# THE RELEVANCE OF MUSIC THERAPY IN THE TREATMENT OF CHEMICAL DEPENDENCY

by

Elizabeth F. Steindel

A thesis submitted to the

Faculty of Graduate Studies

in partial fulfillment

of the requirements

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ELIZABETH F. STEINDEL

A thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

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## Dedication

This thesis is dedicated, in love and gratitude, to my parents, who are with me always in spirit through their love

to the memory of my mother, "the wind beneath my wing"* without whose extraordinary compassion, deep faith in me, and shining example of intelligence, spirituality, and unconditional love this work could never have been completed,

and

to the memory of my father, whose commitment to healing and truth remains an inspiration.

*recorded by Bette Midler

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*Saint-Exupery, Antoine de (1943). The Little Prince. New York: Harcourt, Brace.

## Abstract

This theoretical thesis examines twelve approaches to music therapy and discusses their relevance to the treatment of chemical dependency with specific regard to the following four criteria: providing meaningful, healthy, nonchemical peak experiences, promoting self-awareness, facilitating communication, and enhancing self-esteem. Brower, Blow & Beresford (1989) have proposed an optimal multi-focused integrative model of treatment for chemical dependency which attempts to synthesize the advantages of the five current single-focused models (i.e. moral, learning, disease, self-medication, social) while at the same time seeking to avoid the disavantages of each. The confluence of the treatment goals of this integrative or dual diagnosis model with the four criteria used to evaluate the twelve approaches to music therapy is examined; consideration is given to the problems inherent in attempting to evaluate and measure that which may not be empirically testable; and the implications of these findings for the use of music therapy in the treatment of chemical dependency are discussed.

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# CHAPTER ONE - INTRODUCTION

## Purpose

The purpose of this study is to review the literature on Music Therapy to consider its relevance for chemically dependent clients with specific regard to the following questions:.

(i) Can providing enduring access to healthy peak experiences through music therapy facilitate recovery from chemical dependency by making the absence of mood altering chemicals less devastating?

(ii) Can music therapy provide catharsis and access to repressed material in order to facilitate new insight and understanding in clients recovering from chemical dependency?

(iii) Can Music Therapy provide new avenues of communication through facilitating nonverbal expression for clients recovering from chemical dependency?

(iv) Can Music Therapy enhance self-esteem in clients recovering from chemical dependency?

## Definitions

For the purpose of this thesis, the following terms are to be understood as defined below:

a) "therapy" refers to a process which contributes to improvement in a client's psychological condition (George, Dustin, 1988).

b) "group therapy" refers to a process of therapy which occurs in the context of a group consisting of a therapist (or two co-therapists), and two or more clients (George, Dustin, 1988).

c) "music therapy" refers to the use of music as a means of facilitating the therapeutic process in order to bring about improvement in a client's psychological condition (Gaston, 1968).

d) "chemically dependent" refers to clients who have been diagnosed as addicted to any drug including alcohol; that is, clients who are unable to control their drinking or drug use to the point where it negatively affects their lives. DSM III defines pathological use of chemicals as use

which continues for at least a month and which causes impairment in social or occupational functioning with either "tolerance", the ability of the body to withstand the effects of alcohol, or "withdrawal", the reaction of the body when alcohol is removed from the system (American Psychiatric Association, 1987).

e) "mood altering chemicals" are any chemicals including alcohol that affect the user's mood (Maslow, 1968a).

f) "peak experience" and "non-chemical high" may be used interchangeably and refer to enjoyable experiences which the client finds significant and meaningful and which are not induced by chemicals but, rather, occur during the period of sustained abstinence from chemicals required during the therapy. (Maslow, 1968a).

g) "catharsis" refers to the expression of a strongly felt emotion which has previously been suppressed or repressed, producing relief and accompanied or followed by reflection leading to increased self-understanding (Yalom, 1985).

h) insight" is when one discovers something important about

one's self or the world (Yalom, 1985).

i) "Obtaining access to repressed material" refers to the process whereby a client becomes able to remember, feel and express emotions that were previously forgotten or denied due to their painful or threatening nature (Bailey, 1984).

j) "non-verbal expression" refers to self-expression through music rather than through talking, although this does not preclude the use of words in songs (Murphy, 1983).

k) "self-esteem" refers to belief in and respect for one's self (Webster, 1968).

l) a "model" is a "representation of reality...which makes it possible to conceptualize a problem for the purpose of enhancing our understanding and suggesting solutions" (Brower, Blow, Beresford, p. 147).

m) "denial" refers to a person's inability to recognize and acknowledge feelings, needs or problems (Brower, Blow, & Beresford, 1989).

## Limitations of the Study

As a theoretical study, this thesis cannot determine or prove the effectiveness of music therapy with chemically dependent clients but, rather, will make suggestions regarding the possible relevance to this population of various existing music therapy approaches, based on the extent to which they meet the four criteria generated by the preliminary literature review.

Yalom (1985) comments upon the many problems inherent in a research approach, which include the "methodological morass of measurement of outcome [as well as the difficulty with] selection and measurement of in-therapy variables" (Yalom, 1985, p.6). He notes that "it is easy...to measure the number of words spoken by each patient but extra-ordinarily difficult to measure the meaningfulness of insight, [concluding that] generally, the accuracy of the measurement is directly proportional to the triviality of the variable" (Yalom, 1985, p.6). It is with this cautionary observation in mind that this thesis undertakes to examine various approaches to the use of music therapy with chemically dependent clients, since the four criteria by which these approaches will be judged constitute significantly complex rather than trivial and easily measured variables.

As a study of studies, this thesis cannot provide new data, but will, rather, attempt to analyze and synthesize the already existing data in the music therapy literature as well as in the literature on chemical dependency, much of which may be subjective and anecdotal rather than empirical. An attempt will be made to expand the literature base with regard to the relevance of music therapy to the treatment of chemical dependency by including three music therapy approaches which were not specifically intended for chemical dependency treatment but which may nonetheless prove relevant in terms of the four criteria stated in the Purpose section of this chapter.

# CHAPTER TWO - LITERATURE REVIEW

## A) Literature Bases for the Questions

(i) Can providing access to a healthy, enduring, non-chemical 'high' or peak experience through music facilitate recovery from chemical dependency by making the absence of mood altering chemicals less devastating?

Bill W., co-founder of Alcoholics Anonymous, concurred with Carl Jung (Alcoholics Anonymous, 1984) and Victor Frankl (1968) that the compulsive craving for alcohol may actually be the low level equivalent of the universal spiritual thirst for meaning, beauty and transcendence. The ability of music to touch a person's spirit and to deepen one's awareness of beauty and meaning can be a means for recovering alcoholics to begin to access healthy, meaningful non-chemical highs (Schoen and Gatewood, 1927; Maslow, 1968a; Gaston and Eagle, 1970; Kenny, 1985; Broucek, 1987). Mann writes that "to convince [the chemically dependent person] that there is a possibility of a bearable, even of an enjoyable life without drinking becomes the first task of anyone trying to help him" (Mann, in Murphy, 1983, p.54).

It is during the initial recovery period that chemically dependent people, finding themselves suddenly without the crutch of alcohol or drugs, most need to find a deeper meaning for their lives, a meaning which goes beyond analytical, intellectual and medical interpretation and which

> touches the whole human...the soul of man...which is representative of our body, mind, heart, psyche, emotions, hopes and fears...Musical patterns reach these depths and remind us of our connections to the whole of life...and the significance of each life within that. This aesthetic connecting constitutes a step toward meaning in life, which is, after all, the only reason man wants to live and endure any suffering at all. (Kenny, 1982, p.66)

A recovering alcoholic's initial period of sobriety involves great suffering, and "a major but intangible element of the...torment is [having to finally acknowledge] the impact of the drinking on the spiritual substance of the inner person. This is quite distinct from acquired religious influences...and does not necessarily involve even a belief in a supreme deity. It is that inner quality in each of us that causes us to aspire

idealistically for the best in our own lives and those about us, and that permits us to have faith in self and belief in others" (Strachan, 1990, p.127). During the first stage of sobriety, the pain that the drinking has caused must gradually be faced, and it is during this initial period that relapse most frequently occurs (Strachan, 1990). Recovering alcoholics can be helped to reframe this suffering and confusion into a positive force toward recovery, health and well-being if they can be helped to understand that many songs and other musical compositions have emerged from the pain and confusion of the composers (Adelman and Castricone, 1986). In this way, clients can find meaning in their own suffering, can see the value of expressing feelings metaphorically (Pulliam, 1988) and can have a sense of taking part in their own rehabilitation (Charlesworth, 1982).

Arnheim (1952) urged psychologists and artists to have more direct contact and to co-operatively develop psychological methods that share the "authenticity that emanates from works of art" (p.17). Although it may not be possible to explain or even to fully understand exactly why singing or playing music can make someone feel better, the lifting of a spirit and lightening of a heart defies analysis and is a "non-chemical high" worth striving for. Arnheim also cautions against overemphasis on quantification that can overlook the essence of a work of art by concentrating only on what can be counted

and measured. Music therapy respects the complexity of persons and does not attempt to overanalyze and explain, but rather acknowledges the whole as greater than the sum of its parts (Davis, 1987; Ruud, 1988; James, 1988; Kenny, 1985; Stephens, 1981).

(ii) Can Music Therapy provide catharsis and access to repressed material in order to facilitate new insight and understanding in clients recovering from chemical dependency?

Wheeler (1987) suggests that substance abusers can benefit from music therapy when the goal is to facilitate insight which can lead to re-education and restructuring. The combination of words and music is sometimes able to penetrate more deeply than words alone, putting clients in touch with feelings that may have been repressed due to their painful nature and allowing clients to free up energy that has been blocked by repression of feeling. Once access to repressed material has been gained, discussion of the feelings evoked can lead to new insight and understanding (Bailey, 1984; Isenberg-Brzeda, 1988; Payn, 1974). Participating in music that they find meaningful can help clients access strengths and resources of which they may be unaware (Murphy, 1983) and producing and

sharing the music themselves can provide a sense of empowerment as well as enjoyment (Bailey, 1984). The sense of empathy with others in singing or playing together and then discussing the feelings evoked contributes to the healing by providing such curative factors of group therapy as catharsis, instillation of hope, universality, feedback, and most importantly, a feeling of being important and valuable to the group (Yalom, 1985). Strachan writes that once the alcoholic has stopped drinking and has begun counselling, "though the stages overlap and the recovery process varies with individual alcoholics, one factor is common to all: the return of hope, faith in self, and spiritual well-being" (Strachan, 1990, p.142). This gradual return to hope, although new and fragile, can be nurtured by the catharsis, insight and understanding that music therapy is able to provide.

Concentration and attention span are significant problems with recovering alcoholics, and music's unique ability to capture and hold one's attention on what may be painful subject matter when words alone may fail to do so makes the use of this mode as a focusing device a valuable adjuvant to verbal therapy (Gfeller, 1987; Barclay, 1987; Gaston, 1968).

Moreno (1987) draws an analogy between the communication of a convincing blues singer and the communication between members in Alcoholics Anonymous. In

both cases, the empathy results from having "been there", and blues singer Otis Rush has indicated that singing and playing the blues was a significant emotional release for him. Moreno suggests that "emotional release and confrontation seem to be in line with insight and impulse control" (Moreno, 1987, p.336), a conclusion that supports the "common assumption of the expressive arts model that self-awareness often follows from self-expression" (Adelman, 1986, p.53).

Bailey addresses the issue of choice in music therapy, suggesting that much can be learned about clients' inner selves by paying attention to the types of music they choose at any given time. With regard to her use of songs with cancer patients, she writes,

> If clients are given the chance to choose which songs they listen to and sing, their choices will support their needs and will convey the mood and message they want to hear. Valuable information about the physical, emotional, and spiritual needs of patients can be gained by paying close attention to the songs they choose and the reasons for their choices. The content of song choices often reflects important [and sometimes subconscious] wishes or memories. The music therapist can use the verbal

messages within the songs to promote enhanced exploration of inner thoughts and feelings. Participation is encouraged by discussing song content, eg. reminiscence, relationship, needs and desires, feelings of loss, and death. In moving from the contact to the awareness stage, the music therapist focuses on the themes chosen while encouraging the development of creative expression. (Bailey, 1984, p.32)

iii) Can music therapy provide new avenues of communication through facilitating nonverbal expression for clients recovering from chemical dependency?

Zinker (1977, p.27) refers to the "verbal trap...the well-rehearsed and impenetrable verbalizations that have little energy left in them" and Maslow (1968 b) notes that meeting basic needs often presents a circular dilemma for people who are already feeling isolated from relationships. He suggests that although certain basic needs can only be satisfied by other people, those same needs may keep people from relating to others, which in turn keeps them from getting their needs met. A value of music therapy is that it makes it possible to foster

self-expression, communication and participation without having initially to depend wholly on clients' ability to express themselves by talking (Orff, 1980).

Black (1981) notes that alcoholics typically have poor avenues of communication. The vicious circle of unmet needs due to the inability to articulate them can be broken when the use of music opens up new avenues for communication that have the potential for breaking out of the circular, repetitious predicament of needing others but being unable to relate on a verbal level (Broucek, 1987; Maslow, 1968 b).

A common assumption of the expressive arts model of therapy is that self-awareness often follows from self-expression (Adelman, 1985, 1986), rather than the other way around, and Barclay suggests that "it may be that the production of tone has primacy in terms of therapeutic realization [and] the greatest efficacy for music as a therapeutic agent may be in tone production [as a form of communication]" (Barclay, 1987, p.226).

Brooks (1973) indicated that music therapy groups can assist alcoholics in improving communication skills and James (1988) notes that breaking down the psychological boundaries between individuals with alcoholism is crucial, as a key element of their rehabilitation is derived from positive interaction with their peers. Bailey suggests that singing

uplifting songs together and discussing their special significance in clients' lives can evoke pleasing images and enhance joy, while sharing "the human elements [in sad songs] assists in diminishing feelings of isolation, anxiety and fear [because] the messages in the songs provide support for inner needs and can help people process loss and grief" (Bailey, 1984, p.12) thus making communication less threatening.

Bailey also suggests that "whether people [actively participate] or simply listen, they respond internally...to the self-expressing quality of songs", (1984, p.12) and Adelman and Castricone (1986) recommend validating and reassuring group members who may choose not to share at any given time by acknowledging that it sometimes takes an equal amount of courage to choose differently from the rest of the group in order to be true to one's self. Although Murphy (1975) and Yalom (1985) both note that a session becomes as meaningful to each member of the group as his or her own involvement in the experience, it can also be beneficial for clients to become aware that active listening is also an important part of effective communication and can be a sign of deep involvement in the group process.

An important objective of music therapy is that clients receive a sense that music can be intensely personal and at the same time a public shared expression, a communication of

ideas and feelings to which others can respond. This interpersonal link of empathy and communication extends the therapeutic experience beyond an introverted self-searching to a shared dialogue which strengthens relationships with other people and alleviates some of the potential loneliness which may emerge with inner searching and growth" (Broucek, 1987, p.57).

Strachan suggests that "alcoholism is an illness of the lonely...I know of no more miserable existence than that of the alcoholic: alone, bewildered, frustrated, rejected by all and still idealistic, sensitive, and needing support from and communication with others" (1990, p.249). The unique ability of music to give each person an opportunity to project his private experience through his own personal images (Farnsworth, 1969) makes this modality a valuable one in working with chemically dependent people who have lost their chief means of communication, albeit a destructive one, and are deeply in need of a healthier replacement.

(iv) Can Music Therapy Enhance Self-esteem in Clients Recovering from Chemical Dependency?

Strachan (1990, p.136) lists "returning self-esteem as a crucial stage in the alcoholic's recovery leading to whole sobriety" and Feder and Feder (1981) and Gaston (1968) both note that there is some consensus in the literature with regard to the ability of music therapy to enhance self-esteem. Murphy writes that "the efficacy of music therapy in the treatment of substance abuse patients is being demonstrated in the Breakthrough Concepts program...For many patients, the breakthrough occurs when a connection is made with a strength or talent that can be reinforced or acknowledged" (1975, p.61) thus leading to the enhancement of self-esteem.

Strachan also lists "new interests...which lead to greater emotional stability, comfort and self-esteem" (1990, p.136) as a significant step in recovery, and Murphy explains that

> when a patient makes the connection between the experiences of self-actualization, being creative, letting go and enjoying a new experience, being expressive without fear of reprisal or inhibition and being connected to a group without a chemical high, and is able to replicate that experience as he re-enters his world, the group process and the

> therapists have played a successful part in helping to close the self-reflective loop (Yalom, 1985) which is the crucially important illumination of the process. (1983, p.61)

Strachan believes that "if sobriety is to be achieved [and maintained], a new outlet or relief for the alcoholic's tensions must be found. This will be found in a twelve step program (the most positive and effective longrange therapy), through a clinical counsellor, and through new and productive interests and hobbies " (1990, p.149).

Cassity (cited in James, 1986) demonstrated that participation in a valued group music activity can significantly increase peer acceptance among group members, leading to enhanced self-esteem, and James' results (1988) using songs to stimulate discussion for values clarification with chemically dependent adolescents support his hypothesis that music therapy can positively influence clients' self concept as well as their sense of control over their own lives.

### B) A Review of Theories of Chemical Dependency and Approaches to Treatment

Brower, Blow and Beresford (1989) describe five single

focus models of chemical dependency and the treatment implications, advantages, and disadvantages of each. A sixth multifocused, integrative model, the dual diagnosis model, is also presented as an optimal way of maintaining flexibility to ensure success in treatment.

(i) Moral Model

This model assumes that chemical dependency results from a moral weakness or a lack of willpower. "The substance abuser is viewed as someone who is alienated from God, stubbornly self-willed, and who attempts to dominate and control the outside world...[Treatment goals are to] increase one's willpower in order to resist the 'evil' temptation of substances, to change from 'weak' to 'strong'...and to develop their spirituality" (Brower et al, 1989, p.149). Treatment strategies include "developing a 'positive' reliance on God through religious counselling or conversion, fostering a "negative" avoidance of punishment through sanctions..." (Brower et al, 1989, p.149) and helping clients "discover and follow 'God's will' [in order to achieve] a more 'complementary' relationship with the universe" (Brown, 1985) The advantage of the moral model is that it focuses attention on moral and spiritual concerns and holds people responsible for the consequences of their substance use, thus helping to overcome denial and increasing motivation for change (Brower et al,

1989).

A disadvantage of this model is that it tends to be blaming and judgemental, attitudes which are countertherapeutic and which place the helping professional in an antagonistic relationship with the substance abuser by maintaining that the problem is the client's fault. Another disadvantage is that its emphasis on willpower "sets the stage for failure and thus decreases a substance abuser's sense of self-esteem...since willpower is ineffective for most clients seen in treatment settings" (Brower et al, 1989, p.149).

A third disadvantage, related to the first two, is that a "treatment goal of strength...can, paradoxically, lead to relapse...The moral model is often embraced by patients themselves who enter treatment feeling that they are bad and weak-willed. As a result, some patients ask for our help to make them strong enough to resist substances. Once they feel 'strong enough', however, they can easily reason that they are strong enough to use substances again" (Brower et al, 1989, p.149). This can lead to what Brower, Blow & Beresford have termed "the problem of colluding with denial" (1989, p.152). The therapist, in a misguided attempt to help the client, inadvertently facilitates the substance abuser's denial of chemical dependency by encouraging the client to believe that abstinence from chemicals is not necessary for recovery.

### (ii) Learning Model

This model assumes that chemical dependency results from the learning of maladaptive habits (Marlatt, 1985a). The substance abuser is viewed as someone who has learned bad habits through no fault of his or her own. The treatment goal is to teach new behaviors and cognitions that allow old habits to be controlled by new learning with an emphasis on self-control. The chief treatment strategy is education, consisting of the teaching of new coping skills and cognitive restructuring.

The advantage of the learning model is that although it does "hold people responsible for obtaining and implementing the new learning" (Marlatt, 1985a) it is neither punitive nor blaming for the development of maladaptive habits.

A disadvantage of this model is that its emphasis on control does not take into account the therapeutic value for many substance abusers in admitting their loss of control. In the same way that, in the moral model, clients may reason that they have become strong enough to use substances again, the learning model's emphasis on self-control may lead clients to conclude that one day the use of chemicals will be possible again once self-control is established. Encouraging this attitude is, on the part of the therapist, another form of collusion with the substance abuser's denial of the need for abstinence

because, paradoxically in order to gain control of their recovery process chemically dependent clients need to admit their loss of control, or powerlessness, over chemicals (Brown, 1985). Brower et al (1989, p.150) note that "therapists who can appreciate this paradox of control are in the best position to integrate, as needed, the models that emphasize loss of control with models that emphasize self-control".

Brower et al (1989) also note that "all legitimate treatment approaches [ie not only the learning model] value new learning, whether in the form of lectures, skills training, conditioning techniques or psychotherapy" (p.150).

<u>(iii) Disease Model</u>

According to this model, the etiology of chemical dependency is unknown, but genetic and other biological factors are considered important. The substance abuser is viewed as someone who is "ill or unhealthy, not because of an underlying mental disorder but because of the disease of chemical dependency itself which is defined by an irreversible loss of control [over substances]" (Alcoholics Anonymous, cited in Brower et al, 1989, p.150). Because there is no known cure, chemical dependency, once present, is regarded as always present, with the goal of treatment being complete abstinence, without which the disease is regarded as progressive and often

fatal. Treatment strategies focus on chemical dependency as the primary problem, and the client is guided to develop a positive identification as a recovering alcoholic or addict who is powerless over substances (Brower et al, 1989). This concept of powerlessness is consistent with the philosophy of A.A. and N.A. (Alcoholics Anonymous and Narcotics Anonymous) in which twelve step programs the first step is "We admitted that we were powerless over alcohol/narcotics and that our lives had become unmanageable" (Alcoholics Anonymous, 1946, p71). Another treatment strategy, as in the Learning Model, is education. New behaviours, such as attending AA/NA meetings rather than going to bars are encouraged, and family members learn to stop "enabling" the substance abuse by covering up for the alcoholic (Brower et al, 1989, p.150).

An advantage of the disease model is that, like the learning model, it is neither punitive nor blaming. Guilt is alleviated because people are not held responsible for developing chemical dependency any more than for developing high blood pressure or diabetes, although, as with the learning model, they **are** held responsible for seeking treatment and for taking care of themselves, so that self-care is emphasized, as opposed to self-control in the learning model and willpower in the moral model. Another advantage of this model is its clear focus on the chemical dependency as the primary problem

(Brower et al, 1989).

A disadvantage of the disease model is that it fails to account for those alcoholics who actually are able to return to asymptomatic or controlled drinking, the number of which has been estimated at about 5-15% (Miller, 1983; Vaillant, 1983). The other disadvantage is that the possible independence of co-existing psychopathology [such as depression] is sometimes not appreciated (Brower et al, 1989), which could result in clients remaining clinically depressed and in danger of suicide without the benefit of pharmacotherapy or psychotherapy, which could possibly alleviate the depression.

### (iv) Self-Medication Model

This model assumes that chemical dependency occurs either as a symptom of or a coping mechanism for another primary mental disorder (Khantzian, 1985). The Substance abuser is viewed as someone who uses chemicals either to alleviate emotional pain (eg. depression) or to compensate for deficiencies in psychological structure or functioning. The treatment goal is, therefore, to improve mental functioning, and the strategy is to use psychotherapy or pharmocotherapy to treat the underlying disorder (Brower et al, 1989).

An advantage of the self-medication model is that, like the learning and disease models, it is neither punitive nor

blaming. A second advantage is that, in contrast to the disease model, it stresses the importance of diagnosing and treating co-existing psychiatric problems when present. "The importance of this is highlighted by treatment outcome studies that reveal different (usually worse) prognoses for addicts with additional psychopathology who enter traditional chemical dependency treatment programs" (McLellan et al; Rounsaville et al, cited in Brower, Blow & Beresford, 1989, p.151).

The major disadvantage of the self-medication model is its emphasis on psychopathology as etiology when in most cases, psychopathology is the result rather than the cause of chemical dependency, or else it is difficult to determine what is cause and what is effect (Shuckitt, 1986). Even in cases where psychopathology may be the cause of the chemical dependency, it does not necessarily follow that treating the cause in these individuals will provide sufficient treatment for the chemical dependency because "perpetuating factors of chemical dependency may develop in addition to the psychopathology that initiated the dependency" (Brower,1988, cited in Brower et al, 1989, p.151).

As with the moral and learning models, therapist collusion with the client's denial may subvert the therapy by allowing the client to hope that chemical use will one day be possible once the underlying cause is treated. Brower et al

(1989) describe four possible levels of denial with which chemically dependent clients might present: complete denial, in which neither the dependency nor any other problems are acknowledged; (b) no denial, in which both the chemical dependency and other problems are acknowledged; (c) partial denial (type 1) in which all the problems but the chemical dependency are acknowledged; and (d) partial denial (type 2) in which the chemical dependency is acknowledged and the other problems are perceived as related to the substance use. Brower, et al (1989) consider partial denial (type 1), in which all the other problems are acknowledged but the chemical dependency is not, to present the greatest challenge to the self-medication model because this approach may exclude the chemical dependency as an important focus of treatment, allowing the client to have the illusion of treatment while substance abuse continues.

(v) Social Model

This model assumes that chemical dependency results from environmental, cultural, social, peer, or family influences (Beigel & Ghertner, 1977). The substance abuser is viewed as a product of external forces such as poverty, drug availability, peer pressure, and family dysfunction. The treatment goal is to improve social functioning by altering either their social environment or their coping responses to environmental stress.

Treatment strategies for changing the environment include family or couples therapy, attendance at self-help groups where one is surrounded by non-users, residential treatment, and avoidance of stressful environments where substances are readily available. The strategies for changing clients' coping responses include group therapy, interpersonal therapy, assertiveness training, and stress management (Brower et al, 1989).

An advantage of this model is its emphasis on interpersonal functioning. Marlatt (1985b) found that over one-half of alcoholic relapses are attributable to interpersonal conflicts, and treatment interventions for alcoholics that are directed towards increasing social skills or environmental support have been shown to produce better outcomes six to twelve months after treatment (Eriksen, Bjornstad & Gotestam, 1986; Page & Badgett, 1984). A second advantage of the social model is that it is compatible with other models: the learning model is, in fact, sometimes referred to as the 'social learning model' because the learning process occurs in an environmental and interpersonal context; the self-medication model views chemical dependency as a way of coping with deficits caused by early damaging relationships; and the disease model emphasizes the importance of helping family members to recognize their own co-dependency (i.e., emotional dependency

on the addicted person) and to embark on their own recovery. Thus, most of the other models incorporate the social model to some extent in their treatment approaches, and they also regard improved social functioning as an important measure of treatment outcome (Brower et al, 1989).

The main disadvantage of the social model is that it may encourage clients to blame others for their problems and, in this way, may enable them to avoid taking responsibility for solutions. As with the self-medication model, the therapist's collusion with type 1 denial (in which the client denies chemical dependency but acknowledges other problems) may subvert the therapeutic process by allowing the client to continue to avoid focusing on the importance of the substance abuse problem (Brower et al, 1989).

### (vi) Dual Diagnosis Model

This multifocused, integrative model, which is considered by Brower et al (1989) to be the most therapeutic, differs from the five previously mentioned in that it views substance abuse and other mental disorders as primary, co-existing disorders that can exacerbate one another, rather than viewing one as a symptom of the other. One example of the dual diagnosis model integrates the advantageous elements of both the disease and self-medication models in a way that avoids the

disadvantages of adhering only to one or the other. Brower et al. (1989, p.147) stress the importance of a "treatment match based on a healthy alliance", as opposed to one based on collusion in which the therapist inadvertently strengthens the client's denial of either the need for abstinence or the existence of a chemical dependency. The dual diagnosis model provides an alternative in that the beliefs of both client and therapist are carefully assessed at the outset in order to guard against collusion and also to ensure that a mismatch of beliefs which could result in an antagonistic, countertherapeutic relationship does not occur. The client is invited to believe in the dual diagnosis model in which the argument about what is the primary problem requiring treatment is replaced by the idea that treatment is required for both problems.

The following is a suggested example of an invitation to a client to enter into an alliance without collusion:

> I agree that you appear depressed and this is certainly a problem for you. We need to address that. It is also true from what you have told me that you have a diagnosis of chemical dependency. We need to address that too, and let me tell you why. Any attempt I make to determine the type of depression you have will be confounded by further chemical use. This is because we know that

regardless of which came first (the depression or the chemicals) and regardless of why you use, chemicals make depression worse over long periods of time. In short, you have two problems, both require treatment, and the best way I can treat your depression right now is to give you treatment for chemical dependency. After that treatment is begun, we will be better able to see if other treatments for your depression are needed. (Brower et al, 1989, p.154)

When both the therapist and substance abuser believe in a common explanatory system that does not deny important problems requiring treatment, then a treatment match based on a healthy alliance has been achieved. If an initial period of abstinence proves to be sufficient treatment for the co-existing mental disorder, then a shift from the dual diagnosis model toward other models can be made as appropriate, but the integrative model may "provide the optimal clinical strategy [initially] for bridging discrepant belief systems between therapists and substance abusers" (Brower et al, 1989, p.155).

Another example of the dual diagnosis model is the AA/NA twelve step program, which effectively integrates the

moral and the disease models. Brower et al (1989) note that the disease model is probably the dominant one among clinicians at present, and that alcoholism as a disease has been officially endorsed by the American Medical Association, the American Psychiatric Association, the National Association of Social Workers, the World Health Organization, the American Public Health Association, and the National Council on Alcoholism. Once present, the disease is regarded as always present because there is no known cure, so the goal of treatment according to the disease model is complete abstinence.

The AA/NA programs subscribe to the disease model, but do not end with it. Despite the disadvantages of the moral model, it correctly focuses attention on the importance of moral concerns during the process of recovery for some substance abusers, and the twelve step programs recognize that making a moral inventory of wrongdoing, coupled with making amends when possible, can be beneficial for recovery (A.A., 1976). In fact, the majority of the twelve steps are devoted to moral concerns, although the first three are not, exemplifying the principle of emphasizing different models during different phases of recovery, and although AA and NA refer to themselves as spiritual rather than moral programs, "the spiritual model can be considered a variant of the moral model"

(Brower et al., p.149).

In summary, the optimal approach to the treatment of chemical dependency would be multifocused and would possess sufficient flexibility to be able to incorporate the following treatment goals from the five single focus models described by Brower et al. (1989):

(1) to focus attention on moral and spiritual concerns and to hold clients responsible for their continued substance abuse while at the same time remaining non-punitive and non-judgemental.

(2) to help clients overcome denial by emphasizing self-care rather than self-control or willpower in order to avoid collusion with the client's denial of the need for abstinence, and by addressing the chemical dependency first in order to avoid collusion with type 1 denial (i.e., client acknowledges co-existing psychopatholgy but denies chemical dependency).

(3) to improve interpersonal functioning as a means of relapse prevention.

(4) to provide education for the client regarding the disease concept of chemical dependency, thus alleviating crippling guilt and enhancing self-esteem by encouraging responsibility for self-care and by commending the decision to seek treatment, while discouraging self-

loathing over perceptions of self as lacking in willpower or self-control.

It is the opinion of this author that the goals of the optimal treatment approach to chemical dependency described by Brower et al. (1989) are consistent with the four criteria stated in the Purpose section of Chapter One.

Providing access to healthy, meaningful enduring peak experiences through music therapy is consistent with the goal of helping clients to focus attention on moral and spiritual concerns while maintaining a non-judgemental attitude. Facilitating new insight and understanding by providing catharsis and access to repressed material through music therapy is consistent with the goal of helping clients to overcome denial of the existence of the chemical dependency problem and the need for abstinence. Providing new avenues of communication through music therapy is consistent with the goal of facilitating improved interpersonal functioning as a means of relapse prevention. And lastly, enhancing self-esteem through music therapy is consistent with the goal of alleviating the substance abuser's crippling guilt through teaching that chemical dependency is a disease and that the client is not at fault as long as he or she begins to take responsibility for their treatment.

The remainder of this chapter will describe and discuss twelve approaches to music therapy with specific regard to the four criteria stated in the Purpose section of Chapter one. Since, in this author's opinion, these four criteria are consistent with the goals of optimal chemical dependency treatment described by Brower et al (1989), the extent to which the following music therapy approaches meet these four criteria can therefore be thought to be significant in terms of the relevance of these approaches to the treatment of chemical dependency. The latter three of the twelve approaches to music therapy have not been used in the treatment of chemical dependency but may nevertheless meet some of the four criteria and are therefore discussed here with a view to expanding the literature base to include methodologies relevant to but not specifically intended for work with chemically dependent clients.

## C) Twelve Approaches To Music Therapy

### (i) Miller (1970) Music Therapy For Alcoholics At A Salvation Army Centre

At the Salvation Army's Harbor Light Centre in Cleveland, Ohio, an informal men's orchestra had its beginning in 1959. Starting with guitars and harmonicas, it gradually grew to include such other familiar instruments as string bass, drums, xylophone, woodwinds, and even a vocal gospel ensemble, in addition to the traditional Salvation Army brass in which the men in this particular area lacked background and consequently had difficulty learning to play.

Miller notes that approximately twenty percent of the Centre's residents participated in the orchestra, and out of those, smaller groups of varying proficiency were formed. Many men who had played an instrument at one time in their lives but had abandoned it after falling upon hard times resumed their musical activities, some even starting lessons again. One man "took trumpet lessons as a high school student, but never played in any group. Now, thirty years later, he has resumed his lessons with the same teacher and is playing in the orchestra" (Miller, 1970, p.137).

A technique called "instant music" was developed in 1968

by Harvey Hall, R.M.T. and Louise Steele, R.M.T. with the purpose of drawing an isolated individual into a group activity. "As the one man's musical note is combined with those of the other men to form a musical chord, so it is hoped he will come to recognize his need for co-operation in life if it is to be harmonious" (Miller, 1970, p.137).

The men are expected to complete six sessions, but the unique "instant music" approach had middle-aged alcoholics, most of whom had little or no previous musical experience, actually playing music together at the end of the first session. Miller notes that "although the turnover rate is high, a follow-up study of 85 residents who completed a year of sobriety and employment showed a success rate of at least 50% in completing the next year of sobriety" (Miller, 1970, p.138).

This approach to music therapy meets three of the four criteria generated by the preliminary literature review directly, and one indirectly. Edward V. Dimond, director of Cleveland's Harbor Light, described the philosophy of the seventeen Harbor Light Centres throughout the United States as promoting transformation in men by a complete "renewal of their minds, so as to sense for themselves what is the good and acceptable and perfect will of God" (Dimond in Miller, 1970, p.137). Such a transformation or renewal is consistent with the healthy, enduring peak experience referred to in criteria one,

and the emphasis on seeking the will of God is consistent with Brower, Blow & Beresford's belief that a focus on moral and spiritual concerns is advantageous for chemically dependent clients (1989).

Although the need to overcome denial is not specifically addressed by this approach, Miller does note that after being involved in the music sessions at the beginning of their stay in the Centre, the men usually found it easier to take part in the other group activities such as alcohol education classes, which would deal specifically with the existence of the chemical dependency problem.

The need to improve communication and interpersonal functioning is addressed eloquently and movingly by the metaphor of one man's single musical note symbolically joining with those of the other men to form a musical chord. An increased understanding and appreciation of the power of this metaphor would have significant implications for improved interpersonal relationships, which Marlatt (1985c) considers a key factor in preventing relapse.

The need to enhance self-esteem is clearly addressed by this approach. The "instant music" technique, which allows men to play music together by the end of the first of the six sessions, helps the men to believe in and respect themselves for succeeding at something at a time in their lives when they

may have failed at everything else including staying sober. Men who have little or no musical background cannot fail to feel uplifted by this sudden and unexpected success, while men with a music background who may have let their musical activity lapse can experience the "breakthrough" which Murphy refers to "when a connection is made with a strength or talent that can be reinforced or acknowledged" (1983, p.61). One combo which formed in 1962 out of the original orchestra went on to perform on television, in films for the United Appeal, and played often at Salvation Army gatherings. It is not difficult to imagine how greatly such success must have enhanced the self-esteem and thus the recovery of these alcoholics turned musician.

### (ii) Brooks (1973) The Role of Music Therapy In a Community Drug Abuse Prevention Program

In 1973, Awareness House had fourteen community programs for young people in seven states concerned with helping young people find meaningful alternatives for their own lives, of which music was an important one. Folk music and rock music which takes a non or anti-drug stance was encouraged, and professional musicians and music therapists were invited to share their knowledge, understanding and love of music with the young people in the program. "Socratic

dialogues" (Brooks, 1973, p.6) were encouraged so that the young people became personally involved in exploring the meaning of the music in their own lives, and these dialogues were rewarding experiences for both students and teachers.

This approach meets the criteria generated by the literature review. The program's emphasis is on the need for meaningful and exciting "alternative turn-ons" (Brooks, 1973, p.3) to drugs and alcohol - in other words, healthy peak experiences which can make the absence of mood-altering chemicals seem less devastating. Helping young people understand and believe that they can get "high on people" (Brooks, 1973, p.4) and feel good without chemicals facilitates recovery by allowing the young people to see that a life of abstinence does not have to be a joyless one but can be filled with excitement, meaning, and fulfillment.

Although the form of music used in this approach does not directly address the problem of denial, Brooks does indicate that music, although important, is only one of the alternatives that are part of the program, and it is to be assumed that confrontation by both peers and counsellors as to the existence of the chemical dependency problem would be addressed in other aspects of the program. Certainly, having pleasurable experiences to look forward to would make the difficult task of facing one's chemical dependency more bearable.

There is an emphasis in this program on honest communication, both among the young people and also between the young people and authority figures. Brooks (1973) describes the "evening after a day-long conference [when] top policemen, judges and prison and probation workers of the state of North Dakota came to Awareness House and spent up to three hours in communication with groups of kids...[and] when it was all over, one of the kids brought out his guitar and started one of the most unusual sing-alongs I have ever enjoyed. It was enjoyable in itself, but the thing that had me so high was seeing tough police chiefs and sheriffs, narcs, a state supreme court justice, probation officers and a prison warden sharing their high with long-haired and modly dressed kids. It was beautiful" (p.5). Brooks notes, however, that allowing the young people to play music loudly as background to the informal activities of the program was a "mistake and a misuse of music, [since] many youngsters [used] the loudness as an excuse not to talk, not to communicate [and such use] abuses the rights of others who do want to talk, to communicate" (Brooks, 1973, p.4). Consequently, a music room was established where 'people who really want to listen can do so for the enjoyment of listening and not as a way to hide out, to cover their own feelings or to avoid communication" (Brooks, 1973, p.4). Brooks goes on to say that he would "much rather

see a guitar or a piano in an Awareness House [than a stereo system]. I see so many instances of youngsters getting involved in music; playing, singing along, listening, being happy enjoying not just the sounds but also the camaraderie" (Brooks, 1973, p.4).

The noncompetitive use of music in this program contributes to enhancing the self-esteem of the chemically dependent young people, whose chief contact with music in the past may have been in a "situation of competitiveness, such as in school, or of frustration with weekly one-hour lessons and hours of frustrating practice" (Brooks, 1973, p.5). When professional therapists, through sharing their knowledge and understanding "share themselves with young people who are searching for something, eager to learn, but often put down by our traditional ways of teaching, [the resulting dialogues] can be exciting and a rewarding experience for both student and teacher [and] often those who appear to be the most alienated are actually most easily involved when involvement means honest communication between human beings" (Brooks, 1983, p.6). Brooks also notes that "a counsellor in our California programs was a concert musician who had played in the San Francisco opera orchestra before he got too strung out on heroin. When I visited his program, I found him turning kids back on to piano lessons, Bach and Beethoven, no less!" (Brooks,

1973, p.5) The return of the counsellor's self-esteem must have provided a powerful role model for the young people whose own self-esteem must have been low due to their chemical dependency.

### (iii) Murphy (1983) A Self-help Group Experience For Substance Abuse Patients

The Breakthrough Concepts program at Gracie Square Hospital, a small 250 bed private psychiatric hospital in New York City, is one in which patients are detoxified and rehabilitated to combat alcohol, drug, or mixed substance abuse. Treatment is based on supportive confrontation in self-help groups to break strongly entrenched denial patterns. As part of the interdisciplinary team, the music therapist is both supportive and confrontative with participants in order to meet the treatment goals of breaking down defenses and combatting the isolation of the substance abuse patient (Murphy, 1983). For many patients, non-verbal expression in music therapy is the avenue to confronting their addiction for the first time.

One of the primary goals of the rehabilitation program is to support patients' recognition of feelings in order to help them recognize past self-destructive patterns such as helplessness, blaming, grandiosity, distorted perception, or extreme lack of trust and to take steps to eliminate them.

The treatment consists of two phases: phase 1 consists of detoxification and physiological stabilization; phase 2 includes therapy groups in all the expressive modalities including music, for which patients are encouraged to attend both a songwriting and a music improvisation session every week.

The focus of the songwriting group is on the here and now: feelings about hospitalization, about themselves, and about sobriety and being drug-free. A typical songwriting session includes brainstorming to develop a song lyric, a decision about music for the lyrics, and decisions about the key and whether the song should be in a major or minor mode. In the songwriting group process, each group member is motivated to contribute to the initial stage of developing the lyric. The group brainstorms for ideas, and everyone must contribute one thought about what he or she is feeling at that moment. In developing a song line, the thoughts and feelings of the participants are revealed, and a theme emerges from the brainstorming process.

The focus of the music improvisation group is on facilitating group process which is critical in a short-term rehabilitation hospital setting, by developing musical communication through the use of rhythm instruments. The music therapist initiates the first improvisation pattern, which may include vocal improvisation, and the patients share the

leadership in subsequent improvisation patterns. The patients who volunteer to initiate patterns select the members of their subgroups and the instruments each person will play and orchestrate the pattern. The entire group listens to each of the orchestrations, and a musical closing followed by positive verbal acknowledgement of each person's contribution concludes the session.

Murphy describes the case study of "Paul", a twenty-six year old post-office worker who entered therapy voluntarily with a musical background of singing and playing guitar. He became enthusiastically and actively involved in both the songwriting and the improvisation sessions. He received positive feedback from the group for his musical contributions, and in the last session performed for the group a song which was decidedly optimistic and confident and which differed significantly from his attitude when he first entered the program. Once his in-hospital treatment was completed, Paul entered the Post Alcohol Recovery program at the post-office, at which time he began making plans to further his education.

Murphy notes that "finding a 'high' without chemicals is a new experience for many [and that] listening, using the tactile senses, and harmonizing with others in a music therapy group stimulates the sensorium...[making] the session exciting for the patient" (Murphy, 1983, p.59) and thus making the prospect of

life without chemicals a less dismal one.

The emphasis in this program is on confronting patients' resistance to treatment by breaking strongly entrenched denial patterns (Johnson, 1980), a goal which meets the second criterion of helping clients access repressed material in order to achieve new insight and self-understanding. The purpose of the song-writing sessions is to "help patients be more insightful about their hospitalization [since] acceptance of substance abuse as an addiction or disease is difficult and in some cases unacceptable" (Murphy, 1983, p.54). The therapeutic approach to songwriting is both confrontative and empathic with regard to the situation of confinement and the reason for treatment, and Murphy notes that "in one session, a musically talented group member moved the group to confronting a painful acceptance issue. The nonthreatening, supportive atmosphere of the group frequently frees a patient to express ideas or feelings that had been repressed or unacknowledged. Catharsis occurs when the nonverbal patterns in music improvisation elicit the patients' present emotional states, and the groups are often loud and dynamic in response to the re-awakening of repressed feelings of anger and frustration which many may be feeling in their verbal groups. If an outlet is not available for the tension which results from the individual or group verbal sessions, headaches or other physiological release of muscular

tension can occur" (Murphy, 1983, p.57). One client who was initially resistant to an improvisation session later found that her headache had disappeared by the end of the session, due to her new ability to let go of her tension, which was based on anger, an intense emotional reaction elicited by her counselling sessions and subsequently repressed.

The need to improve interpersonal functioning is addressed by the emphasis on an "evolving interactive process" (Murphy, 1983, p.56) in the music improvisation group. Ineffective communication patterns are discussed, and patients are supported in the "safe" environment provided by the program to take risks in personal interaction in order to decrease isolation, a behavior pattern which is frequently both a cause and effect of chemical addiction. Like other self-help groups in the program, the music therapy sessions demand social interaction, verbal and non-verbal, in processing what was observed and experienced in the group's tasks. In improvisation sessions, members are placed in a situation that requires relatedness, and the social interaction patterns revealed in the sessions are repeated in countless ways in the real world so that analogies are drawn and lessons learned (Murphy, 1983). The avoidance of feelings and intimacy, a way of life with the chemically addicted personality, can be addressed in group sessions, and these blocks can be met

through the group process, which encourages and supports spontaneity verbally and nonverbally and provides an atmosphere for relating and connecting constructively rather than destructively to one's peers and to one's self.

The need to enhance the self-esteem of substance abusers is addressed in the Breakthrough Concepts program. Realizing that poor self-image often leads to use of a chemical substance as a coping mechanism in response to problems in daily living, the program is structured so that positive verbal acknowledgements of each patient's contribution and talents end each session in order to help clients gain confidence in themselves and in their own value. "The process of creating a satisfying music improvisation or a song can be significant in building ego strength, and the severe judgemental attitudes or unrealistic expectations to which many of these patients have subjected themselves are proven irrelevant in a music therapy session because the environment is failsafe; there are no 'bad' improvisations, there are no 'wrong' contributions to a song, and for many patients, the breakthrough occurs when a connection is made with a strength or talent that can be reinforced or acknowledged [and] this has happened for many patients through involvement in music therapy as part of treatment (Murphy, 1983, p.61).

Murphy quotes Yalom (1975, p.122) on the importance of

"closing the loop" for the client by making it possible to replicate their positive experience as they re-enter their world, so that they can maintain their awareness of their strengths and talents and can allow their new interest in music to "stimulate the creative use of time as an alternative to boredom which may itself have contributed to the chemical abuse" (Murphy, 1983, p.54).

### (iv) Dougherty (1984) Music Therapy in the Treatment of the Alcoholic Client

Brunswick House is the alcoholism rehabilitation Centre within Brunswick Hospital Centre in Amityville, New York, a residential therapeutic community of recovering alcoholics sharing experiences and feelings in a chemical free environment. The average stay is 28 days, the first five of which constitute a detoxification period. Music therapy is used as a vehicle for self-expression to share personal problems, overcome isolation, and help clients recognize the control they have over their emotions by controlling the music they listen to, thus teaching the client a new way of coping with emotions without resorting to the use of chemical substances. The primary assumption of the program, because alcoholism is a chronic, progressive and potentially fatal disease (National Council on Alcoholism, 1979) is that "before any treatment can

be viable or successful, the alcoholic client must accept his/her alcoholism" (Dougherty, 1984, p.48). An admission of alcoholism entails recognition of one's powerlessness over alcohol and is therefore the first positive step for alcoholics in treatment (Alcoholics Anonymous, 1983).

> Within the therapeutic community of Brunswick House, there are therapists trained in systematized methods of treatment including Gestalt, psychodrama, role playing, reality therapy, support therapy, transactional analysis, behavior therapy, creative arts therapy, recreation therapy, occupational therapy, stress management and after care. The entire client population is divided into five teams, and each client follows a scheduled therapeutic program with his or her team. This helps reinforce that recovery is a team effort and also provides a safer atmosphere for emotional openness and support...Music therapy sessions are scheduled once a week for each of the five teams...[and] due to the fact that there are daily admissions and discharges...the process of the sessions is open-ended, allowing clients to enter the group at any point during treatment. (Dougherty, 1984, p.48-49)

During the session, recorded music is listened to on high quality equipment in order to elicit feelings. Clients choose selections from rock, disco, gospel, country, pop, jazz or classical music based on a request from the therapist which in turn is based upon knowledge of the client's needs. For example, clients might be asked to select a song which expresses how they are feeling, one which changes their mood, one which brings back memories, or one which seems appropriate for another member of the group. After the selection is played, reasons are given for the selection, and feelings elicited by the music are shared with the group.

This program's emphasis on changing from an old reward system using chemically induced highs to a new one based on spiritual values and relationships (Pattison & Kaufman, 1982) addresses the need for providing access to healthy peak experiences. Dougherty notes that "one client's reaction at the end of a listening session was one of complete revelation: "I have music on all the time, but I never really listened. I never realized the power that music has over what I am feeling!" (Dougherty, 1984, p.50) and the biweekly thirty minute community sing-alongs provide clients with an opportunity to realize that they can have fun without alcohol. As one client commented, "That was fun - I didn't think I could do that without a drink!" (Dougherty, 1984, p.51). Whereas, before

treatment, clients would turn to alcohol to obtain relief from a stressful situation, they now begin to realize that singing or listening to music also has positive mood-altering and stress-reducing capability.

There is also a strong emphasis in the program on the need to overcome denial and provide access to repressed material, leading to new insight and understanding. Although Dougherty states that the client's acceptance of alcoholism must occur "before any treatment can be viable or successful" (Dougherty, 1984, p.48), the process of acceptance is a gradual one which occurs at many levels, so that an intellectual, verbalized acceptance at the beginning of therapy may gradually become an emotional and deeply felt awareness by the conclusion of the program. Dougherty indicates that "in accordance with the treatment theories held by the rehab center, music therapy sessions emphasize the here and now expression of feelings and thoughts and are centred around the commitment to abstinence...the expression of painful conflicts and emotions...and the need for emotional support from other recovering alcoholics" (Dougherty, 1984, p.49).

Clients are held responsible for exploring the depths of their feelings to the best of their ability, and are helped to do so by choosing music which, because of its power of association, has the ability to elicit feelings that may be otherwise

inaccessible. Dougherty notes that the chosen music may often elicit tears, and that the group process may then centre around the value of tears. When the group is supportive and discusses crying as a sign of strength rather than of weakness, clients come to realize that it takes a great deal of courage to be honest about feelings and to risk sharing them with others, and this realization helps to overcome the fear which has caused the denial.

Because clients generally do not find listening to records to be threatening, attendance at these sessions was 80 to 90% at any given time. Dougherty notes that "if clients are to gain anything from music therapy sessions, they must want to be there" (Dougherty, 1984, p.53). The nonthreatening aspect of this approach is therefore a strength, since "experience has shown that if the alcoholic client in a self-help program finds something too threatening or unknown, he or she will choose not to attend that session" (Dougherty, 1984, p.53). In other words, the approach to confronting denial in this program is gentle enough so as not to scare clients away, yet strong enough to help them to gradually face the truth about their feelings and their illness.

The need to improve channels of communication between group members is addressed by this approach. The music therapy sessions are a vehicle for emotional self-expression,

facilitating communication and sharing among members by encouraging feedback about each others' selections. When clients realize that the same song may affect other people differently, discussion often ensues regarding these differences, during which process insight and understanding of others' feelings and life experiences develop. Receiving support in the sessions enables clients to verbalize their feelings freely and honestly, so that by the end of the session they are able to process their feelings by discussion of "how they felt about the risks involved in selecting a song for other people, how they felt about having a song played for them or if a song was not selected for them, and why they may have chosen a song for the group rather than for a particular individual" (Dougherty, 1984, p.51). In this way, personal problems are shared, isolation is broken down, and confidence is gained in discussing and facing problems or feelings.

The need to enhance self-esteem is addressed by the emphasis of this approach on positive feedback regarding clients' choice of music for themselves and for others as well as on learning to view the expression of emotion as a sign of strength and courage rather than of weakness.

Through learning to believe in and trust their own powers of perceptiveness and insight, self-esteem is enhanced, and "this sense of achievement itself is therapeutic and

augments the work of the other therapies in the rehabilitation centre" (Dougherty, 1984, p.53). An additional strength of this approach with regard to enhancing self-esteem is the formation of additional music therapy groups to address the needs of special populations. Because male clients generally outnumber females nine to one, "many female alcoholics in this situation withdraw from the process of the group, making the sessions countertherapeutic for them" (Dougherty, 1984, p.52). Providing an additional weekly music therapy session exclusively for women enables them to share their experiences more freely, particularly when their issues centre around relationships with men. Similar groups are held for black alcoholics, the underlying philosophy being that culture and society play a vital role in alcohol abuse. Although this philosophy is not intended to excuse or justify drinking, it can help clients to see their problem in the context of its larger social perspective and can in this way play a role in helping clients to accept their addiction as a disease and to stop blaming themselves and feeling guilty, while still encouraging them to attempt to change the things they can, beginning with taking responsibility for their own recovery.

(v) Dyck (1984) The Use of Improvisatory Group Music Therapy in the Treatment of Inpatient Alcoholics

Dyck used improvisatory group music therapy with thirty-five patients in a shortterm in-patient recovery program in the Alcohol Treatment Services Unit of a small private psychiatric hospital. There were no limitations made on the age, sex, race or creed of the subjects, but all were eighteen or older. Seventeen patients were in the experimental group and eighteen in the control group.

Dyck hypothesized that after two hourly group music sessions held one week apart, the experimental group, which participated in improvisational music therapy sessions consisting of free improvisation, listening to a playback recording of the improvisation, and verbal discussion with emphasis on affective material, would score higher on self and clinical ratings of group functions than would the control group which participated in non-improvisational music therapy activities. T-tests, regression analysis and a scatterplot to test for correlations were used in the analysis of the data, which did not confirm the author's hypothesis.

The experimental group scored significantly lower on the G.R.S. self-report measure of group function (Group rating scale, Schein and Bennis, cited in Dyck, 1984) and only slightly but not significantly higher on the E.G.B.R.S. clinical measure

(Effective Group Behavior Rating Scale, Schein and Bennis, cited in Dyck, 1984) than did the control group. The score on the musical rating scale developed by the author (M.R.S.) was also slightly but not significantly higher for the experimental group than for the control group (Dyck, 1984).

Dyck suggested as a possible explanation that the G.R.S. may have been inappropriate as a measurement of group function and ability to deal with emotional issues and that, in fact, this self-report instrument "may have been more a measure of comfort level in the group" (Dyck, 1984, p.42). This result was consistent with the literature's emphasis, as found by Dyck in his review, on the alcoholic's discomfort with emotional issues, and Dyck concluded that "if musical improvisation facilitates expression of emotional issues, it seems reasonable that these subjects would, in fact, score lower [on a self-report measure] if they were basing their answers on their level of comfort in the group...[and] if this was the case, the hypothesis should, in fact [have stated] that the experimental group would have a lower self-rating score (G.R.S.) than the control group, but would have a higher clinical rating score (E.G.B.R.S.) (Dyck, 1984, p.42).

Although the results of this empirical study do not at first appear to be consistent with the four criteria in that the experimental group, which received the music improvisation

treatment, scored lower on the group rating scale than did the control group, Dyck's suggestion as to why this may have occurred nevertheless has significant implications in terms of the second and third criteria, which concern providing access to and facilitating expression of repressed material. If, as Dyck suggests, the group rating scale self-report device actually measured comfort-level rather than ability to deal with emotional issues, then a lower rating on this scale might suggest that the music therapy had in fact succeeded in achieving the goal of facilitating expression of emotional issues (Dyck, 1984), and that it may have been this very success that caused the subjects' discomfort. In other words, discomfort and emotional growth could be compatible rather than mutually exclusive results of the music therapy successfully achieving what it set out to achieve. Although further empirical testing of the Group Rating Scale would be necessary in order to ascertain the truth of this assumption, this study makes an important contribution to the understanding of the process of music therapy by pointing out the drawbacks of attempting to assess therapeutic benefit by attending exclusively to client self-report measures and emphasizes the value of obtaining therapists' observations as well as other unbiased observer reports.

This study also suggests that the discomfort that may be

caused by facilitating emotional awareness and expression may need to be balanced by techniques which have been shown to reduce tension level and increase enjoyment, so that the first and fourth criteria, which concern enjoyable experience and self-esteem, are not neglected.

### (vi) Wheeler (1985) The Relationship Between Musical and Activity Elements of Music Therapy Sessions and Client Responses

Wheeler conducted an empirical study using two groups of subjects. The first group consisted of sixteen junior and senior music therapy students in a required course whose ages were approximately 21 - 22 years. This group was subdivided into juniors and seniors. The second group consisted of clients in treatment for substance abuse and was further subdivided into two groups of recovering alcoholics and one group of recovering drug addicts. "All were in residential treatment, with the average treatment time for alcoholics being three weeks for one group and three months for the other, and the average length of treatment for the drug addicts, one year" (Wheeler, 1985, p.53). Both groups being treated for substance abuse were conducted by senior music therapy students from the Montclair State College.

Goals for both groups of recovering alcoholics were

"greater awareness of and ability to deal with feelings" (Wheeler, 1985, p.53). A variety of musical activities were used such as improvising on simple instruments, listening to and discussing song lyrics, songwriting, moving or drawing to music, and singing.

The primary goal for the recovering drug addicts was learning to play the guitar and to deal with affective issues that arose in connection with this task.

The goal for the two groups of music therapy students was to study their group process and the influence of music on this process. Activities consisted of instrumental and vocal improvisation, discussion of song lyrics, and moving, drawing or relaxing to music. Group leadership was on a rotating basis, and neither performance nor leadership was graded (Wheeler, 1985).

Client responses were rated by two therapists and inter-rater reliability was found to be low but sufficient using Pearson correlation co-efficients. Subjects were rated on the dependent variable according to (i) involvement/participation, (ii) enjoyment, (iii) quantity and (iv) intensity of feeling, and (v) tension level in response to selected elements of the music therapy sessions which constituted the independent variable and which included whether the music was (a) live or recorded, (b) improvised or composed, (c) folk, classical, jazz, rock, folk-

rock, show or free improvisation, (d) instrumental or vocal, large or small ensemble or solo, and on whether it (e)contained movement activity and (f) included discussion. The session elements were entered into separate multiple regression equations (Hull, and Nie, in Wheeler, 1985), each predicting one of the areas of client response which had been rated" (Wheeler, 1985, p.56).

Results indicated that use of a combination of art and music with substance abusers increased both involvement in the session and quantity of feelings elicited. Use of rhythm instruments and the inclusion of discussion also increased enjoyment and involvement for this group, but movement to music decreased enjoyment and increased tension level. For the music therapy students, relaxation to music decreased involvement and quantity of feelings elicited, and the use of a large ensemble increased both of these responses, while listening to classical music without movement activities decreased tension level for alcoholics.

Wheeler concluded that the lack of consistency in the findings between the two populations was due to the complexity of the responses with which music therapists deal and that the two populations had reacted to different session elements.

Although this study does not specifically address the

issue of self-esteem, the results do nevertheless suggest that certain forms of music therapy have the capacity to increase enjoyment, quantity of feelings elicited, and sharing of feelings, which do correspond to the first three of the four criteria suggested by the literature review. The use of a combination of art, rhythm instruments, music, and discussion together would seem to have potential, therefore, to enhance recovering alcoholics' lives by making the absence of mood-altering chemicals less devastating through providing a new form of enjoyment and involvement; to facilitate insight by providing access to repressed feelings; and to improve communication through encouraging discussion of the feelings elicited. Although it cannot be assumed that self-esteem also improved as a result of these activities, it is likely that the increased enjoyment, involvement and sharing would also result in clients feeling better about themselves. However, due to the empirical nature of this study, it is not possible to draw conclusions as to the reflective mental processes of the subjects, since no description of process or examples of comments from either therapists or clients are included in the report; thus the "self-reflective loop" concept which Yalom (1975, p.122) deemed crucial to effective group process seems not to have been present, or at least, no mention is made of it in the report of the study.

Wheeler notes, with regard to the study's limitations, that "although rating scales have positive qualities in that they allow raters to give responses which are intuitively meaningful...and can be filled out following a session, they are among the least objective of measures [and] this lack of objectivity is what is thought to be reflected in the low inter-rater reliability" (Wheeler, 1985, p.57). She cautions that, for this reason, "it is suggested that the results and interpretations be considered tentative until substantiated by further research" (Wheeler, 1985, p.60).

(vii) Adelman & Castricone (1986) An Expressive Arts Model for Substance Abuse Group Training and Treatment

The Expressive Arts model integrates techniques from psychodrama, music therapy, and art therapy. It "assumes that self-expression often precedes and evokes self-awareness" (Adelman and Castricone, 1986, p.58), utilizing the concept of the 'Ah ha!' experience which occurs when a group member suddenly grasps the significance of what he or she has expressed. The populations with which the approach was used were not substance abusers but, rather, consisted of one group of ten students majoring in music therapy with an expressed interest in substance abuse treatment, and fifteen treatment staff members at a hospital for detoxification and treatment of

alcoholic clients. The students participated in six weekly sessions of one and one half hours each, while the treatment staff participated in one half day intensive in-service format only. Adelman and Castricone note that "the objectives of this model are congruent with the treatment goals of the disease model of addiction: to facilitate a change in the client's self-awareness and attitude, which can, in turn, change feelings, thinking and behavior" (Johnson, 1980). In addition, this model is educational and experiential and so "supplements conventional group therapy and many of the other facets of a comprehensive substance abuse treatment program" (Adelman & Castricone, 1986, p.58).

Music therapy is one of the modalities presented, along with art and drama therapy. In the first music therapy session, "each person was asked to distill the essence of his or her experience [from a previous dramatic therapy session] into one sentence or fragment" (Adelman & Castricone, 1986, p.56). In the previous session -a dramatic portrayal entitled 'Parts of the Person'- the four major realms of an alcoholic's life which are affected by addiction (i.e.. emotional, physical, cognitive and spiritual) together with representations of the protagonist, the addicted alter ego, and the Voice of Health and Recovery had engaged in a conversation, beginning with but soon transcending a structure. Group members each selected one of

a group of cards, seven of which contained the above-mentioned 'parts of the person', while the remaining cards selected were blank. People holding blank cards were asked to double the 'part' with which they felt the most affinity or understanding, or they also had the option simply to observe. In the music therapy session, the 'position' of each 'body part' was represented by a rhythmically chanted fragment, with each 'part' or voice entering one at a time. The following is representative of what such an improvisation might yield:

Physical: Ah, my head my head/my head

Emotional: Nobody cares/ I'm so alone

Cognitive (Rationalizer): One drink won't hurt/ You can quit tomorrow

Spiritual: Ultimately what does it/ matter?

Protagonist: Mm, you're right/ Hmm that's true.

Voice of health & reason: Listen to me/ Don't do it.

Addicted alter ego: Pour it now/ Pour it now!

The rationale was to "underscore the dynamics of the addicted person and freeze one moment of the characteristic yammering in his head" (Adelman & Castricone, 1986, p.57).

The second music therapy session followed a previous drama exercise in which group members were asked to draw, with crayons and paper, a representation of their own personal

"wall" to illustrate the theme of isolation. "The suggestion was given that they include their own personal graffiti, i.e. sayings, beliefs, verses, guidelines by which they live or captions they would have others believe about them" (Adelman & Castricone, 1986, p.54) and they were asked to keep in mind that some walls keep others out; some keep one's own self inside. In the music improvisation session, group members contrasted the isolation they felt during the "wall" session with their present feelings about their own participation and growing sense of belonging in the group. To heighten each person's sense of self-awareness within the group context, a diverse set of musical instruments was placed just outside of the group circle, including wood xylophones, metallophones, glockenspiels, recorders, drums, symbols, and various small percussion instruments. This exercise was done with the music therapy students, who were already familiar with the instruments. Had they not been, some group jam sessions before the exercise would have been advisable.

Each member was invited to use their chosen instrument, or their voice or body, to express "current personal feelings related to having been part of the group and being with the group at the present moment. The rest of the group was instructed to musically support the soloist on the remaining instruments, perhaps echoing motifs, supporting rhythms,

reflecting moods and tonal qualities as if improvising a concerto. They were not to disparage, steal the show, attempt to alter the flow or mood of the soloist, nor to overpower the soloist dynamically...and their accompaniment was to be an honest expression of their feelings and their relationship to the soloist" (Adelman & Castricone, 1986, p.58). As a result of this exercise, one group member realized that she was inappropriately projecting feelings onto two of her friends in the group that she had actually felt toward her two sisters, and another member became aware of dominating the other members, both in the improvisation and in real life. Adelman and Castricone note that "in the intense but time-limited format of the inpatient treatment program, the Expressive Arts Model represents an efficient method for promoting openness and trust for both staff and clients...with regard to risk-taking, looking honestly at one's defenses, receiving and giving feedback, and exploring the effect of substance abuse on the totality of one's life" (Adelman & Castricone, 1986, p.58).

At the end of both of these sessions, participants remarked on their sense of wellbeing and closeness to other group members, which, in this author's opinion, meets the first criterion of providing meaningful, enduring, healthy peak experiences to make the absence of mood-altering chemicals less devastating. In addition, the emphasis of this approach on

"reframing the suffering and confusion that accompanies treatment for addiction into a positive force toward recovery and health" (Adelman & Castricone, 1986, p.55) is consistent with helping recovering substance abusers learn to find meaning without resorting to the use of chemicals.

The combination of the use of art and drama with music adds to the effectiveness of this approach with regard to overcoming denial, providing access to repressed material, and facilitating insight. Because defenses are confronted directly, although symbolically or metaphorically, through personal expression which is then followed by self-awareness, less resistance is encountered due to an absence of moral judging, labelling, or blaming. Rather, each session provides food for self-reflection, "reducing resistance and lowering defenses, while at the same time highlighting and normalizing these dimensions" (Adelman & Castricone, 1986, p.58). The authors note that treatment staff who participated in the 'Parts of the Person' musical postlude commented enthusiastically that the experience had been satisfying, memorable, and represented a true-to-life portrayal of their clients. Similarly, in the music improvisation group, both the group member who became aware that she was projecting qualities of her sisters onto her friends and the student who realized that her dominating behavior in the music session paralleled her role in the group

outside of the session left the workshop with valuable new insights into themselves and others gained by expressing their own personal metaphors.

This approach also addresses the need to provide new avenues of communication. Through nonverbal expression in the music improvisation group, clients became aware of aspects of their own social functioning that were contributing to a sense of isolation and loneliness. The girl who realized that she had been projecting her sisters' characteristics onto her two friends was subsequently able to see her friends as they really were and to relate to them in a more satisfying and personally fulfilling way. Similarly, the group member who realized that she had been dominating the others both in and out of the music therapy session had the opportunity to observe other group members who accompanied without dominating and in this way was able to learn, through metaphor, a healthier and more socially acceptable form of interrelatedness with others, which might lead to a reduction of the isolation resulting from conflict with and ultimate rejection by people who refuse to be dominated.

Interestingly, Adelman and Castricone note, with regard to several group members who had not yet shared as the end of the session approached, that when these people were "not singled out but [rather] validated and reassured that

sometimes it takes an equal amount of courage to choose differently from the majority, i.e. not to share aloud" (Adelman & Castricone, 1986, p.54), after such remarks of acceptance all but one member did, paradoxically, choose to share their experience with the group. This suggests that removing the pressure to communicate, yet allowing for a change of heart, may be more effective than making self-disclosure compulsory, particularly among recovering clients whose fear of self-disclosure would likely be more pronounced than that of the music therapy students and treatment staff.

It is significant that "even though these participants had [previously] spent a great deal of time together and had many common experiences, they spontaneously and unanimously agreed that the group sessions had deepened and intensified their closeness with one another" (Adelman & Castricone, 1986, p.58) and one session was summed up by one member of the treatment staff who said they learned "more about the other members in that session than they had during months of working together" (Adelman & Castricone, 1986, p.55).

Regarding the enhancement of self-esteem, the emphasis in this approach is on helping people become aware of their own "deep inner strength" (Adelman & Castricone, 1986, p.55), and the empathy that these activities evoked, together with the opportunity for self-reflection that the sessions provided,

facilitated the development of this awareness.

### (viii) Freed (1987) Songwriting With The Chemically Dependent

Freed describes an approach to songwriting with chemically dependent clients which includes techniques for facilitating songwriting as well as suggestions for lyric analysis of the original songs produced in the sessions. The approach is based on the author's experience in a twenty-four day in-patient treatment facility. The average age of those in treatment is 29 years, with a mean school education of 11.7 years. The clients are 80% male, 37% unemployed, and 91% Caucasian. 87 1/2% claim alcohol as their primary drug, while the remaining 12.5% claim drugs other than alcohol as their primary addiction. Freed's approach incorporates the philosophy of the AA/NA programs into the songwriting and lyric analysis process in order to help clients begin to "internalize the recovery program, forming a personal philosophy which will improve the quality of their lives" (Freed, 1987, p.18).

The AA/NA philosophy requires chemically dependent persons to admit three important ideas: (a) that they are chemically dependent and could not manage their own lives, (b)that probably no human power could have relieved their

chemical dependency, and (c) that God, as they understand [God] would relieve them if sought (AA, 1946). Central also to the AA/NA philosophy is an understanding of the Twelve Steps as well as the Serenity Prayer. The twelve steps are as follows:

(1) We Admitted we were powerless over alcohol/drugs - that our lives had become unmanageable.

(2) Came to believe that a power greater than ourselves could restore us to sanity.

(3) Made a decision to turn our will and our lives over to the care of God as we understood him.

(4) Made a searching and fearless moral inventory of ourselves.

(5) Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

(6) Were entirely ready to have God remove all these defects of character.

(7) Humbly asked God to remove our shortcomings

(8) Made a list of persons we had harmed and became willing to make amends to them all.

(9) Made direct amends to such persons wherever possible, except when to do so would injure them or others.

(10) Continued to take personal inventory and when we were wrong promptly admitted it.

(11) Sought though prayer and meditation to improve our

conscious contact with God as we understood him, seeking only knowledge of his will for us and the power to carry that out.

(12) Having had a spiritual awakening as the result of these steps, we tried to carry this message to others and to practice these principles in all our affairs.

The Serenity Prayer, an "invocation for a healthy life" (Freed, 1987, p.14) is as follows: "God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference" (Alcoholics Anonymous, 1975, p.18).

In order to "facilitate personal disclosure and to maximize interaction, the provision of adequate structure for the [songwriting] experience" (Freed, 1987, p.14) is necessary. Techniques used by Freed to provide this structure include creating a nonthreatening environment, lead-in activities, writing new words to pre-existing melodies, and the cloze procedure, which is the practice of deleting specific words of composed songs so that clients can substitute their own words for the purpose of personalization.

To ensure that the environment is nonthreatening, clients are assured that every honest attempt will be acceptable, that assistance from the therapist will be available, that

performance will be optional, and that the focus will be on the person, rather than on the creation of a perfect product. Lead-in activities consist of discussion about chemical dependency issues as expressed in songs that clients choose and listen to, or listening exercises in which clients are encouraged to express feelings elicited by the music. Once an already existing song has been listened to and discussed in the lead-in activity, self-disclosure can be encouraged by having clients substitute their own lyrics which describe themselves, their identity, their feelings and their needs by completing lead-in sentences designed by the music therapist in which specific parts of the sentences are left blank. Writing their own words to familiar existing melodies, a more unstructured approach, allows clients to share experiences and feelings while working together in small groups toward a common goal: the production of a song which reflects their lives, and Freed cites Silverman (1983) that writing, hearing or performing and reacting to his or her own song makes the chemically dependent client feel liberated (in Freed, 1987).

Freed notes that this technique is beneficial because it does not require musical background, and because the song can usually be produced and sung within one session. Once the song has been written and sung, the lyrics are analyzed by focusing on significant words that the clients have written in

order to encourage expression of the feelings underlying those words (Lippin, 1983). Song themes include confronting losses, treatment reinforcements such as the AA/NA philosophy and the Serenity Prayer, and ways to improve self-esteem and to form new and healthier relationships.

The first song (to the tune of Heart of Gold, original music and lyrics by Neil Young) is an example of the cloze procedure. The second, to the tune of the Christmas carol 'It Came Upon a Midnight Clear' is an example of new words written by a group of four clients to a well-known, pre-existing melody. In the song, Heart of Gold, the underlined words were supplied by the client after the original ones had been deleted by the therapist:

Example 1: Heart of Gold

verse 1:

I've been a <u>loser</u> and I've been a <u>fraud</u>.<br>
I've always <u>known it and I am sad.</u><br>
I felt <u>like running</u> whenever I <u>hurt.</u><br>
But now I <u>know that running won't work,</u><br>
'Cause <u>you can't hide from yourself.</u><br>
I want <u>to live my life from day to day.</u><br>
I'll have to <u>work and I'll have to pay.</u>

verse 2:

I need to learn, I need to feel.

I know I can, I want to make happiness real.

When I think back, I feel sorrow and I feel pain.

But now I feel different. It's time to change.

I hope to be happy and never be sad.

When I leave here I'll try the best that I can.

I'll use my time to love and I'll use my time to feel.

Example 2: (to the tune of It Came Upon A Midnight Clear

verse 1

I drank up all the everclear

I toked upon the bong

I partied every day and night

And that's where I went wrong.

I wrecked my car, I went to jail

From heaven the message came,

To change my life completely,

I'd no longer be the same

verse 2

I went to seek the help I'd need
To live life day by day
To give up booze, the pot, the drugs
And try a sober way.
To help with all the suffering
And find life has more to give
And live my life soberly,
That's the way I want to live.

Freed notes the importance of providing recovering clients with "pleasurable nourishment that comes through the senses...[Although] consistent and prolonged drug abuse diminishes the degree of euphoria" (Freed, 1987, p.13), recovering substance abusers committed by the treatment goals to lifelong abstinence may see the future as unbearably bleak without any promise of the kind of euphoria they used to seek. Now, as in the latter days of their active using, they may feel that meaning and enjoyment are lost to them forever, and providing them with pleasurable and meaningful aesthetic experiences during treatment in the form of songwriting may restore their hope and be a welcome change from verbal therapy. Too, the emphasis of this approach on incorporating the AA/NA philosophy into the songs can help clients

internalize these principles in which millions of recovering substance abusers have found hope, health and transcendence. If Bill W., Victor Frankl, and Carl Jung were correct in supposing that an addict's cravings are actually the low level equivalent of the universal thirst for meaning, beauty and transcendence, then the value of this approach with regard to providing recovering addicts with a natural non-chemical meaningful and spiritual high is self-evident.

By incorporating into the songwriting and lyric analysis sessions the AA/NA philosophy, this approach provides an effective way of confronting denial in a non-threatening way. Admitting their chemical dependency and resulting powerlessness over their own lives as the first step in the recovery process and confronting their losses, regrets about past behavior and fears regarding the future through songwriting and subsequent analysis reinforces clients' acceptance of their addiction as a disease and their need for treatment and lifelong abstinence. A deeper understanding of the Serenity Prayer with its emphasis on changing the things we can (Alcoholics Anonymous, 1975) may be achieved by incorporating this concept into the lyrics or by discussion during the songwriting process, and this understanding may alleviate some of the overwhelming and crippling guilt that recovering addicts often feel before they have become able to

begin to make their amends (A.A., 1975). When feelings can be shared through the songwriting process, "the desperate need to share...with other persons who are truly accepting and understanding" (Freed, 1987, p.13) may make it possible for clients to access material previously repressed due to its painful nature, and the non-threatening yet powerful nature of symbolic or metaphorical responses to the use of the cloze procedure in songwriting may penetrate defenses in a way that words alone cannot.

This approach addresses the need to facilitate communication in groups of recovering addicts, so that they have a sense of being "united with others who really care" (Freed, 1987, p.13). When group discussion about the expressive content of the songs takes place, group members can offer suggestions for problems that have been presented, thus increasing self-awareness, enhancing socialization, and improving listening skills, all of which help to establish a sense of mutual sharing and rapport with the group and the therapists. Cloze procedures and writing new words to existing melodies encourage self-disclosure and interaction among group members, and an open and accepting attitude on the part of the music therapist can also help to establish trust and communication (Freed, 1987).

The enhancement of self-esteem is addressed by this

approach in that completing the songwriting task successfully and receiving validation from the other group members meets clients' needs to feel competent and instills confidence that they can gain recognition from others for their accomplishments. The songwriting methods described above make it possible for the songs to be written and performed easily in the group session, making possible immediate reinforcement for their efforts. In addition, the words themselves tend to reflect clients' feelings about themselves, as in the first example, Heart of Gold by Neil Young; verse one reveals the client's poor self-image, but as the song progresses to the second verse, it is evident that this person was striving to feel more positive about himself and therefore had motivation to change. "Processing the lyrics involved questions such as (a)What image would you like to have of yourself? (b)What specific changes do you need to make? (c)How can you make those changes? and (d)How can you build your self-esteem? As a result of lyric analysis, the substance abuser formulated short-term goals concerning self-esteem" (Freed, 1987, p.17). In addition, the incorporation of the AA/NA philosophy into the songs, with specific regard to steps 4,5,6,7, and 10 provides reinforcement for building self-esteem by allowing recovering addicts to slowly begin to face their shortcomings and with the help of their higher power, make

amends to those they have harmed, including themselves, thus making it possible for their wounded self-esteem to heal and grow.

## (ix) James (1990) Adolescent Values Clarification: A Positive Influence on Perceived Locus of Control

Despite the lack of a consistent empirical foundation in the chemical dependency literature regarding whether addicts possess an internal or external orientation (perceived locus of control), the consensus does exist that individuals having an internal orientation respond better to therapy (O'Leary, & Schau, 1975; O'Leary, Donovan & Hague, 1974; Phare, 1965; in James, 1990) and that the process of therapy itself in fact seems to promote an internal orientation (Obitz & Oziel, 1978; Rohsenow & O'Leary, 1978a in James, 1990).

Based on Rollnick and Heather's 1982 postulation (cited in James, 1990) that for rehabilitation to be successful, patients need to be dedicated to lifelong abstinence and to believe that they have the self-confidence and control necessary to achieve this goal, James formulated the theory that promoting adolescents to think in terms of an internal locus of control may enable them to begin to act upon their own value system rather than yielding to peer pressure and other social

influences (James, 1990) and that a new perception of an internal locus of control would promote confidence and self-efficacy in recovering substance abusers. As an initial step in evaluating this theory, which is in some ways a re-statement of Bandura's self-efficacy theory, James pilot-tested the ability of counselors to modify clients' perceived locus of control in the context of substance abuse education groups, using a pretest-posttest control group design and the null hypothesis that there would be no significant difference in mean pretest-posttest gain scores on the abbreviated IE (Internal-External) locus of control Scale between the experimental and control groups.

The sample population was a convenience sample of 20 adolescents currently admitted to a hospital unit specializing in treatment for chemical dependency. All participants had a primary diagnosis of substance abuse or substance dependency as defined by American Psychiatric Association (DSMIII, 1987). The sample consisted of 9 males and 11 females with a mean education level of 9.2 years and a mean length of hospitalization of 24 days.

The instrument of measurement used was the Abbreviated IE Scale of eleven forced-choice questions, for which the respondent is required to indicate which of two statements, one internal and one external, is closest to his views (see appendix B). The validity of this instrument is

documented by Valecha and Ostrom (1974). This abbreviated form of the original 29 item scale was developed to allow for evaluation of locus of control within a short administration time, an important consideration as this study was conducted in four one-hour sessions on Monday through Friday of the same week. In each session, subjects listened to a recorded popular song, analyzed its lyrics, and processed the themes/values suggested by the song. All sessions were conducted by a Board Certified Registered Music Therapist. A list of 15-25 questions outlined for each session served as a format for the processing discussions and was designed to help clients focus on their own values.

The rationale for this study is that by promoting adolescents to think in terms of an internal locus of control, they may begin to act upon their own value system rather than yielding to peer pressure and other social influences, since a study by Brook and Whitehead (1983) indicates that adolescent drug abusers do possess values similar to those of their parents and peers <u>not</u> using drugs.

Yates and Thain (1985) noted that clients who possess perceptions of internal control at the time of discharge from an addictions treatment program will have a lower rate of recidivism; consequently, James' study pilot tested the ability of counselors to modify clients' perceived locus of control

toward a more internal perception.

Subjects were randomly assigned to either the experimental or the control group. While the experimental group participated in the treatment sessions, the control group was provided with alternate activities consisting of occupational therapy craft groups to minimize the interaction of Hawthorne Effect (James, 1990).

Posttest data analysis was conducted on the gain scores between the pretest and posttest means for each group as documented by Campbell and Stanley (cited in James, 1990). The null hypothesis was rejected, as there was a significant difference between the mean gain scores of the experimental and control groups, reflecting a shift from an externally to an internally perceived locus of control.

On the basis of these results, as well as the results of Yates & Thain's 1985 study in which clients with a more internal locus of control at time of discharge reflect lower recidivism rates, James predicted that this method of positively influencing clients' sense of self-efficacy through activities which reinforce their current value system has the potential to be instrumental in preventing relapse in adolescents with chemical dependency.

James indicates that by using popular music familiar to the adolescents, improved attention span usually resulted in

the subsequent discussion groups (James, 1990) and he suggests that by guiding adolescents to be more discriminating in the music they listen to, counselors may be able to help them develop a healthier leisure lifestyle. Although this study does not directly address the first criterion, that of providing access to healthy, non-chemical peak experiences, it does lead clients to question the nature of the music they have enjoyed in the past and in this way draws attention to the fact that their choice of music may have been contributing to their perceived inability to cope effectively without resorting to the use of chemicals.

James notes that, in accordance with the principles of Values Clarification (Simon, Howe & Kirschenbaum, 1978) the participants were not lectured about values and self-control, but were allowed to state their opinions in a non-judgemental atmosphere with the group providing constructive feedback (James, 1990). This produced the non-threatening atmosphere necessary for facilitating access to repressed material (i.e., their own value system with which they may have lost touch due to peer pressure).

This study addresses the need to facilitate communication for clients recovering from chemical dependency by promoting group discussion, although as an example of passive or receptive music therapy it does not provide new nonverbal

avenues of expression as do the active methods. Nonetheless, since clients' familiarity with the popular songs chosen (Material Girl by Madonna, Flowers Are Red by Harry Chapin, Pressure and You're Only Human by Billy Joel) resulted in improved attention span in the subsequent discussion groups, the interest generated by the use of this method was doubtless a motivating factor for clients to communicate their thoughts, feelings, and ideas with each other, an important factor in any substance abuse recovery program.

The criterion most strongly addressed by this study is the need to enhance clients' self-esteem, defined in chapter one as belief in and respect for one's self. Clients learn, through the course of their therapy, that their strongest (if not their only) hope of recovery lies in a lifelong commitment to abstinence. If, however, they also believe themselves unable to follow through with this commitment, demoralization, self-loathing, anxiety, fear and guilt will result, all of which are destructive to self-esteem. If, on the other hand, clients leave the program with a belief in their own self-efficacy due to a new perception of their locus of control as internal rather than external, then they will have begun to develop "a positive healthy attitude [of confidence and respect] toward themselves and their recovery" (James, 1990, p.206).

## Three Additional Approaches:

The following three approaches, although they have not been suggested for use with chemically dependent clients, nevertheless meet the four criteria suggested by the preliminary literature review. They are therefore included with a view to adapting them for use with this population.

### (x) Bailey (1984) The Use of Songs In Music Therapy With Cancer Patients and Their Families

Bailey describes a music therapy approach with cancer patients and their families that addresses issues of "isolation, depression, tension, loss, grief and pain [and that provides] important means for support and tools for change" (Bailey, 1984, p.5). There are three stages in this music therapy process: In the Contact Stage, trust and a working relationship are established between the music therapist and the patient and family members. In the second stage, the Awareness Stage, the focus shifts from "other" to self, as the patient and/or family members, guided by the music therapist, begin to become aware of their own feelings, needs, and desires and become able to express themselves creatively. In the third and final stage, the Resolution Stage, "self-fulfillment and relief are

experienced as a result of processing issues, thoughts and feelings" (Bailey, 1984, p.6).

Bailey lists nine major themes which are addressed throughout the three stage process and which are reflected in the song content. Patients and families are provided with songbooks and songlists so that they can select songs which address their needs and issues.

In the Contact Stage, patients and family often begin by selecting songs about the world rather than about more personal themes such as reminiscence, relationships, needs and desires, feelings, or loss and death, which the music therapist may suggest as people progress to the Awareness Stage. In the final stage, the Resolution Stage, song choice themes usually elicit peaceful images and may reflect feelings of satisfaction, acceptance, or love. Such choices by the patient and family members often do not occur until after feelings of grief and loss have been processed in Stage two, the Awareness Stage. "Hope and pleasure are sustaining themes, often appearing throughout the three stage therapy process" (Bailey, 1984, p.10).

Bailey presents a diagramatic representation of the three stage therapy process; included are examples of songs for each theme:

## STAGES

| Contact | Awareness | Resolution |
|---|---|---|

### Themes and Examples of Songs

| Contact | Awareness | Resolution |
|---|---|---|
| **THE WORLD** | **REMINISCENCE** | **PEACE** |
| This Land Is | When You And I | Wherever You |
| Go | | |
| Your Land | Were Young | |
| Something to | Anniversary | My Way |
| Sing About | Waltz | |

**RELATIONSHIPS**
You've Got A Friend
Parents Are People

**NEEDS & DESIRES**
I Want to Go Home
Take Me Home, Country Roads

**FEELINGS**
It's Allright to Cry
People

**LOSS AND DEATH**
Honey
Danny Boy

**HOPE** and **PLEASURE** are sustaining themes and occur throughout the therapy process.

**HOPE**:How Great Thou Art
His Eye Is On the Sparrow

**PLEASURE**: I Believe In Music
Going To The Zoo

In the case of Peter, a 21 year old man diagnosed with testicular sarcoma metastasized to the lungs at Memorial Sloan-Kettering Hospital, songs were used to improve family patterns of communication, promoting expression of feelings and thoughts, and reducing anxiety.

Although Peter had requested music therapy, he seemed anxious in the first session and allowed his mother to do most of the talking. The music therapist, with guitar as accompaniment, asked Peter, his father and his mother to select songs from lists and songbooks provided, and to sing along. However, Peter's parents made disparaging remarks about his singing ability, confirming his own claims that he could not sing. "The parents chose 'Day by Day' which expresses prayers for closeness to God, and Peter requested 'Let There Be Peace on Earth', a song which globally expresses desire for peace and harmony. Before the therapist left, Peter told her about a song that he loved and wished she knew, a song that a friend of his had written. Again, he insisted that he could not sing it" (Bailey, 1974, p.12).

In the next session, the therapist sat closer to Peter and asked him to try to sing his friend's song that he loved. Peter did so, and "after several attempts, the therapist found the melody despite Peter's rather unmelodic singing" (Bailey, 1974, p.12). As Peter and the therapist sang together, Peter became

"relaxed and calm [and seemed] energized with excitement" (Bailey, 1974, p.12) as his mother watched, smiling. After this, Peter gradually became less inhibited and participated more readily. The friend's song was sung often, and when, several weeks later, Peter had to be re-admitted, he began to write his own words to familiar melodies in order to express his anger, disappointment, and sadness over being back in the hospital.

As Peter began to take charge of the music therapy sessions, his mother began to treat him with respect and admiration, no longer calling him 'Klutz' as she had initially. She told him that she'd love to hear him sing in German, which he did, and Peter's father became less passive and began to look through song books. He requested songs that were meaningful to his past, and he and his wife reminisced together. "This awareness stage of the music therapy process consisted of musical expressions of memories, thoughts, and feelings. Changes occurred. Each family member showed signs of diminished tension and anxiety. Also, each began to function independently in the sessions and the interactions were more positive. It seemed also that the parents experienced relief as a result of observing Peter's release of tensions and concerns" (Bailey, 1984, p.13).

When Peter was discharged, he and his mother wrote a song together entitled 'King Tut', which was "their symbolic

way of dealing with his nearing death [and which] the music therapist recorded for them [when he was again re-admitted]" (Bailey, 1984, p.13).

Just before his death, he "requested the therapist to sit near him and sing 'King Tut' and 'My Way' (And now, the end is near...I did it my way), important sources of support for him during this time. Peter's mother and father also experienced peace and relief during this stage of the music therapy. They heard Peter accepting his impending death and expressing thoughts about having 'lived a life that's full...[in] my way'. They shared joy and intimate closeness in the days before he died (Bailey, 1984).

Although songs, in this case study, were used to help a patient and his family to accept death, many of the emotions and processes they went through were not unrelated to those in the recovery process of chemically dependent clients. Bailey's approach addresses the same needs - for natural, enjoyable and meaningful peak experiences, access to repressed material, improved communication, and enhanced self-esteem- that the approaches to chemical dependency treatment address.

Bailey notes that Peter became "energized with excitement"(Bailey, 1984, p.12) when he suddenly found himself able to sing a song that he loved and which held special

meaning for him. She cites James and Jongeward (1971) in referring to this experience as nurturing the "natural child energies" which can be "channelled into creative and self-fulfilling expression...[as a result of] processing issues, thoughts and feelings [once] the releasing nature of music therapy sessions...where sounds, words and vitality become one...enhances patients' and families' letting go" (Bailey, 1984, p.6).

The unique ability of songs to "evoke pleasing images and enhance joy" (Bailey, 1984, p.12) make it possible for this music therapy approach to "reawaken vitality and creative, life-expanding energies" (Bailey, 1984, p.16), thus providing recovering addicts with access to natural, non-chemical, enduring and meaningful peak experiences. It is significant that in a 1983 study which compared the effects on hospitalized cancer patients of live music singing and guitar playing to the effects of tape-recorded music of the same material, results measured by the Profile of Mood States (P.O.M.S.) questionnaire indicated the particular effectiveness of using live music to assist in relieving tension and promoting vigor, thought by Bailey to be due to the energizing element in live music which provides for a flow of energy from the nearby human body, human voice, and guitar to the listener (Bailey, 1983).

This approach addresses the need to access repressed

material in order to become aware of feelings, needs, and desires and to process these issues in order to experience self-fulfillment and relief. Because the use of song material in music therapy provides the therapist with melodies and words which stimulate emotion and cognition, sad or happy memories which have the potential to provide further insight into present problems may be triggered. Bailey notes that "patients may choose songs about relationships in order to process unresolved feelings of anger, guilt, or rejection (Bailey, 1984, p.9), but she also points out that "an individual may choose a song for pleasure purposes and then respond by feeling loss or grief [in which case] the music therapist's skillful and sensitive support are always important" (Bailey, 1984, p.8) in order that the messages within the songs be used to provide support for inner needs to process the loss and grief.

In the case of Peter, family patterns of communication seemed to reinforce the repression of feelings and thoughts. When the therapist helped Peter become unblocked, a "longing for balance seemed to be fulfilled as Peter, flowing with creativity and ventilating feelings within the music became more assertive" (Bailey, 1984, p.12-13), having found in the music a meaningful outlet for self-expression. Bailey notes that "whether people sing or listen, they respond internally" (Bailey, 1984, p.11) and it is this internal responding which gradually

allows people to unblock their energy and creativity.

This approach points up the strong relationship between the second and third criteria - accessing repressed information and improving communication. As patients find in the music a meaningful outlet for expression and are thus able to unblock their creative energy, channels of communication open up and meaningful human contact in relationships increases through the melodic verbal communication of the songs. "The use of song material in music therapy provides patients and families with melodies and words which stimulate emotion and cognition. Through songs, they can communicate their problems, their past or present unsatisfied needs or desires, their happiness, their loneliness. They can be reminded of sad or happy times which may provide further insight into present problems or which may take them away from their immediate discomforts. Through singing or listening to songs, they can learn or teach, can experience or re-experience events and feelings, can auditorially touch and be touched, using the human voice, an individual's most intimate means of self-expression, as an instrument through which to express feelings and thoughts and extend important parts of themselves (Bailey, 1984).

The theme of reminiscence is used to promote the re-establishment of communication between patient and family

members. Bailey notes that "it is common to observe a husband and wife reconnecting while listening to a song from their courting days" (Bailey, 1984, p.8) and in the Case of David, a 65 year old business manager, husband, and father who was diagnosed with a primary brain tumor and was neurologically impaired, the use of songs provided David, his wife and his son with a way of experiencing deep communion together as David, after a long period of minimal verbalization, was suddenly able to recall and sing the words to songs he'd once known and loved, so remarkably improved were his memory and verbalizations during the singing. This lyrical communication allows relatives to feel that they have a part in contributing to the pleasure and stimulation of their loved one, and this eases feelings of helplessness as well as diminishing the sense of isolation for both patient and family members.

Open discussion on the theme of loss often occurs after people have been able to acknowledge their personal needs, fears, desires and feelings, and this new openness produces a sense of closeness and trust leading to inner resolution and peace. Because the channeling and letting go of energy through the voice stimulates self-other awareness, relief, and relaxation, patients and families usually experience "diminished isolation and increased connectedness as a result of intimate communication by and between human voices"

(Bailey, 1984, p.11), responding internally, whether they choose at any given time to sing or listen, because songs "link feelings to thoughts, images to events and people to people" (Bailey, 1984, p.12). In the Resolution Stage of David's therapy, the song 'Beyond the Sea' (We'll meet beyond the shore/We'll kiss just as before) became a very special source of comfort and communion and allowed David and his wife to remain close and connected despite David's physical deterioration and impending death. Although recovering addicts deal with different kinds of losses, the resulting pain can nevertheless cause barriers to communication, and the sharing of pain, through song, in a positive way which enhances closeness and diminishes isolation could be an important factor in the recovery process.

As previously repressed emotions such as anger, fear or frustration begin to be acknowledged and expressed, the resulting self-assertiveness produces enhanced self-esteem. Themes of hope in the songs "awaken [peoples'] confidence in their own ability to succeed [and] seem to help sustain them through stressful events" (Bailey, 1984, p.7). Themes of reminiscence often enable people to "remember fortunes they have enjoyed, as well as misfortunes they have survived, a process which results in stimulating their often wavering self-concepts" (Bailey, 1984, p.11) and strengthening their sense of self-efficacy. Finally, the use of songwriting as a technique can

satisfy a variety of needs by promoting feelings of self-worth and self-respect and eliciting respect, admiration, and validation from others, resulting in achievement of the ultimate goal of personal wellbeing (Bailey, 1984, p.16).

### (xi) Hoskyns (1988) Studying Group Music Therapy With Adult Offenders: Research in Progress

Hoskyns describes the use of Kelly's Personal Construct Grid (Kelly, 1955), a qualitative method of assessment which takes into account the "complex and often elusive data presented in this field" (Hoskyns, 1988, p.25) in evaluating the benefits of music therapy in a program with a group of adult recidivist offenders at the London Day Training Centre (D.T.C.). The aim of the Centre is to offer responsibility back to the clients and to help them realize that they can make an active choice not to offend (Hoskyns, 1988), and the use of Personal Construct psychology as a measuring device addresses the need for methods that "reflect the episodic changing and multi-dimensional nature of experience" (Hillman, 1975, p.3).

Hoskyns notes that "there seems to be a consensus that there is a vital need for research in music therapy...but not at the expense of the quality of interaction between people involved in the music therapy session itself" (Hoskyns, 1988, p.26). The rapid growth in the number of experimental studies

in the United States may reflect the increased use of recorded music, but Hoskyns points out that "many of the processes in music therapy are non-verbal, emotional, subjectively perceived and therefore difficult to generalize and may show their effects...perhaps months after the music therapy finishes. Measuring the processes and effects can therefore prove a confusing and frustrating exercise" (Hoskyns, 1988, p.26). The exploratory action research used by Hoskyns is based upon Kelly's suggestion that one of the most useful rules for a clinician to observe is that "If you don't know what's wrong with a client, ask him; he may well tell you" (Kelly in Hoskyns, 1988, p.25). Leslie Bunt (1988), with whom Hoskyns has collaborated, suggests that "although outcome studies help to further the music therapy profession's external validity, by the very nature of their design, they do not add much to our understanding of the processes by which the outcomes are reached...One possibility is to explore the potential of self-evaluation, encouraging clients to itemize the central aspects of the music that may have had any effects...Reporting clients' statements verbatim can provide a rich source of information that can be a starting point for further investigations" (Bunt, 1988, p.7).

Personal Construct Psychology allows the clinician and client to collaborate in identifying constructs special to the

client's own view of the world. It is flexible enough to allow music therapy sessions to take their natural course, and can be used as a means to elucidate and reflect on the sessions after they have happened...which has practical and ethical advantages (Hoskyns, 1988).

The music therapy sessions in Hoskyns' study took place one afternoon per week (Friday) for one and a quarter hours throughout the twelve week program. The sessions were optional, but clients were expected to maintain a regular commitment to the group having once chosen it. The group was small, consisting of between three and seven members in addition to the therapist and a student assistant. The sessions were primarily active and non-verbal, in contrast and complement to the largely verbal content of the morning groups, and clients had "opportunities to try out personal approaches and behavior which they have reflected on in the morning sessions. The whole group (including staff) improvise on a range of tuned and untuned percussion instruments, some more unusual ethnic instruments, drum kit, piano, and accoustic guitars. Some discussion often occurs as a result of completing an improvised piece, particularly if the music has been taped. Group members are not expected to have had any experience of playing music prior to joining the group, although some have done so before" (Hoskyns, 1988, p.30-31). Hoskyns

indicates that her own therapeutic role is to be as client-centred (Rogers, 1951) as possible while maintaining the boundaries of the session, and that this usually involves structuring the activities in the early stages and then gradually allowing clients to take a more active role in decision- making, organizing and commenting during the sessions.

Hoskyns interviewed both staff and clients over a period of a year, and from these interviews, trends began to emerge. The staff were interviewed first regarding their opinion of the aim of the D.T.C., the changes noted in clients after twelve weeks at the Centre, the criteria they use for assessing progress, their opinions of the effect of music therapy on clients, and their beliefs about clients' opinions of music therapy. Out of eight staff members, at least half responded that they felt music therapy fostered self-responsibility, made clients calmer, enhanced group cohesiveness, produced a sense of achievement and satisfaction which made clients feel they had something of value to offer the group, and helped clients work out their feelings safely in a nonverbal way (Hoskyns, 1988).

When the clients themselves were interviewed, they were asked if and how music therapy had helped them, what if any misgivings they had about the group, and whether they thought they had been helped with specific regard to offending.

Although thirteen of the fifteen clients interviewed responded that music therapy had helped them in some way, only six of these felt they had been helped with specific regard to offending. Eight clients felt being part of a group was helpful, which was consistent with the staff's responses. However, fewer than half mentioned a feeling of relaxation or achievement, and those who did revealed no details as to what made the music therapy relaxing or how it fostered feelings of achievement or group cohesiveness. Hoskyns concluded that the questions had been too general and that a more indirect approach to this inquiry which would focus on the process of the music therapy itself was needed (Hoskyns, 1988).

Hoskyns decided to videotape a music therapy session, which could then be used as material for self-evaluation and which would allow access to more "emotive introspective information" (Hoskyns, 1988, p.34). A group of three clients watched two filmed excerpts (one early and one late) from a music therapy session which had just occurred one hour previously. Of the three respondents, two commented extensively while the third said very little. Their commentaries were transcribed, and all of the new ideas from the three group members were noted down and made up into a list of music therapy events. From these, a total of fifteen events were extracted; these became the elements of the music

therapy sessions and were then rated over five bipolar constructs on a scale from 1 to 7.

The bipolar constructs were obtained by interviewing group members individually after the second of twelve sessions with regard to what they felt music therapy is about. A research assistant who did the interviewing noted down the individual comments, and each group member chose from this summary two things which seemed most important. These ideas were then made into bipolar constructs by "nominating the opposite to each chosen idea" (Hoskyns, 1988, p.37). For example, one person described frustration, and the bipolar construct therefore became frustration-satisfaction. The first two constructs on the grid (see appendix A) were provided by the researcher, but only after the client had selected three for himself based on the interview. Of these three, two pertained to music therapy, while the third was specifically related to his/her individual contract at the Centre.

Ratings were completed twice, once in week four (Tl) and again in week eleven (T2) in order to assess consistency. To encourage specific details, clients were asked to substitute their own ideas for the more general elements. For example, "taking a risk" was replaced by "playing solo" in one person's grid.

Although a number of clients participated in the music therapy sessions and began grids, only three actually

completed them. The grid shown in Appendix A belongs to a client in his early twenties with eleven previous convictions relating to drug and vehicle offenses. His attendance and involvement was good, and although he had erratic swings of mood, Hoskyns considered him energetic and motivated and felt that he "made good use of music therapy to contain himself and to put over his very volatile feelings" (Hoskyns, 1988, p.37).

The grid was studied by Hoskyns and a number of observations were noted. The largest changes from T1 to T2 over all the constructs seemed to be for the elements: taking a risk, organizing the piece, keeping quiet, starting something new, and not taking notice of others. "Generally, he seemed to rate himself more positively in these areas on the later scoring (T2), suggesting that he felt more autonomous and independent in his actions" (Hoskyns, 1988, p.39). Hoskyns also notes that

> some elements seem strongly linked by the consistent pattern in which they are rated. For example, 'losing myself in the music' is rated almost identically with 'letting off steam'. Another matched pair are 'keeping the beat' and 'playing an instrument that makes people listen'. All four elements are rated similarly from T1 to T2 and all are considered to be at the positive end of each of the constructs. In other words, this person

consistently enjoys doing them and thinks they are good for him. They provide satisfaction, and he understands the music and himself while he is doing them. It is interesting to me as a therapist that this person seems to focus positively himself on the same points that I considered important (i.e. he contains himself in music therapy, keeping the beat, but also discharges his energetic, erratic feelings, letting off steam/making people listen.
(Hoskyns, 1988, p.39)

In several cases, ratings were made at T2 but not at Tl, suggesting that as the sessions progressed the client began to see links where he previously had not.

The biggest leap in any of the ratings from Tl to T2 in the client grid shown in Appendix A was from not understanding music (6) at Tl to definitely understanding it (l) at T2. This surprised Hoskyns, because the group generally seemed more concerned with expression, relaxing, and feeling confident than with the music itself. However, Hoskyns notes that in several places on the grid, 'understanding music' was rated positively in exactly the same way as 'understanding myself', a significance which Hoskyns admits she probably would not

have thought to examine had not the grid highlighted this issue.

Because Hoskyns' article is a description of a research process rather than of a specific approach to music therapy, it really cannot be discussed with respect to the four criteria generated by the preliminary literature review in quite the same way as the other approaches have been discussed. However, it is included because it is this author's opinion that the process of collaboration between the therapist and client in identifying the constructs special to the client's own view of the world contributes positively to the music therapy process as a whole, particularly because the collaboration occurs while the music therapy sessions are going on. The central assumption of Kelly's theory that "every human is their own scientist, continuously engaging in the personal research of understanding" (Kelly in Hoskyns, 1988, p.25) holds the key to the power of this approach to research. Because music therapy is concerned with sharing private worlds which are difficult to describe, Personal Construct Theory is a "convenient way of gaining access to these private worlds because researcher and subject are sharing the process of construing" (Hoskyns, 1988, p.29-30). It is the sharing of this process that allows the research to influence the therapy and vice versa, so that the program as a whole is continually being modified and

strengthened as it evolves, due to the constant stream of feedback from clients to therapist. Thus, with regard to the four criteria generated by the preliminary literature review, this study will be discussed in terms of the interviews with staff, the completed grid of one client, and the observations of Hoskyns, the author, who believes that "the subjectivity of this approach is its strength" (1988, p.40) because it makes it possible to see how one person subjectively perceives music therapy and whether those perceptions change over time.

Based on the information in his personal construct grid, this client apparently found a natural high in the peak experience of being able to let off steam and lose himself in the music during improvisation, since these two elements were consistently rated at both T1 and T2 at the most positive end of the 7 point scale. In the initial interviews before the grids were prepared, a total of 13 out of the 15 clients interviewed responded either that music therapy helped by passing the time, by being something new to try, or by being relaxing (Hoskyns, 1988, p.33). The client whose grid was included stated that the music therapy "widened my brain", and another client who had replied that he did not feel that music therapy had helped him with regard to not offending nevertheless did say that "if you've already made the decision to stop offending, then it can help you realize there are things to help you pass

the time and to get a buzz out of" (Hoskyns, 1988, p.33).

In the initial interviews with staff, four out of eight people responded to the question, "What effects or changes, if any, do you observe in clients after music therapy sessions?" with the observation that "people have worked out their feelings in a safe way" (Hoskyns, 1988, p.32), and Hoskyns, from the personal construct grid, concluded that this client had focused positively on the same points that she considered important - i.e. containing himself in music therapy, keeping the beat, but also discharging his energetic, erratic feelings, and the relationship she noted between this client's positive ratings for understanding both himself and music at T2 suggest that accessing his own erratic feelings and having a safe place to discharge them may have led to insight and self-understanding.

A strength of the Personal Construct Grid approach is that the subjects were interested, willing, and able to use this method, which functioned as a bridge between the music therapy, where the main contact was not through speech, and the largely verbal content of the morning sessions. As such, this exploratory research method seemed to contribute to providing new channels of communication by encouraging clients to reflect upon their participation in the music therapy sessions and to define and express which elements they felt

benefited them particularly and which they felt did not. Certainly, the focus of an improvisatory approach to music therapy is on nonverbal communication, and one client responded affirmatively to the question of whether music therapy had helped him with the statement "It helped me to socialize" (Hoskyns, 1988, p.33), but it seems possible that the process of preparing the grid may also have contributed to improving channels of communication for some clients by promoting reflection, self-expression, and discussion about the music therapy sessions.

The initial interviews, both with staff and clients, suggested that in these music therapy groups, the therapeutic factor that Yalom (1985) considers most crucial in group therapy - the enhancement of self-esteem due to clients feeling that they have something worthwhile to offer the group- may have been operating. To the question "What effects or changes, if any, do you observe in clients after music therapy sessions, four out of eight staff members mentioned "clients having a sense of achievement and satisfaction ...feeling they have something to offer" (Hoskyns, 1988, p.32). This new awareness cannot be overemphasized in terms of its potential ability to help clients who are in treatment precisely because their actions have been harmful rather than beneficial to society. A new belief in their own ability to make a worthwhile

contribution, first in the music therapy session itself and then in the process of producing the grid, can be a powerful factor in the rehabilitation of people who may have felt they had nothing of value to offer, whether those people be prisoners or recovering addicts.

### (xii) (Kenny, 1982) The Mythic Artery

Kenny's approach to music therapy is consistent with the definition of therapy as meaning "any method of healing which seeks to alleviate suffering, develop potential and encourage rehabilitation...a broader meaning which has caused quite a lot of contraversy in traditional professional circles" (Kenny, 1982, p.2) more accustomed to using the most common interpretation of the word deriving from the Greek 'therapeia' which means 'medical treatment'. Kenny, however, points out that a second meaning of the Greek 'therapeia' is 'attendance', which means "being present...giving heed to...listening...waiting for...or directing attention to" (Kenny, 1982, p.3). It is Kenny's belief that while in the medical model, "the therapist does something **to** someone, attendance...concerns itself with intention, [implying] a mutual interchange, an alert, resourceful, caring vigilant patience and guidance, [representing] an attitude, a way of being" (Kenny, 1982, p.3). The task of the music therapist then becomes to match the therapeutic qualities of

music to attend to peoples' needs, to be a person of "good will and good intention" (Kenny, 1982, p.6) concerned with the issues of healing, a resource person and guide who provides musical experiences which direct clients toward health, wellbeing and wholeness.

In the preface to The Mythic Artery, Kenny describes her book as being "in a sense, paradox...an attempt to touch the essence of music in the fullness of all her healing powers, to describe that which cannot be described...[adding that although] words can never reach far enough into music to touch her essence...however, with the trying, our words will become more musical, our respect and wonder more absorbing, our understanding of music deeper" (Kenny, 1982, p.xiii). In the music therapist's attempt to learn to "perceive those attributes in music and needs in people which match and set us on the road to health" (Kenny, 1982, p.7), the concept or image of the mythic artery as a way of thinking about music becomes "an aid in our search for health [because it is an image that is] vibrating...full of life-giving nutrients...It quenches our thirst. It goes to and comes from the heart. It travels through all of time and contains the wisdom of the ages..."(Kenny, 1982, p.55).

Kenny addresses the problem inherent in attempting to evaluate and measure that which is not empirically testable, suggesting that "although some parts of man can be observed

and behaviors quantified, there are many parts of man which are difficult to observe but equally important when drawing conclusions about personality types, diagnoses, and learning...[and] statistical methods sometimes paint a superficial picture...ignoring the deeper levels of existence, the unique individuality of personalities which often pertains directly to difficulties in life" (Kenny, 1982, p.24). She cites the 1978 Task Panel For the Use of the Arts in Therapy for the President's Commission on Mental Health which stated that "the measurement techniques of present statistical methodology are not enough to capture the qualitative effective gains made through exposure to the arts...[adding that] the spiritual qualities of artistic experiences are vague and mystical, though equally valuable even though they are difficult to quantify" (in Kenny, 1982, p.26). Kenny emphasizes that "we must learn to heighten our levels of perception toward healthy activity [using] as many healing agents as possible, [encouraging] clients to experience these influences to the depths of their experience [and that] a music therapy session which taps into the Mythic Artery is a gestalt. There is no separating the complex aspects of the event or monitoring which stimulant has which effect [because in] most cases the effects are not immediately perceptible in behavior change, but rather constitute a deeper, soul-searching initiation for change

which may only become visible in the long-term results" (Kenny, 1982, p.56).

The 1978 Task Panel for the Use of the Arts in Therapy stated that "the arts, if presented in a setting of their own under the supervision and guidance of the creative professional, can provide the necessary opportunity for their inherent healing powers to support the innate strengths and integrity of the patient. If such a healing experience is made possible for the patient, he will carry the knowledge and strengths gained from the creative experience into the life he will take up outside the hospital" (in Kenny, 1982, p.17).

Kenny calls poetry "the music of the language...[sending] arrows through unnecessary semantics [and giving] permission to use words in different ways" (Kenny, 1982, p.99). She describes a music therapy session which requires very little instruction, in which patients are simply asked to "let the music come into your ears and out through your pen in the form of words... [noting that] even if the instructions do not say 'poetry', only stream of consciousness, poetry emerges" (Kenny, 1982, p.99). The following poem was produced by a patient as a result of listening to Samuel Barber's Adagio for Strings:

As a seed under the ground I felt alone,
darkness was all around and I had no friends.
Gradually as I sprouted out of the ground I
began to see how beautiful the world was.
I saw the sun it was warm and good, I saw
the trees swaying in the breeze, the clouds
rolling in the sky all of nature was so friendly
and it felt so good just to be there. (Kenny, 1982, p.108)

Kenny makes no attempt to analyze or explain the poem, or even to determine what effect its production had or will have on the patient. It is enough that it has been written. It is a tangible sign that the patient's creativity is a living, healing force for good and that it has been accessed by the beauty and power of the music. However, in terms of being an appropriate activity to use with recovering addicts, it may be advisable to examine Kenny's philosophy, as well as the patient's poem, with regard to the four criteria stated in the Purpose section of Chapter one.

Kenny suggests some healing qualities of music "which tie it so mysteriously to the human condition" (Kenny, 1982, p.3), the following of which seem to relate specifically to the four criteria.

With regard to providing natural, meaningful peak experience, Kenny suggests that music

-stimulates the emotions, intellect, and body

-transcends situational conflict

-satisfies the need for aesthetic fulfillment

-offers high motivational stimulation

-fulfills man's creative instinct

-is sign and goes beyond sign to spirit

-is an existential reality, a celebration of the moment, yet transcends time (Kenny, 1982, p.4-5).

The above qualities pertain to the power of metaphor, the awareness of meaning, and the "region of visionary irrationality in which the veiled secrets of art dwell, sensed but not understood, implored but not commanded, imparted but not yielding" (Hindemith in Kenny, 1982, p.53).

Frankl identifies man's search for meaning as "the essential ingredient in mental health or illness" (in Kenny, 1982, p.137), and Kenny observes that

> a great deal of illness, pain and suffering can be both endured and fought if a deeper meaning for this pain has been identified. ...a meaning which goes beyond analytical and intellectual interpretations and which touches...the soul of man, [adding that] ...the patterns in music reach these

> depths...[and] remind us of our connections to the whole of life, [an] aesthetic connecting which constitutes a step towards meaning in life (Kenny, 1982, p.66-67)

Jung, Frankl and Bill W., co-founder of A.A., believed that if the creative instinct, the thirst for beauty and meaning, is not properly channeled, it can be subverted into the craving for chemicals. Because it has the potential to fulfil man's need for beauty and satisfy his search for meaning, music can be an experimental ground in which to try out creative processes in order to find more constructive, healthful alternatives for adapting to the culture and expressing one's uniqueness. Music therapy sessions can provide a safe context and basic structure that is specific, reassuring, and supportive within which problems or illness can be given a concrete form through performance or expression, so that people may "identify with the healing elements of music and ritual and venture toward growth and transformation" (Kenny, 1982, p.82).

With regard to the second criterion, facilitating access to repressed material, Kenny suggests that music

-provides an opportunity for release through creation of symbolic form

-contains tensions which are metaphors of life
-acknowledges suffering and joy
-is a resource pool of images
-is a reflection of man and contains all his impulses
(Kenny, 1982, p.4-5)

When chemically dependent clients repress their negative feelings, they deny themselves access to their strengths as well (Strachan, 1990). Kenny refers to the "violet emotions...laughter, tears, awe and wonder, feelings of beauty and religious cravings" (Kenny, 1982, p.10). As recovering addicts begin to face their feelings of anger, fear, pain and loss, these "violet emotions" may also surface, and "self-actualization...often depends on a person's capacity to mobilize contradictory but mutually reciprocal qualities" (Kenny, 1982, p.15). The development of tolerance for and ability to work with paradox is necessary so that clients, rather than being immobilized by the tension of opposites in themselves, are challenged instead to grow through it. By acknowledging in themselves these depths of seemingly opposing feelings, clients may free up energy which has formerly been used in repression, "finding strength where there appears to be none, and re-sourcing one's self or touching one's source again" (Kenny, 1982, p.56).

With regard to the third criterion, improving communication, Kenny suggests that music

-communicates ideas and feelings beyond words

-reflects, dramatizes and focuses on positive or negative connections between people

-represents a pre-verbal or primitive level of communication and therefore broadens the possibilities for communication and eliminates boundaries

-is a place to come together

-provides a meaningful social context

-is a bridge (Kenny, 1982, p.4-5)

In her forward to Music, The Mythic Artery, Kenny states that "music is a primary avenue of emotional expression in all societies. In the act of creating music, there can be a truth in feeling that exceeds the spoken word, and there can be a freedom of response in both the giver and the receiver of a music message that allows music to be an ideal therapeutic tool" (Kenny, 1982, p.ix). Making or listening to music allows clients to express their feelings, which is "one large step toward healing, and they are shared, which is a second large step toward healing. This can take place through playing a classical or jazz piece, spontaneous music, or [as in the case of the poem included above, through] allowing a recorded piece to travel

through [us] to create our expression in poem, paint, clay, or dance. The technique does not make a lot of difference" (Kenny, 1982, p.59). The healing lies in the discovery that "you are not alone. You are not isolated from the ongoing processes of life. Others share the same fears and throughout time have experienced the same myths. This is the healing benefit of connections [and] music is a celebration of these connections" (Kenny, 1982, p.61). "It reminds us that we are not separate...We relate to each other through that which we share as humans. We come together through soul" (Kenny, 1982, p.139).

In terms of the fourth criterion, enhancing self-esteem, Kenny states that music

-is reassuring
-moves the whole man
-is profound
-transcends situational conflict
-provides a source of regeneration and renewal
-is a reflection of man (Kenny, 1982, p.4-5)

Kenny believes that

> Through aesthetic experience, it is possible for each man to find his own frame of reference for the universe. Through valuing beauty, one can find ways of absorbing strength from the world in which

one lives. In a music therapy session, the tunes or expressions may not always sound beautiful to a critic. However, the music therapist hears these expressions as profound representations of human experience. Through the profundity comes beauty - an artist's symbolization through sound of the basic elements which make up life experience - pain, sorrow, joy, sadness, loss, rebirth. If accepted with this attitude, such primitive expressions can form the foundation for a positive attitude toward life [and self] for a person disabled in any way [whether emotionally or physically]" (Kenny, 1982, p.79).

Through working together to create and experience beauty, synonymous in this case with truth as in Keats' Ode on a Grecian Urn, -"Beauty is truth and truth beauty" (Keats, 1925, p.236)- the client and the therapist find symbolic forms, patterns, shapes and textures in music and hear healing themes which transfer to life outside the music therapy session.

# CHAPTER 3

## Summary

The data obtained from the twelve approaches to music therapy presented in the preceding chapter suggest that music therapy may have relevance in the treatment of chemical dependency. Although the majority of the evidence to support the use of this form of therapy is anecdotal and based upon subjective report rather than empirical investigation, still the possibilities inherent in music therapy for providing healing and hope, two powerful elements in recovery, cannot be disregarded.

Of the three empirical studies presented, only James' hypothesis (1990) was confirmed in support of the efficacy of music therapy. In the two other empirical studies by Dyck (1984) and Wheeler (1985), the complexity of the variables and the problems inherent in attempting to define and separate them may have contributed to the results being less positive than anticipated. So, although James' study does provide empirical evidence to support the use of music therapy with chemically dependent clients, the majority of the data presented in this thesis is based on the subjective opinions and anecdotal experiences of

specific therapists and clients rather than on experimental evidence.

Because music therapy speaks to the sensitive, ineffable, spiritual side of us, attempting to define or reduce it to measurable elements may be counterproductive. An alternative method of approaching an assessment of its value is to pay attention to the experiences of individuals in order to allow the uniqueness of each different experience to become part of the texture of our own understanding of the potential of this treatment modality, using the four criteria introduced in Chapter One as a framework upon which to build this understanding.

T.S. Eliot wrote,

> We shall not cease from exploration
> And the end of all our exploring
> Shall be to arrive where we started
> And know the place for the first time (1963).

It is in this spirit that the four questions with which this thesis was begun will now be explored again in an attempt to synthesize and summarize the experiences of

the music therapists and clients presented in Chapter Two.

(i) Can providing enduring access to healthy peak experiences through music therapy facilitate recovery from chemical dependency by making the absence of mood altering chemicals less devastating?

Although the terminology varies from approach to approach, the idea that clients can find a new means of accessing experiences which they find meaningful and enjoyable without resorting to the use of chemicals appears consistently throughout all of the approaches. When people begin to experience good feelings as a result of participation in musical activities, they begin to feel hopeful that a life of abstinence does not have to be one devoid of joy, pleasure and meaning (Brooks, 1973; Murphy, 1983). Having used chemicals to alter their moods for so long, it is a pleasant surprise for them to realize that they do have access to another, healthier, and more enduring method of making themselves feel good, and this realization can lead to feelings of empowerment and increased self-efficacy (Dougherty, 1984; James, 1990).

Because chemical dependency affects people spiritually as well as emotionally and physically, there is a need, during the recovery phase, for experiences that help clients find a sense of meaning and purpose in their lives and which help them reframe the suffering and confusion they are experiencing into sources of opportunity for hope and growth (Adelman & Castricone, 1986). Because twelve step programs, a crucial part of the recovery process, focus on spiritual as well as emotional and physical healing, the use of music, with its unique ability to touch the spirit, can provide clients with a way of internalizing the principles of these programs (Freed, 1987), thus promoting "inner peace and acceptance" (Bailey, 1984) and what Miller refers to as "transformation...a renewal of the mind" (1970, p.138) .

(ii) Can music therapy provide catharsis and access to repressed material in order to facilitate new insight and understanding in clients recovering from chemical dependency?

Because the problem of denial is a significant obstacle to recovery from chemical dependency, there is an emphasis in treatment programs on confronting this defense mechanism.

The intensity of the verbal sessions can be relieved by the music therapy sessions, and the confidence clients feel when they have positive musical experiences can make it easier for them to participate in the other activities (Miller, 1970; Brooks, 1973). Songwriting can be used to help clients accept their addiction and their need for abstinence (Freed, 1987; Murphy, 1983) by helping to free them to express previously repressed or unacknowledged feelings. Emotional states can be elicited by nonverbal patterns in music improvisation, and blocks to therapy can be eliminated in this way (Murphy, 1983). Physical feelings of tension or even pain may be relieved by releasing muscular tension during music therapy sessions, and headaches or backaches which manifest themselves as a reaction to the verbal sessions have been known to disappear during or shortly after the music therapy sessions (Murphy, 1983).

The non-threatening nature of music therapy makes it possible for clients to participate at whichever level they feel most comfortable, even if they wish only to listen creatively (Bailey, 1984), and since success in recovery programs depends upon clients' voluntary attendance, this is an important consideration (Dougherty, 1984).

People with chemical dependency very often have difficulty accepting their emotions and, in fact, may have used chemicals as a way of avoiding dealing with painful feelings. In music therapy, it is possible to awaken and release repressed feelings of anger, pain, fear or grief through the musical activities, and when the healing value of tears and the courage it takes to trust others with them is emphasized, clients can learn new and healthier ways of dealing with their emotions (Dougherty, 1984; Bailey, 1984).

If talking about their feelings is difficult for clients, music therapy can provide an alternative in that self-expression can be initially nonverbal and then followed by a resulting increase in self-awareness, as opposed to the more traditional verbal approaches in which self-awareness is generally expected to preceed self-expression (Adelman & Castricone, 1986). In addition, the use of art activities together with discussion in conjunction with music therapy has in some instances been found to increase quantity of feelings elicited as well as quality of involvement in the session, thus providing another alternative way of promoting self-awareness as a result of self-expression (Wheeler, 1985).

Because music belongs to the realm of art, defense mechanisms such as denial, projection, and rationalization can be explored metaphorically or symbolically, a process which is

often less threatening for people than direct verbal confrontation and which, when it occurs as part of a group music activity, can result in less resistance due to its non-judgemental nature, thus minimizing as well as normalizing defense mechanisms (Adelman & Castricone, 1986). As well, the ability of music to touch the depths of feeling can make it possible to acknowledge both suffering and joy as co-existing as opposed to mutually exclusive states of being (Kenny, 1982; Bailey, 1984).

(iii) Can Music Therapy provide new avenues of communication through facilitating nonverbal expression for clients recovering from chemical dependency?

Because feelings of loneliness, isolation, and alienation are pervasive in chemically dependent clients (Strachan, 1990), an important treatment strategy is to facilitate structured group situations in which communication can thrive. Anyone who has ever sung in a choir, played in a string quartet, or enjoyed an instrumental jam session can attest to the strong sense of cohesiveness and rapport which exists as a result of a combined group effort to produce a finished product that represents at once a common group goal and a unique individual effort. There

is a sense of delving deep in order to access and share with others that which is strong and good and creative in one's self. In the process, bonds between members are formed which may be as deep and enduring as those formed as a result of a relationship based on extensive verbal communication. If this sense of participating in the shared goal of producing music that is meaningful, relevant and enjoyable can be fostered in a group therapy situation, the loneliness and isolation experienced by individuals recovering from chemical dependency can begin to be addressed and healed.

The metaphor of one man's note joining with all the others to produce a harmony which is greater than the sum of its parts (Miller, 1970) can be a powerful symbol, and if clients have a sense of this happening in their own groups, the cohesiveness and camaraderie they experience in the music therapy sessions can positively affect their work in other aspects of the recovery program (Brooks, 1973).

The emphasis is on shared experience, and for clients who find talking about their feelings initially difficult or distasteful, music therapy provides an alternative method of reaching out to others and of participating in a group activity (Hoskyns, 1988).

Clients who suffer from chemical dependency have often grown up in dysfunctional families in which communication has been unsatisfactory. These clients may have learned from a very young age that expressing hurt, fear, or anger is bad or unacceptable. Music therapy can provide a way of releasing these feelings safely in an acceptable way, whether through instrumental improvisation, song selection, or actual singing. A client who has trouble asserting herself in an abusive relationship may find tremendous relief in selecting the song "I Will Survive" (Now you felt like coming back and just expect me to be free/ Well I'm saving all my loving for someone who's loving me...Cause I've got all my life to live/ and I've got all my love to give/ and I'll survive!), and singing the song together with others may produce an added sense of empowerment as a result of group support, cohesiveness and understanding. Thus anger, expressed in a positive, constructive, assertive way can become less threatening, and as a result, blocks to communication may gradually be removed.

The use of a form of paradoxical intention (Frankl, 1968) may contribute to the enhancement of the group process. When clients are reassured from the outset that they will never be required to actively share, perform or do anything in

music therapy that is uncomfortable for them, this reassurance seems to have the paradoxical effect of making people **more** willing to share. When clients are assured that they are participating in a meaningful, valued way even if they only sit and listen actively and creatively, this seems to free them from the pressure to behave in any particular way, thus allowing them to be true to their inner responding (Bailey, 1984; Adelman & Castricone, 1986; Kenny, 1982).

Communication through music is not intended as a replacement for verbal self-disclosure but, rather, as a means of approaching it in a less threatening manner. Certainly, discussion in order to process the feelings which emerge as a result of the music therapy activities is desirable and is the ultimate goal, but for those who find this difficult, self-expression and communication through music may provide a welcome means of connecting in a meaningful way to members of their therapy group or even to family members, and can be a bridge between stages in the recovery process as well as between people (Kenny, 1985).

It is important to note that facilitating communication through music therapy may appear to be having a negative or detrimental effect on the group, while it may, in fact, be having a positive, therapeutic one in terms of the goals of the

recovery program. As feelings begin to surface and to be expressed, the comfort level in the group may go down, and clients may describe the session as difficult or even terrible, depending upon how strongly they have been conditioned to view the expression of intense feelings as unacceptable (Dyck, 1984). In this case, the therapist's attitude of acceptance and confidence that expression of these feelings, although sometimes difficult, will in the longrun prove therapeutic and can be crucial in helping clients to gradually accept and understand their own feelings.

(iv) Can music therapy enhance self-esteem in clients recovering from chemical dependency?

The return of self-esteem is a crucial factor in the recovery process (Strachan, 1990), for without self-esteem, few of us have the strength to endure the difficulties and disappointments of life. To help people come to believe that they are, at the core, worthwhile, basically good, trustworthy, competent and caring human beings is a most important goal of any chemical dependency recovery program. The fostering of respect for and belief in one's self (Webster, 1968) can be facilitated by the music therapy sessions if clients can be

helped to connect or perhaps reconnect with a strength or talent which can then be acknowledged by other group members and eventually by the client him/herself (Murphy, 1983). This can be accomplished by acknowledging each client's contribution, whether this be in the area of performing, songwriting, sensitive song selection for another client (Dougherty, 1984), or perceptive discussion and analysis of song lyrics (James, 1990). What is important is that clients feel that they are part of the group and that they have something worthwhile, valuable and uniquely their own to contribute (Yalom, 1985). This sense of achievement can carry over into other therapies, building ego strength and bolstering confidence (Murphy, 1983; Dougherty, 1984).

With certain clients, eg. women, blacks, the elderly, adolescents, native people) it can be beneficial to establish special population groups in which people feel freer to explore areas of particular concern and relevance to them. For example, elderly clients may find songs from their own era more meaningful due to their reminiscent quality, and women may feel more comfortable with other women if incest or abuse is an issue. Establishing a comfort level for clients in this way may be perceived as a gesture of respect which may in turn help them to respect themselves. In order to avoid a

sense of being placed in ghettos, however, all groups could periodically come together to share the gains they have made in order to be able to reach out to others and broaden their perspectives once they have begun to respect and believe in themselves as a valued part of their own special population.

If music therapy sessions are structured so that clients can come away from each session with a feeling of competence and achievement, self-esteem cannot help but be enhanced. It is crucial, therefore, that the activities be planned in such a way that clients **can** succeed in some way. Group songwriting methods involving cloze procedures or writing new words to familiar melodies (Freed, 1987), metaphorical approaches which incorporate art or drama with the music and which focus on inner strength and resilience (Adelman and Castricone, 1986), instrumental improvisation with pre-tuned instruments so that it is impossible to "do it wrong" (Kenny, 1982, Dyck, 1984), and sing-along sessions which draw on peoples' vast wealth of memories (Bailey, 1984; Dougherty, 1984) - all of these promote healing of wounded self-esteem and make it possible for clients to begin to believe that they can succeed in what they attempt to do, and this sense of self-efficacy can generalize not only to their other therapy sessions but also eventually to their lives outside the treatment centre.

Believing that they can remain abstinent is crucial to self-esteem, since without abstinence there can, in the majority of cases, be no recovery. For this reason, an essential part of the therapeutic process lies in helping clients believe in their own ability to determine and remain true to their values and convictions. Receptive music therapy, in which clients listen to popular songs and then discuss the values contained in them can be a way of helping people become aware of their own internal values as well as of external factors which may have caused them to behave in ways that were not true to their own belief system (James, 1990; Dougherty, 1984). When clients' perceptions of their own locus of control shifts to a more internal one as a result of group discussion of song content, their sense of self-efficacy can be enhanced, resulting in a stronger belief in and respect for themselves and for their own ability to succeed in their commitment to abstinence (James, 1990).

Because every recovery program constitutes a finite, time-limited period following which clients must then find in themselves and in their lives outside the treatment centre the strength and support to continue in their commitment to their recovery, the establishment of new interests which can become a source of sustenance, fulfillment, enjoyment and

renewal is essential (Strachan, 1990; Kenny, 1982). Unless there is some carry-over to their lives outside the treatment program, the gains that clients make will quickly fall away after the therapy ends. If, however, these gains can be carried over into activities which provide clients with a continuing source of regeneration and renewal (Miller, 1970; Kenny, 1982) and if, having found such a source in the music therapy sessions, clients can have the confidence to seek out similar activities **after** treatment, then the self-reflective loop will be closed (Yalom, 1985) as clients re-enter their world with enhanced confidence, self-esteem and belief in their own ability to succeed.

Many of the twelve steps of the AA/NA programs deal indirectly with self-esteem, and the fact that music therapy provides a way for clients to internalize these principles makes this modality a valuable adjunct to verbal therapy, since it is membership in the ongoing twelve step self-help programs which will ultimately determine the success of the client's recovery after the counselling comes to an end.

The twelfth and last step in the AA/NA program states: "Having had a spiritual awakening as a result of these steps, we tried to carry this message to others and to practice these principles in all our affairs''(A.A., 1975, p.18). The phrase "a

spiritual awakening as a result of these steps" points up the importance of clients being able to internalize these principles (Freed, 1987) and the compatibility of music therapy with this aim cannot be overemphasized in terms of its relevance to the treatment of chemical dependency.

# CHAPTER FOUR

## Conclusion

### A) The Confluence of the Optimal Treatment Approach to Chemical Dependency With the Four Criteria for Evaluating Music Therapy Approaches

Based on the data obtained from an analysis of the twelve approaches to music therapy presented in this thesis, it is the conclusion of this author that music therapy can have relevance in the treatment of chemical dependency.

A review of current theories of chemical dependency and approaches to treatment suggests that "a multifocused, integrative model provides an optimal way of maintaining flexibility to ensure success in treatment " (Brower, Blow & Beresford, 1989) by combining the advantages of the five single-focused models - moral, learning, disease, self-medication, and social- while at the same time avoiding their respective disadvantages (Brower et al, 1989). This multifocused or dual diagnosis model, which stresses the importance of a healthy treatment match between therapist

and client in order to avoid collusion with denial, seeks to address the following issues in the recovery process:

(i) moral and spiritual concerns
(ii) the problem of denial
(iii) interpersonal functioning and communication
(iv) understanding of chemical dependency as an illness in order to alleviate guilt while at the same time encouraging personal responsibility

It is this author's opinion that the twelve music therapy approaches included in this thesis address concerns that are consistent with those listed above and that music therapy can therefore provide a potentially relevant alternative or adjuvant method to traditional verbal therapy of addressing these issues.

The need to find a new sense of meaning and source of enjoyment without resorting to the use of chemicals is consistent with the need to focus on moral and spiritual concerns, and music therapy provides a way of accomplishing this aim in a non-judgemental, non-blaming way. Denial may be confronted metaphorically through music or song selection which mirrors clients' emotional needs yet allows them to

gradually become aware of these needs themselves as opposed to directly confronting them before they may be ready. Music therapy also provides a way for clients to connect with themselves as well as with each other without the need for talking, at least initially. Lastly and perhaps most importantly, the easy incorporation of the principles of the twelve step recovery programs into the music therapy approaches makes possible the internalization of these principles by the client, thus contributing to heightened self-awareness regarding the need for treatment and abstinence, enhanced self-esteem resulting from a deeper understanding of chemical dependency as an illness, and a heightened sense of self-efficacy with regard to their own commitment to recovery.

## B) Three Music Therapy Approaches Not Specifically Intended for Chemical Dependency and Their Relevance to the Treatment of this Population

Although Bailey (1984) worked with terminally ill clients, Hoskyns' study involved male recidivist offenders (1988), and Kenny's "Mythic Artery" (1982) addressed the concerns of people with varied problems and conditions, it is this author's opinion that each of these three approaches could be adapted for use with a chemically dependent population.

Bailey uses the releasing nature of music to soothe and energize in order to access the natural child energies, to evoke pleasing images, enhancing joy and re-awakening vitality and creativity. By using the verbal messages within songs to support inner needs and help clients process loss and grief, she helps them give themselves permission to feel their own feelings, providing support for unresolved issues and meaningful outlets for self-expression. She helps clients find a new sense of connectedness within themselves and to the world so that they can auditorially touch and be touched, providing a framework for enhanced communication and diminishing feelings of isolation. And she helps patients discover new confidence in their own ability to give and receive through the selecting and sharing of songs that are precious and meaningful to them and others, thus enhancing self-concept, self-esteem and self-respect.

Hoskyns (1988) provides an opportunity for people who feel they have little or nothing to contribute to feel that they are capable of participating in a shared music experience in which something meaningful is created - an experience in which there is a sense of becoming part of a whole which is greater than the sum of its parts, and of coming to a deeper self-understanding through participating in this greater whole. Socializing as a valued part of the group, as well as feeling that

not only their musical contribution but also their opinions and insights regarding the group process are worthwhile and important, have the potential for enhancing self-esteem as well as improving communication.

Lastly, Kenny's holistic approach, in which she begins by labelling her own attempt to describe that which cannot be described as paradoxical, focuses on the client's wellness, believing deeply in their creativity as a living, healing force for good that can be accessed by the beauty and power of the music. Her approach draws on the power of music as metaphor to stimulate, transcend, satisfy aesthetically, motivate, fulfill, celebrate, and ultimately, to go "beyond sign to spirit" (Kenny, 1982, p.3). By acknowledging both suffering and joy, music, a resource pool of images, becomes a reflection of all of our impulses, thus making it possible for people to acknowledge and accept their own feelings, freeing up energies formerly used in denial in order to help them access their own strength. The ability of music to communicate ideas and feelings beyond words and to strengthen connections between people makes it an important avenue for self-expression and communication, and the regenerative and renewing qualities of music make it possible for people to "find ways of absorbing strength from the world through valuing beauty [in music] (Kenny, 1982,

p.79) and through learning to perceive, in this beauty, their own reflection.

In summary, these three approaches to music therapy, although not specifically intended for use with chemically dependent clients, are nonetheless consistent with the goals of the optimal multifocused treatment model for chemical dependency (Brower, Blow & Beresford, 1989) as well as with the four criteria by which the music therapy approaches specifically intended for use in the treatment of chemical dependency have been evaluated - namely, providing access to non-chemical peak experiences, facilitating access to repressed material, improving interpersonal communication, and enhancing self-esteem.

### C) The Inter-relatedness of the Four Criteria

The ability to access meaningful experiences without the use of chemicals, the facilitation of access to repressed material, the improving of interpersonal communication and the enhancement of self-esteem do not constitute separate entities in the recovery process but, rather, are intricately linked and dynamically interconnected. They have been discussed separately in order to clarify and analyze these aspects of the recovery process but, in reality, are inseparable one from the

other in that an improvement in one area affects all other areas, and the reverse is also true. In each of the twelve approaches, with the exception of Wheeler's (1985) and Dyck's (1984) empirical studies, a sense of enjoyment of the music experience positively affected clients' ability to access repressed feelings, to express these feelings, and to feel better about themselves. The process seems to have been cyclical or spiral in nature rather than occurring in any consecutive or chronological order. In other words, all four criteria worked together to enhance each other, although it seems likely that experiencing something enjoyable and meaningful together (the first criterion) may have occurred first, thus initiating the process.

Once the process was begun, however, in each case the effect was spiral in that improvement in one area seemed to affect all other areas. For example, an experience of meaning or enjoyment as a result of a musical activity may help a client feel less anxious about the quality of her life without drugs. As a result, the client is able to face the necessity for abstinence and treatment. She verbalizes this newfound awareness and her honesty and perceptiveness are reinforced by others, thus enhancing her self-esteem. In the next music experience, the client is more open because she feels better about herself. She allows herself to experience her feelings more deeply,

acknowledging anger and pain. Because of her enhanced self-esteem and a new hope that she does not need to be cut off from pleasure and meaning, she does not feel overwhelmed by the pain she experiences, but rather finds the strength within herself to acknowledge and express these feelings. She is commended by the group leader and other group members, and so experiences healing and hope. This gives her courage to go even deeper within herself the next time and with each new challenge that she meets, self-esteem increases. The healing occurs simultaneously, spiralling back and forth among the four areas, and it is this author's opinion that attempting to separate out the four criteria in order to measure or control them would be counterproductive. Rather, the goal is to provide experiences which are enjoyable and meaningful first, and then to allow the power of the experience to work in the client in whichever areas it can, with confidence that a positive, enjoyable, meaningful experience of music cannot help but have a positive effect on self-awareness, self-expression, and self-esteem, although not necessarily in that order.

## D) Drawbacks of Music Therapy

The greatest difficulty with the use of music therapy would seem to be in selecting activities that all members of the group can find meaningful, enjoyable, and within their capabilities, and it is this task which presents the greatest challenge for music therapists. The types of music therapy addressed in this thesis are

- receptive song therapy (James, 1990; Bailey ,1984; Dougherty, 1984)
- active song therapy (Bailey, 1984; Brooks, 1973; Dougherty, 1984)
- active instrumental improvisation (Dyck, 1984; Wheeler, 1985; Hoskyns, 1988; Miller, 1970; Murphy, 1983, Adelman & Castricone, 1986)
- songwriting (Freed, 1987; Murphy, 1983; Bailey, 1984)
- receptive instrumental music therapy (Kenny, 1982)

Several of the approaches involve more than one type of music therapy. For example, Bailey sings to patients (receptive song therapy), involves **them** in singing, (active song therapy), and also encourages songwriting. Murphy uses songwriting as well as active instrumental improvisation.

With regard to song selection for receptive song therapy, in which clients listen to and discuss the songs but do not participate in singing them, songs may be selected for the purpose of providing a forum for discussion rather than of producing a pleasurable peak experience. In active song therapy, however, the songs selected must be ones with which clients are familiar as well as ones that they enjoy and find meaningful. Inhibitions about singing may need to be addressed, and problems may arise if clients perceive the songs as either too difficult or as not sufficiently interesting or meaningful. In addition, clients may simply not feel like singing, either because of their emotional pain or because they have never enjoyed singing in the past. If this is the case, sensitivity and flexibility on the part of the therapist would be required in order to structure other music activities so that clients do not feel pressured to do something they are not comfortable with or ready for. This is a particularly important consideration since many chemical dependency programs utilize the team approach to treatment, in which all team members are encouraged to participate in all activities in order to promote maximum group cohesiveness within each team.

Active instrumental improvisation avoids the issue of song selection, but may encounter its own obstacles if clients

consider that the sounds produced are not really music (Hoskyns, 1988). This modality requires considerable knowledge, musical background and expertise on the part of the music therapist. Generally, clients are not required to have any particular musical background in order to participate, and this places the onus on the music therapist to structure the activities in such a way as to allow each client to maximize his or her potential, as well as to ensure that the sounds produced really do constitute music. Familiarity with and knowledge of the capabilities of all of the instruments (both tuned and untuned) as well as the ability to instruct clients effectively in their use are necessary attributes for anyone wishing to undertake this type of activity as a group leader, because if the clients do not feel that the end product of their efforts is worthwhile, the therapeutic value of the endeavour will be lost.

Songwriting as a technique has potential in that the songs are produced out of the clients' own experience and are therefore inherently meaningful for them. When undertaken as a group activity, the joint effort can foster a sense of group cohesiveness and achievement, particularly if the session is structured so that clients experience success, such as through the use of cloze procedures or the writing of new words to familiar tunes (Freed, 1987). The problem with this approach,

however, as with the active instrumental improvisation approach, is that the methods used to structure the procedure in order to ensure success may, in fact, be too limiting artistically so that the resulting composition may lack depth and authenticity. This approach too, then, places a heavy demand on the music therapist to be able to maintain the delicate balance of ensuring that the methods used to structure the activity do not preclude the depth and meaning necessary to make the songwriting experience a therapeutic one.

Receptive instrumental music therapy, in which clients listen to instrumental classical music, has the potential to evoke feelings and moods in response to the nature of the selection (Kenny, 1982). This technique requires less structure and less attention to individual taste in music, as clients are simply encouraged to allow the music to flow through them into whatever form of self-expression is agreed upon, eg. writing, dance, art, creative drama. In this approach, the music therapist trusts that the beauty and authenticity of the classical music will in some way touch clients' strength and creativity, and that the emerging work of art will be a reflection of that strength. Although personal preference in music and structuring of the session are less of a consideration in this approach, a great deal does still depend upon the music

therapist's ability to introduce the musical selection in such a way as to allow clients to benefit optimally from this experience. Another consideration is that it is almost impossible to predict which moods will be elicited by any particular selection, so considerable openness, flexibility, and trust in the process on the part of the music therapist is required so that the group members feel confident enough to allow their inner experiencing to flow freely.

## E) Concluding Remarks

On the basis of the data examined, it seems reasonable to conclude that:

a) The use of music therapy can have relevance in the treatment of chemical dependency, since the goals of current chemical dependency treatment programs are confluent with those of the music therapy approaches examined in this thesis with specific regard to the following four criteria:

   (i) Because of its unique ability to energize, to produce a sense of closeness and sharing in a group, and to facilitate the internalization of spiritual principles and the reframing of experiences of suffering into

ones of meaning, music therapy can make the absence of mood altering chemicals less devastating by providing recovering clients with enduring access to healthy, meaningful, drug free peak experiences.

(ii) Its non-threatening nature and ability to be used metaphorically to gently yet powerfully confront denial and promote self-awareness allow music therapy to provide catharsis and access to repressed material, thus making it possible to foster the development of new insight and understanding in clients recovering from chemical dependency.

(iii) Due to its ability to foster a sense of cohesiveness and camaraderie in a group, to provide a meaningful social context, and to act as a bridge between stages in therapy as well as between group members, music therapy can make available new avenues of nonverbal communication for clients recovering from chemical dependency.

(iv) By providing an opportunity for people to connect with a strength or talent in themselves which is subsequently acknowledged and appreciated by the group, this modality can help clients come to believe that they have something of value to offer,

thereby increasing self-efficacy and enhancing self-esteem.

b) There is evidence, although largely subjective and anecdotal, to suggest that other music therapy approaches not specifically designed for the treatment of chemical dependency may be adaptable for use with this population, particularly when the goals of the music therapy approach are consistent with the goals of current chemical dependency treatment programs.

c) The four criteria with regard to which the twelve approaches to music therapy have been discussed do not function independently of one another but are, rather, interrelated and work together spirally.

d) Although music therapy is a potentially valuable modality for the treatment of chemical dependency, its drawbacks in terms of the importance of selecting and structuring activities which can benefit all clients need to be carefully considered before undertaking to use this approach.

## F) Recommendations for Further Research

1. Action research is required to determine the efficacy of specific techniques and methodologies over time, using qualitative data obtained from clients and staff, such as Hoskyns (1988) collected in the form of personal construct grids, in order to provide insight into the processes involved.

2. The "instant music" technique developed in 1968 by Hall and Steele for the purpose of drawing an isolated individual into a group activity was used successfully in the work that Miller (1970) did with alcoholics at a Salvation Army Centre. The metaphor that "as one man's musical note is combined with those of the other men to form a musical chord, so it is hoped he will come to recognize his need for co-operation in life if it is to be harmonious" (Miller, 1970, p.137) seems to be the key to the power of this concept. Qualitative research to explore the inner processes that occur in group members as a result of this technique which enables people with little or no musical background to play music together after only one session would be valuable.

3. A consideration of the value of monitoring the use of music during free time by means of a listening room at a residential centre, as opposed to allowing complete freedom with regard to volume and listening time, would build on the findings of Brooks (1973) that the young people in the Awareness House program tended to misuse music as an excuse to avoid communication with each other when no restrictions were in place.

4. An investigation into the disappearance or reduction of physical symptoms (eg. headache, backache, etc.) following participation in music therapy sessions with clients in residential treatment would provide an opportunity for empirical research regarding the ability of music therapy to enhance physical well-being by providing an outlet for muscular tension resulting from participation in individual or group verbal sessions.

5. A comparison, before and after a course of music therapy, of client perceptions of the value of emotional expression would provide insight into the potential of music therapy to help people come to regard the expression of deep feeling as strength as opposed to weakness. A suggested method of measurement might be based upon Kelly's

concept of bipolar constructs (Kelly, 1955); clients could be asked to reflect upon what they consider to be their most emotional statement in each session, to note it down in private following each session, and to then rate it over a construct such as 'indicative of strength--indicative of weakness' on a scale from 1 to 7 (Hoskyns, 1988; Kelly, 1955).

6. The formation of special population groups in music therapy for blacks, women, the elderly, and native people was suggested by Dougherty (1984). Further study would be valuable with regard to the potential of this approach to enhance clients' respect and appreciation for themselves with specific regard to their own age, sex and culture. Careful attention should also be given to the question of whether participation in the special groups, as opposed to everyone meeting together, tends to have the result of making people feel 'ghettoized', and consideration should be given to possible ways of avoiding this potentially harmful effect.

7. With regard to the findings of Dyck (1984) that facilitating emotional expression among recovering alcoholics may have the added effect of decreasing

comfort level in the group, a study of the relationship between these two variables and possible methods of alleviating anxiety caused by the facilitation of emotional expression would be of value.

8. Research regarding the use of art in conjunction with music therapy to facilitate emotional expression would build upon the findings of Wheeler (1985) that quantity and intensity of expression were enhanced by the combination of these modalities.

9. Qualitative study of the effect of using a form of paradoxical intention (in this case, the option not to share aloud) on the quantity and frequency of emotional expression in music therapy groups for the treatment of chemical dependency would provide insight regarding the inner processes which may operate in clients as a result of the use of this strategy.

10. Follow-up study concerning the value of using structured songwriting procedures for the purpose of helping clients internalize the principles of the twelve step programs, and the longterm effect of this approach on clients' decisions to attend these programs on a permanent basis

after their therapy terminates would enhance understanding of the potential of the songwriting procedures described by Freed (i.e, writing songs to existing melodies and cloze techniques) to aid clients in "forming a personal philosophy which will improve the quality of their lives" (1987, p.18).

11. The development of anthologies consisting of specific categories of music which individual therapists have found valuable, together with suggestions for use, would provide a valuable starting point for therapists wishing to begin to integrate the use of music into their own approaches, and would be useful, as well, for music therapists looking either for new ideas or for corroborating rationale to support tried and true ones.

12. A qualitative study to determine which kinds of music, if any, clients recovering from chemical dependency have found most enjoyable, meaningful and relevant to their recovery process would provide useful information regarding the important process of selecting music to attend to the needs of people recovering from addiction. Anonymous or confidential questionnaires could be distributed at AA and NA meetings with the request that

members with a year or more of sobriety fill them out. These questionnaires would need to be carefully constructed so as to include comprehensive lists from which people could choose their favorite selections, and should also give ample opportunity for respondents to suggest choices which may spontaneously occur to them but which may not appear on the provided list. Alphabetical listings by title, composer and first line would facilitate recognition of special favorites, and categorization by theme and possibly by year of popularity would be useful for the purpose of jogging personal memories of emotional experiences associated with the songs.

13. Although the decision was made not to explore in this thesis the use of guided imagery with music, this subject should nonetheless be regarded as a potentially fruitful area of study.

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Appendix A

Sarah Hoskyns

Table 5
Music therapy grid

| Elements | Enjoy it/ Don't enjoy it | | Good for me/ Not good for me | | Frustration/ Satisfaction | | Understanding music/not understanding music | | Understanding myself/not understanding myself | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **T1** | **T2** | **T1** | **T2** | **T1** | **T2** | **T1** | **T2** | **T1** | **T2** |
| Music Therapy | 1 | 1 | 1 | 1 | 7 | 4 | 6 | 1 | 1 | 1 |
| Expressing yourself in music therapy | 7 | 7 | 7 | 7 | 1 | 1 | 6 | 7 | 2 | 4 |
| Doing the wrong thing in music therapy | 7 | 7 | 7 | 7 | 1 | 1 | 6 | 7 | 2 | 4 |
| Losing myself in the music | 1 | 1 | 1 | 1 | 7 | 7 | 1 | 1 | 1 | 1 |
| Starting something new musically | 2 | 1 | 4 | 1 | 7 | 7 | 2 | 1 | 4 | 1 |
| Getting fed up in music therapy | 6 | 7 | 5 | 7 | 1 | 1 | - | 7 | 6 | 3 |
| Keeping the beat | 1 | 1 | 2 | 1 | 7 | 7 | 1 | 1 | - | 2 |
| Not taking any notice of others | 7 | 4 | 7 | 7 | 2 | 4 | - | - | 4 | 4 |
| Playing an instrument that makes everyone listen | 1 | 1 | 2 | 1 | 7 | 7 | 1 | 1 | 2 | 2 |
| Keeping quiet in music therapy | 7 | 4 | 4 | 2 | 7 | 6 | 3 | 4 | 4 | 4 |
| Messing about in music therapy | 3 | 4 | 4 | 7 | 3 | 4 | 4 | 4 | 4 | 4 |
| Taking a risk in music therapy | 4 | 1 | 3 | 1 | - | 7 | - | 1 | 4 | 1 |
| Changing the beat | 2 | 1 | 4 | 2 | 6 | 5 | 2 | 1 | 2 | 1 |
| Organising the piece | 3 | 2 | 4 | 1 | 6 | 6 | 3 | 1 | 4 | 1 |
| Letting off steam in music therapy | 1 | 1 | 1 | 1 | 7 | 7 | 2 | 1 | 1 | 1 |

FORCED CHOICE QUESTIONS (Valecha & Ostrom, 1974)

A.1. Many of the unhappy things in people's lives are partly due to bad luck.

2. People's misfortunes result from the mistakes they make.

B. 1. In the long run, people get the respect they deserve in this world.

2. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

C. 1. Without the right breaks, one cannot be an effective leader.

2. Capable people who fail to become leaders have not taken advantage of their opportunities.

D. 1. Becoming a success is a matter of hard work; luck has little or nothing to do with it.

2. Getting a good job depends mainly on being in the right place at the right time.

E. 1. What happens to me is my own doing.

2. Sometimes I feel that I don't have enough control over the direction my life is taking.

F.1. When I make plans, I am almost certain that I can make them work.

2. It is not always wise to plan too far ahead, because many things turn out to be a matter of good or bad fortune anyway.

G. 1. In my case, getting what I want has little or nothing to do with luck.

2. Many times we might just as well decide what to do by flipping a coin.

H. 1 Who gets to be boss often depends on who was lucky enough to be in the right place first.

2. Getting people to do the right thing depends upon ability; luck has little or nothing to do with it.

I. 1. Most people don't realize the extent to which their lives are controlled by accidental happenings.

2. There is really no such thing as "luck".

J. 1. In the long run, the bad things that happen to us are balanced by the good ones.

2. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

K. 1. Many times I feel that I have little influence over the things that happen to me.

2. It is impossible for me to believe that chance or luck plays an important role in my life.