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Application of the Helping Model on music therapy practice for individuals with alcoholic use disorder: Theoretical orientation and empirical implication

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ABSTRACT

Research in the field of music therapy and substance-related disorders is growing and diverse within the intended treatment areas and interventions. Evidences of music therapy on this population have been focused on the effects of particular music therapy technique(s) or generalised responses from participants without establishing any theoretical treatment model. The application of music therapy within a solid treatment model based on thorough theoretical orientation is essential to any recovery or rehabilitation programme. This paper establishes the theoretical and empirical implications of music therapy based on Gerard Egan's Helping Model (2013) in treating patients with substance-related disorders, in particular alcohol use disorder (AUD). Egan suggested three principle goals of helping: (1) life-enhancing outcomes; (2) learning self-help; and (3) prevention mentality. This paper will explore whether the therapeutic goals in Egan's Helping Model can be addressed and established at the forefront of a music therapy treatment model for individuals with AUD and introduces empirical music therapy interventions with a case study based on the Helping Model.

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INTRODUCTION

In order for music therapy to be considered a mental health care profession, the therapeutic outcomes of music therapy must be agreed upon by major streams of other health-related professions. To fulfil this ultimate goal, the music therapy profession needs to adopt the general scientific research method including: theory development, theory examination, and clinical application. The processes of theory formation and clinical application are the most likely to produce reliable knowledge regarding therapeutic outcomes and the effects of treatment. As a music therapy researcher and clinician who

has been working with clients with substance-related disorders (i.e. alcohol use disorder) and mental illnesses, including anxiety disorder and depression at a university-affiliated music therapy clinic in a southwest region of the USA, I have developed a strong responsibility to justify the use of music in clinical practice and to improve the way of reporting therapeutic outcomes.

Evidence of music therapy on this population was focused on the effects of particular music therapy techniques or an overly generalised response to musical activities without establishing any systematic treatment model. As a result, the application of music therapy has not reached its full potential in clinical recovery practice for individuals with substance-related disorders. Therefore, the purpose of the present study is to establish a theoretical orientation and empirical implication of music therapy based on a cognitive behavioural treatment model in treating patients with alcohol use disorder. A music therapy case study of one client with alcohol dependence, depression, and drug addiction will be discussed.

Alcohol use disorder (AUD)

Alcohol use disorder (AUD) is the most common substance-related disorder in the USA. It is a combination of alcohol-related medical conditions characterised by alcohol dependence or alcohol abuse (American Psychiatric Association, 2013). It is more commonly referred to as alcoholism. AUD is defined by a cluster of behavioural and physical symptoms which can include withdrawal, tolerance, and craving of alcohol. It is often associated with problems similar to those associated with other substances (e.g. cannabis, cocaine, heroin, amphetamines, sedatives, hypnotics or anxiolytics). Symptoms of conduct problems, depression, anxiety, and insomnia frequently accompany heavy drinking and sometimes precede it. The diagnostic features of AUD highlight major areas of life functioning deficits involved in vocational performance, interpersonal relationships and health. Depending on the actual compound, AUD may lead to various medical problems, social problems, morbidity, injuries, violence, death, motor vehicle accidents, homicides, suicide, physical dependence or psychological addiction.

AUD can induce symptomatology which resembles mental illness; this can occur both in the intoxicated state and also during the withdrawal state (American Psychiatric Association, 2013). The psychiatric health impacts include susceptibility to depression, dysthymia, mania, hypomania, panic disorder, phobias, generalised anxiety disorder, personality disorders, drug use disorder, schizophrenia and suicide. Impairments in working memory, cognitive processing, emotional signals, executive functions, visuospatial abilities, gait and balance are also effects of AUD (Carigulo, 2007).

Treatment for alcohol use disorder

Alcohol dependence or alcohol abuse requires consistent and adaptable treatment schemas in order for an individual to successfully reduce or eliminate the desire to utilise alcohol (American Psychiatric Association, 2013). Behavioural interventions and medications exist that have helped many people reduce or discontinue their alcohol abuse and dependence. Behavioural psychology and several evidenced-based interventions have emerged: behavioural marital therapy, motivational interviewing, a community reinforcement approach, exposure therapy, and contingency management. In children

and adolescents, cognitive behavioural therapy (CBT) and family therapy currently have the most research evidence for the treatment of alcohol use problems. These treatments can be administered in a variety of different formats, each of which has varying levels of research support (Hawkins, Catalano & Miller, 1992).

Psychological treatments for alcoholism or alcohol dependence are typically composed of three phases: management of alcohol withdrawal syndrome, motivation for and initiation of abstinence, and prevention of relapse (Conroy et al., 2008). Treatment can occur once the client has portrayed a readiness and willingness to change, and is willing to be an effective participant in the changing process. Various therapies may be employed to reach a successful outcome, as well as pharmacological efforts. All of these approaches are viable methods to treat AUD but may be contingent on the individual's specific qualities and background. Kielcolt, Aggen and Kendler (2013) reported that genetic factors suggesting a risk for alcohol dependence overlap with genetic factors influencing a sense of mastery. The researchers define mastery as congruent with self-efficacy, sense of control, locus of control, or the belief that one has control over one's outcomes. Mastery has been found to be an indicator of the level of education attained, as well as having positive effects on lifestyle choices. Though mastery is partly heritable (thus genetic), environmental factors may also play a role. Kielcolt, Aggen, and Kendler (2013) concluded that women in particular had lower self-perceived mastery scores than did men that correlated inversely with alcohol dependence. The study suggests that interventions geared toward increasing or raising mastery levels and self-efficacy within alcohol dependence may aid in the treatment process (Kielcolt, Aggen & Kendler, 2013).

In order for individuals with AUD to be motivated for treatment, they must first be aware of their state and the need to change. Luft (1984) defines self-awareness as the knowledge and understanding of feelings, behaviours and interactions. Self-awareness and motivation are effective goal areas to eventually demonstrate a readiness for change (Duval & Wicklund, 1972; Silverman, 2012). A theoretical construct has indicated motivation to be a prerequisite for any successful treatment (Beckman, 1980). Goals of motivation typically require clinicians to focus treatment on identifying triggers and recommending healthy coping skills. Duval and Wicklund's (1972) objective self-awareness theory has determined that enhancing self-awareness can encourage motivation and self-evaluation. It was also demonstrated that an increase in self-awareness was more likely to achieve consistent behavioural changes measured by the individual's self-report (Pryor et al., 1978). These researchers indicated that creating an environment for self-awareness with self-focusing stimuli leads to self-evaluation. Hoyer and Heidenreich (2000) reported that psychological functioning as a whole was increased in a detoxification clinic due to increasing self-awareness from the beginning of treatment until its conclusion. Duval and Silvia (2001) suggested when individuals internally self-analyse their expectations regarding improvement, and their self-perceived outcomes are unfavourable, these individuals will avoid self-focus. Likewise, if these individuals perceived the rate of progress toward improvement to be low in relation to the magnitude of the problem, self-focus was also avoided. If the perception of improvement (i.e. self-efficacy or a sense of mastery) is sufficient, the individuals will likely take action and achieve desired behavioural changes (Duval & Silvia, 2001).

Morin (2011) identified that self-discrepancy is not only an indication of avoidance of self-awareness, but the defining factor between the real self and the ideal self. The discrepancy formed between the real self and the ideal self might result in avoidance of self-awareness; and the effort of

reducing discrepancy by modifying both the real self and the ideal self might produce positive outcomes and a higher rate of progress (Morin, 2011). This positive outcome occurs as a result of motivational factors created by the individual. In general, a person who is self-aware, and whose current self is discrepant from his or her desired self, would be motivated to change his or her current self in order to fit a personal standard of correctness (Duval, 1971). Silvia (2012) called this particular self-evaluating capacity "self-focus" and stated it is generated by the individual's potential motivation. One's expectation that the behaviour changes will fulfil the discrepancy and the needs is a potential motivation (Brehm & Self, 1989; Silvia, 2012). Positive environmental stimuli were capable of influencing an individual to become a self-observer with a great level of self-focus and self-awareness. Self-reports made under a self-focused condition with positive environmental stimuli are more likely to achieve consistent behavioural change (Pryor et al., 1978).

The treatment goals and approach for AUD need to be established upon the specific disorders or problems in the individuals while also considering their strengths and interests. Social skills are significantly impaired in people suffering from alcoholism due to the neurotoxic effects of alcohol on the brain, especially the prefrontal cortex area. Social skills training adjunctive to an inpatient treatment of alcohol dependence is probably efficacious, including managing a positive social environment (Alcoholics Anonymous, 2001). Therefore, treatments for AUD demand a strong client-therapist relationship to accomplish a particular aspect of behaviour fuelled by methods to achieve sobriety, readiness to change and the elimination of psychosocial stressors for further alcohol dependence (Conroy et al., 2008). The successful treatment for AUD should primarily establish therapeutic goal areas of self-awareness leading to motivation and readiness for change in a positive social environment with self-focusing stimuli (Beckman, 1980). Optimal therapeutic interventions might allow individual clients to be 'self-observers' and provide opportunities to develop a sense of mastery through increased motivation.

Music therapy for individuals with substance-related disorders

Music therapy facilitates various musical experiences designed to meet goals of self-awareness that lead to motivation and readiness for change in individuals with substance-related disorders (Silverman, 2012). Evidence-based clinical effects within those treatment areas have been reported (Ahamdi, 2001; Albornoz, 2011). Ross et al. (2008) conducted a naturalistic pilot study to determine if music therapy could affect treatment outcomes for individuals who were dually diagnosed with addiction and mental illness. Ross et al. concluded that music therapy could be a motivational tool for people in substance-related disorder rehabilitation. Silverman (2009) found that a lyric analysis intervention was as effective as verbal therapy in measuring treatment eagerness and working alliance in a detoxification unit. Mossler et al. (2012) measured certain music therapy techniques as a predictor for change in a mental health centre treating individuals with low motivation for therapy. Researchers concluded that positive tendencies toward improvement in interpersonal problems and social relationships occurred as a result of music therapy, particularly through singing or learning musical skills as a therapy (Mossler et al., 2012). Silverman (2011a) found that change readiness was increased and depression was decreased in a detoxification unit using music therapy.

In the realm of substance-related disorders, music can be utilised as an effective treatment medium to engage and facilitate self-awareness in patients. Silverman (2012) measured motivation and readiness for treatment in individuals with substance dependence using songwriting by converting song lyrics into codes within the Circumstances, Motivation, and Readiness for Treatment Scale (De Leon, 1993). By using a frequency count of certain words charged with certain meanings (e.g. "action" or "change"), the researcher was able to quantify responses into functional data collection of the individuals' awareness. Results of this study indicated that songwriting improved readiness rates, possibly because songwriting is an effective tool utilising music and lyrics as a medium to address topics pivotal to relapse prevention and to motivate the client to become self-aware by manipulating the manner in which issues are addressed (Silverman, 2012).

A positive reaction to musical stimuli may serve as an initial motivational factor for treatment within substance-related disorders. In another study conducted by Silverman (2011b) measuring change and depression of patients in a detoxification clinic, participants were either placed in a verbal therapy or music therapy session designed to determine readiness to change, level of depression, and treatment perceptions. Silverman found that those in the music therapy sessions demonstrated more statements of enjoyment, thankfulness and positive cognitive changes, and created a more comfortable environment to address sensitive issues such as triggers, social issues and previous relapses, as opposed to the verbal therapy group (Silverman, 2011b).

By creating an environment suitable for self-realisation, self-actualisation and self-awareness, individuals can transition into functional therapies focusing on behavioural change, behavioural restructuring and eventual sobriety without relapse. In order to begin, however, motivation is necessary for treatment. Individuals will only become motivated if they are aware of the deficits or need for change within themselves (Silverman, 2012). Music therapy is a beneficial therapeutic tool utilising music as a medium for redirecting the focus of individuals inwards to perceive the need for change, which induces motivation. Music therapy sessions construct a positive social environment for self-awareness through the use of music (i.e. self-focusing stimuli). Multiple functional interventions such as songwriting, lyric analysis and music listening can act as a useful environment to gain insight and awareness of the real self versus the ideal self to realise the need for change and to begin treatments.

The next section will introduce a cognitive-behavioural treatment model establishing the therapeutic goals of self-awareness, motivation, and readiness for change published in *The Skilled Helper: A Problem-Management and Opportunity Development Approach to Helping* (Egan, 2013); and an application of the model in music therapy interventions for individuals with AUD.

HELPING MODEL

Gerard Egan was born in Glasgow, Scotland and founded Developmental Eclecticism in the 1970s. Egan is the Professor of Organization Studies and Psychology and Programme Director for the Centre for Organization Development at Loyola University of Chicago. The skills-based model of therapy developed by Egan is an active, collaborative and integrative approach to client problem management. It shares some characteristics of the cognitive-behavioural school and is firmly grounded in the core conditions of the person-centred approach (Jenkins, 2000). Widely taught in counselling courses, the

model was first introduced by its author as a practical model for doing counselling; the model is pragmatic, change-oriented and specifies the appropriate skills available to the helper at different stages of the counselling process (Jenkins, 2000; Riggall, 2016). In a study of the sustainability of Egan's helping model, the trainees or supervisees of a social work practice were continuing to use most stages of the model with service-users or clients in a variety of settings. Further findings show that the model is still useful in situations where shared goals are set by social workers or counsellors, and the utilisation of role-play is the most embedded skill in the model for learning the optimal relationships with clients (Riggall, 2016).

Problem management and opportunity development

The helping model is a three-stage model or framework offered by Egan as useful in helping people solve problems and develop opportunities. The goals of using the model are to help people to "manage their problems in living more effectively and develop unused opportunities more fully" and to "help people become better at helping themselves in their everyday lives" (Egan, 2013, pp. 7-8). Thus, there is an emphasis on empowerment. In addition, the person's own agenda is central, and the model seeks to move the person toward action leading to outcomes which they choose and value. This model is not based on a particular theory of personality development or on a theory of the ways difficulties develop. It is a framework for conceptualising the helping process and is best used in working on issues in the recent past and the present.

Egan (2013) described a three-stage helping model: (1) Help clients explore their concerns: Current picture; (2) Help clients determine problem-managing outcomes and set goals: Preferred picture; and (3) Help clients draw up plans to accomplish goals: The way forward. He also described a therapeutic model for assisting clients in making the necessary and desired changes in their lives with the role of a 'helper'. Egan proposed that the three principle goals of helping are life-enhancing outcomes, learning self-help, and prevention mentality. According to Egan, an essential component in the helping process is the helping relationship itself. Egan (2013) also categorised and sequenced the therapeutic skills needed for the different phases of the helping process. The book's subtitle, *A Problem-Management and Opportunity-Development Approach to Helping*, addresses the goal of achieving positive outcomes alongside clients, ultimately guiding clients to help themselves. Because of Egan's unique approach toward the helping professions, its contents are applicable in all fields, whether in clinical work, the medical profession or any method of therapy. The following section is the summary of the three stages of Egan's Helping Model (2013).

Stage I: The current picture

Stage I of the helping model is the introductory step to helping and being helped. In this stage, helpers (i.e. therapists) encourage clients to acknowledge or consider their problems, issues, concerns and difficulties. Clients tell their stories (Task 1) and are subsequently encouraged to manage feelings of reluctance and resistance (Task 2). During Task 1, Egan addresses the need for helpers to start where the client starts, to encourage clients in the right direction. This contributes to the client's self-identity and overall awareness of the severity of their problem. This can be done by talking about the past to make sense of the present, to be liberated from it, and to prepare for action for the future. Finally, the

helper can enable the client to see problems as opportunities for change and spot previously unused opportunities.

In Task 2 of Stage I, the helper aids clients in managing reluctance and resistance. Egan noted that the seeds of reluctance are in the client, whereas the stimulus for resistance is external – in the helper or the social setting surrounding the helping process. Egan argues that reluctance can stem from a fear of intensity, lack of trust, fear of disorganisation, shame, the cost of change and loss of hope. Resistance to treatment occurs when clients feel that they need to resist help. From here, helpers guide clients in their search for value (Task 3). This is the step when helpers challenge clients to fully participate in the helping process. This requires clients to state that their problem is solvable and to accept challenges that can be turned into an opportunity or effectively managed.

Stage II: The preferred picture

There are three tasks in Stage II: (1) Help clients discover possibilities for a better future; (2) Crafting the change agenda: Help clients move from possibilities to choices; and (3) Help clients discover incentives for commitment to change their agenda. Stage II primarily functions as a trigger for action or as an antecedent for Stage III. During Task 1, it is important for the client to focus on their possible selves. In this task, the helper shows the client how to identify and develop an opportunity in order to manage a problem rather than solve it. This requires extensive creativity and brainstorming for both parties. Egan refers to the concept of divergent thinking, or "lateral thinking" to encourage possibilities for change. Task 2 helps the client move from possibilities to choices. This is where clients shape their goals by specifically relating the goal to a good intention. Egan summarises how goals should be shaped and initiated, including appropriate time frames for meeting goals and whether the goals are sustainable. Task 3 is designed to help clients commit to a better future. This task encourages client self-efficacy and helps clients evaluate their commitment to change and their pre-determined goals. All of these tasks function as a trigger for action and transition into Stage III.

Stage III: The way forward

Stage III is designed and aimed at problem-managing action steps for and by the client. This is considered to be the 'game plan' of the helping process. This stage is divided into three tasks: (1) possible strategies, (2) best-fit strategies, and (3) turning strategies into a realistic plan. In Task 1, strategies are implemented into previously initiated goals. Building strategies includes using a framework to build specific possibilities. Task 2 involves choosing the best-fit strategies for a client. This reassesses the client's ability to make effective decisions for their future. This is the way clients will ultimately accomplish their goals. Helpers can also guide clients in choosing the most effective strategies in terms of benefits, acceptability and the costs of the strategies. This leads the client to Task 3, to help clients formulate viable plans. In this task, Egan contends that the plans add value to the clients' change or need to change. Here, discipline must be developed but the implementation of plans can simultaneously keep clients from feeling overwhelmed. Better strategies can then be developed and a more specific shape of the plan can be carved out.

APPLICATION OF THE HELPING MODEL IN MUSIC THERAPY

Music therapy helping model in alcohol use disorder recovery

Egan's (2013) Helping Model can be applied to music therapy interventions as well as to the overall treatment process in music therapy for patients with substance-related disorders, particularly AUD. Egan developed a sequential design for the overall helping process but he noted that treatment can begin anywhere, and problems, goals and strategies may present themselves at unanticipated times. The overall model can be addressed with music therapy interventions, regardless of the order in which the client or case occurs. Music therapy encompasses the stimulus of musical elements in order to elicit changes in behaviour (Lim, 2008). Music can also be used to gain insight, awareness and knowledge of one's inner self when facilitated effectively (Ahamdi, 2011; Albornoz, 2011; Silverman, 2012). The therapeutic process of music therapy incorporates both the stimulus of music and the therapist as helpers. Although the design of music therapy allows music to elicit and facilitate changes in an individual, the therapeutic helping process is essential to its implementation. Without a strong client-therapist relationship and a therapeutic framework produced by the helper, the change may not take place. The following section is a music therapy application for the three stages of Egan's Helping Model.

Stage I: Current picture
Task 1. The story: Problem situations – Clients tell their stories. Task 2: The real story: New perspectives – Manage feelings of reluctance and resistance. Task 3: The right story: Key issues to work on – Search for value. Stage I Music Therapy Application*: Fill-in-the-blank Songwriting.*
Stage II: Preferred picture
Task 1. Possibilities – Help clients discover possibilities for a better future. Task 2. Goal/Outcomes – Help clients move from possibilities to choices. Task 3. Commitment – Find incentives for commitment to change. Stage II Music Therapy Application: *Lyric Analysis.*
Stage III: The way forward
Task 1. Possible strategies – Building strategies and a framework to build specific possibilities. Task 2. Best-fit strategies – Choosing the most effective strategies. Task 3. Plans to accomplish goals – Turn strategies into a realistic plan. Stage III Music Therapy Application: *Songwriting and Relapse Prevention.*

Table 1: Summary of Egan's (2013) Helping Model and its application to music therapy

Music therapy application: Stage I current picture

During Stage I, a music therapist may implement certain interventions to encourage the client to tell her story, develop perspectives and accept challenges regarding alcohol dependence. At this stage, a music therapist may use a variety of musical elements to gain information. A standard intervention is fill-in-the-blank songwriting. By choosing a song whose lyrics demonstrate themes of awareness, the alcohol use problem or feeling of inner self, the client is able to use existing words as a prompting method to generate their own perspective and story of their problem, to fill in blanks. This may act as a springboard for further discovery of the problem and reveal that others have also been in this situation.

Example: Fill-in-the blank songwriting. Lyrics from *Waiting On The World To Change* by John Mayer

> Me and all my _____
> Are all misunderstood
> They say I stand for nothing
> And there's no way I ever could
> Now I see everything that's going wrong
> With _____
> I just feel like I don't have the _____
> To rise above and _____.

Music therapy application: Stage II preferred picture

During Stage II, the music therapist addresses possibilities for the client and defines or narrows choices. From there, the client also helps to discover incentives for change. In a music therapy setting, this stage can be addressed with lyric analysis, songwriting, music as a reward, or reconstructive efforts at identifying the problem. Lyric analysis provides the client with a tool by which he/she may identify his/her needs, wants and desires. By addressing certain lyrics and applying them to a real situation, the client can choose his/her response or choice more clearly. Songs often indicate the result of choices or feelings, and deeper analysis followed by specific questions regarding the lyric material can aid the client in realising the choices he/she wants to make. In a lyrical analysis of a song addressing the artist's path or story, the client can quickly identify parts of himself/herself he/she may want to change.

Example: Lyric analysis post questions from *I'll Be There* by Jackson 5

1. Who is there for me in times of trouble?
2. Who am I there for in times of trouble?
3. Do I wish I could be there for others?
4. Does my current addiction prevent me from being the person I want to be?
5. What can I do better or differently to be there for someone else?
6. What prevents me from being there?

Music therapy application: Stage III the way forward.

In Stage III, the music therapist guides the client to implement effective strategies and formulate a relevant and specific plan for change. This may become a long-term struggle of maintenance and relapse prevention when paired with alcohol dependence. In order for the client to develop specific strategies and a plan to overcome the problem of alcohol dependence, he/she must first gain insight into his/her problem and realise the need for change, using methods to find possibilities. Stages I and II fuelled these steps and consequently led to Stage III. In a music therapy setting, this stage may rely heavily on music as a reward for correct behaviour as well as an alternative choice to alcohol dependence. In this setting, a music therapist may plan for the client to listen to his/her favourite music only if he/she refrained from drinking alcohol that day. It may also be used as a device to prevent relapse by listening to music or writing music in place of drinking. This requires advanced methods of self-control, and music must be perceived as a stronger stimulus than alcohol for this plan to be effective. Active music engagement during a session may also function as a reward or method for abstinence from alcohol. This includes playing or making music. One way to implement this strategy is to direct the client to keep a journal of his/her behaviour, whether it is thoughts of alcohol, actual intake of alcohol or feelings of being unmotivated. This can then function as the lyrics to a songwriting session with the music therapist, where these situations are given meaning and purpose. It also allows for thoughts to be externalised and addressed directly. In addition, songwriting requires individuals to independently initiate and identify internal discrepancies, choices and thoughts to become externalised and acknowledged.

Example: Songwriting from *What a Wonderful World* by Louis Armstrong.

I see _____, _____ too
I see _____for me and you.
And I think to myself, what a _____world.
I see _____ and _____
The _____ and the _____
And I think to myself, what a _____world.
The _____, _____
I hear _____, saying, "_____."
They really saying, "_____."
I hear _____, I _____
They'll _____.
And I think to myself, what a _____world.

These examples are only a few interventions that may be used for this population in a psychiatric music therapy setting. Each intervention can be tailored to the needs of an individual by utilising their music preferences, skills and their own words to create meaningful results. Music can act as a self-focusing stimulus, reward or functional medium of exchange for ideas and thoughts that may otherwise be difficult to elicit in a therapeutic setting. If the music therapist includes Egan's suggestions of active listening, responding with empathy, understanding, probing and challenging clients it creates the potential for effective therapy. By using functional methods of music alongside

therapeutic skills, achievable goals and strategies can be addressed and explored in treating individuals with AUD.

An essential component described by Egan (2013) in the helping process is the helping relationship itself. According to Egan, the helping process should be a partnership characterised by empathy and respect. The helper involves the client in as much of the therapeutic process as possible. In music therapy, this can translate into sharing goals and objectives with clients, or even helping them choose their own. Egan's helping model can indeed be applied to music therapy treatment for individuals with AUD. An empirical implication on integrating Egan's model to music therapy and its impact will be discussed throughout a case study of a female with alcohol dependence and depression/anxiety in the next section.

CASE STUDY

Client S was a 60-year-old female diagnosed with alcohol dependence and secondary depression. The client had been dependent on alcohol for approximately 20 years, and had concealed her problem from family members and friends until one year prior to beginning music therapy. The client demonstrated criteria stated in the DSM-V for alcohol dependence. Client S had been previously diagnosed with alcohol dependence, depression and drug addiction (Xanax). The client was taking medication for her depression and was involved in Celebrate Recovery, a Christian-centred 12-step Alcoholics Anonymous (Alcoholics Anonymous, 2001) group that met weekly. Client S was in Step 4 of the programme, titled *Made a Searching and Fearless Moral Inventory of Ourselves* at the time of the present study. This step focuses on internal awareness and motivators for external actions. This may include relationships with family members, personality, past history or present struggles dealing with any of these. She was referred to music therapy services by a family member who was concerned with her ability to remain sober.

The purpose of this case study was to demonstrate the author's clinical work with a client with AUD and to explore the effect of music therapy on self-awareness, motivation and readiness for change. Five treatment goals were established in the study: (1) improve self-awareness; (2) improve motivation; (3) establish readiness for change; (4) decrease anxiety; and (5) identify opportunities for self-control. Measurements were taken over the course of eight weeks, and the five goal areas (i.e. self-awareness, motivation, change, anxiety and self-control) were targeted and measured over the eight-week study. Data were collected during at least five sessions for anxiety, six sessions for self-awareness, motivation or change, and four sessions for self-control. Some of the weeks included two interventions whereas others included only one. This is due to the fact that some interventions were lengthier or a specific area was targeted due to the client's self-report.

Assessment of the client in two music therapy sessions demonstrated possible treatment areas for the ultimate goal of sobriety, prevention of relapse and for continual motivation to remain sober. These treatment goal areas are:

1. To establish/improve self- awareness
    a. (Later, motivation and readiness for change were added)
2. To decrease anxiety (as a symptom of depression)

3. Identify opportunities for self-control

For client S in particular, these goals served as functional treatment areas coinciding with the three stages of Egan's (2013) helping model and the 12-step programme goals of AA, of which both end goals are sobriety and prevention of relapse (Alcoholics Anonymous, 2001).

Music therapy treatment areas

Goal 1: To increase self-awareness, motivation and readiness for change.

Objective: Given a self-awareness exercise, the client will identify (either verbally or written) her current emotional state, current motivational level and current desire for change, and differentiate it from her past or future state, level or desire 80% of the time with unlimited prompts from the music therapist.

Treatment Goal 1 was to establish or improve self-awareness within the context of substance abuse or dependence. In order for the client to become fully aware of her choices, decisions, level of coping and possible triggers for temptation or relapse, she had to first establish her abilities and deficits either by self-report or by other measurable indications of awareness. The songwriting technique was used to address this objective. The measurable evidence was constructed by converting song lyrics into codes within the Self-Awareness, Motivation and Readiness for Change. By using a frequency count of certain words charged with certain meanings (e.g. "action" or "change"), the music therapist was able to quantify responses into functional data collection for client S's awareness. Songwriting has improved Readiness for Change rates possibly because songwriting is an effective tool utilising music and lyrics as a medium to bring forth topics pivotal to relapse prevention and to motivate the client to become self-aware by manipulating the manner in which issues are addressed, that is, with musical stimuli (Silverman, 2012). The three stages of Gerard Egan's helping model (2013): (1) The current picture: Help clients explore their concerns, (2) The preferred picture: Help clients determine problem-managing outcomes and set goals, and (3) The way forward: Help clients draw up plans to accomplish goals, were integrated in the contextual measurement of the case study. Egan's three principle goals of helping: life-enhancing outcomes, learning self-help, and prevention mentality were established in each music therapy session addressing Goal 1.

Statements made by the client throughout each session were categorised as either indicators of Self-Awareness, Motivation or Readiness for Change. A content analysis was created to categorise the client's responses as indications of one of these three functional areas. Subcategories, including "reflection", "emotion", "responsibility", "ideal", "self-esteem", "action" and "change" were established to further evaluate the client's progress in each major category and used to represent a particular aspect of the stages that are necessary in order for client S to reach change (Silverman, 2012). For example, "reflection" serves as a major area for acknowledging a discrepancy between the client's "real self" and "ideal self". "Ideal," under the Motivation category, serves as a sub-category to measure responses that appeared motivational because of a prior acknowledgement of self-awareness.

After considering multiple options for categorising the responses of client S, the format in Table 2 was used for data collection of the client's responses during music therapy interventions, as well as in verbal discussions surrounding the music therapy interventions.

Self-awareness motivation change

Session	Reflection	Emotion	Responsibility	Ideal	Self-esteem	Change	Action	Total
3								
4								
5								
6								
7								
8								
9								
10								
Total								

Table 2: Data collection format for Goal 1: To establish/improve self-awareness

Goal 2: To decrease anxiety.

Objective: Given an improvisational exercise, the client will identify her present anxiety using a Likert-scale rating verbally, before and after the exercise.

The client's self-perceived anxiety levels were also measured for four sessions. Anxiety measurements were taken in the form of verbal questions or prompts before and after musical improvisation questions. The criteria for the improvisation included: improvisation for at least two minutes; closed eyes during intervention; no talking during intervention. A Likert-scale was implemented and given to the client verbally, with 5 indicating the highest levels of anxiety and 1 indicating minimal/no anxiety. Examples of anxiety level were given in the form of sentences rather than numbers. The Likert-scale representations for levels of anxiety helped the client to most clearly and accurately define her anxiety level.

Likert-scale rating	Explanation
1	I don't feel any anxiety; I have forgotten that I was anxious in the first place.
2	I don't feel very much anxiety; I am enjoying the activity and have not changed my thoughts due to anxious feelings or thoughts.
3	I feel somewhat anxious; I am enjoying the activity but feel some anxiety.
4	I feel very anxious; I am participating but my anxiety is more dominant in my thoughts.
5	I feel extremely anxious; I can't focus on the activity due to my anxiety.

Table 3: Anxiety measurement Likert-scale for Goal 2: To decrease anxiety

Goal 3: To identify or improve opportunities for self-control.

Objective: Given a journal or writing activity, the client will identify and improve self-control, accurately identifying at least two moments of temptation and struggle within the past week.

The client was asked to indicate at least two instances of temptation or struggle during the week and record it in a journal. In an effort to externalise the temptations and identify opportunities for self-

control, music therapy interventions were then implemented (songwriting) based on the journal entries.

INTERVENTIONS

The following interventions were used during the case study to address each goal area (individual treatment plans in log).

Goal area	Intervention	Number of times goal was addressed in sessions
Self- awareness, motivation, readiness for change	Fill-in-the blank Song analysis Songwriting	5
Anxiety	Improvisation	5
Self-Control	Songwriting Music playing	3

Table 4: Goal areas and music therapy interventions

Sample procedures are provided for each intervention with the general outline and sequence of sessions below. With each intervention, different songs that were familiar or preferred by the client were used. Songs were chosen based on their content suitable for analysis as well as their relevance toward the client's situation. The selection of songs might imply the potential biases, however.

Fill-in-the-blank songwriting

1. The music therapist introduced and sang the song, *Just the Way You Are* by Billy Joel to the client.
2. The music therapist asked the client to fill in the blanks of missing words with her own thoughts of how she feels presently.
3. The music therapist then asked the client how she wants to feel, and asked her to fill in the blank for each prompt.
4. The music therapist supported the client in identifying issues of dissonance between present and future, and whether any wording should be changed after their discussion.

Improvisation

1. The music therapist introduced the xylophone to play.
2. The music therapist asked the client to rate her overall anxiety on the Likert scale, or in her own words.
3. The music therapist suggested to the client a few ways in which to play the instrument and provided a structure for improvisation.
4. The music therapist asked the client to focus only on the improvisational exercise and to continue playing until she felt that the song should "end".

5. The music therapist also asked the client to bring up any thoughts or expressions produced after playing the improvisational exercise, and how they relate to anxiety or anxiety-producing thoughts.

Songwriting

1. The music therapist asked the client if she had any temptations or struggles from the previous week.
2. The music therapist showed the client the song from last week and provided verbal support through the format of the song.
3. The music therapist continued to brainstorm with the client and guided the client through a songwriting method.
4. The music therapist created a melody for newly written lyrics within an original song.

RESULTS AND ANALYSIS

Goal 1: To increase self-awareness, motivation and readiness for change.

Figure 1 is a representation of the client's responses from sessions three to eight. Sessions one and two were assessment sessions and are not included in the data collection. The greatest amount of responses demonstrated "reflection" of either the client's situation, past, present or future. The least amount of responses was verbal indications of "responsibility". Though sessions typically focused on increasing self-awareness, other areas such as motivation and readiness for change were present in sessions as well and were calculated as part of the client's verbal statements regarding overall functioning. The qualitative results for Reflection, Emotion, Responsibility, Ideal, Self-Esteem, Change, Action and Termination are reported in the section below.

Qualitative analysis

Each subcategory is represented with direct quotes and dialogue that occurred during sessions. Italics denote a prompt whereas plain text denotes the client's own words.

Reflection

Fill-in-the-blank intervention (third session): The client was asked to identify herself using prepared prompts in response to listening to *Just the Way You Are*. The exercise sought to aid the client in gaining insight into how she views herself, and what thoughts may be produced with open prompts:

> *I pretend* to be happy when I'm not.
> *I am* non-confrontational.
> *I wonder* if I will get a job.
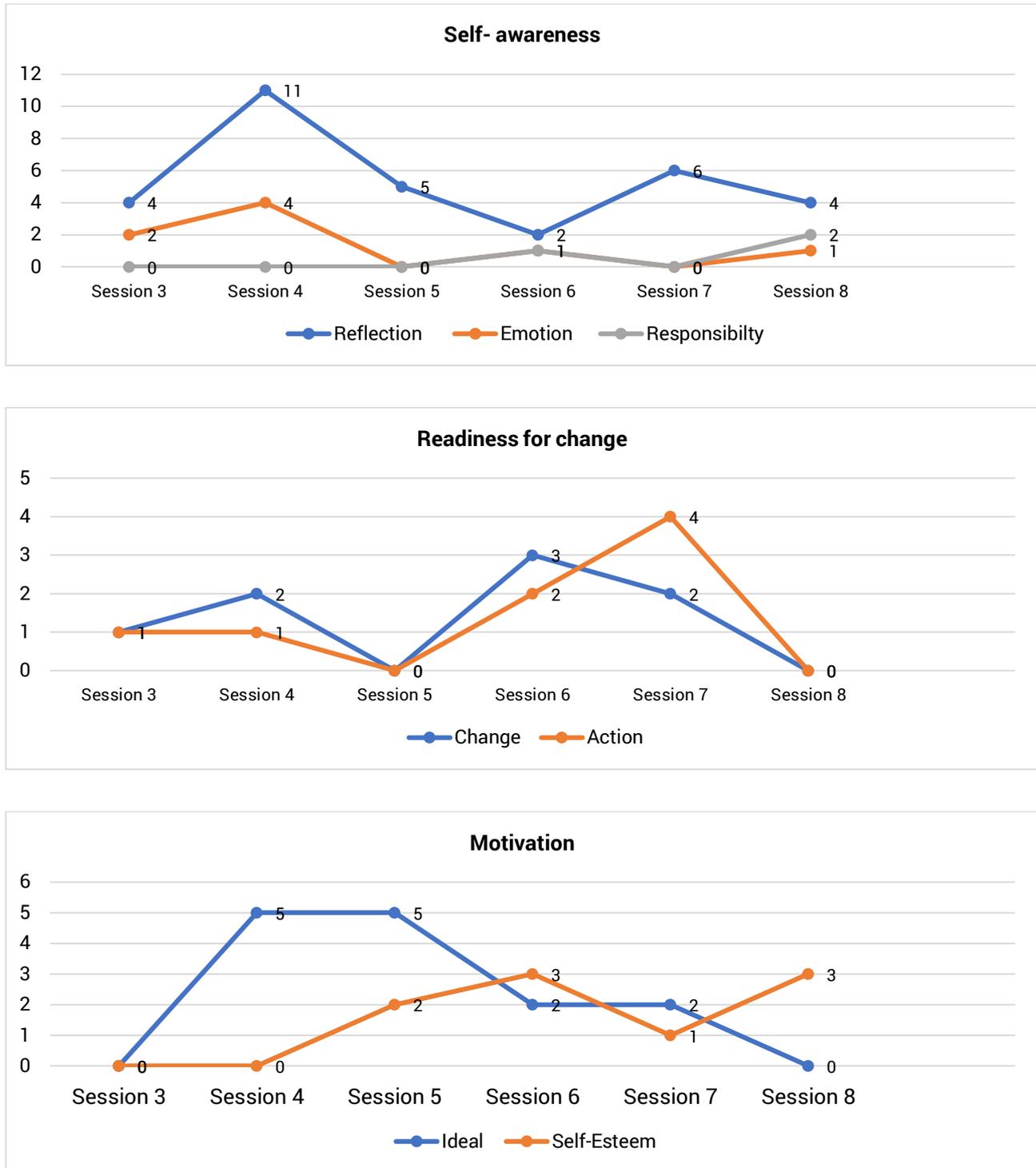> *I understand* life isn't always perfect.

Figure 1: Verbal responses during music therapy

Verbal Statement (fourth session): After asking the client what the intervention helped her to think about, the client reflected on her current employment situation. This led to a discussion of her relationship with her husband and his support of her:

> I still can't find a job. I just know it's because of my age. They are discriminating.
> I used to have a really good job and get paid a lot… I would feel better about being
> unemployed if my husband would just say it's ok. But I feel like my self-esteem

has been crushed because no-one will hire me and my husband tells me to keep looking. I wish I could be ok with staying home while I work on everything that's going on in my life, and that my husband would say that's ok too. Instead, during my downtime, it's hard not to think about alcohol.

Through verbal discussions with the client, she stated that her husband has not been supportive or even acknowledged her alcohol addiction. There had never been a discussion concerning her thoughts or actions pertaining to her addiction throughout their marriage, and she agreed that this was a factor needing serious evaluation. This led to identifying some of her anxieties and issues of self-esteem. Though the client was uncomfortable speaking to her husband, she knew she would have to initiate a discussion on the topic. However, this did not occur during the entire course of our meetings.

Emotion

Fill-in-the-blank intervention (fourth session): The client completed an exercise designed to increase her understanding of her real self versus her ideal self. It became apparent to the therapist that at times the client saw her past self or future (ideal) self as her true self. In an effort to produce thoughts of the client's present self, her emotion regarding her situation in the past began to surface.

> I walked out this morning and "cried myself to sleep".
> I remember "how much pain I was in".
> I've seen "pain" and I've seen "gain".
> I've seen sunny days that I thought "would never come again".
> I've seen lonely times when I could not "concentrate".
> But I always "thought I was strong to see me through".

Verbal statement (fifth session): The next week, the client was comfortable in expressing her feelings after returning from a weekend spiritual retreat. She relayed her anxious thoughts before and after her encounters with strangers who did not know her as an alcoholic and how she felt without anyone knowing of her addiction.

> I was so unsure of whether I would have to tell everyone I was an alcoholic. I was going to introduce myself that way. I am so ashamed of it, but I thought that everyone there might hold me accountable. If there was going to be alcohol there, there's no way anyone would let me drink it, which is good for me. After the retreat though, my new friends told me I was an 'encourager' and 'motivator'. It meant so much to me for them to see that in me, because to myself I was an 'alcoholic'. I felt normal for once.

She stated that she was proud she had an identity that was not tied to her addiction. This was a pivotal moment for the client's self-image and for developing an accurate perception of her real self. Unfortunately, the client had hoped that the spiritual retreat would have, in a way, "cured" her from her addiction. Although during the weekend she did not experience any tempting thoughts, when she

returned it became difficult again. It became evident that the client was consistently seeking something other than herself to fix her problem. The client exhibited some denial in accepting the necessity of putting forth effort on her own.

Responsibility

Fill-in-the-blank intervention (second session): The client refers to her family as she fills in the blanks to identify her responsibility in the situation, and who may be responsible for her care:

> "We all" must make a pact; we must bring "me back".
> Where there is love, "we'll" be there.
> "You" reach out "your" hand to "me".
> "Hope you'll" have faith in all "I" do.
> "Thanks for your help, I'm getting there."

Verbal Statement (third session): For homework, the client was given a list of questions after a song analysis of "I'll be There". Her responses are below:

1. *Who is there for me in times of trouble?*

   My sons have been there for me. And my daughters-in-law, they are my saving grace.

2. *Who am I there for in times of trouble?*

   I try to be there for my kids, but it seems like they are taking care of me these days. I used to be able to help a lot of people at work. My pastor has told me to look into volunteering so I can feel needed again, but I don't know.

3. *Do I wish I could be there for others?*
   Yes. I feel like everyone has lost their faith in me. Especially with watching my own grandkids. I want to be able to watch them, and live long enough to see them grow.

4. *Does my current addiction prevent me from being the person I want to be?*

   Yeah, I feel so trapped, like it controls me. I just want something to keep me from being addicted. That's why I go to counselling and 'Celebrate Recovery'. I hear all of these stories of success and I want that too.

5. *What can I do better or differently to be there for someone else?*

   I could volunteer I think, and stay sober.

6.   *What prevents me from being there?*

My addiction.

This exercise demonstrated that the client had depended on others more than herself for effort, change and relapse prevention. Taking responsibility for her situation was also the least identified subcategory of self-awareness for the client. Oftentimes, the client would refer back to this exercise and place her "hope" in her family to help her. Though family support was and is vital to the client's success, the client's own effort is also necessary. The client also identified her addiction as the key factor that prevents her from "being there" for someone else. Rather than stating herself, or her choices, she chose to make her addiction the primary factor for not being able to help others. Responsibility is essential in increasing and maintaining a realistic view of one's self. The client struggled with this and despite the assistance of countless prompts, was never able to fully admit that she needed to produce effort for her own change.

Ideal

Songwriting: After a relapse, the client was asked to recount her thought patterns throughout the episode from beginning to end. After this, the client was asked to provide concrete motivations that could potentially prevent her from relapsing again. These motivations were embedded into an original song for easy memory if thoughts of relapsing occurred again. It also helped the client to identify simple and real motivators for change:

Because I want to remember without effort.
I want to see my grandkids grow.
I want freedom from my own chains.
And I want to use the grace God has bestowed.

Verbal statement: After relaying the relapse episode and writing her original song, the client discussed in more detail why her motivations led her to wanting to give up alcohol:

I don't want my grandkids to be frightened of me. They won't want to be near a grandmother who is like that. And I want to be a great grandma. I want to be healthy for everyone so I don't miss anything, and so they can depend on me for things.

This exercise led the client to gain insight into her ideal self in a realistic and attainable manner. By outlining specific motivations that would lead her to change, the client was successful in viewing change as a worthy endeavour, and not changing as a problem. This is vital in producing change in oneself. Though the client had not yet found effort within herself to pursue these endeavours, it was the first time she identified to herself that it was necessary.

Self-esteem

Improvisation (fifth session): During an improvisational music activity, the client was asked to comment on anything that came to mind while playing music.

> I sound really good on this instrument! I can't believe I can keep up with you on this drum! You know, I always used to sing in my church choir, I used to love doing that.

Verbal statement: During the client's relapse, she reported that for the first time in her life, after buying alcohol, she drank only one sip and then stopped. After providing verbal support to the client on her improvements despite her relapse, the client reported her thoughts:

> I guess I didn't think of taking one sip as a good thing. I have been so ashamed this whole week. Like everything I worked for had been thrown out the window. But maybe I am making progress. I guess that makes me feel a little better about myself. I'm just telling myself that it won't happen again.

The client had a strong awareness of her lack of self-esteem. She provided many statements throughout improvisational interventions that relayed her need for building her self-esteem. Positive self-esteem statements usually involved her ability to produce pleasant-sounding music without any training. Music therapy exercises proved to be important in showing the client her strengths as a creative individual. The client's own relapse behaviour caused the biggest decrease in self-esteem. Her lack of communication with her husband concerning her addiction and unemployment also contributed to this. In order for motivation to improve, self-esteem was essential for providing a positive view of self and to view the pros of changing as more desirable then the cons of changing.

Change

Songwriting (seventh session): During this intervention the client discussed for the first time that her anxiety was a major cause of her alcoholism. After a brainstorming session with the music therapist, the client wrote original lyrics designed to find ways to change her perception of worry and anxiety:

> If I can live for today, don't look toward the future, my worries of family, slip-ups, and my purpose will all be nurtured. So I need to live in the present and be happy with my life, I have so much to be thankful for and should have no strife.

Verbal Statement (eighth session): For homework, the client was asked to identify her worries and then identify reasons why they are not worth worrying about.

> I realised I have a roof over my head, food to eat, a car that runs, and there is really no reason to worry about everything that could happen. Sometimes, yeah, I get worried even when my son doesn't answer his phone, but it's hard to live that way. Even in social situations I am naturally anxious. I used to turn to

alcohol but now I can't, but it still makes me think of drinking. I think if I had more
to do then I wouldn't think of worrying so much.

The client was aware of her anxieties from initial sessions but had never directly related it to her addiction issues. The client was able to articulate a specific chain of events regarding her anxiety and its effect on temptations. The client realised during this session that change must occur for her to reduce temptations and, as a result, reduce relapses.

Action

Fill-in-the-blank intervention (assessment session): During the client's assessment, she was asked to identify what actions she could or would take for relapse prevention. Although it was her first session, she was able to identify action steps for her lifestyle changes.

> Now if I had the power to "change"
> I would have never "started drinking"
> No more "pills, alcohol"
> And when you trust your "enemies"
> What you get is what you got....
> So "I" keep waiting
> On "me" to change

Verbal statement (ninth session): In the final session the client identified multiple action steps that would lead her to relapse prevention. These were all subjects discussed throughout all therapy sessions:

> I've learned that I can't be alone. I need a hobby if I am really going to change. I've started going to a bible study and meeting friends there. I also know that if I start to worry, it acts as a trigger for wanting alcohol. I know I can play music now to help relax me. My unemployment has caused the most anxiety from day to day, and I think I am beginning to be ok with not having a job because I have a lot to work on for myself. I think this is the biggest part of my life right now (Alcoholism) that I need to focus on, so I'm doing everything I can.

Termination

Prior to the last two sessions it had been reported by family members that the client's relapses had increased and that she was in need of intensive therapeutic care. The client avoided telling the music therapist that these relapses were occurring, and had stated during those sessions that she had remained sober. However, after the ninth session the client contacted the music therapist and said she would be starting an inpatient 30-day Rehabilitation programme for alcohol and drug addiction. The client's comments to her family and to the music therapist disclose her initiative to begin this process:

> I am really scared, but I know I am doing the right thing. I have been having too
> many relapses. I need to go.

These relatively simple acknowledgements prove the client's realisation of herself and her need to change. True motivation is exhibited as a result of self-awareness. Further description of the client's progress is provided in the discussion.

Goal 2: To decrease anxiety

The duration of improvisation was increased every week to indicate a reduction in anxiety. Figure 2 depicts the client's self-perceived anxiety before and after an improvisation intervention. The client consistently had a reduction in anxiety after improvisational interventions as indicated by her self-perceived responses. After each session the client and therapist engaged in a discussion regarding anxiety, which was discussed as qualitative analysis.
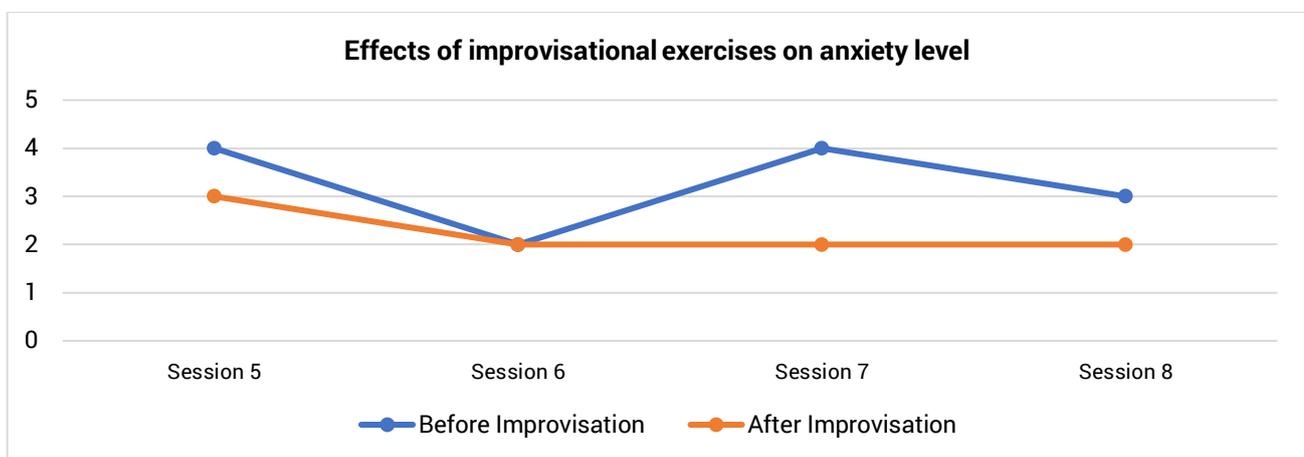

Figure 2: Effects of improvisational exercises on anxiety level

Goal 3: To increase self-control

The client was asked to identify at least two instances per week in which alcohol was a direct temptation, struggle or thought. The client was asked to record this in a journal and to provide these instances to the music therapist at each session. In response to each record, the music therapist implemented a songwriting intervention to acknowledge the incident and provide a memorable behaviour for reducing the temptation. The client only recorded in her journal one time and struggled to meet the criteria for this goal. Suggestions for this behaviour are included in the discussion.

EVALUATION OF MUSIC THERAPY TREATMENT

Overall, the client responded effectively to music therapy treatment. Results indicate that the client successfully increased identification of self-awareness, motivation and readiness for change. Improvisational interventions effectively facilitated reductions in anxiety. Each intervention demonstrated strengths for each goal area as well. It can be concluded that the strongest function of music within sessions for this client was to express interior thoughts of self-focus. This allowed the

client to gain self-awareness. For fill-in-the-blank activities in particular, the client could be guided toward successful conclusions given multiple prompts and semantic information in sentences directed toward the client's interior thoughts. This activity acts as a pivotal starting point for applying interior thoughts to an exterior art form, creating awareness of self as well as of one's surroundings (Albornoz, 2011). In initial sessions, the client was unable to articulate her true realisation of self. Through fill-in-the-blank activities the client began to acknowledge a discrepancy between who she was and who she wanted to be. By specifically incorporating lyrics that identify a tense (past, present or future) the client was guided to recognise her own self relative to her past, present and future situations (Egan, 2013). Fill-in-the blank activities established and facilitated Stage I: The current picture in Egan's Helping Model.

Other interventions such as lyric analysis or songwriting also enhanced goal outcomes. Lyric analysis provided the client with tools to identify her needs, wants and desires. This theme has commonly been found as a beneficial method for increasing self-awareness and readiness for change; therefore, song lyric analysis was exclusively implemented in Stage II: The preferred picture in Egan's Helping model. In lyrical analyses with the client, discussions were often guided toward acknowledgement of the client's story or current picture, which greatly aided in identifying parts of her she wanted to change. This allowed motivation to develop. Motivation naturally occurs as a result of realising a discrepancy between the real self and ideal self (Duval 1971). Although the client never reached an optimal level of motivation to permanently change, she began to recognise discrepancies through lyric analysis.

Songwriting created opportunities for the client to create an original template for her story, which required motivation. This particular application of music therapy might be essential for the problem management and opportunity development in Egan's helping model and optimally established in Stage III: The way forward. In order for the client to choose to resolve inner conflicts she had to be motivated by her recognition of self. Songwriting proved to be beneficial toward gaining an understanding of the client's motivation. Motivation is the result of the recognition of the need to change, which concerns later steps of action (De Leon 1993). Similar patterns were found within the client's songwriting results. When using songwriting in order to identify opportunities for self-control, the client was able to categorise her priorities, tell her story of a temptation and resolve her conflicts through identifying motivations. It was the client's responsibility to record these events over the course of each week. Even though moments of temptation were frequent and identifiable by the client, she was only able to complete this once. The client had not yet mastered the skills necessary for self-control or admitting temptation. Because relapses were intermittently occurring throughout the course of the sessions, the client had numerous opportunities to record her temptations, but chose not to.

Improvisation interventions were consistently effective for the client's anxiety and were also found to have a beneficial effect on the client's self-esteem, which is a subcategory of motivation. The client indicated improved self-esteem with regard to improvisation by realising her strengths as an individual apart from her identity as an alcoholic and gaining a greater sense of her motivation.

Responsibility was indicated as a subcategory of self-awareness. The client made the least gains within this subcategory. Upon close examination, a link can be established between the client's recurring relapses near the end of the study and the client's low outcome of responsibility for her actions. Acknowledging the discrepancy of the real self versus the ideal self is necessary for the client

to obtain fullness of change (Morin, 2011). Throughout sessions, the client demonstrated an avoidance of taking responsibility for her past, present and future; and this step is critical for all of the three stages in Egan's helping model. The client effectively reflected and identified emotional content for her situation, but never fully acknowledged that 'herself' was involved in her own problem. On numerous occasions the client suggested that she hoped someone else would be willing to make an effort to "fix her" or "help her". The client was uncomfortable in feeling confident that she could help herself. Conclusions for this thought process can also be made from her struggle with self-esteem and her distant, hopeful view of her ideal lifestyle. In order for the client to fully accept herself and become ready for change, she had to take responsibility for her discrepancy. This is the ultimate recognition of the real self (Prochaska & Prochaska, 2010). It creates an opportunity for self-help as well as a gateway for discussion of self-limiting thoughts (Egan, 2013).

A promising result from this study, despite the client's relapse, was her initial reason for admitting herself to a rehabilitation hospital. For the first time over the course of the study, the client told her family members that she was in need of help and needed to go on an intensive rehabilitation programme. In the year preceding this study the client was entirely guided by her family to receive help. However, by increasing her own self-awareness, she was able to finally take responsibility of her own future.

This client provided a gateway for initiating a systematic protocol for music therapy treatment within the AUD population. The present case study offers a method for quantifying responses into viable categories to measure success and potential predictors for change. The client's progress provides substantial material for effective interventions for particular goal areas. By utilising qualitative data to substantiate quantitative results, music therapy integrating Egan's Helping model can be seen as a beneficial tool for AUD rehabilitation. The results conclude that music therapy effectively facilitated an increase in self-awareness, motivation and readiness for change. Reductions in anxiety and opportunities for self-control are also observed with regard to this client. Although goal areas may be different for each patient of AUD, this case study provides the empirical approximation for music therapy treatment of a variety of goals a patient may have.

CONCLUSION

Music therapy treatments facilitated to address goals within the substance abuse population (e.g. AUD) are common and in demand. Many different interventions have been used to improve goal areas of these individuals though it is difficult to measure and recognise whether music therapy is an effective tool for treatment without establishing the therapeutic mechanism. Egan's helping model encompasses many aspects of current music therapy treatment processes for the clinical population and provides a framework for a systematic approach to the therapeutic mechanism including establishing goals and defining the optimal, yet practical, music therapist-client relationship. The theoretical orientation for the music therapy techniques such as fill-in-the blanks, song lyric analysis, songwriting or improvisation can be validated through the particular approach of problem management and opportunity development in Egan's book, *The Skilled Helper*. The empirical evidence demonstrated in Egan's three stage-helping model can be transferred to music therapy practice for this population. The three stages in Egan's helping model might be particularly useful for music

therapists to set therapeutic goals and objectives and to determine the scope of music therapy interventions.

Application of music therapy within the practical helping model of therapy developed by Egan can result in a theoretical and empirical understanding of the commonly used music therapy techniques for treating individuals with AUD. The therapeutic response to music (i.e. song lyric analysis) or music production (i.e. songwriting or improvisation) can be naturally embedded in the key therapeutic phenomenon and the relationship between the therapist and clients. The musical experiences and therapeutic relationships have the potential to strengthen the process and outcome of therapy. Music therapy practice incorporated in the helping model can potentially justify the effects of music or musical experience on enhancing the personal lives of the AUD population.

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Ελληνική περίληψη | Greek abstract

Η εφαρμογή του Βοηθητικού Μοντέλου [Helping Model] στη μουσικοθεραπευτική πράξη για άτομα με διαταραχή χρήσης αλκοόλ: Θεωρητικός προσανατολισμός και εμπειρικές επιπτώσεις

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ΠΕΡΙΛΗΨΗ

Η έρευνα στο πεδίο της μουσικοθεραπείας και των διαταραχών που σχετίζονται με ουσίες εξελίσσεται και ποικίλλει εντός των προβλεπόμενων θεραπευτικών περιοχών και παρεμβάσεων. Τα αποδεικτικά στοιχεία της μουσικοθεραπείας σε αυτήν την πληθυσμιακή ομάδα έχουν επικεντρωθεί στις επιδράσεις συγκεκριμένων τεχνικών μουσικοθεραπείας ή γενικευμένων ανταποκρίσεων από τους συμμετέχοντες, χωρίς να καθιερώνουν ένα θεωρητικό μοντέλο θεραπείας. Η εφαρμογή της μουσικοθεραπείας μέσα σε ένα μοντέλο σταθερής θεραπείας βασισμένη σε λεπτομερή θεωρητικό προσανατολισμό είναι απαραίτητη για κάθε πρόγραμμα αποκατάστασης ή επανόρθωσης. Αυτό το άρθρο καθιερώνει τις θεωρητικές και εμπειρικές επιπτώσεις της μουσικοθεραπείας με βάση το Βοηθητικό Μοντέλο [Helping Model] του Gerard Egan (2013) για τη θεραπεία ασθενών με διαταραχές που σχετίζονται με ουσίες, ιδίως τη διαταραχή χρήσης αλκοόλ (alcohol use disorder, AUD). Ο Egan πρότεινε τρεις βασικούς στόχους βοήθειας: (1) αποτελέσματα που βελτιώνουν τη ζωή, (2) μάθηση της αυτοβοήθειας, και (3) νοοτροπία πρόληψης. Αυτό το άρθρο θα διερευνήσει εάν οι θεραπευτικοί στόχοι του Βοηθητικού Μοντέλου του Egan μπορούν να επιτευχθούν και να καθιερωθούν στην πρωτοπορία ενός μουσικοθεραπευτικού μοντέλου θεραπείας για άτομα με AUD και να εισαγάγει εμπειρικές μουσικοθεραπευτικές παρεμβάσεις μέσω μιας μελέτης περίπτωσης βασισμένης στο μοντέλο Βοηθητικό Μοντέλο.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

διαταραχή χρήσης αλκοόλ [alcohol use disorder], μουσικοθεραπεία, ανάρρωση, Βοηθητικό Μοντέλο [Helping Model]