A profile of needs: Music Therapy with HIV infected children in a South African institution

Mikaela Ceridwen Griffiths

22248626

Supervisor: Prof. M. Pavlicevic

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My Creator and heavenly Father, who has given me the gifts and desire to work in this field, and for faithfully guiding my path. Glory to your Name – 1 Corinthians 10 vs. 31.

ABSTRACT

This dissertation profiles the needs of abandoned or orphaned, HIV affected or infected children living in a South African institution. The purpose of my research is to identify the needs of the children; then identify how the staff within the institution perceive that they provide for these needs; and lastly look at what Music Therapy as a discipline can offer the children in regards to the needs identified. Interviews with fulltime and part-time staff members suggest that the needs of the children relate mainly to a lack of individual attention. Inconsistent quality of care and limited opportunities for forming attachments to specific caregivers were identified foremost as resulting in difficulties with forming and maintaining relationships and social functioning with peer members and staff members, in the institutional social cultural context. The therapeutic relationship offered to the children in Music therapy sessions offers opportunities to address the individual and social needs identified.

ABSTRAK

Hierdie proefskrif profiel die behoeftes van verlate en ouerlose, MIV aangetaste of geinfekteerde kinders wat in 'n Suid Afrikaanse instelling leef. Die doel van my navorsing is om die behoeftes van hierdie kinders te identifiseer; daarna om te identifiseer hoe die personeel in die instansie hulle poging om hierdie behoeftes natekom waarneem; ten laaste om te sien wat die musiek terapie as 'n dissepline aan hierdie kinders kan offer aangaande hul identifiseerde behoeftes. Tydens onderhoude met voltyd en deeltydse personeel blyk dit dat die behoeftes van die kinders grootliks as gevolg van 'n gebrek van indiwiduele aandag ontstaan. Wisselvallige sorg en beperkte geleenthede vir die vorming van hegte verhoudinge met spesifieke sorggewers was geidentifiseer gewees as die hoof rede in hul onvermoee om verhoudinge en sosiale funksionering te behou, met ander kinders en personeellede in die sosiaal en kulturele konteks van die instansie. Die terapetiese verhouding wat tydens Musiek Terapie aan die kinders aangebied word maak dit moontlik om geleenthede te skep om hierdie indiwiduele en sosiale behoeftes aantespreek.

SLEUTELWOORDE: Verwerp, VIGS Wesies, Versorger, Kindersorg, Ontwikkelings behoeftes, Emosionele behoeftes, MIV Infeksie, Institusionalisering, Musiekterapie, Sosiale behoeftes, Terapeutiese verhouding.

CHAPTER ONE

INTRODUCTION

1.1. The Mohau Centre

The inspiration for this research project was born out of my experiences working as a Music Therapist Intern at the Mohau Centre, situated on the property of the state hospital, Kalafong, on the outskirts of Pretoria.

The Mohau Centre is a registered children's home for abandoned and orphaned babies and children affected or infected with Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) and can cater for up to 35 children, between the ages of birth to eighteen years.

The Mohau Centre shares its building with a hospice run by the Kalafong paediatric department, which also provides medical care for those children in the centre who are ill or dying. Although the Mohau Centre is partially funded by the South African government (40%), it still relies heavily on donations given by the community or money raised through fundraising events (60%).

The structure of the Mohau Centre is kept in excellent condition, as are the gardens and the children's playground. The interior of the building is brightly painted with murals; the children's bedrooms, with an average of seven beds per room, are brightly curtained with matching bedspreads. The playroom, which looks out onto the playground, is equipped with cots, mini tables and chairs, an assortment of toys, bicycles and tricycles, a television and a radio. It is only the echoing corridors with their linoleum flooring that reveal the stark reality: this is an institution.

At first glance it would seem that the Mohau Centre has many facilities to cater for the children's needs and that these children lack for nothing. However, my experiences over the past year have led me to observe that many of the children experience a range of emotional and physical difficulties that require specific attention and management, and these appear to extend beyond the job descriptions of the caregivers[1].

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[1] Caregiver, refers to any staff member, professional or non-professional, who functions in a role of providing care to the children in the institution, and should not be confused with the title Care Worker which refers to the job description of the staff working with the children in the playroom during the day at the Mohau Centre.

1.2. The HIV epidemic in Southern Africa

The HIV epidemic has reached staggering proportions in South Africa. The current situation for the care and treatment of those infected with HIV has been hindered by the government's stand on the provision of anti-retroviral treatments. For those orphaned as a result of HIV, living situations are far from ideal with orphan-headed households providing care and food for younger siblings (Dorrington, Bradshaw and Bulender, 2002; Van Dyk, 2001).

The Centre for Actuarial Research in Cape Town published provincial indicators for the incidence of HIV/AIDS in South Africa, for 2002. This profile revealed that of the 885 000 orphans in South Africa in 2002, more than one third had been orphaned as a direct result of AIDS. Mother-to-child transmission of the HIV virus was at one in every four births in South Africa in the year 2002 (Dorrington, Bradshaw and Bulender, 2002).

These staggering results shed light on the desperate situation that the country is facing, where a whole generation is being born into orphanhood. Children with HIV infection from birth face a range of physical and emotional difficulties within their limited lifespan, such as lack of financial support for school fees, food, and access to medical care (Nyambedha *et al*, 2003), with the consistent co-morbid perinatal physiological symptom being developmental delay of intellectual and physical milestones (Byers, 1989; Havens & Mellins, 1996; Papola & Alvarez, 1994).

Despite the bleak situation of HIV infection in South Africa, and the overwhelming social consequences of the epidemic, institutions like the Mohau Centre are providing excellent care for as many of these children as possible. However this "excellent care" has a price: namely the effects of institutional life; peers who are ill and dying; and staff members and volunteers who have a high turnover resulting in less opportunities for selective attachments to form between the children and caregivers.

1.3. Music Therapy at the Mohau Centre

My music therapy work within this environment exposed me to the life of children in an institution: I became very aware of the behaviour of the children, the way in which they communicated their needs and emotions and related to the caregivers as well as their peers; and considered how living within the institutional environment affected the relational skills of the children and limited the emotional development of the children.

Observing the children on a weekly basis led me to questioning the role that music therapy can play within this context: what are the needs of the children; what do the caregivers provide; how do the caregivers view the weekly music therapy sessions; and what should I, as a music therapist, be offering and providing when working within this institutional context?

1.4. The research questions

The following research questions were identified as the focus of this study:

1. What are the emotional, social and developmental needs of the children at the Mohau Centre?
2. How do the staff perceive that they provide for the needs of the children?
3. What can music therapy offer the children at the Mohau Centre?

In this project I set out to identify a profile of the emotional, social and developmental needs of the children at the Mohau Centre from the perspective of selected professional or non-professional caregivers who work with the children either on a full-time basis or a part-time basis. The aim of this research is to distinguish what the needs of the children at the centre are, how they are or are not provided for and then finally how music therapy sessions might address some of these needs.

The next chapter elaborates on the themes of the first three sub-headings in this first chapter, drawing from existing literature and identifying gaps to which I hope this study may in some way add meaning.

CHAPTER TWO

LITERATURE SURVEY

The literature survey is divided into three sections: The first section deals with the institutionalised child since this study addresses issues to do with children in the Mohau Centre, which is an institution. Therefore theories of the mother-infant relationship, attachment, maternal deprivation, and the effects of institutionalisation on infant and child developmental processes will be presented.

The second section deals with the HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome) epidemic and the issues that it brings to the family, those infected and the consequences thereof, since most of the children at the Mohau Centre are HIV positive.

The third section looks at music therapy literature with institutionalised clients, those with HIV infection and those with developmental delay. As well as looking at music therapy theory and its relevance and value as a creative arts profession when working in the context of the HIV/AIDS epidemic, and within an institutional setting in South Africa.

2.1. The Institutionalised child

2.1.1. Introduction

Institutionalised children often have histories of traumatic experiences in early childhood such as perceived rejection, abandonment, or have lived with ongoing violence. Consequences of such histories include relationship difficulties such as an inability to form trusting relationships with other adult caregivers, or an inability to develop respectful long-term relationships; limited opportunities for development of selective attachments resulting in attachment disturbances such as unselective attachment behaviour towards any person, or an emotionally withdrawn pattern of behaviour; emotional difficulties such as an inability to love, emotional outbursts and aggressive behaviour; an immature development of the self-concept and development of 'self-in-relation-to-other'. Problems of institutionalisation affect not only the child but caregivers as well. The above issues may result in feelings that the caregiver might not be able to contain, and can reaffirm feelings of distrust and rejection in the child (Hoxter, 1983; Smyke, 2002; Pavlicevic, 1994, 2002). These issues are familiar to me in my role as clinician at the Mohau Centre. The following sections will look at relevant literature on the above themes.

2.1.2. Mother-infant interaction

Infancy is the period when the mother-infant relationship is most crucial in the infant's development as the emotional quality of this first relationship impacts on the infant's cognitive growth and provides a basis for forming human relationships and the way in which the infant will get to know the world (Stern, 1985; Trevarthen, 2002).

Studies have shown that the ability for infants to engage and interact reciprocally within their environment is innate; it is one of the earliest forms of human communication to develop, as it is essential for their survival (Bernieri & Rosenthal, 1991; Brown & Avstreih, 1989; Pavlicevic, 1987, 1997; Trevarthen 2002). The nature of the relationship between mother and infant "demonstrate[s] the sensitivity and susceptibility of mother and infant to one another… [Where it is] not only the mother who adapts flexibly to her infant, but the infant, too, is alert, sensitive and responsive to the mother's own variations of communicative form" (Pavlicevic, 1997: 104).

In the case of an infant within an institution, it can be supposed that this specific and crucial relationship is most likely absent due to the limitations of caregivers with regards to rotational shifts and child to caregiver ratios. The infant, who under normal circumstances would respond and evoke communication with one caregiver, under institutional circumstances would be unable to form and depend on this containing and exclusive dyadic relationship.   A consequence of this limited and inconsistent style of caregiving is the lack of development of the self-in-relation-to-other. Pavlicevic (2002) explains how the infant needs the mother to develop "a sense of self-in-relation-to-another", and that the mother-infant relationship is the beginnings of the development of empathy and the ability to form relationships with other individuals. When the exclusive mother-infant relationship is absent in institutional care we can infer that the development of empathy and ability to form relationships with other individuals is stunted.

The above research indicates that there is a sensitive or optimal period during the first year of life, for establishing the framework of a mutually responsive and fulfilling relationship between infant and primary caregiver, which promotes the development of a secure attachment. In the case of children orphaned or abandoned as a result of the HIV epidemic, I question the extent to which such children are given an opportunity to form secure attachments with primary caregivers who are sick, or develop a secure attachment with a primary caregiver if placed in an institution such as the Mohau Centre, soon after birth.

2.1.3. Attachment theory

John Bowlby drew attention to the value of family life, the need for supportive parents, the influence of early experience on later development, the power of the unconscious, and the operation of defences in caregivers against emotional pain and anxiety in caring for children. His work was based on two central psychoanalytic principles: the enormous importance of the mother for a child's development, as discussed above, and the influence of early experience on later development. His theory surmised that if a child were separated from its mother during the first few years of life it would suffer lasting emotional damage. Bowlby's *attachment theory* holds the basic belief that children need a stable attachment figure, which they will seek out in times of anxiety or danger. This relationship also provides the foundation for the child's capacity to form relationships with other trusted people, and from which the child can explore the surrounding environment. Bowlby also pointed out that a crucial consequence of attachment is that separation from a loved person is painful and distressing, and prolonged separation leads to sadness and mourning (Bower, 1995).

Subsequent research has shown that "children who have experienced a period of maternal care, even if it is fairly brief, may internalise a good enough internal object to see them through later adversity and keep alive the hope of finding something good in life" (Bower, 1995: 30). In the case of children placed in institutional care, this research brings hope that children may be able to form other secure attachments with caregivers in the institutional setting if they were exposed to a period of maternal care. However, the complications of caregivers shift-work at the Mohau Centre make me question whether the children have any stability in terms of care, hence my interest in this study.

2.1.4. Attachment disturbances

The DSM IV describes two patterns of behaviour in Attachment disorders: an emotionally withdrawn pattern, where the child exhibits lack of social reciprocity, failure to seek or respond to comfort, and disturbances of emotion regulation; and an indiscriminate social pattern, where the child is relatively non-selective in seeking comfort from adult caregivers, fails to check back with familiar caregivers, and lacks reticence about approaching relative strangers (Kaplan and Sadock, 1998: 1238).

Longitudinal studies of young children in institutional care have provided support for the premise that institutional care is associated with serious disturbances of attachment. Smyke (2002) found that young children reared in institutions where increasingly limited opportunities for the formation of selective attachments were offered were less

likely to develop preferred attachments. Related behaviours observed were stereotypical behaviour, such as side-to-side or back-to-front rocking, and aggression, which appeared to serve a different purpose in the institution than in a home environment. Forty percent of the institutionalised children were found to have language delay.

Insecurely attached children operate less effectively in interpersonal relationships, and are found to show less sociability in interactions with unfamiliar persons than securely attached children. They tend to be highly dependent, noncompliant, lacking in agency, confidence and assertiveness, and show poor social skills when interacting with peers (Tomlinson, 1997). Such behaviour is blatant in institutionalised children, who are not given the opportunity to bond with a specific caregiver. Unfortunately institution life promotes such a cycle of little opportunity to bond. Although caregivers work full-time to meet the needs of the children in institutions such as the Mohau Centre, it appears that sharing caregivers does not promote the development of secure attachments.

2.1.5. Maternal deprivation

James Robertson observed and described a pattern of response to *maternal deprivation* or separation, which he termed protest, despair and detachment. Children separated from parents went through a period of active distress and searching; which later gave way to apathy; and in cases of long-term separation, detachment and the repression of parental need was noted with children developing superficial, indiscriminate contacts with whatever adult was available. Follow up studies showed that in cases where children returned home, disturbances of behaviour and capacity to form relationships persisted in future relationships (Bower, 1995).

The theory of maternal deprivation focuses on those features of the mother-child interaction that engenders an unhealthy physical, social, emotional and mental development in the child. Maternal deprivation can be understood as the lack of a warm, intimate and continuous relationship with a mother (primary caregiver). Maternal deprivation has been seen to result in disorders of conduct, personality, language, cognition and physical growth, excessive attention seeking and the inability to build up close and trusting relationships with others (Burns, 1986).

Maternal deprivation is not uncommon in institutions, especially when experiences usually present in the complex interactions between mother and child under normal home conditions are absent. This has far-reaching consequences on child

development and the capacity to make relationships with other people, no matter how devoted or efficient the substitute caregiver. Children who have been unable to form a satisfying relationship in early life, especially under institutional conditions, often find it hard to do so in later life (Burns, 1986).

2.1.6. Self-concept development

Children are born into psychosocial contexts that have evolved to safeguard their health and well-being and provide the essential elements of experience that stimulate maturation of uniquely human capacities such as language, emotional understanding and creative abstract reasoning (Richter, 1997).

For the institutionalised child, an aspect of healthy development and healing from past experiences is the establishment of firm boundaries for the self, and for the maintenance of realistic and effective relationships, through which a child's own identity can be established. Many children in institutions have not developed effective boundary control or a firm identity within their environment, and need help from the institution in doing this (Menzies Lyth, 1995).

In contemporary psychology, the development of the self-concept is an important construct in the explanation of human behaviour. The self-concept can be understood as the set of attitudes a person holds towards himself, which influences all aspects of behaviour and functioning in any situation. Self-concept development is a continual process learned and developed out of the mass of 'I', 'me' and 'mine' experiences, as the individual continually discovers new potentials in the process of 'becoming' (Burns, 1986). Within the institutional environment such as the Mohau Centre one is very aware of the lack of individual experiences, as the children are always in each other's company. This begs the question of exactly how many 'I', 'me' and 'mine' experiences institutionalised children have in their limited environment, and to what extent this impacts on their self-concept development.

Self-concept development also relies on feedback from significant others. Parents and primary caregivers are the most significant others in the child's environment, providing the earliest feedback to the infant about how people feel about him. Through feedings, changes, bathing, fondling, caressing, smiles and 'baby talk' dispensed by the parents the infant receives the message that he is valued and accepted and thus is esteemed (Burns, 1986). Again, within the institutional context, especially in the event of multiple caregivers, I question to what extent the institutionalised child's self-concept is

developed in an environment where there may not be one 'significant other' from whom to receive consistent feedback.

When looking at the specific needs of the children at the Mohau Centre and the development of their self-concept, it is appropriate to view the development of the children and fulfilment of needs in the light of the Self-actualisation theory of Abraham Maslow.

Maslow maintained that the environment is important for the fulfilment of basic needs, and therefore people need 'good' societies in which to realise their 'good' potential. Maslow believed that human behaviour could be explained in terms of need gratification, where basic needs are hierarchically arranged. The lower the need in the hierarchy the more urgent it is, thus lower needs must be gratified before higher level needs manifest. The needs in order of importance are: physiological needs (such as hunger, thirst and sleep); safety needs (stability, security, structure, law and order, limits and freedom from fear); affiliation and love needs (belonging somewhere, belonging to someone, and giving and receiving love); self-esteem needs (based on achievements and the esteem of others); and lastly self-actualisation or self-realisation needs (such as truth, justice, meaningfulness, and aesthetic needs) (Moore, 1997).

When looking at the needs of the children at the Mohau Centre in view of Maslow's hierarchy of needs, it is reasonable to question the ability of the institution to provide an environment that allows the children to realise their full potential.

2.2. HIV/AIDS in South Africa

2.2.1. Introduction

Although there has been a general shift in focus of the consequence of HIV infection from a "death sentence", to that of a chronic but manageable terminal illness in more developed countries (DeMatteo *et al*, 2002; Joslin and Harrison, 2002), South Africa and other sub-Saharan countries still face enormous challenges regarding further infection, educational needs, the challenges of poverty on families living with, or surviving family members of HIV infection, and most importantly the provision of medical and psychological care (Van Dyk, 2002; Nyambedha *et al*, 2003). Health care utilisation and community support are of the utmost importance in minimizing the sociomedical problems of people living with HIV infection and AIDS (Goicoechea-Balbona, 1998).

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2.2.2. Poverty

Poverty is responsible for many complications in family life, and furthermore so when compounded with HIV infection. Poor education, unemployment, single parent households, inadequate housing or homelessness and illness compound existing issues of poverty (Jessee *et al*, 1993). Poverty results in many family members travelling long distances for work. Surveys suggest that rural and ethnically diverse communities whose revenues come from seasonal and migratory labour are at a much higher risk of HIV infection because of economic, political, and social inequalities (Goicoechea-Balbona, 1998). Illness resulting from HIV infection can render a family helpless, as primary income family members are unable to work, children are often forced into parental roles of cleaning, feeding and looking after the ill.

In developing countries major health care problems of children are inextricably linked to the social, psychological and physical dimensions of poverty. In developing countries, conditions of ill health (malnutrition, anorexia, parasite load, acute respiratory infection, withdrawal and depression) among children are characteristic of inadequate protection and provision for children in their environments. Malnutrition is the most pervasive problem for child health in developing countries. Statistics estimated that nearly half of all children in developing countries are stunted in growth, and more than half of all deaths among young children can be attributed to the effects of mild to moderate malnutrition in infectious diseases (Richter, 1997).

Richter and Mphelo (in Richter, 1997) found that 70% of women, admitted to a nutritional rehabilitation centre with their malnourished children in South Africa were rated clinically depressed on the bases of their responses to the CES-D scale for depression. This indicates that living within the cycle of poverty has adverse psychological implications for the mental health of caregivers.

In this research project not only the needs of the children are assessed, but also how the caregivers assess what and how they provide for the needs of the children at the Mohau Centre.

2.2.3. Surrogate caregivers

Older relatives, largely grandparents have become the surrogate parents to children and adolescents orphaned by parental death from HIV/AIDS and to those whose infected parents are too ill to serve as primary caregivers (Carten and Fennoy, 1997; Joslin and Harrison, 2002). It has been found that the percentage of non-biological

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caregivers, many of whom are elderly, increase in number with the age of the children (Papola and Alvarez, 1994).

Studies have documented that surrogate caregivers of HIV infected children withdraw from social interactions as the needs of the children affected with HIV become more pronounced. Compounding factors such as poverty, unemployment and socio-economic stress have been found to cause depression in these surrogate caregivers, who seldomly seek help for or deny their own needs (Richter 1997; Mason & Linsk, 2002). Remarking on the problems facing elderly caregivers Richter (1997:102) comments that "care interventions should create the social and interpersonal conditions conducive to child care, and should be aimed at improving the psychological and physical health of caregivers, both as an end to itself and as a mechanism for improving the well-being of small children".

Surrogate caregivers within an institutional setting, need to be aware that their own physical and mental health has a direct effect on the well being of the children in their care. Although caregivers tend to sacrifice their own needs to attend to the welfare of the children in their care, this only perpetuates problems with physical and mental health, resulting in a low quality of care and ultimately results in a frequent turnover of staff in the institutional environment. Certainly my clinical experience at the Mohau Centre corresponds to these points.

2.2.4. HIV orphans

As HIV infection continues to be a family disease with intergenerational consequences (Joslin and Harrison, 2002), the most alarming outcome is the number of orphans that have resulted from the rapid spread of the HIV/AIDS epidemic in the most severely affected sub-Saharan Africa. As the extended family system is burdened with care of young children in the face of poverty, it is not surprising that extended family members are no longer adequately prepared to meet the orphans needs, especially in terms of education, health, clothing and nutrition. For this reason, there are instances of children who are living completely outside of any family structure, whether in orphanages such as the Mohau Centre, or on the street (Nyambedha *et al*, 2003).

2.2.5. HIV infection in children

Children infected with HIV are confronted with the physical effects of HIV progression on development and cognition as well as the psychological issues of adapting to a chronic terminal illness (Havens and Mellins, 1996).

HIV infection is an unpredictable and complex disease in infants, children and adolescents. Originally thought to only affect the immune system, medical science is now aware of its multi-system involvement, including the brain, resulting in marked delay of developmental milestones; particularly motor function, intellectual, and language development; or the actual loss of milestones previously attained by the infant or child (Byers, 1989;Oleske and Czarniecki, 1999; Papola and Alvarez, 1994).

With improvements in treatment, prophylaxis for opportunistic infections, and good supportive care an increasing number of children are living longer (Byers, 1989). With this in mind, children such as those at the Mohau Centre should not only be provided with adequate shelter and a safe environment but also opportunities for the best quality of life, experiencing healthy nurturing relationships and opportunities for healthy identity development.

Long-term surviving children require multiple habilitative, rehabilitative, and palliative care services over the course of the disease, including end-of-life hospice services. Health-care providers need to recognise the multiple difficulties and psychosocial issues in end-of-life care, including children's emotional expression of ambivalence, fear, isolation, anger, loss of control, helplessness or sadness (Oleske and Czarniecki, 1999). Chronic illness associated with HIV infection may require frequent hospitalisation, separation from familiar caregivers, and, in some cases isolation, which may result in or compound emotional and developmental problems in children (Byers, 1989). With institutionalised children such as those living at the Mohau Centre, with histories of orphan hood or abandonment as a direct or indirect result of HIV infection, the psychological trauma related to chronic illness and hospitalisation may further aggravate attachment disorders, separation anxiety and emotional and developmental problems.

2.3. Music Therapy as a therapeutic intervention

2.3.1. Introduction

Music therapists work with the whole person, and see illness as not just a physical condition, but take into account the change in human self-regulatory capacity both physically and psychologically (Neugebauer, 1999). In Improvisational music therapy, clients do not improvise music alone. Therapist and client improvise music together, and this defines the therapeutic relationship as being different and unique from that of other therapies (Hartley, 1999). Music therapy motivates purposeful co-ordinated movements that occur in context of time and a flexible relationship. Music therapy offers a form of communication, through joint activity, active listening and performing through the communicative act without the use or need for words (Aldridge, 1996).

2.3.2. Play and creativity in music therapy

Music therapy offers children opportunities for play, where the imagination can be stimulated, offering opportunities for the child to re-create and re-imagine life, and the creation of a relationship through spontaneous music sounds (Pavlicevic, 1994, 2002).

Play is of the greatest significance to the all-round development of the child, and crucial to human development. Play is a relationship between the child and other children, the child and adults, and between the child and its needs and problems. Repetition in physical play develops coordination through which neurophysical coordination, improved child health and physical development evolve. Play motivates learning, increases control and develops a sense of achievement and self-confidence. Through play a child develops his self-concept. Play involves learning to share, submission to rules and order, promotes leadership and prepares children for the social roles and hierarchies of adult life (Burns, 1986).

From a psychoanalytic view, play is seen as a safety valve for inner tensions, anxieties, fears, and frustrations; and unconscious wishes and fantasies. These are projected into imaginative social, physical and intellectual play. Success and failure are of little importance, and all kinds of behaviour can be released under play conditions (Burns, 1986). Thus play can be seen to have therapeutic value.

Play when defined by its functions, facilitates the libidinization of the body and is an area of importance bridging the realms of the personal and the social. When looking at the playing of music in music therapy the potential of what the child can do is based

upon what the child and therapist are capable of together. Thus, the emphasis on the activity of musical playing within the context of a personal relationship, and the libidinization of the body, is achieved as a communicative act (Aldridge, 1996).

My music therapy experience at the Mohau Centre was that play was focal to our work throughout sessions. There were instances where I as the therapist would literally have to teach a child how to play.

The intimate emotional relationship that develops through music in creative music therapy sessions has many parallels to the mother-infant (primary caregiver-child) relationship and to the mother and infant playing together. Music therapy uses innate mechanisms of communicative musicality, identified in mother-infant interactions, to generate direct emotional communication between the therapist and client (Bernieri and Rosenthal, 1991; Brown and Avstreih, 1989; Pavlicevic, 1987, 1997, 2000; Trevarthen, 2002).

Both the infant and mother learn each other's forms of expressions, gestures and rhythmic structure, and accordingly adjust their own behaviour to fit that structure. "Arousal, affect and attention are learned within the rhythm of a relationship" (1996: 248). The therapeutic relationship in music therapy mirrors the primary relationship of learning to communicate, in which the client can develop communication abilities and find new ways of sounding and expressing himself (Aldridge, 1996).

Since developmental delay is a side effect of perinatal HIV infection, most of the children at the Mohau Centre have developmental delay, which affects their capacity to play, speak or relate. Music therapy is a viable therapeutic form for developmentally delayed children in that in music therapy one of the roles of the therapist is to respond to the abilities and potentials of the child, rather than focussing on their disabilities. Thus the child's limitations are minimized, and an environment is provided where, although temporary, individual change can occur. The acquisition of speech and the ability to communicate meaningfully with another person is an important childhood development. Music therapy encourages and enables children without language to communicate; it has therefore developed a significant place in the treatment of developmental delay in children (Aldridge, 1996).

Developmentally delayed children experience the same emotional conflicts and difficulties as normal children; however they are also more likely to experience rejection

when they fail to meet standards of expectation associated with their chronological age. This rejection can lead to behavioural disturbances. Music therapy allows for the child to play, behave and relate at their individual level, and communicate their emotional states in a non-judgmental environment. By meeting the needs of developmentally delayed children there is a reduction in behavioural problems, enhanced communication possibilities and the child's limitations are minimized (Aldridge, 1996).

One of the complexities of music therapy at the Mohau Centre has been the 'overlap' of various conditions: not only developmental delay, but maternal deprivation and corresponding problems, as well as associated physical and emotional issues related to HIV/AIDS, to which I now turn.

2.3.3. Music Therapy with HIV infected clients

There seems to be no published work on music therapy with HIV infected children either nationally or internationally. However there is a growing body of documented music therapy work with adult clients infected with HIV (Bruscia, 1991; Lee, 1991; Lee in Ansdell, 1995; Hartley, 1999; Neugebauer, 1999). So I present some of this work, keeping in mind that this literature is limited in its transferability when working with HIV infected children.

Hartley (1999) describes his work with HIV infected adults as the therapist and client moving together on a journey where the music offers the potential for client and therapist to be fully alive together. The music embodies a vocabulary, for whatever one wants to express; while the silence in the music provides space for listening and being heard. Adult HIV clients have verbalised a new understanding of life that has been gained through the experience of creating music during music therapy sessions, they have verbalised their surprise at their own musicality, and ability to create music. Clients experience lessened isolation, feelings of being accepted and empowered. Visible results are increased confidence and an energising effect on mood and physicality.

Neugebauer (1999:127) writes of his work in the field of music therapy with HIV positive adults and states that when coming into contact with HIV infected adults we are "meeting people whose lives are overshadowed by death". Music therapy removes the client from the realm of pathology alone, and encourages them to find the realm of their own creative beings. The individual character of each improvisation expresses the emotional condition and state of health of the client. Thus music therapy gives the

client an objective experience of his health, contrary to his everyday experience, which is usually only introspective and subjective in perception, and "at whose mercy he finds himself because of his illness". The act of creatively making music allows active participation in the healing process by opening clients up to the possibility of bringing about active development of musical opportunities, for change. Thus the client becomes active instead of merely being given treatment.

Although we are not, strictly speaking, working in palliative care conditions at the Mohau Centre, music therapy here does have some similarities due to the life threatening condition with which the children constantly live. For this reason I have taken into consideration some literature on music therapy with hospitalised children, as many of the children at the Mohau Centre are frequently hospitalised for secondary infections, as well as being subjected to the trauma of regular checkups and blood count tests.

2.3.4. Music Therapy and hospitalisation

The benefits of music therapy as an intervention and as an outlet for emotional aspects of hospitalisation are well documented (Dun, 1999; Pavlicevic, 1999; Ansdell, 1995; Aldridge, 1996; Wigram and de Backer, 1999).

Dun (1999: 60) has commented on the appropriateness of music therapy for working with hospitalised children with a variety of illnesses and various states of health. She says that the "instant appeal of music for most children makes it a natural medium for this creativity" and that musical activities, instruments and singing songs "are familiar and a source of security in a strange setting".

Emotional aspects of hospitalisation are often confusing to a young child. Music therapy offers a unique medium to express feelings that cannot be conveyed into words. Thus positive and negative energies can be expressed, relaxation and pain control promoted, healthy body parts can be emphasised, and opportunities to make choices and exert some control over the environment are offered. Music therapy engages, encourages and promotes involvement and creativity through active participation. Perceptions and feelings of helplessness resulting from physical, psychological, emotional and spiritual states may be brought into awareness and improved (Dun, 1999: 62).

2.3.5. Music Therapy with HIV infected children in the South African context

The above literature although vast, has shown the enormous needs that are faced by children and their caregivers in the mire of the HIV epidemic. Those infected by HIV are faced with challenges that affect their physical, mental, emotional and spiritual well-being. HIV affected and infected children are faced with growing needs as they live in the repetitive cycles of poverty and deprivation. The impact of HIV has compounded the state of desperation with which many South Africans were already faced, and now growing numbers of orphans, family disintegration, emotional consequences such as grief and bereavement, uncertainty of the future and diminishing health, make the caregiving profession that much more challenging and necessary.

One of music therapy's strengths lies in its ability to use non-verbal communication as a mode of interacting and expressing of emotional states, and as the basis for developing a meaningful relationship (Ansdell, 1995; Pavlicevic, 1997). When working within an institution where the children are all affected by their own histories of abandonment or orphanhood, living with a terminal illness and facing a new life where there are multiple caregivers, it seems that music therapy is ideally placed to contribute to the emotional needs of the children.

Music therapy has the potential and means, (as reflected in the literature above) to allow healing through self-expression within the process of the mutual client-therapist relationship. No matter the physical illness, the mental state, the emotional turmoil, or the spiritual plight, music therapy can offer something of value to the individual in the South African context. With children infected, affected, orphaned or abandoned in South Africa, the value of music therapy can be found in the non-threatening relationship offered, the safety of the therapeutic boundaries, and the supportive and listening attitude that is offered to each client, which ultimately allows for true self expression.

CHAPTER THREE

METHODOLOGY

In the following chapter I present an account of the methodological process used to focus this study and effectively answer my research questions. I describe the methods that I used to generate my data, as well as the process of my data preparation.

3.1. The Research Method

I approach this research study as a naturalistic inquiry within the qualitative perspective choosing to contextualize this profile at the Mohau Centre where I have worked for the past year. Qualitative research is defined by Bruscia (1998: 186) as "the study of interaction and interexperience, as it seeks to explicate the various gaps and bridges that exists between human beings and which make it possible to understand one another's behaviour and experience". Thus this study provides me with an opportunity to explore some of my pre-existing thoughts about music therapy at the Mohau Centre. The purpose of this research study is to compile an idiographic profile (Ansdell and Pavlicevic, 2001) of the social, emotional and physical needs of the children at the Mohau Centre through semi-structured interviews (Robson, 1993) with the part-time and fulltime staff at the Mohau Centre.

I consider this non-generalisable, focused inquiry into the individual situation and phenomena (Ansdell and Pavlicevic, 2001) as both qualitative and naturalistic and as being the most appropriate for identifying and discussing the needs of the children within this particular institutional context.

My own position within the process of this research is one of reflexivity, as my own self-reflection and critical thinking function as a resource within this research project. My interpretations of the themes identified, although subjective, will be treated as a resource – rather than problematic or biased – as I take the stance of "practitioner-researcher" (Ansdell and Pavlicevic, 2001). This has not been easy since as clinician I felt that I knew the answers to some of the questions asked in the interviews and had to focus on being 'researcher'. Therefore, in order to ensure trustworthiness and credibility, and address my own biases, I utilize methods of triangulation. Triangulation can be understood as the use of multiple and different sources, methods, investigators and theories to verify and validate information (Lincoln and Guba, 1985).

In this project, I addressed triangulation as follows: collecting four sources of data using semi-structured interviews: three with permanent Mohau Centre staff members (i.e. Care Worker, Nursing Sister, Social Worker), and one with a part-time Music Therapist (see figure 3.1). This also helped to ensure data saturation since some of the data became repetitive (i.e. mentioned by all four).

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                    ┌─────────────────────────────┐
                    │  Semi-structured Interviews  │
                    └─────────────────────────────┘

┌──────────────┐   ┌──────────────┐   ┌──────────────┐   ┌──────────────┐
│  Care Worker  │   │ Social Worker │   │ Nursing Sister│   │ Music Therapist│
└──────────────┘   └──────────────┘   └──────────────┘   └──────────────┘

│            Full-time Staff            │   │  Part-time Staff  │
│ Non-professional │   │       Professional       │
│              Insider              │   │     Outsider     │
```
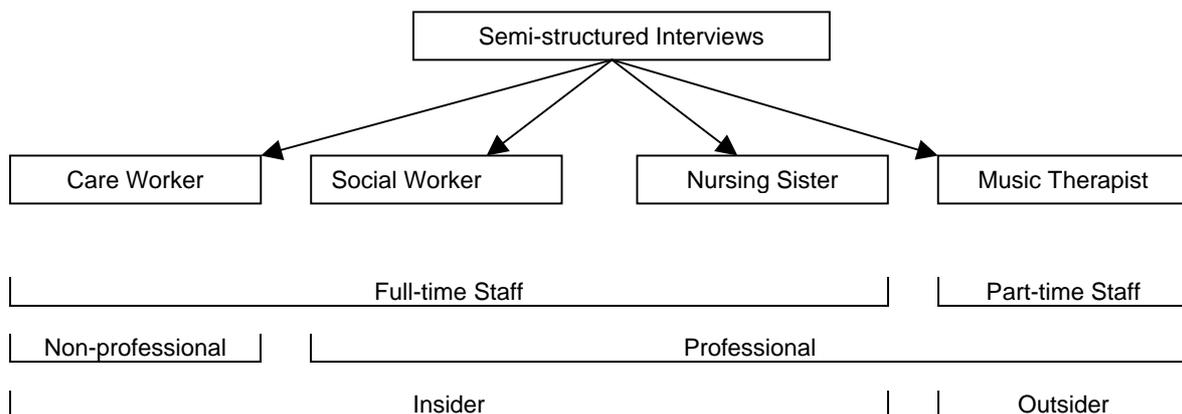
Fig. 3.1 Triangulation in data collection

Bruscia (1998: 183) states that the sources of data selection "determines the research setting, engages the participants, selects and gathers the data in ways which… accomplish the purpose of the study as relevant to the needs of the participants, phenomena and setting; and… enables and assists the participants and/or phenomenon to unfold as naturally and comfortably as possible". Having four data sources also fulfils data triangulation since four sets of interviews would provide information from different perspectives (i.e. fulltime/ part-time; professional/ non-professional; insider/ outsider).

Ethical considerations were addressed for the data collection by using standard informed consent forms (appendix i) written in clear and intelligible language (Wheeler, 1995). Although all interviewees understand and speak English, their second language, fluently, all interviewees were offered the option of the consent form to be explained with the help of an interpreter in their first language. Additional permission was obtained from the Mohau Centre to base the study within the institution.

3.2. Data Collection

This research draws on four sources of research-generated data collected through semi-structured interviews. These were conducted with three adult caregivers who currently work fulltime at the Mohau Centre and one Music Therapist who previously worked at the Mohau Centre part time. It was decided that four interviews would generate sufficient "variation and consistency" of data for the limited time and size of this research project (Robson, 1993; Bruscia, 1998; Ansdell and Pavlicevic, 2001).

A semi-structured interview format was chosen to allow for flexibility within pre-compiled questions inquiring around the area of the institutionalised children's needs. The semi-structured interview format was chosen over the structured interview and unstructured interview format as it allowed for, and included, the predetermined format of questions found in structured interviews; but at the same time allowed for flexibility of question order and relevant information as felt appropriate within the context of the interview conversation, to a greater degree than found in unstructured interviews (Robson, 1993). This was important in the Mohau Centre context with regards to the possible language issues I might encounter within an interview, as well as helping me to focus on relevant information to the study.

I divided my four data sources into data source A and data source B, since these sources necessitated a different interview format, described below.

Data source A is semi-structured interview material collected with three staff members working within the institution on a daily basis. The job descriptions of the three staff members are: the institution's resident Social Worker, the institution's resident Head Nursing Sister and one of the institution's Care Workers. These individuals have a sustained relationship and daily interaction with the children at the institution, and thus observe their behaviour daily.

Data source B is semi-structured interview material collected from a Music Therapist who worked once a week on a temporary basis at the Mohau Centre. Her relationship with the children was limited to weekly periods of half an hour, where the needs of the children were observed and responded to through the client-therapist relationship within the music therapy session. By interviewing someone with experience parallel to my own as a music therapist intern, I hope to elicit insight into the possible ways in which music therapy is able to address the needs of the children at the Mohau Centre.

Data preparation included transcriptions of the recordings of all four interviews. Aspects of the transcriptions that were irrelevant to the interview were bracketed and excluded from analysis. A brief description of each interview completed data preparation.

In the following chapter, chapter four, I present a detailed account of the process of my data analysis and what I identified as the emerging themes from the analysis process. Chapter five follows with a discussion of these themes in light of the literature presented in the literature survey. I then draw this study to conclusion in chapter six.

CHAPTER FOUR

PRESENTATION OF DATA ANALYSIS

This chapter describes and presents the stages of my data analysis[1]. I start with a short summary of each interview, after which I illustrate the process of data transcription, data coding, categorisation of codes, and conclude, with a description of each theme emerging there from.

All interviewees were second language English speakers, and I am aware that their choice of words influenced the coding process. However, I respected the words they used rather than imposing a vocabulary during the interviews.

4.1. Interview summaries

Three interviews, with the Social Worker, Child Care Worker and Head Nursing Sister, were conducted in July 2003 at the Mohau Centre. The fourth interview, with the Music Therapist, was conducted in September 2003, at her home. The interview questions (appendix ii and iii) were slightly modified for the Music Therapist's interview as she was no longer employed at the Mohau Centre, and had been at the Mohau Centre in a part-time capacity. A full text transcription of each interview is available in the appendix (appendix iv – vii).

4.1.1. Interview 1: Social Worker

The interview with the Social Worker was scheduled to take place in her office, where it began. However, one third of the way through the interview, we were interrupted by workmen who had come to fix a leaking pipe, and had to relocate to the boardroom. I did feel that this interrupted the development and flow of ideas in the interview.

The Social Worker has been in the employment of the Mohau Centre for the last year and a half, but has been affiliated with the Mohau Centre for over three years. Her job description includes: the court work for adoptions; managing the programme for the weekend parenting and foster care programmes of the children of the Mohau Centre; as well as some residential care and community outreach work.

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[1] Data analysis was supervised through peer group discussions and supervision so that I could maintain the balance between me-as-researcher, and my investment in the Mohau Centre as a trainee Music Therapist.

The Social Worker presented as willing to impart her knowledge and spoke freely about both the positive aspects as well as the limitations of the institution. I did not feel that she was presenting her answers in a manner to esteem the institution in which she certainly has invested a lot of her time and energy. She shared her experience of and insight into the needs of the children frankly. As expected with interviewing a social worker, her answers focused around the emotional needs of the children for most of the interview.

4.1.2. Interview 2: Head Nursing Sister

The Head Nursing sister is in charge of the medical heath of all the children at the Mohau Centre. She spends most of her time providing palliative care in the hospice that is run by the Kalafong Paediatric department situated on the second floor of the Mohau Centre. She has worked at the Mohau Centre since it was established over six years ago. Her job description includes, referring children for additional therapies or for hospital admissions, supervision of the child care workers and monitoring the nutritional diets of the children.

This interview was shorter than I had anticipated. Her manner was very professional. She spoke about the needs of the children quite clinically when speaking of their conditions, however softened noticeable when she spoke about their needs for nurture and parenting, and of her own foster daughter.

4.1.3. Interview 3: Care Worker

The Care Worker was chosen randomly from the care workers who were on duty on the day that the interviews were scheduled. It was by chance that I interviewed the one care worker who had worked at the Mohau Centre since it was established over six years ago. Her job description includes facilitating the practical day-to-day tasks such as bathing, dressing and feeding the children; changing nappies and toileting the older children; as well as supervising the walk to and from school, and visiting the children admitted into hospital.

The interview with the Care Worker was the shortest of all the interviews. I was very aware that she related to me as if she were inferior to me in some way, and that she placed me in a superior position of 'researcher'. She spoke openly about her personal experience of family members with HIV infection, her personal investment and the connection that she feels to the children at the Mohau Centre, describing them as her "grandchildren".

The Care Worker spoke mostly about the needs of the children from a nurturing perspective where nurture and the need for love, was linked to providing for the physical needs of the children.

4.1.4. Interview 4: Music Therapist

The interview with the Music Therapist took place in her home. The Music Therapist had worked at the Mohau Centre one day a week, for two consecutive years (2000 and 2001). One year was part of her clinical internship, while the other was in a strictly professional capacity.

I was surprised on transcribing the audiotape of the interview, that it was the same length as the interview conducted with the Social Worker, as it had at the time felt much longer. I did wonder whether this distorted perception was perhaps because of the amount of information that she communicated; and the ease with which she spoke and I understood. I was also aware that my listening was biased in the sense that I could relate to the professional perspective from which she was speaking, and relate the experiences that she was describing to my own experiences at the Mohau Centre this year.

The Music Therapist focused mainly on the needs that she saw the children presenting within the sessions. She also commented on some of the observations that she had made during her period of work at the Mohau Centre, and on the Mohau Centre as an institutional whole.

I will now turn to a description of my stages of analysis.

4.2. Data transcription

After the interviews were conducted, they were immediately transcribed verbatim. The next step was to segment my data by bracketing the information that was not relevant to the study.

Before coding could take place, each sentence or new idea in a sentence was numbered as a reference to correspond to each numbered code.

Fig. 4.1 (over page) shows an example of an interview transcript[2].

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[2] A copy of the full transcript of the interview from which this example came, can be found in appendix iv.

Mikaela:	[32] **And then, what do you see as the main emotional needs of the children?**
Social Worker:	[33] It's, we have a different needs in terms of the emotions because of the different backgrounds, [34] so, we cannot generalise that this is the need, [35] it depends on the circumstances, where they come from, [36] so we treat each child individually in terms of providing the emotional, um, providing for their emotional needs, [37] but, I think they, most of the children are, uh, insecured, [38] they have lost trust because of them being abandoned, [39] and them seeing strangers everyday of their lives, [40] them being cared for by different people for this particular time period. [41] So they are very insecured and dependent. [42] So they need to be, their need is for their emotional for them to be secured, [43] and so that they can become independent, [44] and therefore they will gain the trust, [45] and they will gain the, you know they will have hope, [46] and that will help them to improve their self esteem [47] and to be positive.

Fig 4.1 Extract of Interview 1: Social Worker

4.3. Data coding

Ansdell and Pavlicevic (2001:150) describe the aim of coding as "break[ing] up the data into meaningful chunks so that comparison and other analytic procedures are possible". Each numbered "chunk" was labelled with a word that described the content or essence of the sentence (see appendix viii for an example of work in progress). The following example[3] illustrates this process.

CODE	DATA
Child: caregiver ratio	[50] but because there were only one or two, and I mean there are so many children there [57] the fact that there are so many children and few carers
Individualised attention	[46] there wasn't such a thing as individualised attention [53] I would say individualised attention was the one thing [87] and to be heard necessarily as an individual, within a social context [122] I think the whole concept of individualised attention and [123] having a constant other that was not part of the centre…
Nurture	[54] I think just nurture, [55] I mean they all tried their best, everybody involved tried their best to give the best nurture… [58] caused that the nurture wasn't always the best quality nurture that you could find.
Physiotherapist	[27] I once stumbled across a physiotherapist [28] which I think worked mainly with the palliative care, kids that were very sick and dying. [29] so physiotherapy would probably be the only one.

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[3] A copy of the full transcript of this interview can be found in appendix vii.

Presence	[66] because the people were more there in a babysitting kind of capacity
	[69] they weren't focused on the children
Roles	[74] it came out that they didn't really have that family kind of set up, [75] where they got the chance to experience themselves in various roles…
	[77] they didn't necessarily get enough … but their could have been more opportunities for them to experience what it was to have a leadership role, what it was to follow…

Fig 4.2 Coding extract of Interview 4: Music Therapist

Due to the quantity of information in the four interview transcripts, I found that I was overwhelmed with lists of codes. In figure 4.3 below I list all my codes. Since these were too numerous and some were similar, I then revisited the codes. To reduce the quantity, I collapsed codes that were similar, into higher order codes, some of which later became categories. For example "stunted" was placed under the higher order code "developmental delay".

Additional therapies	Feel special	Superficial activity	Emotional - expression	Communication
Physiotherapist	Stability	Observer-not	Musical	Sounding oneself
Occupational	Care	participant	"communication"	Choice
therapist	Nurture	Presence	Mutual contact	Autonomy
Speech therapist	Love	Removed	Self expression	Responsive
Music therapy	Understanding	Outsider	Resistance	Caregiving
Play therapy	Past experience -	Un-invested	Rebellion	Parental figures
Palliative care	history	Community	Relationship	Role models
Selective	Individual experience	Exposure	Individual attention	Limited caregivers
Education	Individual provision	Social learning	Outsider relationship	Inconsistent
Day programme	Insecure	Social expectation	Positive attention	caregiving
Music activity	Untrusting	Morals and values	Unique	Observation for
School programme	Orphaned	Play	Compassion	referrals
Alternative behaviour	Neglected	Stimulation	Interest	Limited nurture
Physical health	Abandoned	Sharing	Comforting/pacifying	Limited individual-
Shelter	Dependant	Manners	Connecting	attention
Physical safety	Isolation	Greeting	mind/emotion	Attachment
Clothes	Behaviour problems	Individual	Childs level	Interaction
Nutrition	Social problems	Health state	Internalise	Attention
Provision	Personal boundaries	Mental state	relationship	Child: Caregiver ratio
Resources (limited)	Testing boundaries	Developmental delay	Transferable	Meaningless
Toiletries	Safe environment	Stunted	Experience	Behaviour difficulties
Hygiene – safety	Situation	Personality	Leadership	Demands
Consistency	Bonding	Extro / introvert	Follower	Clingy
Security	Attachment	Confidence	Development-	Desperation
Independence	Distraction/block out	Aware of needs	opportunities	Withdrawal
Trust	Unrelated	Physical stimulation	Social interaction	Communication of
Hope	Unconstructive	Physical expression	Self expression	needs
Self-esteem	Entertainment	Personal expression		

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Emotionally driven	Attention	Shared group	Social skills learning	Empathy
Emotional trigger	Frustration	expression	Relational individuals	Improvement
(cause)	Tantrum	Recreating family -	Flexibility	Skill
Aggression	Rivalry	unit	Negotiation	Concentration
(consequence)	Uncontrollable	Experimentation	Choice	Attention/memory
Aggressive	Disobedience	Roles	Assertive	Stimulates
behaviour	Discipline	Family	Confidence	development
Destructive	Behaviour responses	Mothering	Imitation	Cognitive
behaviour	Small groups	Sibling rivalry	Compromise	Physical
Emotional instability	Opportunities	Exploration	Giving/taking	Emotional stability
Emotional outbursts	Family structure	opportunities	Listening/responding	Internalised
Fighting	Family roles	Musical community	Turntaking	Modelled behaviour
Hitting	Play	Creating context	Communication	Musical possibilities

Fig 4.3 Table of all codes

4.4. Categorising codes

Once I had completed my coding, my data was prepared for the next step in my data analysis. Each code was placed into a category. Ansdell and Pavlicevic (2001: 151) define categories as "mutually exclusive meaning box[es]". Thus, codes that were similar in meaning were grouped together in a category.

CATEGORIES	CODES	
Additional therapies	▪ Physiotherapy	▪ Music therapy
	▪ Occupational therapy	▪ Psychologist
	▪ Speech therapy	▪ Palliative care
	▪ Play therapy	▪ Selective
Behaviour	▪ Communication of needs	▪ Aggression
	▪ Behaviour emotionally driven	▪ Fighting
	▪ Clingy	▪ Destructive
	▪ Desperation	▪ Hitting
	▪ Withdrawal	▪ Frustration
	▪ Emotional outbursts	▪ Tantrum
	▪ Uncontrollable	▪ Rivalry
	▪ Disobedience	
Educational programmes	▪ Daily programme	▪ Music activity
	▪ School programme	▪ Playroom
Emotional	▪ Consistency	▪ Trust
	▪ Security	▪ Hope
	▪ Independence	▪ Self-esteem (Feel special)
	▪ Understanding	▪ Stability
		▪ Nurture (Care/ Love)

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Past experiences	- Background - Abandoned - Individual experience - Isolation	- Orphaned - Neglect - Insecure - Untrusting - Dependant
Physical	- Physical health - Shelter - Physical safety - Clothes - Nutrition	- Mental state - Developmental delay - Infection prevention - Hygiene (toiletries/ safety)
Physiological development	- Physical stimulation - Sensory stimulation - Developmental learning	Cognition (Concentration/ Attention/ Memory)
Quality of caregiving	- Limited (nurture/ individual-attention) - Observer-not participant - Provision sufficient - Resources (limited)	- Limited Child: Caregiver ratio - Inconsistent caregiving - Limited Bonding /Attachment - Individualised care
Relationship	- Outsider relationship (Relational individuals/ Childs level/ Positive attention) - Unique (New experience) - Safe environment - Mutual	- Interest - Internalise relationship - Transferable - Stability - Modelled behaviour - Communication - Individual attention
Self expression	- Physical expression - Emotional expression	- Shared group expression - Musical "communication"
Social	- Community - Social learning - Social expectation - Morals and values - Sharing - Social rituals (Manners/ Greeting)	- Selfhood (Playroom/ Space/Privacy/ Personal boundaries) - Play - Stimulation - Exposure
Social interaction	- Play/ Experimentation/ Exploration opportunities - Creating context - Family Roles (Recreating family unit/ Mothering/ Sibling rivalry) - Testing/ Boundaries	- Small groups (Family structure/ Family roles) - Social roles (Opportunities/ Experience/ Leadership/ Follower) - Social skills learning
Social skills	- Negotiation - Choice - Compromise - Turntaking (Giving/taking Listening/ responding)	- Flexibility - Empathy - Imitation - Assertive - Confidence

Staff investment	- Parental figures (Role models) - Observation for referrals - Presence (Removed/Outsider) - Un-invested/ Meaningless	Activities (Distraction/ block - out/ Unrelated/ Unconstructive/ entertainment/ Superficial activity)

Fig 4.4 Table of all codes in exclusive categories

Although it was not my intention to necessarily have sub-categories at the beginning of my analysis, it materialised that thinking in categories and sub-categories allowed me to group the filtered information in an accessible and manageable structure. I present my categories in fig. 4.5.
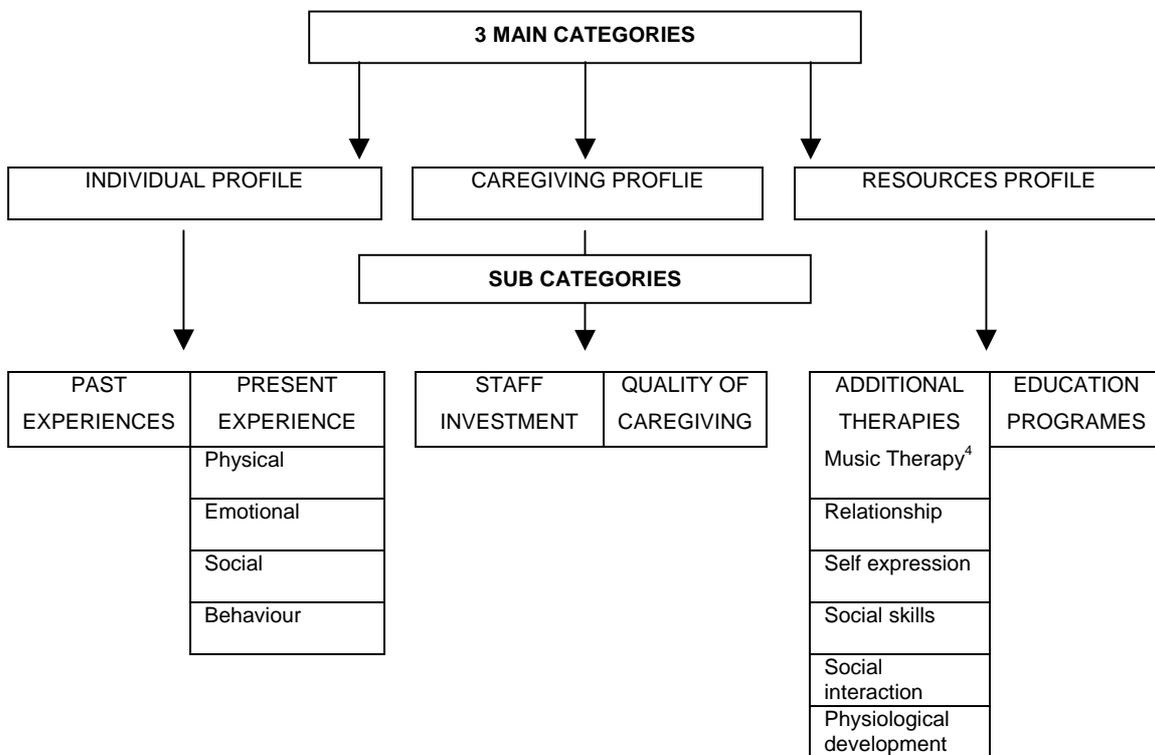
Fig. 4.5 Table showing main and sub categories

Now that my data reduction is complete, I am able to move on to the final stage of my analysis, drawing emerging themes out of my categories. This step of the data analysis was described in supervision as finding "a transverse profile" of my data i.e. slicing through chunks of data.

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[4] Sub-categories listed below ADDITIONAL THERAPIES relate to Music Therapy only.

In the next section of my data presentation, I introduce the five themes that emerged from my data.

4.5. Emerging themes

Each theme is presented in table form, followed by an accompanying description of the theme. To allow a transverse profile to emerge in my themes, and to ensure that themes were indeed relevant to the focus of this study, I kept my three research questions to the side of each table.

4.5.1. Theme one: Current individual health needs

RESEARCH QUESTION	CATEGORY	MUTUALLY EXCLUSIVE CODES	CORRESPONDING INTERVIEW INFORMATION Interviewee Abbreviations **CW**: Care Worker **NS**: Nursing Sister **SW**: Social Worker **MT**: Music Therapist
QUESTION 1:What are the needs of the children at the Mohau Centre?	Physical	Nutrition Clothes Nutrition Shelter Hygiene Clothes Physical health/ Safety Clothes Nutrition Hygiene Infection prevention	CW: [32-34] "…they need food. Warm clothes, mean, I mean we must treat them like the other children outside". SW: [26-29] "we do provide, the physical needs for them, they need, they need to be um, like cared for in terms of their nutrition so that they can be physically healthy and we do provide for that and we make sure that their it's, their dormitories are clean, so the hygiene part of it, because it also effects their physical being and dress them warm according, dress them according to the weather, and we… We… make sure that um... We make sure about the safety as well, so that they don't hurt themselves, we place things according, we, we, we check um the, the area where they playing, so in the playroom we arrange things accordingly, that it doesn't hurt their physical being" MT: [37-39] "they always well clothed and they were seemingly well fed… but think, I know there were a few crises with things like, basic necessities like toilet paper, nappies… disposable gloves for the nurses" MT: [42-43] "the disposable gloves, I think were quite an issue because the nurses were very reluctant to change nappies, which you can understand, if there weren't disposable gloves available… also, the one thing that was constantly finished was the liquid soap, um for washing your hands in the bathroom"

QUESTION 2:How do the staff perceive that they provide for the needs of the children?	Additional therapies / quality of caregiving / educational programmes	Individualised care	CW: [19-23] "Those that can't walk, we roll with them, on the carpets, trying to help them to crawl. Those that are sick we usually visit them at ward 6 or 8… we take them to school, and we enjoy walking with them up to the technikon"
		Physiotherapy Occupational therapy Palliative care	NS: [15-16]"on request we do have the physiotherapist who would when the doctors have seen the kid then they will refer them to the physiotherapist for the different ailments. And then again the OCC's they do come, they are consulted".
		Playroom Educational programmes	MT: [27-31] "I once stumbled across a physiotherapist, which I think worked mainly with the um, palliative care, kids that were very sick and dying. Um, so physiotherapy would probably be the only one, I never saw a physiotherapist *(meaning OT)* I think I saw a referral form once for a speech therapist… [34]There were the two teachers there obviously who ran the day programme, but that was about the only input that I was aware of"
		Play therapy Occupational therapy Speech therapy Physiotherapy Psychologist Educational programmes Individualised care	SW: [22-24] "I do play therapy with them, and the, um, we have you, the music therapist, we have the occupational therapy, we have the speech therapist and the physiotherapist. And we do have um psychologist, um student psychologist sometimes. So those are the other extra services that they get, except for the activities that they do at school, we also have a school programme for the little ones" SW: [33-36] "…we have a different needs in terms of the emotions because of the different backgrounds, so, we cannot generalise that this is the need, it depends on the circumstances, where they come from, so we treat each child individually, in terms of providing the emotional um providing for their emotional needs"
QUESTION 3: What can music therapy offer the children at the Mohau Centre?	Social skills / physiological development	Imitation Attention/ memory/ cognitive Concentration Physical stimulation	CW: [52-55] "usually when he comes from music therapy he can take a stick or anything that hit and dance, so I can learn that he has learnt something. At least he has done something. He knows the sound… that there is a cert(?) without singing there is something in the music a drum or what ever, he is trying to imitate that".
		Developmental learning imitation	SW: [140-141] "it also stimulates the physical… exercise or whatever of the child, that's how I understand what music therapy is" SW: [166-168] "…so it also stimulates their develop…conceptual cognitive development, physical development and emotional stability"
		Confidence Choice	NS: [53-54] "sometimes when these guys come from the music therapist you can hear them imitating, saying something, although not yet fluent. But you can say ooh they've had something from the music therapist". MT: [141-142] "growing into little people that had agency in this little world that we created. So they became more assertive about their needs".

Fig. 4.6 Table of theme one

Description of theme one: Current individual health needs

The children at the Mohau Centre present with very specific health needs: other than providing for the physical needs such as clothing shelter and safety in the environment, the children also have special needs related to their HIV status: continuous monitoring of their nutritional diet and ensuring that their physiological health is maintained through rigorous hygiene procedures, thus preventing HIV infection to caregivers or uninfected peers, and preventing the spread of secondary infections. Due to the HIV status of the majority of the children, acquired through perinatal transmission, these children also present with developmental delay of all milestones. Thus their individual heath needs often require individualised therapeutic intervention through additional therapies, such as physiotherapy or speech therapy, in the acquisition of developmental milestones such as walking and speaking. Music therapy, as an additional therapy, has beneficial outcomes regarding cognitive and physical investment.

4.5.2. Theme two: Capacity for emotional and intimate relationship

RESEARCH QUESTION	CATEGORY	MUTUALLY EXCLUSIVE CODES	CORRESPONDING INTERVIEW INFORMATION Interviewee Abbreviations **CW**: Care Worker **NS**: Nursing Sister **SW**: Social Worker **MT**: Music Therapist
QUESTION 1:What are the needs of the children at the Mohau Centre?	Past experience / Emotional / Staff investment	Emotional needs Abandoned Love Parental figures Security Trust Hope Stability Feel special Parental figures Dependent Stability	SW: [37-38] "most of the children are uh insecured, they have lost trust because of them being abandoned" SW: [42-47] "So they need to be, their need is for their emotional for them to be secured, and so that they can become independent, and therefore they will gain the trust, and they will gain the, you know they will have hope, and that will help them to improve their self esteem and to be positive". SW: [50-54] "…but as I said that um most of them need to be emotionally stable in terms of the trust that they have last because of them, them being abandoned and so on, and that they need to be independent and for that to happen they need to, to improve their self esteem" CW:[26-28] "we must share with them, give them more love. Embrace them as their parents" NS: [27-28] "most of that they are they know that there are no parents, we are the mothers in here, so they depend on us. For everything". MT: [106-107] "emotional outbursts, it sounds very strong, but their emotions weren't always levelled out nicely, it was always this um, "see-saw-i" kind of thing"

QUESTION 2:How do the staff perceive that they provide for the needs of the children?	Emotional / Quality of caregiving	Care – inconsistent Love Nurture	SW: [55-56] "they need to be cared for but because we have different child care workers every time, so that's a problem…" NS: [31] "But if they know that the mum is there who will love them, they will come around you and things will be okay".
QUESTION 3: What can music therapy offer the children at the Mohau Centre?	Self expression / Emotional / Relationship / Social skills	Emotional expression Stability Empathy Modelling roles / behaviour Emotional expression Emotional expression Negotiation	SW: [136-139] "My understanding of music therapy is… the, playing of it, it connects the child to how they feel, and it also helps them to express their feelings or their needs, so it also um, shows one, helps one to… um, understand the personality of a child". SW: [180-181] "…and they understand each other better, than those that are not involved (laugh) even if it, I don't know whether the others are learning from them but I can see the difference, really" NS: [47-49] "what I could deduct was that, music therapy, it, it encourages them, to be open, because what I know is that at times that she will just start a song you know, with her own words… "hi mama…you are beautiful today… I mama love you" just like that, then I say oh… then it becomes a song then she's okay, then I thought maybe she got that from the music therapists". MT: [126-127] "In terms of the music specifically, I think that it was very important for self-expression, for getting them to interact um, in ways that they didn't necessarily get chances, um, in the, in the greater activities of the centre"

Fig. 4.7 Table of theme two

Description of theme two: Capacity for emotional and intimate relationship

The capacity of each child at the Mohau Centre to form and maintain emotional and intimate relationships is affected by both the children's individual histories of neglect, abandonment or orphan hood; as well as the environment of the Mohau Centre and the opportunities for the children to invest themselves, and be invested in relationship with the caregivers who work regularly with them. Thus, past histories seem to play a vital role in limiting the children's capacity for relational investment, while the institutional environment seems to maintain this level of investment, as limited opportunities are available for secure attachment and bonding to occur. Opportunities for individual attention, where a relationship can develop and be experienced as exclusive, can increase the emotional capacity for intimate relationships.

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4.5.3. Theme three: Limited social experience

RESEARCH QUESTION	CATEGORY	MUTUALLY EXCLUSIVE CODES	CORRESPONDING INTERVIEW INFORMATION Interviewee Abbreviations **CW**: Care Worker **NS**: Nursing Sister **SW**: Social Worker **MT**: Music Therapist
QUESTION 1:What are the needs of the children at the Mohau Centre?	Social	Learn social values: (Morals, Sharing) Learn social rituals: (Greetings, Manners)	SW: [58-81] "socially… most of them need to learn to … to cope with the… social demands for them to develop and to go… to grow, but then there isn't that stimulation and exposure, resulting from them staying in an institution, it's difficult for them to learn how to, like the different social morals and values, they don't know them, they, cause of them living here, so they have this social need to know… sharing it's, it's still difficult for them, and um how to like… they normally don't greet, and they don't know how to…, to be, to behave around the visitors, they will just pull them or hit them, or, so they don't have that social background in terms of the moral expectations, so there's a big need for them, but because they are not exposed to the society as such, they are living in this community, they are the community themselves, you know, because they are staying here, so it's difficult for them to learn the social, to be socially um, how can I put that… they cannot, they won't fit into the, the, the normal society out of the environment here because they here most of the time, so there is that need, to try to help them to feed into the outside s... community, into the society and to learn, but it's not possible because they're staying here, and it's an institution, and limited activities, limited social activities, so there's no way that can learn them".
QUESTION 2:How do the staff perceive that they provide for the needs of the children?	Educational programmes / Social	Music Activity Play	CW: [45 – 47] "sometimes when I sing to them then we clap the hands, they dance, or sometimes I bring eh, we take a radio and play some cassettes. Then we dance together, they enjoy it, and they love it, they love… they really enjoy it".

		Communication	SW: [113-115] "and the only way you can communicate to him, it' s through singing or the [claps hands] you know the beat and something, that's the only way you can communicate… because of his mental condition, and the others maybe because of their personality"
QUESTION 3: What can music therapy offer the children at the Mohau Centre?	Social skills / Social interaction / Relationship / Physiological development	Small groups	
		Turntaking	SW: [171-179] "…those that you take in a group, they will always see themselves you know like um, colleagues or classmate or group-mate, whatever you can call it. They see themselves in that, and they share what they do in the sessions, and it keeps them together, and they also learn to share um, showing maybe you teach them that, and they also learn to give each other a chance. Like they would show me how the other one did this and then the other one get a chance like you know? It really helps them to communicate wonderfully, umm. Especially immediately after the session. And then they will remember that every time, and … it's making them close and like brothers and sisters
		Lead/follow	
		Social skills learning	
		Attention	
		Confidence	
		Communication	SW: [162-165] "So it helps them also to talk to me, about the things that they have been doing, they open up, they share, they learn to share, they learn to, to, to recognise their differences in terms of who did this, she didn't do that when she was told to do that, she danced while she was supposed to sit and so on, so they talk to me about that"
		Social skills learning	MT: [128-131] "Socially if I think of the groups it was definitely a, in a sense recreating a little family and experimenting within that set-up, with the various roles that you would have found in a family. Um, I remember distinct occasions where some of the children um, literally took on the mommy role of mothering the other children and caring for them, and um, between the boys often there would be something similar to sibling rivalry, where they would, sort of the one, bully the one in a playful sort of way…"
		Roles	MT: [135-139] "their ability to fit in with structure within the therapy setting, because the initial, um, the initial sessions would always be marked with them not wanting to fit in with the structure or the *modus operandi* which was in a way, I think, a bit of a revolt against the institutionalisation, you know, having their lives structured so extremely. Um, so in a way it's a bit of a dichotomy, that they, that I say that they got to function within structure more, but the context was different".
		Testing boundaries	MT: [143-146] "more able to compromise and to be more flexible in terms of um, letting their will be, not their will, but their, I don't know how to say it. Allowing themselves to be, um, flexible within relationship, um, giving and taking, listening and responding".
		Flexibility	

Fig. 4.8 Table of theme three

Description of theme three: Limited social experience

The closed community of the institution plays a critical role in the limited opportunities
that the children have for learning social values, such as morals and sharing, and
social rituals, such as greetings and manners. Limited opportunities to be part of a
small group or 'family' means that the children are very rarely given the opportunity to
function in different roles, such as the value of being in a leadership position or to
enhance feelings of individual identity needed within the group. The inflexible structure
of the institution also limits opportunities for testing and negotiating boundaries, which
has a direct consequence on the social functioning of the children, my next theme.

4.5.4. Theme four: Social functioning

RESEARCH QUESTION	CATEGORY	MUTUALLY EXCLUSIVE CODES	CORRESPONDING INTERVIEW INFORMATION Interviewee Abbreviations **CW**: Care Worker **NS**: Nursing Sister **SW**: Social Worker **MT**: Music Therapist
QUESTION 1:What are the needs of the children at the Mohau Centre?	Behaviour	Aggressive behaviour Communicating needs Aggressive behaviour Disobedience Communicating needs Aggressive behaviour Withdrawal Rivalry Disobedience Rivalry Communicating needs	CW: [36 – 37] "some of them are very naughty. They hit the other ones, they bite them". SW: [90-96]"Take that emotional, um, um, feeling to the others, also with the grown ups, also with me, they will just hit and um be aggressive to you, so that's mainly the, the behavioural problem that they have, the hitting, and um, being uncontrollable in terms of you know, when we tell them to stop being naughty they won't listen they will hit the other kids, they will push, they will… um, they will tear off things, or break and, and do such things, but aggression is the most problem… [97] there is a need to help them to understand that, things can be done other ways" SW: [105-108] "…they become angry with this because they cannot get what they want according to their needs, so emotionally there is something that triggers this behavioural problem. That it comes out as a behavioural problem, but emotionally there is something that triggers that" NS: [29-30] "these kids they tend to be withdrawn, and then they tend to, you know, fight with each other… [35-36] there are those that become aggressive, to the extent that they want to fight. Fight amongst themselves, and then also they want to kick the caregiver, or what ever". MT: [71-76] "I'm not sure that enough opportunities were created for them to interact in smaller groups always… again it came out in the um, in the way that they interacted and the way that they would argue and fight about toys and that sort of thing. It came out that they didn't really have that family kind of set up, where they got the chance to um, experience themselves in various roles, because they were always just one of a lot of children". MT: [83-87] "…not enough opportunities to develop, so all the things that involve being a social being. And self-expression, that's also a form of being sociable, isn't it. I don't think that they got enough opportunities to express themselves and to be heard, um, necessarily, as an individual"
QUESTION 2:How do the staff perceive that they provide for the needs of the	Quality of caregiving/ Staff investment	Observer-not participant Presence	MT: [61-67] " the playroom. Where the children were often dumped in a way…, but… they would sit there and people would try and play with them but it was often more of just a frustrating situation because the people were more there in a baby-sitting kind of capacity and not really in a, in a interactive capacity".

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QUESTION 3: What can music therapy offer the children at the Mohau Centre?	Social skills / Social interaction / Relationship / Physiological development	Communication Small groups Turntaking Lead/follow Social skills learning Attention Confidence Communication Social skills learning Roles Testing boundaries Flexibility	SW: [113-115] "and the only way you can communicate to him, it' s through singing or the [claps hands] you know the beat and something, that's the only way you can communicate… because of his mental condition, and the others maybe because of their personality" SW: [171-179] "…those that you take in a group, they will always see themselves you know like um, colleagues or classmate or group-mate, whatever you can call it. They see themselves in that, and they share what they do in the sessions, and it keeps them together, and they also learn to share um, showing maybe you teach them that, and they also learn to give each other a chance. Like they would show me how the other one did this and then the other one get a chance like you know? It really helps them to communicate wonderfully, umm. Especially immediately after the session. And then they will remember that every time, and … it's making them close and like brothers and sisters" SW: [162-165] "So it helps them also to talk to me, about the things that they have been doing, they open up, they share, they learn to share, they learn to, to, to recognise their differences in terms of who did this, she didn't do that when she was told to do that, she danced while she was supposed to sit and so on, so they talk to me about that" MT: [128-131]"Socially if I think of the groups it was definitely a, in a sense recreating a little family and experimenting within that set-up, with the various roles that you would have found in a family. Um, I remember distinct occasions where some of the children um, literally took on the mommy role of mothering the other children and caring for them, and um, between the boys often there would be something similar to sibling rivalry, where they would, sort of the one, bully the one in a playful sort of way…" MT: [135-139] "…their ability to fit in with structure within the therapy setting, because the initial, um, the initial sessions would always be marked with them not wanting to fit in with the structure or the *modus operandi* which was in a way, I think, a bit of a revolt against the institutionalisation, you know, having their lives structured so extremely. Um, so in a way it's a bit of a dichotomy, that they, that I say that they got to function within structure more, but the context was different". MT: [143-146] " more able to compromise and to be more flexible in terms of um, letting their will be, not their will, but their, I don't know how to say it. Allowing themselves to be, um, flexible within relationship, um, giving and taking, listening and responding".

Fig. 4.9 Table of theme four

Description of theme four: Social functioning

The social functioning of the children seems to be most affected by the awareness that each child has of his own needs. This theme is closely connected to theme two, in that this theme grows out of the limitations of the children's capacity for emotional and intimate relationships. The children present with a pattern of behaviour that is self-serving. Learned social skills such as empathy are limited, while communicating individual needs are conveyed mainly through negative behaviour patterns. The role that the staff and caregivers play in maintaining this behaviour can be seen as two fold:

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one is a cycle of negative attention; where the children receive attention regardless that it is through reprimands and mild discipline; and secondly, the children, aware of their own need for individual attention, communicate this need through rivalry and aggressive behaviour towards their peers and caregivers. Here again, social functioning is associated with the lack of opportunities for each child to function within a specific role in a smaller 'family' group.

4.5.5. Theme five: Quality of care

RESEARCH QUESTION	CATEGORY	MUTUALLY EXCLUSIVE CODES	CORRESPONDING INTERVIEW INFORMATION Interviewee Abbreviations **CW**: Care Worker **NS**: Nursing Sister **SW**: Social Worker **MT**: Music Therapist
QUESTION 1:What are the needs of the children at the Mohau Centre?	Quality of caregiving / Emotional	Inconsistent Limited Attachment Bonding Nurture	SW: [39-41] "and them seeing strangers everyday of their lives, them being cared for by different people for this particular time period. So they are very insecured and dependent" MT: [50-54] "but because there were only one or two [caregivers], and… there are so many children there, you can imagine that not all the children can effectively relate to them as a significant other. I don't know if I'm saying this right, but I would say individualised attention was the one thing. Um, I think just nurture"
QUESTION 2:How do the staff perceive that they provide for the needs of the children?	Staff Investment / quality of caregiving	Referrals Inconsistent Limited Insufficient Uninvested	NS: [21-22] "we used to observe the kids and how they developing so that we may be able to refer them, to the physiotherapists to the OCC's if they need to be" MT:[45-46] "even though there were quite a few volunteers and caregivers, there wasn't such a thing as individualised attention.... [48] Because there was a lack of consistent interaction with one specific, one or two specific people" MT: [55-58] "they all tried their best, everybody involved tried their best to give to give the best nurture, but I think the nature of the situation, the fact that there are many children and few carers, caused that the nurture wasn't always the best quality nurture that you could find" MT: [68-69] "So even if they were there, they were not really 'there' if you know what I mean. They weren't focused in on the children".

QUESTION 3: What can music therapy offer the children at the Mohau Centre?	Relationship	Individual attention Outsider relationship	MT: [122-125] "I think the whole concept of, um, individualised attention and having a constant other that was not part of the centre that actually did show compassion and… interest, in, in one specific child, if I have to think in terms of the individuals. Um, so it was more the therapy relationship really, than the music, the music facilitated that relationship". SW: [146-147] "that the children need attention, whether you offer whatever kind of therapy, they appreciate that you do individual sessions with them".

Fig. 4.10 Table of theme five

Description of theme five: Quality of care

The execution of "care" offered to the children at the centre is unbalanced, and can be understood hierarchically; as the focus of care is mainly on the physical needs or current health needs (theme one) of the children, while the emotional needs of the children (theme two), become secondary. This imbalance can be understood in terms of the institution context, with rotational staff and high child to caregiver ratios. The limitations and inconsistency of caregiving, which in the best of circumstances would be difficult to maintain, directly affects the functioning and potential growth of each child. Even though these limitations present themselves, the level of investment from each caregiver at any particular moment has a direct outcome on the perceived quality of care. Thus, opportunities for children to experience care or attention removed from the group context would undoubtedly increase in the child's experience of the quality of that care.

I now have five themes. In the next chapter I return to the research questions and attempt to answer each research question, drawing from this data analysis and contextualize discussion in the literature survey in order to draw this study to conclusion.

CHAPTER FIVE

DISCUSSION

In the following chapter I will discuss my three research questions in the light of each of the themes that have emerged through the process of data analysis. While writing up this discussion, I found that my answers to research question two (How do the staff perceive that they provide for the needs of the children?) were closely linked and at times causal to the children's needs identified in research question one (What are the emotional, social and developmental needs of the children at the Mohau Centre?). Thus to avoid repetition I will address research questions one and two, together, before answering research question three. My discussion makes reference to the theory presented in the literature survey, as well as my own insights from my experience working at the Mohau Centre as a Music Therapist intern over the past year.

5.1. Research questions one and two: What are the emotional, social and developmental needs of the children at the Mohau Centre; and how do the staff perceive that they provide for the needs of the children?

The children at the Mohau Centre present with specific needs related to their individual past histories of abandonment or orphanhood, their past and current health status (HIV status), and their individual experience of living and functioning within an institutional environment. Although there was general consensus between all interviewees when identifying the needs of the children, there was quite a polarised view – between the full-time staff and the part time Music Therapist interviewed – on how and to what degree the needs of the children are provided for by the caregivers.

5.1.1. Theme one: Current individual health needs
The most prominent needs identified during the interviews conducted for this study were divided between the physical health and well-being of the children, largely referred to by the Care Worker and the Nursing Sister; and emotional needs of the children at the Mohau Centre, which were more prominent in the interviews with the Social Worker and the Music Therapist (the emotional needs will be addressed further in theme two).

Physical needs identified, are balanced nutritional diets to keep the children physically healthy and free from secondary infections, providing shelter and warm clothing for the children, keeping the children physically safe in the environment and preventing HIV infection between children and staff, or the spread of secondary infections through hygiene maintenance. All the staff members consistently indicated that the physical needs, such as shelter, clothing, nutrition, hygiene and physical safety of the children are met.

> "We do provide, the physical needs for them, they need…[to be] cared for in terms of their nutrition so that they can be physically healthy and we do provide for that and we make sure that their… dormitories are clean, so the hygiene part of it, because it also affects their physical being and dress them warm according, dress them according to the weather… I think that's what we do for now, and I can say that we, we're meeting all their needs, in terms of the physical needs. I don't think that there's any other thing there. Physically" (Social Worker Interview 1: 26-28, 30-31)

> "It's taking care of the health of these kids, …taking care that, that our kitchen lady cook the food, the balanced food and the kids get the balanced diet" (Nursing Sister, Interview 2:12)

> "They need love, they need food. Warm clothes, mean, I mean we must treat them like the other children outside" (Care Worker, Interview 3: 31-34)

> "They always well clothed and they were seemingly well fed" (Music Therapist, Interview 4:37-38)

Providing firstly for the physical needs of the children, seems to be how the full-time staff members perceive their roles as caregivers. This is understandable when taking into consideration the physical health state in which many of the children are admitted, as well as the pressure within the institution to keep the children healthy and free from illness within the closed environment. The secondary role of caregivers is identifying and referring children for treatment:

> "We used to observe the kids and how they developing so that we may be able to refer them, to the physiotherapists to the OCC's [Occupational therapists] if they need to be" (Nursing Sister, Interview 2:21-22)

Children that present with needs outside of physical needs, usually related to developmental delay or illness, are referred for additional therapies. As stated in the

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literature on HIV infection in children, the progression of the disease is complicated in children that have HIV infection from perinatal (mother to child) transmission. For HIV infection not only affects the immune system, but also has a multi-system involvement that results in the noticeable consequence of developmental delay of all milestones (Byers, 1989;Oleske and Czarniecki, 1999; Papola and Alvarez, 1994).   Thus the current health needs of the children relate not only to the current physical needs of the child in terms of food and shelter, as mentioned by the Social Worker and Care Worker, but also in terms of the compounded role that HIV infection plays in the developmental issues of each child within the institutional environment, as mentioned by the Nursing Sister.

> "Mostly, is that these kids they've they developmental stages are very slow, most of them. All their physical and whatever they are very slow" (Nursing Sister, Interview 2: 18-19)

What has emerged out of the data is that within the institution, the full time staff members perceive that they provide for the needs of the children by identifying the needs of the children and then referring the children to additional therapies[1].

However, the perspective of the part-time Music Therapist, who's role in the institution lay in the parameters of being an additional therapy, was that there was no structured multidisciplinary team approach to providing for the needs of the children.

> "I once stumbled across a Physiotherapist, which I think worked mainly with the… palliative care, kids that were very sick and dying… so physiotherapy would probably be the only one, I never saw a Physiotherapist *(meaning Occupational Therapist)*, I think I saw a referral form once for a Speech Therapist, but I personally never saw actually any other therapists" (Music Therapist, Interview 4: 27-33)

It appears as though what is identified as important in meeting the needs of the children is in some way related to how the staff perceive what a need is. My perception of the situation was that identifying physical and emotional needs seemed to be influenced by the interviewees' level of education: that emotional and physical needs are perceived to be linked, and therefore what is evident on the outside of the child is in

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[1] Thus, children that have difficulty learning to walk are sent to the Physiotherapist or Occupational Therapist. Children with difficulties in language acquisition are sent to the Speech Therapist. Children who present with behaviour difficulties are seen by a student Psychologist or by the resident Social Worker for play therapy. While those who present with relationship difficulties are referred for Music therapy. The staff members also perceive that they provide for the children during the end of life stages, with the palliative care in the hospice.

some way a measure of how the child feels or should feel on the inside. Thus if physical needs are being met, the child's emotional needs are also being met.

5.1.2. Theme two: Capacity for emotional and intimate relationship

The individual emotional needs of the children at the Mohau Centre appear to be given secondary consideration to current physical needs of the children. I experienced this split in thinking as: the current health needs of the children are seen as group needs; and emotional needs are viewed as individual. Emotional needs relate to past histories of abandonment or orphanhood, neglect or abuse, and are thus more demanding to the caregivers in the institution in general. Although data showed a general awareness of the emotional needs of the individual, little reference was made to the practical means in which these needs are addressed (this will be discussed further under theme five).

The emotional needs of the children are greatly influenced by the environment in which the children live, as well as the consequences of past histories. As mentioned in the literature in chapter two, the individual history of each child as well as the ongoing experience of institutionalisation determines the capacity to develop long-term, trusting and selective attachment relationships with caregivers in the institutional environment (Hoxter, 1983; Smyke, 2002).

My observations of the emotional relationships between the caregivers and the children are similar to the literature on the effects of institutionalisation on attachment and bonding, and further confirmed by the opinion of the Music Therapist.

> "Even though there were quite a few volunteers and caregivers, there wasn't such a thing as individualised attention. And I think that that's where many of the social problems which eventually cause children to be referred to us came about. Because there was a lack of consistent interaction with one specific, one or two specific people" (Music Therapist, Interview 4: 45-48)

The Social Worker indicated that the children are all given attention according to the individual background of each child, and thus at the level at which the child was able to relate in an emotional and intimate capacity. However, she also indicated that there was a problem with inconsistent caregivers for bonding and attachment forming.

> " We have a different needs in terms of the emotions because of the different backgrounds, so, we cannot generalise that this is the need, it depends on the circumstances, where they come from, so we treat each child individually, in terms of

providing the emotional um providing for their emotional needs…they need to be cared

for but because we have different child Care Workers every time… that's a problem…"

(Social Worker, Interview 1: 33-36; 55-56)

Emotionally the children are deprived of having a constant primary caregiver, due to the rotational timetable of staff working hours. At the same time, the limited number of staff members available to the children at any one time, usually accounts for the lack of emotional relationships developing (Bower, 1995). This not only affects the quality of the relationships between children and caregivers, but also the self-concept development of the individual child within the institution. Since the children spend all their time together in the group – the younger children in the playroom and the older children at school – opportunities for individual emotional and intimate relationships with caregivers are limited. Consequently interaction for necessary feedback between the child and significant other, which contributes to the formation and development of positive self-concepts, is limited (Burns, 1986).

Staff members perceive themselves to be in the role of parents for the children, providing love and security as well as discipline, however, it seems that they are not aware of the degree to which the emotional needs of the children are not met. The Social Worker and the Nursing Sister recognised that the behaviour problems of the children were related to their emotional needs not being met in relationships between the caregivers and children.

> "They need understanding. And love. Because they are easily disturbed… they know
> that there are no parents, we are the mothers in here, so they depend on us. For
> everything. So emotionally if you don't show that love, with them, these kids they tend to
> be withdrawn, and then they tend to, you know, fight with each other. But if they know
> that the mum is there who will love them, they will come around you and things will be
> okay" (Nursing Sister, Interview 2: 24-31)

The Care Worker indicated that the staff provide for the relationship needs of the children by being with the children in the playroom, holding the babies, and interacting with children, by singing or playing with the children, and visiting those who are sick.

> "Those that can't walk, we roll with them, on the carpets, trying to help them to crawl.
> Those that are sick we usually visit them at ward 6 or 8… Sometimes when I sing to
> them then we clap the hands, they dance, or sometimes I bring… we take a radio and
> play some cassettes. Then we dance together, they enjoy it, and they love it… they
> really enjoy it" (Care Worker, Interview 3: 19-20, 45-47)

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The above view contrasts to the view of the Music Therapist who saw the role that the Care Workers played relating to the children as more of a "babysitter" in capacity, rather than as a mother figure and nurturer.

> "Because the people were more there in a baby-sitting kind of capacity and not really in a… interactive capacity. So even if they were there, they were not really "there" if you know what I mean. They weren't focused in on the children" (Music Therapist, Interview 4: 66-69)

> "There is a very irritating thing where they'd put on the radio in the playroom, and it always, almost seemed that they wanted it like a wallpaper effect, because the music wasn't necessarily related in the playroom to a specific activity or to a song or doing something to the tune of the music… some of the children would join in and you know dance a bit or whatever, but it would be fleeting moments and it wouldn't be really focused. And that cause the music to almost be, well from my perspective to become more of an irritation really than a constructive contribution to the morning in the playroom" (Music Therapist, Interview 4: 110-115)

In the above quote the Music Therapist implies that the role the Care Workers employed in the playroom was more as a facilitator of entertainment, keeping the children busy, and not as a mother figure, teaching and interacting with the children in a focused and intimate way.

From my perspective (as both researcher and as Music Therapist intern) the capacity for the children to relate emotionally and intimately is greatly influenced by the limited opportunities for individual attention within the child-caregiver relationships in the institution.

A consequence of being part of a group, where each child has not developed an identity separate to the group and environment, is negative behaviour patterns.

> "Aggression! Most of them are aggressive, and I think… it goes with the emotional instability that when they feel they need attention and it's also individual attention, in terms of the individual needs going back to their background circumstances they come from, so… they take it out, they act it out as aggression… I think they feel that, they don't get attention in the world… Take that emotional… feeling to the others, also with the grown ups, also with me, they will just hit and um be aggressive to you, so that's mainly the, the behavioural problem that they have, the hitting, and… being uncontrollable in terms of you know, when we tell them to stop being naughty they won't

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listen they will hit the other kids, they will push, they will… tear off things, or break…
and do such things, but aggression is the most problem, there is a need to help them to
understand that, things can be done other ways" (Social Worker, Interview 1: 83-97)

Behaviour towards the caregivers and peer group expresses not only the needs of the
children to be viewed as individuals and given individual attention, but also the
frustration that each child experiences when their attempts to gain individual attention
fail. Failure to meet individual needs has a further consequence of diminishing each
child's capacity for developing a sense of empathy towards peers. A lack of empathy
and an over awareness of their own needs for attention, results in behaviour that is
aggressive and demanding.

"They become angry with this because they cannot get what they want according to
their needs, so emotionally there is something that triggers this behavioural problem.
That it comes out as a behavioural problem, but emotionally there is something that
triggers that" (Social Worker, Interview 1: 105-108)

When comparing the current health needs mentioned above with Maslow's hierarchy of
needs (Moore, 1997), we can see that the children's needs are being met on the first
two levels (physiological needs and safety needs) and then only partially on the third
level (affiliation and love needs) which relate to this theme. As stated in chapter two, a
person becomes aware of their need for affiliation and love only once safety needs are
satisfied regularly. Similarly for self-esteem needs, which would only manifest once
affiliation and love needs were satisfied regularly. The children at the Mohau Centre do
have their physiological and safety needs met regularly, therefore I can assume that
there must be a certain amount of frustration that the next level of needs are not being
met, which in light of Maslow's hierarchy of needs, could account for the high level of
aggressive and demanding behaviour.

5.1.3. Theme three: Limited social experience

The children at the Mohau Centre are given few opportunities to be part of the greater
community outside the walls of the institution. Due to the HIV status of the children
within the institution the environment is closed. This I believe is partly due to protective
health factors, but also in my opinion due to the social stigma of HIV infection in South
Africa. The implication of a closed institutional environment is that the children are not
exposed to life outside the institution. Developmentally, the institutional environment
limits the experiences of the children in the greater community, and the children are

exposed only to their peers who are also developmentally challenged, thus the closed environment limits the growth potential of each child.

From the data, two implications of this are apparent. Firstly, the children in the institution are the community.

> "So there's a big need for them, but because they are not exposed to the society as such, they are living in this community, they are the community themselves… because they are staying here, so it's difficult for them to learn the social… they cannot, they won't fit into… the normal society out of the environment here because they here most of the time, so there is that need, to try to help them to feed into the outside community, into the society and to learn. But it's not possible because they're staying here, and it's an institution, and limited activities, limited social activities, so there's no way that can learn them" (Social Worker, Interview 1: 72-81)

And secondly, there is a difficulty in teaching the children the social norms of the outside environment when they are rarely exposed to it.

> "There isn't that stimulation and exposure, resulting from them staying in an institution, it's difficult for them to learn how to, like the different social morals and values, they don't know them… cause of them living here. So they have this social need to know like… sharing it's… difficult for them, and… simple things like, they normally don't greet, and they don't know how to… behave around the visitors, they will just pull them or hit them… so they don't have that social background in terms of the moral expectations" (Social Worker, interview 1: 59-71)

The social needs of the children all relate to being part of the community of the institution (Menzies-Lyth, 1995). Here, learning social rituals such as manners or social values such as morals and sharing are all limited as the environment does not allow for each child to individually relate to one person who can consistently teach and enforce such learning. Were the children receiving such attention from one specific caregiver with whom an attachment was developed, guidance and learning of social values and rituals would possibly be more successful.

The Care Worker implied that the children are separated from the greater community and indicated that she recognised the importance of exposing the children to the community, using the walk up to school as an opportunity to show them the "outside world".

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> "Some ones go to school, when the transport is not here, we take them to school, and we enjoy walking with them up to the technikon. So that they must see the outside world as well" (Care Worker, Interview 3: 22-24)

It is evident that the caregivers recognise the need for the children to experience themselves as part of a greater community, but are unable to provide opportunities for the children to experience themselves in relation to the greater community, outside of the institution. Thus within the Mohau Centre the children are seen as the community, with limited opportunities for experiencing themselves outside of their peer group or the institutional context.

The Music Therapist also identified that within the institutional context, there were almost no opportunities for the children to experience themselves in smaller groups, with roles, as experienced in a family situation.

> "I'm not sure that enough opportunities were created for them to interact in smaller groups always. It came out that they didn't really have that family kind of set up, where they got the chance to… experience themselves in various roles, because they were always just one of a lot of children" (Music Therapist, Interview 4: 71, 74-76)

Although it is evident that as staff members, providing opportunities for being social within the community is limited, the Music Therapist has identified that the children need the opportunity to function in smaller groups, thereby experiencing themselves in different roles within the institution.

5.1.4. Theme four: Social functioning

As mentioned previously, the past history of each child plays a vital role in the behaviour of the individual child (Hoxter, 1983). Many of the children are distrustful of adults due to histories of orphanhood or abandonment as well as neglect or abuse. It is also questionable whether the children at the Mohau Centre have had the experience of a dyadic (mother/ primary caregiver – infant) relationship, due to past histories, which would ultimately affect their ability to form relationships that develop the "sense of self-in-relation-to-other" (Pavlicevic, 2002).

Thus the past history of each child affects the child's functioning in new relationships with caregivers and peers. Difficulties that individual children have in their social functioning within the institutional environment is I believe directly affected by the lack of individual attention from caregivers, thereby maintaining the state in which the child

finds himself. An inability to function socially appears to be related to needs not being met.

> "Some of them are very naughty. They hit the other ones, they bit them" (Care Worker, Interview 3: 36-37)

The children require that their emotional needs of individual attention, love and discipline (theme two) be met, to enable them to function socially with each other. Behaviour such as rivalry between peers, withdrawing from relationships or behaving aggressively towards each other would then possibly be minimised. There is also a need for the children to feel secure and stable within the social context in which they live. This I believe is provided by the institution as a whole, but is limited in individual intimate relationships.

The effect of limited and underdeveloped relationships on the social functioning of the children results in a diminished capacity for functioning and relating socially, and this is most obviously seen in rivalry, aggressive or withdrawn patterns of behaviour.

> "They need understanding. And love. Because they are easily disturbed… they know that there are no parents, we are the mothers in here, so they depend on us. For everything, so emotionally if you don't show that love, with them, these kids they tend to be withdrawn, and then they tend to, you know, fight with each other. But if they know that the mum is there who will love them, they will come around you and things will be okay" (Nursing Sister, Interview 2: 24-31)

As in theme three, the staff recognise the need for the children to learn to function differently and to be taught other ways to behave rather than their present negative behaviour patterns.

> "So that's mainly the, the behavioural problem that they have, the hitting, and… being uncontrollable in terms of you know, when we tell them to stop being naughty they won't listen they will hit the other kids, they will push, they will… tear off things, or break… things, but aggression is the most problem, there is a need to help them to understand that, things can be done other ways" (Social Worker, Interview 1: 92-97)

The staff members however, have not indicated that they supervise the behaviour of the children through discipline or structure in any way other than verbally discouraging negative behaviour. The quote from the Social Worker above also indicates that the

behaviour of the children is perceived to be uncontrollable. This is understandable in terms of limited caregivers to child ratios within the institutional environment, where a lower child to caregiver ratio may possibly facilitate better behaviour patterns and social functioning in the institution.

5.1.5. Theme five: Quality of care

The emotional needs of the children relate directly to the limited opportunities for developing emotional and intimate relationships with caregivers, i.e. the development of security and trust within the environment, and the development of empathy between the children themselves. These ideas have been mentioned in each of the above themes, but it seems important to emphasis the role that the inadequate quality of care given to the children by the caregivers in the institutional environment plays on all of the identified needs of the children.

A salient thread that has emerged throughout this study is the need for and importance of an intimate bond between caregiver and child, for a meaningful and secure relationship to grow. From the data it is evident that the children need consistent caregiving to optimise their social functioning within the environment, and to provide for and satisfy their emotional needs for attention and nurture. The absence of one constant primary caregiver results in a lack of learning social values and rituals, as there is no one constant caregiver who would relate such knowledge to the child.

When looking at how the staff perceive that they provide for the needs of the children, there was no indication from the Care Worker or Nursing Sister that there was inconsistent care due to low caregiver to child ratios. It seems that as staff members they feel neither that the caregiving needs of the children are not being met, nor that the focus of the Care Workers in the playroom is uninvested or not mentally present when working with the children, as indicated by the Social Worker and Music Therapist.

> "They need to be cared for but because we have different child Care Workers every time, so that's a problem" (Social Worker, Interview 1: 55-56)

> "Even though there were quite a few volunteers and caregivers, there wasn't such a thing as individualised attention. And I think that that's where many of the social problems, which eventually cause children to be referred to us, came about. Because there was a lack of consistent interaction with one specific, one or two specific people… Because the people were more there in a baby-sitting kind of capacity and not really in a interactive capacity. So even if they were there, they were not really 'there' if you

know what I mean. They weren't focused in on the children" (Music Therapist, Interview 4: 45-48, 66-69)

It is possible that the Care Workers do not recognise the behaviour of the children as a disturbance in attachment (Bower, 1995; Kaplan and Sadock, 1998) or as a consequence of their needs not being met, but rather as a personality aspect of each child. As stated by the Care Worker when asked about any behaviour problems that the children have:

> "… some of them are very naughty. They hit the other ones, they bit them… and when the other one, maybe the smaller one plays and cries, they all come together. One will come dragging a bicycle; one will come with this toy. And try to comfort the baby who's crying, that's when I saw that this people love each other" (Care Worker, Interview 3: 36-41)

The Care Worker interprets the behaviour of the children more in terms of sibling rivalry and not as a consequence of emotional needs for individual attention not being met. This I believe is related to two factors, namely, cultural ideas of attachment theory and the personal education level of each staff member. It is possible that from my European culture and academic tradition I perceive that certain needs of the children are important to their well-being, whereas, to a Care Worker who has little education, and lives in a low socio-economic community, emotional well-being may be associated more with being fed, sheltered and clothed. I speculate that this relates to Maslow's hierarchy of needs (Moore, 1997) from the perspective of the Care Worker where the Care Worker sees their own and community needs (needs that they identify with) being met in the children.

Socially the children are in competition with each other for the attention of the few caregivers. They are unable to communicate their needs in any way other than through behaviour. Due to attachment disturbances and maternal deprivation the children show behaviour patterns that attempt to gain affection from any person with whom the children come into contact, including seeking attention indiscriminately from visitors to the Mohau Centre (Bower, 1995; Kaplan and Sadock, 1998). This results in a cycle of the children's needs not being met, as the visitors cannot fulfil the role of caregiver, yet the children desiring an emotional attachment and attention, continue to look for attention in any situation.

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A future concern related to the quality of care given to the children by the caregivers, and related to literature of maternal deprivation, is that children who have been unable to form a satisfying relationship in early life, especially under institutional conditions, will find it hard to do so in later life (Burns, 1986). Therefore, we can surmise that identifying and providing for the current needs of the children, emotionally, socially and developmentally, will have a direct effect on and influence the future needs and behaviour of the children.

The quality of care given by the caregivers directly relates to the emotional capacity of the caregivers to be available for the children. Although there is no indication in the data that the caregivers suffer in any way from emotional difficulties, I speculate according to theory in literature that the emotional capacity for the caregivers to develop attachments to the children is influenced by their personal capacity to contain the children's emotional difficulties (Hoxter, 1983). As stated in chapter two, studies with surrogate caregivers (Richter, 1997; Mason and Linsk, 2002) often experience depression as the needs of the children infected with HIV become more pronounced. These are often compounded by socio-economic stress, and a pattern where caregivers' seldomly seek help for, or often deny, their own needs. It is also worth mentioning that as an institution, the needs of the Care Workers should be addressed within the institutional context to improve the level of care giving. As quoted in chapter two: "care interventions should create the social and interpersonal conditions conducive to child care, and should be aimed at improving the psychological and physical health of caregivers, both as an end to itself and as a mechanism for improving the well-being of small children" (Richter, 1997: 102).

The above literature makes me question how I as academic and 'researcher' perceive the caregivers in the institution as meeting or not meeting the needs of the children. Since there is no way of knowing the internal states of the caregivers at the Mohau Centre, or the stresses which they face daily; I question whether, from an economic point of view, the caregivers who are all living in varying states of economic poverty, may experience the institutional context as meeting all needs of the children who are sheltered from the harsh realities of poverty in the surrounding community. Thus, from their personal perspectives, all the physical needs are being met, whereas these needs may not necessarily be being met within their own families or communities.

5.2. Research question three: What can music therapy offer the children at the Mohau Centre?

Music therapy has the potential to address many of the individual needs of the children, as well as the social needs relating to the institutional environment identified in the first two research questions.

5.2.1. Theme one: Current individual health needs

Music therapy offers the child an opportunity to grow in areas that may be neglected in the institutional context such as in cognition, through increasing concentration, attention and memory; and providing opportunities for developmental learning through the relationship and imitation; and addressing emotional aspects of character such as confidence and providing opportunities to exercise choice.

The Care Worker's perception of the benefits of music therapy is that the child's mind was "eased" and "reconnected", i.e. the combined emotional, mental and physical experience, through the act of music making, is therapeutic.

> "It helps them… the sounds of the things, the drums… it helps them to reconnect their minds, to ease their minds" (Care Worker, Interview 3: 49-50)

Music therapy works holistically with the whole child; so many aspects of functioning are addressed within the act and relational aspects of making music with the therapist. An important element of actively taking part in music making is that the child experiences themselves as a whole, using the physical being, and perceiving themselves as a whole in relation to their surroundings, through their senses.

Since many of the children at the Mohau Centre present with Developmental delay of all cognitive and physical milestones due to their HIV status and/or the effects of institutionalisation, music therapy sessions offer continuous opportunities for physical engagement of the body and stimulating physiological development. The latter through: sensory stimulation, conceptual cognition, concentration and learning through the act of playing; while concurrently allowing for emotional expression and the opportunity to release emotions that are not addressed within the institutional context.

> "It also stimulates their develop… conceptual cognitive development, physical development and emotional stability" (Social Worker, Interview 1: 166-168)

As stated by Aldridge (1996) in chapter two, music therapy with developmentally delayed children allows for the child to play, behave and relate at their individual level, and communicate their emotional states in a non-judgmental environment. By meeting the needs of developmentally delayed children there is a reduction in behavioural problems, enhanced communication possibilities and the child's limitations are minimized.

5.2.2. Theme two: Capacity for emotional and intimate relationship

The relationship that develops during music therapy sessions is also important, as it is a unique and specialised relationship, where the child and therapist experience each other in a separate context from the institution.

> "In terms of the music specifically, I think that it was very important for self-expression, for getting them to interact… in ways that they didn't necessarily get chances… in the greater activities of the centre" (Music Therapist, Interview 4: 126-127)

As stated in chapter two, in Improvisational music therapy, clients do not improvise music alone, the therapeutic relationship is defined as being different and unique from that of other therapies, as the therapist and client improvise music together (Hartley, 1999). This selective relationship provides the child with an opportunity for individual attention – one of the needs identified in research question one. Thus the child feels special and valued, which improves self-esteem and confidence and also gives the child a sense of autonomy.

The therapeutic relationship has many parallels to the mother-infant (primary caregiver-child) relationship and to the mother and infant playing together (Bernieri and Rosenthal, 1991; Brown and Avstreih, 1989; Pavlicevic, 1987, 1997, 2000; Trevarthen, 2002). The nature of the individual relationship and individual attention can minimise behaviour problems observed in the institutional context because the child does not need to attract the attention of the therapist or rival with peers to attaining this attention.

> "I think it's… helping in that, the first thing is that the children need attention, whether you offer whatever kind of therapy, they appreciate that you do individual sessions with them, it helps a lot. And the music is, is because we play different music for, from what you doing I'm sure it gives them something to think of, and… it's something like they explore and it's something new for them, and it's something that makes them feel special because… it's something different that they never hear from us, we don't play that kind of a music. So it does help in terms of, of, of making them… happiness results

> in them being you know… comfortable and easy and keeping them busy while… avoid them fighting and so on. So it helps them to know that really, they being appreciated, firstly to be treated individually in that session. Second thing, it helps them to know or to feel… to think of something else that it's… a unique thing for them. So it helps them also to talk to me, about the things that they have been doing, they open up, they share, they learn to share" (Social Worker, Interview 1: 146-163)

Music therapy sessions allow for flexibility within the relationship, as well as the negotiation of boundaries, which is not always possible within the institutional structure. Thus the therapeutic relationship by mirroring the primary relationship of learning to communicate, develops the child's communication abilities of finding new ways of sounding and expressing himself within the music therapy relationship (Aldridge, 1996).

> "But then taken from my little one, I am fostering a child, Pretty, what I could deduct was that, Music Therapy, it, it encourages them, to be open, because what I know is that at times… she will just start a song… with her own words… "hi mama…you are beautiful today… I mama love you". Just like that… then it becomes a song, then she's okay, then I thought maybe she got that from the Music Therapists" (Nursing Sister, Interview 2: 47-49)

Music therapy sessions give the individual child an opportunity to express their emotional feelings in the therapeutic relationship. This learnt ability is also internalised and thus transferred into relationships outside of the therapeutic boundaries. As quoted in chapter two: "children who have experienced a period of maternal care, even if it is fairly brief, may internalise a good enough internal object to see them through later adversity and keep alive the hope of finding something good in life" (Bower, 1995: 30). Thus a positive individual relationship with the Music Therapist, even though only brief, may give the child an experience of relating that the institutional context may not be able to provide, which ultimately may be internalised and transferred into future relationships with caregivers.

5.2.3. Theme three: Limited social experience

What music therapy has to offer the children at the Mohau Centre in terms of their social functioning (theme four) and their limited social experience is closely interwoven. The benefits of the music therapy relationship in individual music therapy session and group music therapy sessions is mutual to both aspects of providing for and facilitating these needs in the children.

As mentioned previously during the discussion of this theme in the light of research question one and two, the opportunities of the children at the Mohau Centre to experience being part of a community outside of the centre is very limited. On a smaller scale, the children also do not have an opportunity to relate to each other in smaller groups in the institutional context, as one would in a family setting. Here music therapy can provide an opportunity for the children to experience themselves in relation to each other in a different context, and in different roles during group music therapy sessions.

> "Socially if I think of the groups it was definitely… in a sense recreating a little family and experimenting within that set-up, with the various roles that you would have found in a family… I remember distinct occasions where some of the children… literally took on the mommy role of mothering the other children and caring for them, and… between the boys often there would be something similar to sibling rivalry, where they would…bully the one in a playful sort of way… or you know hid[e] a toy from the other one or an instrument from the other one in a playful sort of way. So there was that whole thing of definitely of recreating a family kind of set-up… social structure in which they could explore things more I think than in the centre at large" (Music Therapist, Interview 4: 128 – 133)

In the musical activities of the music therapy session, the children are given the opportunity to experience and explore different roles within the group environment, which are closely related to those one would experience in a family setting. As stated in chapter two (Dun, 1999) opportunities to make choices and exert some control over the environment are offered in music therapy sessions, as music engages, encourages and promotes involvement and creativity through active participation (this will be discussed further under the next theme).

Within the music therapy session, structured and focused activities provide the boundaries in which the relationship between group members and the therapist develops. The rules that apply within the greater institution may not necessarily apply within the boundaries of the group music therapy session, hence the children are provided with the opportunity to experience the relationship with their peers and with the Music Therapist in a different manner, to that imposed by the institution.

> "The first thing that comes to my mind is… their ability to fit in with structure within the therapy setting, because the… initial sessions would always be marked with them not wanting to fit in with the structure or the *modis operandi* which was in a way, I think, a bit of a revolt against the institutionalisation… having their lives structured so extremely… so in a way it's a bit of a dichotomy… that I say that they got to function

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within structure more, but the context was different" (Music Therapist, Interview 4: 135-
139)

Music therapy sessions allow for creative self-expression that is listened to, and
responded to. Therefore the group session provides each group member with an
experience of themselves in relation to their peers in a different and unique way and
thereby meets the social functioning needs of the children.

5.2.4. Theme four: Social functioning

In individual music therapy sessions, as well as group music therapy sessions, the
children learn how to relate to the therapist and to each other. The therapist gives the
children a vocabulary that they may not have learnt within the institutional environment
or possess naturally. The children learn how to express themselves emotionally to their
peers and adult caregivers, and the attention of the group and acknowledgement from
the therapist and peers is valued.

> "So it helps them also to talk to me, about the things that they have been doing, they
> open up, they share, they learn to share, they learn to… recognise their differences in
> terms of who did this, she didn't do that when she was told to do that, she danced while
> she was supposed to sit and so on, so they talk to me about that" (Social worker,
> Interview 1: 162-165)

In both individual and group music therapy sessions, the children are encouraged
through the activity of music making to hold leadership positions as well as following
the therapist or their peers, and thus the social skills of turntaking and negotiation are
learned. Sharing is also learnt as instruments and the attention of the therapist is also
shared.

> "It was more about social skills learning to, or growing into little people that had agency
> in this little world that we created. So they became more assertive about their needs,
> but also more able to compromise and to be more flexible in terms of... allowing
> themselves to be… flexible within relationship… giving and taking, listening and
> responding" (Music Therapist, Interview 4: 140-146)

Music therapy sessions offer individual and group members an opportunity to
communicate, by expressing themselves emotionally and physically. What they
contribute to the relationship is listened to, valued, acknowledged and responded to.
As mentioned in chapter two, music embodies a vocabulary, for whatever one wants to
express; while in the silence of the music it provides space for listening and being

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heard. Clients experience lessened isolation, feelings of being accepted and empowered, while visible results are increased confidence and an energising effect on mood and physicality (Hartley, 1999).

The children at the Mohau Centre are affected not only by their own health states, but also by the institutional context in which they live, which includes being part of a large group. The social nature of the music therapy relationship develops social skills such as empathy, sharing, learning to negotiate, turn taking, increasing confidence and initiating ideas through choice and leadership opportunities.

5.2.5. Theme five: Quality of care

One of the most prominent needs, with resulting consequences, identified in this study is the limited individual attention that the children receive, and the effect that the absence of individual attention within relationships with caregivers has on the social and emotional functioning of the children. Since this aspect of institutionalisation is difficult to address (and not the focus of this study) I want to identify what music therapy as a discipline can offer to the children at the Mohau Centre in this area.

Firstly, as previously stated in chapter two, one of music therapy's strengths lies in its ability to use non-verbal communication as a mode of interaction and expression of emotional states, and as the basis for developing a meaningful relationship (Ansdell, 1995; Pavlicevic, 1997). Thus the form, through which communication within the relationship takes place, is a unique experience that is based on the very emotional communicative relationship between a mother and her infant. As already quoted in chapter two the nature of this relationship between mother and infant "demonstrate[s] the sensitivity and susceptibility of mother and infant to one another… [Where it is] not only the mother who adapts flexibly to her infant, but the infant, too, is alert, sensitive and responsive to the mother's own variations of communicative form" (Pavlicevic, 1997: 104). Therefore the role of the therapist is to meet and adapt her own non-verbal/ musical responses to that of the child, and communicate at the level that the child is able. The non-verbal 'message' conveyed to the child is that the relationship is important and valued by the therapist and this results in increased emotional feelings of worth in the child by improving and boosting self-esteem and confidence.

> "It's something different that they never hear from us, we don't play that kind of a music. So it does help in terms of… making them… happiness results in them being you know… comfortable and easy" (Social Worker Interview 1: 152-155)

Secondly, the therapist is focused, attentive and relates meaningfully to each child according to the needs that each child presents. The child does not need to behave in a specific manner to attract this attention and it can therefore be understood as unconditional attention. Thus 'quality of care', can be understood in terms of the interest taken in the child, the focus of the therapist on the actions of the child, and the relationship between the child and therapist.

> "The children need attention, whether you offer whatever kind of therapy, they appreciate that you do individual sessions with them, it helps a lot. And the music… I'm sure it gives them something to think of, and… it's something like they explore and it's something new for them, and it's something that makes them feel special because … So it helps them to know that really, they being appreciated, firstly to be treated individually in that session. Second thing, it helps them to know or to feel… to think of something else… it's a unique thing for them" (Social worker, Interview 1: 146-151, 158-161)

> "I think first of all I think the whole concept of… individualised attention and having a constant other that was not part of the centre that actually did show compassion and "belangstelling" – interest… in one specific child, if I have to think in terms of the individuals" (Music Therapist, Interview 4: 122-124)

Music therapy sessions offer many opportunities for social, emotional and cognitive development, but all of these cannot take place outside of the relationship that develops between the client and therapist. Here, music therapy offers an opportunity for a relationship to develop where the music acts as the facilitator to the relationship, and all areas of the child's functioning are addressed.

> "So it was more the therapy relationship really, than the music, the music facilitated that relationship" (Music Therapist, Interview 4:125)

Finally, the holistic approach of music therapy allows the child to explore and experience himself through fantasy play, actively making music, and experiencing his "self-in-relation-to-other" in the therapeutic relationship (Pavlicevic, 2002). As stated by Neugebauer (1999) participating and relating in music therapy sessions removes the client from the realm of pathology alone, and encourages them to find the realm of their own creative beings. In the closed institutional environment the (possibly unaware) children are treated in accordance with the imminence of their HIV status progressing into AIDS. The character of musical improvisations within the music therapy sessions provides an opportunity for the child to express the personal experience of his internal

condition and state of health. Thus the child has an objective individual experience of his health, possibly contrary to his everyday introspective and subjective experience of his own, or his peer groups, progressive HIV illness.

In conclusion to this chapter I can summarise what music therapy sessions and the therapeutic relationship can offer the children at the Mohau Centre. Firstly, music therapy sessions offer a mutual relationship within a protected space, where the individual child or group of children can express who they are in the moment, physically, emotionally and socially. Secondly, individualised or small group attention provides opportunities for each child to experience himself "in-relation-to-other", or as a group 'in-relation-to-community'. Thirdly, music therapy sessions provide opportunities to grow developmentally, cognitively, and emotionally and engage each child physically. And fourthly, music therapy sessions offer a relationship that is dependant and focused on the child, allowing them to feel special, needed and central to the relationship between themselves, the therapist and the music.

I now turn to my last chapter where I will conclude this research study.

CHAPTER SIX

CONCLUSION

My main focus at the beginning of this study was from the perspective of the HIV epidemic in the South African context. My questions focused on what music therapy as a discipline, would contribute to the needs of abandoned or orphaned children affected or infected with HIV who were placed in the Mohau Centre institution. As the study developed I found that the focus of this study and the themes that emerged shifted from HIV infected children to that of institutionalised children. My shifts in thinking, as well as some of the limitations of this study, fall into four general areas, which I will discuss below.

1. Staff needs not addressed in my original thinking

The focal point of the interview questions was on the children and their needs. When planning the interview questions I did not take into consideration how the role of caregivers in the institutional context would influence the current needs of the children at the Mohau Centre, and thus these questions were not addressed in the interviews. Issues relating to the caregivers within the institutional context were also not addressed more specifically in the interview questions.

2. The children's emotional needs are primary and their HIV needs are secondary

As the data was analysed and the study progressed I realised that the main needs of the children related more to aspects of institutionalisation and issues relating to past histories of abandonment and orphanhood, while the HIV and health status of the children seemed to play a more secondary role. The focus of this study shifted from HIV infection, to the institutional aspects and effects on the children living at the Mohau Centre. Thus I realise that needs relating specifically to the children's HIV status were not solely addressed. I suggest that further research into the area of children affected or infected with HIV in South Africa, may focus on identifying needs that relate specifically to children infected with HIV in an institutional context.

3. The staff-children as dyad.

Through the data analysis process the emerging needs of the children related more directly to institutional environment of which relationships with the caregivers are an integral part. Thus as identified through the emerging themes, the quality of care given by the caregivers at the Mohau Centre played a significant role in maintaining the

diminished capacity of the children to develop positive self-concepts, function reciprocally in relationships, and develop a secure attachment with a significant other.

4. Music therapy relationship

When answering my last question on what music therapy as a discipline could offer the specific needs identified, these related mainly to the social functioning of the children in the institutional context as a closed community. Here both past histories and the present environment affected the capacity for the children to develop and maintain relationships with their peers and more importantly with the caregivers in the institution. Thus it seems that what music therapy sessions have to offer first and foremost in this institutional context is an opportunity for the children to experience themselves in a reciprocal, intimate and purposeful relationship. In this relationship issues that relate to the developmental growth – cognitive, physical and emotional – of the child are addressed through the communicative musical relationship.

Lastly, the small amount of music therapy literature published nationally highlights the need for the South African music therapists' community to publish work that is done within the unique climate of our country. This research study has revealed that we need to build up literature that relates specifically to the South African context, as I believe we are limiting ourselves when we rely on literature based on international work.

APPENDIX I

CONSENT FORM

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

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

UNIVERSITY OF PRETORIA
UNIVERSITEIT VAN PRETORIA

PRETORIA 0002 SOUTH AFRICA

Consent to participate in Research Project

I _____ agree to participate in an interview for the

purpose of Music Therapy research at the Mohau Centre, Kalafong hospital.

I give the researcher permission to make use of and reference to my answers in the

dissertation, and understand that any information that is obtained and identified with

me in this study will remain confidential.

I give permission for interviews to be recorded and transcribed. I understand that

confidentiality and anonymity will be maintained. I give permission for supervisors to

read the transcripts if necessary and understand that transcripts will remain the

property of Pretoria University when the research project is completed.

I am aware that I am free to withdraw from this study at any time without consequence.

Signature of Participant: _____ Date: _____

Signature of Researcher: _____ Date: _____

Signature of Witness: _____ Date: _____

APPENDIX II

SEMI-STRUCTURED INTERVIEW QUESTIONS:

MOHAU CENTRE STAFF

1. How long have you worked at the Mohau Centre?

2. What activities/therapies are offered to the children?

3. What do you see as the main needs of the children at the centre?

   - Physical
   - Emotional
   - Social
   - Could you describe any behaviour problems (if any) of the children at Mohau?
   - Could you describe the emotional problems (if any) of the children at Mohau?

4. What is your role/task as caregiver/staff member at the Mohau Centre?

5. What role does music play in the day-to-day activities of the children?

6. What do you think Music Therapy is?

7. What do you think Music Therapy offers the children at Mohau?

8. Have you noticed any change in the behaviour of the children who go to Music Therapy each week? If yes, please describe.

APPENDIX III

SEMI-STRUCTURED INTERVIEW QUESTIONS:

MUSIC THERAPIST

1. For how long did you worked at the Mohau Centre?

2. How many children did you work with?

3. What other activities/therapies were you aware of that were offered to the children?

4. Looking back, what do you see as the main needs of the children at the centre?

    a. Physical
    b. Emotional
    c. Social
    d. Could you describe any behaviour problems (if any) of the children at Mohau?
    e. Could you describe the emotional problems (if any) of the children at Mohau?

5. What role did you see music play in the day-to-day activities of the children?

6. What do you think Music Therapy offered the children that you worked with?

7. Can you comment and describe on any behaviour changes that you noticed in the children with whom you worked?

APPENDIX IV
INTERVIEW 1: SOCIAL WORKER

Interview information that contained personal details of interviewees was not included in the appendix copy, but is available from the author on request.

Mikaela: [19] **Thank you, all right, my first question is uh, I've already asked you, was how long you've worked at the Mohau Centre, and then second question is um, your role and your task here at the centre which you've already described… so I'll just go on to the next question which is, what activities and other therapies are offered to the children here at the centre?**

Social Worker:[20] Except for social work? [21] Except for the therapy? [22] I do play therapy with them, and the, um, we have you, the music therapist, we have the occupational therapy, we have the speech therapist and the physiotherapist. [23] And we do have um psychologist, um student psychologist sometimes. [24] So those are the other extra services that they get, except for the activities that they do at school, we also have a school programme for the little ones, little class, for the school readiness and yeh I think that's it.

Mikaela: [25] **What do you see as the main needs of the children at the centre? There's different criteria, if you could talk about the physical needs first?**

Social Worker:[26] yah… they, we, we do provide, the physical needs for them, they need, they need to be um, like cared for in terms of their nutrition so that they can be physically healthy and [27] we do provide for that and we make sure that their it's, their dormitories are clean, so the hygiene part of it, because it also affects their physical being and [28] dress them warm according, dress them according to the weather, and we... We… make sure that um... [29] We make sure about the safety as well, so that they don't hurt themselves, we place things according, we, we, we check um the, the area where they playing, so in the playroom we

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arrange things accordingly, that it doesn't hurt their physical being. [30] I think that's what we do for now, and I can say that we, we're meeting all their needs, in terms of the physical needs. [31] I don't think that there's any other thing there. Physically.

Mikaela: [32] **And, then what do you see as the main emotional needs of the children?**

Social Worker:[33] it's, we have a different needs in terms of the emotions because of the different backgrounds, so, [34] we cannot generalise that this is the need, [35] it depends on the circumstances, where they come from, [36] so we treat each child individually, in terms of providing the emotional um providing for their emotional needs, [37] but, I think they, most of the children are uh insecured, [38] they have lost trust because of them being abandoned, [39] and them seeing strangers everyday of their lives, [40] them being cared for by different people for this particular time period. [41] So they are very insecured and dependent. [42] So they need to be, their need is for their emotional for them to be secured, [43] and so that they can become independent, [44] and therefore they will gain the trust, [45] and they will gain the, you know they will have hope, [46] and that will help them to improve their self esteem [47] and to be positive and also to mention another…

[Knock-knock at office door –
Workmen to fix the ceiling, move interview to boardroom]

Mikaela: [48] **lots of people around needing your attention. Okay, we were talking about the …**

Social Worker:[49]…emotional needs yeh, as I was saying, that we, um, there is um different needs emotionally according to the, [50] but as I said that um most of them need to be emotionally stable [51] in terms of the trust that they have lost because of them, [52] them being abandoned and so on, [53] and that they need to be independent and for that to happen they need to, [54] to improve their self esteem and [55] they need to be cared for [56] but because we have different child care workers every time, so that's a problem…

Mikaela: [57] **And socially, what needs do the children display?**

Social Worker:[58] Socially, um, I think um, most of them need to learn to … to cope with the… um… how can I put it, the social demands for them to develop and to go… to grow, [59] but then there isn't that stimulation and exposure, [60] resulting from them staying in an institution, [61] it's difficult for them to learn how to, [62] like the different social morals and values, [63] they don't know them, they, [64] cause of them living here, [65] so they have this social need to know like um… [66] sharing it's, [67] it's still difficult for them, [68] and um how to like, simple things like, [69] they normally don't greet, [70] and they don't know how to…, to be, to behave around the visitors, they will just pull them or hit them, or, [71] so they don't have that social background in terms of the moral expectations, [72] so there's a big need for them, but because they are not exposed to the society as such, [73] they are living in this community, they are the community themselves, you know, [74] because they are staying here, [75] so it's difficult for them to learn the social, to be socially um, how can I put that… they cannot, [76] they won't fit into the, the, the normal society out of the environment here because they here most of the time, [77] so there is that need, to try to help them to feed into the outside s... community, [78] into the society and to learn, [79] but it's not possible because they're staying here, and it's an institution, [80] and limited activities, limited social activities, [81] so there's no way that can learn them.

Mikaela: [82] **Can you describe any behaviour problems that you've noticed?**

Social Worker:[83] Aggression! [84] Most of them are aggressive, and I think that's… [85] it goes with the emotional instability that [86] when they feel they need attention and it's also individual attention, [87] in terms of the individual needs going back to their background circumstances they come from, so um, [88] they take it out, they act it out as aggression because uh. [89] I think they feel that, they don't get attention in the world… you know? [90] Take that emotional, um, um, feeling to the others, also with the grown ups, also with me, [91] they will just hit and

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um be aggressive to you, [92] so that's mainly the, the behavioural problem that they have, the hitting, and um, [93] being uncontrollable in terms of you know, [94] when we tell them to stop being naughty they won't listen [95] they will hit the other kids, they will push, they will… um, they will tear off things, or break and, and do such things, [96] but aggression is the most problem, [97] there is a need to help them to understand that, things can be done other ways…

Mikaela: [98] **So, um, from what I can understand, um, of you describing the behaviour problems, you are sort of linking the behaviour problems to emotional problems…?**

Social Worker: Hmm, mm, [99] it's, it's not just behavioural, [100] there's always something emotionally that they feel, and they want to express, [101] because they're not living in a normal situation, family life, or in among society where they were to be told, [102] they would know by now to deal with this emotion or how to, or where to, to, [103] who to approach or what to do [104] their sources are so limited that it's facing them but they, they, [105] they become angry with this because they cannot get what they want according to their needs, [106] so emotionally there is something that triggers this behavioural problem. [107]That it comes out as a behavioural problem, [108] but emotionally there is something that triggers that.

Mikaela: [109] **Oh, right. What role does music play in day-to-day activities?**

Social Worker:[110] Sho! I think everything is individual here, [111] it depends on the um condition of the children [112] like we have Ernest, I don't know if you know him, he's um, cerebral palsy… [113] and the only way you can communicate to him, it' s through singing or the [claps hands] you know the beat and something, that's the only way you can communicate… [114] because of his mental condition, [115] and the others maybe because of their personality, [116] there are those who are extrovert, [117] if you play music they will dance, [118] some will be afraid because they are introvert, [119] or maybe that they are socially um, they don't have this confidence, or [120] maybe they don't like music,

[121] but it depends on, on the personalities, [122] also on the condition, like Ernest is an example, [123] I think it's the mental condition that forces him to be in that, to understand or to like music. [124] Maybe he likes music we don't know, but we take it as a matter of fact, [125] but the others do love music, [126] they do dance, and it makes them happy. [128] The minute you play music it brings them together, [129] like they will do a certain type of dance, you know, the in in-thing dance, the bigger ones would know, and it brings them together, to a certain extent, [130] and it also helps me to see, their personalities, [131] to a certain extent and it also helps me to, to get them to, to open up to talk sometimes, you know, about, [132] while they're still dancing, join them, and it helps… [133] To a certain extent… [134] also depends on the individual children…

Mikaela: [135] **Can you explain to me what you think Music Therapy is? Your understanding of it?**

Social Worker:[136] My understanding of music therapy is… the… the… how can, I don't know which terms you use, [137] but the big part of it, the, playing of it, it connects the child to how they feel, [138] and it also helps them to express their feelings or their needs, [139] so it also um, shows one, helps one to… um, understand the personality of a child [140] and it also stimulates the physical, you know, (laugh) exercise or whatever of the child, [141] that's how I understand what music therapy is.

Mikaela: [142] **And uh, can you link what you've just said to um, what you think music therapy actually offers the children here, at the Mohau Centre?**

Social Worker:[143] Yeh, but the difference would be the kind of music, but I think it really does, it does link with that, but it, its, … [144] you talking about the music that we play for them, or the music…?

Mikaela: [145] **In the session… you've spoken about what you know of music therapy, and I wanted to know how you thought what we do in music therapy, how it, what it offers the children, when you've spoken about the emotional and physical needs of the children, so**

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how do you see music therapy offering what the children have as needs?

Social Worker:[146] As needs? Oh, okay, so far, um. I think it's, it's helping in that, the first thing is that the children need attention, [147] whether you offer whatever kind of therapy, they appreciate that you do individual sessions with them, it helps a lot. [148] And the music is, is because we play different music for, from what you doing I'm sure it gives them something to think of, and it's, it's, it's [149] something like they explore and [150] it's something new for them, [151] and it's something that makes them feel special because it's, it's, [152] it's something different that they never hear from us, we don't play that kind of a music. [153] So it does help in terms of, of, of making them… happiness results in them [154] being you know um comfortable [155] and easy [156] and keeping them busy while um, [157] avoid them fighting and so on. [158] So it helps them to know that really, they being appreciated, [159] firstly to be treated individually in that session. [160] Second thing, it helps them to know or to feel that um… to think of something else that it's not like… [161] it's, it's a unique thing for them. [162] So it helps them also to talk to me, about the things that they have been doing, they open up, [163] they share, they learn to share, [164] they learn to, to, to recognise their differences in terms of who did this, she didn't do that when she was told to do that, she danced while she was supposed to sit and so on, [165] so they talk to me about that, so, [166] so it also stimulates their develop… conceptual cognitive development, [167] physical development and [168] emotional stability, [169] I think it does wonders (laugh).

Mikaela: [170] **Well that brings us to our last question, which is, have you noticed any change in the behaviour of the children who go to music therapy each week?**

Social Worker:[171] Uuhh, like I just said, that, they see, those that you take in a group, they will always see themselves you know like um, colleagues or classmate or group-mate, whatever you can call it. [172]They see themselves in that, and they share what they do in the sessions, and it keeps them together, [173] and they also learn to share um, showing

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maybe you teach them that, [174] and they also learn to give each other a chance. [175] Like they would show me how the other one did this and then the other one get a chance like you know? [176] It really helps them to communicate wonderfully, umm. [177] Especially immediately after the session. [178] And then they will remember that every time, and it's it's like it's, it's, [179] it's making them close and like brothers and sisters [180] and they understand each other better, than those that are not involved (laugh) even if it, [181] I don't know whether the others are learning from them but I can see the difference, really. [182]The fact that it's, it's, it's a different kind of music, [183] it makes it… um… work for them, for everyone, [184] because if it was normal things that we do it wouldn't make that such a, it's too emotional, [185] I'm like just, you know, pleasure and fun, then.

Mikaela: [186] **Thank you Esther, that's all…**

Social Worker:Thank you (laugh), okay… all right.

APPENDIX V
INTERVIEW 2: NURSING SISTER

Interview information that contained personal details of interviewees was not included in the appendix copy, but is available from the author on request.

Mikaela: [9] **So then can you tell me, the first question is how long you've worked here at the Mohau Centre, everything included?**

Sister: [10] um, six years, since opening nearly seven years…

Mikaela: [11] **That's a long time. You must be very attached to the place and the children. Can you explain then what your role is as the staff member, you know you've spoken about what your job is, they needed someone to head up the medical bit, can you speak a little bit more around what your job entails here at the Mohau Centre, what you do with the kids?**

Sister: [12] Uh, more or less it's… everything, it's taking care of the health of these kids, and above that taking care of the care workers, making sure that they are doing the correct job, and also by looking at the kitchen, taking care that, that our kitchen lady cook the food, the balanced food and the kids get the balanced diet. [13] And at the same time taking care of the visitors of the, people who want to come and see the centre, orientating them and telling them about the centre and all that.

Mikaela: [14] **Can you speak a little bit about the activities or other therapies that are offered to the children here? That you know of?**

Sister: [15] Uum… on request we do have the physiotherapist who would when the doctors have seen the kid then they will refer them to the physiotherapist for the different ailments. [16] And then again the OCC's they do come, they are consulted.

Mikaela: [17] **Can you tell me what you see as the main needs of the children at the centre? I've divided them up into physical, emotional and social, but maybe we can just start with physical? What do you see as the physical needs of the children at the centre?**

Sister: [18] Mostly, is that these kids they've they developmental stages are very slow, most of them. [19] All their physical and what ever they are very slow. [20] So, with that in mind, we need to encourage even our caregivers, [21] we used to observe the kids and how they developing [22] so that we may be able to refer them, to the physiotherapists to the OCC's if they need to be.

Mikaela: [23] **Okay, and on an emotional level? What do you see as the needs of the children?**

Sister: [24] They need understanding. [25] And love. [26] Because they are easily disturbed. [27] And then uh, most of that they are they know that there are no parents, [28] we are the mothers in here, so they depend on us. For everything, [29] so emotionally if you don't show that love, with them, these kids they tend to be withdrawn, [30] and then they tend to, you know, fight with each other. [31] But if they know that the mum is there who will love them, they will come around you and things will be okay.

Mikaela: [32] **mm, and uh, the social needs of the children, how they interact with each other and the caregivers, what do you see as needs there? Or difficulties, if you want to talk from a difficulties point of view?**

Sister: [33] So far, aah, we don't have the, I haven't noticed any much, it's just that they have different behavioural problems, [34] so I wouldn't know whether, when they are easily disturbed, then, they, they, they, [35] they become, there are those that become aggressive, to the extent that they want to fight. [36] Fight amongst themselves, and then also they want to kick the caregiver, or whatever.

Mikaela: [37] **What you've said just led to the next question, which was, um, could you describe any behaviour problems or emotional problems that you've seen the children working through? Is there anything you want to add to what you've already said?**

Sister: [38] Yeh, I've seen in most of all a few of them they've got a very aggressive behaviour, um, [39] it's just that we don't know what the reason would be… it was even, when they are playing you know, they are playing games, if perhaps one of the children ah, does the same thing with him or her, then she becomes so upset, and cries and throw temper tantrums, and all that, that's the…

Mikaela: [40] **Because somebody's copying what they are doing?**

Sister: mmm, mmmm. [41] Or if they don't want to play with them.

Mikaela: [42] **All right, um, could you talk a little bit about the music here at the centre? What role does music play in just day-to-day activities with the children? (pause) Have you noticed music in the centre?**

Sister: [43] Ya, it's just that culturally we like dancing and singing with the music, and a   lot of … sometimes we play the cassettes, radio cassettes, and the CD's, then they play them, [*55] then the kids will dance and enjoy that. [44] And then even if on the TV when there is they can also imitate the singers and cram the songs.

Mikaela: [45] **(laugh) Lovely. Can you, can you tell me what you see music therapy as? How would you describe it or what is your understanding of it?**

Sister: [46] It is just a pity that initially when we, we started this programme of the music therapy, were never taken in to go and see exactly what is happening, what is it that you people are doing with our kids, so it's different, it's difficult to, to sort of say, the role that you as music therapists do to our kids. [47] But then taken from my little one, I am fostering a child, Pretty, what I could deduct was that, music therapy, it, it encourages them, to be open, [48] because what I know is that at

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times that she will just start a song you know, with her own words… "hi mama…you are beautiful today… I mama love you" just like that, then I say oh then since I started whist… then it becomes a song then she's okay, [49] then I thought maybe she got that from the music therapists.

Mikaela: [50] **that actually leads us to our last question, which is (laugh) um, had you noticed any change in the behaviour of the children that go to music therapy? So, other than her, have you noticed?**

Sister: [51] yah, it's herself and then Mpumi, there's another one and she is also taking classes at the school, the music classes and the dancing classes… so I think there…

Mikaela: [52] **Thank you very much…**

Sister: [53] Although, on a very mmm, subtle ….way, sometimes when these guys come from the music therapist you can hear them imitating, saying something, although not yet fluent. [54] But you can say ooh they've had something from the music therapist.

Mikaela: **Thank you so much, I really appreciate that you came.**

APPENDIX VI

INTERVIEW 3: CARE WORKER

Interview information that contained personal details of interviewees was not included in the appendix copy, but is available from the author on request.

Mikaela: [9] **Oh, that's wonderful. Um, what is your job? If you were to describe it to me, pretend I don't know, what do you do everyday with the children?**

Care Worker: [10] Everyday for the children, first thing in the morning when I come in, I greet them because I like them, they hug me and I hug them. [11] From there, change my clothes into the clothes which I work in. [12] And then I start to clean them, bath them, brush their teeth put them in the clean clothes, start to give them breakfast. After that I make bedding as well, and then from there, I take them to the playground, I play with the children for the whole day, and then at tea time, I got to tea time, feeding time, I feed them, give them bottles, change their nappies. And when there are sick ones, we take them to the hospital, for checkups, and then… that's all.

Mikaela: [13] **whoou! That's not all, that's a lot!**

Care Worker: [14] It's not all, actually (smiling) but I become so touched sometimes, when, some, one of the children becomes so sick, [15] I think back of my own children, I asked my manager to call a priest, from my church, and then he came and prayed for the children. [15] I'm a Catholic.

Mikaela: [16] **I'm an Anglican. (laugh) that's good that they come. We need that, to hold on to. Um. Could you tell me what activities, and what other therapies the children have here at the Mohau Centre?**

Care Worker: [18] Well, some of them are playing outside as I am speaking now; they are in the sand pit, playing there. [19] Those that can't walk, we roll with

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them, on the carpets, trying to help them to crawl. [20] Those that are sick we usually visit them at ward 6 or 8.

Mikaela: [21] **And then do some children go to school?**

Care Worker: [22] Some ones go to school, [23] when the transport is not here, we take them to school, and we enjoy walking with them up to the technikon. [24] So that they must see the outside world as well.

Mikaela: [25] **Mmm, that's important. Um, can you tell me what you see as the main needs, physical needs of the children?**

Care Worker: [26] Eh, the physical needs that I've seen is, we must share with them, [27] give them more love. [28] Embrace them as their parents. [29] I think that's a most important thing.

Mikaela: [30] **And on an emotional level, giving them love, what do they need?**

Care Worker: [31] They need love, [32] they need food. [33] Warm clothes, mean, [34] I mean we must treat them like the other children outside.

Mikaela: [35] **Okay, and um, can you describe any behaviour problems or emotional problems you see the children displaying?**

Care Worker: [36] Displaying… some of them are very naughty. [37] They hit the other ones, they bit them (laugh) some, [38] and when the other one, maybe the smaller one plays and cries, they all come together. [39] One will come dragging a bicycle; one will come with this toy. [40] And try to comfort the baby who's crying, [41] that's when I saw that this people love each other.

Mikaela: [42] **It's a big family, mm.**

Care Worker: [43] Yah, it's a very big family.

Mikaela: [44] **Okay. Can you talk about music, and with the children here?**

Care Worker: [45] yes, sometimes when I sing to them then we clap the hands, they dance, or [46] sometimes I bring eh, we take a radio and play some cassettes. Then we dance together, [47] they enjoy it, and they love it, they love… they really enjoy it.

Mikaela: **[48] Okay. Do you, can you tell me what you think music therapy is?**

Care Worker: [49] It helps them… um… lets say the sounds, the sounds of the things, the drums, you see, it helps them to reconnect their minds, [50] to ease their minds.

Mikaela: **[51] Um, have you seen any of the children that go to music therapy? Have you seen what music therapy has done for them? Are their any changes in their behaviour, that you've noticed?**

Care Worker: Yes, I've noticed. Like um… [52] Andries, usually when he comes from music therapy he can take a stick or anything that hit and dance, [53] so I can learn that he has learnt something. At least he has done something. [54] He knows the sound… that there is a cert(?) without singing there is something in the music a drum or whatever, [55] he is trying to imitate that.

Mikaela: **[56] So you've seen him learning? Okay, that's all I needed to ask you. Thank you very much Magdalene.**

Care Worker: Pleasure

Mikaela: **I really appreciate that you came, today, thank you.**

APPENDIX VII
INTERVIEW 4: MUSIC THERAPIST

Interview information that contained personal details of interviewees was not included in the appendix copy, but is available from the author on request.

Mikaela: [26] **And while you were at the centre, during your internship year and while you worked there, what activities and other therapies were you aware of? That were happening at the same time…**

Music
Therapist: [27] Umm… umm, I once stumbled across a physiotherapist, [28] which I think worked mainly with the um, palliative care, kids that were very sick and dying. Um, [29] so physiotherapy would probably be the only one, [30] I never saw a physiotherapist *(meaning OT)* [31] I think I saw a referral form once for a speech therapist, um, [32] but I personally never saw actually any other therapists. [33] Besides therapy. Only therapy or do you need to know about education? [34] There were the two teachers there obviously who ran the day programme, um, [35] but that was about the only input that I was aware of, that I can remember.

Mikaela: [36]**That's great, thanks. Then um, when you look back at that time, if I was to ask you what you saw as the main needs of the children at the centre, um, I've already put them into sort of three categories. But so maybe we can just start at what you saw as the physical needs of the children at the centre?**

Music
Therapist: [37] Um, they always well clothed [38] and they were seemingly well fed, um… [39] but think, I know there were a few crises with things like, basic necessities like toilet paper, nappies, um, disposable gloves for the nurses. [40] Um, are we talking specifically about the children now?

Mikaela: [41] **Yes, and the centre.. you can talk about…**

Music

Therapist: [42] Well the disposable gloves, I think were quite an issue because the nurses were very reluctant to change nappies, which you can understand, if there weren't disposable gloves available. [43] Um, also, the one thing that was constantly finished was the liquid soap, um for washing your hands in the bathroom, we often got there that there was none of that.

[Press pause – take baby to grandfather]

Mikaela: [44] **Okay, that was the physical needs of the children at the centre, um. If I was to ask you the question again, this time looking at the emotional needs of the children?**

Music

Therapist: [45] Even though there were quite a few volunteers and caregivers, [46] there wasn't such a thing as individualised attention. [47] And I think that that's where many of the social problems which eventually cause children to be referred to us came about. [48] Because there was a lack of consistent interaction with one specific, one or two specific people, [49] um, I mean the teachers were there constantly and the house mothers, um, [50] but because there were only one or two, and I mean there are so many children there, [51] you can imagine that not all the children can effectively relate to them as a significant other. [52] I don't know if I'm saying this right, [53] but I would say individualised attention was the one thing. [54] Um, I think just nurture, [55] I mean that they all tried their best, everybody involved tried their best to give to give the best nurture, [56] but I think the nature of the situation, [57] the fact that there are many children and few carers, [58] caused that the nurture wasn't always the best quality nurture that you could find.

Mikaela: [59] **So, if we were summing that up we, you could, am I hearing you right, when you say that one of the main emotional needs of the children was that they didn't have a specific person to which they…**

Music

Therapist: [60] Yah. Can I say it like this? [61]The scenario in my head is, um, the playroom. [62] Where the children were often dumped in a way, [63] and I'm not s…, I don't mean this in a bad way towards the centre obviously but, um, [64] they would sit there and people would try and play with them [65] but it was often more of just a frustrating situation [66] because the people were more there in a baby-sitting kind of capacity [67] and not really in a, in a interactive capacity. [68] So even if they were there, they were not really "there" if you know what I mean. [69] They weren't focused in on the children.

Mikaela: [70] **And then the same question again, what do you see as the main social needs of the children?**

Music

Therapist: [71] I'm not sure that enough opportunities were created for them to interact in smaller groups always. [72] Um (pause) yah, again it came out in the um, in the way that they interacted [73] and the way that they would argue and fight about toys and that sort of thing. [74] It came out that they didn't really have that family kind of set up, [75] where they got the chance to um, experience themselves in various roles, [76] because they were always just one of a lot of children. [77] They didn't necessarily get enough, and I'm not saying that there wasn't, but they could have been more opportunities for them to [78] experience what it was to have [79] a leadership role, [80] what it was to follow, so… [81] but I'm saying this with my therapists glasses on, obviously. Um…

Mikaela: [82] **Which is why you're being interviewed…**

Music

Therapist::   [83] Yah, not enough opportunities to develop, [84] so all the things that involve being a social being. [85] And self-expression, that's also a form of being sociable, isn't it. [86] I don't think that they got enough opportunities to express themselves [87] and to be heard, um, necessarily, as an individual, within a social context.

Mikaela: [88] **I've got a sub-question around this, which is can you describe any particular behaviour problems, that you might have witnessed in the children at the centre? Anything obvious that comes to mind…**

Music

Therapist: [89] Um, toy – fighting about toys, one thing I remember in the playroom. [90] Um, being very clingy, um, at times… if…if…I remember like in the observational phase, where we didn't actually work with the children, when we had to spend the entire day there, at the end of the day, they would sort of be, very clingy, and not want you to leave, [91] but then if you come there the next week there wasn't really recollection, [92] so there was almost this desperate need to hang on to something. Um. [93] Behaviour problems…

Mikaela: [94] **The next question is describe any emotional problems that you might have observed, so you can talk around it together…**

Music

Therapist: [95] Um, just have to give me a few minutes to think….
[96] One thing that often happened was the children who were not participating in the therapy programme were often at the door and, er, [97] sort of not respecting the boundary of the closed door, [98] but bursting in and wanting to be part of the session but not being allowed, um, and visa versa, [99] the children that were in the session were often very reluctant to leave the session once they'd finished. [100] And literally often had to be carried out, as if they didn't want to go back, [101] and that caused quite a bit of difficulty. [102] Um, it was always… you know often in the beginning of therapy it was always the extremes… um, n…[103] at first not wanting to come at all, and then once they got into, [104] really not wanting to leave, [105] but not in a coy playful sort of way but in a very most desperate kind of way. Um. Yah… [106] emotional outbursts, it sounds very strong, [107] but their emotions weren't always levelled out nicely, it was always this um, "see-saw-i" kind of thing. [108] If I can say, in terms of emotional sort of problems... (Looks at me questioningly)

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Mikaela: [109] **Um, oh, that's great yes. Um, what role did you see music playing in the day-to-day activities of the children? As an observer, did you ever see music playing a role in the day-to-day activities?**

Music
Therapist: [110] There is a very irritating thing where they'd put on the radio in the playroom, and it always, almost seemed that they wanted it like a wallpaper effect, [111] because the music wasn't necessarily related in the playroom to a specific activity or to a song or doing something to the tune of the music. [112] It was sort of just there in the background to say oh, we've got some music here and whatever… [113] some of the children would join in and you know dance a bit or whatever, [114] but it would be fleeting moments and it wouldn't be really focused. [115] And that cause the music to almost be, well from my perspective to become more of an irritation really than a constructive contribution to the morning in the playroom.

Mikaela: [116] **But did you still feel that it was there for the children, it wasn't for the workers listening to the radio? Did you perceive it as something that they were putting on for the children?**

Music
Therapist: [117] It was children, child-like kind of music, nursery songs and that sort of thing, [118] but activity wise not really structured, [119] it was more like a wallpaper effect. Um, [120] I'm not too sure about the teaching room itself, I think they did learn a few songs there and have a time where they sang a few, um, spiritual/religious kind of songs and maybe one or two um, songs like "Mary had a little lamb", and the usual nursery songs. So there was some music used…

Mikaela: [121] **Um, a question in a different line… what do you think, what do you think, music therapy offered the children that you worked with?**

Music
Therapist: [122] Um, well, I think first of all I think the whole concept of, um, individualised attention and [123] having a constant other that was not

part of the centre[124] that actually did show compassion and "belangstelling" – interest, in, in one specific child, if I have to think in terms of the individuals. [125] Um, so it was more the therapy relationship really, than the music, the music facilitated that relationship. [126] In terms of the music specifically, I think that it was very important for self-expression, [127] for getting them to interact um, in ways that they didn't necessarily get chances, um, in the, in the greater activities of the centre. [128] Socially if I think of the groups it was definitely a, in a sense recreating a little family and experimenting within that set-up, [129] with the various roles that you would have found in a family. Um, [130] I remember distinct occasions where some of the children um, literally took on the mommy role of mothering the other children and caring for them, and um, [131] between the boys often there would be something similar to sibling rivalry, where they would, sort of the one, bully the one in a playful sort of way. Um, or you know hid a toy from the other one or an instrument from the other one in a playful sort of way. [132] So there was that whole thing of definitely of recreating a family kind of set-up. [133] Um, social, structure in which they could explore things more I think than in the centre at large.

Mikaela: [134] **And then last question. Can you um, comment and describe any behaviour changes that you noticed in the children that you worked with, that you can think of?**

Music
Therapist: [135] Um, the first thing that comes to my mind is the, their ability to fit in with structure within the therapy setting, because the initial, um, [136] the initial sessions would always be marked with them not wanting to fit in with the structure or the *modis operandi* [137] which was in a way, I think, a bit of a revolt against the institutionalisation, you know, [138] having their lives structured so extremely. [139] Um, so in a way it's a bit of a dichotomy, that they, that I say that they got to function within structure more, but the context was different. Um, and, [140] it was more about social skills learning to, [141] or growing into little people that had agency in this little world that we created. [142] So they became more assertive about their needs, [143] but also more able to compromise [144] and to be more flexible in terms of um, letting their will be, not their

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will, but their, I don't know how to say it. Allowing themselves to be, um, flexible within relationship, um, [145] giving and taking, [146] listening and responding,.. that sort of thing. Um, yah.

Mikaela: [147] **Thank you very much, that's everything, that's great.**

APPENDIX VIII

WORK IN PROGRESS

PAGE EXCERPT FROM INTERVIEW 1: SOCIAL WORKER

PAGE EXCERPT FROM INTERVIEW 2: NURSING SISTER

PAGE EXCERPT FROM INTERVIEW 3: CARE WORKER

PAGE EXCERPT FROM INTERVIEW 4: MUSIC THERAPIST

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