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Women With Addictions:
Music Therapy Clinical Postures and Interventions

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Abstract

Like men, women have been using alcohol and drugs since ancient times; yet we are just beginning to uncover important information about women's unique trajectory to and through addiction. Straussner and Brown (2002) write, "There is little or no denial left today: women can be and are addicts at alarming rates" (p. 34). Close to 15% of the members of the American Music Therapy Association (AMTA) report working with clients who have addictions (AMTA, 2011). It is likely that some of these members work with women who struggle with addictions, and it seems feasible that some would work predominantly or exclusively with women. And yet, few treatises exist to inform music therapy clinical practice with this clientele. With the present report, we hope to expand the knowledge base in this important area of clinical practice. We first present statistics and other research findings pertaining to women with addictions. Then, based on our collective experiences with women who have alcohol and drug addictions, we present suggested postures and interventions for ethical, effective, and meaningful music therapy clinical practice.

Women With Addictions:

Music Therapy Clinical Postures and Interventions

Introduction

Each year, the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services conducts the National Survey on Drug Use and Health (NSDUH). This survey gleans data pertaining to the nationwide prevalence and incidence of alcohol, tobacco, and illicit drug use, abuse, and dependence among people aged 12 years and older. NSDUH 2010 revealed that nearly 9% of the respondents were classified with *substance use disorders* (SUDs) during the year prior to the survey (SAMHSA, 2011).

SUDs are characterized in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) by dependence or abuse of alcohol and/or illicit drugs (American Psychiatric Association [APA], 2000). *Dependence* involves physical tolerance to the substance and withdrawal upon cessation, increased time spent seeking, using, and recovering from use, and failed attempts to stop. *Abuse* refers to a maladaptive pattern of use that negatively impacts work, school, home, or interpersonal relationships and/or that results in hazardous situations or legal troubles for the user. (Note: Although terms like *substance use*, *abuse*, *dependence*, and *addiction* are not synonymous, they are used interchangeably in the professional and popular press. When referring to publications in which a distinction is made, we have preserved the distinction; however, in other cases—primarily for ease of writing and consistency—we have

avored the term *addiction(s)* to represent these closely related terms.

Furthermore, while the DSM-IV-TR categorizes addictions to several types of substances and activities [e.g., food, sex, gambling, etc.], the present report is concerned exclusively with alcohol and drug addictions.)

Like men, women have been using alcohol and drugs since ancient times; yet we are just beginning to uncover important information about women's unique trajectory to and through addiction. (For a detailed historical view of women and addiction, the reader is referred to Straussner and Brown [2002].) We know—recognizing, of course, that the information we obtain from self-report measures is inherently limited and biased—that the prevalence of addictions has been and continues to be generally higher among men (11.6%) than women (5.9%), but that among 12 to 17 year-olds, this gap appears to be narrowing (SAMHSA, 2011). Straussner and Brown (2002) write, “There is little or no denial left today: women can be and are addicts at alarming rates” (p. 34).

Thanks to efforts of institutions such as the United Nations Office of Drugs and Crime and the National Institute on Drug Abuse (NIDA), which advance multi-faceted research agendas pertaining to sex differences and addictions, we are learning about the biological and psychosocial factors that idiosyncratically impact the etiology and progression of women's use and abuse. Research projects initiated and supported by these types of organizations also enable us to identify women's unique needs regarding prevention and treatment (NIDA, 2011).

Although less than 4% of the members of the American Music Therapy

Association (AMTA) reportedly work in drug/alcohol treatment settings, close to 15% report working with clients who have addictions (AMTA, 2011). Sex-specific statistics are not available, but it is certain that some of these members work with women who struggle with addictions, and it seems feasible that some would work predominantly or exclusively with women. And yet, few treatises exist to inform music therapy clinical practice with this clientele. With the present report, we hope to expand the knowledge base in this important area of clinical practice.

We first present statistics and other research findings pertaining to women with addictions. Then, based on our collective experiences with women who have alcohol and drug addictions, we present postures and interventions for ethical, effective, and meaningful music therapy clinical practice. The primary author (SG) has provided intermittent group music therapy services for six years with women, ages 17 to 65, who reside in a 20-bed, 30-day treatment program in Ohio. Another author (MC) has extensive experience with this clientele: As an independent contractor, she provides expressive arts therapy (including music therapy, art, and writing) to clients in both residential and outpatient treatment programs and an affiliated halfway house in Pennsylvania. The remaining authors (JJ, AL) are students who completed a music therapy practicum in the Ohio residential program, working with a women's group two times per week for four months under the supervision of the primary author, who was present at every session. In order to broaden our understanding of the topic of women and addictions and in preparation for this report, we also consulted with two additional music therapists, each of whom has many years of psychiatric experience and

has published seminal works on the topic of music therapy and addictions.

All interventions described in this report were applied in small (3 to 6) to moderate-sized (7 to 12) groups; the women were seen between two and four times per week, with group membership changing periodically, according to the specifics of each program.

Review of Literature

Straussner and Brown (2002) purport that, for men and women, addiction is equally and essentially about the loss of control. Nonetheless, by virtue of fundamental differences between the sexes, women differ from men in onset and patterns of use and thus have distinctive needs with respect to treatment and recovery (Kauffman, Dore, & Nelson-Zlupko, 1995; Straussner & Brown, 2002). It has been reported that women typically begin using drugs and alcohol later than men, yet they enter treatment programs earlier in the course of their addictions (Brady & Randall, 1999). Women and men differ with respect to substance choice, as well, although patterns of use have changed somewhat over the decades. Females aged 12 to 17 are now just as likely as males in the same age group to use and abuse alcohol. Women of all ages are still more likely than men to gravitate toward the use of psychotherapeutic drugs (e.g., tranquilizers, sedatives, and stimulants) and to use prescription drugs and pain relievers non-medically (Kauffman, Dore, & Nelson-Zlupko, 1995; SAMHSA, 2011).

Straussner and Brown (2002) acknowledge that disparate life conditions lead to differences in the ways that addicted men and women *experience* their addictions:

The stages and tasks—the process of being addicted and being in recovery—are the same for men and women. Differences abound, however, in the meanings attached to these processes, and to other issues and conflicts that people face, which may greatly influence their experience of addiction and recovery (p. 42).

It is important to note that the “other issues and conflicts” that shape addicted women’s experiences are not divergent from the issues and conflicts of women who do not develop addictions. In other words, addicted women and non-addicted women within a given society are more alike than different in their profiles and the challenges that they encounter. However, certain issues and conflicts differ notably between women and men and thus can be considered idiosyncratic risk factors for the development of addictions and relapse among women. (Note: Here, relapse refers here to a return to use after a period of abstinence during which a woman may or may not have been involved in treatment.)

Some risk factors for addiction and relapse are *biological/physiological* in nature. For instance, women—whose metabolism rates differ from men’s—require less of a given substance to achieve that substance’s effects. This means that women not only get drunk/high more quickly, but also that they may experience detrimental physical effects of the substance (e.g., liver disease, hypertension, anemia, overdose, etc.) and/or develop tolerance—one criterion of dependence—more rapidly than men (National Center on Addiction and Substance Abuse [CASA], 1996; Kauffman, Dore, & Nelson-Zlupko 1995).

Additionally, the incidence of co-morbidity—that is, the concomitant presence of a SUD and another psychiatric disorder—, which is already higher in the addicted population, is higher among female than male addicts (CASA, 1996; SAMHSA, 2011). It is estimated that nearly 50% of women admitted to treatment for alcohol addiction are, in fact, dually diagnosed (SAMHSA, 2002). Women who drink and use drugs are more likely than men to be diagnosed with depression, anxiety disorders, eating disorders, and PTSD (Brady & Randall, 1999; CASA, 1996; Kessler, Crum, Warner, et al., 1997). Regarding relapse, Charney and colleagues (1998) found that, in particular, among both men and women, “the presence of depressive diagnosis, depressive symptoms, and negative mood states was related to an increased rate of relapse” (p. 138). Women, in particular, are more likely to report relapse as a result of negative mood states (McKay et al., 1996), which may have physiological origins.

Other risk factors may be considered *psychosocial*. For instance, research supports the contention that women with addictions are more likely than addicted men to have grown up in a family with one or more addicted family members (Kauffman, Dore, & Nelson-Zlupko, 1995). Women are also more likely than men to live with an addicted partner, and their use more apt to be negatively influenced by this arrangement (Lex, 1995; United Nations, 2004). Familial factors play a role in relapse as well; not only are women more likely to be married to a spouse who is addicted, but they are also more likely to relapse when they are experiencing marital stress (Walitzer & Dearing, 2006). However, children in the home can serve as a protective factor for relapse; some

researchers have noted a correlation between having more children at home and abstinence from drugs and alcohol (Saunders et al., 1993). Social support is another important factor. Women appear to be more vulnerable to social pressure in that they are more likely than men to relapse in the company of others who are using (Rubin & Stout, 1996).

Trauma is a strong predictor for addiction: The prevalence of self-reported exposure to traumatic life events is significantly higher among addicts than the general population (Hyman, Paliwal, & Sinha, 2007) and greater for women than men in both inpatient and outpatient treatment settings (Farley et al., 2004; Johnson et al., 2010; Rice et al., 2001). One report by CASA (1996) states that 70% of women in treatment for addiction have been sexually abused, as compared to 12% of men. Trauma such as incest and rape—more commonly perpetrated against women than men around the globe—is frequently reported by women as having precipitated the commencement of their alcohol and drug use or abuse (Kauffman, Dore, & Nelson-Zlupko, 1995). Another report shows that between 66 and 90% of women in treatment report trauma such as domestic violence, early childhood assault, and loss of their own child (Hien, Cohen, & Campbell, 2005). Trauma-based relapse is also prevalent among women (Straussner & Brown, 2002).

A woman's perception of self-efficacy may be a part of her addiction and relapse equation. Connor and colleagues (2011) consider self-efficacy—an individual's belief in his or her own ability to overcome adversity—(specifically, *refusal* self-efficacy) to be a valuable coping skill that could shape an individual's

ability to deal with the challenges of addiction.

Treatment for Women With Addictions

While around 23% of women require some type of treatment for their addictions, only about 9% of these individuals actually appear to receive any professional help (SAMHSA, 2011). Reasons for this underrepresentation are multi-faceted. A report by the United Nations (2004) highlights a few of the most relevant causes:

Cultural taboos and stigma mean [women's] substance use problems are often not acknowledged by themselves, their families or helping professionals who could support them in seeking treatment. Pregnant and parenting women using substances face particular societal condemnation, and pregnant women often delay seeking services with serious implications for the mother and the foetus. Women who are parents usually have primary responsibility for childcare, as well as other household responsibilities. However, few treatment services provide childcare, and in some cultures it is very difficult for women to leave their homes and family responsibilities to seek treatment (p. v).

Homelessness, lack of health care insurance, fear of losing custody of their children, and limited access to transportation are also considered unique barriers for women who need treatment (Weissman & O'Boyle, 2000).

Gender-sensitive treatment programs for women are those in which both context and content reflect and address women's unique needs. (Note: We recognize a distinction between *sex* and *gender* that is not apparent in much of

the related literature—sex being determined by biological factors and gender being a matter of one's identification with maleness or femaleness and corresponding roles; however, in this report, we have opted to use language consistent with the resources consulted.) Gender-sensitive programs are thought to be more effective than traditional programs, which are designed for men; some argue that women ought to be served in women-only programs (Straussner & Brown, 2002). Weissman and O'Boyle (2000) write about the dire need for gender-sensitive programming:

Treatment issues that are most important to women's abuse of drugs, such as domestic violence and sexual assault, are among the most uncomfortable to disclose in a coeducational group. Therefore, if the program is not for women only, it should offer extensive gender specific treatment sessions. Peer support is also effective for women by providing supportive networks and role models for success (p. 2).

The provision of childcare naturally increases the likelihood that a woman with children would be able to access treatment for her addiction.

As stated above, there are but a few published resources to inform music therapy practice with women who have addictions. In most publications highlighting the role of music therapy in addictions treatment, either both women and men are involved or sex is not specified. In the latter case, since more men than women are diagnosed with SUDs and treated, it is assumed that these publications do not refer to women-only groups.

Cevasco and her colleagues (2005) conducted a study to evaluate the effect of various music therapy interventions on depression, stress, state and trait anxiety, and anger levels of female substance abusers in an outpatient treatment facility. Using both standardized and nonstandardized measurement tools, including pre- and post-session narrative journals with an embedded Likert scale, the researchers collected data on the impact of three different interventions: (1) structured and creative movement to a variety of popular music forms; (2) rhythm activities, such as hand drumming, improvisation, and recall; and (3) competitive team games, such as “Name That Tune” and playing notated rhythms. No statistically significant difference was found between pre-session and post-session scores on the standardized measurements. The researchers report that, “data collected on daily journal scores immediately before and after each session for each intervention, however, indicated progress for several individuals on decreased levels of depression, stress, anxiety, and anger” (p. 74). However, because both narrative and scalar data were apparently collected in the journals and the researchers do not describe their analytic process, it is unclear how they arrived at this conclusion and thus impossible to determine the validity of the claim. An obvious limitation of this study is that, due to high attrition in the program, just 10 of the 20 women originally involved in sessions participated in and provided data for all three interventions. The researchers call for further research with female clients, in particular, to identify music therapy interventions that may elicit desired emotional change.

In an earlier study (Silverman, 2003), women addicts were asked to

compare effectiveness and enjoyment of various treatment groups. Music therapy was identified as the group that best served to decreased impulsiveness and that was the most enjoyable, most therapeutic, most relaxing, and most energizing. The researcher notes the limited number of participants (N=8) and post-test only design as obvious limitations of the study. Additional methodological problems justify cautious interpretation of the results. First, the dependent measures were neither standardized nor piloted. Second (curiously), the visual analogue scale used by the researcher combined the dependent variables of enjoyment and effectiveness; thus, the participants may have been led to believe that enjoyable treatment equates with effective treatment. (*Effective* may have been defined for the participants, but there was no evidence of this in the research report.) Indeed, the participants in this study may have felt physical and/or emotional pleasure during the sessions and thus believed that music therapy had been effective.

Enjoyable treatment *may be* effective and effective treatment *may be* enjoyable. As a therapeutic goal, client enjoyment may be associated with an activity-oriented level of practice (Wheeler, 1983), in which primary aims are to help them reduce anxiety and find social support. However, not all music therapists in addictions work at this level of practice. Many therapists with demonstrated expertise in addictions are of the opinion that effective treatment must involve psycho-emotional and psycho-spiritual recovery, which often translates as the uncovering, experiencing, and expression of many feelings—including *distressing* feelings of fear, anxiety, shame, guilt, sadness, anger,

loneliness, regret, grief, etc. (Borling, in press; Borling, 2011; M. Carlini, personal communication, January 9, 2012; K. Murphy, personal communication, January 9, 2012; Pickett, 1991). Recovery may also involve the identification, confrontation, and resolution of conflict in relationships with family members, friends, and acquaintances—conflict that likely conjures similarly distressing feelings. Addiction can be viewed as a complex emotional and spiritual disease that requires more than the “feel-good” treatment approach suggested by Silverman’s (2003) study.

A single subject case study by Pickett (1991) has as its focus a 35 year-old woman who was dually diagnosed with depression and addictions to food and alcohol. The client also had experienced trauma within an abusive marriage. The therapist provided weekly sessions using the Bonny Method of Guided Imagery and Music (GIM) in order to help the client address issues surrounding trust, parenting skills, and grief. As the client and therapist worked together, the client was able to confront images that represented her addictions to food and alcohol as well as her feelings toward the addictions. These feelings were personified in four self “characters”: Judge, Nasty, Tender and Child. Through Imaginal interactions with these characters, the client was able to identify feelings of guilt, shame, and sadness and work through them with the therapist’s support. GIM, as an analytical therapy (Wheeler, 1983), was especially effective with this dually diagnosed client; conventional treatment approaches may have been less likely to help her confront all aspects of her addictions and the concomitant emotions.

Clinical Postures and Interventions

As neatly chronicled by Borling (in press), music therapists may find themselves working in a variety of settings with clients who have addictions, including intensive inpatient and outpatient programs, day treatment/partial hospitalization, and residential-therapeutic communities (TC). These treatment settings apply to men and women alike, but Borling notes that “the TC environment is particularly effective in meeting the needs of women who are pregnant or have children” (p. 3).

In our experience and that of the other therapists with whom we consulted, music therapy within a TC can address issues that are particularly relevant to women in recovery: It supports their unique needs for safety, helps them feel included and make meaningful connections with others, enables emotional expression and validation, and encourages self-respect and self-empowerment toward spiritual healing. Each of these four inter-related needs will be addressed in turn, below, with descriptions of clinical postures and considerations, interventions, and supporting anecdotal material.

It should be mentioned that the types of interventions described in this article span different levels of music therapy practice, as have been outlined by authors such as Wheeler (1983) and Bruscia (1998): According to Wheeler’s classification, some interventions are considered activity-oriented, or *supportive* in nature, while others are designed toward the development of insight, or *reeducative* goals. One author (MC) uses GIM in her work—in traditional

individualized applications, considered a *reconstructive* method, and in adapted applications (i.e., group format, abbreviated music listening, more directive verbal guiding, etc.), considered a *re-educative* tool toward the development of personal insight.

Of course, it is expected that all therapists working in addictions will practice within their areas of training and competence. Whether male or female, or whether entry-level professional or advanced practitioner, the music therapist working with women who have addictions must demonstrate personal and professional health and maturity. Self-awareness (including the awareness of boundaries and countertransference reactions that could negatively impact the clients or therapeutic process), responsibility, open-mindedness, and a deep value and respect for each client are imperative attributes and conditions. Regular supervision is also essential, as treatment can become highly emotionally charged when the women's issues are evoked and channeled through the expressive medium of music.

Safety

In that most women come into treatment with a history of serious and repeated trauma—in many cases, physical and sexual abuse at the hands of a family member, family friend, or partner—the importance of creating a safe environment cannot be overemphasized. Rapport within the group (necessary for the “work” of therapy) begins with the perception that one is safe and can thus begin to lower defenses. The therapist must consider both the physical and emotional “space” in which therapy occurs. The physical space should be clean

and organized, with adequate light and ventilation. Chairs should be comfortable, especially since some women may be pregnant or have physical disabilities or injuries. To underscore the importance of creating a safe physical environment, we offer the story of one woman—her face deeply scarred by years of physical abuse by her male partner—who, in the middle of a song discussion, abruptly walked to the window and closed the venetian blinds, stating that she could not relax as long as she could see the male residents smoking on a distant patio.

The emotional space should be welcoming and free of judgment. In our experience, women with addictions come into each session with a host of difficult feelings that beg for some type of catharsis. Pounding on a drum, sobbing while listening to a tender song, screaming expletives in an angry rap—these types of outward responses to internal woundedness need to be not only allowed, but invited. It is also imperative that the therapist serve as an emotional safeguard, particularly when the group members are not able to do this for themselves: Aggression toward others (whether real or threatened), manipulation, put-downs, etc. should not be tolerated. Finally, the therapist can establish a safe and genuine emotional space through authenticity in her own verbal and musical expressions of emotion.

Musical rituals. Consistent (and thus predictable) session openings and closings can help clients feel secure. Examples of such rituals are an “emotional check-in” on a drum that is passed around the circle, a positive affirmation that is chanted or sung, or a closing song with a hopeful or empowering message, such as “Hero” (Mariah Carey & Walter Afanasieff), “I Believe I Can Fly” (R. Kelly), or

“You Gotta Be” (Des’Ree Weeks & Ashley Ingram). Music rituals often evolve with client input.

Therapeutic singing. We have found that group singing is a “safe” experience for new or defended groups. Sitting in a circle with a variety of freestanding drums and hand-held rhythm instruments, we invite the women to select songs to re-create from a prepared binder of lyric sheets. Song material is carefully pre-selected to reflect common themes and clinical issues, such as grief, family, hope, self-worth, relationships, denial, spirituality, and so forth. Within a physically and emotionally safe environment, each woman can make an ongoing decision about her level of involvement: Some—too wounded to find their voices—sit back and let others completely guide the process while they look on and simply begin to feel again. Others select songs but do not sing. Still others dive in head first, singing fervently, playing, discussing the songs—even dancing—with little or no inhibition. There is ample room for all responses, and all are accepted. As a woman makes a selection, she is encouraged to share briefly about her choice: Why this song? What is the message of the song for you? The women in the circle reverberate with one another’s unfolding stories, reflecting and validating the painful emotions that are often elicited. This process of relating on a personal level builds unity and diminishes feelings of isolation and loneliness through the principle of *universality*—a sense that one’s problems are similar to another’s (Yalom & Leczsz, 2005). This is absolutely critical for personal growth during times of emotional hardship.

Song communication. We have also used song communication (Bruscia, 1998) as way to promote a sense of safety and lay the foundation for difficult emotional work. In song communication, members are invited to select a song that they would like to share with the group. This is to be more than a preferred song; it should somehow connect to their lives—past, present, or future. Before or after listening to a woman’s chosen song, she is encouraged to talk about its personal significance. No lyric sheets need be used. We have found this to be a low-pressure way to begin the process of developing self-insight through personal sharing within the group; each individual can decide exactly when, what, and how they share, and thus feel as though they are in control of the situation.

Inclusion and Connectedness

Many women come into treatment with the belief that they are entirely alone and must “face their dragons” in solitude. While it is true that each woman must ultimately decide for herself that (and when) she is ready to recover and take the first step in that direction, she neither needs to nor can recover on her own. Group music experiences can foster a sense of belonging to a larger recovering community, as collective music experiences naturally call upon the cooperation and combined effort of many to achieve a mutual objective. Women who unite in music, each bringing forth an equally unique and valuable musical “voice” to create something as one, cultivate a connectedness that extends beyond mere verbal discussion and thus promotes unity with others (Davis,

Gfeller, & Thaut, 1999), while counteracting feelings of isolation that may lead to despair and, ultimately, to relapse.

Drumming. Community drumming, or *drum circles*, can function particularly well to encourage inclusion. Referencing the African tradition, everyone has something to offer the circle and anyone is welcome. Drum circles allow for sharing and support of one another through the in-the-moment creation of authentic music. This creative experience helps the women communicate and connect, even when past life experiences have suppressed or altogether stripped them of their words. As with therapeutic singing, each player is accepted for whatever she contributes; unique rhythms, timbres, energies, and styles are all valued for what they add to the community.

Conscious Drumming, developed by Jim Borling and Bob Miller (as referenced in Matney, 2007), can promote a sense of inclusion and help women make profound interpersonal connections. A *talking stick* is placed in the center of the drum circle to be picked up by any circle member whenever she has something to say. As she speaks, the group provides a unison heartbeat, which both supports and acknowledges her words. When her *talk* is finished, she returns to her place in the circle, which resumes free musical expression. In these and other similar drumming experiences, quiet women have asserted themselves, flat affects have turned into tears, trapped spirits have let loose, and skeptics have taken off with rhythmic solos.

Improvisation. Instrumental and vocal improvisation can help women strengthen interpersonal bonds. Music facilitation techniques of *intimacy* (such as

sharing instruments) and *empathy* (such as reflection) (Bruscia, 1987) promote closeness and understanding. In *reflection*, each woman in turn improvises on her current emotional state. The other group members listen carefully and then reflect her emotional state with their own playing, either joining with the individual player as a support for her emotional expression, or starting after she has finished as a way to validate her expression or engender insight. In either case, the reflectors may benefit from altruism—attending unselfishly to the immediate needs of another (Yalom & Leczsz, 2005)—, while developing stronger interpersonal skills.

Song communication. Song communication, described above, can be a powerful way for the group to continue to support an individual who is “graduating” from treatment and moving on to the next phase of her recovery. A goodbye song is chosen by the graduate or by a member of the group and played, in live or recorded fashion, during the graduate’s final therapy session, sometimes accompanied by discussion and sometimes by simple well-wishing, tears, and hugs.

Emotional Expression and Validation

While women in active addiction commonly deny and mask truths, music experiences and creations very seldom tell falsehoods. One truth leads to a second truth, which leads to a third truth, and on it goes. Albeit, these truths may be in the form of metaphors, similes, designs, analogies and colors; nevertheless, the women present them to be understood and validated by self and others. Experiencing the truths contained in music expression works to

compound the courage, confidence, and strength needed for emotional healing to take place.

Song discussion. Song discussion remains an important intervention for supporting feelings that are difficult to express and receiving support from others. Upon reflection of the women we have treated, the song “Comfortably Numb” by Pink Floyd comes to mind: *Hello...Is there anybody in there?* While the women are physically present, they are emotionally disconnected—turned off, numb, and simply unable to express. Nonetheless, they are waiting to come back to life—to feel again. Song listening and discussion can invite this process. Women in early stages of recovery often begin to open up when they encounter the song “Addicted” (Kelly Clarkson), an excerpt of which appears below:

*It's like I can't breathe
It's like I can't see anything
Nothing but you
I'm addicted to you
It's like I can't think
Without you interrupting me
In my thoughts
In my dreams
You've taken over me
It's like I'm not me
It's like I'm not me*

The song “Alive Again” (Matt Sevier) often speaks to women when they are still very uncertain about being a part of the group. The residents understand the lyrics; they know, deep inside, that these lyrics express their truths. They, too, are desperate for change in their lives:

*A walking shadow...Another addict
Years older but exactly the same*

*In desperation, you change
You learn to cry again
And you're alive again*

One young woman asked the authors to bring in the song, "Who I Am Hates Who I've Been" (Relient K) as a way to communicate to the group that she had moved past denial, was dedicating herself to change, and wished this for her peers:

*I'm sorry for the person I became
So sorry that it took so long for me to change
I'm ready to be sure to never become that way again
'Cause who I am hates who I've been
Who I am hates who I've been*

The song, "I Am Changing" (Jennifer Hudson) often connects with women in later stages of recovery when they are beginning to heal and believe that change is possible. Again, the women understand these lyrics. They feel confident and hopeful in this stage, and hearing a female vocalist aids in their identification with the character's optimism:

*I am changing, gonna get my life together now
I am changing, yes, I know how
I'm gonna start again, I'm leaving my past behind
I'll change my life—I'll make a vow
And nothing's gonna stop me now.*

Composition. Songwriting is also a useful intervention for emotional expression. Song transformation, in which the women create their own lyrics to familiar songs, is one way to ease into the process of creation, which takes considerable courage for women in treatment. For many of them, the physical act of writing is a formidable challenge. And not only are they being asked to collect their thoughts and express them, but they are being invited into a highly personal process. With the structure of a familiar song, they feel some support and

security. "Lean on Me" (Bill Withers) has been one highly successful song

structure:

Sometimes in our lives
We all have _____
We all have _____
But, if we _____
We know that _____
Lean on me, when you _____
And I'll _____
I'll help you _____
For, it won't be long 'til I'm gonna need
Somebody to _____

The 12-bar blues is another helpful starting point:

Woke up this mornin', I was feelin' _____
Yeah, woke up this mornin', I was feelin' _____
I said to myself, _____

Old blues tunes such as "The Thrill is Gone", "Walking by Myself", "Stone Crazy",

"Those Lonely Lonely Nights", "Black Night", "The Things I Used to Do" and

"Farther Up the Road" have been used in groups as seeds from which women

can "grow" original material. The song lyrics are spontaneously written and

melodies improvised and sung in the group, giving women opportunities to both

express their own and validate their own and others' thoughts and feelings.

Songwriting is a way for women to put damaged pieces of their lives back

together again, giving them a capacity for power and change. It offers a chance

for them to be in control, to make choices and tell their own stories, which is part

of the healing process:

"The Things I Used to Do"

Party everyday and drink every night
Stressed out all day long, it just wasn't right

*My man putting me down
 Telling me I don't got all my wits
 Always putting up with people's shit
 I do everything wrong, I just got to be strong
 Life was such a chore
 Ain't going to do this any more
 (Lois)*

"Black Night"

*Black nights have followed me most of my life
 Those black nights with no highlights
 The things I used to do, I don't do anymore
 But those black nights seem to haunt me still
 Loneliness, depression, wrong choices
 Shadowing my soul once more
 Faces of hope, faces of pain, faces of change and serenity
 Love and peace, bring it on home to me
 I can't wait, I can't stand the agony
 (Hazel)*

"The Thrill is Gone"

*I'm tired of the games, tired of the abuse
 Been tied down too long, it's time to cut you loose
 Waited up night after night, watching the clock tick
 The bar or me, which will you pick?
 You're such a dick!
 Ain't gonna let you have control
 Not gonna play the fool, you think you're so cool
 Pretty face, nice body, but a nasty soul
 The thrill is gone—it's time to move on.
 (Stephanie)*

While these song-writing experiences may initially appear simple, most women in recovery are greatly challenged by this task. Not only do they have to draw upon their personal stories to write, they also have to take a risk to present their songs and, thus, their inner feelings. These women come to treatment holding fast to

myths about emotions, about thoughts and feelings and, ultimately, about themselves—myths such as *Letting others know that I am feeling bad is a weakness*, *Negative feelings are bad and destructive*, *Going to a therapist means you're crazy*, *Some emotions are really stupid* and *No one ever knows how to help me*. By accepting the challenge to share these pieces of self, the women take a risk in viewing self and others as okay and in thinking *There is nothing wrong with having these feelings*.

Self-Respect and Self-Empowerment

Women who have lost themselves to drugs and alcohol and who no longer remember themselves as clean and sober have little concept of their *real self* and little self-respect. A false sense of self—an *addicted self*—has become their daily reality. The addicted self is the whore, the good-for-nothing wife, the neglectful mother, the shameful daughter, etc. This is a self that society has typically stigmatized and condemned, and the women have internalized this condemnation. While they embrace the idea of change, they are also deeply fearful that they will not be able to change or that the changes they make for the better will dissolve once they leave the security and support of the treatment setting. In fact, this will be the case for many, as relapse is probable. For these women, treatment must provide *repeated* opportunities to let go of the false, addicted self and reclaim a healthy, affirmative identity. Greater self-awareness of strengths, limitations, interests, talents, ambitions—that is, finding the answer to the questions, *Who am I when I am healthy?* and *What do I value in that person?* —is intimately connected to enduring recovery.

Spontaneous composition.

We have used the song “I Am A Bright Light” (Barry Bernstein) as a way to gently introduce the concept of a positive self-image. We sing through the original song while standing in a circle and providing a rhythmic ostinato with egg shakers:

*I am a bright light
I am a bright light
I am a bright light
Perfect just the way I am*

Then, each group member is encouraged to compose and insert her own self-description as a way to begin the process of claiming strength and pride: *I am a caring mom, I have a pretty face, I am a trusted friend, etc.* Women who are unable to claim an affirmation for themselves are assisted by others in the group who have come to appreciate their positive attributes.

“You are More” (Tenth Avenue North) is another song that lends itself to personal composition within the context of the larger group. In response to the question, “Don’t you know who you are?”, the original chorus reads:

*You are more than the choices that you've made,
You are more than the sum of your past mistakes,
You are more than the problems you create,
You've been remade.*

One group spontaneously re-constructed and personalized the lyrics as follows:

*I am more than the drugs that brought me here,
I am more than the shame and the guilt and fear,
I am more than the things I did to survive,
I've come alive.*

Music Imagery (MI). Self-empowerment is about authorizing the vital, positive forces within the self to take control. Often, this process begins with the ability to let go of past trauma and resulting emotional injuries. In comparison to other types of therapy, music is better able to address the deeper, work of spiritual recovery—the search for positive identity and longing for wholeness that underpins all other recovery issues. One of the authors with advanced training in GIM (MC) has used music imagery (MI) experiences, adapted from traditional GIM, to help women with the process of self-discovery and spiritual recovery. In an effort to accommodate group work and time constraints, this author often uses themed scripts. The experience begins with a brief relaxation induction with short pieces of music to encourage attention to a single, beginning focal image. The listening experience, with the script, lasts between four and ten minutes; post-music integration and processing follows. (Some sample MI script titles and descriptions appear in Appendix A; a sample script appears in Appendix B.) Post-music integration includes having the women complete a writing piece (such as a poem or a short story) or a work of art (such as a mandala or other drawing).

A scripted MI exercise such as *Letting Go* can assist women in releasing negative feelings. The women are asked to call up something they want or need to let go of, to give it an image, to hold onto this image somewhere in their body, and then to let the music in and around the place where they hold on. They are asked to allow the music to help lead them to any experience that they need in the present moment.

One woman assigned her deep, immense feelings of shame the image of a grave. This image remained at her feet as she stared into its darkness. Although it felt difficult to do, this woman forced herself to continue staring into this grave. The music seemed to help tether her there; at the same time, her body felt as though it was getting lighter and lighter. She realized that she was floating above the grave, slowly distancing herself from her shame. Following the exercise, this woman stated that, in the imagery, she buried her shame. She decided that, in order to start over in life, she could leave all that shame in the grave and rise above it.

Following participation in *Reflection in the Mirror*, one group member wrote the following poem:

“The Real Me”

*Who is this person that I see?
 Who not long ago was my enemy
 Who is this person that I see?
 I couldn't believe was kin to me
 Who is this person that I see?
 Who was trying to bring death to me
 Who is this person that now I see?
 Full of hope, joy, and at peace to me
 Who is this person that now I see?
 Who really wants the best for me
 Who is this person that now I see?
 By the grace of God it's the real me
 (Lynda)*

This woman experienced meaningful imagery during the exercise and was excited to share two different reflections of herself—the *addict self* and the *real self*. She saw the “*enemy*” *addict self* and the clean and sober *real self*, “*full of*

hope, joy, and at peace.” The fact is that music, in its very special way, connected this woman to that part inside of herself that was most authentic, most healthy, most at peace, and most sacred.

Letting Go is used to assist women who need to move past feelings of embarrassment, shame, and guilt. For female addicts, these feelings can be almost as crushing as the addictions that have been slowly killing them. Entering treatment, and with a heightened sense of how their addictions have affected and continue to affect others (especially their families and children), the women carry these feelings around like huge weights on their shoulders. The weight of shame prevents movement and growth. We have heard the heaviness in their words following this experience:

Shame was one of the biggest things that kept me from reaching out for help in the past. It is still hard for me to deal with today because I know how much pain and suffering I caused my family and loved ones.

Shame—I’m full of it; it’s deep, immense—I want rid of it; I just want to feel good about myself.

I feel so guilty, all the people I hurt. I was mean and selfish, my life chaotic.

I shut people out sometimes because of feeling ashamed of how my life seems to be crumbling around me.

Sometimes women have a very powerful first imagery experience; however, most work at piecing together a series of smaller understandings and insights gained from multiple MI experiences.

Music-supported movement. For some groups, letting go of self-negativity requires much more physical energy than imagery can provide. Music-

supported expressive movement can help women to physically feel the weight of embarrassment, shame, guilt, sadness and other feelings that burden them. For example, to the music of Rodrigo's *Concierto de Aranjuez*, the women collectively experience how difficult it is to move forward with so much expressed weight on their shoulders. As they grow tired of moving with this additional weight, they make an effort to let it go. The music changes and encourages freer, lighter movements. A Strauss waltz allows the women to reconnect with their inner, innocent child. The music supports the release of heavy burdens with new images of dancing and fancy, dreamlike ballrooms.

Structured, even choreographed, music-supported movement has also helped women to let go of unwanted feelings that are blocking progress in their recovery. In one experience, women are given paper plates to dish out helpings of anything not wanted or needed (e.g., guilt, shame, anger, fear, hurt, depression, bad news, men, extra calories, etc). They verbalize what they have put on their plates and then, to the music of "The 12th Street Rag", the group performs a paper plate routine to the beat of the music. The choreography involves rotating the plates around the circle. The women quickly lose track of their unwanted helpings and most discover that they could care less; their plates are gone, and that is all that matters.

Movement can help women connect with the sacredness of their physical selves. When asked what aspects of her spirituality she needed to claim or reclaim, Tasha identified with her experiences as a member of a liturgical dance team in her church. As Tasha's addiction increasingly took hold of her life, she

abandoned this activity and her image of her body as a sacred vessel deteriorated. In music therapy, she was given the opportunity to teach her peers one of the dances that she had performed in church. In an unprecedented show of compassion, nine of ten group members participated, even those who had formerly refused any involvement in movement or dance. Afterwards, Tasha cried as she thanked the women and spoke about how meaningful the session had been, not only in terms of re-accepting her physical body, but also in re-identifying her faith as a source of personal power. Borling (in press) writes, "Oftentimes this [spiritual] level of recovery is simply referred to as an adoption of spiritual principles in one's daily activities that may be quite separate from any religious traditions, while at other times there may, in fact, be a strong re-acquaintance with lost traditions and religious activities" (p. 5).

Many of the women with whom we work state that they loathe their bodies. Years of substance abuse, coupled with physical and sexual abuse, prostitution, pregnancies, poor nutrition, and lack of exercise and appropriate medical care have left them in poor physical condition and with an inferior body image. Some speak of feeling completely disassociated from their physical bodies—numb. We have found that group line dances, such as the "Electric Slide" and "Cupid Shuffle", presented from a supportive, activity-oriented approach (Wheeler, 1983), can start to bring greatly needed awareness to what their bodies can do and be. Choreographed dance and exercise to uplifting music adds positive energy and levity to the lives of these women, most of whom have long forgotten how to have nonsexual and sober fun.

Song discussion. Songs that have the potential to touch women at the core of who they are—at that very foundational level of being a woman—can guide them toward a more positive sense of self and a deeper spirituality. One such song is “Healing of the Heart” by music therapist Ken Medema, which includes the following lyrics:

*Where, tell me where do we begin
 Somebody tell me how,
 How do we even start
 How do we start to walk
 To walk across that long, long bridge
 On the road to forgiveness
 Long, long road to forgiveness
 All the way to forgiveness
 And the healing of the heart*

This song, with its focus on *forgiveness* and *healing of the heart*, touches the very soul of women in recovery who desperately need to forgive themselves for past affairs in order to begin moving in a positive spiritual direction. Prompted by hearing this song, one woman returned to group a week later with a personal composition, which she titled “Sinner’s Prayer”:

*Every day the same routine
 Every day I live in sin
 May God release the demons within me
 That make me live with such rotten things*

*Only me and God knows
 The wicked ways I unwillingly chose
 I live my life in consequence
 Such disrespect to all God’s creations*

*I fear for the day I will be judged
 I cannot quit
 Not even for God’s love
 For there is something deep inside of me*

*That takes over my mind and my body
So I pray in this moment of clarity
God, will you accept my sincere apology?
Help me live you will
And lead me on a path to serenity.
(Sandra)*

Tormented by her sins and, at that time, not yet able to forgive herself, this woman prays in a moment of clarity for God's forgiveness and help. To her credit, she writes to the God of her understanding, acknowledges something greater than herself and recognizes the need for forgiveness and help. All of this is evidence of movement in the positive spiritual direction that is necessary for lasting change.

Conclusion

Addiction is a multi-faceted illness that affects people in profound ways. For women in particular, addiction carries with it intense anxiety, shame, grief, and loneliness. Significant past trauma is a near-certain correlate. The music therapist's nonjudgmental and supportive presence is monumentally important throughout the period of treatment and recovery so that women may begin to feel and face these difficult emotions rather than remained trapped in numb isolation.

A woman's recovery is a search for identity—a striving for wholeness. In order for women to have any chance at becoming whole, they must feel safe, make meaningful connections with others, have opportunities and encouragement to feel and express their deepest emotions, identify who they are at the core of their being, and connect with their intrinsic spiritual life forces. In the hands of a compassionate and competent music therapist, music—as a

refuge, a form of communication, an outlet for raw expression, a reflection of who we are and who we want to be, and a treasured and sacred life experience—can provide the support necessary for women to move to and through the recovery process with hope, courage, and success.

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Appendix A – MI Script Titles and Descriptions

Letting Go -- The intent is to give an image of something or someone you want or need to let go of.

In My Heart --The intent is to find a place where (self and other) forgiveness resides in the heart.

A Special Place --The intent is to recall or discover a place that feels safe and secure.

On A Road --The intent is to see self on a road, look behind to see where you've come from, look ahead and around you to see where you are drawn to go.

I've Got A Name --The intent is to visualize all the letters of your name and notice what characteristics they connect with.

Reflection in the Mirror -- The intent is to stand directly in front of a mirror, notice what you see and what you feel about the image in the mirror.

Appendix B – Script for *A Special Place*

Music: *Unconditional Love* (M. Stillwater/G. Malkin), *Unspeakable Grace*, Novato, CA: New World Library.

Close your eyes and make any adjustments in your chair until you feel comfortable. Now bring your attention to your breathing. Notice that, by breathing deeply, you can fill your body with air. Take a long, deep full breath, filling your entire body with air and slowly letting it go. Take another long, full breath, filling your body with air and slowly letting it go. As you exhale, let your breath carry out any tension, any worry, anything that you don't need right now.

Breathe in—and let go. As your body breathes very naturally on its own, imagine, in your mind's eye, a place that you have felt safe and secure. This place can be from a long time ago and very familiar or it can be one you haven't been to in a long time. You may want to imagine what a safe place would be like if you do not have one.

Take your time and see, in your imagination, a place that feels safe to you. It can be real or imaginary, or a mixture of both. It can be anywhere you want it to be—a room, a house, a building, a boat, somewhere outside. Allow your senses to fully experience this place. Notice what's here, the colors, textures, smells.

As the music begins, allow it to join you in this special place and let it help you to experience what you most need at this time. . . .

The music has ended. . . bring your imagery to a close, knowing that you can hold onto anything that feels significant—anything that you need.