Mother voices: An exploratory study on the experiences of music therapy for pregnant women in distress from the Cape Flats

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Abstract

The period of pregnancy is of utmost importance in human development due to the plasticity of the baby's brain during this time. Reducing child mortality and improving maternal health are part of the South African government's Millennium Development Goals, yet South Africa continues to have some of the worst maternal and child health rankings globally. Music therapy has been used with pregnant women as a non-pharmacological treatment method, though as of yet no studies on this topic have been conducted in South Africa. The objective of this study, carried out at the Hanover Park Midwife Obstetric Unit (MOU) with five pregnant women, was to discover their experiences with music therapy and to determine the techniques they found most useful. Data in the form of a questionnaire, participant observation through video recording, a final interview and focus group, and rating scales were collected during and after seven 45-minute sessions. Through thematic analysis (Braun & Clarke, 2006) five overarching themes were identified. The women experienced music therapy as a space of personal exploration; as a space to connect with others; as a space to develop connection to the baby; and as a regenerative space. Lastly, the affordances of the therapeutic relationship and the preferred techniques were also analyzed. The study demonstrates the potential for music therapy to be a beneficial treatment during pregnancy for women from at-risk populations.

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Chapter 1: Introduction

1.1 Background and context

Reducing child mortality and improving maternal health are included in the South African government's Millennium Development Goals (MDGs). Many women are not receiving sufficient health care after the birth of a baby, and often do not have adequate support in their transition to a different family structure with the addition of a new family member. Many face social isolation during this time. In combination with factors such as abuse, a previous history of depression, and a traumatic birth, women can become vulnerable to mental health problems after the birth of a child (Ayers, Sawyer, & Smith, 2010).

The plasticity of a baby's brain is at its highest in the final trimester of pregnancy and up to the first two years after birth (Kolb, 2009), making this a period of utmost importance in human development. The World Health Organization (2015) has prioritized addressing perinatal mental health because of the challenges infants of depressed mothers face, such as higher rates of malnourishment and diarrhea. Maternal depression can affect infants' ability to develop secure attachment and regulate affect, and even their basic survival (Schore, 2001). Children of depressed mothers have increased cognitive and motor delay, more frequent problems with breastfeeding, and lower academic achievement. Despite these challenges many mothers with postpartum depression never receive treatment (Black, Engle, & Wachs, 2009). Thus, the two goals of decreasing child mortality rate and improving maternal health are linked.

South Africa, like many developing countries, faces some severe problems when it comes to maternal and early childhood quality of life. Some examples of the health-related concerns for South African mothers include HIV and AIDS, rape, infanticide, suicide, and malnutrition. South Africa has the highest rate of HIV-infected residents in the world. Because depression results in lower adherence to antiretroviral medication, this can lead to adverse health outcomes for the baby in the case of prenatal depression in pregnant women with HIV (Doll, Richter, & Rochat, 2006). Over 40% of maternal deaths are HIV related and this is the main reason the maternal mortality rate is triple the WHO's MDG target (Barron et al., 2015).

South Africa also has the highest rate of reported cases of rape globally and one of the highest rates of gender-related violence and domestic abuse (Turner &

Honikman, 2016). Domestic abuse is defined as abusive acts, whether physical, sexual, emotional, psychological, or financial, committed by someone who lives in the same house. Research conducted in the informal settlement of Khayelitsha in Cape Town found that high rates of gender-based violence and gender inequality cause women to become particularly vulnerable to mental illness (Cooper, Molteno, Swartz, & Tomlinson, 2004).

Another indication of the mother-infant health care emergency in South Africa is that infanticide (killing of a child under one year) is recorded at 27.7 per 100,000 live births. The rate is four to 10 times higher in South Africa in comparison to countries like New Zealand or the USA, where figures range from 2.1 to 6.9 per 100,000 live births. This troubling statistic "points primarily to a failure of maternal and reproductive health services" (Abrahams et al., 2016, p. 2). South Africa also has the highest rate of fetal alcohol syndrome in the world, related to the use of alcohol to cope with stress (Comulada et al., 2011).

While suicide is one of the leading causes of maternal mortality in many countries, this has yet to be established in South Africa due to inadequate reporting. Some potential reasons why there is a high suicide rate among pregnant women include HIV/AIDS, high rates of adolescent pregnancies, and poverty (Honikman & Field, 2013, p 129).

Prenatal depression is one of the strongest predictive factors for a diagnosis of postpartum depression, a serious health concern that, when untreated, can lead to poor health outcomes for both women and children. In lower and middle income countries, it is also associated with poor child growth, poor mental development, and higher risk of infant diarrhea, as well as maternal disability, which affects the care-giving capacity of mothers (Comulada et al., 2011). While postpartum depression can strike any woman, from impoverished to affluent, women with a low socioeconomic background are more at risk. Providing adequate mental care for mothers needs to be a priority in health care initiatives to break the cycle of poverty and lack of education. Music therapy has been shown in a Cochrane review to have potential as an alternative intervention to psychotropic treatment for people struggling with depression (Crawford, Gold, Maratos, & Wang, 2008).

The current study involved a small group of participants from the Cape Flats district of Hanover Park within Cape Town. This is an area that experiences some of the highest levels of gang violence in South Africa (Lambrechts, 2013). Violent crime is one of the strongest predictors of postnatal depression. In another study in which

1035 women were interviewed antenatally, the strongest predictor of postnatal depression was exposure to extreme societal stressors such as witnessing a violent crime or experiencing danger of being killed (Norris et al., 2009). In South Africa, low-income populations still have little access to psychological and emotional support services (Benjamin, 2014). Furthermore, there are no dedicated mental health services during the perinatal period, and it is difficult to maintain adequate healthcare in the face of high patient numbers and staff shortages. Consequently, this is an important setting to focus on providing maternal health care.

Most studies concerning the use of music therapy have been with postnatal, rather than prenatal, depression. No study has yet been done to examine the experiences in music therapy of pregnant women in distress in South Africa, particularly in contexts such as the Cape Flats where there is a high level of violence and poverty. More research is also needed globally to explore the experiences of women who are encountering psychological difficulties during pregnancy, and how music therapy may be a support through this time.

1.2 Rationale for research study

In preparation for this study, I obtained my Prenatal Bonding Course certificate, offered by Mary DiCamillo, MT-BC and author of the Sound Birthing program. Personally, I felt I would have benefited from having a support group during my own pregnancy, and I felt that equal access to decent healthcare, even more so during maternity, is important. Because so much is at stake during the prenatal period, for the health of both the baby and the mother, resources need to be directed toward ensuring adequate care. Music therapy is uniquely suitable for this client group because it is non-pharmalogical. Avoiding medication during pregnancy is often desired by both the doctor and the mother-to-be for improved health outcomes. Music therapy provides the opportunity to improve mental health without the use of medication. Exploring the experiences of women in at-risk populations with music therapy could further aid practitioners in what will be most beneficial in order to provide the best possible care. There has yet to be a research study within the Cape Flats on the use of music therapy during pregnancy.

1.3 Aims

The study aimed to explore the experiences that a number of women with prenatal depression had of music therapy. Specifically, I aimed to explore how participants experienced music therapy as an intervention for their symptoms and how they experienced active (music making) as well as receptive (music listening) music therapy techniques.

1.4 Research questions

The proposed study was, therefore, guided by the following research questions:

1. How do women experience individual music therapy sessions as an intervention for their symptoms of prenatal depression?
2. Which music therapy techniques did they find most beneficial?

1.5 Chapter outline

The chapters will proceed as follows. First, the literature review will explore what has been published on the subject of music, music therapy, and pregnancy during the perinatal period, including labor. Studies on infant attachment and bonding are also mentioned. The background on the literature leads to a rationale for the current study.

After the necessity of my study has been established, the methodology chapter will explain the theoretical underpinnings of the manner in which I went about obtaining my research. It includes descriptions on the paradigm, how the participants were selected, the design of the study, the research quality and ethical considerations.

The next chapter, data analysis, introduces the participants and describes the equipment used during the music therapy sessions. The content of the sessions is summed up. Then, as required by thematic analysis, the process is described whereby through the coding of thick descriptions of video clips, the final interview, and the focus group the development of my categories and themes are obtained. These provide the answers to my research questions.

The discussion chapter then delves deeper into the data, drawing ties from previous studies as mentioned in the literature review to my findings. The techniques

used within the sessions are described within the context of the rating scales with more information about the feedback the women provided as to which were most helpful and why.

The conclusion briefly summarizes the study and the answers to the research questions, and provides recommendations for future research.

Chapter 2: Literature Review

2.1 Introduction

In this literature review I will be discussing the effects of perinatal depression (a term that encompasses the existence of depression from pregnancy to the end of the first year after childbirth), and music therapy as an intervention. Studies will be mentioned that involve the use of music therapy for women before, during, and after the birth of a child, as an intervention used to treat depression, diminish pain, regulate sleep, and reduce anxiety.

My focus in this study will be on the use of music therapy with pregnant women in distress. However, adequate prenatal care cannot be separated from its importance in the prevention of postnatal depression. Therefore, I will give some background in the use of music therapy with postnatal depression, in addition to research with women during pregnancy and labor.

2.2 Mental health during pregnancy in South Africa

Up to one in three women in South Africa have experienced mental health problems related to pregnancy, with rates as high as 47% in rural areas (Kathree et al., 2014). Clinical depression is characterized by the following, as defined by the World Health Organization (2015): Depressed mood; loss of enjoyment; less energy; less concentration; less self-esteem; guilt/unworthiness; pessimism; ideas/acts of self-harm; disturbed sleep; disturbed appetite; weight loss/gain; and restlessness/agitation. Untreated antenatal depression is correlated with a higher incidence of miscarriage, a higher risk of bleeding during pregnancy, higher rates of caesarean section delivery, higher rates of preterm delivery, prolonged labor, and low-birth-weight babies. These mothers are at risk of self-medicating with alcohol or drugs, reduced sleep and appetite and subsequent poor antenatal weight gain, and increased probability of maternal mortality and suicide (Turner & Honikman, 2016). In South Africa, nearly half of poor pregnant women experience mental illness--at a rate three times higher than the prevalence in developed countries, and even higher than the rate in countries like Nigeria and Uganda (Abiodun, 2006).

2.3 Music, music therapy and pregnancy

A study by Liebman and Maclaren (1991) found that anxiety levels decreased in a group of pregnant adolescents who attended music therapy sessions that included music and relaxation techniques. The results were statistically significant. Yang et al. (2009) concluded that using music incorporating a patient's own preferences lowers anxiety during high risk pregnancies.

Another study by Chang, Chen, and Huang (2008) examined the role of music therapy in improving psychological health during pregnancy in a group of 236 women. In a paired t-test, the music therapy group showed a significant decrease in the scores on the Perceived Stress Scale (PSS), State Trait Anxiety Inventory (S-STAI) and the most prevalent screening test, the Edinburgh Postnatal Depression Scale (EPDS) (Brealey, Hewitt, Green, Morrell, & Gilbody, 2010), after two weeks. The control group only showed a significant decrease in PSS after two weeks. This decrease was not as substantial as in the experimental group.

In 2013, a study concluded that extensive prenatal exposure to a melody is recognized neurologically by an infant for several months after birth. Fetal auditory learning begins at 27 weeks gestationally, so that rather than being a 'blank slate,' newborns already recognize familiar environmental sounds, including mother's voice, native language, and prenatally exposed melodies (Partanen, Kujala, Tervaniemi, & Huotilainen, 2013).

Research has been conducted by Franklin-Savion (2016) on group music therapy with women who are undergoing fertility treatments. Emotional distress decreased due to the intervention. A mixed method approach was used to discover the rate of depression through questionnaires, and the participants' experiences of music therapy through interviews.

In a study by Nussberger (2016), who provided short-term music therapeutic interventions of just one or two sessions, it was found that the stress-reducing factor of music was helpful in high risk pregnancies to relax the mother and delay labor.

2.4 Music therapy during labor

Music therapy is increasingly used as an intervention in hospitals in preparation for giving birth because of the benefits such as reducing the negative pharmacological load, normalizing sleep patterns, reducing stress before a

caesarean section, and decreasing the likelihood of premature labor (Sidorenko, 2000). Earlier studies have shown a correlation between increased satisfaction and success in the childbirth experience when music therapy is used during labor (Clark, McCorkle, & Williams, 1981). All participants in another study by Hanser, Larsen, and O'Connell (1983) reported decreased pain when music was used as a relaxation and diversion tool during labor as compared to the same setting with no background music. A further study discovered that women who had attended a music therapy group then reported feeling significantly more control over the birth through focused listening to music and using it as a coping strategy (Browning, 2001). Phumdoung and Good (2003) discovered in their study of the use of music during active labor that women in the music group felt both less sensory pain and less emotional distress than those without.

Some of the most large-scale, controlled studies to date concerning music therapy during labor have occurred in Taiwan. One study looked at the role of music therapy in pain reduction during labor (Liu, Chang, & Chen, 2010). The experimental group reported a significant decrease in pain during the latent phase of labor compared to the control group, who received routine care only.

In another study with 64 women, the role of music therapy in improving satisfaction and reducing anxiety during cesarean delivery was explored (Chang & Chen, 2005). The experimental group received routine care and music therapy, whereas the control group received routine care only. Compared to the control group, the experimental group had significantly lower anxiety and a higher level of satisfaction regarding the cesarean experience.

2.5 Music and postpartum depression

Although my study is on prenatal distress, due to the lack of literature, I am including a section on the related area of postpartum depression. Also known as postnatal depression, it is one of the most common forms of depression. Factors most commonly associated with postpartum depression are those that are also related to mental illness overall: poor social support, marital problems, stress, and a history of emotional problems (Paykel, et al., 1980; Stewart, Robertson, Dennis, Grace, & Wallington, 2003).

Some risk factors increasing the likelihood of the diagnosis of postnatal depression are depression or anxiety during pregnancy and experiencing stressful

life events during pregnancy (Mallikurjun & Oyebode, 2005). This makes the diagnosis of prenatal depression more serious because it can indicate a propensity for depression after birth, risking the well-being of the child.

While pharmacological treatment is most commonly used to treat postpartum depression, studies have found many women prefer to avoid the risks associated with antidepressants during pregnancy and breastfeeding (Whitton, Warner, & Appleby, 1996). Non-pharmacological therapies, music therapy among them, are evidenced-based treatments without the same negative side effects associated with orthodox medicine (Mantle, 2002). The WHO has recommended limiting pharmacalogical treatment during the perinatal period (World Health Organization, 2015).

EEG studies have found that depression and anxiety were reduced in depressed and withdrawn mothers after listening to music (Tornek, Field, Hernandez-Reif, Diego, & Jones, 2003). In addition, mothers with postnatal depression are reported to need to talk about their child-related experiences and feelings (Knudson-Martin & Silverstein, 2009); therapy is a potential opportunity to do so.

A case study by Robb compared a depressed mother and her infant with a nondepressed mother and her infant. The depressed mother had quieter, lower pitch and more pauses. There was a corresponding low affect in the baby which diminished as clinical symptoms reduced. The healthy dyad had more frequent, happy, ‘singing-quality” interactions (1999). This suggests that regularly timed and shared reciprocal interactions may improve the mood state of the infant.

Another study was conducted in a mother-baby unit for mothers with postnatal depression and their infants over a five-week period. Four dyads participated in group music therapy using singing, musical improvisation, and moving. Over the course of five sessions, there was a significant increase and duration of intersubjective moments, suggesting increased dyadic autonomy and self-efficacy (Van Puyvelde et. al, 2014).

Sixty first-time mothers in another study were divided into a control group, who received no music therapy prior to breastfeeding, and an experimental group, who received music therapy. The experimental group displayed significantly less anxiety-related behaviors and more behaviors associated with relaxation and comfort, while breastfeeding at the hospital (Procelli & Standley, 2017).

2.6 Infant development, bonding and attachment, and music therapy

Studies show attachment, a bonding process shared together by infant and caregiver, serves the function of both care to ensure survival, as well as to develop cognitive and emotional development (Sullivan et. al, 2011). An infant prefers his or her mother's voice to any other voice, making it an important tool for bonding and attachment (DeCasper & Fifer, 1980.) In fact, attachment is believed to begin in the last trimester of pregnancy when the fetus's olfactory and systems are fully functional (Sullivan et. al, 2011.)

Studies have shown that music and sound can affect the development of the infant, from improving feeding, to lulling to sleep (Arabin, 2002). According to the president of the Italian Gordon Association for Music Learning, music is a way to stay connected to the unborn child during each stage of development (Barker, 2010).

Intuitive musical engagement, also called communicative musicality, occurs between a mother and her child and fosters bonding and playful interaction (Malloch, 1999). In cases of maternal depression, intuitive musical engagement between a mother and child may not occur (Drake, 2008). This lack of engagement puts the child at risk of insecure attachment and difficulties in communication, interaction, emotional expression and cognitive development (Pavlicevic, 1997).

Lullabies are labeled by McDonald (1990) as 'transitional tunes.' They are more than just music, alleviating infant anxiety through messages of security and support. A study in Ireland followed six pregnant women who learned three lullabies over the course of four group sessions. The study concluded that singing reduced maternal stress, and some women reported a profound feeling of love and connection to their unborn babies. All women reported an increase in attachment and a satisfactory experience (Carolan et. al, 2012). This indicates a potential for music therapy to foster communicative musicality and increase attachment between mother and child, which improves the health outcomes for both.

2.7 Most advantageous music during pregnancy

Lasky & Williams state that amniotic water is an excellent sound conductor; it is believed the baby can hear by the fifth month of pregnancy, though the auditory system is not fully developed until the last trimester (2005). Verny and Kelly suggested that intense, loud, syncopated musical styles could raise blood pressure and cause hypertension (1988). Clements found that Vivaldi, Telmann, Bach, Handel

and other Baroque composers were appropriate as they resemble a heartbeat at rest (1979). However, though there are multiple Mozart-related products for babies, no study has proven Mozart as superior. Rather, the music experience is an 'affective relationship' and that if a mother finds Mozart's music boring, then that could also become associated within the relationship before and after birth--therefore, a variety of music is best (Barker, 2010). Folk songs and chants have also been found useful by prenatal practitioners (Barker, 2010). Lullabies sung prenatally have a calming effect after birth (Arabin, 1992): a mother and father's voice is the best music for an infant.

2.8 Disadvantaged groups

Studies have shown that significantly worse outcomes for babies and women occur in disadvantaged groups (D'Souza, 2004). This can be seen in South African governmental institutions, where the average number of psychological therapy sessions obtained by clients fell below two sessions per client due to lack of resources (Ahmed & Pillay, 2004). It is important to explore the role that music therapy can play for disadvantaged women and their babies because they are at the greatest risk of poor health outcomes. The World Health Organization believes, as do I, that all women deserve equal access to quality health care (World Health Organization, 2015). Pregnant women in Hanover Park are disadvantaged economically; here, the allocation of extra health services is needed.

Due to gender-based power imbalances, empowerment with this South African group becomes a relevant theme, and therefore a feminist research standpoint emphasising power sharing, emancipation, and equality will be applicable in this study (York & Curtis, 2015). It is a sociocultural context that has long condoned both interpersonal and systemic violence, and the therapy will be rooted within the construct of accomplishing personal transformation, facilitating social change and recovery (Curtis, 2007).

While the use of music in clinical healthcare settings is no longer in the beginning stages in several countries, such as the USA, it is still a growing area of research in other countries around the world. There is a limited number of studies available and much room to explore the role of music therapy on prenatal distress (Terry & Terry, 2012).

As of this writing, no studies have been conducted on music therapy as an intervention for pregnant women in an at-risk population, particularly in the context of high levels of poverty and trauma as in the current situation in the Cape Flats. With the challenges many disadvantaged women are currently facing, and the importance for the health of the women and babies to have access to non-pharmacological interventions for mental health during pregnancy I am interested in exploring whether and how music therapy can be helpful for pregnant women in distress.

2.9 Conclusion and Rationale for Study

The use of music during and after giving birth shows potential for increasing healthy post-birth outcomes (Trappe, 2012). No studies on music therapy and antenatal mental health in Africa have been published, despite research demonstrating the usefulness of music therapy in treating depression, and the imminent and pressing need the World Health Organization has placed on the psychological health of mothers especially during pregnancy. This suggests that more research on the efficacy of music therapy perinatally within local populations is needed.

The most important time for brain development starts prenatally and ends by age two (Kolb, 2009). The mother and child-in-utero are considered a symbiotic dyad, difficult to divest one from the other; and the promotion of attachment is one of the most significant factors to help children be able to grow into healthy, independent and resilient adults (Winston & Chicot, 2016). Providing adequate support during pregnancy is a recognition of the importance of the mother in creating our future society. The significance of the first few years of a child's life cannot be overstated. And when an environment is high-risk, the need for support increases.

Chapter 3: Methodology

In this chapter I will present the paradigm upon which I based my research, the manner in which I designed my study, how participants were selected, where my study took place, and how the data was collected. I will then discuss data preparation, data analysis, research quality and ethical considerations of my study.

3.1 Research paradigm

This research study was grounded in an interpretivist paradigm, involving the subjective exploration of experience. A paradigm includes a particular ontological premise, an epistemology approach and an aligned methodology. Ontology is the "study of being" (Crotty, 1998, p.10). The ontological approach I took was relativist and constructivist. It was relativist in that it was based on the belief that truth can be learned in many ways and is not absolute. The constructivist-interpretivist believes there exist multiple realities and, therefore, multiple meanings and interpretations (Ponterotto, 2005). The epistemology (how reality is experienced) that framed my research was transactional and subjective. Transactional means that truth arises in the interaction between an individual's thoughts or 'constructed realities' and elements of a rhetorical situation (Berlin, 1987). The role of the subjectivist researcher is to construct an impression of the 'unknowable' psychological world of the participants as they see it (Ratner, 2008).

My study was also viewed through the lens of Husserl's (1936) lived world philosophy. This relates to the phenomenological goal of throwing light on a particular phenomenon and, in practical terms, to learn of another's experience (Finlay, 2009). Nothing can appear in our lifeworld—our shared human experience—except what is lived. Consciousness is intersubjective and can be communicated to one another. The interplay between researcher and participant involves capturing lived experience (Ponterotto, 2005). With this in mind, the philosophy of honoring lived world experience through the practical application of hearing the experiences of the women who participated was crucial for understanding their needs and how to best serve them as health professionals.

3.2 Qualitative research

This research was qualitative and involved describing how a group of pregnant women in Cape Town who have been screened as 'women at risk' experienced music therapy. Qualitative research is a process undertaken to understand the meaning, context, and perspective of participants' actions and viewpoints. It is focused on words rather than numbers (Maxwell, 2005). The goals of qualitative research include using a collaborative and open-ended approach and obtaining relatable and in-depth answers to research questions (Creswell & Miller, 2000).

Guba & Lincoln (1994) state that the difference between quantitative and qualitative research can be defined more from a paradigm perspective than one of methodology. A qualitative study obtains 'truth(s)' subjectively through words, pictures, or objects rather than statistically as in a quantitative mode, in an attempt to provide an initial understanding rather than a final course of action.

As a female researcher working with female participants, I used principles of feminist qualitative research. This included exploring relationships between knowledge and power; staying grounded in women's experience and recognizing the role of emotions and gendered embodiment; taking into account diversity of women's experiences and the interconnected power relationship between women; and acknowledging that knowledge is always partial (Harding, 1987). Furthermore, the ethical concerns of the power dynamics within interviews required special reflexivity within feminist theory (Aléx & Hammarström, 2008).

3.3 Setting

The Hanover Park Midwife Obstetric Unit (MOU) is located in one of the most dangerous areas in Cape Town. In 2017, Cape Town ranked the fifteenth highest murder rate in the world, (Woody, 2018) and this statistic is bolstered by the frequency of gang activity in the Cape Flats (Pinnock, 2016). Due to weak policing and challenges within the justice system, within the so-called "colored" communities a vigilante justice system developed. Gang bosses were the result of the inability of the state to provide a monopoly of force. Pinnock (2016) explored the role that Cape Flats gangs played in providing poorly educated, young "colored" males with a sense of belonging and purpose in an environment characterised by family dislocation, poverty and violence. The Group Areas Act in the 1960s separated communities based on skin color. When crime increased, so did prison populations, and within the prison populations gangs solidified (Pinnock, 2016).

The dynamics of family life in this area are particularly relevant in relation to the current study. Pinnock (2016) highlights the absence of male role models and the consequent influence of female-headed households in poor communities. All of these factors were important to take into account as I entered the space to work with these women.

I went into the MOU a total of six times. I took an Uber with my bag of instruments, flowers, and art supplies. Heading from the center of Cape Town into the Cape Flats is an adrenaline rush in itself. When I mentioned the Cape Flats as a destination, one taxi driver made the sign of the cross. Always, the mountains and trees cradled the freeway, and white mini-vans carrying passengers for only R10 per ride careened alongside my Uber. Everyone knows that these vehicles, not the police, own the roads and drivers cater to their whims. They follow no speed limit nor law. The buildings change color as one leaves the CBD. Pink, green, and yellow houses line the streets. Hanover Park is yet another world as one drives deeper into the Cape Flats. When crossing into the neighborhood's borders, there are people idling on the streets. Graffiti marks the walls and a watchfulness pervades the air.

As an American, I did not know enough when I chose this location to have fear strike my heart when I heard the words "Hanover Park." The first day I went there, I was dropped off at the wrong building. It is easy enough to do. Google may have mapped the surface of the moon, but large parts of the outskirts of Cape Town remain a blur. On that occasion I walked from the building where I had been dropped off to the MOU, accompanied by a kind local woman who, I learned through the conversation along the way, hoped to get a job as a housekeeper from me. I actually walked through the taxi rank and down the alleyway. Later, I would learn, walking in Hanover Park is unheard of. The chance of crossfire is too high. Once I received the signature required to host the sessions at the MOU, I went straight to sleep at home because the experience was so emotionally draining.

The second time I visited the MOU was brief. I gave the mental health counselor on-site the flyers announcing the sessions, and we discussed how to best recruit women to the study. She showed me where the sessions would be held, and we agreed that sessions would begin once I had let her know I had garnered sufficient participants.

The third time I went to Hanover Park MOU was the first day I held the sessions. I did not have a car, and took a taxi with my drum, bags of snacks, guitar, piano, and

backpack full of art supplies. Liesl was there sweeping the small room I would be holding the sessions. She offered to help me set up the room.

In the meantime, was that gunshots? I came out of the trailer that I was hurriedly organizing. I heard the counselor asking the same thing. Yes, it was gunshots. “Is that normal?” I asked. “It’s not normal,” she replied, but then went on to say an elderly man was shot dead just outside the hospital while picking up medication for his wife, seemingly targeted randomly. She explained that innocent people often got caught in the crossfire here, and in fact it could affect people coming to the session today. I began to realize there was a strange dichotomy to come to Hanover Park to offer therapeutic interventions to ‘relax’. My own anxiety was very high all day, and continued to be so late into the evening. It was like the buzz of a strong espresso to be in what amounted to a war zone (with a similar number of fatalities to areas in Afghanistan). Although a nerve-wracking beginning to the sessions, it was also a fair one: these women heard those noises on a regular basis, and I was asking them to come to the MOU in the midst of this environment.

At the end of each session, after ensuring each woman had caught their ride back home, I ducked from pillar to pillar while waiting for the MOU gates to open for my taxi. It was walled off completely, with no windows, for safety’s sake. But the doors had to open each time a woman arrived from the outside. Security guards manned the gate. I found myself hiding from a potential sniper by jumping behind a corner each time the gate opened. It was surely a ludicrous sight considering the keyboard and guitar I had slung over my shoulder while doing so. Each week the same tattooed man begged from me. The security guards were, I felt, rather lackadaisical about letting him come in. I passed them apples and flowers on occasion, if I had extras.

The final day I was picked up by my taxi, the driver announced that after some 13,000 rides, this was only the second time he’d been to Hanover Park--and then mentioned the first time, which I pointed out was a neighborhood which was not in Hanover Park. He then corrected himself: so it was the first time he’d ever come to Hanover Park in all of those rides. It was not an area most people voluntarily entered.

3.4 Selection of participants and research design

This research was a multiple exploratory case study of five pregnant women expressing distress who received music therapy sessions. A case study is “a strategy

of doing research which involves an empirical investigation of a contemporary phenomenon within its real-life context using multiple sources of evidence" (Robson, 1993, p.146).

I was interested in learning how these women experienced music therapy in their setting, and which techniques they found most useful. This was an instrumental, rather than an intrinsic, case study, because I explored the experiences of these participants as exemplars of a more general phenomenon (Willig, 2008). The benefit of a case study is that a more accessible and detailed picture can be painted that may not be available in purely experimental research. Great care is required on the part of the researcher to use reflexivity in managing subjectivity, to clearly establish parameters, to rigorously organize data, and to follow a set theoretical framework (Zainal, 2007).

The study was conducted at the Hanover Park MOU. It services the Athlone area and includes part of the Cape Flats districts. These regions in Cape Town have the highest rates of substance and alcohol abuse, child and partner abuse, rape, and adolescent pregnancy. Consequently, these women are particularly vulnerable to mental illness (Meintjes, Field, van Heyningen, & Honikman, 2015).

At the Hanover Park MOU, women are screened for mental illness at their first antenatal visit and referred to an on-site counselor when this is deemed necessary after the initial screening. The MOU is a 24-hour labor ward, where women can also attend antenatal and postnatal checkups. Between 200 and 300 women receive care at the MOU each month. Rather than using the term "prenatally depressed" pregnant women, the PMHP uses the term "distressed" because the initial screening does not provide an official diagnosis, as would be the case with the term "mental illness." When a person is experiencing some sort of mental suffering, it is called "mental distress" (PMHP Handbook 2013, p. 9).

The viability of this project was discussed with Dr Simone Honikman, the director of the Perinatal Mental Health Project (PMHP), a nonprofit organization devoted to providing mental health care services to pregnant and postnatal women, and Bronwyn Evans, clinical services coordinator of the PMHP. The PMHP develops, evaluates, and optimizes maternal mental health delivery systems through service provision at three maternity facilities, including the Hanover Park MOU. They oversaw the process in which I received referrals for women to work with and provided a space for me in which to conduct the music therapy sessions.

The operations manager of the MOU, Loretta Abrahams, gave her consent for the sessions to take place at the MOU. The HPCSA-registered counselor at Hanover Park MOU assisted in arranging the space and coordinating the times that I could come. I met with her on August 28 to give her the forms and flyers. Over the course of three weeks she gave potential participants the information and consent forms and a form with the times that were available (see Appendix B). She explained what music therapy was to the potential participants and those who were interested then contacted me. Women who lived in or near Hanover Park and who attend the MOU, and who were identified as at risk were the potential participants. Women who were taking antidepressants were excluded from the study. Once I had five women who had agreed to attend, I began facilitating the sessions. The signed consent form is included in appendix A.

In qualitative research a small sample size is justified when considering the fact that more in-depth data that can be obtained. While generalizing on the grounds of a single life story could be incorrect (as a second life story could immediately contradict those findings), “several life stories taken in the same set of socio-structural relations can support each other and make up a strong body of evidence” (Bertaux and Bertaux-Wiame, 1981, p. 187).

The availability of women who came to the MOU on the selected days was variable and difficult to determine in advance, so convenience sampling was used. As the researcher I paid for their taxi fares and offered four available times when they could attend. Therefore, they did not need to come in only when they had prenatal appointments scheduled.

I chose to come into the MOU four times. Research has shown the beneficial nature of music therapy for depression after four sessions (Ashton, 2013). Due to time constraints with the facility and university more sessions were not possible. I attended the MOU over a period of one month (three Tuesdays and one Thursday). While I provided two time slots, one in the morning and one in the afternoon, one day each week over the course of the month, all participants preferred to attend in the afternoon.

I came into the MOU for four full days over the course of three weeks. I was available during the day, for approximately eight hours. Sessions were 45 minutes each as per standard protocol (Aalbers et. al, 2017; Watson, 2007).

Group sessions were decided upon with the recognition that pregnant women can become isolated due to changes in work and family life, and that encouragement

to build support systems can be helpful from someone who can listen and guide them towards social connection. Three group sessions were held, but on one day the women arrived at different times and I, therefore, conducted sessions with them separately.

Two group sessions were attended by three women, one group session was attended by four women, and four individual sessions with four women were conducted (three women received four sessions, and two others received just one session). This made a total of seven 45-minute sessions. Following each 45-minute session was a 15-minute period in which snacks and drinks were provided while taxis were called.

In the music therapy sessions I used a variety of techniques, both active and receptive. Bruscia (1998) explains the difference between active and receptive music techniques. Active music therapy is when the client is engaged in music-making through improvisation, composition, and re-creation. Receptive music therapy involves listening to music. Most research in the music therapy field concerning pregnancy has focused on receptive techniques (Erkkilä, 2008). Consequently, the use of active music making through improvisation and song writing was of particular interest to my study. Using a client-centered approach, techniques involved music-facilitated relaxation, lyric discussion, or music-guided art and movement exercises, depending on the needs of the women as they presented in sessions (Brooke, 2006).

As an HPCSA-registered music therapy Masters' student I was suitably able to conduct the sessions under supervision. Participants received counseling with the Perinatal Mental Health Project while they were participating in the study. They therefore had adequate additional support if any material arose in the music therapy sessions that they would like to process further (during or after the study).

3.5 Data collection

For this study I collected data through the following methods: (a) a pre-session questionnaire; (b) participant observation through video recording of sessions; (c) final interviews, consisting of a semi-structured interview with M. and a focus group with S., H., and Y; and (d) rating scales. The reason I collected these forms of data was to enable me to gather the experiences of these women as stated in my research questions.

3.5.1 Questionnaire

A short questionnaire (see appendix B) including a few introductory questions was offered at the beginning of each participant's process. The intention of the questionnaire was to offer participants the opportunity to provide introductory information privately. The questionnaire was designed to introduce me as the music therapist and researcher firstly to what the women were experiencing emotionally and, secondly, what they preferred musically. I used the information from the questionnaires to guide our sessions and to give context to the other forms of data collected.

3.5.2 Participant observation through video recording

Participant observation is the process enabling researchers to learn about the activities of the people under study in the natural setting through observing and participating in those activities. DeWalt and DeWalt (2002) state that "the goal for design of research using participant observation as a method is to develop a holistic understanding of the phenomena under study that is as objective and accurate as possible given the limitations of the method" (p.92). Participant observation is characterized by such actions as having an open, nonjudgmental attitude, being interested in learning more about others, being aware of the propensity for feeling culture shock and for making mistakes, the majority of which can be overcome, being a careful observer and a good listener, and being open to the unexpected in what is learned (DeWalt & DeWalt, 1998).

There are limitations to participant observation. DeWalt and DeWalt (2002) note that male and female researchers have access to different information, as they have access to different people, settings, and bodies of knowledge. Participant observation is conducted by a biased human who serves as the instrument for data collection. The researcher must understand how his/her gender, sexuality, ethnicity, class, and theoretical approach may affect observation, analysis, and interpretation. In qualitative video analysis, which is highly influenced by ethnographic research, the aim is to reveal connections, patterns or phenomena not previously described, and often implicit for the people being observed. As the patterns found are always related to the specific historical and cultural frame in which they take place, here the interpretation is dependent on the context (Lincoln & Guba, 1985).

I video recorded the sessions using an iPhone. The implications of recording sessions introduced issues related to consent, ethics, and the dynamics of therapy. I especially needed to consider the coercive power inherent in the therapist-client relationship and to adequately provide informed consent (Funkenstein, Kessler, & Schen, 2014). When video recording the researcher must be aware of how this can be intrusive, aspects of interaction can be missed, it can be labor intensive in order to code all details, concerns about the discoverability and confidentiality of participants can be raised, the viewing space is limited, and there are costs involved (Asan & Montague, 2014).

Video recording can be beneficial in that researchers can analyze events retrospectively, simultaneous events can be captured, potential exists for multi-viewing, and a permanent and complete record is created (Asan & Montague, 2014). Furthermore, notes written by hand are somewhat unreliable, and important information could be lost. In the field of music therapy, a video microanalysis is considered “the most comprehensive and powerful tool” (Wigram & Wosch 2007, p. 312) because video researchers can capture complex data, both nonverbal and verbal, and re-watch the session repeatedly (Lee & McFerrin, 2015).

3.5.3 Final interview and focus group

At the conclusion of their final session, the women were asked to remain after the session to reflect on the experience with the interview questions in appendix B as a guide. There was only one participant, A., who only attended the first session and who did not respond to a request for a final interview. The right to decline or withdraw was made clear in the participation and consent forms. The other three women, H., S., and Y. comprised the members of the focus group.. I had a semi-structured interview at the conclusion of my session with M., since she preferred to come as an individual rather than attend the group. Semi-structured interviews are those in which the clients, whether individually or as a group, answer predetermined open-ended questions. These are commonly used by various healthcare professionals during research (Corbin & Strauss, 2008).

These interviews, lasting approximately 30 minutes to over an hour, are given only once, and are guided by a list of questions or topics that need to be investigated by the researcher (DiCicco-Bloom & Crabtree, 2006). The guide exists to ensure the interviews remain methodical and thorough with each respondent (Jamshed, 2012). I

used semi-structured interviews because this method was most appropriate to obtain the answers to my research questions.

The interview schedule was developed as follows. The questions I used were essentially sub-questions of my research study (Creswell, 2013). McNamara (2009) suggests several recommendations for creating effective research questions for interviews which include the following elements: (a) wording should be open-ended; (b) questions should be as neutral as possible; (c) questions should be asked one at a time; (d) questions should be worded clearly (this includes knowing any terms particular to the program or the respondents' culture); and (e) "why" questions should be included with care.

First, the participants were asked about their earlier experiences with music as a soft opening or icebreaker. Next, we explored their experiences in the music therapy sessions and whether their current concerns were addressed. The women were asked about the usefulness of the various techniques, and then the schedule concluded by asking if there was anything else they wanted to add, as an opportunity to make the interview as comprehensive as possible.

I used a focus group because the women had experienced the music therapy process together; they then could find value in talking about their process together. Focus groups entail a group of people being interviewed in a discussion setting in the presence of the session moderator (Creswell, 2013). Focus groups are beneficial when the interaction among respondents will encourage the sharing of more information, when interviewees can cooperate together, when there are time limitations, and when members interviewed individually may be less likely to offer answers to research questions (Krueger & Casey, 2009). However, some difficulty may arise if there are some individuals who dominate the focus group; all individuals need a platform to offer insight during a focus group (Creswell, 2013).

There are further potential downsides to the interview and focus group. Kvale and Brinkmann (2009), for example, discuss how the interview situation cannot be compared to a simple conversation in which both partners freely share. Instead, the very nature of the interview is one in which the power lies vested in the interviewer. After all, it is based on the interviewer’s agenda and is subject to the interviewer’s interpretation. There are no easy solutions to this power dynamic, but consciousness of it influenced the manner in which I offered the questions and in which I considered the results. Recording the interview and focus group allowed me to focus on the

questions and answers in the moment and allowed for me to write verbatim transcriptions afterwards, as discussed by Jamshed (2014).

3.5.4 Rating scales

At the beginning of the focus group and final interview, I administered a 5-point rating scale. Each woman ranked each therapeutic technique on a score from one to five, from less useful to more useful. Choosing an optimal level of points is one important consideration of designing a rating scale as it affects validity; 5 points has been found to increase quality (DeCastellamau, 2018). This did not qualify my study as mixed methods, since this was offering only supplementary data that could be explored qualitatively in the interviews.

3.6 Data preparation

I chose excerpts from video data that were relevant to my research questions. I chose one five-minute clip from each of the seven sessions. I used a variety of clips from different techniques in order to address the second question, about the most useful techniques, in particular. I also looked for clips which showed a shift of some kind, because the goal of music therapy is to be, as Bruscia says, a “dynamic force of change”: in fact, one of Bruscia’s definitions of music therapy is “a systematic process of intervention wherein the therapist helps the client to promote health, using experiences and the relationships that develop through them as dynamic forces of change” (Bruscia, 2014, p. xxi).

The clip from the first session showed the introduction and relaxation portion. The clip from the second session showed the participants sharing about images, natural objects, and writing the poem. The clips from the third and fourth sessions showed improvisations, and the clip from the fifth session showed “the Museum of Motherhood” intervention with clay. The clip from the sixth session showed the “three circles” activity, and the clip from the seventh session was from the lullaby singing and lyric rewriting.

I then wrote thick descriptions of the excerpts. My task was to write “thickly” a description that produces for readers the feelings of experiencing the events (Denzin, 1989). Denzin further describes thick description as a narrative that “presents detail, context, emotion, and the webs of social relationships…[and] evokes emotionality

and self-feelings…The voices, feelings, actions, and meanings of interacting individuals are heard" (Denzin, 1989, p. 83).

The questionnaire answers were already in textual form. The data was prepared in order to be analyzed and discussed (Gavrielodou & Odell-Miller, 2017). I transcribed the interviews verbatim (Silverman, 2001). I also had a focus group at the conclusion of the sessions with my group of three women. Therefore, there were two verbatim transcriptions (one of the individual interview and one of the focus group) in addition to the thick descriptions, which can be found in Appendix C.

3.7 Data analysis

I used thematic analysis to analyze the data I collected through the questionnaires, interviews, and thick descriptions I wrote of select video excerpts of the sessions. Thematic analysis is suited for an interpretivist study because it allows for a detailed and in-depth exploration of another person's life-world (Smith & Osborn, 2004). It can be used within studies that have varied theoretical underpinnings (Clarke & Braun, 2013).

Through thematic analysis one can identify implicit and explicit ideas within the data (Guest, 2012). It is suited for a qualitative study because it is an examination of language patterns (Clarke & Braun, 2013). Braun and Clarke (2006) list the steps required to achieve a thematic analysis as follows: first, familiarization with the data; second, coding; third, searching for themes; fourth, reviewing themes; fifth, defining and naming themes; and last, writing up, which entails compiling the data together to tell a persuasive story about the results of the research.

3.8 Research quality

Determining quality in a qualitative research study is still a matter of some debate. As an interpretivist study, my research assumed a search for truth that is open-ended and contextual, in other words dependent upon situation and place to find meaning (Creswell & Miller, 2000).

Lincoln and Guba (1985) describe ways to obtain trustworthiness in a qualitative study using credibility, transferability, dependability, and confirmability through persistent observation, triangulation, and maintaining a reflexive journal. I sought triangulation through the use of multiple participants, and through multiple means of

data collection (Creswell & Miller, 2000). The idea is that depth of involvement determines the quality, not any external procedures (Aigen, 1993). Thus, thick, rich description of the study, rather than reporting of mere facts, is vital (Creswell & Miller, 2000).

Bruscia (2014) offered some ideals of quality to consider in the planning of a qualitative music therapy research study, including obtaining authenticity through first, educative authenticity, by providing understanding of others--specifically pregnant women from the Cape Flats. Second, tactical authenticity is sought through transferability. Qualitative research is not generalized, but I hope that other clinicians may be able to use this in their own practice or context if, from my detailed descriptions, they deem there to be similarities to their own work. Finally, personal authenticity, through my taking responsibility of my own awareness and actions, is what is known as reflexivity. Reflexivity involves disclosing assumptions and bracketing them--or putting them aside--as much as possible during the course of the study (Creswell & Miller, 2000).

My supervisor also checked my codes and themes. The researcher as participant-observer has a long history in the social sciences. This means that I am a researcher-as-instrument: I am the data collector, and the data analyser. I am also the music therapist and this requires an ability to be musically creative and to be sensitive to the aesthetic of music (Aigen, 1993). To manage this ethically and in the best interest of participants, I sought to balance these roles through peer debriefing, detailed observation, and significant reflection on my own personal biases, needs, and assumptions (Turry, 2010).

This is held with the concurrent understanding that I acted as a “passionate participant” not a “disinterested scientist”; and that an interest in the topic partially informs the reason for doing the study (Guba & Lincoln, 1994). Indeed, as part of the interpretivist paradigm, it is understood that it is neither possible nor desired to eliminate values from a study.

I maintained rigor by being strict in the application of my method (Flick, 2007). This included searching for disconfirming evidence--that which disconfirmed or negated any themes I have established. This is part of the view that reality is complex and constructions are multiple (Creswell & Miller, 2000).The study aims to achieve what Bruscia (2014) calls aesthetic integrity: that unrealized possibilities can come to light; that researcher and participant are mutually transformed; and that the study will be presented creatively, relevantly, and authentically.

3.9 Ethical considerations

The psychiatrist Daniel Stern (1998) has written that becoming a mother is one of the most significant physical and psychological changes a woman will ever experience. The topic of family and its creation is a sensitive one, and pregnant women are considered a vulnerable group due to potential health concerns.

This vulnerability means that the research design and implementation had to be considered very carefully. I encountered these women at a time of crisis and stress (as well as potential strength and resilience) and I asked them to explore their experiences in music therapy. This required a level of rapport (Dickson-Swift, et. al, 2007). Consultation with my supervisors, and reflexivity and self-inquiry were part of the internal safeguarding process (Bruscia, 1998).

To ensure beneficence and avoid doing harm (nonmaleficence), all women were treated fairly and with respect and informed of their rights before beginning the study, including their right to withdraw from the study for any reason or at any time (Anderson & Handelsman, 2010). I ensured their confidentiality through the use of pseudonyms, and no one other than my supervisor and I observed the videos. I obtained the consent from the Western Cape Department of Health (Hanover Park MOU is a government facility). All music therapy sessions were supervised by Andeline dos Santos, board-certified music therapist. Participants completed an informed consent form (see appendix A). At the start of the music therapy process I explained the purpose of the study and what to expect during our sessions. The consent form states that the participants grant the permission for other researchers to use the data in the future. Data will be archived at the University of Pretoria for 15 years after completion of the study.

As mentioned, participants were also seeing the counselor at the unit and so if any issues were to arise during or after the sessions that require further support this was available for them. There was also a psychiatric team available at the MOU during the day. Had any woman's mental health deteriorated substantially, she had the option to be referred immediately back to the counselor to determine if she needed medication.

3.10 Conclusion

The following chapter will explain what data were gathered from the seven sessions led at the Hanover Park MOU. The analysis that took place and the

consequent findings will be explored.

Chapter 4: Data Analysis

4.1 Introduction

In this chapter, the participants in the study will be introduced. The equipment used within the session will be explained, then the procedure and list of techniques in the session will be delineated. An outline of the sessions will be provided, then the manner in which the categories and themes were derived will be described.

4.2 Participants

The first session was conducted on September 20. The referring counselor saw about 10-15 women per week, and in those three weeks I received six referrals, however, one woman was offered a job before the sessions began and could no longer attend. The five women who participated were Anathi* (A.), Habibah*, (H.), Sabriyaa* (S.), Yonesipho* (Y.) and Michele* (M.). They ranged in age from 18 to 37. Two women (Y.; M.) were pregnant with their first baby; two women (S.; H.) already had multiple other children and this pregnancy was likely to be their last; and the fifth woman, A., was pregnant with her second child. A. attended the first session only, M. attended the last day only, and S., Y., and H. attended four sessions (three as a group, and one as individuals). No one had had music therapy before.

A. came from Philippi with Xhosa as her home language. She was the mother of a four year old with disabilities. H. lived in nearby Newfields. English was her first language. She was a student of Arabic and came from the Islamic community. She was the mother of three children. She was experiencing problems in her marriage.

S. had four children, and this pregnancy was a surprise as she was separated from her husband and the youngest child was eight years older. She witnessed her brother's murder by gang members in 2015. Her house in a different part of Cape Town was petrol bombed, so she moved to Hanover Park. She spoke Afrikaans.

Y. was a first-time mother who initially experienced mixed feelings at her pregnancy as a single mother. She was a university student and still lived at home with her siblings. She spoke Xhosa as her first language and came from Nyanga. M. lived in

Athlone. She attended the final day's session after cancelling three times before due to anxiety. She brought her brother along to her individual session. She had too much anxiety to attend with the rest of the group. She intended to stay home with the baby and no longer continue schooling.

The women explained why they wished to do the music therapy sessions: S, who had almost no teeth but talked the most, said, "We weren't informed what it would be about. Music takes part of my life and I thought it's gonna be fun." H. said, "I wasn't very interested, thinking about my religion, but [the MOU counselor] said it will be just women, there won't be any men, you'll feel comfortable, you'll be able to open your face. I've cut music out of my life for a long time…And when she said it's therapy I said I'll give it a try. It's completely out of the box and the comfort zone. If the partner was going to be here I wasn't going to come. I wouldn't feel comfortable." A. said, "It's because I like music." Y. contributed: "It seemed interesting, and I thought why not do it."

4.3 Equipment

A variety of handheld instruments were available, including the cabasa, the mbira, the rainmaker, the xylophone, the triangle, and bells. I decided against the djembe as being both too bulky for the room and too loud and potentially startling for the babies. I used an iPhone to play the recorded songs, which included Beethoven's *Moonlight Sonata*, Vivaldi's *Four Seasons*, nature sounds, lullabies such as *Thula Baba* (a popular Zulu lullaby), *The Original Broadway Cast Album* of *The Secret Garden*, Judy Collins' *Who Knows Where the Time Goes*, OneRepublic's song *I Lived*, *The Comeback*.by Danny Gokey, and Mariah Carey's *Hero*. I offered art materials including glitter pens, crayons, clay, glue and small natural objects such as stones.

4.4 Music therapy sessions

The initial session began with consent forms and the administration of the questionnaire. The final sessions concluded with an interview in the case of individual M. and a focus group in the case of H., S., and Y. The seven sessions had a variety of music therapy techniques, as shown in Table 1, Therapeutic Techniques.

[Table 1]: Therapeutic Techniques Used Within Each Session

Therapeutic technique	*Session 1*	*Session 2*	*Session 3*	*Session 4*	*Session 5*	*Session 6*	*Session 7*
Flowers/ Colors/Values	x	x	x	x	x	x	x
Pregnancy Affirmations	x		x	x	x	x	
Journals Discussion	x	x			x		
Postcard and Natural Object		x		x	x		x
Relaxation/ Breathing to Music	x		x		x	x	
Visualization to Music		x			x	x	
Museum of Motherhood and Clay		x			x		
Singing Lullabies	x				x		x
Instrumental Improvisation			x	x	x		x
Mandalas					x		x
Poem/Lyric Writing		x			x		
“You Are My Sunshine” Lyric					x		x

Re-writing							
Singalong "Swing Low, Sweet Chariot"		x					
Inspiring Song Discussion							x
Three Circles/Sonic Sketch			x	x		x	
Toning			x	x		x	

Therapeutic technique explanations:

1. Flowers/Colors/Values

A theme for each session, this was a discussion of the symbolism behind a given flower and color.

2. Pregnancy Affirmations

The ladies were given affirmations to aim towards a calm, peaceful pregnancy.

3. Journals Discussion

The ladies were given journals, a specific recommendation from the ethics board to help them deal with any difficult feelings over the course of the therapy.

4. Postcard and Natural Object

The ladies could choose images and objects they felt drawn to in order to identify and share their mood.

5. Relaxation and Breathing to Music

The ladies were to close to their eyes, focus on the present moment, and practice breathing for 5-10 minutes in a guided meditation.

6. Visualization to Music

The ladies were led to visualise colors or nature while listening to music.

7. Museum of Motherhood and Clay

The ladies were given clay after visualizing “the museum of motherhood” walking through and seeing a statue that symbolized what being a mother meant to them

8. Singing lullabies

The ladies were given handouts and sang through the following lullabies: Twinkle, Twinkle Little Star, Hush Little Baby, Thula Baba, All the Pretty Little Horses, Kumbaya, and Rock-a-Bye Baby.

9. Instrumental improvisation

The ladies were given instruments and instructed to play how they were feeling as I accompanied on the keyboard.

10. Mandalas

The ladies were given a blank mandala and instructed to fill in what their sources of strength and resiliency were using art materials while listening to music.

11. Poem/Lullaby writing

The ladies wrote a poem/song for their baby.

12. Lyric Re-writing “You Are My Sunshine”

The ladies were given a fill-in-the-blank worksheet and put in their own words to the song “You Are My Sunshine”

13. Singalong “Swing Low, Sweet Chariot”

The ladies were invited to sing this song and to make up lyrics on the spot.

14. Inspiring song discussion

The ladies were asked which song they listened to when looking for inspiration.

15. Three circles

The ladies were given a sheet of paper with three empty circles to fill, symbolizing before, now, and the future while listening to music.

16. Toning

The ladies sang on vowels, noting how the sounds felt reverberating in their bodies.

With supervision, I chose a five minute clip from each session which exhibited potential to answer my research questions using a set of criteria: first, each of the seven sessions needed one representative clip. Second, the totality of the clips should have variety of techniques exhibited. And third, there needed to be an observable shift, whether through verbal, embodied, or musical expression, that occurred within the clip. I transcribed the clips, and created codes summarizing their content.

Session Summaries:

Session one:

We started the session after consent forms by sharing our purpose for the sessions. I explained I was a student at the University of Pretoria, originally from the US. I told them I was interested to learn how they experience music therapy. I would ask questions at the end of our process together. We moved into introductions: name, how many months they had been pregnant for, and a movement to show how they were feeling. After a brief discussion and passing out of journals and affirmations, we did a relaxation to music. The music used was sounds of nature, and *Moonlight Sonata* by Beethoven. The sessions concluded with a gift of a flower yet to bloom. I said that we did not know what the flower would look like just yet, only that it would be beautiful. I explained how when you give birth you have to completely open up--not just literally, but emotionally and spiritually. Weeks later, S. sent me a photo of her beautifully blooming flower.

Session two:

While the previous session was marked with gang activity outside, this session's context included a protest led by mothers who had lost children to gang violence.

Just the month before, the Hanover Park Civic Centre held a memorial service for children killed by gang violence. The protests were meant to highlight the lack of sufficient aid by the South Africa Police to deal with the gang violence and drugs.

This was a group session with H., S., and Y. The theme was serenity. S. said she thought about what she learned over the week before bed and looked forward to it all week. Y. said she wrote lullabies and her brother helped her. There was a sense of friendship among the participants already. I explained that I never had a group of pregnant women who I could spend time with when I was pregnant and that is what motivated me to pursue this research study. The participants came up with their own idea that they could gather the items from our sessions and put them in a keepsake box for their babies. We used postcards and natural items to elicit conversations about feelings and how they were feeling emotionally. S. then volunteered a poem she had been thinking of during the week: what she thought motherhood would be like.

H. shared that her journal writing had turned from negative to positive. We next did a visualization on the color white and I passed out white roses which, I mentioned, symbolized innocence and serenity (Kandeler & Ullrich, 2009). We listened to *Come to My Garden* from Secret Garden. We imagined being in a safe and serene place. We then imagined going to a museum of motherhood and made a clay image for the statue we saw there. The song was *The Girl I Mean to Be* from the Secret Garden. Next the women were offered the opportunity to improvise lyrics using the melody from *Swing Low, Sweet Chariot*. Because singing was tentative, I encouraged them to write lyrics down and create a poem for their baby while I quietly played on the piano. Y. read us her poem aloud:

To my daughter:

The first time I heard I was carrying you inside of me I had mixed emotions

I never thought I'd get to love you this much. First time you kicked I was so happy because I knew for sure that you were alive inside of me.

Your kicks are a constant reminder that you're living inside of me

you're a full human being

I certainly can't wait

to see you

to hold you tight

to put you to sleep

to change your nappy

most importantly I can't wait

to love you

You are my joy and pride

You mean everything to me

You must always know that

Mommy loves you, mommy adores you my angel

H then shared her lyrics:

My serenity

Soft and silky skin, twinkling eyes

Tiny hands with a grip so strong I can't deny that you are mine

I watch you sleep and count your smile

Your warm embrace is so serene

little arms around my neck is my serenity

“I don't know where that came from, maybe it was the music,” H. remarked. Then she shared another poem:

my sweet baby

at night I tuck you in, make sure you're warm

check up on you because your peace is my peace

my sweet baby

patiently I wait for you to open your eyes

my sweet baby

looking forward to another day

my sweet baby

Session three:

It was quieter in Hanover Park on this day. More children were on the streets because the first week of October in South Africa is a school holiday. I saw many small children walking with their mothers on the drive into the neighborhood. Mothers and children must go on walks even in, as my taxi driver called it, Gangster's Paradise. Today I wanted to focus on the theme of relationship in the session because I was aware that feeling support from a partner is one of the most important indicators of a woman's satisfaction with her pregnancy (Røsand et. al, 2011). On this day, all of the women arrived at different times and had different reasons for being late.

As a result, this became an individual session with Y. Pregnancy affirmations, the themes of which included my body, my baby, my birth, and my recovery were given to her on a handout. We spoke about the flower theme of our session. Flowers have been shown in multiple studies to be a powerful positive emotion inducer both immediately and long-term (Haviland-Jones, et. al 2005). Flowers provide psychologically and physiologically relaxing properties (Ikei, et. al, 2014). I suggested that a chrysanthemum could symbolize rebirth, and lavender could symbolize soothing (Koulivand et.al, 2013) according to traditional flower symbolism. We then did vowel toning (i.e. singing on different vowels and tuning into her individual energy). Then she was invited to choose an instrument that represented her support system and we improvised together. We moved into the three circles technique (dos Santos, 2018) using pieces by Haydn. We ended the session with a relaxation while reflecting on the flower of optimism and joy, sending gratitude for our support systems.

Session four:

This was an individual session with S. (who also brought along her daughter Razia, "R.") Carrying a large bag of potatoes, S. had walked from a far neighborhood. She wanted her daughter to experience music therapy and therefore brought her along. S. announced she was relieved to have been accepted to witness protection. We talked about the first days of a baby's life and why being prepared in this time was important. S. encouraged me to consider doing this process again when I left South Africa. S. and R. chose a postcard and natural object. We did the vowel toning, and then a themed improvisation on the support system or partner. R. was on the frog scraper, and S. was on the beaded shaker. The improvisation that followed was the clip I chose to code. Next, we moved into the three circles technique, reflecting on what the music elicited in them thinking on the theme of past, present, and future. Then we explored their experiences. The improvisation spurred reflections on S.'s partner and her emotions related to being a single parent. R shared that it was her first time to play a musical instrument at all, at the age of eight. I provided handouts on pregnancy affirmations, and asked R. what she thought of the day's session. She felt she had had a new experience, and she shared that she was excited to babysit and bathe the baby. She explained, "My mommy never had that where she could get up and go somewhere, so I'm happy for her."

Session five:

This was an individual session with M. (who also brought along her brother). I had decided that (M.), aged 18, was not going to attend after her third cancellation. She had too much self-confessed anxiety to try, it appeared. However, she did indeed come on the final session day. She brought her brother as a support due to her anxiety. Her brother was also quite reticent and had difficulty looking into my eyes and spent most of the session reading. Because she was coming in for just one session, I thought I would try to do as many of the other activities that she had missed as we could. This was a choice made from the standpoint of the researcher in order to collect data more than as the therapist. M. completed a questionnaire. We did a relaxation and visualization then sang lullabies. She frequently smiled and peeked at me out of the corner of her eye. I tried not to look at her to respect her space. We rewrote the lyrics for the song *You are my Sunshine*. She passed me the paper to read rather than say it aloud. Her song was about her "little angel". We did

the Museum of Motherhood to Enya's song *Only Time*. She made a clay statue; I made one concurrently. This was the moment in the session that she spoke the most, and it was the clip I selected for coding. We moved on to a short musical improvisation. Using strength and resilience songs, such as *I Lived* by OneRepublic, we created a mandala symbolizing the gifts she wanted to share with her son. We then had an interview to talk about her experience of music therapy.

Session six:

This was an individual session with H., who shared that she found it difficult to sustain friends, explaining, "I have this thing where I hold on to people. Letting go takes a long time." After a brief flowers/colors/values mention about chrysanthemums, we did a visualization and relaxation to a nature sounds piece called *When the Sun Rises,* then sat in silence for a moment. After discussing pregnancy affirmations, we did vowel toning. Then we improvised a song about her husband. She was on the scraper and I was on the keyboard. I encouraged her to be guided by the following: "You can think: do I agree with this or don't I?" I wanted her to feel she, and not anyone else, was her own most trustworthy voice: she herself had said she never doubted her own instincts. Next, we did the three circles or sonic sketch technique, with three pieces by Vivaldi. The following interaction, after the three circles music faded away, is the clip I chose to include for coding. I started the recorded song by Judy Collins, *Who Knows Where the Time Goes?* I used H.'s own words when I suggested the following: "Reflect on this theme--of letting go and acceptance and acknowledging the impermanence of everything. Everything comes to an end." We ended with a talk about her support system, specifically the ladies in her Arabic class.

Session seven:

This was a group session with H., S., and Y. S. said she planned to keep her remembrance book from these sessions for a lifetime. I passed out postcards for them to choose from. The ladies sat in silence, pondering. We then rewrote the lyrics of *You are My Sunshine*. Perhaps due to everyone knowing the song, vocal participation increased. We spoke about yellow gladiolas, symbols of strength and resilience (Durant, 1976) and happiness (Ünal, 2015). I asked the group members to think about the sources of their strength and resilience in their lives, and what gifts, or

personal qualities they were proud to possess, that they would pass on to the baby. We listened to music and reflected on periods of life which were difficult, but which resulted in becoming stronger. We listened to Mariah Carey's song *When You Believe* and spoke about listening to music to "pump up oneself" for labor and birth. It was then time for the final focus group.

4.4 Video excerpts

Table 2, Video Clip Excerpts, presents the excerpts that were selected, the length of each one, and where it was positioned within each session.

[Table 2: Video Clip Excerpts]

Excerpt	Length	Portion of Session
Session One	5:00	Following consent forms, affirmations, and journals, 26 minutes into the session this clip is the icebreaker and the subsequent activity. It consists of the techniques of body movement to express emotions, and of relaxation to music.
Session Two	4:58	This is 2-7 minutes into the session: this is the introduction of postcards and natural objects and a response to what happened in journals that week: poem/lyric writing.
Session Three	5:00	This is the middle of the arc of the session. It followed the affirmations, flowers/colors/values, and toning. It is of an instrumental improvisation with Y. This was 13-18 minutes into the session. After this clip came the three circles and relaxation to music, concluding the session.
Session Four	5:00	This clip is after the toning and choosing an image to represent her current state, and preceding the three circles, from 7-12 minutes into the 45 minute session. It is an instrumental improvisation with S. and daughter R.
Session Five	5:00	This is solidly in the middle, from 27-32 minutes into the session, following postcards, lyric rewriting, and lullabies, and

		preceding mandalas. It is the museum of motherhood and clay technique with M.
Session Six	4:58	This is nearly the end of the session, preceding the final relaxation to music, 46-51 minutes into the session. It is the three circles technique with H.
Session Seven	5:00	This is the initial activity after the icebreaker, 9-14 minutes into the session. An instrumental improvisation followed. It is lyric re-writing of “You Are My Sunshine” with H., S., and Y.

Excerpt Session One:

This selection included the initial movements that the women provided to share how they were feeling, and a guided relaxation.

Excerpt Session Two:

The recitation of the following poem by S. was the clip chosen for session two. It was preceded by the women discussing natural objects and postcard images as a means to symbolically express their current state.

With your first kick

I'm like shocked cause I know that there's growth inside of me

And then then you're born and they place you on my belly and your umbilical cord is still connected

First thing I do I check nose in place, eyes in place, mouth in place, ten fingers, ten toes, (“It's a natural mom instinct “) laughed H.

I'm grateful I hold you in my arms every day you clutching to my breast staring me in the eye when suckling and I stare back

And I'm so grateful and I say a little prayer and I say shukeriara for my perfect masterpiece

And I hope that you bless my child with the character of...[unintelligible]

Excerpt Session 3

This clip was a themed improvisation with Y. about her support systems. She was on the cabasa while I was at the keyboard. The codes that came from the music were descriptions of each micromoment of our mutual playing together.

Excerpt Session 4

S. brought her daughter, R., to the session. This clip is an improvisation of the three of us together: me on keyboard, R. on the frog instrument, and S. on the cabasa. The codes that came from the music were again descriptions of each micro-moment of our musical interactions.

Excerpt Session 5

This individual clip with M. was her reflections on the technique of Museum of Motherhood and clay in which M. made a statue of a representation of what motherhood meant to her.

Excerpt Session 6

This individual clip with H. was her exploration of emotions elicited by Vivaldi's concerto in a minor and the three circles technique.

Excerpt Session 7

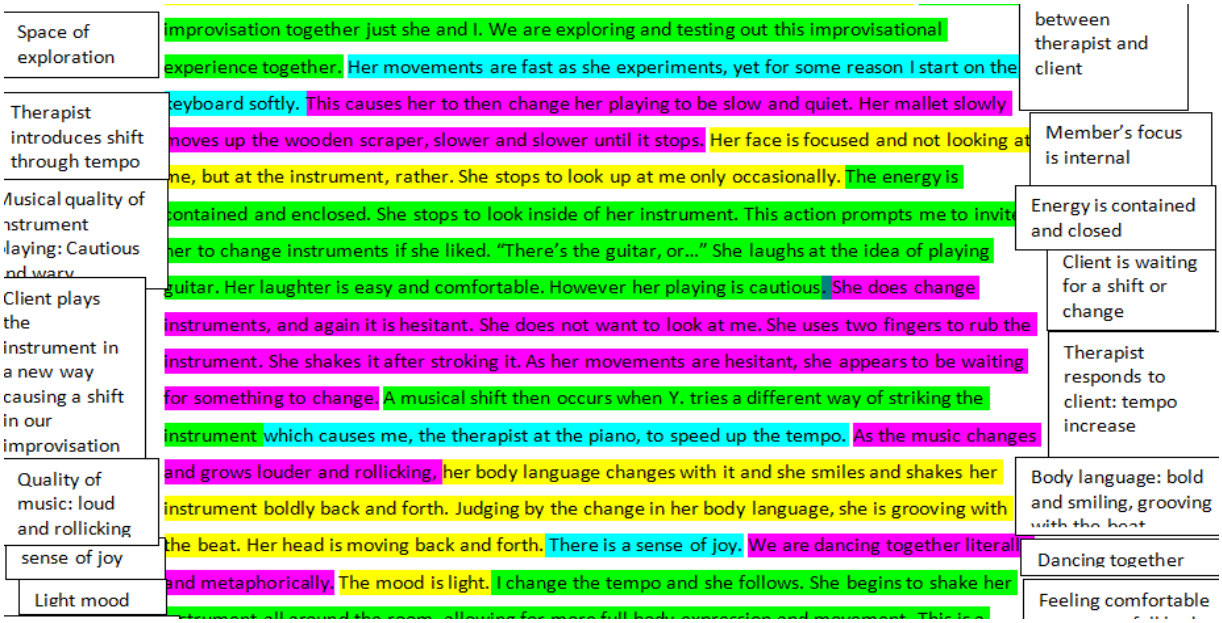
This clip with the final group session with H.,S., and Y. was the lyric re-writing of "You Are My Sunshine" using fill-in-the-blank worksheets.

4.5 Data analysis

4.5.1 Coding of video excerpts

After writing the thick descriptions I began the process of coding. An example is included below of a section of the thick description from the third session with Y. The

codes that were assigned to the text are listed on the right and left columns (the full thick descriptions with coding can be found in Appendix C). Each highlighted section is a separate code, or shorthand label, representing a different "chunk" of transcript text (Creswell, 2003), meant to describe what I saw it to represent. I generated my hypothesis of themes *a posteriori*, by coding the data first and discovering the themes after the process of solidifying meaning within the data, forming subcategories and then categories (Glaser & Strauss, 1967).



4.5.2 Coding of focus group transcripts

I then coded the transcriptions that I had written of the interview and focus group. The final interview and focus group were guided by the set of questions found in appendix B. An example is included below of a section of the transcript with the codes that I assigned. (The full transcriptions with coding can be found in Appendix C). The following is an example of coding within the transcript of the interview with M.

KH: Would you say your view of yourself or your pregnancy changed? Did anything shift or open?

Client felt more connected to the baby after our session

M: Maybe…connecting more with the baby.

KH: Was there anything else you'd like me to know about you, the experience, it can be negative, this did not work.

Client found session tiring (and is tired overall)

M: Tiring. [right away].

KH: Because it's a new experience and that takes a lot of energy, yeah, I can see that. Are you able to rest a lot at home. Are you a student?

M: No, I'm not. I sleep a lot but I like to get out and do something…but I'm just too tired. I don't like going too far too long because I have nausea.

The following is an example of an excerpt from the focus group with codes:

The process of music therapy works faster than traditional verbal therapy

MT enables expression and release of thought and feelings

Creative therapy allows you to leave expression of experiences on paper

The journal is an important tool for reflection

MT enabled letting go of anger

MT is a safe space to discuss experiences

In MT unique experiences are valued

S: To be able to see it makes more sense as well.

creativity enables insight

Y: You can go through verbal counseling for years and be the same. With this at least it helps to get it out of your mind. They say writing something helps with forgetting and all of that. So once you put it in the creativity and all that stuff, at least it comes out.

S: You're venting it.

Y: You're leaving it on the paper.

S: The fact you can reflect on it, the fact that when you're feeling down and take it out and look through your journal and you can reflect, and you can tell yourself why am I allowing myself to be this space when I've come from this, so that is how I feel.

KH: And did music therapy relieve any symptoms that you had before coming, like feelings like anxiety or depression or difficulties?

Music facilitates experiencing a wide range of emotions

S: Yes it made me reflect on anger and let it go, because the music takes you through all the emotions,we could speak about different experiences and each of our experiences was so unique we could learn from each other, so it was good.

Learning from one another's experiences

4.5.3 Categories

I then grouped all 189 codes from the thick descriptions and the transcripts into sub-categories and categories. This resulted in 91 subcategories and 12 categories. The following table shows a sample of the categories and the subcategories with examples of codes in each. (The full table with all the codes that were grouped in each subcategory can be found in Appendix C).

[Table of Categories and Subcategories]

CATEGORY	SUBCATEGORY
MUSIC THERAPY AS A PLAY SPACE	Sharing humor
	Curiosity about therapist's contribution
	Curiosity about instruments
	Space of exploration
	Optimism/joy/light mood
	Enjoyment
	Gratitude
	Valued new experiences
	Experiencing new ways of being
MUSIC THERAPY AS A REFLECTIVE SPACE	Music therapy as a space of and opportunity for reflection
	Emotional state: contemplation
	A sense of waiting to understand
MUSIC THERAPY AS A SPACE TO EXPRESS AND PROCESS EMOTION THROUGH CREATIVITY AND SYMBOLISM	Verbal emotional expression
	Embodied expression
	Values emotional expression and release of thought and feeling

	Life stage: feeling loving
	Introducing shift from control to vulnerability
	Reminiscing through symbolic exploration
	Emotional expression within symbolism
	Music therapy is surprising for its encouragement and development of creative capacity
	Values working with symbols
	Creative externalisation enables insight
	Values creativity of music therapy
MUSIC THERAPY AS AN INTENSE EXPERIENCE	Music therapy is more tiring and intense than verbal counseling
	Music therapy is intense
	Members make others more concerned
MUSIC EXPERIENCED IN RELATION TO POSITIVE CHILDHOOD EXPERIENCES	Exposure to music: through children
	Exposure to music: less as an adult
	Diverse childhood experiences with music
	Sharing childhood experiences with journaling
	Positive childhood experiences with music
	Music preference: gentle music
	music therapy is a safe space
MUSIC THERAPY AS A SUPPORTIVE RELATIONAL SPACE	Learning from one another
	Enabled hearing about others experiences
	Lessened isolation
	Member offers advice/plays a mentorship role
	Sharing difficulties

	Clients reassure one another
	Expresses a desire for sessions to continue
	Relational connectedness
	Empathic resonance with other's expression
	Provision of affirmation or validation
	Seeking affirmation and validation
MUSIC THERAPY AS A SPACE TO BE SEEN, HEARD AND UNDERSTOOD	Energy quality: tentative
	Energy quality: internal
	Energy quality: closed and contained
	Energy quality: explosive
	Energy quality: discrepancies between the therapist and client
	Energy quality: muted
	Energy quality: driving
	Musical quality: tentative
	Musical quality: structured and familiar
	Musical quality: rollicking
	Musical quality: cautious
	Musical quality: dynamic and full-toned
	Musical quality: in tune
	Musical quality: caressing
	Introducing shifts within improvisation
	Emerging voices
	Feeling known and understood
MUSIC THERAPY AS A SPACE TO EXPRESS CONNECTION TO THE BABY	Expressions of positive associations with motherhood
	Expressions of positive feelings toward baby

	Poem as expression of connection to baby
	Feelings of connection to baby
	Pure love as the connection between mother and baby through symbolic rep.
	Feelings of gratitude for having a baby
	Feelings of gratitude about baby
	Perceived as answer to prayer
MUSIC THERAPY AS RELAXING	
	Music therapy is relaxing
	Music therapy is rejuvenating
MUSIC THERAPY AS RESILIENCE PROMOTING	Music therapy aids self esteem
	Recommended for abused women
	Music therapy aids starting over
	Recommended to aid in setting boundaries in personal relationships
	music therapy is healing
	Music therapy increased sense of self
	Self efficacy
ROLE OF THE THERAPIST	Responsiveness mainly to therapist
	Therapist role: advice
	Therapist role: shares feelings
	Therapist role: inflexibly applied rhythm
TECHNIQUES PREFERRED	Intervention preference: relaxation, visualizations, and mandalas
	Intervention preference: sonic sketch
	Intervention preference: listening and visualization
	Intervention preference: visualization and art creation

	Intervention preference: listening to music
	Intervention preference: new experience such as writing poem
	Intervention preference: new experience such as playing instruments
	Intervention preference: journal
	Intervention preference: relaxation

4.5.4 Themes

I then grouped the 12 categories into themes according to how the meaning of the categories related to each other. Five themes were developed. The following table shows how the categories were grouped into respective themes:

Theme	Categories
Personal Exploration	Music Therapy as a Play Space Music Therapy as a Reflective Space Music Therapy as a Space to Process Emotion Through Creativity and Symbolism Music Therapy as an Intense Experience Music Therapy in Relation to Positive Childhood Experiences
Music Therapy as a Space to Connect with Others	Music Therapy as a Supportive Relational Space Music Therapy as a Space to be Understood
Music Therapy as a Space to Develop Connection to the Baby	Music Therapy as a Space to Develop Connection to the Baby

Music Therapy as a Regenerative Space	Music Therapy as Relaxing Music Therapy as Resilience Promoting
Affordances of the Therapeutic Relationship and Techniques Used	Role of the Therapist Techniques Preferred

The first theme, personal exploration, refers to discovery through play, reflection, creative and symbolic expression, intense experience, and remembering positive childhood experiences. The second theme, a space to connect with others, refers to music therapy being a space to experience shared support and understanding. The third theme, music therapy as a space to develop connection to the baby, contained data related to the opportunity music therapy provided the participants to develop a closer bond to the growing child. The fourth theme, music therapy as a regenerative space, referred to the women's references to the sessions being able to help them relax and replenish their inner selves, and to identify sources of strength, leading to increased resilience. The fifth and final theme, affordances of the therapeutic relationship and techniques used, identified what role the therapist had to offer in the musical interactions within the therapist-client relationship, and which techniques were most useful.

4.6 Conclusion

This chapter has detailed the content of the sessions and the process in which research was carried out, and in which data were analyzed. In accordance with thematic analysis, using thick descriptions and video transcripts, codes were derived. From these codes, sub-categories, categories, and finally themes were developed in response to my research questions. The following chapter will discuss the findings further and relate them to the literature.

Chapter 5: Discussion

5.1 Introduction

My research study initially began out of a deep belief on my part that women deserve equal access to quality healthcare, especially women who already face socioeconomic challenges; and that pregnancy is one of the most important times in both a woman's and a child's life. The importance of adequate mental health services is paramount. The women in distress who were included in my study had much to share about their experiences as pregnant women within music therapy. I will begin discussing the results of the study by presenting each theme in relation to the first research question: How do pregnant women in distress from the Cape Flats experience music therapy? I will then discuss how the findings addressed the second research question.

5.2 Theme 1: Personal exploration

First, the women experienced music therapy as a place of personal exploration. Partially what drew them to the music therapy group, it seemed, was a background of diverse and positive experiences with music in childhood. Though some women had allowed music to drift out of their lives, they all agreed that it was an experience that was beloved and shared within their families.

Rafieyan and Ries (2007) suggest:

> Music is a normal part of most people's everyday lives. To be able to experience music (either by listening or taking part in playing it) in an unfamiliar hospital setting may help put patients into a more 'normal' frame of mind, as opposed to one in which they may feel helpless, victimized, and frightened (p. 50-51).

One of the unintended results of the study was to learn what drew these women to music therapy in the first place.There is little to no research on why people choose music therapy (as opposed to being specifically referred, for example.) In a hospital setting, a team may recommend music therapy when a patient is not able to engage in verbal psychotherapy, is withdrawn, or does not have a good family support

system (Rafieyan & Ries, 2007). A study by Kong and Karihalios (2016) found that parents of children with special needs sought out music therapy for the following reasons: for reduced frequency of seizures, improved self-expression, stress relief, increased response, and interest in music. In the case of a population who has the ability to avail themselves of therapy and can choose which type they prefer, however, what draws this kind of client to music therapy in particular? I found little academic research on the subject.

In speaking with these women, it emerged that music was a positive presence in the majority of these women's lives as well as in the lives of their family members. This did not necessarily mean playing an instrument (only one woman mentioned owning a guitar), but that the women in general had grown up listening to music in their homes of origin. S. said, "It's always been a part of my life; with my kids it's a whole diversity as well. Each child brings a different genre of music. It's like new things they would bring that I would adjust to." Y. mentioned different members of her family: her uncle, her grandma, and the music they liked.

Having this love of music drew them, naturally, to wanting to experience what music therapy could offer. This, combined with curiosity and a spark of interest in what the therapeutic aspect of music therapy entailed, brought these women together. The women, coming from the different linguistic and religious and cultural backgrounds that they did, had little in common at first glance, but a love of music united them.

The process of music therapy included space for personal reflection, another aspect of the theme of personal exploration. This included the experiences of "not knowing" and waiting. This kind of space is not surprising considering these women were all pregnant. Pregnancy is a liminal space. It is temporary. It is a place of expectation for an arrival date coming in the future. We explored creating grace in that space, and in embracing the femininity of awaiting motherhood, including its burgeoning belly and stretch marks.

It has been shown that musicking creates a liminal space through the loss of boundaries, collective vulnerability, the handing over of responsibility to a higher power (if this is relevant for the client), the capacity for joyful play and the potential for empowerment, enabling transformation (Boyce-Tillman, 2009). As S. said, "I tell myself God has a bigger plan. I don't know what it is but I see it taking place." These are ideas that came up consistently in my work with the participants. The liminal

space of pregnancy resonated with the potential of musicking as a transformative space.

Musicality can create liminality first by leaving the everyday behind, and second by marrying emotion and intellect through the organizing creativity that is art (Boyce-Tillman, 2009). Custodero (2005) states that through transforming musical material (timbres, pitches, rhythms, melodies and so forth) we transform ourselves through the experience. Other terminology in psychology associated with liminality include “peak experiences” and “flow” (Schaefer, Smukalla, & Oelker, 2013). It is a sense of opening up as boundaries dissolve; the sense of a quality of losing control (Boyce-Tillman, 2009).

Reflection occurred not only inside the session, but outside of them too. “I used my journal a lot,” said S. “I could reflect what these sessions do for me, like the writing of a poem, you don't normally do that.”

Playing is the source of creativity and “it is only in being creative that the individual discovers the self” (Winnicott, 1971, p.73). According to Winnicott (1971), a pediatrician and psychoanalyst whose ideas have also inspired music therapists, this true self stems from the ability to feel truly alive inside and it is developed through play.

Another description of liminality or that which is “in-between” was offered by Winnicott (1971). He called this the “transitional space.” Similar to the “borderland” that liminality is, the transitional space is one that relates to the psychology of child development: it is a space that a child can explore through creative play, in the process building self-stability. In conflict studies, a transitional space can include a building in which people can meet to negotiate peace and in which neglected voices can be heard (Bouwen et al., 2008). This is particularly meaningful considering the context of my study: a gangster’s “war zone” where violence is an everyday affair. The Hanover Park MOU became our peace-making space, where these women of different cultural backgrounds could meet together and have a shared experience. When people enter such a transitional, liminal space with problems, they can leave the space having experienced a degree of transformation, having entered a different time/space dimension briefly (Boyce-Tillman, 2009).

In the case of Winnicott’s (1971) ideas of play, a “transitional object” is necessary to facilitate an experience that is both “real” and “made up” at the same time. This allows the player to enter into a zone in which reality can transition from the imagination to the real world. Music therapy provides this transitional object in the

form of musical instruments or tunes (McDonald, 1990). As an example, in Y. and I's instrumental improvisation, we created this space in which the instruments could take us to a different world where surprise and playing "in the moment" could occur.

Over time it became clear that the music therapy space was one where emotion could be expressed and processed through creativity and symbolism, another aspect of personal exploration. This expression was verbal, but it was also embodied, as shown through movement, body language, dancing, and posture. It became clear that not only was this a space of expression but that the release of thought and feeling that this provided was valued. These shifts often occurred not through the talking, but through the symbolic and creative capacity the sessions provided, and by externalizing the internal, insight was reached. This was not always "negative" emotion that needed processing. For example, Y. created a statue of what being a mother meant to her. She chose red clay because, as she said, she loves her baby so much. She could not wait to rock the baby in his or her bed and change nappies. She therefore elected to make a baby in a cradle.

It has been suggested that music is ideal for processing emotion due to the paradox inherent in its structure and complexity (Boyce-Tillman, 2009). While emotional expression is often a goal of creative arts therapies, it is not always clear what this means exactly: what is emotion and how does one know when it has been expressed? Juslin and Sloboda (2012) suggest that emotions are short, intense affective reactions. Expression is the "outward manifestation of emotional states" (Kania, 2014 p. 19). Juslin and Västfäll (2008) suggest music could create emotional reactions through "acoustical characteristics of the music that are taken by the brain stem to signal an event lead to experiencing emotions" (p. 564), through multiple repetitions linking emotions with stimuli; through mimicking the perception of the emotional content of music; through visual imagery; through recalling a specific life situation; or through the violation, delay or confirmation of the direction of the musical framework. All of these processes can lead to emotional experiences.

Emotion was expressed verbally when the women shared stories from their lives, in an embodied way through dancing or movement, and through posture, facial expression, and tears. S. shared,

> For me the listening took me through all the stages, angry to relaxed, by listening to the music. In the creativity, you could see it, so it comes out in you. [If] you're just saying things, it's not coming out. If you do creative things, you look at it afterwards and you can say okay, this is what is going on, to be able to see it

> makes more sense as well... You can go through verbal counseling for years and remain the same, once you put it in the creativity and all that stuff, it comes out, you're venting it, you can reflect on it. You can look through your journal and reflect, why am I allowing myself to be this when I've come from this?

Something of a dichotomy emerged during this process of expression. Some women, in particular M., spoke of music therapy as being more intense and tiring than traditional verbal counseling. M. was already anxious and sleeping a lot at home, but besides that, I suggest that at least two other reasons may have informed this experience of intensity in music: first, the bypassing of defenses, and second, the physical arousal response that music produces.

Music has the potential to bypass the defensive operations of the higher cortical functions of the brain and move directly to the limbic system where emotions are processed (Hussey, 2003). This notion lends itself to a psychodynamic consideration of processes within music therapy. Defenses operate unconsciously and include repression, denial, projection, isolation, and reaction formation--meant to protect from pain. In order to become whole, however, according to psychodynamic theory, those defenses eventually need to become loosened and the parts of self need to be integrated (Caligor et al., 2018). By its very nature, music bypasses defenses and penetrates the inner world, including emotional conflicts and repressed memories (Montello, 2002). The necessity for creating a safe space, and a place that further emotions could be processed once the music therapy concludes, became an important part of carrying out this research ethically. The women were within a facility that could provide counseling even after the conclusion of our music therapy process, so that if issues were unearthed from our short time together, they would have continued support. In future, working with this clientele could be spread out over a longer period so that the supportive relationship could be present throughout the pregnancy and birth.

Secondly, intense emotions are accompanied by increased physiological arousal. Rickard (2004) suggests that emotionally powerful music can change the degree of physiological reactivity of recipients. Consequently, the intensity of the experience in music therapy is directly related to the choice of music the therapist offers and the experience can be modified by taking account of the emotional impact the music provides. "Intensity" is not necessarily to be avoided, even in pregnancy. IMEs (intense musical experiences) have been shown to lead to an experience of

harmony and self-realization, as well as the development of manifold resources. Furthermore, they can cause long-term changes in personal values and perceptions of meaning of social relationships, engagement, activities, and personal development. They can be related to spirituality and an altered state of consciousness. Intense musical experiences can make life more fulfilling, spiritual, and harmonious (Schaefer, Smulkalla, & Oelker 2014). Thus, the fact that the sessions were experienced by some participants as intense and tiring may be an indication that the potential for change was present.

The creation of music involves more full-bodied energy than simply talking. It becomes important to consider the number of interventions offered in a session, and the ability to take time to fully process each experience.

Alongside this intensity within personal exploration, the participants also experienced the development of what could best be described as a play space. It was a place in which participants shared humor, experienced curiosity toward other contributions and instruments, and valued new experiences. It was a space of enjoyment, gratitude, exploration, and optimism, joy, and light mood. In the play space, the ability to let go of responsibility and to take risks safely, means that true joy can be experienced (Joyce-Tillmann, 2009).

The PMHP requested that I, as music therapist coming for just four sessions, would keep the sessions on “the lighter side”, while focusing on the playful, rejuvenating, resilient and well self. The women expressed both enjoyment and gratitude, for their pregnancies and for the sessions, consistently throughout the process. H., in the final focus group, stated that the sessions helped her “move away from negativity” and develop “a more positive life perception.” Y. shared during the natural object symbolizing that she was drawn to the pink beads because she was “full of love” and felt like “something good was going to happen.”

There was an experience of letting go and release: both a freedom from negative energy, and a release of it. The theme of letting go came up in H.’s individual session. She said she had no close friends, so I asked: “In your past, then, you've had friends, but it's been more short term, and then after a while it just fizzles out, or is it an explosion in the end?” She replied,

> Intense, I think. I have this thing where I hold onto people. Letting go takes a long time…I think I need to realize that life is full of ups and downs: there aren’t always good times. There are opposites. When things are not going in your favor, you must find that place inside

> you, even if you think you're a weak person, why is God putting me through this, it doesn't last forever, nothing lasts forever, everything is temporary in life, the sadness, I just need to get through it, and not let so many things around you affect you.

I encouraged her to continue, “So there's been a sense of learning how to let go?” H. replied, “A sense of learning that I can't control everything, that I can't have it my way…” She was to be divorced within months after the end of our sessions.

In our focus group S. said, “It made me reflect on anger and let it go, because the music takes you through all the emotions.” Emotional release was a goal for the sessions. We reflected on how, when it came time to give birth, there would also be literal opening up and release to allow the baby to come into the world.

Letting go is a theme that is explored in the use of music therapy with palliative and cancer care (Clements-Cortez, 2017) as well as mindfulness-based music therapy programs for women with cancer (Lesiuk, 2016). While most research on using music therapy to practice release has taken place in cancer care and hospice settings, this was also an element that was relevant in this group. A sense of release has also been reported by respondents during IMEs (intense musical experiences) in which an altered consciousness was achieved through the absence of everyday life stressors and requirements during the music (Schaefer, Smukalla, & Oelker, 2014). Beyond catharsis, which is the expression and discharge of emotions (Konieczna-Nowak, 2016), letting go and release when used with pregnant women in this case refers to removing unconscious blockages, moving on from past experiences, reducing stress, and accepting what is through increased mindfulness. The act of childbirth itself requires letting go of control. These steps contribute to the ability to physically release the baby in the act of giving birth.

5.3 Theme 2: Music therapy as a space to connect with others

The music therapy group appeared to be supportive because it was perceived as safe, creating a supportive relational space. The members felt they could learn from one another, hear about others’ experiences, and thus isolation was reported to lessen. At times members could offer advice or act as a mentor to others within the group, and affirmation, validation, and empathic resonance with other’s expression

could be given. The women could share difficulties, reassure one another, and develop relational connectedness.

The emotional expression inherent in music created a space of “collective vulnerability” (Boyce-Tillman, 2009, p. 196) in which empathy could be developed and the emotional worlds of others could be explored. Some members of the group made other members more concerned at times. For example, when S. and H. shared how painful birth was, Y., a first-time mother, said that she was now very afraid. Yet as Y. and S. said, the feeling of not being alone, of breaking the isolation, was one of the most important aspects of the therapeutic space, even if it meant talking about the difficult parts of motherhood. Y. also elaborated on this in the focus group:

> Actually I liked the sessions. I've been praying for something like this: in the society where I come from you can't speak about things openly. When I say to my grandmother, I wonder what happens when you go into labor, she says you can't talk about that. I was in a shell.
>
> .

The ability to ask questions and talk openly about the experience of pregnancy emphasized the benefits of music therapy as a group, rather than individually. Additionally, group work is critical for abused women to break the silence and social isolation imposed by the abuser (York & Curtis, 2015). Group therapy becomes an opportunity to expose members’ “negative self-evaluations and to receive support and goodwill in return” (p. 386). H. shared that her journaling had allowed her to break through negative thoughts, and S. encouraged H. with supportive words after she shared.

The music therapy sessions provided a space in which each client could feel understood and known, past a surface level interaction, within the therapeutic relationship. One definition of intimate is “characterizing one’s deepest nature; essential; intrinsic” (Merriam-Webster, 2019). Research shows that babies establish a relationship with their mothers through body movements and sounds and this occurs even before birth (Shoemark, 2016). Music can promote and encourage this first intimate relationship (Edwards, 2011). In our sessions, feeling understood was developed through what emerged from the instrumental improvisations such as the energy quality and musical quality; through the voices emerging louder and more confidently within the session, and through the valuing and validation of unique experiences. The knowing of one another beyond words is explained by the idea of intersubjectivity (Trevarthen & Malloch, 2000). A parent and baby understand one

another without words: through musicality, gesture, and facial expression. We experienced intersubjectivity in our sessions, expressing ourselves not only verbally, but physically and affectively too.

Kim (2016) suggested that music therapy provides greater affective and physical intimacy than talk therapy. In this study of hospice patients with their caregivers, intimacy was observed through how the participants moved closer to one another physically, and expressed affection through touch, tears, smiling, or softened facial expression. A client in music therapy in a study by Turry (2004) reported how the sustaining chords played by the music therapist at the piano during an improvisation made her feel listened to deeply as she sang. This provided motivation to continue to enter into the music and also to create. Working together with a music therapist permits depth of emotion and provides a platform to share that depth with others (Turry, 2004). Especially in this environment, building a safe space was paramount (as emphasized by deJuan (2016). Although time was short with these clients, a measure of being known was reached due to the essence and quality of music itself providing a template in which emotion can be expressed: the client could share her inner world with the therapist through music.

According to Austin (1996, p. 32), “in order to grow and transform, the client needs an experience of having his/her feelings and true self heard, seen and valued in relationship”. H. shared that, [in verbal counseling] “I would speak, and still feel like you don't understand me, [after music therapy] I go and [negativity] doesn't go with me and it doesn't follow me.” As S. said, “We could speak about different experiences and each of our experiences was unique so we could learn from each other.” Unique experiences were valued and validated within the music therapeutic space.

5.4 Theme 3: Music therapy as a space to develop connection to the baby

Besides the music therapy space being one that could create relational connectedness with between the group members, it also offered a space to develop connection to their babies. This was coded from the thick descriptions as expressions of positive feelings towards the baby, positive associations with motherhood, and feelings of gratitude for having a baby. Writing the poem/lyrics for the baby was most frequently referred to as being useful in developing that connection, as well as the mandala in which they symbolically created the gifts they would like to pass on to their babies.

There is a developing collection of studies using music therapy to promote attachment in vulnerable parenting situations. For example, vocal improvisation and sense of synchrony creates a deeper bond and emotional intimacy among members of the family and with the child (Edwards, 2011).

Attachment theory was formally developed by Bowlby (1981) and Ainsworth (1967). It holds that every infant has the need for a secure primary relationship with a caregiver, usually the mother. The basis of this relationship is the mother's ability to notice and "read" the baby's cues and needs, and to respond appropriately and sensitively (Goldsmith, 2010), thus setting up a cycle of reciprocal positive interaction. Attachment focuses on the infant-mother (or infant-primary caregiver) dyad as the primary relationship that sets the pattern for interactions later in life (Meyer, Wood & Stanley, 2013). Winnicott (1971) thought the mother's quick response to feed her baby gave the baby a sense that whenever he/she was hungry, food appeared as if the baby himself/herself made it happen. This sense of power caused a baby to feel assured, calm and inquisitive, and eager to learn without requiring the upkeep of defences.

Music therapy draws on principles from attachment theory, as responding to musical cues imitates the original mother-child relationship. Repairing any disruptions in this relationship between infant and mother becomes a central part of the therapeutic process (Ridley, 2013). Attachment begins antenatally (Chang et. al, 2015). Lander (2017) discovered improved confidence and increased desire to establish communication with the baby in a study of one music therapy program in Scotland working with prenatal attachment in a vulnerable population.

In my initial screenings of the women through the questionnaire none mentioned a lack of attachment to their babies and indeed all claimed to feel attached already. Rather, the techniques offered in sessions for the development of attachment to the baby appeared to reinforce the attachment already present. Perhaps the music therapy space was one in which to share that loving bond with other mothers-to-be, and to discuss ways that they wished to improve upon their own experience with their own mothers. For example, Y. shared the following story during our final session:

> My mother and I had a huge fight. She wanted me to have an abortion. She kicked me out of her house. I'm 20 years old, maybe she had high expectations. At midnight I went to a relative's house. I hit a rock bottom, it didn't fall into place. Until I went to therapy with [the MOU counselor], things fell into place again. I've learned from that experience now, I'm sure

what happened between my mother and I, won't happen to me and my baby…

I asked, “Have you forgiven her for her reaction?” Y. responded, “Yes I have. She can be a grandma. I also did it with myself to have peace with myself.” I asked, in relation to our mandala work, “So for you the gifts that you're going to share with your baby are…?” Y. said, “First life, I also choose to give my baby *love*, because I could not be open to my mom, she was very strict, yoh, I know where to correct her faults so I don't do the same thing with my baby.”

A. chose the word “wow” to demonstrate her awe at being pregnant. M.’s statue in the *Museum of Motherhood and Clay* was of a naked mother and baby breastfeeding, symbolizing “pure love, pure trust.” Later, M. would say that she felt the session helped her to feel more connected to the baby.

Having other family members attend a session provided opportunities for them to bond with the baby as well. For example, after the three circles technique R., S.’s daughter, shared: “I want to play with the baby and have fun helping people and enjoy myself.”

I felt some conflict about using local music compared to older studies that have been completed on the preferences babies have prenatally for classical music such as Vivaldi, which imitates a heartbeat at rest (Verny & Kelly, 1981). One study with pregnant women in Brazil demonstrated preferences for classical music such as Strauss and Bach in order to minimize distress (Tabarro, et. al, 2010).

There is evidence to suggest that local music would be beneficial. For example, an RCT by Arya, et. al (2011) with 260 women found that pregnant women who listened to a prerecorded “Garbh Sanskar” audio cassette (Times Music Inc., Mumbai, India) containing a medley of instrumental music, natural sounds, and chants from religious scriptures later had infants who scored significantly better on 5 of the 7 indicators on the BNBAS (Brazelton Neonatal Behavior Assessment Scale). The music from local sources was found to be beneficial for both mother and infant. In another study, it was found that the mother’s music listened to during pregnancy had the highest impact on the physiological and behavioral parameters of the infant compared to no music at all or lullabies (Kurdahi, et. al, 2017).

More studies are needed on African music during pregnancy. Music as healing is an ancient practice within Africa, and its integration into hospital settings with

pregnant women (for example, using African music and lullabies) deserves further research. In this study we sang, “Thula Baba,” a Zulu lullaby, and the women wrote their own lullaby lyrics.

5.5 Theme 4: Music therapy as regenerative

The term “regenerative” is defined as a state of renewal, restoration, or revival (Merriam-Webster, 2019). In the group conducted for the current study this entailed both providing a space for relaxation, and for building resilience. The sessions were described by all of the women as relaxing. Y said in the focus group, “So I've heard a lot, and it helped me relax a bit. Before I had a shell.” Later she also continued, “It helped me relax a lot, because I don't get so much time to listen to headphones, at least here I can relax. When I get home I'm a much better person than what I left.”

Decreased anxiety levels through music therapy and relaxation were shown in a study by Liebman and MacLaren (1991) in third trimester anxiety with pregnant adolescents. Music was also shown to reduce psychological stress in another study with 236 pregnant women by Chang, Chen, and Huang (2008). Relaxation has long been shown to be a benefit of music therapy with this client group, and the experiences of the women in the current study confirmed this.

In an RCT with 409 pregnant women, it was found that music improved the vital signs of pregnant women (González, et. al, 2017). Vital signs are clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's life-sustaining functions. Many studies show maternal stress, anxiety, or depression during pregnancy introduce an increased risk for her child to experience adverse outcomes, from ADHD or conduct disorder to impaired cognitive development, potentially caused by increased absorption of cortisol (Glover, 2016). Increased emotional support for the stressed, depressed, or anxious pregnant mother leads to better outcomes for the child.

Music therapy was also resilience-promoting. In our sessions S. described her personal transformation from trauma to healing:

> Last year we were being harassed by the guys that shot my brother, there was a lot of abuse because they were harassing us, I used to pray a lot for the abuse to stop. Since we came here there's more light in our lives, we can really reconnect with ourselves, it's a rebirth. There's more love where we're at now. Because at where we used to stay in our old house, it was a bigger

> house, now the house is smaller and the family is closer, there's only three rooms now, we're sitting together eating, we watch TV together, we sit in the front room around the table, and do homework. It's a whole new experience, it's a new rebirth and we can connect and we're a lot closer now as a family. Before [R.] and her sister couldn't connect, they were fighting all the time, now they love each other…Prayer is my pillar of strength, I have a one-on-one relationship with God, the adjustment has been so good, from the abuse and seeing my brother be murdered, I'm actually healing from everything that I went through. The new baby gives me courage and strength and makes me want to move on and leave this behind me.

S. was able to share her strengths with the other women in the group, including prayer and her relationship with God, love, and family connection. These strengths were perceived by her as being sources of her resilience in difficult circumstances.

One of the most surprising results, at least for me as facilitator, was that music therapy was a resilience-building space for women who had been abused. Though I was aware these women may well have been affected by IPV, it was not a focus of the sessions. Preparation for the baby was our primary goal.

The three characteristics shared by physically abused women in a study by Cascardi, et. al (1995) were low self-esteem, self-blame, and perceived helplessness to escape the abuse. The study sought to discover risk factors for women's likelihood of abuse within relationships. While IPV is a relevant issue to any group of women due to its prevalence, women in South Africa face the highest rate of domestic violence in the world. The needs that music therapy addressed resonated with these three that Cascardi addressed, according to S:

> Because you're actually refreshed, and leaving what you're carrying on your shoulders, I would advise you to do this in the U.S. for abused and battered women. It's gonna help their self-esteem, move away from the negativity, and tell themselves 'I don't need to be abused.'

In the past, music therapy interventions with abused women have been shown to aid expression of creativity, develop self-esteem, and improve relationships with family members (York & Curtis, 2015).The women stated in our focus group that music therapy could aid in starting over, in setting boundaries, and in recovering from

abuse. The sessions provided a space for autonomy and increased self-esteem. They offered opportunities to feel emotionally refreshed and “provided a relief from the burdens of life” according to S.

Cohen suggested the musical liminal space as an antidote to violence. The experience of agency is paramount to overcoming the sense of powerlessness (Joyce-Tillman, 2009). The women in the current study, living in one of the highest crime zones in the world, were no strangers to violence due to the gangs in the area. Every nine seconds worldwide, a woman is beaten, coerced into having sex against her will, or killed by an intimate partner (National Coalition Against Domestic Violence, 2012) and, in particular, women in this economic group are vulnerable (leaving a partner becomes more difficult without adequate financial resources). The specifics of some of the client’s relationships with their spouses only emerged in the final interview, or even afterwards.

When working with women affected by IPV, a feminist standpoint becomes especially appropriate, acknowledging the systematic injustices women face in a patriarchal culture. Goals of music therapy in this framework become to empower, to facilitate recovery, and to bring social change (York & Curtis, 2015).

“In reclaiming their own voices and in speaking for others without voices, women can enhance their own healing and empowerment” (York & Curtis, 2015. p. 384), an idea which surfaced in the focus group at the conclusion of our sessions. In her own words, S. shared, “I can personally say I've healed a lot from where I've come from and what I've been through, I lost my brother and I actually saw that, this baby is a new beginning, my brother may be gone but it will be replaced by a son.” In reflecting on her mandala, S. shared that it was her ability to love, to remain optimistic, and to self-heal that she was looking forward to sharing with her baby. S. said, “Yeah, I don't stay stuck in that dark space. I'm looking forward to the new rebirth and growing with this baby.”

Musical improvisation gives a traumatized person the power to respond according to their own choice--something taken away by the perpetrator (Volkman, 1993). In a study by Volkman (1993) it was found that creating a safe space; exploration, expression, and integration; and group closure were important steps in trauma recovery for physically and sexually abused women. Because trauma is experienced as helplessness, isolation and the loss of power and control, the goal of trauma recovery is the restoration of safety and empowerment (Herman, 1992).

Restoration is a state of regeneration, and a consequent theme the women shared was a result of participating in the music therapy sessions.

The clinical basis of our therapy space came from following the needs of the women. As facilitator, I could provide a framework, but I was neither “the teacher” nor the “expert” on any of the women’s lives. This leads me to my final theme.

5.6 Theme 5: Affordances of the therapeutic relationship

Certain codes emerged from the thick descriptions of my session clips that highlighted the role of the therapist. I adopted a feminist approach in the sessions: I carefully disclosed music and personal experiences with the participants as an intentional act of power sharing to move towards an egalitarian, rather than hierarchical framework (York & Curtis, 2015).

At times, I also offered insight and advice, particularly about what research shows as helpful for the baby prenatally when it came to music, such as the baby’s preference for the mother’s voice. I also provided the musical fabric, particularly in instrumental improvisations. Music therapists use various musical elements, such as song structure, rhythmic patterns, or musical styles in order to bring about a sense of familiarity and focus. This may be especially helpful when clients are trying to cope with anxiety (Rafieyan & Ries, 2007).

I sought to create a space in which the women could feel safe, as is the fundamental requirement of all therapeutic interventions. With each client, I sought to focus on the whole person, not just the collection of symptoms. As Rafieyan and Ries (2007) mention, whereas medical staff are trained to focus on the illness, music therapists tend to address the positive aspects of the client, such as the sense of hope, spirituality, and joy.

5.7 Rating scales summary

I determined the least and most preferred techniques through interviews and through rating scales administered at the end of the final session. The women filled out a rating chart of preferred techniques (a summation of which is included in the appendix). The women found the techniques of flowers/colors/values and three circles most helpful for a rating of 5 across the board for the four women who filled it out. (A. only attended the first session and did not provide any feedback afterwards.)

The next most preferred techniques were the lullaby singing, relaxation and breathing to music, the museum of motherhood and clay, and mandalas at an average score of 4.75. The next rated technique was the writing a poem at 4.5. Visualization to music, improvising on musical instruments, and affirmations rated at 4.25. The journals and inspiring song discussion rated at 4. The postcards and natural objects and the vowel toning ranked at 3.75. And the singalong to “Swing Low, Sweet Chariot” with an attempt at vocal improvisation was lowest at 3.5.

During the focus group, the women specifically mentioned what was most helpful to them individually. S. enjoyed playing instruments and journaling, as well as the three circles. “You can see where you were going, where you are, and where you're going, the healing power it has, you could have been in such a dark place before, you can see where you've come from and where you're actually going.”

Y. liked visualizing to music and then putting it on paper. “I think listening and visualization was more useful. I get to listen to the music and then I had to put them down. I never thought I would be able to do that, to create art afterward”. M. liked the relaxation to music, as did H. “ I did enjoy the relaxation and mandalas the most: that's my favorite part,” said H.

I will first discuss the following least preferred techniques: the singalong, “Swing Low, Sweet Chariot”; followed by the techniques discussed as being moderately preferred, including journals, lyric re-writing, visualization and the museum of motherhood and clay. Improvisation was polarizing: it was either described highly or as mediocre by the four women. Finally, the most preferred techniques will be discussed: the three circles, flowers/colors/values, relaxation and breathing, and mandalas.

Singalong: “Swing Low, Sweet Chariot”

When it came to techniques that the participants perceived as being beneficial and less beneficial, they identified the singalong “Swing Low, Sweet Chariot,” as the least beneficial. In this intervention, I invited the women to improvise lyrics in the moment. There was great hesitancy to do so. They instead preferred the alternative: lyric re-writing rather than lyric improvisation.

Lyric Re-Writing: “You Are My Sunshine”

When given the song framework and printed lyrics with a fill-in-the-blank option, the women felt more comfortable to come up with their own lyrics on the spot. Considering the space--one in which women's voices have been traditionally silenced--the free improvisation may have felt too intimidating. Lyric re-writing appeared to be a more welcoming, less threatening alternative.

Toning

Toning is the technique of sounding one's own voice to cause an internal shift: change in the body can cause a change in mental state (Kenny, 1982). In what Bonde and Wigram (2002) call "musical parameters as metaphor" (p.100), tone formation within the body raises the question: how is the sound produced, and is it in balance and harmony, or the opposite? Bruscia describes using toning to restore vibratory patterns allowing the body to function in harmony (Bruscia, 2014). The lack of interest in this technique by these participants, however, does not mean it is not suitable for pregnant women. In fact, toning has been shown to be an effective management of pain relief during labor through the following: physical and emotional release, self-listening and self-confidence, bodily vibration, increased ability to cope with pain, useful forms of focus, positive connection with a partner, and a sense of relatedness with nature, origins or spirit (Pierce, 2001). Feeling more comfortable using their voices in the sessions was a gradual process for these women. After four sessions their voices were only just beginning to emerge. With this client group, it would be interesting to see how vocal toning would develop over a longer process. It would also be interesting to devote an entire session to the process, rather than only five minutes in the third session, as in the case of our process, and to really encourage them to explore their voices.

In a study on attachment by Ridley (2013) with 19 at-risk women over the course of 22 weeks, the researcher found that two of the women never vocalized at all, and the majority needed much encouragement to do so. The researcher interpreted this in relation to low self-efficacy (struggling to effectively make choices and decisions). In our short four weeks together, confidence was still low. Toning over a longer period may indeed have been shown to be more useful.

Improvisation

Two clients in the group enjoyed improvisation at a score of 5; two others ranked it much lower at a score of 3. Rafieyan and Ries (2007) state that one beneficial part of improvisational music therapy is that

> By inviting the patient to take an active role in music—be it singing or playing instruments—the therapist is offering the patient a sense of control (e.g., “Which instrument am I going to use?” “How much do I want to play?” “How do I want to use this time?”) and a perception of “doing” rather than “being done to (p.50).

This sense of control, or agency, is vital to combating violence, to increasing bravery, to overcoming oppression, in short, to empower (Cohen, 2008). One such moment came with H., when I offered the following theme: “What we can improvise on is your relationship with your husband, or with your support system in general. You can play any instrument, it's like a time of exploration, it's a time of seeing what the sound is like, does it match what I'm feeling?” H. had the scraper and said she would prefer to improvise on the theme of her relationship with her husband. I started on the keyboard. My phrasing matched hers. My playing was smooth and then I moved into a tapping pattern like hers. She interrupted to say, “Is the music supposed to make me feel angry?” I said, “Is it the way I'm playing or is it because it's how you feel?” She said it was because of the instrument she had chosen, because she felt like she was in control with it (due to her ability to strike precisely with the mallet). Issues of control were relevant in H.’s relationship. Her husband was abusive. In this improvisation H. had a moment to claim her agency.

Y. and I improvised together in the third session, a clip I included as a thick description. During the improvisation she was dancing and smiling. We transitioned into a new section and she began playing the instrument differently, upside down. She stroked it slowly and I also played more slowly, so that our interactions directly influenced one another. This interplay was playful, spontaneous and enjoyable. As Y. said immediately following our improvisation together, “It was nice; it was fun.”

S. said at the conclusion of our improvisation together with her daughter, R., “It was nice for me. I like the beat in the beginning, it excites you, the sound travels through your body and relaxes you. I felt at peace.” It was also the new experience of it all that made an impact: “We got to play a new instrument-- it was just fantastic,” said S. in summing up some of her most memorable experiences from the music therapy sessions.

Flowers/Colors/Values

This technique was appreciated by all the women. It gave something tangible for them to focus on in the sessions and provided a theme for each session. The first session was symbolized as an unknown, yet-to-bloom flower, representing how the fruits of the process we would have were yet to be realized. The second session was symbolized as white roses, representing innocence and serenity. The third session was symbolized as lavender and chrysanthemum, representing soothing and rebirth, and optimism and femininity. The symbol chosen for the fourth session was yellow gladiolas, a symbol of strength, resilience, and happiness.

Mandalas

Sanskrit for circle, a mandala is a Jungian-based image of the self, meant to integrate conscious and unconscious material. It has been found to reduce depression, anxiety, and symptoms of trauma during art therapy (Potash, Chen, & Tseng, 2015). The women were encouraged to reflect on the following: “What are your sources of resilience and strength in your life? And not only that but connected to that, what gift are you going to be giving to the baby?” M. shared that she wanted to give the gift of nature and writing to her son. Having spoken little throughout the session, the mandala enabled her to reflect and share after the creation of art.

Journals

I invited the women to reflect in a journal (that I provided them) about their sessions and to record what techniques they used at home and how often. Homework exercises in a previous music therapy study were found to be effective for practicing music therapy techniques at home (Hanser, 1994). The women were asked to use some of the breathing and music listening techniques at home and to journal their experiences. S. found the journals to be particularly effective: she hoped to share it with her son when he grew up one day, and she pressed and saved every flower she received into the journal.

Affirmations

Pregnancy affirmations, the themes of which related to topics such as “my body”, “my baby”, “my birth”, and “my recovery” were given on a handout. These were recommended by Verny (2002) and DiCamillo (2016) in prenatal music therapy courses as preparation for labor. When Y. was asked whether there was an affirmation that gave her an emotional reaction, Y. shared that she chose to make herself beautiful. She did not want to wear baggy clothes. The affirmation was, “I choose to feel beautiful, vibrant and healthy.” She rejected the idea that she had to sleep or watch TV all day as a pregnant woman.

Museum of Motherhood and Clay

When S. “visited” the museum of motherhood to make a statue of what motherhood meant to her, she made an anchor. She then described her symbol, elucidating what motherhood meant to her:

> As mothers we provide that safe haven, that security, serenity, we are always checking up. We are always asking are you good? Hey what's up, are you sick, are you tired, why are you not speaking? As mothers we have to play role as father, mother, the doctor, the teacher, a whole lot of roles in one and it's an honor actually…The job is never done.

This intervention was one in which the women could discover their attitudes about motherhood and what role they believed mothers should play.

Three Circles

This involved a paper with three blank circles, called the “three circles technique” (dos Santos & Wagner, 2018). Three sections of Vivaldi from the Four Seasons were played as the women drew within the three circles. The women were asked what the music reminded them of their pre-pregnancy past, their present pregnant state, and their future after the baby was born. Y. shared, “This triggered the idea of the relationship my father will have with the baby. He loves her a lot and is very supportive in everything.” I probed her further: “What kind of relationship did you have with your father growing up?” Y. replied, “My mother used me as an object because my parents split before I was born. She would always say no when my father wanted to see me. Despite that he would come and see me when my mom

wasn't home, he would take me to buy clothes." "So, you felt despite what your mom was doing you could see that your father loved you?" I responded. Y. shared more about her support system and her experience with the three circles and improvisation techniques:

> It felt good. It represented the space that I'm in right now. The people around me. I'm at peace with everything and I have a very good support system and all of my family. It [the musical improvisation we did] kind of cheered me up…I love myself. I do love myself. I'm at peace. Sometimes I feel I can't wait to give birth so I won't have a big stomach anymore. I want to wear nice tops and jeans. I feel sad so that I can go back to normal again…This [referring to the first circle] is my support system-the heart means we love each other, we understand each other. We're really supportive. When I need to talk I know [my grandma is] always there. This [referring to the next circle] is my family. For some reason they are all girls but it's fine.

This observation caused us both to laugh. She continued:

> In my family, family always comes first and we always support each other. It feels like they're the ones who are pregnant, not me. I will know when it's too much. Especially my brothers. Must I massage your feet? The younger one will take my legs and put them on the top. I will say I'm fine, not in the mood for this. The brother says I don't want you to wake up with sore feet. Sometimes I feel like when are you coming out…I'm so tired now. But all in all it's good.

I told her, "The sense that I'm getting right now is that this is a lucky baby. She's going to be coming to a very supportive and happy family to welcome her." The three circle technique prompted rich imagery and helped to facilitate discussion about the participants' current situations. It was ranked highly by every group member.

Relaxation and breathing

Because too much stress is considered developmentally undesirable for the growing baby (Nwebube, Glover, & Stewart, 2017), relaxation and breathing are priorities for pregnant women (Lothian, 2011). As discussed, relaxation and breathing were important parts of each session for these pregnant women. Besides the benefits of stress reduction (Sidorenko, 2000), it also served as a way to debrief from a more in-depth technique such as the three circles. In H.'s session, we listened to Judy Collins' *Across the Morning Sky* with lyrics that included, "I do not count the time." We reflected on the theme of letting go, acceptance, and acknowledging the impermanence of everything (a phrase present in the lyrics). As we closed our eyes, I said, "You can reflect on lavender, the color and scent of peace and serenity and soothing. You can send soothing thoughts to the baby as well... "I will still be here, I have no thought of leaving," sang Judy Collins. H. swayed slightly to the music. The song ended and H. said, "I'm really gonna miss you."

5.9 Conclusion

The voices of these women from this area of the world deserved to be heard. It is an area rife with violence, substance abuse, and poverty. As pregnant women the participants in this study were especially vulnerable. They reported that four sessions of music therapy provided notable resources for them: It gave a space to play, to reflect, to express emotions in creative ways, to build resilience, to relax, to be understood, and to develop connection with the other group members and with the baby. The women also mentioned that their interest in music had stemmed from their childhood, and that the experience of music therapy was at times tiring and intense. Music therapy was also a support for women who were experiencing problems in their relationships at home, whether through IPV or with parental or child relationship difficulties. While the first four themes clearly addressed my first research question, the fifth and final theme, affordances of the therapeutic relationship, addressed my second research question. My role as music therapist became important from a feminist perspective to provide an egalitarian space where power balances could be tested. I sought to provide the safe place in which a trusting relationship could be developed, and I provided the musical framework from which the women could explore.

It became apparent what techniques were most useful to these women in this process. With this group of women, the reflective and receptive techniques appeared to provide the most perceived benefits. Based on the experiences these women had,

music therapy is a promising treatment option for pregnant women as a way to both prepare to attach to the baby and as a way to strengthen self through connecting with others and building internal resources while in an environment of distress.

Chapter 6: Conclusion

6.1 Conclusion

This study, involving a thematic analysis of thick descriptions of seven sessions with five pregnant women and a final interview and focus group, took place over the course of four weeks. The women came from neighborhoods of Cape Town within the Cape Flats, an area rife with poverty, crime, and health problems due to gang violence. They were reported to be “in distress” by the Perinatal Mental Health Project. My two research questions were: How did these women experience music therapy? And which techniques did they prefer?

The women reported experiencing the sessions as a space of personal exploration, as a space to connect with others and with the baby, and as a regenerative space. Their preferred techniques were rated using rating scales as well as discussed on the final day of therapy, and included the relaxations to music, visualizations, three circle technique, mandalas, and journaling.

Other studies have found that receptive music therapy, using techniques that are more music-listening based, have been the preferred methods for prenatal music therapy. That was also the case, in general, with the women in this study. The unexpected findings included the value the women received from the therapy as domestic abuse survivors. In fact, the sharing of stories from these women created a picture of what they were facing as pregnant women in distress. From going into witness protection, getting expelled from home, facing divorce, having absent or abusive partners, experiencing debilitating anxiety, to surviving gang violence, these women bravely chose to open up and share with one another. Witnessing is one of the primary goals of therapy (Lord, 2008), and is valuable in research so that this client population can be better served.

Another finding was that the music therapy was experienced as more intense than verbal therapy, which, given the nature of the brief amount of time we spent in sessions together, was unexpected. Also, “letting go” as a means to reach acceptance rather than catharsis, was a meaningful result that emerged from the women’s stories during our therapy process, and one that felt especially relevant in preparation for labor and birth as a physical letting go is required.

It is my hope that sharing these participants' experiences will provide insight into what might be useful with this population in regards to music therapy, and that research on music therapy and pregnant women in distress can be expanded.

6.2 Limitations of the study

There are several potential limitations of this study. One constraint during the study was time. After obtaining permission from the PMHP, the government, and the director of the MOU itself to conduct the study, there was only a period of less than a month to find pregnant women who qualified and consented to participate, which relates to the second constraint, a small sample size, and the third, a limited number of sessions. All of these factors, in addition to the nature of the study as qualitative, lead to an inability to generalize the research findings.

Furthermore, some data obtained, such as the preferences of certain musical interventions, came after only five minutes of participation in a session. For data collection to become more significant, more in-depth amounts of time should be spent on each intervention in order to obtain a more accurate response.

Another potential limitation to consider is my lack of background on early childhood African music and lullabies as an American visitor to the country. Perhaps someone from South Africa would be more familiar with local rhythms and melodies which could illicit new and different responses.

6.3 Recommendations for future research

There are several avenues to continue with the study of the use of music therapy with this client population that are related to my findings. The following five questions are potential fodder for future research.

First, what draws adults to pursue music therapy as opposed to other therapies? In my study, it briefly was shared by most participants that positive childhood experiences, combined with curiosity, led them to request a music therapy session. More studies are needed on the reasons people actively seek out music therapy.

Second, what African music for babies is preferred during pregnancy? The women mentioned some preferred music, but due to the dearth of studies of music

therapy in pregnancy on the African continent, there is not much literature on which local music is preferred during pregnancy, or which lullabies are sung most.

Third, how would results vary if the therapy period were extended through pregnancy? This was a short-term intervention. More studies are needed on the use of music therapy throughout the entire prenatal period and on the efficacy of various techniques over more sessions.

Fourth, how can the qualities of “letting go” and “release” be used to support and prepare pregnant women for labor in music therapy? This is in reference to acceptance rather than catharsis.

Fifth, a larger sample size with quantitative methodology and assessment is recommended. The frontier of music therapy during pregnancy using RCTs is still greatly unexplored. In 2017 a systematic review was conducted to determine the effectiveness of using music-based interventions to reduce levels of stress or anxiety in pregnant women. While it was found that anxiety was significantly reduced, it was also found that additional research with higher quality methodology and greater rigor of assessment would be valuable (van Willeswaard, K., et. al, 2017).

This research was important from the feminist research perspective, emphasizing that all deserve access to quality health care. It was found that music therapy could be a supportive, resilience-promoting, playful, reflective, expressive, creative, relaxing, connection-building space for these women. There is vast potential for music therapy to be provided prenatally.

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Appendix A

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Music

PARTICIPANT INFORMATION AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT: Mother voices: An exploratory study on the experiences of music therapy for pregnant women in distress from the Cape Flats

PRINCIPAL INVESTIGATOR: Kalli Hiller

CONTACT NUMBER: 0629403161

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this study. Please ask your doctor any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to take part. If you say

no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you initially agree to take part. *Because the therapy will take place as a group, I cannot guarantee confidentiality by the other members, though each member will be asked to keep the sessions and their content confidential.*

What is this research study all about?

- *I am interested in learning about the experiences of music therapy for women with prenatal distress..*
- *You are invited to participate in music therapy process.*
- *The sessions will be recorded.*
- *You can attend from one to four sessions according to what you feel able.*
- *In the sessions, we will do activities such as music-based relaxation, songwriting, lyric discussion, and music listening.*

Will you benefit from taking part in this research?

- *The benefits of this study will include future researchers understanding more about how music therapy can help women experiencing prenatal distress. You may also find that music therapy is beneficial for you personally.*
- *If you feel that you would like additional support after the session(s), you will be referred to the counselor that you are seeing at the MOU.*

Who will have access to your medical records?

- *Your identity will remain confidential.*
- *Future researchers may use data gleaned from this research in their studies.*

Will you be paid to take part in this study and are there any costs involved?

- *No, you will not be paid to take part in the study. There will be no costs involved for you, if you do take part. Transport will be provided, and a journal to record your thoughts and feelings.*

Declaration by participant

By signing below, I ……..……. agree to take part in this research study

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressured to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 2005.

Signature of participant

Signed at (*place*) .....…..…….. on (*date*) ……...…….. .

Signature of researcher

Signed at (*place*) .....…..…….. on (*date*) ……...……..

Signature of supervisor

Kalli Hiller

Session Time Sign Up Form

Four group music therapy sessions will be offered in the month of _____, 2018 at the following times:

Tuesday afternoons from 3 to 3:45 pm (taxi pick up time at 2:30)

Tuesday mornings from 10 to 10:45 am (taxi pick up time at 9:30)

Please **circle the time** you prefer.

You will be sent a reminder about the session via text the day before.

Please list your **name and phone number** here to receive the text:

_____

The sessions will be offered free of charge. Furthermore, you will be provided taxi transport free of charge with an Intercab to come to and from the sessions. In order to book the taxi, please write the address you would like to be picked up from and returned to on the days of the session.

Address to be picked up before the session

Kalli Hiller

_____

Address to be dropped off after the session

_____

Should you have any questions, please contact Kalli at 062 940 3161.

Appendix B: Questionnaire

Note: There are no wrong answers. This is only for me to get to know you better.

1. How is music part of your life right now?

2. What kind of music do you like?

3. Is there any kind of music that you don't like? What is it?

4. Who is your favorite band or performer?

5. What are some memorable experiences you've had with music?

6. How are you experiencing your pregnancy so far? How do you feel about your upcoming labor and birth?

7. Do you expect to feel attached to/connected to/loving towards your baby once he or she arrives? Why/Why not?

8. How do you feel towards your baby at the moment? Why?

9. Do you know or spend time with any ladies who are going through similar experiences?

10. How is depression affecting your life right now?

Kalli Hiller

Final session interview questions

1. How, if at all, did music play a role in your life as a child?

2. What concerns do you have about your upcoming labor and birth? Did today's session address those concerns in any way? Please explain.

3. How did you experience the music therapy session(s)?

4. Did you prefer listening to music or making music or both?

5. What was useful about this process for you? What was less useful?

6. Has your view of yourself, your pregnancy, or of music changed after the sessions? If so, how?

7. How did you experience music therapy differently than verbal counseling?

8. Did music therapy relieve any symptoms of depression, and if so, how?

9. Did you keep a journal about your experiences with breathing and music listening? What was it like to do these techniques at home?

10. Is there anything else you would like to add?

Kalli Hiller

Kalli Hiller

Appendix C: Thick Descriptions

Session 1

"So I think we're gonna start. I'd like to just go around the room and have everyone say their name, how many months along you are, and then you can make a movement to show how you're feeling. Any movement." A little bit of nervous laughter from everyone and then I ask, "Who wants to start?"

Emotional expression: nervous laughter

"Ok. I'm S. I'm four months, having my fifth child, and I'm feeling all right." She gives the slightest movement with her hand. It's almost imperceptibly the thumbs up. "Let's see a movement; is this your movement?" I demonstrate the thumbs up.

Body language: Member opts for what she says is the easiest

Emotional expression:

"Yes I think that's the easiest," says S.

"I'm A., I'm also four months pregnant, and I'm feeling oh, wow." Her face breaks out into a big smile. She cradles herself in a hug and speaks in a whisper. "I can't wait to hold this baby." S. says, "You are excited." "Yeah I am" affirms A."That's great," I say. "Is it your first baby?" asks S. "No, it's my second. My other one is disabled."

Body language: Member shows how excited she feels for the future

Empathic resonance with other's expression

"I'm Y. and I'm seven months pregnant," says Y. "You're carrying so small," says S. "I'm feeling great," says Y. She shakes her fingers in a wave.

Emotional expression: feeling great

H. is almost not visible in the camera. Her movements are small and uncertain. Her hand wavers back and forth and she sits quite still. "My name is H. I'm three months along, I knew at six weeks. Which isn't usually the case. I'm feeling somewhere in between. I'm anxious, scared, depressed," says H. in a barely audible voice. "Mixed feelings," says S. "Mixed feelings," agrees H. "Great," I say and then I conclude the introductions with my own.

Body language: small, uncertain, still

Member has difficulty expressing and another member of the group puts it as 'mixed feelings'

Emotional expression: anxious, scared, depressed

"I'm Kalli and I'm feeling: Woo we're gonna do this, it's time!" My hands do an explosive, fireworks motion. I continue:

Therapist contributes feelings to continue solidarity within group

"I brought journals. What I'm going to talk about…So, the journals are for several things. They are for you to use as you like. There are a couple things I can suggest you can use them for. Does anyone keep a journal?" A. and Y. shake their heads no. "I used to keep a journal but I stopped writing," says H. "I was in my teens," says S. "First one thing you can use it for is a dream journal…" I continue on to explain journals and affirmations and relaxation to music.

Feedback about journaling as a teenager but no longer

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Energy: stilted within the extremely small space. Silence, uncertainty prevail in the first session

Everyone sits with their eyes closed. Not every face is visible. H. is silent the whole session. Y. is considering her surroundings and doesn't offer much. A. appears suspicious as she glances around the room frequently, even though it is a relaxation intervention. The energy is stilted but the room is so small as to not allow much movement at all. I've already removed several chairs from the room, and there's a container full of magazines, a refrigerator, and a tray with condiments behind us. The space is extremely limited and one that doesn't allow for much 'vital' movement. Nevertheless, it's also the first time we all meet and the uncertainty is apparent. When I leave the room, no one speaks. Friendships are not formed and the members of the group come from the variety of backgrounds that can be expected in a South African context. I begin with the following words: "Take the time to honor the fact that you're here and you're doing something for yourself. It's an amazing gift. Let's stretch your head a little bit, and roll your shoulders.Take in a deep breath in through your nose and out through your mouth, and again through your nose. Relax each part of your body, sit back in your chair and get as comfortable as you can. Feel your feet, feel how they're positioned, feel which way they're facing. Tighten your toes, breathe in from your nose, and out through your mouth. You can wiggle your toes and relax.And squeeze and tighten and release...Just appreciate this moment. Next is buttocks, pelvis, and stomach and relax, and breathe in and out. Tighten the fingers.The right environment is so important for you and the baby...Provide that space of caring for yourself..despite everything else that might be going on in your life...to sometimes take a few moments to just breathe. Tighten your shoulders and lift them up to your ears and breathe. You can tighten your face and squeeze your nose, notice how your face feels, all the muscles in your face." S's posture truly does appear relaxed. S. used her hand to squeeze her nose. I say "Notice how your face feels." The words I'm speaking are coming to me in spacious periods. As their therapist, I sense they appear to truly be resting. The music playing is the sound of water flowing. As it comes to an end I have to move to change the song and I choose Beethoven's Moonlight Sonata. I don't break the silence with speaking. My head is bent with a slight smile, but something I think of to move into inviting people to slowly open the eyes--before the song is ended which is a bit jarring, however I ask if they are feeling sleepy. S. says "completely relaxed". I invite the others to look for that music or musician and give themselves 10 minutes a day to relax. Babies can hear outside of the belly I explain. "It's going to be different for every person. Babies are sensitive to really loud or intense music, but any kind of music that is your kind of

genre, babies often like the same music that the moms like, the same hormones are released and the same pleasure is received. Take the time during the day and listen to the music you like, and give yourself that gift." I do most of the talking in this session, especially with all the administrative tasks that needs to be done. The energy and facial expression from A. made me doubt she would return, and in fact she never did, nor did I get any feedback from her about her experience of the session.

Session 2

I hesitantly ask people to share and H starts, though she usually does not. H. shares, "I chose this [a postcard image of a sandy and vast desert] because I feel lonely, there's a lot going on right now, the desert is always lonely and empty…and I like this color [green stone] it reminds me of forestry, trees. Have you been to Kirstenbosch? I love that place. I haven't been in a while." Despite the content of her words, H. speaks with a smile and seems upbeat. She says the desert is always lonely and S interjects with how empty it can feel. H. doesn't look at the rest of the group when she is sharing, she appears to be magnetically drawn toward one person. Most often this is the therapist. S. says she chose her postcard because of her children. "This is how colorful my life is every day…You can try how hard to be serious, they can make you laugh even when you're angry, it's like a cartoon," asserts S. emphatically, with eyes widely open. The other women are smiling. Others respond affirmatively and laugh with her. Regarding her natural object S. says that what she likes about her rock is, "The orange color and the smoothness of it, but my life is not this smooth." Y. says, "I'm in a great space now in my life. I like the color pink, and also these things are so beautiful I love them, pink is a representation of love. I'm filled with lots of love these days. I don't know why. Maybe something good will happen." She waves her hands around to demonstrate and her body shimmies with a youthful and optimistic energy. She chose small pink beads as her natural object. S. gives encouraging "hmms"showing active listening. She likes to be a "co-therapist" and provide advice and insight. She looks around at everyone and as the oldest of the group, provides a mothering and nurturing energy. I introduce a shift by asking: "Just wondered if anyone had any experience over the last week with affirmations, or music?" S. then responds, "I have a poem in my head but it completely represents what I think

Emotional expression: relaxed

Member offers advice

Therapist provides verbal advice and scientific information

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motherhood is going to be like. The poem is my little masterpiece." She then recites with confidence:

With your first kick

I'm like shocked cause I know that there's growth inside of me

And then when you're born and they place you on my belly and your umbilical cord is still connected

First thing I do

I check nose in place, eyes in place, mouth in place, ten fingers, ten toes,

I'm grateful I hold you in my arms every day

You clutching to my breast staring me in the eye when suckling and I stare back

And I'm so grateful and I say a little prayer and I say shukriya for my perfect masterpiece

And I hope that you bless my child with the character of (unintelligible)

I say "Wow, amazing." S. affirms, "I've had that in my mind in the whole week…"

The others nod and are captivated. H. laughs at the counting body parts section and interjects, "A natural mom instinct!" The rest of the group is smiling and affirming her experience. H. worries that what she could share " is too negative". I reassure her that the "journal is for negative feelings." Her eyes are glued to mine. She is still, he voice is soft, and her eyes seem to be seeking affirmation.

Reflection on image: Sharing about feelings of loneliness

Sense of connection to baby

Feelings toward child: Expresses gratitude for having a baby

Feelings toward child: expresses wishes for

Empathic resonance with other's

by group

Celebrating what mothers do instinctively

Looking for affirmation in the therapy space

Reflection on object: Reminisces on a location she loves in nature

Focuses on sharing with MT rather than with other

Empathic resonance among group

Wish for a

Feelings toward child: views child as perfect

Validation

Sharing humor

Member plays

Member's concern about disturbing positive group sharing with negative

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Individual Session with Y.

Curiosity to try the instruments

Space of exploration

Therapist introduces shift through tempo

Musical quality of instrument playing: Cautious and wary

Client plays the instrument in a new way causing a shift in our improvisation

Quality of music: loud and rollicking

sense of joy

Light mood

Surprise and spontaneity induce laughter, sense of humor

Quality of instrument playing: caressing

Enjoyment

As I explain what the improvisation is about, Y. is lifting and examining instruments, touching and feeling them. She does this even as I am speaking, like her curiosity is too great to wait. It is our first improvisation together just she and I. We are exploring and testing out this improvisational experience together. Her movements are fast as she experiments, yet for some reason I start on the keyboard softly. This causes her to then change her playing to be slow and quiet. Her mallet slowly moves up the wooden scraper, slower and slower until it stops. Her face is focused and not looking at me, but at the instrument, rather. She stops to look up at me only occasionally. The energy is contained and enclosed. She stops to look inside of her instrument. This action prompts me to invite her to change instruments if she liked. “There’s the guitar, or…” She laughs at the idea of playing guitar. Her laughter is easy and comfortable. However her playing is cautious. She does change instruments, and again it is hesitant. She does not want to look at me. She uses two fingers to rub the instrument. She shakes it after stroking it. As her movements are hesitant, she appears to be waiting for something to change. A musical shift then occurs when Y. tries a different way of striking the instrument which causes me, the therapist at the piano, to speed up the tempo. As the music changes and grows louder and rollicking her body language changes with it and she smiles and shakes her instrument boldly back and forth. Judging by the change in her body language, she is grooving with the beat. Her head is moving back and forth. There is a sense of joy. We are dancing together literally and metaphorically. The mood is light. I change the tempo and she follows. She begins to shake her instrument all around the room, allowing for more full body expression and movement. This is a moment that she demonstrates her ability to alter the tempo too. Laughter and humor ensue as there is an element of surprise in the spontaneity of our expression. The energy explodes upward. My piano playing responds with a tremble. After this climax the music decrescendos. It slows to a pause and seeming end. She plays the cabasa caressingly. However, rather than stopping altogether, she holds the instruments in a new way and introduces a new beat which I then extend. It sounds like a clock ticking impatiently. After the tick tocking, we move into rolling arpeggios. We lean into a decresendo by running our fingers over our instruments and the song is finished. She says, “That was good. It was nice, it was fun. Yeah! Cool, I enjoyed it.” Throughout the playing there is a

Discrepancies in energy between therapist and client

Member’s focus is internal

Energy is contained and closed

Client is waiting for a shift or change

Therapist responds to client: tempo increase

Body language: bold and smiling, grooving with the beat

Dancing together

Feeling comfortable to express full body movements

Energy: upward and explosive

Client introduces new beat to extend improvisation

Reciprocity and being together

sense of reciprocity, of dynamic interaction. We laugh and have a shared moment of being together.

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S. is shuffling and organizing the postcards and smiling. R. is her youngest daughter and S. has decided to bring her to the session for the first time. This is S's third session. This improvisation is meant to launch a conversation and allow some emotional expression. My instructions are, "While thinking about your support system or how you connect with your partner, you can choose an instrument you like to play and we're gonna make a song together, you're welcome to play." S. tries out the cabasa with a quick shake as I'm talking. R. immediately plays on the frog instrument and follows my rhythm. I am playing the keyboard. R. can barely contain her curiosity about the instruments. When I look away or need to leave the room she takes the opportunity to quickly examine or play the instruments surreptitiously. The energy of the music is percussive and driving, and then my accompaniment introduces a shift by beginning the song "Hallelujah". There is a repeated rhythm together that we follow and a sense of a lack of flexibility. While I am exploratory, lilting, and melodic on my instrument, I am quite dominant as to determining the kind of song. It feels as though S. is unassumingly along for the ride. Perhaps as this is a first time for instrumental improvisation she is waiting to see and understand what is to be expected. There is a sense of submissively following and going with the flow. S. often speaks of submission, to God's plan, to hope, to waiting to see what her partner would decide. The music slows, and it appears we may be coming to a stop. R. scrapes her instrument to encourage us to continue and so the song picks up again. S. is steady and does not take the lead. She is clearly following the lead of the MT. This is a direct contrast to the fact that when speaking she normally does dominate. The improvisation, therefore, is a new way of experiencing interaction. The music is dynamic, fast, and full-toned, and doesn't seem to ever pause, similar to the chattiness that S. often brings to the therapy session. S. looks over at R. They are having a shared experience it seems, as evidenced by the mutual eye contact and smiles. We move into an accelerating crescendo. We try to stop at the same time. It doesn't quite happen, and we all laugh together. S. says "nice one". R. says her instrument, the first she has ever played, sounds like a frog. We move into the three circles intervention and I use the word "reflect" which is one that S. often uses--she has a keepsake box, where she saves her journal and flowers. S. often reiterates that for her these sessions contain elements that she can reflect on during the week, and furthermore she wishes to record her experiences to be able to reflect on them later. The Vivaldi strings start for the next intervention..

Barely contained curiosity and interest in instruments

A lack of flexibility and a repeated rhythm by the therapist

Role reversal (follows in music, leads verbally); experiencing new ways of

Experience of mother-daughter connectedness

Laughter and enjoyment

Music therapy as a space of and opportunity for reflection

Energy: percussive and driving

A sense of waiting by the client to understand what is expected in the improvisation

Client reflection: Submission to God's plan, to hope, to partner

Music quality: dynamic, fast, full-toned, lacking pauses

Member expresses desire to record experiences

Kalli Hiller

Individual session with M.

M., her brother, and I are seated at the table in what is our first and last session, about halfway through the session. I explain what the next intervention is going to be. “We are going to do a kind of visualization where we are going to be walking through a museum and afterwards we are going to do a clay thing. But if you can just imagine…Have you been to a museum before?” -”Yeah” she interrupts. I quickly continue, “It’s called the museum of motherhood.” The recorded music from the iPhone begins. “Who can say where the road goes,” sings Enya.

“So when you’re walking through there, you open the door and go inside. There’s a lot of statues. And there’s statues that represent what motherhood means. You can take some time walking around and looking at the statues.” About a minute of listening to the music, and I begin speaking again. My voice is slow and measured. “And perhaps one of the statues speaks to you…what would that statue say.” More silence ensues. The music continues. M.’s eyes remain closed.

“How does it feel inside the museum?” I ask. My guitar falls over and jars us . I decide to turn the music off and begin the next portion.

“What we’re gonna do now is we can make the statue inside the museum with clay.” I pass her the clay, she grins and I laugh a little. “I will make one with you. Actually I do have another clay.” I get it out of my bag. We sit in silence and make our statues. The silence is for about three minutes. M.’s most frequent movement is rolling of her clay.

Sharing humour together between

“Would you like to share first or shall I?” “I can’t pick it up” she says. We laugh together. “You don’t have to pick it up” I say. “It’s a mother breastfeeding her baby.” says M. “Lovely,” I say, “you can breastfeed lying down, so it’s fine.” “Is there anything that the statue had a message for you?” I ask.

Symbol: pure love between mother and baby

“I don’t know. For me they are both naked, so something like pure love.” She rubs her hand over her neck where large bruises peek out of the top of her shirt. “Pure love pure trust” I say.

(At the end of the session M. shares she feels more bonded to her baby.)

Kalli Hiller

Individual session with H.

The clip starts with the instruction regarding the final circle in the three circle activity. It is “one final reflection of what you see your relationship and support system looking like in the future.”

Beginning to open up within the space; feeling safe

Body language: Hunched posture and focused facial expression

H. is a Muslim woman who comes each week dressed in a niqab. She uncovers her face during the session, however. Vivaldi’s Four Seasons symphony is playing. H.’s body language is hunched. Her face is focused. She peeks over at what I’m doing. She finishes her art before me and stares at the page, seeming lost in contemplation. The music fades away. She shakes her head. Her eyes dart, she laughs, and her fingers splay. To encourage her to begin sharing about what she has just experienced with the three circle art intervention, I say, “Were you just kind of going with the colors that you felt?” “But I can explain to you what it's about,” she says. Her voice is soft. “This is how I feel most of the time, like my life is just dark, so I chose the color black. There's a storm inside me to get out or get through. And then these are the people that I love very very dearly. The one passed away. This is the color that came to my mind because he was always a bright person and made me laugh. It's my uncle; he passed away of cancer. This is the color that I think about my spouse, he's also a nice color I think.” Her voice breaks a bit. “Because there are barriers in my life blocking me from people that I love.” “Do you want to describe more to me about the barriers? What kind of barriers are they. How are they blocking you from the people that you love?” I ask. “I don't know how to love,” Haneefah is crying. The room is quiet and yet it is difficult to hear her. The energy is muted. It is like the voice coming from someone who has been silenced. We nod together at each other. The song with its stringed instruments is not intentionally a sad-sounding song, and yet when given that space to reflect it seems she goes to a place of sorrow. Her face clouds over. Tears begin to fall and she wipes them. As she blows her nose, she is a forlorn figure. As her therapist I sit without moving. I fumble over my words. There is space between the words I speak. I do not know the depths of her experience; this is our third session and she has not spoken much before. The shift that occurs here is the appearance of tears. Normally she enjoys speaking about her strengths and her power and needing to control, and even her anger but here she is vulnerable. She did not or could not share her exact narrative in our sessions, but

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she was able to express and feel through the music and art what she could not articulate.

Curiosity

Emotional state: contemplation

Hesitancy to share

Reflection: Member claims her ability to interpret own

Voice: soft and cautious

Emotional expression: life is dark

Symbol: storm

Reflection: loss of loved one and loss of brightness

Symbol: barrier

Energy levels: muted

Not knowing how to love

Emerging voice

Emotional expression: sorrow

A sense of not knowing

Emotional shift: appearance of tears in contrast to the usual presentation to stay in control

Emotional expression: Allowing vulnerability and release of self-professed anger and need to control via art and music

Kalli Hiller

Final group session

I'm playing and singing "You Are My Sunshine" on the guitar. They sit in silence and I transpose the song to a lower key. They sing louder with me than they have before. They all know the song. Their voices are fuller and more present in the room. I continue humming and strumming. They begin to explore in the fill-in-the-blank worksheet with the lyrics from "You Are My Sunshine" I've handed out. Unfortunately Y. is only occasionally in the screen. She is sitting closer to the rest of the group than she has in previous sessions. H. says "Oh!" and erases, causing Y. to laugh. There is a sense of camaraderie through acknowledging others contributions and openly sharing more personal experiences. I explain that everyone can share but only if they want to. S. shares first as is her typical role. She shares her lyric re-writing of "You Are My Sunshine." She says, "I chose 'You are my baby, my last-born'"-and her emphasis on these words causes everyone to laugh. After all, she has shared enough about her personal situation that everyone knows this baby was a big surprise--and she already has four. "You're sending a message to this one!" I say. "Yes, and to my body,"says S. She doesn't change the rest of the lyrics from the original song and says "it's okay" when I ask if she wants us to sing through it. H. sits with her head bowed not looking up. I explain the idea that if you know the lullaby you can change some words and make it special for your baby. Y. shares. She calls her baby her angel, her only angel: "because she is an angel" says Y. and S. reassures her that the baby is coming. "Don't worry" she says--knowing that Y. is eight months into her pregnancy and ready to wear cute clothes again. The atmosphere is supportive and encouraging. There is a clear framework to work within. The worksheet provides a way to create new lyrics while retaining the familiar tune, which makes participation musically easier. In other songs in the past the singing was quite out of tune; for some reason, today, it's not. Already, they are feeling more comfortable to reach out and grab a strawberry during the session, so freedom of movement and freedom to share began to increase. More talking, more sharing, more laughing, more singing: their voices are beginning to be heard. After only three sessions together (one session was individual) it feels like the group feels comfortable to share personal experiences and insight, such as accidental pregnancy and anxiety about labor, with one another.

Increased vocal presence and participation

Development of camaraderie

Willingness to share

Sense of humour

Awareness of one another's stories through group sharing

Member opts out of singing her song

Expression towards baby: you are an angel

Empathic resonance with other's expression

Supportive and encouraging atmosphere

Structure and familiarity allow for easier participation

Musical quality: singing in tune (shift from previously)

Emerging voices

Increase in sharing, freedom of movement, and freedom of expression

Kalli Hiller

M. Final Interview

KH: This is…this is my first time asking these questions. It feels like it's funny to do it on a one on one position because it's actually difficult to say…What was more useful for your particular situation…For someone who is experiencing anxiety.

Client found relaxation most useful for her anxiety

M: The relaxation. [instantly]

KH: So just to take a moment to breathe and to focus. Do you think that you have some songs at home, to take the time before bed and breathe and practice on it at home and reflect on it in the journal?

M.: [nods, agrees].

KH: What is different doing this compared to verbal experience. Do you also go to talking counseling, or not very much?

M: Not really anymore.

KH: But you have done it before. What's the difference between that and what you just did.

MT is more relaxing than verbal counseling

M: It's more relaxing and it makes you think…[trailing off].

Music therapy offers space for reflection

KH: So it kind of brings up different things than regular counseling might?

M: [nods and agrees.]

KH: What would be an example of what has come up for you?

[She speaks so quietly it's impossible to hear even in the session.]

KH: Perhaps was it the thinking of, the clay for example, bringing up different ideas…

It's more focused on the baby. Whereas perhaps in the traditional counseling you're only talking about you. I don't know actually, I've never done counseling here. The point of this study is not to say one is better or worse, just what would music therapy offer that is different. Did you like listening to music, making music, or both?

Client preferred listening to music

M: Listening.

KH: The kind of music that was used was like, relaxing? Okay.

KH: Did you have music as a child growing up?

Client grew up in a musical family

M: Yeah, there's a lot of musicians in our family.

KH: Really? So music's a big part of your heritage. You mentioned that you played the guitar.

M: No not really, but I still have one at home.

KH: But you don't really get it out and play or anything?

M: No.

KH: Well it's awesome you still have one. A lot of kids love to play guitar. How old are you?

M: I'm 18.

KH: Would you say your view of yourself or your pregnancy changed? Did anything shift or open?

Client felt more connected to the baby after the session

M: Maybe…connecting more with the baby.

KH: Was there anything else you'd like me to know about you, the experience, it can be negative, this did not work.

Client found session tiring (and is tired overall)

M: Tiring. [right away].

KH: Because it's a new experience and that takes a lot of energy, yeah, I can see that. Are you able to rest a lot at home. Are you a student?

M: No, I'm not. I sleep a lot but I like to get out and do something…but I'm just too tired. I don't like going too far too long because I have nausea.

KH: So it's best to do short things and then go back home and rest. Well, thank you so much for coming today, and that you helped me with my study, and thank you too [to brother], it's amazing you had someone to come out and try it with you…

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Focus group

Women are ages 37 (S.), 20 (Y.), and 28 (H.)

KH: Was there music in your house?

Music pervasive in childhood home

Diverse music in childhood home

Y: There was a lot of music in my house, my mom, my aunt loved to sing, my uncle was a rapper. There was a lot of music. [With an enthusiastic tone of voice and body language]

S: There was a lot of diversity.

Music pervasive part of client's life

Love of music in childhood home

Y: Yes. My old uncle loved music, he would play Akile, Michael Bolton, who's that other guy now, Asha, there was a lot of music, I am exposed to music. Even with my grandmother, my grandmother loved music, everyone at home.

Client's children introduce her to diverse

S: It's always been a part of my life, with my kids it's a whole diversity as well, cause from 18 up to 8, they all bring a different genre of music, that I fall into, it's like new things they would bring that I would adjust to and like.

Less exposure to music as an adult

H: I'm not exposed to music so much anymore.

KH: But as a child you were? As a child what were you surrounded by?

Preference for gentle music

H: When I could choose my own it was always...soft...ballet…

KH: Classical?

H: Classical, yes.

KH: So have any of your concerns come up about your upcoming labor and birth in the music therapy sessions and if so what, how?

Clients share stories about difficult parts of birth with clients who have not given birth

S: [laughing] I think we covered everything today. With our experience we scared you a bit. [Referring to stories of labor and birth pain.]

Y: Yes you did scare me; now I'm terrified.

Some clients made other clients more concerned

S: But you shouldn't be, you should tell yourself it's not what other women are gonna go through, it's what I'm going to go through.

Clients reassure one another

Advice from one member to another member: focus on your individual experience

Learning from one another

Y: But I will definitely do the squats. Starting today.

S: Even the breathing techniques, you should start taking on the breathing techniques, especially at night when you cannot sleep.

Some group members took on a mentorship/leadership role

Sharing experiences of difficulties sleeping

Y: Yes I cannot sleep now ! [agrees emphatically].

Advice from one member to another member: breathing techniques

S: When you are so exhausted, if you go and lie down in a certain position take the breathing on and you will definitely see a change.The relaxation breathing, in through your nose and out through your mouth, you'll see the relaxation that you're gonna get for you and the baby, and then I think you can go to sleep easier.

KH: Did any of that come up, with the music, or talking through it or anything.

Expressing a desire to have music during labor for its pain relief and relaxation properties

S: Like I said it would be nice to have music when you go into labor, it would relax your body and mind, it's gonna soothe you, it's gonna take away that pain, it's gonna make the pain easier.

Y: You're not allowed to go in with music?

H: Maybe we should change that.

KH: I wonder why they don't allow it, are they worried it will disturb the other women?

S: Probably yes, but I've never experienced birth with music.

KH: Well at least some of the practice of relaxation and breathing, and just being able to talk about other people with your concerns, and the ability to talk and throw ideas out and can I say a sisterhood of a shared experience?

Comfortable to express humour

H: My main concern is that my vagina is too small [smiling].

S: Believe me if you do your squats and relax more it's gonna open.

KH: It has for the first three hasn't it.[laughing].

S. tells H.: Your mind is on it too much.

KH: Easier said than done I guess.

S: I know that.

KH: But what was it like to listen versus actually making the music. What was helpful, what wasn't.

Music listening facilitated a range of emotions

S: For me the listening took me through all the stages, angry to relaxed, by listening to the music. That's why I think it would be a good thing to listen to music in labor.

Music listening led to relaxation

KH: Well, you can labor at home and you could use it up until that point in any event.

Members offering each other advice

S: You know I made a mistake with my first baby. I made myself a hot bath and that made my contractions go away, so please don't do that.

KH: That is the difficulty, because I wanted it to be comfortable and cozy, and I almost went to sleep. Some people can have water births, but ...

S: That's why I'm saying please don't do that. I did it and I made a big mistake.

Preference: relaxation, visualizations, and mandalas

H: I think I did enjoy the relaxation and visualization and mandalas the most, that's my favorite part.

S: You can see where you were going, where you are, and where you're going.

KH: The three circles activity that we did?

Three circles enabled reflection and insight

S: Yes, the healing power it has, you could have been in such a dark place before, and right now you're in such a good space. You can see where you've come from and where you're actually going.

Preferred activity: listening and visualization as a new experience

KH: And for you, Y., what was useful?

Y: I think listening is more useful and visualization. I liked both actually. I got to listen to the music and visualize and then I had to put them down, so that was kinda interesting. I never thought I would be able to do that, to create art afterward, everything…

Visualization and art creation increased sense of self

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KH: Great....Did anything about you or your view of your pregnancy or what's going on in your life right now, has it changed or shifted over the last few weeks?" I ask.

MT experienced as healing

S: I can personally say I've healed a lot. It's been amazing. From where I've come from and what I've been through in the past, like I lost my brother and I actually saw that, and this baby is a new beginning. My brother may be gone but it will be replaced by having a son again.

MT experienced as a space to embrace baby as a new beginning after loss

KH: Oh, so you know it's a boy. Have you thought about naming him after your brother?

S: His daughter is having a baby in October and she's naming her son after her dad and I don't want to steal that from her.

KH: Wow, two boys.

Client feels lucky to be expecting a boy

S: We've sort of been lucky.

KH: And anybody else want to add anything?

The sessions provided client with one place to share openly

MT perceived as an answer to prayer

Y: Actually I liked the sessions because I've been praying for something like this, because I felt like being pregnant and in the society where I come from, you can't speak about things openly. You can't speak about this or about that. When I say to my grandmother I wonder what happens when you go into labor she says you don't speak about stuff like that. I don't know what happens. It feels like you're in a shell. Sometimes you want to hear different experiences.

Sessions lessened feelings of isolation

Sessions enabled hearing about others' experiences

S: [at the same time] Different experiences.

Hearing the experiences of other women helped the client to relax

Y: So I've heard a lot, and it helped me relax a bit.

H. is on the phone saying where she is.

Sessions lessened feelings of isolation

S: And the fact that you're not going through it alone.

Y: Alone, yes that's what I like also.

KH: Do you need to go? Can I ask you a couple questions before you go?

[This is directed to H., whose ride is waiting for her.]

Expressing humour

H: Yes I can see you. [She's making a joke because she has covered up again. We laugh.]

KH: What was your experience with-did anything shift or change?

More positive life perception

H: My perception of life has changed, I don't see some things in such a dark way, I'm more positive, I smile more,

Expressing sadness that sessions have ended

and I'm actually sad that it's come to an end.

KH: The dark thing was big on your image, the biggest thing is on the other side.

Clients offer one another encouragement

S (to H.): You're doing things you still love, it's not that the dark thing is keeping you on the dark space.

Music therapy offers more than verbal therapy through symbols and other creative means

KH: For you what is different verbal counseling versus this, not to say one is better than the other. But just what is different.

H: Verbal counseling is just verbal. This is more..

Values the creativity of MT sessions

S: Creative

Client values how she can express her emotions through MT

H: This is getting out your emotions, colors and flowers, objects that you wouldn't think would mean something to you…

Values working with symbols in MT

[I pass her a flower.]

KH: Chrysanthemum is the symbol of the birth of the child.

Purple is also the symbol of rebirth.

MT allows more opportunities to be fully understood

KH: Did it help with any symptoms of depression or anxiety?

Music therapy allows more expression

H: It [music therapy] did help a lot. I would speak, with verbal sessions, I would still go home and still feel like you don't understand me, I didn't express myself. Here I leave all my negative energy and it doesn't go with me and it doesn't follow me, I don't know if that sounds good or what.

Release of 'negative energy'' in MT

Freedom from 'negative energy' after MT

KH: This is just your experience, there isn't good or bad, ugly is okay in this room. Did you want a chocolate, or a cracker, or a juice? [She's packing up to leave early.]

H: My kids are gonna be like what? I'm gonna hide this away.

KH: Do you need any supplement for the taxi? Sorry H., you can blame it on me.

[I tell her because she is running late.]Thank you so much for being here. You all brought something very special to the group; it wouldn't have been the same without you.

[She covers her face and leaves the room.]

Discussion about and coming to an understanding of cultural differences

Y: Must she wear the veil?

KH: Is it not a choice by the husband?

S: No, it's a choice by the wife. Sometimes when husband is jealous other men don't get to...you know? But it's the lady's choice at the end of the day.

Y: Even if the husband wants it?

S: It's the lady's choice at the end of the day.

Y: But isn't it hot, when you're wearing all black?

KH: I also thought that, but in Morocco ,the more loose clothing I wore the less hot I was so I was protected from the sun.

S: And the black keeps out heat.

Affirmation of different cultural expressions

Y: Oh….So she's very cool. [we all laugh].

KH: Well, I'm not sure; we'd have to ask her.

KH: We talked about how the view of yourself changed. So how did you experience it different than verbal counseling?

Creativity in MT enables expression

S: In the creativity, you could see it, by doing it, so it comes out in you, verbally you're just saying things and it's not really coming out. If you do creative things you're actually looking at it afterwards and you can say okay, this is what is actually going on.

KH: For you to be able to see it makes it feel more real and helps to make changes.

Externalisation through creativity enables insight

The process of music therapy works faster than traditional verbal therapy

Kalli Hiller

S: To be able to see it makes more sense as well.

Y: You can go through verbal counseling for years and be the same. With this at least it helps to get it out of your mind. They say writing something helps with forgetting and all of that. So once you put it in the creativity and all that stuff, at least it comes out.

MT enables expression and release of thought and feelings

S: You're venting it.

Creative therapy allows you to leave expression of experiences on paper

Y: You're leaving it on the paper.

S: The fact you can reflect on it, the fact that when you're feeling down and take it out and look through your journal and you can reflect, and you can tell yourself why am I allowing myself to be this space when I've come from this, so that is how I feel.

The journal is an important tool for reflection

KH: And did music therapy relieve any symptoms that you had before coming, like feelings like anxiety or depression or difficulties?

Music facilitates experiencing a wide range of emotions

MT enabled letting go of anger

MT is a safe space to discuss experiences

S: Yes it made me reflect on anger and let it go, because the music takes you through all the emotions,we could speak about different experiences and each of our experiences was so unique we could learn from each other, so it was good.

In MT unique experiences are valued

Learning from one another's experiences

Y: It helped me relax a lot.

Provided opportunity to focus on self

S: Yeah it was like a 'me time.'

Provided a place to relax

Y: Because I don't get so much time to listen to headphones, at least here I can relax.

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Felt like a better person after the session

When I get home I'm a much better person than what I left.

Provided refreshment and a relief from the burdens of life

S: Because you're leaving actually refreshed, and leaving what you're carrying on your shoulders.

KH: Did you keep a journal, did you do anything techniques-wise at home?

Frequent journal use for reflection

Client enjoyed new experiences such as writing a poem

S: I used my journal a lot. I could reflect what these sessions do for me, like the writing of a poem, you don't normally do that, and I like the fact we got to play a new instrument, it was good, it was just fantastic.

Enjoyment of new experiences in sessions

Client enjoyed new experiences

Y: I used my journal. I used it for various stuff, drawing clothes, drawing dresses, I didn't know it could happen.

Surprised by creative capacity

Journal stimulated a range of creative expressions

KH: Do you imagine drawing dresses for your daughter?

Art as a relief

Y: Yes I do! Once I have the pencil… At least I relieve myself through art.

KH: Is there anything else you wanted to add?"

Client suggests MT to aid moving away from negativity

Client suggests MT for abused women

S: I would advise you to do this in the USA, for abused and battered women. This is also very good. It's gonna help their self esteem, move away from the negativity, and refresh, and find their feet, and tell themselves I don't need to be abused. I'm glad we could be your guinea pigs and we could relate.

Client views MT as useful for enhancing self-esteem

Client suggests MT for reestablishing a new life

Client expresses enjoyment and gratitude for the sessions

Client suggests MT to aid setting boundaries in personal relationships

Client suggests MT for rejuvenation

KH: Wow that's amazing. I'm glad that's a message you got. All right, well, I guess it's time to pack up and be off for good.

[Table of subcategories and codes]

SUBCATEGORY	CODES
Sharing humor	Sense of humor
	Sharing humor
	Comfortable to express humor
	Surprise and spontaneity induce laughter, sense of humor
	Warm laughter among group members
	Sharing humor together between client and MT
	Expressing humor
	Member's concern about disturbing positive group sharing with negative feelings
Curiosity about therapist's contribution	Curiosity towards therapist's contribution
Curiosity about instruments	Barely contained curiosity and interest in instruments
	Curiosity to try the instruments
Space of exploration	Space of exploration
Optimism/joy/light mood	Sense of joy
	Light mood
	Client suggests MT to aid moving away from negativity
	Optimistic
	More positive life perception
	Enjoyment
Enjoyment	Laughter and enjoyment
Gratitude	Client expresses enjoyment and gratitude for the sessions
Valued new experiences	Enjoyment of new experiences in sessions
Experiencing new ways of being	Role reversal (follows in music, leads verbally); experiencing new ways of being

Music therapy as a space of and opportunity for reflection	Music therapy as a space of and opportunity for reflection
	Reflection: loss of loved one and loss of brightness
	Client reflection: Submission to God's plan, to hope, to partner
	Music therapy offers space for reflection
Emotional state: contemplation	Emotional state: contemplation
A sense of waiting to understand	A sense of not knowing
	A sense of waiting by the client to understand what is expected in the improvisation
	Client is waiting for a shift or change
Verbal emotional expression	Emotional expression: nervous laughter
	Emotional expression: feeling great
	Emotional expression: feeling all right/ambivalence
	Emotional expression: anxious, scared, depressed
	Wish for a smoother life
	Emotional expression: life is dark
	Not knowing how to love
	Music listening facilitated a range of emotions
Embodied expression	Body language: Thumbs up
	Body language: Member moves in relation to how excited she feels for the future
	Body language: small, uncertain, still
	Body language: bold and smiling, grooving with the beat
	Dancing together
	Emotional expression: tears

	Body language: Hunched posture and focused facial expression
	Contrast between facial expression and actual emotional content
	Feeling comfortable to express full body movements
Values emotional expression and release of thought and feeling	Client values how she can express her emotions through MT
	MT enables expression and release of thought and feelings
	Creative therapy allows you to leave expression of experiences on paper
	Release of 'negative energy' in MT
	Freedom from 'negative energy' after MT
	Music therapy allows more expression
	Music facilitates experiencing a wide range of emotions
	MT enabled letting go of anger
Life stage: feeling loving	Life stage: feeling loving
Introducing shift from control to vulnerability	Emotional shift: appearance of tears in contrast to the usual presentation to stay in control
Reminiscing through symbolic exploration	Reflection on object: Reminisces on a location she loves in nature
	Reflection on image: Sharing about feelings of loneliness
Emotional expression within symbolism	Symbol: barrier
	Emotional expression: Allowing vulnerability and release of self-professed anger and need to control via art and music without words
	Symbol: storm
Music therapy is surprising for its encouragement and development of creative capacity	Surprised by creative capacity
Values working with symbols	Values working with symbols in MT
Creative externalisation	Externalisation through creativity enables insight

enables insight	
Values creativity of music therapy	Music therapy offers more than verbal therapy through symbols and other creative means
	Values the creativity of MT sessions
	Creativity in MT enables expression
Music therapy is more tiring and intense than verbal counseling	Client found session tiring (and is tired overall)
Music therapy is intense	The process of music therapy works faster than traditional verbal therapy
Members make others more concerned	Some clients make other clients more concerned
Exposure to music: through children	Client's children introduce her to diverse music
Exposure to music: less as an adult	Less exposure to music as an adult
Diverse childhood experiences with music	Music pervasive in childhood home
	Diverse music in childhood home
	Music pervasive part of client's life
Sharing childhood experiences with journaling	Feedback about journaling as a teenager but no longer
Positive childhood experiences with music	Love of music in childhood home
	Client grew up in a musical family
Music preference: gentle music	Preference for gentle music
music therapy is a safe	Beginning to open up within the space; feeling safe

space	
	The sessions provided client with one place to share openly
	MT is a safe space to discuss experiences
	Willingness to share
Learning from one another	Learning from one another's experiences
	Learning from one another
Enabled hearing about others experiences	Sessions enabled hearing about others' experiences
Lessened isolation	Sessions lessened feelings of isolation
	Sessions lessened feelings of isolation
Member offers advice/plays a mentorship role	Advice from one member to another member: breathing techniques
	Some group members took on a mentorship/leadership role
	Advice from one member to another member: focus on your individual experience
	Member offers advice
	Member plays a nurturing role in group
	Members offering each other advice
	Clients share stories about difficult parts of birth with clients who have not given birth
Sharing difficulties	Sharing experiences of difficulties sleeping
Clients reassure one another	clients reassure one another
Expresses a desire for sessions to continue	Expressing sadness that sessions have ended
Relational connectedness	Clients offer one another encouragement
	Member has difficulty expressing and another member of the group puts it as 'mixed feelings' and she agrees
	Reciprocity and being together
	Development of camaraderie

	Experience of mother-daughter connectedness
	Supportive and encouraging atmosphere
Empathic resonance with other's expression	Active listening by group members
	Empathic resonance with other's expression
	Empathic resonance with other's expression
	Empathic resonance with other's expression
	Empathic resonance among group members
Provision of affirmation or validation	Provision of affirmation or validation
	Affirmation of different cultural expressions
Seeking affirmation and validation	Seeking affirmation and validation
Energy quality: tentative	Hesitancy to share
	Energy: stilted within the extremely small space. Uncertainty, silence prevail in the first session
Energy quality: internal	Member's focus is internal
Energy quality: closed and contained	Energy is contained and closed
Energy quality: explosive	Energy: upward and explosive
Energy quality: discrepancies between the therapist and client	Discrepancies in energy between therapist and client
Energy quality: muted	Energy levels: muted
Energy quality: driving	Energy: percussive and driving
Musical quality: tentative	Musical quality of instrument playing: Cautious and wary
Musical quality: structured and familiar	Structure and familiarity allow for easier participation
Musical quality:	Quality of music: loud and rollicking

rollicking	
Musical quality: cautious	Voice: soft and cautious
Musical quality: dynamic and full-toned	Music quality: dynamic, fast, full-toned, lacking pauses
Musical quality: in tune	Musical quality: singing in tune (shift from previously)
Musical quality: caressing	Quality of instrument playing: caressing
Introducing shifts within improvisation	Therapist responds to client: tempo increase
	Client plays the instrument in a new way causing a shift in our improv
	Therapist introduces shift through tempo
	Client introduces new beat to extend improvisation
Emerging voices	Increased vocal presence and participation
	Emerging voices
	Emerging voices
	Increase in sharing, freedom of movement, and freedom of expression
Feeling known and understood	Discussion about and coming to understand cultural differences
	MT allows more opportunities to be fully understood
	Awareness of one another's stories through group sharing
	In MT unique experiences are valued
Expressions of positive associations with motherhood	Positive associations with motherhood
	Celebrating what mothers do instinctively
Expressions of positive feelings toward baby	Feelings toward child: views child as perfect
	Expression toward child: you are an angel
	Feelings toward child: expresses wish for blessing
Poem as expression of	Poem: pride in and confident sharing of

connection to baby	
Feelings of connection to baby	Sense of connection to baby
	Client felt more connected to the baby after the session
Pure love as the connection between mother and baby through symbolic representation	Symbol: pure love between mother and baby
Feelings of gratitude for having a baby	Feelings toward child: Expresses gratitude for having a baby
Feelings of gratitude about baby	Client feels lucky to be expecting a boy
Perceived as answer to prayer	MT perceived as an answer to prayer
Music therapy is relaxing	Expressing a desire to have music during labor for its pain relief and relaxation properties
	Music listening led to relaxation
	Provided a place to relax
	Hearing the experiences of other women helped the client to relax
	Emotional expression: relaxed
Music therapy is rejuvenating	Provided refreshment and a relief from the burdens of life
	Client suggests MT for rejuvenation
Music therapy aids self esteem	Client views MT as useful for enhancing self-esteem
	Felt like a better person after the session
Recommended for abused women	Client suggests MT for abused women
Music therapy aids starting over	Client suggests MT for reestablishing a new life
Recommended to aid in setting boundaries in personal relationships	Client suggests MT to aid setting boundaries in personal relationships

music therapy is healing	MT experienced as healing
	MT experienced as a space to embrace baby as a new beginning after loss
Music therapy increased sense of self	Provided opportunity to focus on self
	Visualization and art creation increased sense of self
Self efficacy	Reflection: Member claims her ability to interpret own art
	Member opts out of singing her song
Responsiveness mainly to therapist	Focuses on sharing with MT rather than with other members
Therapist role: advice	Therapist provides verbal advice and scientific information
Therapist role: shares feelings	Therapist shares feelings to continue solidarity within group
Therapist role: inflexibly applied rhythm	A lack of flexibility and a repeated rhythm by the therapist
Intervention preference: relaxation, visualizations, and mandalas	Preference: relaxation, visualizations, and mandalas
Intervention preference: sonic sketch	Three circles enabled reflection and insight
Intervention preference: listening and visualization	Preferred activity: listening and visualization as a new experience
Intervention preference: visualization and art creation	Intervention preference: visualization and art
Intervention preference: listening to music	Client preferred listening to music

Intervention preference: new experience such as writing poem	Client enjoyed new experiences such as writing a poem
Intervention preference: new experience such as playing instruments	Client enjoyed new experiences such as playing an instrument
Intervention preference: journal	Member expresses desire to record experiences
	Art as a relief
	Frequent journal use for reflection
	The journal is an important tool for reflection
	Journal stimulated a range of creative expressions
Intervention preference: relaxation	MT is more relaxing than verbal counseling
	Client found relaxation most useful for her anxiety
Subcategories: 91	Codes: 189