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Dissertation in partial fulfilment for the degree of

MMus (Music Therapy)

Music Therapy in home-based settings: Clients with Cerebral Vascular Accident and their caretakers

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Abstract

Cerebral Vascular Accident is one of the leading causes of disability worldwide. Most people who have suffered from a CVA are cared for at home by a caregiver who is usually a close relative or friend. The aim of this study was to explore the role that music therapy sessions could play in enhancing the relationship between individuals who have experienced a CVA and their primary caretakers in the home context. The study made use of a sample of three such dyads. The sessions took place in their home settings. Sessions included listening to and singing familiar songs, drumming, vocal and instrumental improvisation and movement. A total of 16 sessions were conducted. Videotaped recordings were made of each session and the last session from each dyad's therapy process was transcribed verbatim. Three themes emerged from the thematic analysis. The therapy process allowed them to explore difficulties and challenges in their relationships, there was enhanced communicating and relating, and there was an expressed desire for a return to the self that once was as well as a hope for the future.

Keywords:

Cerebral Vascular Accident, Music Therapy, relationship, caretaker, communication, challenges, hope

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CHAPTER ONE

1. Introduction

1.1 Background and context

The second leading cause of death worldwide is Cerebral Vascular Accident (CVA), also termed stroke (Bertram, Katzenellenbogen, Vos, Bradshaw & Hoffman, 2013:76). CVA does not always end in mortality and non-fatal strokes have significant psychosocial and financial implications for the individual, the family and the community (Bryer & Connor, 2005:195). Individuals who have suffered from a CVA are highly likely to present with a wide variety of cognitive and behavioural impairments due to neurological damage. Withdrawal, apathy**,** irritability, disinhibition, reduced anger control, impaired social perception and egocentrism are common features following CVA (Magee et al., 2011:5). Aphasia, a disorder of language (King, 2007:14), affects between 12 and 38 percent of those within the acute stroke population. Aphasia impacts social participation and activities of daily living. It is linked to depression as well as isolation and social withdrawal in the person who has suffered CVA. This then adds to the total cost of stroke recovery as it prolongs rehabilitation (Ali, Lyden & Brady, 2015:400).

Most social relationships are severely affected after a stroke. Primary caregivers, usually close family members, are profoundly impacted. Depression has been reported as the most common diagnosis for caregivers of stroke patients (Schulz, Tamplins & Rau, 1988:131) and is mainly caused by breakdown in communication between the person who suffered the CVA and the caregiver (Taylor et al., 2008:102). A breakdown in communication can specifically be seen in lower income groups where patients and caregivers do not have funds to get full-time professional help (Bryer & Conner, 2005:200). A qualitative study on the importance of social relationships was conducted by Lynch, Butt, Heinemann, Victorson, Nowinski, Perez & Cella (2013) with nine long-term stroke survivors and six caregivers. Their findings highlighted the importance of social relationships particularly in terms of social support, communication, independence and role changes. Impairment in these areas directly influences social functioning and quality of life. Frustration in the both parties was highlighted as the most prominent aspect that influenced the relationship (Lynch et al., 2008:4).

Music therapy is a tool that can be utilised in the promotion of quality of life and support of social relationships (Ruud, 1998:1). Social interaction is a common goal in music therapy interventions. Music therapy provides a structural framework in which individuals can interact and respond to improve communication skills and social interaction (Magee, 2011:5). Baker

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and Wigram (2004) found that song singing and vocal exercises can help to increase rate of speech, articulation and intonation, which can enhance intelligibility and natural speech patterns. Singing and listening during music therapy interventions helped to improve mood and orientation of caregivers and enhanced general caregiver well-being as was reported in a study by Sarkamo et al. (2014). Song composition with lyrics sequenced to tasks of daily living also helped to assist in the rate of completion of these tasks. In this study by Hitchen, Magee and Soetrik (2010) it was found that the intervention assisted the client in gaining independence in relation to his tasks and alleviation of frustration. A sense of agency was restored for the client. Agency can be described as an ability to take action and to influence one's own life. It is also the ability to handle tasks, take responsibility for behaviour and to experience enhanced autonomy (Wheeler, 2015:151). In the event that a sense of agency can be restored for a person who has suffered from a CVA he/she may feel more responsible for his/her own life and actions and this can create feelings of mastery, achievement, empowerment and competency (Ruud, 1998:11). In a music therapy session a client has the opportunity to initiate different actions and to test the outcome of these actions in a safe and non-threatening environment. The client will have opportunities to explore their relationship and develop more effective communication (Stewart, 2002:183).

My personal interest in this study stems from my experience during our clinical placement phase at frail care facilities. I often found that individuals are institutionalised because the primary caretaker could not keep up with the emotional demands of the person who suffered a CVA and that there was a breakdown in communication and relationship between them.

The existing research in the area of music therapy and CVA focuses mostly on rehabilitation centres and also concentrates on the person who has suffered a CVA. There is a gap in the literature in relation to understanding what music therapy may offer home-based individuals who have suffered from a CVA who attend sessions with their caretaker. The focus of the study was to explore how music therapy enhanced the relationship between individuals who have suffered from a CVA and their caretakers.

Music therapy sessions for three pairs of participants were structured around free improvisational activities, song singing, movement and listening activities. Each of the sessions followed the same basic structure. The pair had the opportunity to engage in reflection during and after activities. They were engaged with one another not just in music, but also through verbal processing. Each participant were able to reflect verbally during sessions. Although the participants that suffered the CVA displayed some symptoms of Aphasia they were still able to communicate.

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1.2 Aims

The aim of the study was to explore the role that music therapy sessions could play in enhancing the relationship between individuals who have experienced a CVA and their primary caretakers in the home context.

1.3 Research question

The research question for this study was, therefore, as follows:

What role can music therapy play in enhancing the relationship between an individual who has experienced a CVA and their primary caretaker in the home context?

2. Overview of the dissertation

In chapter two I will discuss the literature that I have found in the field and explain how this relates to the research. In chapter three I will discuss the methodology of the study, including research design, sampling, data collection, data analysis and the ethical considerations. Chapter four entails a presentation of the data analysis. I offer a detailed explanation of how the analysis took place and what the findings were. In chapter five I will discuss the research findings. This will be integrated with a reflection on the existing literature that was presented in chapter two. In chapter six I will conclude, discuss the limitations of the study and make recommendations for further research.

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CHAPTER TWO

2. Literature Review

2.1 Introduction

In this literature review I will discuss relevant research on CVA, how neuroplasticity plays a role in the rehabilitation process and I will also explain how neuroplasticity has been explored in relation to music therapy. I will then examine literature demonstrating how music therapy can play an important role in re-establishing communication and relationship after a person has suffered a CVA.

2.2 Cerebral Vascular Accident

According to the annual report of the Heart and Stroke Foundation of South Africa (2014:9), CVA is one of the leading causes of death and disability in the country. Up to 240 strokes occur daily in South Africa of which 60 result in death. Approximately 180 of these individuals will be in need of rehabilitation (Steyn, 2007:2).

CVA is caused when a part of the brain is deprived of blood flow because of a ruptured artery or blood clot and subsequently dies. Survivors of CVA will classically have residual damage, referred to as a lesion in either the right or left hemisphere of the brain. Lesions are parts of brain tissue with impaired function because of the injury. The rehabilitation treatment plan will depend on the type, severity and area of the lesion (Baker, 2006:26).

A variety of interventions are offered to people who have suffered from a CVA. Dobkin (2005:1677) (a neurologist at the Geffen School of Medicine at the University of California in Los Angeles) states that the general guideline after acute CVA is approximately 16 days of hospitalisation followed by two to six weeks of in-patient rehabilitation and up to six months of out-patient rehabilitation. The cost relating to care is one of the fastest growing expenses for medical funds worldwide (Dobkin, 2005:1677). It is after the individual has left the caring facility that the primary caregiver takes over and he/she is usually a close family member or friend.

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2.2.1 Types of CVA

CVA can be divided into two groups: Ischemic CVA or Haemorrhagic CVA. Ischemic CVA occurs when an artery is blocked by fatty deposits in the blood that form a clot and stop blood flow to the brain. Haemorrhagic CVA refers to the rupture of an artery. This causes damage to the surrounding tissue in the brain (Baker, 2006:26).

Aphasia is a disorder of language (King, 2007:14) and affects between 12 and 38 percent of people who have suffered a CVA. Parietal and temporal lobe lesions in left hemisphere CVA can cause disorders of language such as Broca's aphasia that influences modes of expression, and Wernick's aphasia that influences reception of language (Baker, 2006:27). Aphasia impacts social participation, activities of daily living and is linked to depression, isolation and social withdrawal. Disturbed prosody, laboured and slow speech with long pauses, difficulty in naming objects and finding words, trouble with repetition and sentence construction and echolalia (repeating another person's words) are all characteristics of Broca's aphasia (Baker, 2006:27). Persons with Wernick's aphasia might still have the ability to speak fluently, but will use inappropriate words or the incorrect order of words. Auditory comprehension might also be influenced and there may be difficulty in articulation and vocal control or sequencing speech sounds. Personality and behavioural changes can be present and individuals might have disinhibited behaviour, may feel extremely tired, may laugh or cry inappropriately and may display poor tolerance of frustration. Cognitive disturbances such as perseveration, poor short-term memory and attention span, neglect of right visual field objects, impaired analytical and abstract thinking might also occur in Wernick's aphasia (Baker, 2006:28).

The communication difficulties mentioned in relation to left hemisphere CVA are also applicable in right hemisphere CVA. Individuals might have difficulty following fast-paced conversations or have trouble finding meaning in conversation. Non-verbal communication such as vocal intonation, eye contact and gestures cannot generally be understood (Baker, 2006:28). Persons with right hemisphere CVA may also present with flattened or limited affect and frequent or instant mood changes. Fatigue, excessive crying, apathy, poor insight, impulsivity egocentricity and inappropriate behaviour can also be present. Divided and alternate attention as well as initiation and task completion problems might occur. Short-term memory and problem solving abilities might be impaired and other problems can be present, such as neglect of objects in the left visual field, difficulty with directional concepts (up/down,

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left/right), lack of awareness of certain body parts, poor depth perception and difficulties with awareness of time (Baker, 2006:29). The inability to keep track of time is called dyschronometria. Persons who suffer from dyschronometria can only perform tasks for a short period of time and then get distracted and suffer from a loss of focus. They are unable to tell what they were busy doing before they got distracted and cannot do basic time keeping unless time is set on a clock to indicate task completion. Dyschronometria is caused by cerebellar damage (Lagarde, Hajjim & Yelnik, 2009:360).

For effective interpersonal communication there must be shared meaning between the sender and the receiver of the messages (Guerrero, Anderson & Affifi, 2007:16). Difficulty in communication experienced after a CVA can lead to messages being misinterpreted by the individual's partner. Adjustments in both non-verbal and verbal communication may be required in order to meet new challenges. Communication styles may need to be adjusted to avoid miscommunication (Guerrero, Anderson & Affifi, 2007:17).

2.2.2 The importance of relationship

Writing from the persepctive of Western conceptualisations of healthy relationships, Guerrero, Anderson and Affifi (2007) suggest that three features should be present in healthy interpersonal relationships. Firstly people in close relationships interact in meaningful ways that go beyond basic tasks. They interact on an emotional and social level, encouraging each other and using words of affirmation. They listen to each other and offer help. The engagement in such a relationship is one of self-disclosure. Secondly, this relationship also has repeated interactions over time and, thirdly, it is characterised by unique interaction patterns. The pair share relational history and common experiences. They share inside jokes and hold private information and knowledge that shapes how they interact with each other. Furthermore, close relationships have the characteristic of emotional attachment and this may be the reason why feelings of happiness, sadness, pride and disappointment may be common experiences within them. Close relationships also help to fulfil needs such as the need to belong to a social group or the need to feel loved and appreciated or to care or nurture someone else (Guerrero, Anderson & Affifi, 2007:7).

According to Floyd (2006:5), need fulfilment in close interpersonal relationships is built on the pillars of affection, inclusion and control. Adults who regularly receive affection are reported to have better psychological and physical health and have stronger and better relationships (Floyd, 2006:5). Communication that is affectionate in nature strengthens

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relationships and allows people to feel better about themselves and others. Others also refer to relationships within a social network and fulfils the basic need for safety and survival and helps to alleviate loneliness and low self-esteem. The need to be in control of one's own life is the third pillar. In successful interpersonal relationships there is shared control between the partners and they make decisions together. Partners in such a relationship are reported to be more satisfied with the relationship (Chau & Bowpitt, 2005:6; Guerro, Anderson & Affifi 2007:8).

2.2.3 The impact of CVA on relationships

A study by Lynch et al. (2013) highlighted the importance of social relationships after suffering a CVA. This qualitative study was conducted with nine long term stroke survivors and six caregivers (Lynch et al., 2013:1). In this study participants were asked during focus groups to describe their quality of life and how they experienced changes in their relationships. Analysis of the data for this particular study revealed that the maintenance of healthy social relationships may be the most important and salient influence on recovery and quality of life after the incidence of CVA, from the perspective of both the caregiver and the person who suffered the CVA. People who experience a CVA depend mostly on the primary caregiver for activities of daily living and, as such, social relationships are critical to their survival (Lynch et al., 2008:8).

The rehabilitation of a stroke survivor has significant psychosocial and financial implications for the individual, the family and the community (Bryer & Conner, 1995:195). Health services treat acute illness and rarely provide sufficient rehabilitation initiatives or out-patient guidance. This increases the burden on the primary caretaker (Steyn, 1995:6). When there is the availability of emotional, informational and instrumental support from family members and friends this assists the person who has suffered a CVA to better manage the acute and chronic phases of disability (Shulz, Tompkins & Rau, 1998:131). A wide variety of cognitive and behavioural impairments due to neurological damage can be present after suffering a CVA such as withdrawal, apathy, irritability, disinhibition, reduced anger control, impaired social perception and egocentrism (Magee et al., 2011:5).

Quality of life is inhibited where there is a breakdown in communication (Lynch et al., 2013:4). In their study on the issues that are important to people who suffered from a CVA and their caretakers, Hanger, Walker, Paterson, Mcbride and Sainsbury (1998) interviewed two patient-caretaker dyads. They found that, even after two years post the event of the

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CVA, communication difficulties were still listed as one of the main effects. It was also mentioned in the interviews that frustration, depression, tiredness, emotionalism, aggression and personality changes impact not only the life of the person who suffered the CVA, but also the caregiver and the relationship between the pair (Hanger et al., 1998:50). This can result in a decline in the caregiver's own health, social life and well-being. When the caregiver breaks down or suffers burn-out this often results in the person suffering from the CVA being placed in a nursing home (Visser-Meiley, Post, Riphagen & Lindeman, 2004:601). In a quantitative study conducted by Tsouna-Hadjis, Vemmos, Zakapoulos and Stamatelopoulos (2000) with 43 post-stroke patients it was found that functionality within everyday living, social interaction and a decline in depression are associated with high levels of family and caregiver support. The better the communication and relationship between the person suffering from CVA and their caregiver the better the outcome for the recovery or adaptability to the disability (Tsouna-Hadjis et al., 2000:881).

Impaired communication skills, caused by aphasia, lead to frustration and depression not only for the patient, but also for the caregiver. Besides physical factors this presents as one of the main challenges for rehabilitation (Dobkin, 2005:1682). Schulz, Tompkins and Rau (1998) conducted a longitudinal study of 162 pairs of persons from nine different hospitals. These pairs consisted of persons who had suffered a CVA and their primary caretakers. They investigated the effects of a CVA on persons who provide the sufferer with social support. Their research demonstrated that the prevalence of depressive symptoms is between 2.5 to 3.5 times higher than that found amongst middle-aged and elderly people who have not experienced caring for a loved one who has experienced a CVA (Schulz et al., 1998:138). Taylor et al. (2008) conducted a quantitative study on the effect of spousal caregiving and bereavement on depressive symptoms. Their sample included 1967 community-dwelling couples, where one was the caretaker who assisted the disabled partner in activities of daily living. It was found that there were higher levels of depression for the caretaker applicable to both genders (Taylor et al., 2008:100).

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2.3 Neuroplasticity

In this section I will discuss the role of neuroplasticity in the rehabilitation of a person who has suffered from a CVA. This is important to consider contextually for the current study because neuroplasticity offers the opportunity for damaged brain tissue to regenerate and regain lost ability after suffering a CVA and music therapy is a method to promote

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neuroplasticity. Pascuale-Leone et al. (2011:302) describe neuroplasticity as “nature’s invention to overcome limitations of the genome and adapt to a rapidly changing environment”. The brain has the ability to restructure itself and to form new neural connections throughout life and also subsequent to injury. Brain reorganisation takes place when undamaged axons grow new nerve endings to reconnect to neurons whose links have been damaged or severed. Undamaged axons can also form new nerve endings and connect with undamaged nerve cells, forming new pathways to accomplish optimal functioning (Stegemoller, 2014:211). Although the human brain is most susceptible to change up until a person reaches the age of 20, neuroplasticity can continue until death (Stegemoller, 2014:216).

In a quantitative study conducted by Pascuale-Leone et al. (2011:302) the human brain was found to be able to adapt to environmental demands when stimulated with sensory input, motor actions, reward signals and awareness of surroundings; especially after injury. Using transcranial magnetic stimulation (TMS), electroencephalography (EEG) and magnetic resonance imaging (fMRI) the same researchers also found that plasticity of the brain declines with age and is also dependant on variables such as genetics, biological factors and environmental influences (Pascuale-Leone et al., 2011:306). The enriched environment that is important in the shaping and re-shaping of neural pathways can be described as involving multimodal stimulation including social interaction, physical activities and cultural activities such as singing and dancing (Nillson & Linden, 2009:19). Research has been conducted examining the role of an enriched environment for persons who have experienced a CVA particularly. For example, Janssen et al. (2012:524) found that an increase in activity level relates to a better functional outcome in rehabilitation. Environmentally enriched methods such as social interaction, listening to music and playing an instrument were some of the activities that increased activity level. In a study by Kolb (2008:10) frequent exposure to complex sounds, such as music, and increased social experiences enhanced learning, memory and neuroplasticity in the animal brain. In humans recovering from neural damage the effect of complex auditory stimuli such as music and speech is still largely unexplored (Sarkamo et al., 2010:2717).

The brain is an ever-changing structure and music therapy includes unique features that could facilitate neuroplasticity throughout the lifespan (Stegemoller, 2014:216). Stegemoller (2014:216) explains that a neuroplasticity model for music therapy is based on three basic principles: increase in dopamine, neural synchrony and a clear signal. Dopamine is a neurotransmitter that is involved in motivation, reward-seeking behaviour and reinforcement

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learning. When the dopaminergic neurons and sensory stimuli are paired this results in cortical remapping which plays an important role in neuroplasticity (Stegemoller, 2014:216). A neuroimaging study by Salimpoor, Benovoy, Larcher, Dagher and Zatorre (2011) has shown that listening to music stimulates dopaminergic regions and that it can, therefore, affect emotional states. Intense pleasure in response to music leads to dopamine release. Music is paired with a task to be learned or relearned. Music serves as the reward and motivation for the completion of a non-musical task or behaviour (Stegemoller, 2014:217).

2.4 Music Therapy

Music therapy in neurological rehabilitation is fairly new in comparison with other settings such as palliative care, psychiatry and special education (Baker, 2006:15). Specific benefits of music therapy such as social interaction, emotional expression and the improvement of speech and communication promote neuroplasticity and the recovery of function after a person has suffered a stroke (Stegemoller, 2014:219). Thaut and McIntosch (2014) reviewed research data over the past twenty years and found that gait, arm, speech, language and cognitive rehabilitation were influenced most notably by the use of Neurological Music Therapy in stroke rehabilitation. The data showed that pulsed, rhythmic auditory cues had an effect on the entrainment of neural activation patterns into more regular and synchronised patterns, which resulted in more controlled movements for the person who had suffered a CVA. The rhythmic cues also provided anticipation for onset, duration and completion of tasks. The synchronisation to beats can be controlled and adapted to the persons' movement capacity and ability because the rhythm supplies a time reference for the motor system to map and scale the movements (Thaut & McIntosch, 2014:108).

The properties of music are important for rehabilitation because of the shared production features of the spoken language and musical vocalisation in singing. In melodic-rhythmic intonation the vocal output is slower than talking. The lengthened syllables can assist a person who has experienced a CVA and has resultant speech difficulties Thaut & McIntosh, 2014:109). Spatial visual impairments have also been reported to improve after playing on instruments (Thaut & McIntosch, 2014:110).

Social interaction is a common aim in music therapy with clients who have suffered from a CVA (Wheeler, 2000:274). Aphasia, as mentioned before, can cause breakdown in communication and relationships after the occurrence of a CVA. Baker and Wigram (2004:177) found that song singing and vocal exercises can help to increase rate of speech,

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articulation and intonation in persons who have suffered neurological damage and have speech difficulties as a result. Song singing can also assist in enhancing intelligibility and natural speech patterns.

Sarkamo et al. (2014:634) reported that singing had a positive effect on working memory of dementia patients and general well-being of the caretaker. This quantitative study attempted to determine the efficacy of a music intervention based on coaching caregivers to use singing and music listening regularly as part of everyday care. A ten-week music listening coaching group was established and sessions consisted primarily of listening and singing familiar songs coupled with occasional vocal exercises and rhythmic movements. Compared to usual care, both singing and listening improved the mood and orientation of the caregivers as well as their attention. Singing enhanced general caregiver well-being and music listening had a positive effect on quality of life (Sarkamo et al., 2014:634).

The reported feelings of frustration, grief and anger experienced by caregivers might also be attributed to the fact that the person who suffered a CVA also endures loss of physical function and independence (Baker, 2005:295). Songs composed with a lyrical sequence to match that of a daily task were found to improve the memory of clients suffering from neurological damage. Singing these songs while busy with the task also improved the rate of completion. Hitchen, Maagee and Soetrik (2010) conducted a study with a 23-year old man who had suffered a brain injury two years prior. He was extremely aggressive verbally and physically and displayed a lack of interest in activities and personal care. Music therapy was used as part of his rehabilitation to increase duration of, and attention to tasks. A tooth-brush song was composed to assist this young man, taking into account his age and his preferred music taste. The blues style and structure that was chosen was familiar to the client and helped to reduce anxiety as it is predictable and repetitive. Rhythm and tempo were adjusted to reduce agitation and to not overstimulate the client. After a four-week intervention the client was able to complete the task independently and without the music being played to him by another person. This technique was very effective in assisting him to gain independence in relation to his task (Hitchen, Magee & Soetrik, 2010:66).

Sarkamo et al. (2008) conducted a qualitative study with 60 in-hospital patients in Helsinki who had suffered an acute stroke. The injuries were in the left and right temporal, frontal, parietal or subcortical brain regions. Participants in the experimental group each listened to their favourite music or genre for an hour per day. They also had weekly contact sessions with the music therapist to provide more musical material and receive assistance in using listening equipment. Primary caregivers and family members were also asked to assist. It

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was found that regular, self-directed music listening enhanced cognitive recovery and prevented negative mood in comparison to the control group who received no listening material or listened to audio books only (Sarkamo et al., 2008:872).

In the literature discussed above it is clear that communication and relationships are affected severely when a person suffers a CVA. Research has focused mainly on the person who has suffered the CVA and how rehabilitation methods can assist in attaining quality of life. To my knowledge there has not, however, been research conducted specifically into how music therapy might function as an intervention for communication and relationship between a client who has experienced a CVA and his/her caregiver.

2.6 Conclusion

The chapter has discussed the different types of CVA and it impacts not only on the person who suffered the CVA but also the primary caregiver and close relationships. In the above literature review the relational and communicative difficulties between a person who has experienced a stroke and his/her caregiver have been discussed. Music therapy and the impact thereof on persons in rehabilitation after suffering a CVA have been reviewedIn the next chapter I will discuss the research paradigm and design, sampling, data collection, data analysis and ethical considerations.

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CHAPTER THREE

Research methodology

3.1 Introduction

In this chapter I will discuss the research paradigm and the research design that I used in the study. I will also explain the sampling, data collection and analysis that I employed as well as the ethical considerations.

3.2 Research paradigm

The research paradigm for the proposed study is interpretive. A research paradigm incorporates a particular ontology and epistemology (Matthews & Ross, 2010:24). The ontology of interpretive research holds the understanding that reality is developed through experience and social interaction (Terre Blanche, Durrheim & Painter, 2006:7). In this study the relationships between individuals who had suffered a CVA and their caretakers was explored through observing their social interaction throughout the music therapy process. The participants also had the opportunity to reflect on their relationships during the sessions.

The epistemological position for the study highlights participants' subjective experiences of their inner world (Matthew & Ross, 2010:24). Social realities are multi-layered. Experience is complex and may differ in each situation and for each individual. Interpretivism offers the opportunity for different perspectives to be explored (Willig, 2013:20). As researcher and therapist, I had the opportunity to access the participants' world through observation and listening to how they make sense of their reality and the 'rules' that direct their actions. The participants' accounts of their experiences and actions are used as reflections of underlying meaning. I attempted to interpret the participants' accounts with an empathic understanding (Matthews & Ross, 2010:284) and to examine the situation and events from their point of view (Holloway & Wheeler, 2010:6).

Reflexivity is an important component of interpretive research. Reflexivity encourages the researcher to critically reflect on how he/she as a person is implicated in the research and the findings. Reflexivity encourages awareness of how the researcher's own reactions to research will influence the process, findings, insights and understandings (Willig 2008:18). I critically reflected upon the various ways in which I was involved in the research, being both

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the researcher and the facilitator of the music therapy sessions (Willig, 2008:52). This will be discussed further in the section on research quality**.**

3.3 Methodology

Flowing from the ontological and epistemological features of interpretive research I have used a qualitative methodology because the main aim was to explore the relationship between the participants. In this study qualitative data was collected that is descriptive and rich in detail in order to uncover the subjective meanings of the participants (Matthews & Ross, 2010:25).

Qualitative research methodology aims to explore social phenomena in depth. The objectives of qualitative enquiries are to describe the qualities of experience and the specific emotions and reactions to interaction and interdependence (Hogan, Dolan & Donnely, 2009:3). This methodology was well suited for the study as relational qualities were under investigation. In qualitative research attempts are made to understand the experience of the participants, taking into account their values, rituals, symbols, beliefs and emotions (Hogan et al., 2009:5). During the research process I attempted to capture the thoughts, feelings and interactions of participants during the music therapy process. Participants had the opportunity to reflect on the music making process and how it impacted upon their relationships. The flexibility of a qualitative study gives the researcher the opportunity to change the design with information that emerges during the process (Wheeler & Kenny, 2005:26). The interpretation of the uncovered meaning was placed in the social context of the participants (Matthews & Ross, 2010:24).

3.4 Research question

As mentioned, the research question for this proposed study is as follows:

What role can music therapy play in enhancing the relationship between an individual who has experienced a CVA and their primary caretaker in the family context?

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3.5 Design of the study

For this research I made use of a case study design (Willig, 2008:74). A case study is an empirical inquiry that investigates a contemporary phenomenon or case in depth and in context. Multiple-case design is the selection of two or more cases (Yin, 2014:62). This study included three pairs of individuals who have suffered a CVA and their caretakers.

The benefits of a case study is that it is flexible and adaptable to the participants' responses and it also allows for the exploration of how relationships in the dyads are developing (Alridge, 2005:25). The researcher in this case was also the therapist and, therefore, there was the possibility of being able to adapt procedures or plans if unanticipated events took place (Yin, 2014:74). Robson (1993:163) proposes that the researcher utilising a case study design should continuously ask questions and be a good listener and observer, using all the senses (Robson, 1993:163). In a case study design the researcher must continually be able to recognise bias and how it influences the study (Alridge, 2005:28) as well as being open to contradictory findings (Robson, 1993:163). In this study I had to put my own preconceived ideas and opinions aside in order to listen and observe the sessions as researcher and to interpret the data as truthfully as possible through the process of reflexivity (Finlay, 2002:210). Reflexivity involves a critical reflection of the researcher's own place in the study but is also the process of how knowledge is generated and, thus, requires an awareness of the factors that influenced this. Reflexivity involves introspection where I, as the researcher, explore my own experiences and meanings to gain better insight into and interpretation of the research. It also involves intersubjective reflection and focuses on how my relationship with the participants affects the outcomes of the research. The mutual collaboration of the participants as part of the research also influences the context of the relationship and the process of the research. The power relationships and social positions of the researcher and the participants have an impact on the research and must be acknowledged. I am also aware that there are a variety of possible meanings in language and that the findings and the description thereof must carefully be reflected on (Finlay 2000:209).

3.6 Sample

In this study I utilised purposive sampling. Three pairs of participants were selected according to features relating to the research question (Matthews & Ross, 2010:154; Silverman, 2006:250). The three pairs of participants who were invited to participate in the study included home-based individuals who have suffered a CVA and who live with their

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primary caretaker. The participants are all residents of the community in which I live and matched the criteria for the study.. Participants had to be able to read and write in the event that they were not able to speak in order to enable them to participate in the reflection during the sessions. Participants could have been of any age or gender. They had to be able to communicate in English or Afrikaans, as these are the two languages in which I am proficient.

The participants were able to read and write and were all able to speak fluently in either English or Afrikaans. Five of the participants were female and one male.

The participants were informed of the aims of the study and what the research process would entail (see appendix A) in a pre-consultation. Informed consent was obtained (see appendix B) and they also consented to the sessions being video recorded (Suzuki et al., 2007:297). Participants had the right to withdraw from the study at any time without being penalized.

3.7 Data collection

I used participant observation to collect data. Four sessions were conducted with the first pair and six sessions were conducted with the other two pairs. Sessions lasted for approximately half an hour, depending on the activity level and concentration of the participants. The sessions consisted of greeting activities, music listening, song singing, vocal and instrumental improvisation and movement. The sessions were video recorded. Full sessions of the recordings were selected in consultation with my research supervisor to provide data concerning how the pair relate and communicate with each other. Musical interactions and the verbal reflections from the sessions were analysed in order to address the research question. In the next chapter the decision to use full sessions will be explained in detail.

The researcher as participant-observer does not engage in passive observation, but takes on a variety of roles. The researcher actively participates in the activities being studied (Yin 2014:115). The benefit of this type of data collection is that I was able to perceive reality from ‘inside’ each case and not from a position external to it. This method provides the opportunity for the case to be studied in context. Insight can also be gained into interpersonal behaviour and motives. A challenge of this type of data collection is that the participant role is time consuming and requires more attention than the observer role. As participant-observer I did

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not have time to make notes during sessions as a direct observer would be able to do (Yin, 2014:117). I overcame these challenges by using video recordings.

Video recordings have the advantage of being permanent sources of information that can be watched several times and different phenomena can be observed simultaneously (Sparman, 2005:246). This form of data capturing is thorough and the opportunity for thoughtful interpretation is enhanced. Phenomena can also be illustrated to others. A limitation of video recordings is that there is an absence of contextual data (Sparman, 2005:247).

3.8 Data preparation

The excerpts were viewed in detail and thick descriptions (Ponterotto, 2006:547) were written including transcriptions of verbal discussions in which participants reflected upon their relationships. These conversations were transcribed verbatim. Care was taken when the data were transcribed to reproduce the spoken word as accurately as possible into the written word to ensure accuracy of analysis of the data (Poland, 1995:291).

3.9 Analysis

The prepared data were analysed using thematic analysis. Thematic analysis is a process through which key ideas or themes are identified (Matthews & Ross, 2010:373). Through thematic analysis one has the ability to describe and organise a set of data in detail and to interpret different features of the research topic (Braun & Clarke, 2006:78). The aim is to explore the data for meaning and similarities or differences and the relationships between them. Thematic analysis, according to Morse (1994:23-43), involves cognitive processes. Firstly the phenomena under study must be understood. Synthesising must take place next and relations and linkages must be found between important aspects. Theorising then occurs in order to interpret why these phenomena appear. Recontextualising is the last process where new knowledge about the phenomena is explored in context.

The process of thematic analysis is a recursive process with continuous movement. I familiarised myself with the data by reading the thick transcriptions. I then generated codes. A code is a word or short phrase that captures the essence of a portion of the data (Saldana, 2013:3). I sorted the codes into categories and, finally, into themes. This process moved back and forth to create meaning (Braun & Clarke, 2006:93).

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The benefit of thematic analysis is that it is flexible and useful in summarising large amounts of data. It also allows for social and psychological (Braun & Clarke, 2006:97). I took care not to use data collection questions as themes. Themes are not overlapping and consideration was given to internal coherence and consistency (Braun & Clarke, 2006:94).

3.10 Research quality

Trustworthiness is the main consideration for research quality in a qualitative study. It is important to evaluate the worth of the study. Trustworthiness involves establishing credibility, transferability, dependability and the confirmability of the study (Lincoln & Guba, 1985:290).

Credibility entails prolonged engagement in the field to learn and understand the culture, social setting and the phenomenon under investigation (Lincoln & Guba, 1985:301). In the study I took care to understand the cultural background of the participants and especially the social setting as it directly influenced the outcome of the study. Participant observation enabled me, the researcher, to identify characteristics and elements in the situation that impacted upon the phenomenon being studied (Lincoln & Guba, 1985:304). Transferability was achieved by writing thick descriptions. When describing a phenomenon in rich detail, the reader can evaluate if the conclusions drawn can be transferable to their own time, setting, and situation (Hays & Sing, 2012:200). Dependability refers to how the phenomenon will stay consistent with repeated observations in the same context or when different methods of data are used (Lincoln & Guba, 1985:305). In the study the same pattern of sessions was followed with all sets of participants. The session plan included listening to and singing of familiar songs, vocal and instrumental improvisation and movement. In qualitative research multiple layers of meaning can develop from the data that gave me an in-depth perspective of the phenomenon. Triangulation, which is the use of multiple perspectives, can be used to gain a better understanding and interpretation of the data (Hayes & Singh, 2012:201). In this study this was done through the use of multiple cases. Care was taken to give accurate descriptions of the participants and the music therapy process. The data was reflected as accurately as possible to apply the principle of confirmability (Hayes & Singh, 2012:201).

3.11 Ethical considerations

The ethical considerations for the study were based on the four philosophical principles as described by Wassenaar (2006:67). These included autonomy and respect, nonmaleficence,

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beneficence and justice. Voluntary, informed consent was obtained from the participants to take part in the study. This addressed the principle of autonomy and respect, because they had the opportunity to choose to be part of the study and to terminate participation at any time, and that their choices were respected without penalties (Ansdell & Pavlicevic, 2001:102). The consent form contained clear and detailed information about the study, methods, benefits and risks (see appendix A). Participants were informed of the intended use of the data collected and that the findings will be used for the purpose of a Masters mini-dissertation. The consent form was explained and it was also explained that if any other researcher would like to use this data their permission would be requested. I kept all information about the participants confidential and have used pseudonyms in all written documentation to ensure anonymity (Olivier, 2003:16). The data will be stored for archiving purposes at the University of Pretoria for 15 years.

Non-maleficence requires the researcher to make sure that no direct or indirect harm comes to the participants because of the research and that they are not wronged in any way (Wassenaar, 2006:67). In the study the participants were provided with a participant information form (see appendix B) and I did not subject them to wrongdoing such as observing them without their knowledge. The participants had the benefit of attending six music therapy sessions and I attempted to maximise the benefits of the research for the participants. The principle of justice states that the participants must be treated with fairness and equity during all stages of the research (Wassenaar, 2006:68) and this was ensured to the best of my ability.

The dual role of the therapist and researcher can enhance the research process. Intuition, insight and the capacity for spontaneous analysis in the process can benefit the research. As observer and participant in the research; I took full responsibility for the clinical relationship, quality, accuracy and trustworthiness of the research material (Ansdell & Pavlicevic, 2001:103; Olivier, 2003:16). This dual role can, however, also be problematic in the sense that the participants can view the researcher in a role of power and that can influence the participants. I addressed this by remaining aware of the client's well-being in the therapeutic relationship (Ansdell & Pavlicevic, 2001:104) and constantly attended supervision.

Ethical consent for the study to proceed was granted by the Ethics Committee of the University of Pretoria on 30 June 2016.

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CHAPTER FOUR

Analysis

4.1 Introduction

In this chapter I will give a short description of the participants and the music therapy process, followed by an explanation of the data and the process of analysis. In this qualitative study I utilised thematic analysis. This is a process in which key ideas in the form of codes are identified and sorted into themes (Matthews & Ross, 2010:373). My focus in the analysis was on describing and analysing the features of the relationship of the dyads and the role that music therapy may have played in enhancing their relationships.

4.2 Participants

4.2.1 The first dyad: Mr and Mrs K

Mr K is a 67 year- old Afrikaans speaking man who is four months into recovery after suffering from a CVA in April 2016. He refused any medical attention right after the incident, but was willing to be treated by a general practitioner in the following months. He refused any form of therapy and only allows home-based care provided by his wife, Mrs K. After the CVA he was not able to walk unassisted or get up from his bed. His left side and speech were affected by the CVA. He was able to speak with slurred articulation. His speech has fully returned. His wife also reported that he had difficulty doing simple mathematic tasks, but it appears as if he is regaining analytical skills. His concept of time has also improved. Two months after the CVA he was still unable to guage the length of time and would easily get frustrated when people who had just left the premises had not yet arrived at their destination. His gait has returned to full functionality. Arm movement, especially on the left side, is still restricted. He still needs assistance with personal hygiene. He can get out of bed and walk unassisted, but needs assistance when walking up and down stairs.

Physically, home-based care is a challenge for Mrs K, as Mr. K is big in stature and is heavy to lift. She takes care of him on her own. Mrs K expressed a feeling of being stuck in this situation and that she does not have any time to be alone or to leave the house. The double-story house in which they live is another challenge as living quarters are on the top floor. He

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is not able to walk up and down the flight of stairs unassisted and this restricts the physical space in which they can move about. Both of them expressed their frustration with this limitation. They reported having a good relationship and communication, although within the process of therapy it became clear that they avoid conflict and are not always communicating openly about the true nature of their emotions.

Mr K is self-employed and manages their own business from home. Mrs K is responsible for all business that Mr K is unable to attend to. Mrs K also owns her own event company and Mr K was responsible for the music at weddings. The dyad both reported a love for music and that they were known for their loud music that always played in their house. Since Mr K suffered the CVA they have not listened to music in the same way as before. Mr K will only play pre-recorded music when requested to do so. He will only choose a playlist instead of actively choosing each song, as he did before the onset of the CVA, when he was still supplying the music at functions.

4.2.2 The second dyad: Mrs M and Ms L

Mrs M is a 60 year-old Afrikaans speaking woman who suffered from a CVA in July 2015. She is now 14 months into recovery. She suffered the CVA after been diagnosed with a bacterial lung infection. The lung infection restricted oxygen flow to the brain. She suffers from Aphasia and presents with slurred speech, although this has improved moderately in the past three months. She has balance problems after the stroke and difficulty with all motor movement. Mrs M still needs assistance with tasks of daily living like bathing. She is not allowed to enter and exit the bathtub without assistance and showering is a risk as she cannot sustain her balance when she bends down. She can dress herself, but this takes time.

Her primary caretaker, Ms L, is Mrs M's 30 year-old adopted daughter. Ms L is a single mother with a five week-old baby. The dyad currently live with Mrs M's biological daughter and her family. The living conditions are strenuous on the family as the three-bedroom house is now occupied with three adults, two teenagers and a new baby. The parents and two teenage children are sharing a bedroom to make space for Mrs M in the one bedroom and Ms L and the baby in the other bedroom. Mrs M needs oxygen when sleeping and needs to be monitored during the night.

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The relationship between Mrs M and Ms L seems to be comfortable and relaxed. Mrs M regularly expresses her gratitude for the care that she receives from Ms L. Ms L reports that Mrs M can become difficult at times and that it puts a lot of strain on her to always be available for her, especially after the arrival of the baby. Ms L appears to be extremely tired. On several occasions Mrs M's biological daughter entered the sessions, made a few comments ,and left again.

4.2.3 The third dyad: Ms B and Ms N

Ms B is a 46 year-old female Xhosa speaking client, who suffered from a CVA 13 months ago, in July 2015. After the CVA she suffered from Aphasia and complete paralysis of the left side of her body. She regained her speech and the use of both legs, but still uses a walking stick. Her left arm is still paralysed. She reports having memory difficulties. She appears to have organisation of thought. She can perform tasks of daily living like sanitary routines.

Her primary caretaker, Ms N, is a 56 year-old female friend who resides with Ms B. She is a full-time domestic worker. She works from half past seven in the morning and arrives home between two and three o'clock in the afternoon. She has full responsibility of the household.

Ms B's 19 year-old son also resides with the two women in the one bedroom house. The two women share a bed. The house belongs to Ms B. Ms N volunteered to take care of Ms B in exchange for staying in her house.

The two women report to have a good relationship. Ms B states that Ms N is taking very good care of her. They speak to each other in soft tones. Ms N reported that she often finds Ms B still in bed after returning from work and that she encourages her to get up more often and move around the house, but that this seldom happens. This seems to be a source of frustration for Ms N. She believes that Ms B will recover faster when she moves around more. Ms N is in the position of being dependent on Ms B for accommodation and so tends to avoid conflict. During the last session the dyad had a visitor. The dyad invited her to join the session.

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4.3 Music therapy process

The music therapy process consisted of six sessions for dyad two and three. Dyad one terminated their participation after four sessions. The reason for termination was unclear. Mrs K reported that Mr K did not want to attend sessions any more. He only stated that he is not a child. She did not force him to continue with sessions. Although the dyad did not complete all six sessions, I was able to capture relevant data for analysis in their last session. Because of early termination I included the interview with Mrs K as additional data source. In this interview she had the opportunity to reflect on the sessions and the music therapy process. For all dyads each session was approximately half an hour in length.

Music therapy sessions consisted of listening activities, movement, improvisation and vocalisation. The participants had the opportunity to consistently reflect on their experience of the music therapy process and their relationship.

The main aim of the listening activities was for relaxation purposes at the beginning of sessions. Music that was familiar to the dyads was used. The listening activities seemed to put the clients at ease and they appeared more comfortable in the music space after listening to familiar music. The dyads spontaneously started sharing musical experiences and memories. Co-creation of imagery also took place between the dyad. Listening to familiar music reminded all three dyads that they shared a passion for music before the onset of the CVA. A general reluctance and resistiveness was present towards movement in all three dyads at the start of the process. The caretakers encouraged more movement and, in some instances, overattuned and accelerated the pace of movements beyond that which was comfortable for their partner. During the music therapy process clients became more comfortable in movement and started dancing without being prompted and encouraged. Clients started to initiate movements as soon as the pre-recorded music started and spontaneous movement was also present during vocalisation and instrumental improvisation. Reluctance to playing drums was present for both the first and second dyad. The third dyad (Ms B and Ms N) took the instruments without encouragement. During the music therapy process the dyads became the provider of the music and spontaneously initiated changes in tempo and dynamics. Participants also started to sing spontaneously and with more self-confidence. They often exchanged leadership roles in the music.

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4.4 Data collection and preparation

4.4.1 Video recordings

As explained in the previous chapter I used video recordings as the data collection method. I was able to watch the video recordings several times and observe different aspects of the relationship between the dyads. This afforded me the opportunity to apply thorough and thoughtful interpretation to the data (Sparman, 2005:247). In relation to the research question I specifically focussed on phenomena connected to the relationship between the dyad as well as the potential influence of Music Therapy on their relationship.

The research question for the study specifically focussed on the relationship between the person who suffered from a CVA and the primary caretaker and how this relationship could be enhanced by music therapy. Instead of selecting a few excerpts from moments throughout the therapy process I elected to analyse the last session for each dyad in full. Short excerpts from the data, in my opinion, was not sufficient enough to capture the influences of the music therapy process on the relationship between the dyad. During the last session of each dyad I was able to demonstrate the influence more clearly and therefor used full sessions instead of short excerpts. In the last session the dyads had the opportunity to reflect on how the music therapy process had influenced their relationship. For dyad one, I included the last session that the dyad did together, to demonstrate the influence of the music therapy process on their relationship. I also included session four with Mrs K, as it contained her reflection on the music therapy process.

4.4.2 Data preparation: Thick descriptions

Thick descriptions were written for each of the last sessions. This was appropriate for the current study as Ponteretto (2006:543) points out that thick description are used for describing social action and behaviour in a particular context. I was able to capture expression of the thoughts and feelings of the participants as well as the relational web between them. I specifically looked at how the members of the dyad interacted with one another on a verbal and nonverbal level. Information regarding how they related to each other during music making and listening was observed. In the thick descriptions I included verbatim transcriptions of all the spoken words. Actions and movements were also included and written in italics.

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4.5 Analysis

In the next section I will describe the analysis of the thick descriptions. I will discuss the process of coding, categorising and developing themes.

4.5.1 Coding

Firstly, I placed the thick descriptions into a table. I numbered the lines in the thick description for ease of reference back to the text. For the full thick decriptions from the last session with each dyad see Appendix D. Codes were then written in the right hand column, as a word or short phrase that captures the essence of the line or paragraph in the thick description (Saldana, 2013:3). Abbreviations were used to make a distinction between the different people in each dyad. The abbreviations PES (person who experienced a stroke) and CT (caretaker) have been used throughout. Below is an example of a thick description and the codes that were assigned. This thick description is from the last session with dyad one. I had invited the dyad to take part in a movement activity where each partner gets an opportunity to take lead in the initiation of movement and the other partner is invited to mirror the exact movement.

83	(The pre-recorded music starts playing)		
84	CT:	*Starts with waving hand movements.*	
85	PES:	En as jy nou waai? [Why are you waving?]	
86	PES:	*Reluctantly starts following the wave movements at a much slower pace than CT.*	CT Much faster than PES
87	CT:	*Change of hand movements. Opens and closes fingers.*	
88	PES:	*Looks out the window after looking at his hands that cannot keep up with the pace*	PES Seems embarrased at lack of ability in relation to

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		and says: Hoe seer is my hand. *He stops moving*.	CT; PES Gives up attempt to match CT
89	CT:	*Encourages him to start again by making bolder movements and moving his body forward in encouraging motion.*	CT Encouragement
90	PES:	*Starts laughing when CT does new movement. PES continues movement in slower tempo than CT.*	CT Pushing tempo of movement
97	CT:	*Moves her leg in an up and down movement.*	
92	PES:	Nee man! [No man!] *PES cannot keep up with the fast pace.*	CT Attempting to push PES beyond ability
93	CT:	*Starts laughing.*	
94	PES:	*Looks at her and completely stops moving.*	PES seems frustrated with own limitations
95	CT:	*She appears to realise that PES feels embarrassed by her laughter and blows him a kiss.*	CT Attempts playfullness
96	PES:	*He does not respond to her kiss.*	PES embarrased
97	CT:	*She prompts by saying*: Kom nou! [Come on] *and PES reluctantly returns the kiss*.	CT encourages, PES reluctantly responds to encouragement
98	T:	Ruil…sy moet alles doen wat oom doen. [Swap around…she must follow all your movements now.]	
99	PES:	*He crosses his arms over his body, followed by a rolling movement of the hands. He crosses arms over the body again and then drops hands to his sides and then rubs his head. He moves his hands up and down. He moves his fingers pretending to play the piano, matching the music. He starts with up*	PES initiates movement

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		and down hand movements again and then changes the tempo of his movements from flowing to rigid, moving and stopping, each movement being for the duration of four beats. He goes back into a flowing movement with his arms.	
100		*CT's hand movements are much higher than PES's during the whole exercise and CT moves faster than PES.*	CT more extreme movements, CT missmatch movements of PES, CT Overattunes
101	PES:	*He touches his shoulder as if in pain, stops and shakes his head. He rests for a while and starts rolling his shoulders*.	
102	CT:	Wil jy amen sê? [Do you want to stop?]	CT reads PES's body language
103	PES:	Hoekom nie? Wat is verkeerd daarmee? [Why not, what is wrong with it?]	CT highlights PES's limitations, PES: irritation about limitations
104	(The music stops.)		

Table 4.1 Example of a thick description with codes

4.5.2 Developing categories

The codes were then sorted into categories according to similar content. Fifteen categories were developed altogether. In table 4.2., below, the left-hand column contains reference to the thick description. The corresponding codes are written in the right-hand column. The fourteenth category has six subcategories.

Category	**Codes**
1. Conflict	

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O7, O59	PES not avoiding conflict
O103	CT and PES in power struggle
O68	PES and CT in confrontation
O99	CT Experiences PES as being over sensistive
O79	PES Experiences antagonism
2. Expectations held by others	
O152, 0167	PES has high expectation of self and recovery
C159	CT has high expectation for PES to become self
C161	CT: impatient with progress
O152	PES feels frustrated with slow recovery
3. Irritation and frustration	
O123	PES communicates irritation with CT completing senetnces
C95	PES frustrated with own limitations
C104	PES experiences irritation about limitations
D15	CT: alleviation of frustration through communication
O152	CT realises PES irritation with aphasia and disability
O174	PES admits to be irritated
C143	Frustrated with medical advice received
O77	PES experiences irritation and frustration
O195	PES frustrated - finances
O19, O20	PES experiences stress about finances
O24	PES admits inability to deal with stress
Z12	CT frustrated with high level of responsibility
O148	CT experiences religious inner conflict after CVA - causing frustration
O121	PES realises less completion of sentences from CT after music therapy
D8	Caretaker needs space
D8	CT needs space for self care
O142	CT: strong will to move in own direction
C57	CT: longing for silence

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4. Disability and limitations	
D21	PES realises limitations of disability
Z61, C89	PES realises abilities in comparison to CT
C97	PES embarassed about limitations
C104	CT highlights PES's limitations
O215	CT disabling PES - reminding her of inabilities
C93	CT attempting to push PES beyond limits
C57	CT experiences isolation
C22	PES - patient surrender
C15	PES resisting medical care
O94	PES feels victimized
O104	PES admits to difficulty being dependant on others
O187	PES experiences low self-confidence
O152	PES gets tired
O118	CT - difficulty dealing with PES emotions limitation
D15	CT realises over-protection hinders healing process
O85	PES experiences loss of thoughts
O92	PES admits realisation of lost thoughts
O110	PES expresses sadness and need to be alone
C24	PES resists care
O208	PES scared of driving
D8	CT awareness of taking over tasks of daily living from PES
O179	CT wants to control tasks of daily living
O217, O174	PES needs to do tasks of daily living
Z89	PES takes responsibilty for own health
5. Difficult emotions	
O1	PES feels like burden to family and CT
O44, O108	PES experiences guilt - inability to provide
C20	PES feels helpless
O124, O114, O112	PES cries
D21	PES feels guilty for terminating music therapy

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O40	PES expresses her longing for love an dto be loved
O217, O174	PES articulates need for independence
O172	CT has difficulty accepting own feelings
O65	PES projecting feelings onto CT
O77	PES projecting feelings onto CT
O15	CT projects feelings onto PES
O24	PES displays insight into own feelings
O40	PES expresses longing for love and to be loved
Z85	PES utilises music as mood regulator
O100	PES mentions awareness of sensitivity
6. Improved vocal abilities	
Z45	PES displays improved language abilities after music therapy process
Z48	PES extends vocal ability
7. Open lines of communication	
D10	PES and CTdisplay open lines of communication
C75	Signs of past good communication in relationship
O201	CT expresses the importance of listening for good communication
D8	PES and CT new open communication after music therapy
O128	CT acknowledge music therapy created greater awareness of interruptions
D15	PES and CT experience enhanced communication after music therapy relating to difficult situations
Z74	CT- solidify friendship during music therapy process- enhanced communication
C19	CT display physical affection
8. Shared Experiences	
C149	PES and CT share new musical experiences

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O156	Music therapy helped to recover shared musical memories
C110	PES and CT shares new experience
Z76, C115	Shared thoughts and experiences
C65	CT reflects on shared experiences
Z82	PES states that friendship solidifies through shared experiences
O156	PES states that music therapy reminded them of music relationship
C58	PES and CT shared memories before CVA
C53	PES and CT shared longing to be in nature
C66	PES reflects on shared value of peacefulness
O44	PES values honesty in relationship
O44	PES experienced betrayal in past relationships
C153	PES values co-operation
C75	PES values good communication
O40	PES reflects on complexity of relationships
O40	PES deep inner conflict about realitionships and reality of relationships
9. Enjoyment and stimulation	
C68	PES sharing current pleasureable experiences
Z78	CT shared laughter in shared experience with PES
D6	CT experiences uplifting moments in music therapy
I156	PES, realises happiness during music therapy
C116	PES acknowledges pleasure of making music
O27	PES finds pleasure in music
C78,	PES and CT experienced laughter together
O46	CT expresses need to be happy
C149	CT experiences stimulation
C110	PES and CT dancing again after music therapy
Z90	PES and CT experience pleasure in movement
Z89	PES uses dancing as expression
O75	PES states that music makes life easier

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10. Motivation	
C110	PES motivated to be more active
Z70	PES expands activity repertoire
Z70	PES interested in other activities
Z6	PES tests more abilities after music therapy
D13	CT experiences return of motivation after music therapy
D8	PES extends range of movement
Z24	PES displays growing confidence in movement and vocalization
Z6	PES becomes more involved in community after music therapy
11. Normailty	
C159	CT longs for normality
C159	PES returns to self after music therapy
C110	PES actively makes music again after music therapy
C110	Music and listening back in relationship after muic therapy
D11	PES motivated to get better after music therapy
Z70	CT experiences relief in change and improvement in PES during music therapy process
12. Empathy	
O120, O148	CT displays more empathy after music therapy
O120	CT shows awareness of PES feelings after music therapy
D8	CT is more sensitive to PES's needs and wants
D8	PES and CT reports deeper awareness of each other after music therapy
13. Affirmation and recognition	
O109	Affirmation- children wants to help mother

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C90	CT encourages PES
O170	CT validates PES's feelings
O97	CT expresses affirmation and will to take care of PES
O133	PES thankful for care
O152	CT acknowledges strength of PES
O135	PES acknowledges strength of CT
14. Caretaker roles	
C15	CT: multiple roles of CT
O128	CT making peace to change roles
O131	CT realises change of roles
14.1 Medical carer	
C23	CT delivers medication
C143	PES displays distrust in medical care
C142	PES places CT in control of medical appointments
14.2 Decision maker	
O62	CT makes decisions
C22	CT in position of power
C21	CT from wife to caretaker and decsion maker
14.3 Assistant	
O85	PES asks CT to help with lost words
O176	PES suffers from a loss for words, asking for assistance from CT
14.4 Acting on behalf of PES	
O35	CT - uncomfortable with silence
14.5 Conflict avoider	
O3	CT avoids conflict, diverting conversation
14.6 Spokesperson	

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O22	CT realises interruption of PES
O15, C59, C163, O54, O47, O111	CT talks on behalf of PES
15. Hope	
C155	PES hopes to get better
C159	CT hopes for better quality of life
C155	PES hopes for better quality of life
Z45	PES expresses hope to be involved in community
O44	PES wants better life for children
C166	PES wants to please others with music
C166	PES articulates passion to reach people through music
D11	PES is motivated to get better
Z93	PES shares hope to be remembered for laughter

Table 4.2 Categories and corresponding codes

4.5.2.1 Conflict

The category ‘conflict’ includes codes that deals with dissonance in the relationship and experiences of antagonism. Although the dyads reported having good relationships there was underlying conflict that surfaced during the music therapy process and manifested in antagonism and experiences of being defensive. Codes relating to confrontation were grouped under this category.

4.5.2.2 Expectations held by others

The two people in the dyad each had their own expectations about the recovery process and the pace of the recovery. Expectations influenced the way in which the dyad related and communicated with each other.

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4.5.2.3 Irritation and frustration

Irritation and frustration were put in one category as it was not always possible to clearly distinguish between the two emotions. Irritation and frustration were present because of a range of factors, such as limitations that the dyad experienced, aphasia, finances, responsibilities of the caretaker and tasks of daily living.

4.5.2.4 Disability and limitations

The person who experienced the CVA had difficulty accepting that they are now dependant on the caretaker. The music therapy process reminded them at times of their inabilities and limitations. In this category I grouped codes relating to the disabilities and limitations of not only the person who experienced the CVA but also of the caretaker.

4.5.2.5 Difficult emotions

The person who experienced the CVA experienced a range of difficult emotions such as feeling like a burden to the family, guilt because of an inability to provide for the family and helplessness, to name a few. The caretaker, on the other hand, also had her own emotional challenges, such as acceptance of feelings of being stuck in the situation. All codes relating to difficult emotions were grouped in this category. I also included a few codes here that related to how they had gained insight into their own emotions.

4.5.2.6 Improved vocal abilities

During the music therapy process the participants extended their vocal abilities. This led to improved use of language which enhanced communication between the dyad.

4.5.2.7 Open lines of communication

The music therapy process offered the participants an opportunity to openly communicate with each other. Codes relating to communication were grouped together in this category. Examples include greater awareness of interrupting each other and listening to each other.

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4.5.2.8 Shared experiences

Shared experiences afforded the participants opportunities to reflect on their past musical experiences and to recover memories. They experienced their friendship improving through new shared experiences.

4.5.2.9 Enjoyment and stimulation

Codes containing elements of laughter, happiness and pleasure were grouped together in this category of enjoyment and stimulation. The participants reported that they experienced uplifting moments and that music makes them happy.

4.5.2.10 Motivation

The participants reported feeling motivated to regain health. This motivation manifested in an interest in extending their repertoire of activities of daily living. Codes relating to motivation and extension of activities were grouped together.

4.5.2.11 Normality

'Normality' was another category that was identified as participants mentioned that, after the music therapy process, the person who experienced the CVA now displayed characteristics of how they used to behave before the CVA occurred.

4.5.2.12 Empathy

The music therapy process resulted in participants reporting enhanced empathy for each other in the relationship. Deeper awareness for participants in the dyad, sensitivity to wants and needs, and empathy were grouped together in this category.

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4.5.2.13 Affirmation and recognition

In the 'affirmation and recognition' category, codes were included that described assurance that the dyad offered each other as well as encouragement and recognition. They also expressed thankfulness towards each other and this too was grouped in this category.

4.5.2.14 Caretaker Roles

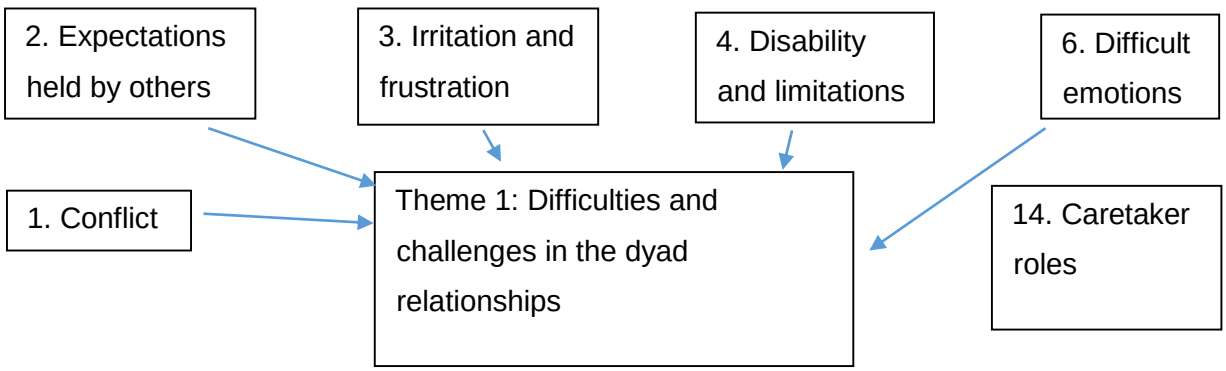
The caretaker took on many roles in day-to-day life and in the music therapy process. All codes relating to these different roles were placed under the cateogory 'caretaker roles'. These include roles such as medical supervisor, assistant, conflict avoider, spokesperson and acting on behalf of person who had experienced a stroke.

4.5.2.15 Hope

'Hope' is the last category and includes codes relating to hope for a better quality of life, hope to be involved in the community and a hope to have meaning for other people. The hope to be remembered for laughter and to reach people through music was also included in this category.

4.5.3 Themes

Three themes were developed as the categories were considered. The diagram below shows how the categories were grouped together to form themes.



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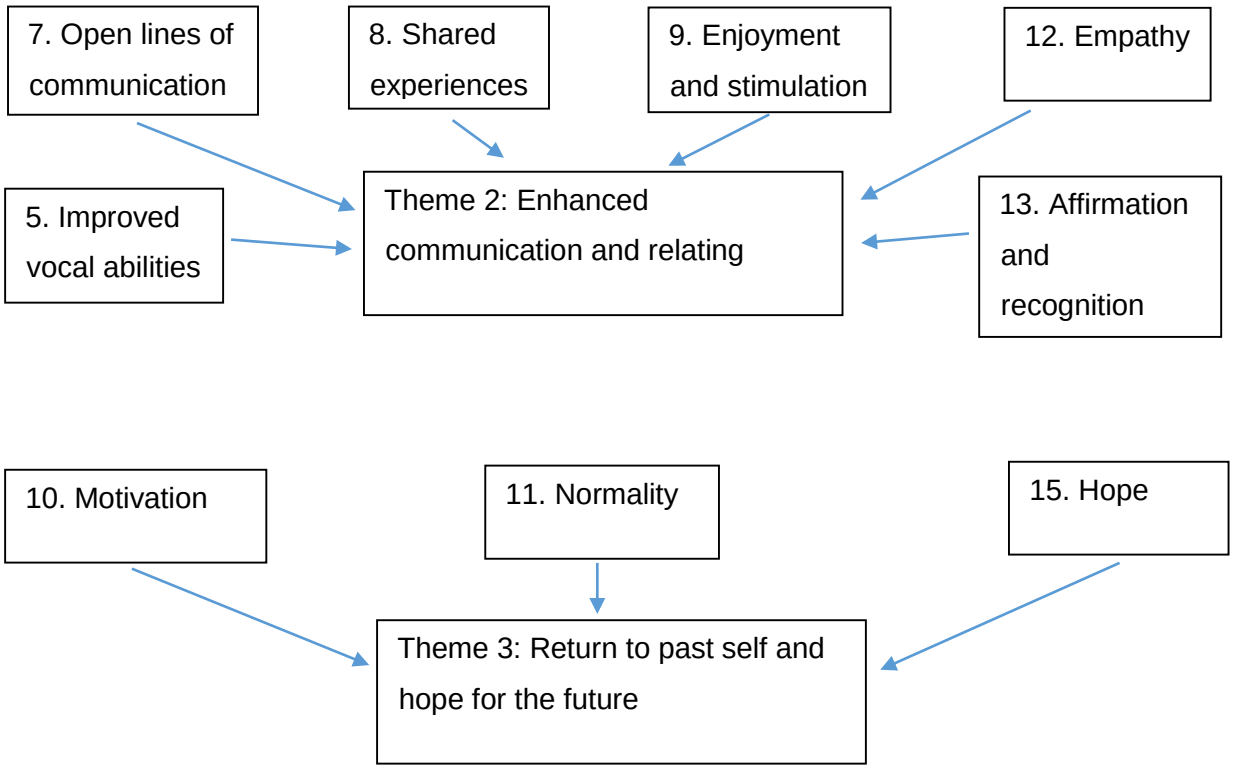

Figure 4.3 Categories and themes

Categories relating to the difficulties and challenges that the dyad experienced were grouped together to develop the first theme. The categories develop theme two contain the different elements that enhance communication and relating in the dyad. The categories in this theme include ‘improved vocal abilities’, ‘open lines of communication’, ‘shared experiences’, ‘enjoyment and stimulation’, ‘empathy’, and ‘affirmation and recognition’. Theme three, the return to past self and hope for the future, holds the following categories: ‘motivation’, ‘normality’ and ‘hope’. Motivation and a sense of normality appeared to lead to hope for a better quality of life and hope for the future.

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4.6 Conclusion

This chapter has described the process of analysis and how three themes were developed from the thick descriptions of video recordings. The process included coding, cateogorising and theme development.

In the next chapter I will discuss the three themes in more detail in order to address the research question. The themes will be discussed in relation to the literature that was explored in chapter two of this study.

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CHAPTER FIVE

5. Discussion

5.1 Introduction

In this chapter I will discuss the findings of the study. I will explore the three themes that emerged from the data in order to address the the research question, namely what role music therapy can play in enhancing the relationship between an individual who has experienced a CVA and their primary caretaker in the home context. I will also draw links between the themes and the literature reviewed in chapter two. The three themes under discussion will be: difficulties and challenges in the dyad relationships, how the music therapy process enhanced communication and relationship and, lastly, their goal of returning to a past experience of self and their hope for the future.

5.2 Difficulties and challenges in the dyad relationships

Although all three dyads reported having good relationships, it became clear during the music therapy process that they also experience a range of difficulties and challenges. Research has identified various struggles encountered by both the person who suffered a CVA and the primary caretaker. A number of factors influence the way that a caretaker and the person who has suffered from a CVA relate and communicate. Aphasia influences reception of language, social participation and activities of daily living and can cause depression, isolation and withdrawal (Baker, 2006:27). Mr K, in dyad one, experienced symptoms of aphasia immediately after suffering the CVA and Mrs M from dyad two sometimes struggle to find words to express herself. After a CVA personality and behavioural changes can be present and individuals might experience disinhibited behaviour, may feel extremely tired and display poor tolerance and frustration. In the data Mrs M mentions how tired she feels. She explains it as a tiredness that reaches deep within her soul. Signs of frustration were noticeable in all three dyads. Baker (2006:28) also describe some cognitive disturbances such as perseverance, poor short-term memory and impaired abstract and analytical thinking as challenges that can be faced by someone that suffered from a CVA. High levels of irritation and frustration can lead to conflict. Expectations about recovery held by the two people in the relationship can create difficult emotions and can be a source of struggle, both physically and emotionally. The caretaker takes on many different roles to negotiate the successful recovery of the person that suffered from the CVA.

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During the music therapy process these factors became apparent and will now be discussed further. In the discussion I will refer to the person who experienced the stroke as PES and the caretaker as CT.

5.2.1 Conflict

All three dyads initially reported not having any communication difficulties, however, the music therapy process became a platform for them to explore this aspect of their relationship further. Participants took the opportunity to voice underlying conflict. Mrs M (from the second dyad) directly addressed this when she said:

> …ek dink, reg nou, wil ons mekaar vermoor. [I think, that right now we want to kill each other.] (O53)

> Jy besluit hoe jy voel…jy het dit netnou gesê. [You decide how you feel…is that not what you just said?] (O7)

In this instance the caretaker was not ready to address the conflict and utilised strategies to avoid it, like diverting the conversation or ignoring comments made by Mrs M. Ms L then experienced antagonism and expressed it by saying:

> …en ek is nie gewoond dat hulle (die kinders)…daai vibe teenoor my het nie. [I am not used to them (my children) having that kind of vibe towards me.] (O79)

> Ma, jys is fyngevoelig. [Mom, you are being over-sensistive.] (O99)

In retaliation Ms L commented that her mother is over-sensitive towards anything that might be said to her. Floyd's (2006:5) argument was that close interpersonal relationships are built on pillars of affection, inclusion and control. All three of these pillars are important in maintaining the relationship. In this instance each of these factors is impacted and this may threaten the health of the relationship. Affection appears to be influenced particularly and this can create a feeling of separation for Mrs M and may be a reason why there is a reaction of 'over-sensitivity'.The sensitivity to the words and actions of one another becomes volatile through distorted perceptions and expectations.

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5.2.2 Expectations held by others

Both partners in the relationship have their own set of expectations particularly about the pace of and goals for recovery. Music therapy sessions gave the dyads space to reflect on these expectations. The person who had experienced the stroke was perceived to have high expectations of full recovery with unrealistic time frames. Ms L articulated this when she said:

> Ek dink partykeer sy verwag te veel van die dag, haar verwagting is te hoog te vinnig. [I sometimes think that she expects too much from a day. Her expectations are too high, too soon.] (O152)

Those who had experienced a stroke also has preconceived ideas of the expectations of others concerning their recovery. For example, Mrs M said:

> …ek is op ‘n sad plek, wat stupid is, want ek moet op ‘n ander plek wees. [I am in a sad place. That is stupid, because I am supposed to be in another space.] (O167)

The caretaker also holds expectations for the recovery of their loved one and, at times, communicated impatience with the tempo of recovery. For example Mrs K, explained:

> Die ou gees wat uitkom en sprankel en uitkom…en dis wat ek graag wil sien. [The old soul needs to come out, that is what I would like to see.] (C159)

> ’n Towerstaffie sou gehelp het. [A magic wand could have helped a lot.] (C161)

The expectations held by self and by others create irritation and frustration when this is not met in the expected time frames.

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5.2.3 Irritation and Frustration

Irritation and frustration were apparent in the music therapy process in both parties. These feelings of frustration are also described in the literature by Baker (2005:295). Feelings of frustration, grief and anger can be experienced by both parties because of a loss of physical functioning and independence. Impaired communication skills caused by aphasia as well as physical challenges have been reported to cause frustration and depression for both members in the relationship (Dobkin, 2005:1682).

On several occasions during the music therapy process the caretaker completed sentences on behalf of the person who had experienced a CVA. Those who had experiened a CVA explained that this is a cause for great irritation and frustration as the intended message is not always conveyed. For example, Mrs M asked the following:

> Wat sal jy sê as iemand jou sinne aanhoudend klaarmaak?...aanhoudend en baie kere is dit wat jy wou sê en baie kere is dit nie wat jy wou sê nie. [What would you say if someone completed your sentences all the time? Sometimes it is what you wanted to say and sometimes it is not all what you wanted to say.] (O126)

During the process Ms L became more aware of this and consciously attempted to stop doing it. Mrs M noticed this and made mention of it in the session:

> Jy maak nie meer my sinne klaar nie. [You do not complete my sentences any more.] (O121)

Physical challenges also created high levels of frustrations. During a movement activity the frustration of Mr K caused him to stop participating when he was not able match the tempo of movement of Mrs K. The frustration could also be noticed when Mrs K attempted a moment of playfulness by blowing a kiss to Mr K and he only returned the kiss after she verbally prompted him.

External factors such as stress about finances also create frustration and irritation. It can also cause feelings of being overwhelmed, as the person who experienced the CVA is not able to provide for the family any more. Mrs M articulates this frustration and fatigue in the following words:

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> Nou onthou ek, ek moet wag vir geld. [Now I remember, I have to wait for money.] (O195)

> Ek is sielsmoeg…daar waar dinge te veel is. [I am tired deep within my soul. Things are too much for me to handle.] (O24)

5.2.4 Disability and limitations

Mrs M, especially, displayed signs of fatigue and excessive crying. In the last session she explained that there were times before the CVA that she did not cry for long periods of time. Now she wants to cry excessively. The literature reviewed in this study indicated that people who have experienced a CVA might present with. Fatigue, excessive crying, apathy, poor insight, egocentricity and inappropriate behaviour can also be present. Short-term memory and problem solving abilities might be inhibited (Baker, 2006:28; Lagarde, Hajjim & Yelnik, 2009:360).

Mrs M mentioned the experience of ‘lost thoughts’. For example, during a session Ms L would try to draw Mrs M’s attention by asking her a question. Mrs M responded by saying

> Ek weet, maar my gedagtes waai. [I know but my memories blow away.] (O92)

In the music therapy process, especially during movement, it became apparent that participants in the study who had suffered a CVA measured their abilities alongside that of others. Ms N explained that, after music therapy she was once again able to move like the other people in their congregation moved:

> I can also move like they are moving in church! (Z61)

In dyad one, movement highlighted Mr K’s sense of limitation and this resulted in feelings of embarrassment. Mrs K reacted with words of encouragement which, in some cases, were experienced by Mr K as being discouraging. During the session Mr K stopped moving despite encouragement from Mrs K. Ms L had a tendency to try take over the task. This

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action highlighted Mrs M's disability even more which seemed to lower Mrs M's self-esteem. Mrs M said that she experienced low self-esteem in the following quote:

> Ek weet nie of ek die selfvertroue het nie…om my kar te bestuur nie. [I do not know if I have the self-confidence to drive my own car.] (O187)

The person who experienced the stroke also commented on how difficult it is to be reliant on another person and that they often feel like a burden to the family. This resonates with literature on the difficulties of losing independence (Baker, 2005:295). It was expressed, for example, in phrases by Mrs M:

> Ek dink Ms S bid vir die dag wat ons huis toe gaan. [I think Ms S is praying for the day that we will go back home.] (O1)

> …omdat ek verleë en afhanklik is van iets en iemand vir die eerste keer in my lewe in hierdie situasie. [I am embarrassed to be dependent on someone. I am in this situation for the first time in my life] (O104)

Difficult emotions that were mentioned were guilt because of an inability to provide for the family and a feeling of helplessness. This feeling was articulated in the following phrase Mrs M:

> Maar die ma is veronderstel om 'n place of safety en 'n safe haven te wees. [A mother is suppose to be a place of safety and a safe haven for her children.] (O108)

Sadness and a need to be alone was articulated by Mrs M. Ms L had difficulty dealing with the emotion of Mrs M especially when she started crying. The caretaker in this situation was required to deal not only with her own emotions but also those of her loved one.

5.2.5 Caretaker roles

In the current study the caretakers had to fulfil many different roles such as: medical carer and supervisor, decision maker, assistant, conflict avoider, spokesperson and acting on behalf of the person they are caring for. The literature indicates that primary caretakers of persons who have experienced a CVA can suffer from a decline in health, social life and

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general well-being because of the high responsibility that they are required to carry. They can also suffer from burn-out (Visser-Meiley, Post, Riphagen & Lindeman, 2004:601). During the music therapy process the caretakers realised that some of their roles may need to change to assist the person they are caring for in regaining their health. Mrs K explained,

> Ek (is) geneig om te veel te wil doen en dit het ek ook besef. [I realised that I tend to do too much and I realised that (during the music therapy process).] (D8)

The participants in the study, particularly Mr K, appeared to have a distrust in professional medical care and resisted going to specialists and therapies. The caretaker is placed in control of not only delivering medication, but also of arranging medical appointments and decisions. When these decisions and appointments are questioned by the person who is receiving the care this creates tension within the relationship, as was the case in all three dyads.

Aphasia results in the caretaker being asked to assist when there is a loss for words and this places the caretaker in the role of spokesperson. The caretaker also acts on behalf of the person who experienced the CVA. On many occasions in the music therapy process the caretaker interrupted and talked on behalf of the PES. The habit of completing sentences and interrupting the person they are caring for became a source of tension in the relationship. In the next section I will discuss how music therapy assisted in enhancing communication to assist the participants to find a different manner of relating to one another.

5.3 Enhanced communication and relating

In this section I will discuss how communication and relationships were enhanced by the music therapy process. I will discuss how enhanced vocal abilities helped to improve communication. The music therapy process created a platform for open lines of communication. New shared experiences, stimulation and enjoyment also contributed to heightened communication and relation. I will conclude this theme by discussing how affirmation and recognition in the music therapy process contributed to enhanced communication and relating.

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5.3.1 Improved vocal abilities

The literature suggests that music therapy in neurological rehabilitation has the benefit of enhancing social interaction, emotional expression and improvement in speech and communication for a person who has experienced a CVA (Stegemoller, 2014:219). During the music therapy process the participants indeed reported that they were able to experience improvement in vocal ability during and after singing.

The participants in the study were hesitant and unsure to sing at first. During the process, they started to sing more spontaneously and, in the last sessions, they were able to initiate new songs and improvise melodic lines without being prompted by the music therapist. Ms N noted how much of an improvement she could see in Ms B after singing. Ms N replied,

> …she said my tongue is loose now, it's not 'vas' [stuck]. (Z48)

> I want to talk now, cause I want to preach in church, I also want to preach. (Z45)

This resonates with the literature that states that song singing and vocal exercises can help to increase the rate of speech, articulation and intonation in persons who have suffered neurological damage and have speech difficulties as a result (Baker & Wigram, 2004:177). Song singing can assist particularly in enhancing intelligible and natural speech patterns.

5.3.2 Open lines of communication

Participants reported that, through the music therapy sessions, they related to one another better now as they are able to communicate I an enhanced way. Caretakers became aware that with improved speech abilities there was now no need to complete sentences on behalf of the person they are caring for and there was a heightened belief in their competence. It also opened lines of communication and Ms L mentioned that without the music therapy process she might have not been aware of what was bothering Mrs M:

> Nee, ek sou nie agter gekom het dat dit haar pla nie en ek meen syt my altyd gevra om dit te doen. [No, I would not have realised that it was bothering her. I mean she always asked me to do it.] (O128)

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Mrs M also commented:

> Jy maak nie meer my sinne klaar nie. [You do not complete my sentences any more.] (O121)

Mrs K, from dyad one, reported that it is easier now to talk about concerns that emerged during the music therapy process. Although they experienced a good and open relationship before music therapy, there were some sensitive issues that they both avoided and the music therapy sessions gave them the opportunity to explore this in a safe environment. Mrs K said,

> Ja, daar het goed uitgekom waaroor ons kon praat. [Yes, things came out that we could talk about.] (D10)

A greater awareness of the importance of listening to the other person to enhance communication also evolved from the sessions:

> Luister…ja, ek moet luister. [Listen…yes, I have to listen.] (O201)

The dyads shared new enjoyable experiences during music making and, as Ms N reported,

> As I can see, it did make it better…we [Ms N and Ms B] two together. (Z74)

5.3.3 Shared experiences

Literature indicates that close interpersonal relationships are characterised by shared relational and interactional experiences (Guerrero, Anderson & Affifi, 2007:7). Shared experiences create a sense of belonging and inclusion, and fulfil the basic need of safety and survival as well as alleviating loneliness and low self-esteem (Lambert, Stillman, Hicks, Kamble, Baumeister & Fincham, 2013:1419).

Music therapy created opportunities to recover shared musical memories and to be involved in new experiences. Mrs M commented that she had forgotten how happy music makes her feel and that music therapy helped her to remember that again. Two of the dyads, Mrs M and Ms L and Mr and Mrs K, had never experienced drumming before and, although they were hesitant at first, they commented on the value it had for their experience of being together in

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the music making process. Mrs K reported on what stood out for them in the music therapy session by saying:

> Die saam van die kitaar en die musiek. Die luister van die musiek en die konsentreer, waarnatoe gaan die musiek…en om te kan volg al kan ons nie trompie speel nie. [The playing together of the guitar and the music. The listening to the music and the concentration, of where the music is moving to and being able to follow although we can not play the trompie] (C149)

Being together also created an experience for Ms N and Ms B's friendship to grow stronger. Ms N explained it in these words:

> Dit maak ons 'friendship' vas. [It (the music therapy process) makes our friendship stronger.] (Z82)

5.3.4 Enjoyment and stimulation

Mrs K reported that music therapy lifted her emotionally:

> Dit was vir my as versorger in die eerste plek, rerigwaar…dit het my bietjie uitgekry uit 'n plek waar ek was. [In the first place it was for me as caretaker, really…it got me out of a place where I have been.] (D6)

The literature shows that song singing and listening to familiar songs improves the mood and orientation of caretakers. It enhances general caregiver well-being and has a positive effect on quality of life (Sarkamo et al., 2014:634). Mrs M also expressed the need to be happy and explained that music makes life easier. Participants realised during music listening that music can serve as a mood regulator and that it makes them feel better about the circumstances they are in. For example Mrs M and Ms N said, respectively:

> Maar ek moet vir jou sê met die dramas in ons lewens op die oomblik het die musiek dit vir ons makliker gemaak. [I have to tell you that, with all the drama in our lives, that music made life easier.] (O75)

> Dit help dat ons nie kwaad mekaar…want sien jy, hy help daai 'music therapy'…hy werk vir ons jy lag. [It (music therapy) helps in that we do not get

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> angry with each other, because you see that music therapy helps. It works for us, we laugh.] (Z85)

The pleasure that the participants experienced during music therapy sessions was audible in their loud bursts of laughter on several occasions. They also explained, during conversations after initial music therapy sessions, that they were able to talk freely and experience laughter together. For example Ms N explained:

> So, as ek miskien een ding dink, dan dink sy ook daai ding wat eke dink en dan praat ons oor hom en dan is ons weer lekker en ons lag. [So, if I think about one thing, she also thinks about the same thing and then we are communicating well with each other and we laugh.] (Z76)

Besides their experiences of joy and laughter, they became more aware of each other in the relationship and acted with more empathy and understanding towards each other. This also enhanced the relationship. The literature confirms that it is important in relationships for people to interact in meaningful ways that go beyond basic tasks. Affirmation and encouragement in relationships helps to form a deeper social and emotional bond and strengthens the relationship (Guerrero, Anderson & Affifi, 2007:6). During Mrs M and Ms L's last session Ms L explained,

> Ek dink nou maar net voordat ek praat en ek maak nie my ma se sinne klaar nie, want ek dink nou hoe dit haar laat voel. [I think now before I talk and I do not complete my mother's sentences any more. I think about how it makes her feel.] (C120)

5.3.5 Affirmation and recognition

Affirmation, as mentioned above, is a very important component of a healthy relationship. Music therapy gave the participants opportunities to demonstrate affirmation and recognition for each other. The recognition and affirmation was mostly expressed by the PES, as he/she voiced thankfulness for the care that he/she receives. All three caretakers constantly affirmed their willingness to assist their loved one. The caretakers in all three dyads also constantly offered encouragement to the other party. There was recognition from both parties for the strength that they see in the other person.

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Affirmation and recognition also served as motivation to the person who experienced the CVA to return to his/her 'old self'. When the dyad started to notice progress in the healing process there was a sense of hope for the future.

5.4 Return to past self and hope for the future

During the music therapy sessions movement improved noticeably for the participants in the study who had experienced the CVA and they displayed growing confidence in this regard. A review of the literature shows how music therapy in the rehabilitation of CVA can improve gait and arm movement (Thaut & McIntosh, 2014:108). Rhythmic cues in music produced anticipation for onset and completion of movement. Ms B even attempted dancing without her walking stick and was motivated to expand the repertoire and range of her movement. A general increase in activity level was noticeable and reported by the caretakers in all three dyads, not only during music therapy sessions, but also inbetween sessions. There seemed to be an increased interest in other activities and the caretakers reported that their loved one appeared to become their 'old self' again. Ms B started reading again, went for walks outside and started doing tasks of daily living. The caretakers seemed relieved and reported that some form of 'normality' appearerd to have returned for the person they are caring for. Ms N and Mrs K reported on this as follows:

> To me…to me it means a lot, because I can see B, there is a lot of change in her. Yesterday afternoon, she was lying down with the Bible. She was reading in the Bible yesterday afternoon. Really this therapy of yours is working, really working. (Z70)

> Ek kan verseker sê hy het lus vir gesond word. [I can say for sure that he wants to get healthy.] (D11)

The participants shared a hope for a better quality of life and the hope to lead a fulfilling life. This is clear in Mr K's comment:

> Op die einde van die dag…as 'n ou net beter anderkant uitkom. [At the end of the day one should just get better at the end of the process.] (C155)

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5.5 Conclusion

In this chapter I have discussed the findings after analysing the data. In the next chapter I will conclude and discuss the limitations of the study. I will also make recommendations for future research.

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CHAPTER SIX

Conclusion

6.1 Introduction

In this chapter I will summarise the findings of the current study. I will also discuss the limitations and make recommendations for further studies.

6.2 Summary of findings

The present study explored the role that music therapy can play in enhancing the relationship between an individual who has experienced a CVA and their primary caretaker in the home-based setting. From the analysis of the video recordings of sessions, it was found that music therapy offered the participants opportunities to explore difficulties and challenges in their relationship. It also offered them opportunities for enhanced communication and relating. There was a move towards a return to the old self, the one they experienced before the occurrence of the CVA, and the participants articulated hope for the future.

The sample included three groups with different relational dynamics and socio-economic circumstances. Conflict, frustration and irritation were present in all three dyads. All three sets of participants' experienced difficult emotions accompanying disability and limitations. During the process of music therapy all three caretakers realised that adjustment of roles will have to take place now that the person who has experienced a CVA is regaining their health. The dyads shared new experiences that these provided them with enjoyment and stimulation. The participants who had experienced a stroke reported improvement in vocal abilities. The dyads found a platform for open communication which in turn enriched their relationship. For the person who had experienced the CVA renewed motivation appeared to influence a return to aspects of their former self. The caretakers also experienced some return to normality. This gave the dyads hope for the future and hope for a better quality of life.

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6.3 Limitations of the study

A limitation of the current study is that the sample size consisted of only three dyads of which one dyad did not complete the process. The early termination dyad one resulted in the inclusion of an additional data source to include the reflection of dyad one on the music therapy process. I was, however, able to capture enough data to answer the research question. Another limitation was that I did not conduct separate interviews with the participants before the sessions started. I believe that the participants would have been able to answer more truthfully about their communication difficulties in their relationship if the other party was not present. More than six sessions would have given participants, who have never experienced active music making before, an opportunity to become more comfortable during the sessions. Their discomfort could have influenced their self-esteem and confidence.

6.4 Recommendations for future research

In the current study the participants were all able to read, write and speak. Further research is recommended on the impact of music therapy on the relationship between a person who experienced a CVA and a primary caretaker in the home-based setting, where severe aphasia is present. I would also recommend further investigation into how roles and expectations in the relationship have an influence on the recovery process of a person who experienced a CVA.

6.5 Conclusion

Music therapy played a role for the participants in this study in enhancing their relationships by giving them opportunities to explore their difficulties and challenges, enhancing their communication and relating through experiencing shared new experiences and opening communication, and through creating hope for normality and a better quality of life. Music therapy, therefore, appears to be able to play an important role in the relationships and rehabilitation of a person who has experienced a CVA and their primary caretaker in the home-based setting.

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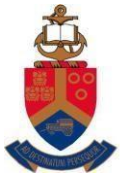
APPENDICES

APPENDIX B



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
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FACULTY OF HUMANITIES

MUSIC DEPARTMENT

Pretoria 0002 SOUTH AFRICA

TEL (012) 420-2316/3747

FAX (012) 420-2248

Participant Information

Study Title: **Music Therapy in home-based settings for clients who have suffered from a Cerebral Vascular Accident and their caretakers**

Dear _____,

In this study I will investigate what role music therapy can play in enhancing the relationship between an individual who has experienced a CVA and their primary caretaker in the home context. I will do a six week music therapy intervention. The purpose of the study is to undertake research for a mini-dissertation as part of my MMus (Music Therapy) degree. I would value your participation in this process.

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I will be participating in sessions as well as doing the research. I will video record the sessions in order to interpret and analyse the process. Video recordings will only be used for the purpose of the study and will be kept confidential.

Participation in this study is voluntary and you may terminate the sessions at any time without any negative consequences.

All video recordings and session notes will be destroyed in case of termination.

I assure confidentiality. No identifying names or information will be used in the writing up of the dissertation. After the study has been completed, the findings will be made available in a mini-dissertation and will also be written up in the form of an academic and scientific journal article. Data will be stored for archiving purposes at the University of Pretoria for 15 years. Should any of the data be used for further analysis, permission from participants will be obtained in the form of informed consent.

I would greatly appreciate your participation in the study.

Please contact me if you have any queries or concerns.

Estine Brown

Researcher/Student

E-mail: estinebrown@yahoo.com

Cellphone number: 084 722 0937

Andeline dos Santos

Supervisor

E-Mail: andeline@musickeys.co.za

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APPENDIX A

FACULTY OF HUMANITIES

MUSIC DEPARTMENT

Pretoria 0002 SOUTH AFRICA

TEL (012) 420-2316/3747

FAX (012) 420-2248

Participant Consent Form

Study Title: **Music Therapy in home-based settings for clients who have suffered from a Cerebral Vascular Accident and their caretakers**

I, _____ hereby give consent to participate in the music therapy sessions and that the focus of the research will be to observe what role music therapy can play in enhancing the relationship between an individual who has experienced a CVA and their primary caretaker in the home context. I hereby give/do not give my consent for these sessions to be recorded. I understand that these recordings will only be used in order to describe and interpret the collaborative process.

With full acknowledgement of the above, I agree that I will participate/not participate in this study on this _____(day) of this _____(month) of _____ (year).

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Participant Details

Participant name:_____Signature:_____

Participant Contact Number:_____
Date:_____

Researcher & Supervisor Signature

Researcher name:_____Signature:_____

Date:_____

Supervisor name:_____Signature:_____

Date:_____

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APPENDIX C (Actual names have been replaced with pseudonyms)

	Session C: Group 1		
1	T:	Hoe gaan dit met oom vandag? [How are you today?]	
2	PES:	Oraait [All right.]	
3	T:	Is oom reg? [Are you comfortable?]	
4	PES:	Ek het darem survive, so ek is reg. Ek wil net weer dokter toe gaan dat hy kyk wat de hel gaan aan dat my been so geweldig swell. [At least I have survived. I just want to go back to the doctor so that he can check what the hell is going on that my leg keep swelling.]	
5	T:	Kan dit die medikasie wees wat dit doen? [Can it be the medication?]	
6	PES:	Ek is net bekommerd oor hierdie spul pille, jinne suster hier word pille gedrink. Jy verstaan nie. [I am just worried about all the pills. You do not understand the amount of pills that I need to take]	
7	CT:	Jy het nog nie gedrink nie. [You did not drink it yet.]	
8	PES:	Bring dat sy kan sien wat is die oggend se pille. [Bring it so that she can see it.]	
9	CT:	Verskoon as ek dit nie nou doen nie gaan ek vergeet. [Excuse me, if I don not do it now, I will forget.]	
10	T:	Beweeg oom baie? [Are you moving around a lot?]	
11	PES:	Nie baie nie, waar gaan jy die duiwel heen. En die ander ding is om af te gaan is niks, ek like dit om uit te kom, maar ag die twee bleddie bene pyn so date k nie kan opstaan nie. [Not so much. Where the devel will I go	

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		to. The thing is to go down is easy. I like to go out, but the legs are so painful that I struggle to get up.]	
12	T:	Aggenee, was dit voor die tyd ook so gewees? [Oh no. did you experience that before the CVA?]	
13	PES:	Ja, maar nie so erg nie. [Yes, but not that bad.]	
14	T:	Wie is oom se dokter? [Who is your doctor?]	
15	PES:	Koos Nel, nou sê 'n ou wat gister hier was: Ja: niks teen Koosnie, kry net vir jou 'n tweede opinie…weet jy dis maklik gesê. Maar nou, Kooshet my nou al van A-Z. Nou moet die nuwe dokter weer begin by A…nou hoekom maak jou hart so…want ek het 'n beat wat ek mis al van toeka se dae af. Hy ken al die goete. As ek daar instap dan kyk…twa-twa-twa. Hy ken my, maar om nou na 'n ander een te gaan. Dis net so goed ek gaan na 'n spesialis toe. [Koos Nel. The guy that was here yesterday suggested that I go for a second opinion. Koosknows me for a very long time and knows about my heart that skips a beat. We have gone through testing different medications and will have to do it all over again with a new doctor. It will be just as good as going to a specialist.]	PES - resisting medical care
16	*The CT brings the pills.*		
17	T:	Daarsy…lyk soos sweets. [There you go. It looks like sweet.]	

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18	CT:	Hy sê dit lyk soos ‘n skaap wat jy mieliepitte gee. Jy prop hulle in en dan peul hulle anderkant uit. [He says it looks like when you are feeding sheep mielies. You push them in on the one side and then they fall out on the other side.]	
19	*CT touches PES’s head affectionately*.		CT displays physical affection
20	PES:	My pa het so gelike om die ramme…dis soos ‘n kinderprentjie…maar ek sien al die jarre die ramme daar in die kampie by die huis, dan loop hy…Hyt gelike van rook jong, dan het hy die emmertjie met die mielies hang hier so aan sy arm en die ander loop hy die pyp en light. Dan kry daai ram daai emmer aan die hande miskien net so bek vol mielies. En die een dag was hy bietjies te hoog gewees vir die ou ram. Die ou ram besluit toe net hy het genoeg gehad van jou. Toe hy so wegstap stamp die ram hom van die agterkant af op sy rug. [My father like to feed the rams. He walke with his bucket mielies on his arm while smoking. While he lights his pipe, the ram will try to get hold of the bucket. As he turned around to walk away, the ram bumped him from behind.]	PES - feeling helpless
21	CT:	Hy moes toe maar oorgee. [He had to surrender.]	CT becomes caretaker and decision maker
22	PES:	Toe eet hy al die mielies en toe het hy nie ‘n saak met die wêreld nie. Vir my lyk dit gaan dit net so, daar word net ingeprop.	CT - power PES -Patient surrender

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		[The ram then ate all the mielies and he did not have a care in the world. It seems to be the same here. The pills just get pushed in.]	
23	T:	Ek sien sy vang hom so van die kant af. [I see that she pushes them in from the side.]	CT delivers medication
24	PES:	Ja maak die bek oop. [Yes, open your mouth.]	PES Resists care
25	CT:	Ja julle twee. [Yes, you two.]	
26	PES:	Ja. [Yes]	
27	T:	Ek het vir julle ‘n liedjie gebring. Dit is ‘n Country instrumental. So daar is nie woorde by nie, so kom ons luister. [I brought a piece of music for us to listen to. It is an instrumental, without any words.]	
28	(Music starts playing.)		
29	*PES touches own face while listening intently.*	Watse lied is daai? [What song is that?]	
30	T:	Dit is net instrumente wat speel. [It is only instruments playing.]	
31	CT:	Maar ek ken nie die… [But I do not know the…]	
32	PES:	Dis hoekom ek vra, ek probeer hom ken. [That is why I ask. I am trying to recognise the song.]	
33	CT*: Experiences discomfort sitting in the sun.*	Sjoe die sonnetjie braai vir my. [The sun is hot.]	
34	T:	Wil tannie skuif? [Do you want to move?]	
35	CT:	Kan ek maar? [If I may.]	
36	T:	Ja, asseblief. [Yes, please do.]	
37	*The chairs are being moved out of the sun.*		
38	(The music starts		

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	playing again.)		
39	PES: *Shakes his head and moving his fingers up and down.*		
40	(The music stops.)		
41	T:	Waaraan het die musiek oom laat dink? [What did the music make you think of?]	
42	PES:	Waaraan? [About what?]	
43	T:	Ja. [Yes.]	
44	PES:	Rustigheid. [Tranquility.]	
45	T:	Watse prentjie het in oom se kop opgekom oor rustigheid? [Did any picture come to mind about tranquility?]	
46	PES:	Ek het nie aan so iets gedink nie. [I did not think about something like that.]	
47	T:	Watse prentjie is vir oom rustig? As daar 'n gedagte oor rustigheid by oom opkom? [What type of picture represents tranquility for you?]	
48	PES:	Oepsie. [Oops.]	
49	CT:	Oepsie. [Oops.]	
50	*Pes and CTshares a moment of laughter.*		
51	PES:	Een wat baie mooi is…is wat ek van hoou. Daai een wat jy…daai forest tipe ding, waar die sproei so staan. [One that is very beautiful is when the mist is above the water in the forest.]	PES and CT - Co-creating imagery
52	CT:	Misty Forest.	
53	PES:	Ja, kyk dieselfde as jy jou op so draai (pointing to painting on the wall). Dis natuur. [Yes, if you turn like that and look at that picture on the wall. That is nature.]	PES and CT Share longing to be in nature
54	T:	Wat beteken rustigheid vir tannie? [What	

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		does tranquility mean to you?]	
55	CT*: laughs loudly*	Ek is nou rustig. Ek geniet die see en ook die natuur soos die stilte waar ons jare terug op die plaas. Hier in die middae ses uur half sewe as die voëls so kom in die bome en hulle 'tjirp' so…dan daar aandskemer wat so kom…dis vir my rustig. [I am calm right now. I also enjoy the ocean and nature, like the peacefulness we experienced on the farm years ago. Especially in the afternoon at around six o'clock, half past six when the birds come and sit in the trees when it becomes dusk.]	
56	PES:	Ja daar was dit darem…dis regte natuur. [Yes, that was true nature.]	
57	CT:	Dan is dit mos stilte as mens in die veld is, daar is mos nie….net jy en die vader. [Then it is very quiet in the field. Just you and God.]	CT-longing for silence
58	PES:	My pa het altyd….jy sal ook weet. Baie van die ouer mense het die manier gehad van jag. Ek praat nie hier van die word jag nie…springbok skiet…. Dan het hulle nou 'n sekere dag gekies en dan het hulle 'n klomp boere bymekaar en dan het hulle opgelaai en geskiet, maar ek het sommer die eerste jaar gestop…toe ek op die plaas gekom het, maar…uhm…wat ek gesê het, dis 'n dag van jou lewe wat jy weggooi. Weet jy, daai punt wat ek wil maak…dan sit jy daar agter 'n miershoop, dan sien jy daar spring 'n voëltjie…en in daai wêreld is daar niks nie en dan kyk jy so. Wat sien jy? Dan word dit lateraan so warm dit lyk of dit sulke…[My dad used to arrange hunting on	PES & CT shared memories earlier life

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		the farm. That is something I immediately stopped when I took over the farm, because it is a day of your life that you throw away. The point I want to make is that you sit there behind an ant hill. You can see all the birds hopping in the field. In that environment there is nothing. What do you see? It gets so hot that you later see…	
59	CT: *helps PES to find the correct word.*	Golwe. [Waves.]	CT - Interrupting PES
60	PES:	Maar, dis nou stilte. [That is tranquility.]	
61	T:	Daar is niks. [There is nothing.]	
62	PES:	Daar is niks…dis nou hy daai…jy hoor jouself asemhaal. [There is nothing. You can hear yourself breathe.]	
63	T:	Is daar vir julle dae wat julle nog daardie rustigheid kan kry? [Are there days that you can still experience tranquility like that?]	
64	PES:	Nie daai rustigheid nie…heeltemal ander tipe van omgewing, ander tipe van lewe. [No, not that type of tranquility. It is a whole different environment.]	
65	CT:	Ons rustigheid hierso is om, om…soos ek sê ons geniet die rustigheid van die see en die verskil van die see en die berge, en bymekaar. [Our tranquility here is to be together and to see the ocean and the mountains.]	CT Reflecting on shared experiences

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66	PES:	Ek het gister vir die predikant gesê wat hier was, Jan, ken mekaar van die tagtiger jare af…en…almal…het gewarra warra toe ons die huis gebou het…so vreeslike storie. Nou sê ek vir hom suster: Ek geniet hierdie view…vergeet die huis. Ek dink ek het dit nou die dag ook vir jou genome, vergeet van die huis dis haar smaak gewees en dis dit. Niks met die natuur uit te waai nie, maar die ding is as jy daar gaan sit dan sien jy van daai berge af van Patensie reg rondom tot by St. Francis. [I told the minister yesterday, we know each other since the eighties, that when we built this house it was a commotion. I enjoy the view, forget about the house. I built it according to her taste. Nothing to do with nature. When you go and sit there you can see from Patensie all around to St. Francis Bay.]	PES Reflecting on shared value of peacefulness
67	CT:	Die sonopkoms en die maan. [The sunrise and the moon.]	
68	PES:	Ja, die sonopkoms en die maan is regtig mooi. [Yes, the sunrise and the moon is really beautiful.]	PES and CT sharepleasureable current experiences
69	CT:	Al daai goed. [All those things.]	
70	T:	Dis iets wat julle twee deel? [Is it something that you share?]	
71	CT:	Mmmm	
72	PES:	Weet jy die maan maak sulke strate so oor die see. Jissie dis darem maar mooi. [Do you jnow the moon makes lines over the	

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		ocean. That is so beautiful.]	
73	T:	Van hier kan jy dit seker mooi sien? [From here you must have a beautiful view?]	
74	CT:	Ja, jy sien hom opkom en dan kruip hy…dan maak hy daai pad. En as die son opkom in die…hier is die mooiste sonopkoms wat jy in jou lewe kan dink. Rerig, dit geniet ons baie en dit wat ons deel en die kleur van die wolke wat verander. [Yes, you can see him rise and then he makes that line. You can also see the most beautiful sunrises. We enjoy it a lot. We also share the colour changes of the clouds.]	
75	PES: *interrupting CT*	Jy weet ons het nou die dag…ekskuus man, ek praat jou nou dood. Ons het nou die daggepraat van kommunikeer. Ek het altyd gesê: my swaer, haar broer was in King Williams Town. Dan klim hy en sy vrou in die kar en hulle praat nie 'n word nie…dis nou maar net hy….Ek en sy klim hier in die kar en dan praat ons aanmekaar. Dis die verskil, al praat ek ook net nonsense…ons gaan nie stilbly nie. Die dag as ons ses voet onder toe gaan. [You know, we have talked the other day about communicating. My brother-in-law is from King Williams Town. Him and his wife will get into the car and then they will not talk at all.Us on the other hand talk all the time. Even if we talk nonsense, we will still talk. The day we are six feet under..]	PES - values good communication, PES Past good communication in relationship
76	T:	Ons gaan nou iets doen, en oom mag nie praat nie. [We are now going to do an	

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		activity and you are not allowed to talk.	
77	*PES and CT laugh together.*		PES & CT experienced laughing together
78	PES:	Dan sal jy my mond moet toeplak. [Then you will have to cover my mouth.]	PES talks a lot
79	T:	Julle sit so net mooi reg.(opposite each other) Gewoonlik doen ons hierdie terwyl ons staan, maar julle gaan nou net so sit want ek wil nie hê oom moet te lank staan nie…so eerste gaan ek 'n stukkie musiek opsit en tannie gaan eerste die leiding vat. Julle gaan…die gaan soos 'n spieël wees…Wat tannie ookal tannie se hande beweeg, moet hy volg. Hoe tannie ookal beweeg moet hy volg. [You stay seated as you are at the moment. We usually do this standing, but I do not want you standing for too long. I will play a piece of music and you (Mrs K) will take the lead. It will be like a mirror. You (Mr K) have to follow her exact movement.	
80	*PES and CT sit opposite each other and they share a moment of laughter.*		
81	T:	Maar moenie worry nie, ons gaan netnou omruil…so al wat julle moet doen is net volg en ek sal sê wanneer julle kan ruil, maar wat sy ookal doen moet oom volg. [But do not worry we will swap places. So all that you do is follow and I will indicate when you must change roles.]	

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82	PES:	Jy hoor ons mag nie praat nie? [You hear we are not allowed to talk.]	
83	(The pre-recorded music starts playing.)		
84	CT:	*Starts with waving hand movements*.	
85	PES:	En as jy nou waai? [Why are you waving?]	CT Much faster than PES
86	PES:	*Reluctantly starts following the wave movements at a much slower pace than CT.*	
87	CT:	*Change of hand movements. Opens and closes fingers.*	
88	PES:	*Looks out the window after looking at his hands that can not keep up with the pace and says: Hoe seer is my hand.* [My hand is sore.] *He stops moving.*	PES embarresed at lack of ability in relation to CT, PES gives up attempt to match CT
89	CT:	*Encourages him to start again by making bolder movements and moving body forward in an encouraging motion*.	CT Encouragement
90	PES:	*Starts laughing when CT does new movement. PES continues movement in slower tempo than CT)*	CT Pushing tempo of movement
97	CT:	*Moves her leg in an up and down movement.*	
92	PES:	Nee man! [No, man!] *PES can not keep up with the fast pace.*	CT attempting to push PES beyond

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			ability
93	CT:	*Starts laughing*.	
94	PES:	*Looks at her and completely stops moving*.	PES Frustrated with own limitations
95	CT:	*She realises that PES feels embarrassed by her laughter and blows him a kiss.*	CT Attempts playfullness
96	PES:	*He does not respond to her kiss*.	PES embarresse d
97	CT:	*She prompts by saying*: Kom nou! [Come on!] *and PES reluctantly returns the kiss.*	CT encourages, PES reluctantly responds to encouragem ent
98	T:	Ruil…sy moet alles doen wat oom doen. [Swap around, she must follow all your movements now.]	
99	PES:	*He crosses his arms over his body followed by a rolling movement of the hands. He crosses arms over the body again and then drops his hands to his sides and then rubs his head. He does up and down hand movements. He moves his fingers, pretending to play the piano, matching the music. He starts with up and down hand movements again and then changes the tempo of his movements from flowing to rigid move and stop movements. Each movement equaling four beats. He goes back into a flowing movement with his*	PES initiates movement

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		arms.	
100		*CT's hand movements are much higher than PES's during the whole exercise and CT moves faster than PES.*	CT more extreme movements
101	PES:	*He touches his shoulder as if in pain, stops and shakes his head. He rests for a while and starts rolling his shoulders.*	CT missmatch movements of PES, CT Overattunes
102	CT:	Wil jy amen sê? [Do you want to stop?]	CT reads PES body language
103	PES:	Hoekom nie? Wat is verkeerd daarmee? [Why not, what is wrong with it?]	CT highlights PES limitations, PES irritation about limitations
104	The music stops.		
105	T:	Hoe is dit om nie te praat nie oom? [How was the experience of not talking to each other?]	
106	PES:	Nee, ek moet raas…jy moet haar vra wat het ek twee aande terug gedoen. {No, I have to make a noise. You must ask her what I did two nights ago.]	
107	T:	Wil ek weet? [Do I want to know?]	
108	PES:	Woensdagaand? [Wednesday evening?]	

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109	CT:	Ja, ek dink jy sal wil weet. Ek het my beste vriendin, die een wat so skilder, Sannie. Ek weet nie of jy haar ken nie, Sannie, in elk geval. Toe sê ek sy moet kom braai, en 'n broodjie en sommer so kuier 'n bietjie. En hy sit hier en ek vra hom: Maak tog vir ons bietjie musiek…En hy staan op en hy gaan sit een van Freddie se playlists op…'Ek like nie daai musiek nie…jy weet dit'. En ek weet nie of hy hom vir my vererg het nie en hy gaan en hy gaan speel vir ons die lekkerste musiek en ek en syt 'n wyn of twee in. En hy raas daar agter en op dieselfde manier wat hy altyd gedoen het…en hy maak met sy hande so…(waving) foto's en bewyse is daar. En ek en sy is aan die dans en hy gooi vir ons daai musiek en op die end van die aand dans ek en hy. [Yes, you want to know. I have invited by best friend, Sannie, over for a braai. He was just sitting here and I asked him to put on some music. He just switched on a pre-set playlist of Freddie. He knows I do not like that music. I do not know if he got angry with me for asking him to put on other music, but he started to actively make music again (DJ). We had a wine or two and he makes a noise just like he used to do before he got ill. He throws his hands in the air in a wave like motion. In the end he was dancing with me.]	PES - DJ again after music therapy, Music and listening back after music therapy, Shared musical experience after music therapy, Dancing again after music therapy, PES motivated to do more activity, CT and PES shared activity PES motivated to be more active PES and CT new shared experience
110	T:	Ooo regtig? [Oh really?]	
111	*CT and PES laughing together*.		

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112	CT:	Sjoe dit was nou…. [That was…]	
113	PES:	Ja, daar was nou…hoe sal ek sê, daai een folder dink ek is 59 ure…aanmekaar…jy weet self wat is 40 megabyte. [Yes, that was, how will I put it, that one folder has got 59 hours of music. You know 40 megabyte.]	
114	CT:	Nou toe is dit net soos altyd, raas ons dat die hele wêreld kan hoor. [Then it was like it has always been. We make a noise that the whole world can hear us.]	PET and CT shared past experience
115	PES:	Dis lekker as ons raas. [It is enjoyable to make noise]	PET acknowledge pleasure of making music
116	T:	Ek is so bly dit het dan uitgekom. [I am so greatfulthat it came out.]	
117	PES:	Nee kyk, ek was nou al groot genoeg toe ek met die musiekmakery en ons het op daai stadium gespeel van die kassette af…dan weet jy waste storie is daai? [I was already a grown-up when I started supplying music at functions. At that stage we played from cassettes.]	
118	T:	Dan moet jy hom terugdraai tot waar hy moet wees? [You have to manually rewind to the song you want to play?]	
119	PES:	Dan moan die ouens vandag oor hulle met ‘n CD moet speel. Ek sê julle weet nie waarvan julle praat nie…want nou speel die ding dan sit jy en luister langsaan na die volgende liedjie om hom te soek waar is hy….vandag is dit ‘n kwessie van druk	PET Reminiscing past relationship with music

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		die knoppie en jy weet. [And today people complain because they have to play from CD's. They do not know what they are talking about. While the song is playing you haveto use a separate player to look for the next song. Today you can only push a button.]	
120	T:	Jy sit dit op die playlist aan en dit speel sommer vanself. [You just put on a play list and it plays on its own.]	
121	CT:	Mmm	
122	T:	Aangesien oom nou ewe skielik hierdie… [Because of this new…]	
123	*T hands the drums to PES and CT.*		
124	PES:	Net nie stilbly nie. [As long as we do nnot have to be quiet.]	
125	T:	Nee. [No.]	
126	*T takes the guitar.*		
127	T:	Gaan oom hom so kan vashou dat oom met altwee hande kan speel? Is oom reg? [Will you be able to hold the drum in such a way that you can play with both hands?]	
128	PES:	Pasop net dat jy nie teen die kant kap nie, hys skerp. [Be careful not to bump the guitar. That edge is sharp.]	
129	T:	Nee ek is reg. Gee vir ons 'n beat aan. [No, I am fine. Can you give us a beat?]	
130	PES:	Wat? [What?]	
131	T:	Gee vir ons 'n beat… [Supply us with a beat.]	
132	PES*: is laughing*	Nee ek weet nie… [No, I do not know.]	PET reluctant and unsure

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			of how to play drum
133	T:	Enige iets…ons speel saam. [Anything, we will play with you.]	
134	*PES starts playing in quavers.*		
135	T: *matches the rhythm and intensity of PES's playing on the guitar*		CT waits for prompt to start playing
136	PES:	*Keeps on playing on the drum but only with light finger tapping.*	
137	T:	*T slows down tempo to match PES.*	PES - awareness of diminuendo
138	PES:	Sy weet nie hoe om trompie te speel nie. [She does not know how to play the Jew's harp.]	PES - resistivenes s to playing drum
139	*PES and CT laughs at their private joke.They both stop playing.*		
140	PES:	Die sonnetjie is vandag hier hoor… [The sun is here today]	
141	T:	Gaan oom bietjie na daardie voete laat kyk hierdie week? [Are you going to get those feet checked out this week?]	
142	PES:	Ja, ek gaan nie vandag nie, sal maar Maandag. Mrs K moet maar 'n afspraak maak. Want ek is bekommerd oor hierdie spul pille. Ek dink die goete maak nou kak…dis more en aand. Wat vir my die beste van alles is…of ek nou lê en…ek wys haar vanmore toe ek opstaan. Toe is hulle	PES places CT in control of medical appointment s, PES - distrust in

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		nou min of meer dieselfde shape, toe wys ek haar hierdie een aan die buite kant hoe lyk hy. [Yes, I will go on Monday. Mrs K will have to make an appointment. I am worried about all these pills that I have to take. I think they are making things worse. It does not matter what position I take the stay swollen. Look at this one on the outside.]	medical care, PES Frustrated with medical advice he received
143	T:	Oom se voet bo-op is ook geswel. [Your foot is swollen at the top as well.]	
144	PES:	Lig jou voete…is ook al wat hulle sê…lig jou voete dan moet ek op my bleddie hande staan…want hoe anders gaan ek dit doen? ['Lift your feet', is all they say. What must I do? Stand on my hands?]	
145	T:	Tannie, sê vir my, as daar een ding is word of sin wat vir tannie uitstaan van vandag se sessie, wat sal dit wees? Mrs K, if there is one thing that stood out for you in today's session, what will that be?	
146	CT:	Die kitaar…ek dink dit was vir my. [The guitar, I think it was for me.]	
147	T:	Wat van die kitaar? [What about the guitar?]	
148	CT:	Die saam van die kitaar en die musiek. Die luister van die musiek en die konsentreer waarnatoe gaan die musiek…en om te kan volg al kan ons nie trompie speel nie. [The togetherness of the guitar and the music. The listening to the music and concentrating to listen where the music is going and to be able tofollow, even if we can not play the Jew's harp.]	PES and CT shared new musical experience, CT experience stimulation
149	T:	En vir oom? [And for you, Mr K?]	

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150	PES:	Mmmm, die saam, ek stem saam met haar die saam. [Yes, also the togetherness.]	
151	CT:	Definitief nie die deel waar jy moes stilgebly het nie. [Definitely not the part where you had to keep quiet.]	
152	PES:	Nee, dis nou ‘n straf…maar…uhm…die saamwerk op baie gebiede, maak nie saak wat jy doen nie en jou kitaarmusiek is goed, so. [No, that was punishment, but co-operation on many levels, it does not matter what you are busy with. And your playing was good.]	PES values co-operation
153	T:	Ons het nou vier sessies gedoen en julle het nou so bietjie ervaar wat musiekterapie doen…wat sou oom se verwagting wees, wat sou oom graag hier uit wou kry? [We have done four sessions now and you have experienced music therapy now, what will be your expectation of the process?]	
154	PES:	Uhm…aan die einde van die dag, jy weet…toe die ding begin het, het hulle bly neuk ek moet spesialis toe, hospital toe en ek moet daai. Toe sê ek dit gaan nie werk nie…op die einde van die dag…as ‘n ou net beter anderkant uitkom. [At the end of the day, you know when I just got out of hospital, they wanted me to see a specialist. I told them it will not work. At the end of the day…if you just end up better at the end of the process.]	PES longing for progress in health, PES hopes to get better, Better quality of life
155	T:	Mmmm	
156	PES:	Dis die groot ding. [That is the big thing.]	
157	T:	Wat is tannie se verwagting? [What is your expectation, Mrs K?]	

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158	CT:	Ek stem saam en ek wil vir jou sê, verlede week…uhm…die wat hy, ek het hom nou al ‘n paar keer gesê hy moet musiek opsit dan het hy nie regtig belangstelling gehad nie. Hy sou iets opsit en dit los…en so aan en ek kan sien hy herleef…uhm Woensdag. Die ou gees wat sprankel en juitkom en dis wat ek graag wil sien…ek wil…uhm al is dit nooit weer soos dit was nie, maar dit kan so wees. En dit is wat ek graag wil hê vir hom. Veral vir hom. Omdat ek nie vir hom hierdie lewenskwaliteit gun op hierdie oomblik nie. Soos ek sê mens wil hê dit moet… [I agree, and I want to tell you: I told him a few times to switch on some music and he never showed interest. He will put on a play list and leave it there. On Wednesday I saw the old spirit returning. Even if it is never like it has been before. I do not want him to have this quality of life that he has at the moment.	CT - longs for normality, PES returning to self after music therapy, CT - expectation for PES to become self, CT - Hopes for better quality of life for PES
159	PES:	Die, die… [The..the..]	
160	CT:	Towerstaffie sou gehelp het… [A magic wand would have helped]	CT impatient with pace of progress
161	PES:	Die person wat ‘n buitestander is…moet onthou…mens verskil van mens tot mens…’n person wat ‘n buitestander is soos jy sal op die einde van die dag dink hierdie man praat sommer nonsense, maar ek vertel jou dat elke mens ‘n hoogtepunt in sy lewe het wat hy in belangstel. My skoonpa was so oor kanaries, absoluut mal. Hy het ‘n stoel en ‘n boek gevat en	PES passion for music

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		binne in die kanariehok gaan sit en lees, jy weet…nou so is ek… [The person that is an outsider might think this man is talking nonsense. But I tell you that each person has a highlight of his life. My father-in-law was like that about his canaries. He took a book and went to sit inside the cage to read.]	
162	CT:	*CT interrupts PES*. Dit was vir hom rustigheid. [That was tranquility for him.]	CT interrupting PES
163	PES:	Ja, dit is rustigheid, maar wat musiek aanbetref ek het redelik baie musiek gemaak op 'n hele verskillende klompie plekke en so aan…en daar is een ding. Jy moet jou groep lees. Jy kan nie net jou smaak opsit nie, dit werk nie uit nie. Maar ons het byvoorbeeld toe Marlene en Frik getroud is het ek byvoorbeeld. Dit was nou hier by ons huis…en ek het alles hier bo weggevat en paar mense wat hier was….en aan die einde van die dag het ek hier getry en daar getry en ek sien toe van die groter mense wat hier is begin vervelig raak vir die spul…en…uhm…to gaan ek terug na die 50's toe en die volgende oomblik [Yes, that is tranquility. With regards to music: I made a lot of music to a whole lot of different people and in different locations. It is very important to read your clients.You can not just play your own taste of music. That does not work. For example when my daughter got married. It was here at our house. I have tried everything and	PES - relationship with music

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		the people got bored. In the end I started playing music from the fifties again. The next moment	
164	CT:	CT *interrups PES*. Rock en Roll en twist…	
165	PES:	Al hierdie jong spanne wat hier buitekant gesit het het soos ‘n trein binnekant toe gekom. Toe sê my swaer vir my: Koot nou het jy hulle. En sy het ook altyd daai ding vir my gesê: “nou het jy hulle”. Maar jy weet om die regte ding…en dan weet jy waarvan hulle hou en jy weet jy kan amper sê 90 persent van die aand verder wat jy gaan speel en dan is dit maklik…en dan like ek….dit like ek as die mense dit so geniet…dis vir my dis nog altyd vir my ‘n lekkerte. [Everybody that was sitting outside came back inside like a train. My brother-in-law said: ‘Mr K, now you got them’. And then you know for at least ninety percent of the evening what you will play and what they like. I love it when people enjoys themselves like that. I get great pleasure from it.]	PES passion to reach people through music, PES wants to please others with music

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166	T:	Ja, hierdie is maar dieselfde speletjie as ek weet wat het julle dan is dit hoekom ons die eerste twee keer so bietjie voel en dan weet ek wat het julle en dan kan ons bou daarop om musiek verder te maak, dis waarvan julle hou, so ja. So ons gaan maar verder van hier af. Dankie vir julle tyd. [Yes, this is very similar. I first have to get to know you and then we can build on that in future sessions. Thank you for your time.]	
167	PES:	Ons moet vir jou dankie sê. [We have to thank you.]	
168	CT:	Ons moet vir jou dankie sê. [We have to thank you.]	

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APPENDIX D (Actual names have been replaced with pseudonyms)

	Session D Group 1		
1	T:	Hoe voel die oom vandag? [How does Mr K feeltoday?]	
2	CT:	Hy's all right. [He is good.]	
3	T:	Ek wil net die klank opneem dat ek later kan skryf. So al wat ek by tannie wil weet…en onthou hierdie hoef nie positief of negatief te wees of wat ook al te wees nie. Ek het regtig net nodig om julle 'experience' te hê daarvan. [I just want to record the sound to write it up later. All I want to know from you, and it does not have to be positive or negative, is just your experience.]	
4	CT:	Ek verstaan. [I understand.]	
5	T:	So sê vir my hoe was die experience vir tannie? [Can you tell me how the experience was for you?]	
6	CT:	Dit was vir my as versorger in die eerste plek, rergiwaar…dit het my bietjie uitgekry uit 'n plek waar ek was. [It was for me as caretaker, really uplifting.]	CT experiences uplifting moments in MT
7	T:	Ok [Good.]	

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8	CT:	Dit het my ook laat dink aan goed wat ek verkeerd doen. Kyk ek het verplegingsagtergrond, so ek het 'n empatie in die lyf wat jy in elk geval nie kan wegvat nie…so vir so 'n mens is dit in elk geval nog erger en wat ek wou sê is dat dit in my geaardheid is…uhm…is ek geneig om te veel te wil doen en dit het e kook besef. Ek het nou gister met hom gepraat en vir hom gesê dit is reg ek gaan vir jou so sê (that PES wants to terminate Music therapy) maar dan gaan hy doen wat ek vir hom sê. Hy gaan himself afdroog ek gaan daar naby wees dat daar waar hy nie kan bykom nie, ek sal hom help en ek gaan hom aantrek sover as wat hy kan ek….uhm…ja gaan saam met my beweeg. Jy gaan jou eie onderarm aanrol aansit, dat jy jou arms kan oplig en dank an ons, terwyl ons dit doen dit meer as een keer doen. Dan is dit sommer terselfdertyd 'n oefening, en so aan. En soos vanoggend…jy weet…trek ek sy skoene aan en so aan. Toe ek klaar die skoene aangetrek het, Hy sê vir my: 'Oe daai ding maak my jou seer', ek maak hom reg. Ek sê: Gee nou weer myne aan'. Dit (music therapy) het dit vir my uitgebring…Dit (music therapy) was vir my positief en ook my gemoed het ligter geword en so aan…So, gesien op daai manier het dat ek hom eerder op daai manier moet help as om hom net te pamperlang en so aan. [It made me think of things that I do wrong. See, I was a caretaker before and that type of empathy you can not take away from someone. I want to do too much, that I also realized. I talked to him yesterday and said it is fine if he wants to terminate sessions but then he will have to do what I tell him to do. He must dry himself after a bath. I will be close by, but I will not do it on his behalf anymore. I will help him to get dressed but will not do it for him	CT new awereness of taking over tasks of daily living from PES, PES & CT new open communication after MT, CT helping without disabling, CT more sensitive to PES needs and wants, CT allows PES to do tasks of daily living alone after MT, PES extention of range of PES & CT deeper awareness of each other after MT, CT chooses different way of caring enabling rather than disabling, CT needs space for self care,

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		anymore. He will have to move with me from now on. While we put on roll-on, we will move the arms up and down a few times and make an exercise from it. I also asked him this morning to pass my shoes. I saw that I can help him in a different way, rather than to spoil him.]	
9		Vir my as versorger het dit baie beteken, ek sal dit enige tyd aanbeveel…en ek kan ook sien met hom dat dit vir hom, vir hom laat dink het. Hy het byvoorbeeld vir my gesê hy was geskok om te hoor dathy my vashou. Ek sê toe: dis nie jy wat my vashou nie…dis die omstandighede wat my vashou.' [For me as caretaker it meant a lot. I can recommend it anytime to anybody. I can also see that it made him think. For example he told me that he was not aware that he was keeping me from doing things outside the house. I told him that it is not him, but the circumstances.	

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10		Ja, daar het goed uitgekom waaroor ons kan praat. Ek kan vir hom sê en hy het gesê: As jy iewers wil heengaan, gaan. Ek kan agterkom hierdie week het hy regtig prober. Jy weet, want as ek opstaan vra hy: 'Waar gaan jy?' en as ek sê ek kom nou, ek gaan badkamer toe of wat ook al 'Ek gaan kombuis toe'…PES: Hoe lank gaan jy wees? Maar dis maar 'n lewenspatroon, dis net baie erger en ja ek….dis ongelukkig dat hy nie wil verder nie, maar ek het jou gewaarsku van die begin af. [Yes, things came up that we discuss. I can tell him now when I want to go to town. I can see that he tried his best this week not to ask me where I am going every time I get up. It is a life pattern that got much worse since the CVA. It is a pity that he does not want to continue, but I have warned you from the start.]..	PES & CT open lines of communication
11		Maar ek het nou geleer by jou…die bietjie wat ek nou by jou gekry het en so aan…op aanbou. Ek kan verseker sê dat hy lus het vir gesond word. Hy het dryf, hy wil nou gesond word want hy wil nou hier uit kom. Verstaan jy? [I learned from you now. The little bit that we have done. I can build on that. I can see that he has got the will to get better now.	PES motivated to get better after MT
12	T:	Ja. [Yes.]	
13	CT:	En dit was nie so nie…so ek dink regtigwaar dit het vir ons goed gedoen. [That has not been the case before music therapy. It did us good.]	CT experiences return of motivation after MT
14	T:	En kommunikasie gewys? [And communication?]	

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15	CT:	Kommunikasie gewys…ons het nog nooit ‘n problem gehad met kommunikasie nie, maar hierdie ding het kommunikasie uitgebring soos ek nou vir jou gesê het. Hy het vir my gesê hy het nie besef hy hou my vas nie en vir my ook weer laat besef dat ek oorbeskermend is. En daai kommunikasie het ek vir hom gesê: ‘Ek gaan dit nie weer vir jou doen nie. Ek gaan daar wees vir jou as jy vashaak dan help ek jou. Maar elke dag…daai kommunikasie…ek sal met hom moet praat daaroor en nie net stilbly nie. Hoe ek dit sien en hoe ek voel en hoe ons moet aangaan om te kan gesond word. So…ja.[We have never had a problem with communication, but this thing enhanced communication like I said before. I also made me realize that I am over-protective. I can now communicate to him that I will ot help him with everything anymore. I will be there for him when he gets stuck. I have to talk to him about it and not keep quiet. I can tell him how I see it and how I feell about this recovery process.]	PES & Ct ex[eriences enhanced communication after MT CT realises over protection hinders healing process CT - alleviation of frustration through communication
16	T:	Sê vir my tannie is daar enige spesifieke rede hoekom hy nie wil aangaan nie? {Is there any specific reason why he does not want to continue?]	
17	CT:	Nee, hy sê net hy is nie ‘n kind nie. [He just said he is not a child.]	
18	T:	O ok [Oh.]	
19	CT:	Hy gaan nie skool nie, moenie vir hom laat drom speel nie. [He is not going to school en he does not want to play the drum.] *(laughing)*	
20	T:	Dis doodreg. [No problem.]	
21	CT:	En hy voel baie sleg daaroor. [He feels very bad about it.]	PES Feeling guilty for terminating MT PES realisation of disability

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22	T:	Hoekom? [Why?]	
23	CT:	Hy sê hy is baie jammer daaroor. Dat hy… [He says he is very sorry about it.]	
24	*There is silence.*		
25	T:	Glad nie. Dis presies waar ons wil wees in die studie om te sien wat werk en wat werk nie. En die goeie ding is om nie net positiewe goed te gaan present in 'n studie, is ook nie goed nie. So ek kan nou sê dat die gewerk het op hierdie en hierdie punte en hierdie en hierdie punte het nie gewerk nie as gevolg van die en die ding. [No reason to feel bad. This is exactly what we want to achieve with the study. To see participant's real experiences and not just present all the things that worked out.]	
26	CT:	Dis reg, dis reg. [That's good, that's good.]	
27	T:	So dis fantasties. Dankie vir julle hulp. [So that is fantastic. Thank you for your participation.]	
28	CT:	Ons moet vir jou baie dankie sê. [We have to thank you.]	
29	T:	Dit was regtig 'n goeie paar sessies en ek is bly dat daar tye was wat na die eerste sessie wat julle vir my kon sê hy was weer lus om musiek te te maak en hy was weer lus om dit op sy manier te doen. En dan is dit al wat belangrik is. {It was really a good few sessions and I am glad that there were times that he actively started making music again.]	
30	CT:	Dis die betaling wat mens kry. [That is the payment that one gets.]	
31	T:	Baie dankie. [Thank you.]	
32	CT:	As daar enige vrae is dan kom vra jy vir my. [Please come and ask if you have any other questions.]	

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APPENDIX E (Actual names have been replaced with pseudonyms)

	Session O Group 2		
	The caretaker is getting the fan for the baby and settling in to the session.		
1	PES:	Ek dink my dogter bid vir die dag wat ons huis toe gaan. [I think my daughter prays for the day that we will leave.]	PES feels like burden to family and to CT
2	Daughter:	Mammie, jy kan nie vir my besluite maak nie, ek besluit hoe ek voel. [Mom you can not decide on my behalf how I will feel. I will decide for myself.]	
3	CT:	Daai top lyk regtig mooi ek is bly jy het hom aangetrek. [That blouse is really pretty.]	CT avoids conflict bydiverting conversation
4	PES:	Lyk stunning. [Looks stunning.]	
5		Long conversation about clothing.	
6	Daughter:	Dit laat my soos ‘n bat voel. [It makes me feel like a bat.]	
7	PES:	Jy besluit hoe jy voel, jy het dit netnou gesê. [You decide for yourself how you feel, that is what you just said.]	PES not avoiding conflict

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8	CT:	Toe sê ek vir haar dis in die mode, toe sê jy vir my ek klink nou nes Kyla: 'Mammie moet dit dra want dit is in die mode'. [I told her it is in fashion and she told me I sound just like her daughter: 'Mom, you must wear it, it is high fashion.']	
9	PES:	Wat hoor jy van die kind? [What do you hear from her?]	
10	Daughter:	Niks. [Nothing.]	
11	CT:	Ek moet haar foon laat regmaak. [I have to get her phone fixed.]	
12		*A long conversation about baby clothes follows*.	
13	CT:	*Adresses T*: Jy kan maar jou song speel, ons sal stilbly. [You can play your song now. We will keep quiet.]	CT leadership role, avoiding conflict
14	T:	Tannie sê tannie is nie lus vir dans vandag nie? [You said that you do not feel like dancing today?]	
15	CT:	*Answers on behalf of PES*: Sys nie lus vir dromme vandag nie, maar dans gaan sy dans. [She does not feel like drumming but she will dance.]	CT talking on behalf of PES, CT projecting feelings on PES
16	PES:	Ek is van balans af. [I am off balance today.]	PES displays resistiveness
17	T:	Is dit? [Really?]	
18	PES:	Ja, ek weet nie wat dit is nie, dis hierdie week, dis hierdie week wat ek uhm… [Yes, I do not know what it is. It is only this week.]	
19	CT:	Ek dink die stresfaktor is maar ongelooflik hoog op die stadium, vir ons almal, en my pa. [I think the stress factor is very high on her. For all of us, and my father.]	PES experiences stress about finances
20	PES:	Ja! [Yes!] *Drops her head in her hand*.	PES affirms high stress levels about finances, non verbal

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			communication
21	CT:	Maar erger op ma as ons. [It is worse for mom.]	
22	CT:	En sien, daar doen ek dit weer dat ek haar sinne klaarmaak….*laughing* [You see, there I do it again, completing her sentences.]	CT realises interruption of PES
23	T:	Wat wou tannie graag gesê het? [What did you want to say?]	
24	PES:	Nee, ek, dit was just ok…ek gee nie om dat sy daai sin klaargemaak het nie. Ek is sielsmoeg…daar waar jy kom waar dinge te veel is. [No, it was just…fine. I do not mind that she completed that sentence on my behalf. I am extremely tired. Deep within my soul. There where things are too much to handle.]	PES insight into own feelings, PES admits inability to deal with stress
25	T:	So kom ons sit terug en relax en ons haal asem and just be. [So, let us sit back and relax and just be	
26		(The pre recorded music starts playing.)	
27	PES:	*PES smiles in recognition when music starts playing.*	PES finds pleasure in music
28	PES:	*She sings without prompt to the recorded song.*	PES sings spontaneously-progress during process of MT
29	PES:	*She keeps the beat of the music with hand movements in the air, swaying from side to side.*	
30	T:	Ons haal diep in…..en uit…. [We breathe in and out.]	
31	PES:	*PES is actively participating in relaxation exercise.*	
32		*CT's baby cries CT tends to baby.*	
33	PES:	*Keeps on singing.*	
34		*There is complete silence in the room after the song stopped.*	

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35	CT:	*Breaks the silence*.Het jy al daai musiekvideo gesien? [Have you seen that music video?]	CT-discomfort with silence
36	T:	Nee. [No.]	
37	CT:	Dis op Hartbeespoortdam geskiet. [It was shot in Hartbeespoort.]	
38	PES:	Ja, Weet jy hoeveel musiekvideos is op Hartbeespoort geskiet? [Yes, do ou know how many videos they shoot there?]	PES joins conversation
39	T:	Nee. Wat beteken hierdie liedjie vir tannie? [No. What does this song mean to you?]	
40	PES:	Uhm….êrens…is daar nog mense wat lief is vir mekaar. Jy weet dit gaan mos so (hand moving up and down). Jy kan nie vir 20 jaar so (showing equal with hand) life weesvir iemand. Jy weet? Jy kan nie vir hom so konstant lief wees nie. Dis ridiculous…en…ek het op 'n stadium in my lewe gewonder of ons bedoel is om een mens…of ons bedoel is om een maat te hê vir die res van ons lewens. Ek het regtig gewonder daaroor…uhm…hierdie is vir my 'n great song omdat hierdie…ek hou van die sanger….kyk hy finasier al sy songs. Het jy hom gesien met die klavier wat so brand agter hom? [Somewhere in this world there are still people that love each other. You know feelings change. You do not feel the same about someone all the time, it fluctuates. I wondered at some stage in my life if we are meant to love one person for a whole life time. I like this song because I like the artist, He finances all his own music recording. Have you seen him with the burning piano behind him?]	PES express longing for love and to be loved, PES deep inner conflict about relationships, PES Question own life choices and relationships
41	T:	Nee. [No.]	
42	PES:	Hy is baie oulik…hy is baie oulik…hy kom so oor as eerlik. [He is very nice, and presents himself	

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		as honest.]	
43	T:	Is daai vir tannie belangrik? [Is that important to you?]	
44	PES:	O ja, baie. Want as jy weet as…as…jy in die lewe een ding verwag of glo en dit kom uit dit is nie so nie, dit was nooit so nie…hoor hier dis 'n skok wat jou jare vat om te verwerk…Ja, ek wil dit nie vir my kinders hê nie. [Oh, yes. Because if you expect one thing and gets another it is not nice. It is a shock that takes years to process.]	PES values honesty in relationships, PES Experienced betrayal in relationships, PES wants better life for children, PES experiences guilt - inability to provide
45	T:	Ms L, wat beteken die liedjie vir jou? [Ms L, what does the song mean to you?]	
46	CT:	*CT keeps her eyes averted.* Happiness. Ek het hom in die kar seker agt keer geluister. Nee, dis vir my 'n baie mooi song. Dis 'n diep song… [Happiness. I have listened to it in the car several times today. It is a deep song.]	CT expresses need to be happy
47	PES:	Kyk, syt hom gesien hier, wat is die plek se naam? [She saw the artist her in town. What is the name of the place?]	PES interrupts CT
48	CT:	Daar waar Je'Vista is…die plek voor Je'Vista. [There where Je'vista is. The place before it became Je'vista.]	
49	PES:	*PES refers to the baby and asks*: Is dit nou bietjie koud vir haar?	
50	CT:	Nee, sys besig om teen die slaap te baklei. Sy slaap en dan maak sy net skielik haar oë oop. *laughing* soos Nicholas Louw 'Rock daai lyfie' *laughing*. [No, she is just fighting the sleep, like Nicholas Louw in 'Rock daai Lyfie'.]	PES & CT shares musical memories
51	PES:	Ek is mal oor Nocholas Louw. [I love Nicholas	

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		Louw.]	
52	CT:	Ek het nou juis aan hom gedink. [I also just thought about him.]	
53	PES:	Hy is vir my happiness. Hy het gewerk saam met Ms L by Burger Ranch en Ms L hou aan vir my en Helen sê Nicholas wil vir my. [He is presents happiness for me. He worked at the Burger Ranch with Ms L. She kept on asking me to come over because Nicholas wants to sing..]	
54	CT:	*CT interrupted PES*. Purple Rain sing. [Purple Rain.]	CT interrupts PES
55	PES:	Purple Rain sing…ok. En hyt opgetree daar. Daai tyd het hy 'n karretjie gehad wat hy gestoot het…verstaan jy…dis in die tyd van min dinge en ek het…ek en en Helen het daar gaan koffie drink en hy het daai liedjie vir haar gesing en as jy kyk van daar af tot nou toe die groei in hom…nice. [Purple Rain sing and he also performed there. That time he was still pushing his car. It was a time of not having a lot of things. Helen and I had coffee there and he sang the song for us. He has grown a lot since then.]	
56	T:	Baie gegroei. [Grown a lot.]	
57	PES:	Ja. [Yes.]	
58	T:	So gepraat van groei…wat dink tannie het hierdie proses waardeer ons nou gegaan het, hierdie 6 keer wat ons musiekterapie saam gedoen het, wat het dit beteken vir julle verhouding, indien wel enige iets? [Talking about growth, do you think you're your relationship has grown during these six sessions of music therapy?]	
59	PES:	Ons twee? *Gesturing to CT*. Ek dink reg nou wil ons mekaar vermoor. [I think right now we want to kill each other.]	PES not avoiding conflict speaking freely

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60	PES/CT :	*PES and CT are laughing together.*	
61	T:	Ja, Hoekom? [Yes, why?]	
62	CT:	My ma voel ek is geirriteerd met haar. [My mom feels that I am irritated with her.]	CT makes decisions about PES feelings
63	PES:	Wat? [What?]	
64	CT:	Ma voel ek is geirriteerd met ma. [Mom feels that I am irritated with you.]	
65	PES:	Ek voel nie so nie. Jy is geirriteerd. [I do not feel like it. You are irritated.]	PES projection of feelings
66	CT:	Is nie. [I am not.]	
67	PES:	Ja. [Yes.]	
68	CT:	Ek is nie. Jy speel dan met Milan, lekker. [I am not. You play with the baby all the time.]	PES & CT in confrontation
69	PES:	Ja, ek gaan nou nie meer nie. [Yes, but I am not going to do it any more.]	
70	CT:	Dis oraait, sy moet slaap. [It is fine. She has to sleep.]	
71	T:	Dink tannie die musiekterapieproses het enige iets vir julle verhouding beteken? [Do you think the music therapy process did anything for your relationship?]	
72		*There is complete silence in the room.*	
73	PES:	Weet jy ek dink die hele fout met die ding was, ons het dit nie regtig met mekaar bespreek nie, ons het die eerste een bespreek, Ms L?	
74	CT:	Ja. En daarna het ons nie weer daaroor gepraat nie. [Yes, and after that we never talked about it again.]	
75	PES:	So involved geraak met ons lewens op die oomblik…uhm…maar ek moet vir jou seê met die dramas in ons lewens op die oomblik het die musiek dit vir ons makliker gemaak. [We got so involved with our lives, but I must say that music made it easier to cope with all the drama in our	PES states music makes life easier

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		lives,]	
76	T:	In watter opsig het dit dinge tussen julle makliker gemaak? [In what way did it make things easier?]	
77	PES:	Daardie is nie 'n vraag wat jy moet vra nie…(laughing) Vra vir Lovey…uhm…sys hiper geirriteerd. As ek Ms S so kyk is sy ook hiper geirriteerd so ek sal nie weet nie….en dan onmiddelik word dit vir my persoonlik. [That is not a question you should ask me. She is highly irritated and if I look at my daughter like that she is also irritated. It becomes personal for me then.]	PES experiences irritation and frustration, PES projection of feelings CT
78	T:	Hoekom? [Why?]	
79	PES:	Want dit is my kinders…en ek is nie gewoond dat hulle…daai vibe het teenoor my nie. [I am not used to my children having that kind of attitude towards me.]	PES sensitive to behaviour of family
80	T:	Dink tannie dis teenoor tannie? [Do you think it is directed towards or because of you?]	
81	PES:	O ja. [Oh. Yes.]	
82	T:	Hoekom? [Why?]	
83	PES:	Want dit is. [Because it is.]	
84	T:	Wat dink tannie het tannie gedoen dat hulle so voel? [What do you think you have done to make them feel like that?]	
85	PES:	Die feit dat Ms S vir my gesê het…uhm…ek weet nie wat dit was nie…Liewe Vader Ms L![The fact that my daughter said…uhm…Ms L!]	PES asking CT to help with words
86		*PES gets distracted by the dog that gets too close to the fan.*	PES lost thoughts
87	CT:	Hy gaan sy stert lekker trek. [The fan is going to pull its tail.]	
88	PES:	Kyk hoe lyk daai ding! [Look at that thing!]	

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89	CT:	Waai ding? [Which thing?]	
90	PES:	Daai bank. [The couch.]	
91	CT:	Estine praat met jou! [Estine is talking to you!]	
92	PES:	Ek weet maar my gedagtes waai…Syt gesê: dink ek nie dit was vir haar om te besluit nie. [I know but my thoughts are blowing away. She said that it was not for her to decide.]	PES admits loss of thought
93	T:	Yes.	
94	PES:	Nou hoe meer persoonlik kan dit wees? [How much more of a personal attack can it be?]	PES feels victimised
95	CT:	Kan ek daai antwoord asseblief? [Can I please answer that?]	
96	PES:	Ja. [Yes.]	
97	CT:	Syt dit mos nie lelik bedoel nie…Jyt gesê Ms S kan nie wag vir ons om huis toe te gaan nie. En Ms S het vir jou gesê dat dit vir haar lekker is om jou hier te hê…dis mos nie persoonlik nie. Sy is moeg om dit elke keer vir jou te sê…Mammie as sy ons nie hier wou gehad het nie het sy nie huis toe gekom at all nie…As sy moeg is vir ons sal sy so sê. Sy is nie moeg vir jou nie. [She did not want to offend you. You said that your daughter can not wait for you to get home. Ms S said on numerous occasions that she likes having you you here. That is not a personal attack. If she did not want us here she would have stayed at work during the day. She is not tired of you.]	CT expresses affirmation and will to take care of PES
98	PES:	En ek is ontsteld oor die feit dat haar man gedink het ek praat met hom. [And I am upset that her husband thought that I was talking to him.	
99	CT:	Ma jy is fyngevoelig. [You are being over-sensitive.]	CT accuses PES of being over-sensitive
101	PES:	Baie. [Yes, I am.]	PES admits to being over-sensitive

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102	CT:	Moenie wees nie. [Do not be.]	
103	PES:	Hoekom moet ek nie wees nie. Hoe lank bly ons al hier? [How can I not be. How long have we been staying here?	
104	CT:	Jyt ‘n krokodilvel, niks pla jou gewoonlik nie. It comes in here and goes there and f## the world. Dis hoe jy is…dit pla jou nie… Hoekom pla dit jou nou? [Usually you do not care what other people say. Why does it bother you now?]	CT affirmation of strong personality of PES
105	PES:	Omdat ek verleë en afhankilik is van iets en iemand vir die eerste keer in my lewe in hierdie situasie. [Because I am embarrassed and dependant on someone for the first time in my life.	PES admits to difficulty of being dependant on other
106	CT:	Ms S hulle was ook al in hierdie situasie. {They have also been in this situation before.]	
107	PES:	Ja maar dit was Ms S hulle. [That was them.]	
108	CT:	Ms S hulle weet hoe dit voel. [They know what it feels like.]	
109	PES:	Maar die ma is veronderstel om ‘n place of safety en ‘n safe….[The mom is suppose to be a place of safety..]	PES - guilt - inability to provide for children
110	CT:	*CT interrupts PES*. Nou is Ms M ons safe haven…syt ons gehelp om Milan hier te kry, so dis nie vir haar ‘n issue dat ons hier is nie. [Now Ms S is our safe haven. She helped to get Milan here. It is not an issue for her to have us here.]	CT affirmation - children wants to help mother
111	PES:	Ek voel net of ek net in die kamer kan ingaan en die deur sluit. [I feel to go into the bedroom and lock the door behind me.]	PES expresses emotion and need to be alone
112	CT:	CT interrupts PESEn slaap?	CT – interrupts PES
113	PES:	En huil….eers huil. Ek is glad nie iemand wat huil nie…ek het op ‘n stadium kon ek nie onthou of dit twee of drie jaar laas was wat ek gehuil het nie.	PES wants to cry

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		[And cry, first I want to cry. I am not someone that gets emotional. At some stage before the CVA I could not even remember how long it has been since I cried. Maybe two or three years.]	
114	T:	Hoekom? [Why?]	
115	PES:	Want ek het gesien met my egskeiding, al wat dit doen, dit maak jou oë puffy en dit gee jou hoofpyn gewoonlik…en wat anders bereik jy daarmee? Voel jy beter? Aikona…ek voel nie beter nie. [I saw through my divorce that crying does not help. It only gives you a head ache and puffy eyes. You do not achieve anything.]	PES needs to cry - out of character
116	T:	Maar tannie het nou die behoefte om te huil? [Now you feel the need to cry?]	
117	T:	So daar is tog ‘n doel daarvoor en dis fine. [So there is a purpose for it and it is fine.]	
118	PES:	Ja dit is. [Yes, it is.]	
119	CT:	*CT sits very quiet almost motionless*.	CT - difficulty dealing with PES emotions
120	T:	Ms L wat sou jy sê het die musiekterapie vir julle verhouding, if anything? [Ms L, what do you think did the music therapy process to your relationship, if anything?]	
121	CT:	Ek dink nou maar net voordat ek praat en ek nie my ma se sinne klaarmaak nie, want ek dink nou hoe dit haar laat voel. So ja. [I think before I speak and I do not complete her sentences. I think of how it makes her feel.]	CT more empathy after music therapy, CT more aware of PES feelings after music therapy
122	PES:	Jy maak nie meer my sinne klaar nie. [You do not complete my sentences any more.]	PES realises there are less completion of sentences from CT after music therapy
123	CT:	Is dit ‘n goeie of ‘n slegte ding? [Is that a good or bad thing?]	

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124	PES:	O nee, dis ‘n goeie ding *laughing* dis vreeslik as jy praat en iemand…gee my ‘n tissue. [It is a good thing. It is awful if you talk and someone…please hand me a tissue.]	PES communicates irritation with CT completeing sentences
125	CT:	*CT gets up to fetches a tissue*.	PES cries
126		*There is complete silence in the room while PES wipes her tears*.	
127	PES:	Mmmm…nee dis definitief ‘n goeie ding. *PES wiping her eyes* Wat sal jy sê as iemand jou sinne klaarmaak? Aanhoudend en baie keer is dit wat jy wou sê en baie kere is dit nie wat jy wou sê nie. [It is definitely a good thing. What will you say when someone completes all your sentences? Sometimes it is what you wanted to say and other times it is completely wrong.]	
128	T:	Ms Ldink jy as julle nie hierdie proses gedoen het dat jy dit sou agtergekom het? [Ms L, do you think you would have realized that you did this without the music therapy process?]	
129	CT:	Nee, ek sou nie agtergekom het dat dit haar pla nie en ek meen syt my altyd gevra om dit te doen.. en ek sal nie meer in beheer van alles probeer wees nie, so…ja. [No, I would have never known. She always asked me to do it. And I will not try to be in charge of everything.]	CT acknowledge MT a platform for enhanced communication, CT willing to change roles
130	PES:	Maar jy is..jy het “n a-tipe persoonlikheid. [But you are an A-type personality]	
131	T:	Tog is dit wat van jou verwag is op ‘n stadium? [It was what was expected from you at some stage?]	

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132	PES:	Jy sien ja….want toe ek uit die hospitaal uit kom. Ek kon sekere woorde nie onthou nie…ek het geweet wat ek wou sê…ek kon dit vir jou beskryf en dan kan ek die woorde nie eers uitkry nie…dat ek vir haar prentjies in die lug geteken het…en dan het sy my woorde klaar gemaak. How grand is that? [You see, when I came from hospital, there were some words that I could not remember. I could describe it, but could not say it. I made pictures in the airand she knew what I wanted to say. That is incredible.]	CT realises change of roles
133	T:	Ms L, wat dink jy van hierdie hele siekte van jou ma…watter strong points het jy van jouself geleer? Kom ek vra so: wat het tannie van haar geleer in hierdie tyd wat tannie siek was? [What strong points did you realize about yourself during the illness? What did you Mrs M learned about Ms L?]	
134	PES:	Jis, sy het baie vir my gedoen…sy was elke dag of ek in Johannesburg in die hospital was en of ek in Pretoria in die hospital was, sy was elke dag daar. [She did a lot for me. She visited me every day, wether I was in Pretoria or Johannesburg. She was there every day.]	PES thankful for care
135	T:	So as tannie nou….ek het na die sessies geluister…het tannie gesê sy was niee die maklikste kind in die huis nie, wat het tannie nou van haar gesien deur hierdie siekte proses. [You mentioned before that she was not an easy child. What did you see now?]	
136	PES:	Ek het haar strength gevoel…ja…sy kan oorvat so. In al haar posisies waar sy gewerk het was sy in bestuurders posisies…jy weet dis een ding om dit so te weet, dis ‘n ander ding om dit te ervaar. [I felt her strength. She can take over, In each of	PES acknowledge strength of CT

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		her positions at work she was in a managerial position. It is one thing to know it. It is completely different to experience it.]	
137	T:	Ja, dit is. [Yes, it is.]	
138	PES:	Dit was vir my great. [It was great for me.]	
139	T:	Ms L, ek dink dit is iets wat jy moet embrace en nie voel dat dit verkeerd is nie. Ek het dit ook gesien te midde van 'n nuwe baba en in iemand anders se huis. Nog steeds met jou ma cope en die ding handle. [Ms L, think it is something that you should embrace. I also saw how you handled your mom and the new baby in this new situation.]	
140	CT:	Mmmm	
141	T:	Ek dink dit is iets waaraan jy moet dink, dit is regtig 'n strength van jou. [I think it is a strength of you.]	
142		*CT is very quiet and only nods her head*.	
143	PES:	Kyk, laat ek vir jou sê, syt haar eie idees waarnatoe sy wil beweeg. [She has got her own ideas of where her life should go.]	CT strong will to move in own direction
144	T:	Which is great.	
145	PES:	Ja, dit is great. [Yes, it is great.]	
146	T:	En dis wat ek nou wil vra, wat het jy in hierdie siekte proses anders begin sien van jouself? [So what did you learn of yourself during this illness of your mother?]	
147	CT:	Van myself? [Of myself?]	
148	T:	Ja. [Yes.]	

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149	CT:	Ek weet nie of ek regtig iets van myself gesien het nie…uhm…ek dink ek het net geleer om meer empatie…is dit empatie? Met ‘n saak te hê en sag te wees teenoor my ma omdat sy siek is en mense wat so is. Ek het baie keer in die verlede gevoel: Ag dis nie my problem nie, so ja…en ek dink dit het my in ‘n mate ook tot op my knieë gebring want toe my pa en ma geskei is het ek die Here baie kwalik geneem en ja…dis soos ek sê dit het my weer tien tree vorentoe gebring, maar weerin my geloof in gebring. [I don not think I have seen anything of myself. I just learned to have more empathy with people that is sick. I often felt in the past that it is not my problem, but this brought me to my knees. I also felt anger towards God for making my mother this ill. It has enriched my spiritual life.]	CT more empathy after MT, CT experience religious inner conflict after illness
150		*CT stops talking to T and starts talking to the baby*.	
151	CT:	Dis maar ek. [That is just me.]	
152	T:	Wat het jy van jou ma gesien vandat sy siek geword het? [What did you see in your mother since she became ill?]	

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153	CT:	She puts on a fight, she doesn't give up. My ma is 'n ongelooflike sterk vrou…en die siekte het haar nie onder gekry nie en daar was baie kere wat dit vir haar rerig rerig baie moeilik was waar ek kon sien sy raak geirriteerd: met die feir dat sy nie haar woorde kan onthou nie en dat sy goed nie vir haarself kan doen nie. Daar was baie goed wat sy nie kon doen nie..uhm..dit het haar geirriteer…selfs met die foon dat sy nie 'n sms kon stuur of haar laptop aansit nie, het sy aangegaan. En daar was dae wat sy gesê het: Its not worth it, ek wil nie eers meer lewe nie, maar sy het gecope en deurgedruk en aangegaan. En syt elke dag…sy vat elke dag soos dit kom. Ek dink partykeer sy verwag te veel van die dag, haar verwagting is te hoog te vining. Dis wat ek dink. En dis nie 'n slegte ding nie, maar ma moet dit tyd gee. Cause it didn't happen overnight. [My mother is extremely strong. The illness did not break her spirit. Yes, she got irritated when she was physically not able to do things like work on her computer or when she can not find her words. She coped and persevered. She takes every day as it comes. I just think that some days she expects too much from a day, much too soon. That is what I think. She must give it time]	CT acknowledge strength of PES, CT realises irritation with aphasia and disability, PES gets tired, PES high expectation of self and recovery, PES feels frustrated with slow recovery
154		Complete silence in the room.	
155	PES:	Ja, ek hoor. [Yes, I hear what you say.]	
156	T:	As daar een ding is wat julle van hierdie musiekterapieproses vat? Wat is dit? [What will be the one thing you take from this music therapy process?]	

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157	PES:	Dat musiek my gelukkig maak, ek het vergeet…ek het dit vergeet…my ousie het eendag vir my gesê: ons is dieselfde, ons hou van musiek en ja, dis waar. Onshou baie van musiek en as ek dit nie mis het nie, Lovey, jy hou ook van musiek ne? [Music makes me happy and I forgot about that. My maid once said to me that she and I are the same. We both like music. You also love music, Ms L?	PES - realises music = happiness during MT, PES admits that MT reminded them of musical relationship, MT helped to recover shared memories in music
158	CT:	Ja, een liedjie beskryf jou gevoel vir daardie dag. Kan na ‘n liedjie te luister en ‘n gevoel gee soos wat jy ons daardie dag laat teken het (referring to previous session) [Yes, one song can describe the emotion of a whole day. Like when that day when we listened to the song and we had to draw a picture about it.]	
159	PES:	Wat? [What?]	
160	CT:	Daai dag wat ons moes teken…en een word skryf as ons na ‘n liedjie geluister het. [That day that we had to draw a picture after we listened to a song.]	
161	PES:	Ja. [Yes.]	
162	CT:	Dit is ‘n gevoel wat jy kry van die musiek of die beat of van die woorde. [It is a feeling that you get from the music or the beat or the words.]	
163	PES:	Ja. [Yes.]	
164	T:	Hoe sal jou liedjie vandag klink? [What will your song sound like today?]	
165	CT:	Myne? ’18 ‘till I die’ [Mine? Eighteen until I die.]	
166		*PES and CT laughs together*.	
167	T:	Hoe sal tannie se liedjie vandag klink? [What will your song sound like today, Mrs M?	
168	PES:	Myne is, ek is op ‘n sad plek, wat stupid is, want ek moet op ‘n ander plek wees. [Mine? I am at a	PES high expectations of

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		sad place, which is stupid. Because I should be at a different place.]	recovery, shaped by PES perception of others opinions
169	T:	Sê wie? [Says who?]	
170	PES:	Sê die samelewing. [Says the community.]	
171	CT:	Nee ma, jys geregtig om sad te wees en om happy te wees en om moerig te wees, jys geregtig daarop. [No mother, You are allowed to be sad and to be happy and to be angry.]	CT affirmation of valid feelings of PES
172	T:	Verseker. [Definitely.]	
173	CT:	Moet net nie voor Ms S wees nie want sywil hê ons moet op 'n happy plek wees, al die tyd. [Just do not say that in front of my daughter. She wants us to all be happy all the time.]	CT projection of feelings onto family members
174	T:	Al is sy nie altyd op 'n happy plek nie, maar ek dink die belangrike ding is dat ons dit vir mekaar sê byvoorbeeld: ek is vandag geirriteerd, en dit is fine. [Even when she is not always happy. The important thing is that we can tell each other how we feel.]	
175	PES:	Ek is geirriteerd vandag met my kar wat al vir hoe lank in die donnerse son staan 'how about that'. Ek wil hom nou vat en hom laat was! [I am irritated today because my car is standing in the sun. I want to take him to get washed. How about that?]	PES admits to be irritated, PES expresses need to do tasks of daily living
176	T:	Weet tannie wat is die mooi ding van wat tannie nou gesê het? Tannie het netnou gesê Ms S is geirriteerd en Ms L is geiiriteerd, maar tannie is nie geirriteerd nie. So wat wil tannie met hom doen? [It is great that you owned your own feelings just now.	
177	PES:	Hy moet gewas word en ons het 'n….wat noem jy die ding Lovey? [He must get washed and we	PES loss for words, asking for assistance

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		have a…] She is gesturing with hands for cover, asking for help with loss of words.]	from CT
178	CT:	Seil. [Cover.]	
179	PES:	Seil, seil dis wat ons oorsit…uhm…ons kyk baie mooi na ons karre. [Cover…cover. That is what we should put over. We take good care of our cars.]	
180	CT:	So more, as ons klaar by die tee was sal ek jou kom aflaai en jou kar laat was en die seil opsit. {Tomorrow when we are done at the tea, I will take your car to get it washed and then I will put the cover on.]	CT wants to control tasks of daily living
181	PES:	Tee? [Tea?]	
182	CT:	CT touches her face as if tired.Ma's en dogter… [The mom and daughter tea.]	
183	CT:	Ma's en baba tee by die borsvoeding kliniek, maar ek borsvoed nie meer nie. *CT laughs loudly*. Nou gaan ek in Nadine vasloop… [The mother and daughter tea at the breast feeding clinic, and I am not even breast feeding any more. I will also bump into Nadine.]	
184	T:	Sy het ook opgehou en weer begin en weer opgehou. [She also started and stopped again.]	
185	PES:	Wat het sy gedoen? [What did she do?]	
186	CT:	Dis sy wat sê dat haar kind by Smiley mishandel was.	
187	T:	As dit tannie laat beter voel om die kar te was…doen dit dan. Nou vra ek die vraag? Wil tannie die kar laat was of moet Ms L hom laat was? [If it makes you feel better to get the car washed, you should do it. Do you want to do it yourself or do you want Ms L to do it?]	
188	PES:	Ek weet nie of ek die selfvertroue het nie…om my kar te bestuur nie. [I do not know if I have the	PES admits lack of self-confidence

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		confidence to drive my own car.]	
189	T:	Nee, maar tannie mag nie bestuur nie, dis wat die dokter gesê het, maar sy kan tannie vat en… [No, you are not allowed to drive. That is doctor's orders.]	
190	PES:	Luister, jy verstaan nie, ek gee nie 'n damn om wat die dokter sê nie. [Listen, you do not understand, I do not care what the doctor says.]	
191	T:	Ek weet, maar as tannie self sê dat tannie se balans nie goed is nie… [I know, but if you say yourself that you balance is not good…]	
192	PES:	Nee, en veral nie hierdie week nie. [No, and especially this week.]	
193	T:	Dan kan tannie nie bestuur nie. Maar my vraag is…. [Then you can not drive. My question is still..]	
194	PES:	*PES interrupts T*. As ek aantrek staan Marie agter my. [When I get dressed the domestic worker stands behind me.]	
195	T:	My vraag sal nog steeds wees en ek dink dit is belangrik vir almal wat hier in die huis bly…Tannie het gesê tannie wil die kar gaan was…laat sy tannie vat om die kar te gaan was…laat tannie self uitklim en sê: Was my kar! Klein goedjies….baby steps. [My question is still, and I think it is important for everybody living in one house. If you want to take your car to get washed you should say so.]	
196	PES:	Nou onthou ek, ek moet wag vir geld. [Now I remember, I have to wait for money.]	PES frustrated - finances
197	T:	Tannie moet dit sê. [You haveto say it.]	
198	PES:	Ken jy die gevoel van wag vir geld? [Do you know the feeling of waiting for money?]	

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199	T:	Ek ken die gevoel, ek sal my bankstaat vir tannie wys (laughing) [I know the feeling, you should see my bank statement.] *Everybody laughs together*.	
200	PES:	Eks jammer…my bankstaat… [I am sorry, my bank statement…]	
201	T:	Ms L, een ding wat jy vat van hierdie proses? [Ms L, one thing that you take from this process?]	
202	CT:	Luister, ja, ek moet luister… {Listen, I have to listen.]	CT - listening important for communication
203	T:	Ek dink dis daai ding wat jou ma gesê het: 'Ek wil my kar vat om te gaan was.' [I think the important thing is that your mother wants to take her car to get washed.]	
204	CT:	Dit reen in elk geval weer moreaand. [They predict rain for tomorrow evening.]	
205	PES:	Dan is hy toe onder die seil en ons kan hom nie toemaak as hy nie gewas is nie, want dan is hy vol grond. [Then he will be under cover. We can not cover him if he is not washed, because he will be full of mud.]	
206	CT:	Jy kan hom vat om te was, ek sal hom toemaak onder die seil. [You can take him to get washed, I will cover him.]	
207	PES:	As jy dit nou vir my sê is jy mal! [If you say that you are crazy.]	
208	T:	Hoeveel van die toemaak… [How much of it…]	
209	PES:	Ek is bang om te bestuur! [I am scared to drive!]	PES scared of driving
210	T:	Tannie gaan nie bestuur nie, tannie mag nie bestuur nie… [You can not drive, you are not allowed.]	
211	CT:	Jy gaan aan die passasierskant langs my sit. Milan kan in die Kangol op jou bors wees. [You	

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		are going to sit on the passenger side of the car with the baby.]	
212	T:	Ek dink dis klein dingetjies wat tannie weer selfvertroue gaan gee, soos om uit te klim by die karwas en te sê: was my kar. [I think it is small things that will give you confidence again, like getting out at the car wash and ask them to wash your car.]	
213	PES:	Ja, en weet jy wat…ek kan…sy sou saam met my uitgeklim het en dan vat…dan loop ons saam in…ons het dit 'n paar keer gedoen dan kom ek allenig tot daar…so…jy sal moet saamloop. [You know what, I can. You just have to walk with me.]	
214	CT:	Ja. [Yes.]	
215	T:	Dalk kan sy aan die een kant vashou terwyl jy toemaak. [Maybe she can hold the one side while you close the car with the cover.]	
216	CT:	Ek dink aan haar rug. [I think about her back.]	CT disabling PES - reminding her of inabilities
217	T:	Sy hoef net vas te hou. [She can only hold the one side.]	
218	PES:	Ek moet my kar toemaak. [I have to cover my car.]	PES need to tasks
219	T:	So kom ons maak hierdie paar sessies toe. Probeer saam met my sing. [So let us end the sessions. Try to sing with me.]	
220		*T strums and softly sings on the guitar and sings on 'aah'.*	
221	PES:	*PESstarts singing with closed eyes.*	
222	CT:	*CT is not participating*.	
223	T/PES	*PES and CT sing together with a decrescendo until there is silence.*	

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APPENDIX F (Actual names have been replaced with pseudonyms)

Session z Group 3			
1	T:	So you say the leg is all right when you dance?	
2	PES:	No, not today	
3	T:	How was church?	
4	PES:	Church was very nice…	
5	T:	So, can you join more?	
6	PES:	Yes, more and more. They preached so nice yesterday.	PES testing more abilities after MT, PES more involved in community after MT
7	T:	So how was your day today?	
8	PES:	I was sleeping...the whole day…me and my son.	
9	T:	And you? *Adressing CT*	
10	CT:	All right, all right…just a Monday is not 'maklik'. [Easy.]	
11	T:	Deurmekaar? [Crazy, disorganized]	
12	CT:	Always 'deurmekaar'. [Disorganised]	CT high level of responsibility
13	PES:	Monday is always a blue Monday.	
14	T:	So we are going to sing a bit.	
15	PES:	What?	
16	T:	We are going to sing.	
17	PES:	What we going to sing?	
18	T:	I am going to start and then you can follow and then you can take over, ok?	PES initiates vocalization and movement
19		*T starts singing, PES immediately follows on 'ooooo', without prompt.*	PES confidence in music- progress in music therapy

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			process
20		*PES initiatesdance.*	
21		*T matches rhythm of dance movements of PES on the guitar.*	
22	V:	*Claps with PES' singing and dancing.*	
23	CT:	*Takes tambourine without prompt and plays with PES.*	
24	PES:	*Dances without walking stick*	PES growing confidence in movement and vocalization
25	T:	Beauty is going to sing alone now…	
26	PES:	*Starts singing and does flowing arm and leg movements*.	
27	CT:	CT takes over melodic line.	CT comfortable in leading melodic line
28	T:	Weare going into something new now, Beauty is going to sing us something new. *T initiates key change and slowsdown tempo of music.*	
29	PES:	What?	
30	T:	Anything you want…	
31	PES:	I must think first…	
32	T:	You can sing anything you want….la-la-la also. *T demonstrates a melodic line that is in contrast with the original melody.*	
33	PES:	I must sing…must sleep tonight first and think.	
34	T:	It doesn't have to be a song you know already, just like we did now.	
35	PES:	*PES starts singing- 'My heart is full of glory'.*	PES starts singing after initial doubt
36	T:	*T plays chord progression for the song on the guitar.*	
37	CT:	*CT picks upthe tambourine and plays with T and PES.*	CT initiates instrumental play

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38	V:	*V joins in the singing*.	
39	PES:	*PES continues with up and downarm movements and dancing from side to side, without prompt.*	PES moves without prompt and encouragement, Progress in music therapy process
40	V:	*V claps her hands and then takes the rain stick.*	
41	V:	*V starts talking in native tongue.*	
42	T:	So what are you saying?	
43	PES:	She says I can talk now oraait…[Good]	PES improved language abilities after MT
44	T:	Yes can you talk now?	
45	PES:	I want to talk now, cause I want to preach a church, I also want to preach.	PES expresses hope to be involved in community
46	T:	So what made you talk now?	
47	V:	Mama shame.	
48	PES:	She said my tongue is loose now. Its not ‘vas’. [Stuck.]	PES better vocal ability
50	PES:	*PESinitiates a new song.*	PES confidence in relationship with music
51	V & CT:	*Everybody joins in singingtogether with PES.*	Musicking
52	T:	Come get up. *T invites CT & V to join in movement with PES.*	PES & CT provides music
53		*PES/CT/V/T moving, dancing and playing together.*	Musicking
54	V:	*V uses the rain stick.*	
55	CT:	*CT plays on the tambourine.*	
56	PES:	*PES plays on the drum.*	
57	T:	*T takes the drum and holds it for PES to play while dancing she is dancing and playing*	

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		simultaneously.	
58	PES:	*PES plays and dances freely.*	
59	V:	V is talking in native tongue.	
60	T:	So what is she saying?	
61	PES:	I can also move like they are moving in church.	PES realises abilities in comparison with others, PES growing self-confidence through MT process
62	PES:	*PESinitiates another song.*	
63		*V/PES/CT/T singing together.*	
64	CT:	*CT Leads the melodic line.*	
65	PES:	*PES starts the song from the beginning when the other ends.*	
66	T:	*T is clapping hands to the rhythm of the song.*	
67	PES:	*PESdances while she is singing.*	
68		*The song comes to an end.*	
69	T:	Now I want to know…what did this music that we did together, the therapy…what did it do to your relationship? What did it do for the two of you? Ms N? Ms B?	
70	CT:	To me…to me it means a lot, because I see to Ms B there's a lot of change in her. Yesterday afternoon, she was laying down with the Bible. She was reading in the Bible yesterday afternoon. Really this therapy of yours is working, really working.	CT experiences change, improvement after MT, PES interested in other abilities - reading, PES expanding activity repertoire
71	T:	Did it change your relationship?	
72	CT:	No, theres no change between me and her…no nothing. Theres no change…theres nothing that changed.	CT - unchanged relationship with PES after MT

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73	T:	Did…do you think it made it better…your friendship?	
74	CT:	Yes it did make it better. As I can see it did make it better…we two together.	CT - solidify friendship during MT - enhanced communication
75	T:	Why?	
76	CT:	Because what I think she also thinks the same….me and her….ons sien altyd 'goeters' [things] saam in een way.	CT - shared thoughts and experiences
77	T:	Ja, ja sê in Afrikaans. [Yes, you can speak in Afrikaans.]	
78	CT:	So, as ek miskien 'n ding dink, dan dink sy ook daai ding wat ek dink en dan praat ons oor hom en dan is ons weer lekker en ons lag. [So, when I think one thing, she thinks the same as me and then we can talk about it and then we can laugh about it.]	CT Shared laughter in shared experience
79	T:	En jy Ms B? Wat dink jy? [And you Ms B, what do you think?]	
80	PES:	Wat? [What?]	
81	T:	Wat het die musiekterapie vir jou beteken? [What did the music therapy mean to you?]	
82	PES:	Its oraait…Maak ons friendship vas. [It was fine, it solidified our friendship.]	PES - solidify friendship through shared experiences
	CT:	Dit was goed om jou hier by ons te hê. {It was good to have you here with us.]	
83	T:	Dit was vir my goed om hier by julle te gewees het. Ek wil net nie hê die musiek moet ophou nie. [It was also nice for me to be here with you. The music must continue.]	
84	PES:	Dit help dat ons nie kwaad mekaar….want sien jy hy help daai music therapy…hy werk	PES utilize music as mood regulator

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		vir ons, jy lag. [It helps that we do not get angry with each other. You see that this music therapy thing works. It helps us to laugh.]	
85	T:	Het julle altyd kwaad geword vir mekaar? [Did you get angry with one another?]	
86	PES:	Nee ons het nie….nooit. [No, never.]	
87	T:	Nou dans jy elke keer? [Now you dance all the time?]	
88	PES:	Ek dans…ek het gister…sy vra, sy vra en nou? Hoekom dans jy so? Eks sê ek wil hê jy moet vir madam sê hoe het ek heeltyd gedans het. [I dance, ask her. She asked me why are you dancing. I told her that she must tell you how I danced.]	PES dancing as expression, PES taking responsibility for own health
89		*Everybody share a moment of laughter.*	PES & CT experience pleasure in movement
90	PES:	Toe ons van die kerk af gekom…ek het bietjie gedans hierso…ek dans vir haar…ek dans… [When we came from church I danced here. I danced for her.]	
91		*All laugh together.*	
92	PES:	I like it always people must laugh…there in my church…because when I talk they laugh they kaugh. I like it people must always remember me because I let the people laugh…They must not be angry, I like if they can laugh…always…always…always…	PES shares hope to be remembered for laughter
93	T:	Thank you so much for your time and that I could visit.	
94	PES:	OK	
95	CT:	OK	
96	T:	I think this was a good end to our sessions.	
97	PES/CT:	Yes.	

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