

*How to deal music?
Enhancing coping
strategies in music therapy
with clients suffering from
addiction problems*

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Abstract

This article describes some of the music therapeutic techniques that the authors use in their daily treatment as music therapists and observation practice with clients suffering from addiction. The article depicts the comparisons and differences between addiction problems combined with psychiatric and forensic ones.

The musical assignments stress the additional value of the action oriented methods of music therapy in comparison with verbal processing. A couple of key-aspects will be addressed such as: addiction, music (therapy), coping strategies, analogy, body-language. The two authors show their specific music therapy methodology, illustrated by examples from their practice in an addiction service respectively forensic psychiatric setting.

Introduction

Clients suffering from addiction are commonly known to encounter major setbacks and problems in their treatment processes. By listening to 'Brown Sugar' from the Rolling' Stones or Techno-House Music they

might start craving for heroine or XTC. Yet music is used in a therapeutic way to help clients with substance dependencies to combat their addiction. This article describes such a music therapy program tailored to clients with addiction problems, to tackle some of their major difficulties and specific impairments. The focus is behavioral, intertwined with a cognitive psycho therapeutic attitude to offer a client insight in his¹ behavior and the choice to make changes. Music is used as the powerful tool to encourage people to act (Hakvoort, 2002) and (unaware) show their coping strategies. It touches feelings of longing (sometimes even craving), pain, and pleasure. The bio-psycho-social model is the emphasis in the treatment of addictions. Music therapy addresses upon the underlying psychological and social problems. In this article the focus will be on enhancing coping strategies.

After explaining some of the theoretical backgrounds, we will describe the music therapy methodology. All this will be illustrated by examples of assignments and fragments from cases of the daily practice of both therapists.

View upon Addiction as guiding principal of treatment

This article makes use of different terms for addiction. Partly to distinguish between different stages of consumption (use, abuse, dependency, addiction) and partly to avoid using the term ‘addiction’ too often. There is also a distinction between narcotics (such as marijuana, cocaine, heroine, XTC, medical drug) and alcohol (including all alcoholic beverages). To describe all addictive substances (excluding Cigarettes) the term psy-

1. In this article the authors choose to use the masculine form. Wherever it says he, him, his, man, one can read she, her and woman as well.

choactive substances is used, to underscore their influence on the psychological perception and reaction of the consumer.

The use of psychoactive substances is widespread. Use can proceed to abuse and might turn to dependency or addiction. The way an addiction evolves is a multifaceted process, always changing and influenced by social attitudes. Formerly there was a major distinction between abuse of alcohol and narcotics. A phenomenon of the last couple of years is the poly-drug abuse, people using stimulating narcotics ('ice', cocaine) alternating with downers (heroin, benzodiazepine). The latest 'trend' is the addiction to alcohol and party drugs (such as XTC), especially for youngsters. Since addiction is a very complex problem, a single intervention will not yield any lasting result.

The Dutch Health Care Council (2002) reports addiction as an almost chronic illness of bio-psycho-social etiology. Apart from possible brain damage, many addicts are diagnosed with medical and psychiatric disorders, sometimes leading up to criminal behavior.

Most recent views about the treatment of people suffering from substance abuse derive from the idea that treatment can only help a person if there exists a tacit knowledge of the client; his physical conditions, his psychiatric and personality disorders, his life story, his personal and social functioning. If addiction is a progressive pattern of biological, psychological, mental, behavioral and social decline, then it can only be tackled by integrated treatment of social, cognitive, behavioral approach, combined with a medical, psychiatric one.

The bio-psycho-social model

In 1979, van Dijk published a model in the Netherlands, in which he described addiction as the result of a vicious circle of biological, psychological and social processes leading to addiction. Engel (1980) refined this into the bio-psycho-social model in which multi-dimensional models, derived from different etiologic theories were integrated. The attractive aspect of this model is that it does not only look into the problem of addiction from different diagnostic angles, but offers the opportunity to focus on the relatedness of the different aspects. The assumption is the hierarchy that runs from the smallest systems in an individual (atoms, molecules, cells, organs) to the biggest ones (relations, families, environment, society, culture). The client lives on the crossroads between biology and social context.

The bio-psycho-social model (BPS) organizes the possible interventions that could make up the treatment of clients with problems caused by abuse of narcotics. The advantage of BPS is that it offers a lot of leads for multi disciplinary treatment. Music therapy is just one of the instruments in the treatment of this complex illness. Since the focus of music is on (physical) action, coping, interaction, communication and emotions, it should specifically address the social and psychological components of addiction disorders.

Many of the clients are diagnosed with additional personality pathology, apart from their addiction (Minkhoff, 2001). Most characteristically they depend on restricted and rigid coping mechanisms, which limit their interpersonal relationships (de Jong, van den Brink, Harteveld & van der Wielen, 1993; Verheul, 1997). The addiction itself and the addictive negative influence on behavior are strongly linked to these behaviors. The

incapability of handling adequate coping strategies seems to be the trigger and risk factor of substance abuse. (Dijkstra & de Jong, 2003)

COPING

In this article the term coping is used as defined by Lazarus and Folkman (1984): Coping is the manner in which a person reacts (cognitive, behaviorally, and emotionally) to a situation that demands adjustment. Within this context, substance abuse has become an inadequate coping behavior.

The description of coping by an unknown author (2002) gives a glimpse of the authors ideas about coping: People react differently if they have to cope with problematic events. The way a person reacts depends upon his character and the severity of the problematic situation. Each person copes with a situation in his own unique way. Research has shown that disorders MIGHT evolve from long-term or regular exposure to severely problematic situations (Barrett, Doebbeling, Schwartz, Voelker, Falter, Woolson & Doebbeling, 2002).

There are many possible factors contributing to the manifestation of physical and mental disorders. An important factor is the unique way in which an individual observes, interprets and reacts. Every person makes his own judgement of a situation. This determines whether an encounter has been stressful or not. After the judgement followed by the reaction, the coping.

The efficiency of the reaction is determined by situation (duration, context, person, etc.). Therefore it is impossible to set a standard for effectiveness of a reaction. In other words: Adequate coping is situation-related. Coping strategies depend on a situation and the stress that appear out of the circumstances. A coping strategy that might be successful at one moment is unsuccessful in another. If the same kind of coping strategies reappear in different situations, it is called coping style. If a person

always uses this coping style in strongly differing situations, the coping style is described as rigid.

The Utrecht Coping List (UCL by Schreurs, van de Willege, Brosschot, Tellegen & Graus, 1993) categorizes coping behavior in four major groups:

1. Situation oriented behavior (confrontation, evasiveness, no action → changing the problematic situation)
2. Perception influencing behavior (optimism, accepting, compliance, pessimism, devastation → changing ones reaction by influencing observation and interpretation)
3. Arousal reducing behavior (→ eliminating or diminishing uncomfortable feelings, for example by using substances such as narcotics and alcohol)
4. Expression of emotions

Substances might be used for different coping styles. The use of psycho-active substances can be a coping strategy used to reduce arousal. Another person might use drugs, to confront a situation he otherwise might not have been able to challenge. Yet another might use substances to be more able to express his feelings or to accept an ‘unchangeable’ situation. But being ‘stoned’, increases the feeling of inadequacy to act. It increasingly undermines feelings of control and self-respect. Clients show improvement if they can develop their behavior repertoire, which encourages their feelings of self-esteem, self-respect and satisfaction.

Music and body language

Music therapy offers major possibilities to improve and develop coping strategies. Clients have to learn how to deal with (their) emotions, impulses and interactions with other people (Smeijsters, 2000). Music-making forces clients to act. In the action many of their coping styles become visible and audible. If a client is able to get a cognitive hold on

these strategies, he might try out alternatives. The assignments given to clients work on the principle of analogy (Smeijsters, 1992, 1993). The basic assumption of analogy is the idea that musical behavior shows major similarities with personal behavior. The analogy process theory, as described by Smeijsters, assumes that actions performed during a specific situation mirror the way a person acts in similar situations in their daily life. Musical behavior may be compared with non-musical behavior. If repetitive patterns of a client's behaviors pop up in different musical situations, the therapist can attribute this pattern to the personal coping profile of the client.

One of the tools to enhance the possibility of discussing these musical behaviors with clients in an unbiased manner, is video-registration during the sessions. It can help the client to review and rehear his (musical) performances and coping mechanisms. In a later stage the video helps to gain insight, reflect upon and evaluate a client's behavior. It can also motivate a client to monitor his or her progress during the (music therapy) treatment. The interpretation of the behavior recorded on video is (partly)based on the principles of Emerging Body Language (EBL) by Rutten-Saris (1992). EBL is based on the idea that every individual has the (sometimes unconscious) capacity to tune in to the rhythm and charisma of another person. The capacity to share sensations without words appears to be fundamental to the way we interact with other people (e.g. Stern, 1985; Rutten-Saris, 2002; Condon, 1977; Trevarthen, 1989). Rutten-Saris distinguishes between five basic interaction structures that develop between a child and its parents. During the first years of a person's life these interactions become implicit neurologic structures, which induce a person to act and cope (Cools,1985, 1997; Dornes, 1994; Lichtenberg, 1990; Stern, 1985). During the observation (and video-recording)

the music therapist and clients focus (partly) on the following five interaction structures:

- Attuning → moving the same way as the other at the same moment
- Taking turns → moving the same way as the other, one after another
- Exchanging → adding new movements while alternating
- Play-dialogue → playing with the expectations forthcoming from the exchange
- Task/theme → Performing a task, or utilizing a theme

The therapist has to engage a client to use different interaction structures and coping strategies by offering different musical assignments and situations while playing. If certain behaviors occur repeatedly during these changing assignments, the client is probably stiffened by a rigid coping style. The treatment will be directed towards enhancing his coping strategies, uvia music therapy.

Methodology

A considerable number of music therapists have written about the possible goals in the treatment of those who abuse substances (Bednarz & Nikkel, 1992; Freed, 1987; Gallagher & Steele, 2002; Treder-Wolff, 1990). We underline most of those goals and recognize the different interventions. However, in this article we shall emphasize the enhancement of coping strategies, to add a detailed description of a methodology about substance abuse treatment to the literature.

One of the major focuses of music therapy programs is to offer clients an awareness for alternatives for their coping strategies. Before he is able to do so, therapist and client both have to become aware of the strategies that are used. The substance abuse is an obvious one. It is normally linked to other (rigid) coping styles. First sessions are built around the need for the music therapist to observe a client and assess his coping

strategies and style. It gives the client the opportunity to get acquainted with music, the therapist and other group members. As soon as there is a working relationship, the therapist helps the client to relate musical behavior to daily situations.

Most of the time these first sessions are held within a group setting. It helps clients to become conscious of the fact that they share the same experiences (Levine, 1982). In an addiction clinical setting it challenges clients to share situations and painful moments. In forensic psychiatry the therapist can switch from one person to the other, which reduces tension in session.

Clients suffering from addiction tend to cling to coping strategies like evasiveness and denial. If we would use a one-dimensional treatment strategy, we would not be able to tackle their problems. Therefore we use an eclectic method focussing on music, coping, behavior, action-oriented, and emerging body language with the bio-psycho-social approach. The musical assignments stress the additional value of the action-oriented methods of music therapy combined with verbal processing. During the process of making music a client has to act. He behaves in a personal style, fueled by his own strategies and cognitions to act in a certain way (Hakvoort, 2002; Smeijsters, 2004).

The music therapy program

The music therapy program is organized in five different phases:

PHASE 1 INTRODUCTION

The goal of this phase is to create treatment conditions and to get to know one another. This phase lasts one or two sessions. Most of the time we use music listening assignments, to see what musical style or which songs trigger what kind of memories or reactions (such as craving, avoid-

ing). We assess as well what kind of musical and treatment history the client has and how well he can function within a group.

In the first phase clients bring their own music to which they listen together. In this way they have a kind of “safe” introduction with the music as an intermediary. The therapist encourages the clients to have verbal exchange about their music, to get to know each other. It provides the therapist with the opportunity to check if the client is able to listen and analyses the music in a dimensional way; beyond the easy judgement of beautiful-awful. In this phase they can expand in awareness of the effects of music on emotions and feelings. On the social level the client can take the simple step of learning to respect different musical tastes of group members.

PHASE 2 OBSERVATION AND REGISTRATION

The goal of this phase is to record the most important (and rigidity of) the client’s coping strategies by using structured rhythmic assignments. Assignments that are used in the second phase to assess coping strategies are:

Drum circle (rhythmic assignments) .

1. Every patient and the therapist choose a drum. Each plays one beat, together they (have to) form a steady pulse (to assess listening skills, anticipation skills, musical feeling). Therapist stops.
2. The tempo or volume of this pulse is raised or lowered (to assess listening skills, anticipation skills, musical feeling, motor skills). Therapist stops.
3. The pulse has to continue, but now each member can withdraw from the task to play by raising his hand. His neighbors have to play their own single beat, but earlier (to assess social awareness, attention span, empathetic behavior, anticipation skills). Therapist stops
4. Instead of one beat a small pattern might be repeated by the group. Each person has to start (at least) once. They have to play a rhythm that they expect that everybody else might be able to remember and to repeat (to assess social awareness, attention span, empathetic behavior, anticipation skills, individual cognitive strategies to start a pattern

- or remember a pattern). The one who started stops first. The clients stop in turn.
5. One person starts with his own drumming pattern. The next joins in with his own drumming pattern, that fits within the first one. Each client joins in, one after another with his own rhythm. In this exercise there is an invitation and assessment of the interaction-structure Taking-turns → moving the same way as the other, one after another (to assess social awareness, attention span, empathetic behavior, anticipation skills, individual cognitive strategies to make up a pattern, strategies to stick to ones own pattern). The one who started stops first and then one after another.

FIGURE 1. Drum Circle (Participants of a workshop at the EMTC conference in Finland)



This exercise determines differentiation in treatment that is focussed primarily on addiction or on forensic issues.

With a treatment focus on addiction, the next step is to stimulate the group cohesion, by Attuning (moving the same way as the other at the same moment).

6. Clients play exactly the same basic rhythm together. Once the rhythm is synchronized the group has to continue to play the rhythmic pattern, while varying in dynamic with the whole group at the same time.
7. Next every client, one after the other, has to play a solo, while the group plays the basic pattern to give the solo a musical foundation. Each member of the group has to play his solo, and can take his own time and make variation in dynamics, pattern and tempo. The interaction structure of this last part is Exchanging (adding new movements while alternating).
8. Finally the clients start with the same basic rhythmic pattern and now they can do a solo if they like, sometimes with more clients at the same time. The interaction structure is Play-dialogue (playing with the expectations forthcoming from the exchange).

FIGURE 2. Drum Circle 2 (Participants of a workshop at the EMTC conference in Finland)



Most forensic clients are not capable of higher interaction structures. They have major problems with empathy. Assignments that follow in this second phase are:

9. As 5, but now they have to come to an end together. One client (after another) is pointed out as the ‘conductor’ of this closure (to assess social awareness, possibilities to ask for attention, empathetic behavior, anticipation skills, individual cognitive and behavioral strategies to end a situation).
10. As 6, but now there is no assigned conductor (to assess social awareness, possibilities to ask for attention, empathetic behavior, antici-

tion skills, individual cognitive and behavioral strategies to end a situation).

Example:. The four men participating in this second session for forensic offenders substance abuse group start off slightly nervous. They chuckle a lot. As soon as I give them the first musical assignment of the drum circle, some macho coping mechanisms pop up. They hardly listen to one another and each plays as loud as possible, only concerned with his self. They do not dare to confront one another with any inconvenience (for example the enormous noise) and only tend to discredit one another's musical achievements. During assignment 4, one of them is not able to reproduce the rhythm and becomes the laughingstock of the others. I cut off this behavior and confront each member of the group with their coping styles as shown so far.

Mister C. is playing very dominantly (loud, with all the power of his muscular arms), can hardly listen to anyone. He ridicules those that are less musically talented and keeps playing, even if one of the others or I are talking. He seems to be incapable of integrating his peers into the music. He has to act as the tough, macho guy trying to make his group members laugh. His coping style during this session is to overpower others, to diminish arousal by laughing about others and change his perception of the music therapy situation by becoming sarcastic.

Mister E. plays very hesitantly, but joins in the laughter. He has trouble following the musical patterns and asks about the necessity of music therapy. He accepts my explanation and keeps participating. When he becomes the laughingstock he sits down on his chair and pushes his conga away from him. As soon as he feels that I firmly reject and tackle this bullying, he shares more about his behavior and insights. His coping style during the session has been evasiveness. But in such a way that he attracts a lot of attention. As soon as he feels protected, he tends to seek acceptance and affirmation from the therapist, by expressing feelings and degrading his group members.

Mister R. starts by showing off his musical talent, playing the drum kit. His verbal reactions and musical ones do not match (For example he says: "I played well, on the right instrument", while switching three times to a different one and not joining in the first assignments). He tries to bond with Mister C. by laughing about all his jokes and adding fuel to the flames. His coping style is to show off, to bond with someone who seems to be 'stronger' and to reduce tension by cynical remarks and laughter.

Mister S. starts off saying that he does not want to have anything to do with Mister R. He plays very carefully, is very attentive to what the others do and adjusts to all their changes. However, he forgets to listen to himself. His playing (laughing and speaking) is all very soft, but he is capable of saying what he would like to change so they can play better together. His coping style is adjusting to any other person, losing touch with himself. Yet when he gets the attention he is able to speak up, but does not ask for it.

During the following assignments, they work more seriously, but the restlessness and the incapability of disclosing any of their feelings remain. If I link this feeling to craving for a cigarette (or a joint), each of them agrees immediately.

Phase 3 Recognition. The goal of this phase is for the client to recognize personal strategies by elaborate musical coursework. One of the most frequently used tools for both therapists is popular music (e.g. Horesh, 2003).

In phase 1 and 2 the therapists help the clients to set up a coping strategy scheme and formulate their goals and objectives for change and alternatives. The personal coping strategies and style are linked to the clients' daily life and the transfer is made to high risk situations of drug/alcohol abuse.

An example of primary addiction care:

Gary is a 40-year-old man, with a serious drinking problem; he alternates sober periods with extreme alcohol abuse. During his drinking episodes he behaves in an aggressive way, and has caused a lot of problems in his social environment (work, family, friends and neighborhood). When he is drunk he seems to express that he is "mad at the world".

During the music therapy he is always friendly and cooperative. He always follows the initiatives of other clients. He applies himself to whatever someone else wants, even if he has ideas of his own.

In his point of view he has no social problem at all. While playing the music (assignment 5 and 7) he follows and conforms to all the

dynamic patterns of other group members. He starts to develop his own initiatives but when someone else prompts another idea Gary conforms again. During the verbal exchange, he does not recognize, nor is he aware of this behavior. During this exercise his interaction structure seems to be limited to attuning, while his coping strategies are limited to denial and evasiveness.

In phase 2, in the course of his solo there were two other clients playing terribly loud and they were not aware of Gary's efforts to sound his solo. The other group members were very irritated by the loud playing of these two. After the improvisation, Gary said, that he didn't hear it and it didn't disturb his playing and if it did, it didn't matter. He seems to be unable to really register what is going on and partly seems to be in denial. The video of this improvisation shows the interaction structures of Gary: playing, attuning, taking-turns and exchanging. Only when his exchange turn is not confirmed by the two others, his body freezes more and more and the intensity of his musical performance fades. The more he freezes his movement and playing, the more tension is visible in his mimics. The group interpreted this facial expression as angry. He makes the transfer to his personal coping style: Due to the fact that he denies, ignores and trivializes his surroundings, he builds up a lot of stress and tension and feels frustrated about everything. He recognizes this kind of undefined tension. He labels this as high risk situations, maintaining his drinking habit. This is his coping strategy to reduce arousal. While drunk, he is able to feel and express his anger about everything. Gary chooses to learn to express himself and be aware of his own feelings. He chooses to use his voice and work on the song "sorry seems to be the hardest word" by Elton John and Timothy Rice.

Phase 4 *Experimenting with new strategies.* The objective of this fourth phase is to learn new coping strategies, how to handle and when to use them.

Bring about new (coping) strategies by vocal exercises. Both therapists use a lot of popular music such as rap and popsongs.

After the client has chosen his own goals, what he wants to learn in this phase, he is guided to choose his own musical tools to achieve for these

changes. The client is encouraged to use his voice, to learn to express himself in a more personal way.

In primary addiction care this phase is kept in a group setting, so a client chooses the way he wants to get support from the other group members. He can choose to do it alone, together, parts together, etc. In forensic treatment this fourth phase is done on an individual basis, due to social and empathetic impairments of the clients.

This is a text example of a client in the forensic setting who suffers from poly-drug-dependence. He rapped to a beat of one of his former gang-members, using his own text. The first text he wrote *during phase 2* of his music therapy treatment. It focusses on violence and drugs¹:

This is the first time I'm writing on command
What you gonna be and where you gonna stand
Three weeks ago I was going in smooth
Smoking my joints, that's the whole damn truth
I don't give a shit if you really don't know me
But wait... I will come and I will show you
(...)
What do you want every day again?
Fuck you with your gate and better be straight
The three weeks are flying. I was forced to therapy
Do you really want to know, who I really want to be?
Ha, ha, that's a goddamn question
I know the answer, but never will I mention
What's going through my mind.

1. Thanks to N.V.d.V. for allowing us to use his text.

During phase 4 he rewrote the text as:

When I wake up it's every day the same,
Put the music on, it's nothing but a game.
How do you feel about music everyday?
It really doesn't matter if you're straight or if you're gay
Every week I'm waiting for the music therapy
That's how it is, to make my pain free.
My soul, my pain, it's all in order
When I hiss scandal, it's nothing but disorder
"Three strikes you're out", it really doesn't matter,
I really have to laugh; I really know what's better
Critical decisions gonna pull me through,
Thanks for supporting; I know now what to do.

FIGURE 3. Working with lyrics (Participants of a workshop at the EMTC conference in Finland)



Phase 5 *Termination and evaluation* . The goal of this last phase is to help the client to acknowledge his new coping strategies and to recognize how and when to use them in a transfer to his daily life. Of course this phase is meant as the round-off, with all the persistent rituals.

An example of a 32-year-old woman, who recently finished her treatment in an addiction clinic: Music therapy was one of Lisa's therapies during her 5 months of treatment.

During the first phase of music therapy she was often composed. When she talked you could barely hear her voice; group members often had to ask to repeat herself more loudly. When she played, she did not make loud noises or sounds and she never played exceptional patterns. At the same time she had a strong desire to make music; she enjoyed playing together with the other clients

and making up rhythmic patterns. While ‘moving together’ with the others she felt safe enough to play. As soon as the more individual assignments were introduced such as playing solo as described in phase 2 part 5), she hesitated. The moment she played her solo she neither played different patterns nor did her volume rise above the volume of the others. Her body-language showed less movement and she stared more and more at the floor, she lost the potential to ‘take turns’ and exchange with the other group members, her body seemed to “freeze”. During the verbal analyses of that experience, she disapproved of her struggle to play and spoke about herself in negative words. She felt sad and trapped in her own body.

After this experience we started to make a transfer to her daily life. In her daily life she felt isolated, although she had friends and a social system, she often felt stupid and stiff in contact with others. She had difficulties sharing her insecure feelings with other people. Making contact with others was like playing the solo; she felt insecure and started to freeze without sharing any of these feelings.

Drugs, party-drugs (XTC), cocaine and alcohol helped her to feel free and open, to integrate into the groups she wanted to belong to, and to make contact with others more easily. Abuse for her was the way to cope with low self-esteem and introvert conduct.

The goals she set for herself in music therapy, were: higher self-respect, accepting and learning to handle her introvert part, sharing problems, doubts and worries with other people.

She was ready to start with phase 4, experimenting with new strategies. Liza decided to use her voice as her main instrument during music therapy treatment. It was the result from the beginning; she wanted to change the fact that she never spoke loudly. She chose her favorite song “Don't know why” from Norah Jones and experimentally worked on it step by step. During this phase the therapist and group members coached her about how to move her body and how to use her voice. She started to sing the song together with all other clients. The next step was to sing it with two others, followed by small parts of solo voice. And finally she sang her favorite song alone with a microphone using the group members as her audience. Although she kept her moments of ‘freezing’ she learned to accept that this was a part of herself and she learned to accept how to handle this part of herself.

During the last phase of music therapy she rounded off her music therapy group sessions. The last time she was there she chose to play a drumming solo while the others kept the beat steady. This time she still played a little bit insecure, but very loud.

Three months after finishing the group sessions she had a serious relapse, expecting she could now use drugs and alcohol in a social way. Instead of hiding, isolating and blaming herself, she decided to ask for professional help and support again. She now comes every 3 weeks for individual music therapy, to practice coping strategies such as making her self heard and dealing with insecurity. In addition she visits a weekly support-group to help her to stay clean.

Discussion and conclusion

Music therapy can help clients suffering from addiction to (re)gain better coping strategies. Music offers a client the possibility to act in a structured, playful, safe environment. A well-trained music therapist is capable of manipulating these situations musically, to provide the right confronting experiences, so the client can obtain insight, and practice with coping styles and strategies. They cannot just talk their way out, but a client has to act to prove that he can deal with different situations in different ways and has more alternatives to choose from than narcotics or alcohol.

The basic principles of the method are: introducing client's own musical preferences, using popular music, using voice and rhythm, combined with the transfer from musical to common behavior with a focus on addiction, coping and body language.

During music therapy treatment, clients are placed in situations that show similarities with their daily life. Yet the musical context makes it distinctively different. This helps a client to reconsider his condition and choices from a distance. It can help him to gain insight in his coping

strategies, because it has no direct personal consequences if he falls short. The therapist has to stimulate the client to make transfers of these musical processes and learning experiences to his daily life; especially to promote application of the new coping strategies in situations that might otherwise trigger substance abuse.

There are major differences between the two client groups, because the primary focus of clients in forensic setting is upon their offence and related problems. Addiction is one of the related problems that is addressed, always in relation to the behavior that led up to the offence. The emphasis is placed on elaborating empathetic coping skills and confronting problematic situations. Addiction is viewed as a major risk factor for relapse but has a different place in the bio-psycho-social treatment (compared to an addiction clinic).

Although the authors work in different clinical settings and have adjusted the music therapy program to their own needs and experience, they are both excited about this methodology. It offers the therapist a focussed, goal-oriented and musical method to help clients conquer some of their major problems with substance abuse. It influences overt behavior and coping styles, but also offers clients a better insight and understanding of their own actual behavior and reactions. This methodology can be used with a variety of clients with coping problems or rigid coping styles (probably even without addiction problems) as long as they do not suffer from mental limitations.

However, as we stated at the beginning of the article, substance abuse is a very complex problem. Most of the clients will have (major) relapses, especially if the only component of their treatment would be focussed around this topic of enhancing coping strategies. Only in the complete bio-psycho-social treatment might a client develop enough to conquer his

addiction. Relapse prevention is very crucial in this treatment, where relapses are very common as well.

It would be interesting to compare and measure the coping skills of clients before and after their music therapy treatment by using the UCL (Utrecht coping list), and to compare musical with non-musical coping strategies. This might even result in a validated music therapy assessment list.

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