cancer.

### **6.4 Conclusion**

According to Glavovic, Scheyvens and Overton (2003:291) adolescents who are ill need to develop social resilience to “absorb change”. In this study, social resilience is a dynamic process wherein uncertainty, crisis and change is considered normal as opposed to exceptional. In addition to socialization and building resilience, identity development is important as well. The adolescents who participated in this study each walked away having expressed themselves as a resilient being. Participating in vocal improvisation within a group music therapy context, the participants could express these degrees of resilience within the Discourse of being a teenager, sick patient, hip hop musician, or within an explorative space that was “in-between” these recognized Discourses. This is particularly valuable in this pediatric oncology context as there is limited/no psychosocial support aiding in the expression of social resilience.



## REFERENCES

- Adz, K. 2012. South African teens: the next generation. Huck. Online: <http://www.huckmagazine.com/perspectives/reportage-2/south-african-teens> [Accessed on 19 November 2016].
- Aigen, K. 2008. An analysis of qualitative music therapy research reports 1987-2006: Doctoral studies. *The Arts in Psychotherapy*, 35(5):307-319.
- Albritton, K. & Bleyer, W.A. 2003. The management of cancer in the older adolescent. *European Journal of Cancer*, 39, 2584–2599.
- Aldridge, D. 1995. Spirituality, hope and music therapy in palliative care. *The Arts in Psychotherapy*, 22(2), 103-109.
- Aldridge, D. 2003. Music therapy references relating to cancer and palliative care. *British Journal of Music Therapy*, 17(1), 17– 25.
- Ansdell, G. 2002. Community Music Therapy & The Winds of Change. *Voices: A World Forum for Music Therapy*. 2(2). Available at: <<https://www.voices.no/index.php/voices/article/view/83>>. Date accessed: 23 Nov. 2017. doi:10.15845/voices.v2i2.83.
- Ayson, C. 2008. Child parent wellbeing in a paediatric ward. *Voices: A World Forum for Music Therapy*, 8(1),1–16.
- Béné, C., Wood, R.G., Newsham, A. & Davies, M. 2012. Resilience: new utopia or new tyranny? Reflection about the potentials and limits of the concept of resilience in relation to vulnerability reduction programmes. *IDS Working Paper 2012*, p.405.
- Biswas-Diener, R. & Kashdan, T.B. 2013. What happy people do differently: One of life's sharpest paradoxes is that the key to satisfaction is doing things that feel risky, uncomfortable, and occasionally bad. *Psychology Today*. Online: <https://www.psychologytoday.com/articles/201307/what-happy-people-do-differently> [accessed on 27 October 2017].
- Braun, V. & Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.

Burr, V. 1995. *An Introduction to Social Constructionism*. London: Routledge

Chen, A. 2011. The old person's guide to 'swag'. Online: <http://gawker.com/5804708/the-old-persons-guide-to-swag> [Accessed: 25 October 2017].

Clark, P.G., Rochon, E., Brethwaite, D. & Edmiston, K. 2011. Brief report screening for psychological and physical distress in a cancer inpatient treatment setting: a pilot study. *Psycho-Oncology*, 20:664–668.

Clements-Cortes, A. 2017. Singing and vocal interventions in palliative and cancer care: music therapists' perceptions of usage. *Journal of Music Therapy*. 10. Available from: [https://www.researchgate.net/publication/319606685\\_Singing\\_and\\_Vocal\\_Interventions\\_in\\_Palliative\\_and\\_Cancer\\_Care\\_Music\\_Therapists%27\\_Perceptions\\_of\\_Usage](https://www.researchgate.net/publication/319606685_Singing_and_Vocal_Interventions_in_Palliative_and_Cancer_Care_Music_Therapists%27_Perceptions_of_Usage) [accessed 25 October 2017].

Clift, S. Hanox, G., Morrison, I. & Bärbel, H. 2007. Choral singing and psychological wellbeing: Findings from English choirs in a cross-national survey using the WHOQOL-BREF. *International Symposium on Performance Science*, 201–207.

Daykin, N., McClean, S. & Bunt, L. 2007. Creativity, identity and healing: participants' accounts of music therapy in cancer care. *Creativity, identity and healing health: an interdisciplinary journal for the social study of health, illness and medicine*, 11(3),349–370.

De Decker, A., Hermans, D., Raes, F. & Eelen, P. 2003. Autobiographical memory specificity and trauma in inpatient adolescents. *Journal of clinical child & adolescent Psychology*, 32(1), 22-31.

De Santis, C.E., Lin, C. C., Mariotto, A.B., Siegel, R.L., Stein, K.D., Kramer, J.L., Alteri, R., Robbins, A.S. & Jemal, A. 2014. Cancer treatment and survivorship statistics, 2014. *CA: A Cancer Journal for Clinicians*, 64(4), 251-272.

Diener, E. & Rober-Biswas Diener. 2008. *Happiness: unlocking the mysteries of psychological wealth*. Blackwell: Oxford.

Dingle, G. A., Brander, C., Ballantyne, J. & Baker, F. A. 2012. "To be heard": The social and mental health benefits of choir singing for disadvantaged adults. *Psychology of Music*, 41(4), 405–421.

- Dosamantes-Beaudry, I. 1997. Embodying a cultural identity. *The Arts in Psychotherapy*, 24(2), 129-135.
- Esposito, J. 2014. Pain Is a Social Construction Until It Hurts: Living Theory on My Body. *Qualitative Inquiry*. 20(10),1179-1190. <https://doi.org/10.1177/1077800414545234>
- Featherman, C. 2016. Disability and Discourse analysis. *Critical Discourse Studies*, 13(1), 137-139. DOI: 10.1080/17405904.2015.1105419
- Finlay, L. 2002. Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research*. 2(2), 209-230.
- Freitas, H., Oliveira, M., Jenkins, M., & Popjoy, O. 1998. The focus group, a qualitative research method. Isrc, merrick school of business, university of baltimore (MD, EUA), WP ISRC No. 010298.
- Gee, J. P. 2011. *An introduction to discourse analysis: theory and method*. 3rd ed. New York: Routledge.
- Geertz, C. 1973. Thick Description: Toward an Interpretive Theory of Culture. *The Interpretation of Cultures: Selected Essays*. New York: Basic Books.
- Gergen, K.J. 2011. The self as social construction. *Psychological Studies*. 56(1):108–116.
- Glavovic, B., Scheyvens, R.A. & Overton, J.D. 2003. Waves of adversity, layers of resilience: exploring the sustainable livelihoods approach. In: D. Storey.; J. Overton, & B.N. Eds, (eds.), *Contesting development: pathways to better practice. Proceedings of 3rd Biennial Conference of the Aotearoa New Zealand International Development Network*. Palmerston North, 289–293.
- Gray, D. E. 2004. *Doing research in the real world*. London: SAGE Publications.
- Greaves, M. 2001. *Cancer: the evolutionary legacy*. Oxford: Oxford University Press.
- Grue, J. 2016. *Disability and discourse analysis*. New York: Routledge.
- Haase, J., Kintner, E. & Robb, S. 2014. The Resilience in Illness Model, Part 1: Exploratory evaluation in adolescents and young adults with cancer. *Cancer Nursing*, 37(3).

- Haase, J. and Robb, S. 2014. Music therapy has positive effects on young cancer patients' coping skills. Online: <http://inscopearchive.iu.edu/headlines/2014-02-06-headline-music-therapy-inscope.shtml> [Accessed: 23 September 2017].
- Hadley, S. & Yancy, G. 2012. *Therapeutic uses of rap and Hip-hop*. London: Routledge.
- Han, I., Kleifgen, E., Martin, C., Zarling, E. 2011. The Physiological Response to Music Tempo, The Investigation of the 'Pump-Up' Song". *Journal of Advanced Student Science*, 1:435.
- Halkier, B. 2010. Focus groups as social enactments: integrating interaction and content in the analysis of focus group data. *Qualitative Research*. 10, 71.
- Hancock, B. 1998. *Trent focus for development in primary health care: an introduction to qualitative research*. Nottingham: Trent Focus.
- Hays, D.G. & Singh, A.A. 2012. *Introduction to qualitative inquiry in Qualitative Inquiry in clinical and educational settings*. New York: The Guilford Press.
- Hodgman, M. 2013. Class, race, credibility, and authenticity within the hip-hop music genre. *Journal of Sociological Research*, 4(2), 402–413.
- Jones, B.L., Parker-Raley, J. & Barczyk, A. 2011. Adolescent cancer survivors: identity paradox and the need to belong. *Qualitative Health Research*, 21(8), 1033–1040.
- Jørgensen, M. & Phillip, L. 2002. *Discourse Analysis as Theory and Method*. London: Sage.
- Keck, M. 2012. Market governance and social resilience. The organization of food wholesaling in *Dhaka, Bangladesh*. Unpubl. PhD Thesis. Bonn.
- Keck, M. & Sakdapolrak, P. 2013. What is social resilience? Lessons learned and ways forward. *Erdkunde*, 67(1), 5–19. DOI: 10.3112/erdkunde.2013.01.02 <http://www.erdkunde.uni-bonn.de> ISSN 0014-0015
- Krefting, L. 1991. Rigor in Qualitative Research: The Assessment of Trustworthiness. *The American Journal of Occupational Therapy*. 45 (3), 214-222.
- KRS-One. 2009). *The gospel of Hip Hop: First instrument*. New York: PowerHouse.
- Krueger, R. A. 1994. *Focus groups. A practical guide for applied research* (2nd ed.). London:

Sage.

Latham, B. 2007. Sampling: what is it? *Quantitative Research Methods*. 1-14. Retrieved from [www.webpages.acs.ttu.edu/~riatham/.../Sampling\\_Methodology\\_Paper.pdf](http://www.webpages.acs.ttu.edu/~riatham/.../Sampling_Methodology_Paper.pdf).

Lincoln, Y. & Guba, E. 1985. Establishing trustworthiness. *Research Enquiry*.

Lorenz, D. 2010. The diversity of resilience: contributions from a social science perspective. *Natural Hazards*. 67:7. DOI: 10.1007/s11069-010-9654-y

Luff, P. & Heath, C. 2012. Material realities and the problems of perspective: Some 'technical challenges' of video analysis: social actions, objects, objects, material realities and the problems of perspective. *Qualitative Research*. 12(3), 255-279. DOI: 10.1177/1468794112436655

Mack, N., Woodsong, C., MacQueen, K. K., Guest, G. & Namey, E. 2005. Module 2: Participant observation. *Qualitative research methods: a data collectors field guide*. New York: FLI.

Malterud, K. 2001. Qualitative research: Standards, challenges, and guidelines. *Lancet*, 358(9280), 483–488.

McFerran, K. 2010. *Adolescents, music and music therapy*. London: Jessica Kingsley Publishers.

McMillan, R. 1999. 'To say something that was me': developing a personal voice through improvisation. *British Journal of Music Education*, 16, 263-273.

Molassiotis, A. & Cubbin, D. 2004. "Thinking outside the box": complementary and alternative therapies use in paediatric oncology patients. *European Journal of Oncology Nursing*, 8, 50–60.

Norris, S., Roeser, R.W., Richter, L.M., Lewin, N., Ginsburg, C., Fleetwood, S.A., Taole, E. & Van der Wolf, K. 2008. South African-ness among adolescents: the emergence of a collective identity within the birth to twenty cohort study. *Journal of Early Adolescence*. 28(1): 51–69.

North, A.C. & Hargreaves, D.J. 1999. Music and adolescent identity. *Music Education Research*, 1(1), 75–92.

Obrist, B., Pfeiffer, C. and Henley, R. 2010. Multi-layered social resilience: a new approach in mitigation research. *Progress in Development Studies*, 10 (4), 283–293. DOI: 10.1177/146499340901000402

- Paal, P. 2010. Popular images of cancer. *Written cancer narratives: an ethnomedical study of cancer patients' thoughts, emotions and experiences*. ELM Scholarly Press.
- Pasiali, V. 2012. Resilience, music therapy, and human adaptation: nurturing young children and families. *Nordic Journal of Music Therapy*, 21(1), 36-56, DOI: 10.1080/08098131.2011.571276.
- Patton, M. Q. 2001. *Qualitative evaluation and research methods* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Pavlicevic, M. 2004. Taking music seriously: Sound thoughts in the newer South Africa. *Journal of Music Research in Africa*. 1(1), 3-19. [doi.org/10.1080/18125980408529729](https://doi.org/10.1080/18125980408529729)
- Pentheroudakis, E. & Pavlidis, N. 2005. Juvenile cancer: improving care for adolescents and young adults within the frame of medical oncology. *Ann Oncology*, 16,181–188.
- Puig, A., Lee, S.M., Goodwin, L. & Sherrard, P.A.D. 2006. The efficacy of creative arts therapies to enhance emotional expression, spirituality, and psychological well-being of newly diagnosed Stage I and Stage II breast cancer patients: A preliminary study. *The Arts in Psychotherapy*, 33, 218–228.
- Reagon, C., Gale., N., Dow, R., Lewis, I. & van Deursen, R. 2017. Choir singing and health status in people affected by cancer. *European Journal of Cancer Care*. 26. <https://doi.org/10.1111/ecc.12568>
- Robson, C. 1993. *Real World Research: A Resource for Social Scientists and Practitioner-Researchers*. Great Britain: T.J. Press Ltd.
- Ruby, D. 1980. Exposing yourself: Reflexivity, anthropology and film. *Semiotica*. 30, 153-179.
- Ryan, M. 2004. *Narrative Across Media: The Languages of Storytelling*. Nebraska: University of Nebraska Press.
- Saarikallio, S. & Erkkilä, J. 2007. Music and adolescents' mood regulation. *Psychology of Music Psychology*, 35(1), 88–109.
- Sauvé, M. 2004. *The therapeutic effects of vocal improvisation*. A thesis for the degree of Master of Arts in Canadian Studies, Carleton University, OTTAWA, Ontario.

- Seidman, D. 2009. *Teens in South Africa*. Mankato: Compass Point Books.
- Seitz, D., Besier, T. & Goldbeck, L. 2009. Psychosocial interventions for adolescent cancer patients: a systematic review of the literature. *Psycho-Oncology*, 18, 683–690.
- Shenton, A. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, 22, 63–75.
- Simons, H. 2009. *Case study research in practice*. London: SAGE.
- Skewes, K. 2001. *The experience of group music therapy for six bereaved adolescents*. PhD thesis. The University of Melbourne.
- Skinner, D., Tshoko, S., Mtero-Munyati, M., Segwabe, P., Chibatamato, P., Mfecan, S., Chandiwana, B., Nkomo, N. & Chtiyo, G. 2004. *Defining orphaned and vulnerable children*. Cape Town: HSRC Publishers.
- Skott-Myhre, H.A. 2008. Youth and subculture as creative force: creating new spaces for radical youth work. Toronto: University of Toronto Press.
- Small, C. 1998. *Musicking. The meanings of performing and listening*. London: University Press of New England.
- Sparrman, A. 2005. Video recording as interaction: participant observation of children's everyday life. *Qualitative Research in Psychology*, 2(3), 241-255, DOI: 10.1191/1478088705qp041oa
- Stake, R.E. 2005. Qualitative Case Studies. In N. K. Denzin & Y. S. Lincoln, eds. *Handbook of Qualitative Research*. London: SAGE Publications, 453–4.
- Starks, H. & Trinidad, S. 2007. Choose your method: a comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, 17(10), 1372-1380.
- Stige, B. 2010. Reflection musical participation, social space, and everyday ritual. *Where music helps: community music therapy in action and reflection* (Eds. Elefant, Cochavit, et al.), Ashgate.
- Stige, B., Malterud, K., & Midtgarde, T. 2009. toward an agenda for evaluation of qualitative research. *Qualitative Health Research*, 19(10), 1504 –1516.
- Suzuki, L. A., Ahluwalia, M. K., Arora, A. K., & Mattis, J. S. 2007. The pond you fish in determines

the fish you catch exploring strategies for qualitative data collection. *The Counseling Psychologist*, 35(2), 295-327. doi: 0011000006290983

Strebel, A., Crawford, M., Shefer, T., Cloete, N., Henda, N., Kaufman, M., Simbayi, L., Magome, K. & Kalichman S. 2006. Social constructions of gender roles, gender-based violence and HIV/AIDS in two communities of the Western Cape, South Africa. *Journal of Social Aspects of HIV/AIDS*. 3(3):516-528.

Tervo, J. 2001. Music therapy for adolescents. *Clinical Child Psychology and Psychiatry*, 6(1), 79–91.

Tervo, J. 2005. Music therapy with adolescents. *Voices: A World Forum for Music Therapy*, 5 (1). ISSN 1504-1611. Available at: <<https://voices.no/index.php/voices/article/view/216/160>>. Date accessed: 18 Oct. 2017. doi:10.15845/voices.v5i1.216

Viega, M. 2013. 'Loving me and my butterfly wings': A study of hip-hop songs created by adolescents in music therapy (unpublished doctoral dissertation.) Temple University, Philadelphia, PA.

Viega, M. 2015. Exploring the discourse in hip hop and implications for music therapy practice. *Music Therapy Perspectives*. 34(2), 138-146.

Voss, M. 2008. The vulnerable can't speak. An integrative vulnerability approach to disaster and climate change research. *Behemoth* 1 (3), 39–56. DOI: 10.1524/behe.2008.0022

Williams, D. 2011. Standards and quality in qualitative inquiry. *Qualitative Enquiry in Daily Life*. Online: <https://qualitativeinquirydailylife.wordpress.com/about/> [Accessed 12 October 2017].

Willig, C. 2013. *Introducing qualitative research in psychology*. Berkshire: University Press.

Woodgate, R.L. 2010. The importance of being there: perspectives of social support by adolescents with cancer. *Journal of Pediatric Oncology Nursing*, 23(3), 122–134.

Young, R., Sproeber, N., Groschwitz, R.C., Preiss, M. & Plener, P.L. 2014. Why alternative teenagers self-harm: exploring the link between non-suicidal self-injury, attempted suicide and adolescent identity. *BMC Psychiatry*, 14 :137 <http://www.biomedcentral.com/1471-244X/14/137>



## Appendix A & B



Faculty of Humanities  
Department of Music

### Guardian Information

STUDY TITLE: Music therapy groups for adolescents in oncology inpatient wards: The affordances of vocal improvisation for the expression of social resilience.

Dear \_\_\_\_\_,

My name is Leigh-Ann Collins and I am a music therapy student from the University of Pretoria. I am going to do a study that explores how teenagers, who have cancer, can benefit socially from joining in a music therapy group. Music can be a useful way of showing our emotions or building relationship with others. In music therapy sessions, we do music activities such as singing together or playing instruments, as a way of expressing ourselves and getting to know others. In this group, I would like to focus on the teenagers using their voices (like singing together or rapping) as a way of getting to know each other. This can benefit them socially in terms of how they relate to their family and their friends. I would like to invite your child to join this group.

Here are some things you need to know about the group:

- The group will include six sessions, each lasting about 45mins in the ward. Your son/daughter won't be forced to attend, for example, on days that they are feeling very sick.
- The sessions will be recorded on video – the recordings will only be for me and my supervisor to see as data for the project. The video material will then be kept safely the University for 15 years.
- Your son/daughter is welcome to withdraw from the study at any time and all information about them will then be removed from my records.
- The information will be kept confidential and anonymous.

Please contact me if you have any more questions. Your participation will be greatly appreciated. If you are willing to participate in this study, please complete the attached consent form.

Leigh-Ann Collins  
Researcher/ student  
Email: [collinsleighann75@yahoo.com](mailto:collinsleighann75@yahoo.com)  
Number: 076 669 8509  
Student number: 12059944

Research Ethics Committee Office:  
Tel: 012 356 3084 or 012 356 3085  
E Mail: [fhsethics@up.ac.za](mailto:fhsethics@up.ac.za)  
Physical address:  
University of Pretoria  
Faculty of Health Sciences  
Tswelopele Building, Level 4, Rooms 4-59 and 4-60  
Dr Savage Road, Gezina, Pretoria

**Guardian Consent Form**

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_, hereby do / do not give my consent for my child to participate in this research project that involves six music therapy sessions with short interviews before and after each music therapy session. I give /do not give my consent for these sessions to be video and audio-recorded, and used for research purposes only. I understand that the study will remain anonymous and confidential.

**PARTICIPANT/ PARTICIPANT PARENT/GUARDIAN DETAILS:**

Participant name: \_\_\_\_\_ Signature: \_\_\_\_\_

Participant Contact No: \_\_\_\_\_ Date: \_\_\_\_\_

On behalf of the participant: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to participant: \_\_\_\_\_

**RESEARCHER & SUPERVISOR SIGNATURE:**

Researcher Name: \_\_\_\_\_

Researcher Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Faculty of Humanities  
Department of Music

### Participant Information

STUDY TITLE: Music therapy groups for adolescents in oncology inpatient wards: The affordances of vocal improvisation for the expression of social resilience

Dear \_\_\_\_\_,

My name is Leigh-Ann and I am a music therapy student from the University of Pretoria. I am researching the experiences of young people with cancer in music therapy groups. In this group, I would like to focus on using our voices (in different ways...like singing together or rapping) as a way of getting to know each other and building relationships with other teenagers on the ward. I'd like to invite you to join this group. If you would like to join us, your parents/guardians will also be asked to give their permission.

Here are some things you need to know about the group:

- We'll have six sessions, each lasting about 45mins in the ward. You won't be forced to attend, for example, on days that you are feeling very sick.
- I'm going to video record sessions – the recordings will only be for me and my supervisor to see as I get data for the project – they'll then be kept safely at the University for 15 years. You can ask me if you want to see any of the videos.
- You can also choose to leave the study at any time. If you do this, all information about you will be removed.
- The information about you will be kept confidential and anonymous.

Please contact me if you have any more questions. Your participation will be greatly appreciated. If you are willing to participate in this study, please complete the attached consent form.

Leigh-Ann Collins

Researcher/ student

Email: [collinsleighann75@yahoo.com](mailto:collinsleighann75@yahoo.com)

Number: 076 669 8509

Student number: 12059944

Research Ethics Committee Office:

Tel: 012 356 3084 or 012 356 3085

E Mail: [fhsethics@up.ac.za](mailto:fhsethics@up.ac.za)

Physical address:

University of Pretoria

Faculty of Health Sciences

Tswelopele Building, Level 4, Rooms 4-59 and 4-60

Dr Savage Road, Gezina, Pretoria

**Participant Assent Form**

I, \_\_\_\_\_, hereby give / do not give my consent to participate in this research project that involves six music therapy sessions with short interviews before and after each music therapy session. I give /do not give my consent for these sessions to be video and audio-recorded, and used for research purposes. I understand that the study will remain anonymous and confidential.

**PARTICIPANT DETAILS:**

Participant name: \_\_\_\_\_ Signature: \_\_\_\_\_

Participant Contact No: \_\_\_\_\_ Date: \_\_\_\_\_

**RESEARCHER & SUPERVISOR SIGNATURE:**

Researcher Name: \_\_\_\_\_

Researcher Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix C



**STEVE BIKO ACADEMIC  
HOSPITAL**

Private Bag x169 Pretoria 0001

Enquiries: Dr AP van der Walt  
Tel no: +27 12 354 2336  
Fax no: +27 12 3542151  
E-mail: [andrevdw@gpg.gov.za](mailto:andrevdw@gpg.gov.za)

For attention:  
**Ms. Leigh-Ann Collins**  
Masters student U.P.

[Collinsleighann75@yahoo.com](mailto:Collinsleighann75@yahoo.com)

GP study ref. number: None

Dear investigator

**Re. PERMISSION TO CONDUCT RESEARCH AT STEVE BIKO ACADEMIC  
HOSPITAL**

**TITLE: MUSIC THERAPY GROUPS FOR ADOLESCENTS IN ONCOLOGY  
INPATIENT WARDS: THE AFFORDANCES OF VOCAL IMPROVISATION FOR  
EXPRESSION OF SOCIAL RESILIENCE.**

Permission is hereby granted for the above-mentioned research to be conducted at Steve Biko Academic Hospital as well as to access the relevant patient records. Ethics approval by U.P. Faculty of Health Sciences Research Ethics Committee (ref. no. 188/2017) is noted.

Yours sincerely

**Dr AP van der Walt**  
DIRECTOR CLINICAL SERVICES



14 June 2017

## Appendix D: Thick descriptions of video excerpts

| SESSION 1_12:20-15:00_5 participants | Initial notes | Recognizing Discourses | Characteristics of resilience |
|--------------------------------------|---------------|------------------------|-------------------------------|
|--------------------------------------|---------------|------------------------|-------------------------------|

### SESSION NOTES:

The room was a room for isolated patients. The room was unoccupied. The walls were bright green with animals and plants painted on the them. One half of the room was filled with two beds squeezed next to each other. The other side of the room contained six chairs in a circle, and 6 drums in front of each chair.

**Pre-music space:** five participants are present, four male and one female. All of them are between 13 and 15 years of age. TL, the oldest of the group, had a beanie on his head, but wore a t-shirt. He had a drip machine attached to him. His posture was up-straight. Next to him was KH, also having a machine attached to him. He was very quiet, and had a slight hunched over posture. Az, the only female in the group, was dressed warmly. She did not have a machine. W was the youngest. He has impaired vision and often faced his head towards the roof when engaging with others. Sitting between him and TL, was O fiddling with a drum, and had a machine. Little, if any interaction between the participants. Therapist gets equipment ready. Participants sit in the circle and look at each other.

**Greeting song:** I introduced everyone through their name tags and everyone listened attentively. I then began to teach the greeting song. We all started with the chorus, "shaboya, sha-sha, shaboya, ah-yeah!". This alternates with verses wherein each member gets a chance to say their name, hometown and play a beat, as everyone else responds with "Yeah!". I had to frequently encourage the "yeah"-responses. Each member spoke very softly. O gave a more complex beat, whereas TL seemed very hesitant. His turn was, however, interrupted by a nurse needing to check his fluids. I then did a very brief call-and-response with him, wherein I played a short beat to be responded to by him. He engaged by responding with similar beats to hers. During the chorus, I added more complex rhythms to her playing, and Az attempted those rhythms, but was a bit unsteady. She continued to play.

This excerpt is taken from the activity following the greeting song. During this, the GM were playing on a common pulse, but with various rhythmic patterns each. Then, without anyone saying something, a new common pattern emerged from everyone's various individual patterns. It was repeated several times. The pattern included a space of silence wherein each member was invited to improvise a beat, and then later, a vocal call. The group would respond by imitating the individual call in the following space. Everyone sat against the back of the chairs, but in an upright, engaged posture (not slouching).

**EXCERPT:**

As the group continues the pattern, I initiated vocal calls. I invited the group with hand gestures to respond. The group initially responds out of time and softly. K and TL does not respond vocally, but are playing the pattern on their drums. O, W and Az smile and respond audibly. The second call has a facial invitation from me (a smile and raised eyebrows) that was met louder than the first call. I made calls that were two beats in duration, and simple in rhythmic structure. It was mostly vowels, such as, "ah-yeah", "e-e-e-e" and "ah-ye-e". In response to the fourth sound made by me, TL looked away from the group, smiled, and responded to the call with the group.

After a few calls, I looked at K, and tilted my head towards him with a smile and raised eyebrows, inviting him to lead the calls. The group continued with the pattern. K smiled, played the pattern, and shook his head slightly. As he shook his head, O, sitting at the other side of the circle, jumped in with a clear, high pitched syncopated sound. K smiled at him and turned his posture towards him. W looked at K, with a slight smile, but K was looking at O (his face was not visible). After four calls that were softly responded to by the group, the drumming became slightly "dissynchronized". O chuckled softly and stopped calling. The GM also looked around at each other, and sometimes at him during his calls.

In response to the "dissynchrony", I kept a steady pattern on the drum and turned to Az sitting next to me. I then said, "okay, Az!". Az laughed shyly looking down as she was playing. She began to make clear, high pitched sounds that was responded to by the rest of the group. Most GM smiled. TL's playing was now very soft, with small irregular hand movements. He was looking down at his hands smiling as he responded.

I then said, "okay, everyone" and began to sing the same phrase ("ay-ye-e") repeatedly in each space as the pattern on the drum continued. I began to gradually increase the tempo. The group's playing became louder. When the tempo became very fast, TL, looked away and laughed as he stopped playing. Almost as if he could not keep up. O leaned forward and attempted to play even faster. W played very softly at his own tempo and smiled. When the group reached an ending to the climax, I resumed with the pattern at the original pace.

I invited TL to lead the vocal call. He looked at her blankly as he continued to play the pattern with the rest of the group. I then verbally invited him, but he continued to stare at me. I then used my hand to supplement my words by pointing at my mouth as I said, "sing something". He then stopped playing and

GR uncertainty

participants as compliant adolescent patients

GR increasing responses

therapist directs

therapist

therapist directs roles

therapist

K refuses leadership/ insecure/ put on spot/ uncool?

K: participant as patient

O takes initiative

O: participant as hip-hop musician

K: low confidence &amp; risk-taking

O: self-efficacy; initiative; spontaneity; problem solving; empathy

therapist intervenes and grounds music

therapist

AZ shyly leads group imitates AZ

AZ as musician

AZ: self-efficacy; low Confidence; risk-taking

therapist intervenes &amp; challenges GR

participant as patient

TL: indicates emotion; withdraws from intensity

therapist

O: accepts challenge

participant as musician

W: at own pace

participant as musician

TL: small range of emo expr; withdrawal from challenge

O: self-eff; achievement orient;

W: sense of control

therapist directs roles &amp; affirms

therapist

TL: "passively" refuses leadership; put on spot

participant as patient unwilling/self-conscious adolescent

TL: poor communication; no risk taking; blunted affect

continued to look at me blankly. I nodded at him with a smile turned the verbal invitation to W. W smiled and shook his head as he very softly said he did not want to. I smiled and said, "that's fine".

W: effectively communicates refusal of leadership  
therapist affirms

unwilling/self-conscious adolescent

W: no risk-taking; low confidence; open communication

I then invited K again (who refused the first time). He scratched his head as if contemplating. I then leaned inward towards to my drum and went "shhhhh". The rest of the group played slightly softer. K then softly called vocally in a low voice. The rest of the group softly responded. After calling four times he leaned his head downwards, stroking his drum with a flat hand, saying, "eish". The rest of the group imitated that sound and movement and some chuckled in response to it. He called one more time using a call he had used previously. The group's playing became slightly out of sync again, TL leaned backwards, and I intervened, changing the focus of the playing.

therapist creates space for K

participant as musician

K: self-efficacy when there's space

K: takes on leadership

therapist

therapist intervenes

**SESSION NOTES:**

Toward the end of the session, I asked the group how they say "goodbye" in their language. Most said, "sanibonani". I then played the guitar and verbally invited the group to think about how we can sing that to greet each other. After long silences, and looking at each other, O softly sang a line. I asked him to sing it louder. The group smiled and sang it when I asked everyone to repeat what he sang. This became the hook of the song. TL seemed as if he wanted to say something, by opening his mouth, then keeping quiet. I invited him to share, but he shook his and smiled. I then asked him to think of a word that we can use the following day. He nodded.

| SESSION 2_10:32-14:00_4 participants | Initial notes | Recognizing Discourses | Characteristics of resilience |
|--------------------------------------|---------------|------------------------|-------------------------------|
|--------------------------------------|---------------|------------------------|-------------------------------|

**SESSION NOTES:**

The room we used in the previous session was occupied by two new patients. We had the rest of our sessions in the playroom. The playroom is smaller, colourful, filled with toys, and lots of light. It is also next to the toddlers' ward, resulting in frequent noisiness from outside. The participants were TL, TA, O and TH. It was O and TH's first session. O was the only one with a machine. TH wore his hoodie over his head. The rest were dressed in t-shirts and shorts/jeans.

**Build-a-beat:** During this excerpt, the group was engaged in a "build-a-beat" groove. In other words, one person started with a beat on his drum, and each GM had to add a beat of their own, until the group reached a full groove which continued for a while. The previous day, the group initiated the writing of the greeting song. TL seemed as if he wanted to contribute, but did not. I had asked him to think of a line for the next day. As the group continued their groove, I asked him to say his line. He was too shy. I then re-introduced our call-and-response wherein each GM had a turn to lead a vocal phrase as in the previous day due to it being familiar. I started singing short vocal phrases, and gradually invited each GM to have turns singing as well.



**EXCERPT:**

As each GM continued to play their part of the overall lively groove, that included several complex rhythmic patterns. Some GM moved their heads or upper bodies to the beat. I asked TL to “give us the word”. He looked around at the other GM as everyone continued to play. TH played louder than the rest. His hoodie was over his head. The GM occasionally glanced a peak at each other. I began to interject vocalizations every few phrases. The GM looked at me every few moments with blank faces. I then leaned inward and forward, playing softer. The group’s playing gradually went softer. I then said, “I’m gonna sing something, then you copy me by being louder than the drums.” I called with very short phrases including “ah!”, “hey!”, “he-he!”, etc. O and TH shouted them back, TA smiled and responded softly, and TL only smiled slightly, without responding. These calls were one beat each.

As we continued to play as a group on the drums, my vocal phrases became longer (between two and four beats) and sillier, e.g. “wraaagh!!”, “wha-who-wheeee!”, etc., the group’s groove went slightly unsteady, irregular and not together, but regained its “togetherness”. Most of the GM also moved their upper bodies to beat of the music and smiled. TL and TA looked at each other after one very silly call, leaned forward and laughed. TH looked around the room frowning quite often, and did not respond vocally in those moments. He play very loudly.

I invited O to lead the calls. He took a while to look up at the roof, smile, and then give a very soft, low pitched call. I asked him to sing louder, and he did. His calls were very rhythmic and monotone. The other GM did not look at him at all. I then invited everyone to copy him. TA then glanced at him with a blank expression.

I then invited TH to go next. He looked away, and then down at his lap with no expression. The other GM did not look at him, except O briefly looking his way. I then nodded at TL to go, but he looked at her with no expression. She then nodded at TA. He smiled widely and responded with “hey-hey!”. He repeated the same call throughout. O smiled and responded with me. TH looked down as he played, moved his upper body to the music, and did not respond vocally to O’s call. TL looked at TA as he played, and then looked around the room.

I then invited TL to call again, but he shook his head. TH was still hunched over, playing louder. O looked at TL and smiled.

**SESSION NOTES:**

**Fill-in-the-blank song-writing:** After this excerpt, each GM filled in a piece of paper with “the hospital...” (complete the sentence); “the doctors...”; “my body...”; and “I feel...”. After they filled it in, we collaborated by writing a chorus for a rap song. They did not know how to start, so I gave them a hypothetical scenario: “What would you say to someone who had cancer and had to live in the hospital?”, some GM still did not know what to say. In that moment, a baby started crying outside. I then explained to them that that baby was experiencing pain due to cancer. What they would like to say to that baby. Then the group collaborated in writing their own lines, and by combining them into an order that suited all. O and TH led the melodic structure of the chorus.

After we practiced the chorus a few times, and adjusting it accordingly, TH was invited to start the verse rapping. He was too shy. No one wanted to. I invited them to read it, but they were still reluctant. I went as an example.

TL REFUSES  
SOLO WITH  
BLUNTED  
AFFECT;  
TH OVER-  
POWERS GR;  
DIRECTIVE  
THERAPIST

THERAPIST  
INTRODUCES  
HUMOUR; TH  
RESPONDS AT  
OWN TERMS;

O LEADS  
TENTATIVELY;  
DIRECTIVE  
THERAPIST

MEMBERS  
REFUSE  
LEADERSHIP; TH  
SEMI-  
WITHDRAWN/  
ON OWN TERMS

TH  
OVERPOWERS

TL: PARTICIPANT AS  
POWERLESS  
PATIENT/ SELF-  
CONSCIOUS ADOL;  
TH: PARTICIPANT AS  
CONFIDENT  
ADOLESCENT/  
PATIENT TAKING  
CONTROL;  
THERAPIST;

THERAPIST; TH:  
PARTICIPANT AS  
ADOLESCENT  
PATIENT ASSERTING  
CONTROL;

O: PARTICIPANT AS  
MUSICIAN;  
THERAPIST

PARTICIPANTS AS  
TENTATIVE  
PATIENTS;  
PARTICIPANTS AS  
SELF-CONSCIOUS  
ADOLESCENTS; TH:  
PARTICIPANT AS  
ADOLESCENT  
PATIENT ASSERTING  
CONTROL  
TH: PARTICIPANT AS  
ADOLESCENT/  
PATIENT ASSERTING  
CONTROL; TL:  
PARTICIPANT AS  
SELF-CONSCIOUS  
ADOL PATIENT

TL: LOW SELF-  
ESTEEM, NOT  
ACHIEVEMENT  
ORIENTATED,  
BLUNTED  
AFFECT; SELF-  
ORIENTATED  
CONTROL; TH:  
BLUNTED  
AFFECT;  
ASSERTS  
CONTROL AT  
COST OF GR;

TH: UNHAPPY,  
ASSERTS  
CONTROL

O: RISK-TAKING  
ADAPTABLE

GR: NO RISK-  
TAKING; TH: OWN  
TERMS,  
EMBODIMENT OF  
MUSIC (PHYSICAL  
ENGAGEMENT/INV  
ESTEMENT)

TL: LOW SELF-  
EFF; TH:  
OVERPOWERS  
(EXPRESSION OF  
LACK  
OF/POSITIVE  
RESILIENCE)

TH was one of the last to go, but was the only one who risked rapping. He did so by putting his head between his legs, with his hoodie completely over his face. One could hear his very soft, but rhythmic way of reading/rapping his verse

| SESSION 3_11:40-15:00_4 participants   | Initial notes   | Recognizing Discourses  | Characteristics of resilience   |
|--|---|---|---|
| <p><b>SESSION NOTES:</b></p> <p>TL, Az, W and TH were present during this session. TL and Az both wore beanies and were dressed warmly. TH was playing a kwaito song through the speakers during setup as background music. He sat waiting with a drum. W were hunched over and rested his head on his hands. None had a drip machine attached to them.</p> <p>When I asked how everyone was doing, TL yawned and said fine. TH had the drum sideways on his lap, and rested his head on his arms, on the drum. When I asked him how he was, he said, “better” with a blunted affect.</p> <p>During this session, I played a Blues progression on the guitar as I sang questions to each GM. For example, I asked them about their favourite sports, food, colours, etc., as well as where they come from and who their friends are. Each GM had a turn to answer the questions while singing their responses. TL, W and TH were hesitant in their responses. Each GM could select a small instrument from a pile to play throughout.</p> <p>The excerpt picks up after the final question has been answered, but continues with the same musical structure. Only the words change from questions to improvised melody lines. To demonstrate to the GM, I sang a few phrases with syllables (whilst playing the guitar). The group responded by copying me as they played their instruments. TL chose a djembe drum, TH a shaker (later swapped it with a smaller drum), W a tambourine.</p> <p><b>EXCERPT:</b></p> <p><b>Az chose the microphone.</b> I invited Az to lead the call and response, as I just did. She smiled, chuckled and asked, “anything?”. The boys were fiddling with their instruments. She used a melody I just did, but added words, “I like netball, I like pizza.” She then stopped and smiled. The boys did not look at her, or respond vocally. They were still busy with their instruments. I responded to her vocally. I then invited her to give the microphone to TH.</p> <p>As she handed it to him, all GM smiled. He looked at me blankly. I then said, as I played the same repetitive guitar progression, “go lalala or something.” He responded with “aaaaih”, whilst leaning back on his chair, swinging it, and looking down to his side, smiling. I then asked him to hold the mic for me. He sat up straight and held it upwards for himself. I sang, “la-la-lalala”. He looked at me with wide eyes, and responded with a blunt, witty and loud, “laaah!”. He then laughed with the other GM. I then imitated him and the quality he did it with. He sat back in his chair, holding the mic with both hands close to his face. He repeated the same sound for three consecutive calls. As I matched him, he repeated it pushing his head swiftly forward, and beginning to shout his call. I continued to match him. The repetitions became much faster, louder and accented. Az and W played their shaker and tambourine faster and louder as they smiled at what was happening between TH and me. TL watched us, with a blunted affect, lightly tapping his drum. TH and I went gradually louder and faster with our turn-taking on “la”. After a few moments, we reached very loud and fast climax, and stopped as TH started laughing loudly. The rest of the GM laughed as well.</p> | <p>directive therapist;<br/>Az: accepted leadership;</p> <p>TH: façade of disinterest, responds for first time, with humour, initiates crescendo;<br/>Therapist facilitates</p> | <p>Az: Participant as confident musician; therapist</p> <p>TH: participant as musician, therapist</p> | <p>Az: risk-taking, creativity</p> <p>TH: resistive, humorous, initiative, creative</p> |

I then invited TH to copy me again. I started to sing a short phrase as the guitar progression continued. TH then imitated the whole phrase, still with the same blunt and witty quality as before. As I changed the varied melody of "lalala" to "lal-lo-la", TH and Az laughed. I then added a facial expression wherein I stretched my tongue out and made a "eeegggh" sound. He immediately imitated it, as well as the silly quality I did it with. Everyone laughed. I then said, "okay, you start and then we copy you." The others laughed again as he responded by looking away, not smiling, and making a "aaaaii" sound. I imitated his sound. He then made a very loud "ha!" sound into the mic, leaning forward, frowning, and jolting his shoulders as he shouts it. I imitated him quickly and this led to a brief shout-like call and response as before. This time he ended it with an extended shout at the end. TL looked at him with a blank expression while Az and W chuckled.

I responded with, "nice! Okay, W!". TH handed the microphone to W. he smiled looking down at the floor. The others smiled as well and softly played their instruments. W began to sing "laa-laa-lalala" that was copied by the group. He varied his melody slightly and repeated some of the phrases. The group's playing was a bit softer than the singing. TL played a steady beat matching the beat played on the guitar. W then added a phrase sounding childlike (the melody sounds like the first phrase of itsy bitsy spider). The rest giggled and copied him. As he repeated his first phrase, TH sat sideways in his chair, looking around the room, shaking his shaker to the beat of the group's music, and sang audibly with the group.

As W decided to end his round, I said "nice!" to him. I then said TL's name and W handed him the microphone. TL took it, held it in front of, but far from his face, and paused a moment. He then began to sing W's phrase that was repeated often, in a very low pitch. (His back is facing the camera thus facial expressions are unclear). He occasionally looks at me and smiles slightly as he sings. TH continues to look around the room, but sometimes mimes singing along with his mouth, but different rhythms (his mouth does not match the singing of the group). His playing of the shaker is on the beat of the group's music.

As TL stops singing, I verbally invite him to sing again, but something different to what he was singing now (it was all material that W introduced). He looks at me blankly and then at TH. TH looks back at him and points at me. TL then holds the microphone in front of me (sitting next to him). I then sing new material that the group copies without any encouragement. After three short turns, I nod at TL inviting him to continue. He then held the microphone for W (sitting next to him). I then say, "no, no, its your turn." He then reaches pass me to hold it for Az. I then put my hand on his (holding the mic), and pushed his hand towards his face. The rest of the group laughed, as did he while looking at the rest. TH smiled at him, and pointed at him subtly. TL remained silent.

I invited the group to put their instruments down. TL was about to push his drum away, then I invited him to keep it. He then started playing it. I then pointed at the microphone in his other hand. He then held it closer to his face. He then opened his mouth and paused. I nodded and smiled at him. He then quickly sang, "lililililili". Everyone copied him. He then sang longer notes, but short phrases. His second phrase was "lililililili" and the third, "lalalalalaaaa". He then ended his fourth phrase with a scooping "ooooeeh" and passed the microphone to W as he sang it. Everyone laughed.

W sang similar phrases to what he sang before. TH did not respond vocally, but reached for drums close to him and tapped on them, seemingly oblivious of what the group was doing. During his turn, he passed the microphone to Az. After everyone laughed, and Az going, "how?!", TH took the microphone. He then sang a very fast and short melody that we all copied. He then began to shout as before. After I matched him again, he ended our climax by raising his hand high in the air, and hitting his drum loudly as he shouted with his head jolted forward in the same moment.

TH: façade of disinterest, imitates therapist; TL: blunted affect

W: takes on leadership, child-like melody; TL: matches guitar; TH: façade of disinterest/engagement, actively engaged in music

TL: responds vocally for the first time, after many invitations; TH: resisting conformity/lacking confidence, thus defences up/actively exploring ideas

directive therapist; TL: resists leadership

TL: leads vocally

W: accepts leadership; TH: seemingly bored, tries to avoid turn, initiates extreme expression

TH: participant as adolescent who challenges, participant as musician; TL: participant as self-conscious adolescent, participant as tired patient

W: participant as musician; TL: musician; TH: participant as seemingly resistive, but engaged adolescent musician

TL: participant musician; TH: participant as musician

TL: participant as self-conscious adolescent patient; therapist

TL: participant as musician;

W: participant as musician; TH: participant as humorous adolescent/musician

TH: risk-taking, humorous, wide-range of expression, little regulation, increased responsiveness, humour as defence; TL: blunted affect; self-conscious

W: risk-taking, humour; TL: begins to show empathy/responsiveness; TH: disinterest, yet engaged

TL: risk-taking, enjoyment, tentative, reliant; TH: disinterest, yet engaged, resists conformity, explorative

TL: blunted affect, lacks confidence, somewhat playful, resistive

TL: risk-taking, creative, tentative, reliant

W: risk-taking, self-efficacy; TH: risk-taking, humorous, initiative, wide-range of expression, little regulation; increased responsiveness; humour as defence

**SESSION NOTES:**

Just after the excerpt, Az sang animals sounds during her turn that was responded to by the rest of the GM. Later in the session, each GM had their own drum. As a group, we stroked the top of the drums. TH continued to play his drum very loudly, even though some GM frowned at him, I asked him verbally to join the rest, and Az indicated to him with her hand what to do. He continued to play.

At the very end of the session, he suggested the melody for the ending song.

**SESSION 4\_32:00-34:00\_2 participants****Initial notes****Recognizing Discourses****Characteristics of resilience****SESSION NOTES:**

Today is Saturday and most patients are absent. Due to the core GM, TH and W, being present and to be discharged soon, I decided to come despite the low numbers. Both TH and W entered the room very quietly. Neither of them had a machine with them, and were dressed with shorts and hoodies (not covering their faces). When I asked how their day was to determine the word to use in the greeting song (Sanbonani, sanbonani, it's a \_\_\_\_\_ day), they said it was boring. I asked them about that and they explained that the girls had been taken to a party and the boys were left at the ward. They also shared with me how they miss their families, and told me about them.

**Greeting song:** When we started with the greeting song (after the long verbal discussion), TH started the song and led it. W smiled, placed his hands folded in front of his mouth and softly sang along. I only accompanied on the guitar. IT was very gentle and almost sombre. As he sang, "its a boring day", we all laughed and the mood picked up to a lively and light atmosphere.

**Complete the phrase-rap:** I then put on a rap instrumental on which we would each freestyle rap about our day. Both were faced towards the centre of the group, clapped their hands and moved their upper bodies to the beat as they freestyled, and as the others we freestyling in their turns. TH asked if he could record it with his phone.

The next round, each had to rap one line and pass the mic to the other one. Each line had to narratively continue from the next. TH and W engaged by keeping their own lines short, and closely listening to the other's line. Once, TH extended his turn for about six lines, before being reminded to pass it to W. W looked at him and smiled. As TH rapped, he looked down, moved to the beat, and held the mic with both hands. He repeatedly sang, "cause I'm breaking the boring; I'm getting funny". This turned into our chorus. I played on the drum with W as he continued.

This excerpt begins with each of us playing the same beat on our own drums. Each had a turn to vocally improvise a syllabic-beat on "la-la". The turns were irregular, meaning it had no order of who was next. So, whoever had a beat that flowed the previous person's beat could go. For contrast, W and I began to gently stroke the drum as we continued with longer phrases of vocal improvisation. TH continued to play his beat.

**EXCERPT:**

As we each play our drums to the same beat (ta-ta-ta-taa), I hold the mic in my one hand and sing a short phrase (pa-ra-pa-paa). I then held the mic for W. He turned his head, smiled and looked down. I then sang another phrase and held it for TH. He held his head still and smiled. I said, "anything". He then sang a short "pa-pa-para-papa" phrase. Before his phrase was completed, he quickly held the mic to W. He paused, then smiled and completed TH's phrase, but softer, and with "mam-mam-mam-mam". AS he sang, his head was leaning on his one hand, resting on his knee. The other hand was playing the beat. As he sang, TH added additional short beats in his playing, and played louder.

W: resists leadership, tired/disinterested;  
TH: accepts leadership, initiates turns

W: participant as self-conscious/tired adolescent patient; TH: participant as leader musician

W: tired; TH: creative, facilitates roles, inclusive

After W's phrase, I went again, and complicated my vocal rhythms with "ti-ki-tiki-ti-kiti-ti". I then held it for TH to complete my phrase. He reverted to the basic beat on the drum, and kept vocally quiet for two bars. He then began to sing new phrase with many pauses in between short notes. He varied the sounds: "yeah....mmm-mmm-m..... (whistle)." I then held it for W again, and he repeated a similar phrase as before on "pa-ra-pa-ra-papapa". As he sang, TH played very loudly, and added additional strong beats to the group's basic beat.

I then gave one final loud beat on the drum and began to gently stroke circles on the drum. W copied me. TH continued to play the same beat, very loudly. I then leaned forward over my drum, and went "shhhhh". W still sat with his head resting on his arm, and smiled as he looked at me, and then at TH. TH began to stroke his drum for 3 seconds before hitting it again. I looked at him, smiled, and shook my head. He began to stroke, hit, stroke, hit. I then said, "just like this, just like this". I then began to sing a new phrase louder than the stroking. As I sang, TH began to play loudly again, louder than what I was singing. I then shook my head, and pointed at the drum as TH played and looked at me. He continued to hit it. I then stopped singing and calmly said, "uh-uh, don't hit it".

He stopped and I repeated my phrase. I then held the mic for him. As he lifted his hand to play again, I placed the mic in between his hand and his drum. he smiled and pushed it away. He then completed my phrase loudly. W smiled and stroke his drum. I then held it for W to sing. He sang his phrase and smiled broadly. He sang louder than he did in the whole session so far. It was then my turn to sing vocally. As I started to sing, TH stroke faster and louder. He then started to hit it loudly again. I then smiled and said, "heeeey, we can't hear others sing when you play so loudly." By this stage, W was bent over sideways with his head on his knee. His face was facing me. W's head was still on his arm, and he was looking away from TH, with a blunted expression. I then began to play with TH, increasing my volume as well. I changed the beat from a syncopated beat to a straight forward 4/4 beat. He sat up straight, leaned forward and towards me. He began to frown. He played even louder than before. I shouted, "Pa!" as I we played. He responded by vocally by shouting a phrase I sang earlier (pa-ra-pa-ra), and by repeating it. He looked directly at me as he shouted and played louder and louder. I sang/shouted with him at his dynamic level. at this stage, we were both screaming. W sat with his head on his arm, smiling and playing the recurring beat with us.

I then changed the drum and vocal beat from the recurring beat to a count-down beat. TH stopped with me. He then laughed very loudly and reached out for a high-five with me. W's head was looking down towards the floor as he smiled broadly and scratched his head. After TH gave me a high-five, he touched W's head. As W looked up, I reached out to high-five him as well and he gave one back gently. W then looked at TH and gave him a harder and faster high-five, almost like a snap.

#### SESSION NOTES:

**Singing with a familiar song:** After the excerpt, we listened to a song W suggested: "Don't judge me" by Chris Brown. The intention was to use the lyrics as a basis from which we could rap/sing our own lyrics. TH did not know the song, but used the printed lyrics I handed out to them, to song with. He sang softly. As the song progressed, we all stood up and danced to it. TH kept looking at the words. He then began to rap the lyrics over the song, and later put the paper down. He then rapped the words he rapped earlier ("it's a boring day; we're getting funny") over the recording. He danced with W and I as he rapped till the end of the session.

TH: creativity; adds complex intricacies to the group's music

TH: participant as confident musician

TH: creative, self-efficacy; self-esteem; explorative

therapist intervenes; W: complies and smiles; TH: uncompliant, challenges boundaries

Therapist; W: participant as compliant musician; TH: participant as adolescent patient who challenges

W: obedience, compliant; TH: uncompliant, challenges boundaries

TH: challenges; complies humorously, extreme release of emotions; W: sings louder than usual, enjoyment, withdrawn from moment, exclusion due to feeling less important; therapist meets challenge

therapist; W: participant as more confident musician, also withdrawn observer; TH: participant as adolescent who challenges, participant as creative musician, participant as leader musician

W: obedience, compliant; TH: uncompliant, challenges boundaries, leadership, extreme release of emotions

therapist intervenes; TH: initiates W's inclusion, and high-five with therapist; W: smiles and gives high-five

therapist; W: participant as musician; TH: participant as adolescent, empathetic/responsible leader musician

W: excluded to included; TH: extreme release of emotion, enjoyment, inclusive/empathetic leadership

## SESSION 5\_7:00-11:00\_3 participants

## Initial notes

## Recognizing Discourses

## Characteristics of resilience

## SESSION NOTES:

On this day, W, TH and Az ere present, all dressed warmly. TH and W were very early and played around with the instruments as I setup.

**Greeting song:** TH started to sing the greeting song as we all prepared to start. We then explained to Az that yesterday it was a boring day. She laughed and asked them softly if it was. TH nodded and smiled. I then asked them how their day was and they said they were all happy. We then sang the word "happy" in the song.

**Group singing:** I sang "laaaaaa" as I played the guitar. I invited them to sing with me, but TH said it is boring. I then played the guitar in a more rhythmic and lively way (on a 4/4 I IV progression throughout the activity) and invited him to choose the next melody that we will all be singing. He sang a brief "la" and dropped his head between his legs with his hands over his face. I encouraged him to try again. W then intervened by singing "nananana" on the melody I did as the example. Az went next and sang "meow, meow, meow, meow, meow". During TH's turn, he sat up straight, placed his hands over his face, and peeked at me between his fingers. When I told him I can see him, he laughed loudly. The excerpt picks up from here.

## EXCERPT:

I began to sing TH's name for three bars, then paused for the fourth bar. He looked away, and sang "ha-ha-ha-ha-ha-ha" over the same melody I used to sing his name. The others laughed. I then repeated his name for three bars, and he did not respond as before. Instead, Az sang TH's part in the fourth bar, very softly. TH then responded with a variety of sounds that we all copied, e.g. TH bar 1: "ha!" (posture facing away from the group), GM bar 2: "ha!", TH bar 3: "(sighs deeply and places head on hand)", GM bar 4: "(sigh deeply and place heads on hand)", etc. TH then smiles (still facing away), and placed his hands over his face. He then keeps quiet for a few counts, and the group waits for him. He then drops his head down and blows out a quick breath. The group imitates him. He then goes "hi!" and I imitate him, but extend his sound into "hiiiiiii!". He turns a bit more inwards to the group, but places his hands over his face again.

I then told the group that they are welcome to sing anything they want to sing. As I spoke, TH quickly dropped his hands and looked at me. I then immediately began to sing very long and gentle phrases. As I sang TH looked at me and tapped his hand on his knee to the beat of the guitar's playing. He then suddenly lifted his head to the roof, closed his eyes, and began to howl loudly with a smile. After I matched his dynamics level, he hit his hands on his legs, leaned forward and made a very fleeting "woof!" sound. As all of this happened, Az sat up in her chair, smiled, sang long and high-pitched phrases with me. She was also rocking in her chair. W sat bent over with his hands over half his face, and elbows resting on his knees. He mostly had a blunted expression.

I then began "ooooe" sounds that were very off-key/atonal. Az looked at the roof and tried to softly sing similar off-key sounds (softly). W was now spreading his fingers over his face, peaked at TH and smiled. TH (still facing away from the group) made irregular, loud and accented "wooo!" sounds that I immediately echoed in between my off-key sounds. "ooooe" to "hiiiiii". TH then made a sharp and quick sound, "eeeiyyyy!". I echoed him by shortening it and singing it as part of a short rhythm. Az leaned forward and laughed. TH then made a grunting sound hat I echoed again. In this moment, TH turned his body towards me, leaned forwards, clapped his hands repeated and laughed. He also waved his index finger at me and then rubbed his head as he went "eeeeeh!".

TH: seeking attention through apparent disengagement/asserting leadership; Az: intervenes by taking on TH's expected role

TH: initiates participants vocalizations, self as clown, asserting leadership; Az: imitates model; W: tired? Or disengaged? Or frustrated due to exclusion?

Az: explores different sounds independently; TH: façade of disengagement/testing boundaries, creative sounds, loses façade once matched

TH: participant as self-conscious adolescent musician; Az: participant as musician;

TH: client as adolescent/musician leader; Az: client as musician/compliant adolescent; W: client as disengaged adolescent patient/tired patient

Az: client as independent musician; TH: client as creative adolescent/musician

TH: resistance, but fully engaged, seeks attention, (possibly shy due to girl being present? Self-aware); Az: assumes role, increasing confidence/self-efficacy, independence, initiative

TH: fully engaged, seeks attention/asserts leadership, creative, humour; Az: enjoyment; fully engaged, dependent/compliant; W: disengaged, façade of happiness

Az: independent, explorative, tentative; TH: creative, allows empathy, tests boundaries, humour (as defence?), lowers façade

I asked W to join in, and he said “e-e” with his face still cover, and hoodie over his head. Az sang what I was singing, and TH began to clap his hands I a repeated rhythmic pattern (ta-ta-taa), that I matched with the guitar’s strumming. He then began to whistle short notes in the key of the guitar.

W: withdrawn; Az: imitates therapist; TH: creative variations

W: client as withdrawn adolescent patient; Az: client as complaint musician; TH: client as musician/hip-hop musician

W: resistive, withdrawn; Az: dependent, compliant; TH: creative, explorative, self-esteem  
Az: compliant, explorative, increasingly confident; TH: creative, allows contact humour; W: compliant, resumes engagement/ includes self, tired

I began to sing more varied sounds, such as, “weeee-wooo-waaah”, etc. Az softly sang similar and slightly different sounds. TH began making animal sounds like roars. Az laughed and waved her index finger at TH. He looked at her and smiled. The strumming pattern changed to more percussive (muting every 4th beat). TH placed his head on his arm. W then made a very soft, but long “aaaaahh” sound, slightly off-key. I then said, “well done, W!”. He smiled and kept quiet.

Az: explores different sounds independently, initiates direct contact with TH; TH: creative sounds; W: participant

Az: client as musician; TH: client as hip-hop musician; W: client as compliant musician/ tired patient

I started to play the guitar very softly. TH looked around at me. I asked everyone to move in closer. He looked at me blankly. I then indicated with my hands how he should move. He came in bit by bit. Everyone was sitting closer to the centre of the group, and leaned in. I then asked everyone to close their eyes. TH leaned back on his chair, and closed his eyes. I then said, “we will be making sounds together, as loud as we can.” TH then lifted his arms in the air, gave one loud clap and made a loud, long, and low-pitched sound on “uuuuh”. I then matched him. Az giggled and joined me with long sounds. As I went louder, TH gave one loud shout, “aaaagh!” and clapped again. Az went louder with me and then laughed again. W sat with his face in his hands, resting on his legs. It is unclear of what he did vocally. TH leaned back and placed his hands over his face.

TH: is creative and engaged; W: façade of disengagement; Az: laughed and followed therapist

TH: client as hip-hop musician; W: client as withdrawn patient; Az: client as compliant musician

TH: creative, expressive in regulatory manner, humour; W: withdrawn, inward; Az: “happiness”, compliant

I changed my sound to “ooh”. Az laughed. TH looked at W and pushed his shoulder. W looked at him smiling broadly and placed his face in his hands again. TH then began to roar loudly. Az laughed again. TH leaned away, rested his head on his hand and closed his eyes. The rest of us continued to wale. It seemed as if W joined us softly with his face mostly covered. Az kept watching me and copied me. TH then began to sing the melody from the previous day, “it’s a boring day”. We made snoring sounds, and he smiled. W sat up and looked at us smiling. The music gradually went softer. I told TH that he is funny, then he said, “no, I’m boring”. The others laughed.

TH: humorous and inclusive; Az: happy self, compliant; W: façade of disengagement

TH: client as hip-hop musician; W: client as withdrawn patient; Az: client as musician

TH: compliant, creative, expressive in regulatory manner, humour; W: withdrawn, inward, Az: “happiness”, compliant

#### SESSION NOTES:

After this we did an instrumental improvisation. We then had a verbal discussion (transcribed) on our process. We then ended with the greeting song.

## SESSION 6\_32:00-34:00\_4 participants

## Initial notes

## Recognizing Discourses

## Characteristics of resilience

**SESSION NOTES:**

During this final session, Az, TH, W and KH were present. KH only attended the first session, as he was too ill to attend the other sessions. This day he is feeling better and is dressed warmly. The rest are dressed warmly, but less than KH. W was sitting with his face in his hands, resting on his legs. His eyes were closed. I asked him if he was okay, he nodded with a slight smile and droopy eyes.

As I set up, TH played a kwaito song from his phone through the sound system. The rest sat in silence and listened. TH and W then said they wanted to sing about their friends at the hospital. I asked them how they would like to sing about it, then TH said they could ask each other questions. This conversation was short, and not more than just explained.

**Greeting song:** We started the greeting song by all singing together. W sang with, still resting his face on his hand. After a few repetitions, we added drums. We shared drums in pairs. W said his hand was sore but could still play. KH said he did not want to play. AS we started to sing the song again, TH and Az played their drums. W did not play on the drum between him and KH, but he sang with. KH looked at TH playing and started to tentatively play on the drum next to him.

**Song-writing:** I handed out paper to everyone and explained that they could write four lines about their friends at the hospital. As they started, I saw KH is not writing anything. I went to assist him. He told me that he does not have any friends at the hospital. I said that that's fine and that he can write that. He did. He then looked at me as if asking "what now?". I asked him to write about how he felt about it. He wrote, "I feel lonely". I then asked him if he has friends at home, and he said yes. "he then completed his verse with, "I have friends at home. Their names are \_\_\_ and \_\_\_\_." At this point, W was feeling ill and asked if he could go. TH wrote about W as his best friend.

Az struggled to write, so I went to assist her. TH and KH were done and waiting. They sat next to each other, but with a lot of space between them they did not engage with each other (they stay in the same room). I then asked them to write the chorus together. They looked at each other but did not say or do anything. I then gave them more direction about how they could do it. They still did not do or say anything. I then asked TH if he would mind asking KH the questions he suggested before to add in the song. He started to write on his own piece of paper. When I asked him why he was not engaging with KH, he only looked at. (Later I saw on his paper that he was writing the questions down). By this point, Az was finished as well.

Due to time running out, I suggested the lyrics for the chorus: "friends, friends everywhere; we have friends, far and near." KH gave ideas on how the melody of the chorus can go, but he did this almost inaudibly. We used what he suggested and sang this over an instrumental hip-hop rap-track. We sang the together until we all knew it.

Once we all seemed comfortable with the chorus, I invited each GM to sing/rap/read their piece of paper as the back-track continued to play, while I held the microphone in front of whoever was going. TH went first. He read-rapped his verse. After the first line, he stopped and looked down smiling. I encouraged him, and he continued his verse. We all went back into the chorus. After the chorus, it was Az's turn. She smiled and read her verse. TH was kneeling and resting his arms on a drum. KH was sitting leaned forward, with his hands on his legs, listening. After we sang the chorus again, KH prepared to rap his part. He rapped quietly, but used his whole body to rap, i.e. he pulsed his upper body to the beat, moved his hands slightly to accentuate his words, and in between pauses he added words like, "ah-yeah" and "mm-mm". Az tapped her foot as she listened to him. TH looked at his phone (he asked to record our songs). I invited KH to repeat his verse again, and he increased his movements and dynamics slightly. When he "made a mistake", he stopped, looked down, and continued.



This went into the chorus for a final time. TH started to sing very loudly. As the chorus finished, and the space for another verse came, I began to rap questions for each GM. The excerpt picks up here.

#### EXCERPT:

We are still listening to a hip hop backtrack without words, fitting words into the rhythmic patterns of the music. I held the mic for myself, moved my upper body to the beat, and rapped, "TH, TH, were do you come from?". I then held the mic for him. He was still kneeling, but looking down at the floor, smiling for a few moments. I called him to respond. Then KH said an unclear, soft yet audible word to him. TH then looked halfway up to the mic and said in a slight rap-like voice (different rhythmic phrase than when spoken), "I come from Mpumalanga." I then responded with the sounds KH made earlier in his pauses, "ah-ah". I then rapped to KH, "KH, KH, what is your favourite food?" I leaned slightly back, started to move his upper body to the beat, and immediately began to rap back, "my fa-vou-rite food is...ah...ah...yeah... ah...ah..." he then paused and touched his chin, and flicked his hand up as he said, "ah.. chicken licken". TH laughed with him. I then rapped to Az about what he favourite animal is. She asked, "animal?". I nodded. She said in a speaking voice, "elephant".

I then passed the mic to TH and invited him to ask one of us a question. He asked KH in a slight rhythmic varied speaking voice, "where do you live?". KH immediately answered, moving his upper body and hands to the music, "I live in Mpumalanga." Az and each leaned to the mic and answered the same question. Az spoke her answer. TH then asked KH, "what is your favourite sport?". KH then answered in the same way again, "my fa-vo-rite sport is soccer." I then took the mic and pointed at the paper with the chorus written on it. We then sang the chorus at a moderate dynamic level. The GM looked at the paper and moved their feet or upper bodies to the beat.

I then passed the mic to KH and nodded at the others. He then looked at TH and rapped, "ah, man, where do you come from?" still moving his hands to accentuate some of his beats. TH responded by speak-rapping again, "I live in Mpumalanga" without looking up at KH. We then repeated the chorus once.

I then held the mic I the middle of the group and said, "does anyone wanna say something to the group?". KH placed his hand on his head and looked down as he shook his head. TH whistled and looked down. Az smiled and kept quiet. TH began to softly sing the chorus and the others joined him softly. At the end of the chorus I said, "KH, you can do this." He took the mic, moved to the music again, and rapped a few lines of which most were unclear to hear. I sounded as if he said, "My name is KH and I like [unclear], uh .... yeah.... uh.... yeah." I then went and rapped two lines about myself, "my name is Leigh-Ann and I like, I I I like, music!". KH went again, and rapped with the same quality as before. I asked him to repeat his one line and he said, "music is like life to me". I then responded with, that's so cool!" and passed the mic to Az. She began to softly speak-rap over the mic by repeating some words and fitting them into the phrase. She said that she likes netball. I then passed the mic to TH and said he can end it off for us. He took the mic, put it right against his lips and kept quiet. He moved his feet to the beat. After a while of keeping quiet he began to sing the chorus and we all joined in.

#### SESSION NOTES:

The session ended with a verbal reflection that will be transcribed.

TH: rapper, tentative and supported by KH; KH: rapper, supports TH; Az: tentative, in presence of men, possibly not as interested in hip-hop

Therapist facilitates

TH: participant as hip-hop musician; KH: participant as hip-hop musician; Az: participant as musician; therapist

TH: tentative, lower self-efficacy, risk-taking, 'happiness'; KH: confident, supportive/empathetic, collaborative; Az: shy, lower self-efficacy/esteem, culturally compliant

TH: rapper, facilitates/leads music; KH: responds and moves like rapper; Az: tentative/shy

TH: participant as hip-hop musician; KH: participant as hip-hop musician; Az: participant as musician;

TH: self-efficacy, risk-taking, 'happiness', collaborative; KH: confident; Az: shy, lower self-efficacy/esteem

KH: sings and moves like rapper, facilitator/leader of music; TH: attempts to sing like rapper

TH: participant as hip-hop musician; KH: participant as hip-hop musician;

TH: self-efficacy, risk-taking; no eye-contact; KH: confident, collaborative

facilitating therapist; KH: free-style rapper, embodies music; Az: shy, but when encouraged, attempts to rap; TH: resistive

therapist KH: participant as hip-hop musician; TH: participant as musician/hip-hop musician; Az: participant as hip-hop musician

KH: confidence, self-efficacy, talents valued by self and others, attractiveness to others, sense of control; Az: risk-taking, increasing self-efficacy and -esteem; TH: tentative, resistive, embodied/ physical engagement in music, self-esteem; resourceful, challenged?

**Appendix E: Grouping of discourses and characteristics of resilience**

| <b>Sick Patient Discourse</b> |                                     |  |                                     |  |                                     |                                       |
|-------------------------------|-------------------------------------|--|-------------------------------------|--|-------------------------------------|---------------------------------------|
| <b>Session</b>                | <b>S1</b>                           |  | <b>S2</b>                           |  | <b>S3</b>                           |                                       |
|                               | <b>characteristic of resilience</b> | <b>potential lack of resilience</b>  | <b>characteristic of resilience</b> | <b>potential lack of resilience</b>  | <b>characteristic of resilience</b> | <b>potential lack of resilience</b>   |
| <b>TL</b>                     |                                     | limited range of emotional expression, withdrawal from challenge, poor communication, no risk-taking, blunted affect | self-orientated control             | low self-esteem, not achievement orientated, blunted affect, low self-efficacy | somewhat playful                    | tired, blunted affect, low confidence |
| <b>Az</b>                     |                                     |  |                                     |  |                                     |                                       |
| <b>TH</b>                     |                                     |  | asserts control                     | unhappy  |                                     |                                       |
| <b>W</b>                      | open communication                  | no risk-taking, low confidence   |                                     |  |                                     |                                       |
| <b>O</b>                      |                                     |  |                                     |  |                                     |                                       |
| <b>TA</b>                     |                                     |  |                                     |  |                                     |                                       |
| <b>K</b>                      |                                     | low confidence, no risk-taking   |                                     |  |                                     |                                       |
| <b>GROUP:</b>                 |                                     | compliant  | enjoyment, cohesive                 | tentative, no risk-taking  |                                     |                                       |
| <b>Session:</b>               | <b>S4</b>                           |  | <b>S5</b>                           |  | <b>S6</b>                           |                                       |
|                               | <b>characteristic of resilience</b> | <b>potential lack of resilience</b>  | <b>characteristic of resilience</b> | <b>potential lack of resilience</b>  | <b>characteristic of resilience</b> | <b>potential lack of resilience</b>   |
| <b>TL</b>                     |                                     |  |                                     |  |                                     |                                       |
| <b>Az</b>                     |                                     |  |                                     |  |                                     |                                       |
| <b>TH</b>                     |                                     |  |                                     |  |                                     |                                       |
| <b>W</b>                      | commitment                          | tired/disinterest  | commitment                          | tired, façade of happiness, withdrawn, compliant, inward                       |                                     |                                       |
| <b>O</b>                      |                                     |  |                                     |  |                                     |                                       |
| <b>TA</b>                     |                                     |  |                                     |  |                                     |                                       |
| <b>K</b>                      |                                     |  |                                     |  |                                     |                                       |

| Discourse of being a Teenager |                              |   |  |  |  |   |
|-------------------------------|------------------------------|---|--|--|--|---|
| Session:                      | S1                           |   | S2   |  | S3   |   |
|                               | characteristic of resilience | potential lack of resilience  | characteristic of resilience   | potential lack of resilience                               | characteristic of resilience   | potential lack of resilience  |
| TL                            |                              |   |  | self-conscious, self-orientated control                    | resistive (control), playful,  |   |
| Az                            | culturally compliant         |   | culturally compliant   |  | culturally compliant   |   |
| TH                            | -                            | -   | confident, asserts control, expresses emotions, embodies music (physical investment) | self-orientated control, overpowers                        | risk-taking, humour as defence, wide range of emotional expression, increased responsiveness, challenges boundaries, | little self-regulation, challenges boundaries at group's expense, resistive |
| W                             |                              |   |  |  |  | self-conscious  |
| O                             |                              |   |  |  |  |   |
| TA                            |                              |   |  |  |  |   |
| K                             |                              |   |  |  |  |   |
| GROUP:                        |                              | self-conscious  | cohesive   | no risk-taking   |  |   |
| Session:                      | S4                           |   | S5   |  | S6   |   |
|                               | characteristic of resilience | potential lack of resilience  | characteristic of resilience   | potential lack of resilience                               | characteristic of resilience   | potential lack of resilience  |
| TL                            |                              |   |  |  |  |   |
| Az                            | culturally compliant         |   | happiness, culturally compliant  |  | culturally compliant   | low self-efficacy, low self-esteem  |
| TH                            | challenges boundaries,       | little self-regulation, challenges boundaries at group's expense, resistive, uncompliant, | resistive, fully engaged   | self-aware (female present), seeks attention (destructive) |  |   |
| W                             |                              | self-conscious, compliant, obedient   | commitment   | disengaged, resistive, withdrawn                           |  |   |
| O, TA, K                      |                              |   |  |  |  |   |

| Hip-Hop Musician Discourse |  |                              |   |                              |   |                              |
|----------------------------|--|------------------------------|---|------------------------------|---|------------------------------|
| Session:                   | S1   |                              | S2  |                              | S3  |                              |
|                            | characteristic of resilience   | potential lack of resilience | characteristic of resilience  | potential lack of resilience | characteristic of resilience  | potential lack of resilience |
| TL                         |  |                              |   |                              |   |                              |
| Az                         |  |                              |   |                              |   |                              |
| TH                         |  |                              |   |                              |   |                              |
| W                          |  |                              |   |                              |   |                              |
| O                          | self-efficacy, initiative, spontaneity, problem solving, empathy                                 |                              |   |                              |   |                              |
| K                          |  |                              |   |                              |   |                              |
| GROUP:                     |  |                              |   |                              |   |                              |
| Session:                   | S4   |                              | S5  |                              | S6  |                              |
|                            | characteristic of resilience   | potential lack of resilience | characteristic of resilience  | potential lack of resilience | characteristic of resilience  | potential lack of resilience |
| TL                         |  |                              |   |                              |   |                              |
| Az                         |  |                              |   |                              |   |                              |
| TH                         | empathetic/responsible leader (end of session), inclusive, extreme release of emotion, enjoyment |                              | creative, empathetic, humour, lowers façade of disengagement, allows humour in direct contact, expressive in regulatory manner, compliant (other-awareness) |                              | self-efficacy, risk-taking, enjoyment, collaborative, resistive (challenges leadership), confidence, physical investment in music                             | often avoids eye-contact     |
| W                          |  |                              |   |                              |   |                              |
| O                          |  |                              |   |                              |   |                              |
| K                          |  |                              |   |                              | confident, supportive, empathetic, collaborative, talents valued by self and others, attractiveness to others, sense of control, physical investment in music |                              |
| GROUP:                     | collective enjoyment   |                              |   |                              |   |                              |

|               | Explorative Space (Musician)                             |                              |                              |                              |  |   |
|---------------|--|------------------------------|------------------------------|------------------------------|--|---|
| Session:      | S1   |                              | S2                           |                              | S3   |   |
|               | characteristic of resilience                             | potential lack of resilience | characteristic of resilience | potential lack of resilience | characteristic of resilience   | potential lack of resilience              |
| <b>TL</b>     |  |                              |                              |                              | more compliant & engaged (almost as empathetic), risk-taking, enjoyment (emo expr), creative               | tentative, dependant, self-conscious      |
| <b>Az</b>     | self-efficacy, risk-taking                               | low confidence               |                              |                              | creative, risk-taking  |   |
| <b>TH</b>     |  |                              |                              |                              | increasing responsiveness<br>humour, initiative, creative, wide range of emotional expression, risk-taking | resistive, no regulation of emotions/self |
| <b>W</b>      | sense of control   |                              |                              |                              | risk-taking, humour, self-efficacy   | self-conscious                            |
| <b>O</b>      | self-efficacy, achievement orientated                    |                              | risk-taking, adaptable       |                              |  |   |
| <b>TA</b>     |  |                              |                              |                              |  |   |
| <b>K</b>      | self-efficacy (when there's space made for him by other) |                              |                              |                              |  |   |
| <b>GROUP:</b> | supportive, enjoyment, empathetic, affirming             |                              |                              | low empathy                  | supportive   |   |

| <b>Session:</b> | <b>S4</b>  |                                     | <b>S5</b>   |   | <b>S6</b>   |  |
|-----------------|--|-------------------------------------|---|---|---|--|
|                 | <b>characteristic of resilience</b>                                      | <b>potential lack of resilience</b> | <b>characteristic of resilience</b>   | <b>potential lack of resilience</b>   | <b>characteristic of resilience</b>                   | <b>potential lack of resilience</b>            |
| <b>TL</b>       |  |                                     |   |   |   |  |
| <b>Az</b>       |  |                                     | enjoyment, fully engaged, independent, explorative, accepts leadership (1st time), increasing self-confidence and self-efficacy, independence, initiative | compliant, tentative  | risk-taking, increasing self-efficacy and self-esteem | self-conscious, lower self-efficacy            |
| <b>TH</b>       | begins to indicate leadership, inclusive, empathy, creative, explorative | low self-regulation                 | fully engaged creative, humour,   | resistance, self-conscious, seeks attention seeks attention (self-orientated) | enjoyment, risk-taking                                | when KH leads: tentative, lower self-efficacy, |
| <b>W</b>        | actively includes self   | compliant                           | actively includes self  |   |   |  |
| <b>O</b>        |  |                                     |   |   |   |  |
| <b>TA</b>       |  |                                     |   |   |   |  |
| <b>K</b>        |  |                                     |   |   |   |  |
| <b>GROUP:</b>   | enjoyment, supportive  | low empathy                         |   |   |   |  |

## Appendix F: Scores

## Session 1-2:

## Call and response beat S1-2



## Session 2:

S2B  
1 Don't cry you be fine

2 Don't cry, you will go home  
when you feel better.

3 Don't cry everything was going to be fine

4 Be strong it going to be fine.

The hospital hospital is so nice because helping me

The doctors doctors keep help me

My body My body is good

I feel Feel well

The hospital like it sometimes

The doctors love it because they my life

My body love it it need fruits

I feel better



The hospital has hope.

The doctors healed me.

My body is healed.

I feel very better.

<sup>animator</sup> the hospital IS HELPFUL

The doctors ARE COOL

My body NEEDS EXISIS

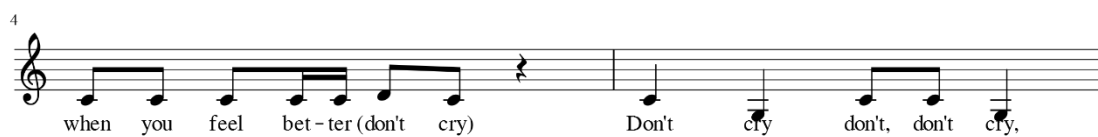
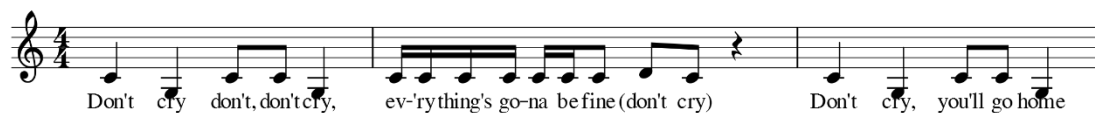
I feel 1000% strong

*relia*  
 The hospital \_\_\_\_\_  
 The doctors Hes Helps me  
 My body is fun  
 I feel better

## Don't Cry

Fill-in-the-bank Song Writing

TA, TH, O, AZ, TL



**Session 3:****TL's Vocal Improvisation**

E A E A E A E A

TL:li li li li li (Group echoes) TL:li li li (Group echoes)

5 E A E A E A E A (pause)

TL: tra la la la (Group echoes) TL:tra la la la (Group echoes) TL: lu - lu

**Session 4:**

Don't judge me – Chris Brown

I don't wanna go there  
 We should never go there  
 Why you wanna go there  
 I guess I gotta go there  
 You're hearing rumors about me  
 And you can't stomach the thought  
 Of someone touching my body  
 When you so close to my heart  
 I won't deny what they saying  
 Because most of it is true  
 But it was all before I fell for you

So please babe  
 So please don't judge me  
 And I won't judge you  
 'Cause it could get ugly  
 Before it gets beautiful  
 Please don't judge me  
 And I won't judge you  
 And if you love me  
 Then let it be beautiful  
 Let it be beautifu-u-ul , let it be beautiful  
 Let it be beautifu-u-ul , let it be beautiful

Everything I say right now  
 Is gonna be use in another fight

And I've been through this so many times  
Can we change the subject  
You gonna start asking me questions like:  
"Was she attractive, was she an actress ?"  
Baby the fact is, you're hearing rumours about me  
And saw some pictures online  
Saying things, they got you so angry  
Making you wish you were mine  
Before we start talking crazy  
Saying some things we'll regret  
Can we just slow it down and press reset

You're beautiful  
So babe  
So please don't judge me  
And I won't judge you  
'Cause it could get ugly  
Before it gets beautiful  
Please don't judge me  
And I won't judge you  
And if you love me  
Then let it be beautiful

Just let the past  
Just be the past  
And focus on things  
That are gonna make us laugh  
Take me as I am, not who I was  
I'll promise I'll be, the one that you can trust

So please  
So please don't judge me  
And I won't judge you  
'Cause it could get ugly  
Before it gets beautiful  
So please don't judge me  
And I won't judge you  
And if you love me  
Then let it be beautiful  
Let it be beautifu-u-ul , let it be  
Let it be beautifu-u-ul , aye let it be beautiful, yeah yeah yeah

I don't wanna go there baby  
We should never go there

## Session 6:

## Friends, Friends, Everywhere

TH, W, AZ, KH



Friends, friends, ev' - ry-where, we have friends, far and near

Chorus S6

Friends friends everywhere  
we have friends far & near

thami

Koketo S6

I don't have friends in hospital

I feel lonely

I have friends at home

I feel happy when i'm with them

The name of my friend is Wize

---

Today is boring day

Because my friends have some pains.

I feel be happy when I saw my friend playing.

Azelia Sb

I have a friend at a Hospital

My friend's name is Kgomutse and Sakeliso

I Live loves very much

I like music.



# Improvisational Rap

TH, Az, W and TH

K:T-H, T - H, where do you come from? TH:I,I, I come from Mp-u-malan - ga

5

TH:Hey,man, what is your fa - vou-rite food? K:I like chi-cken - li - cken.