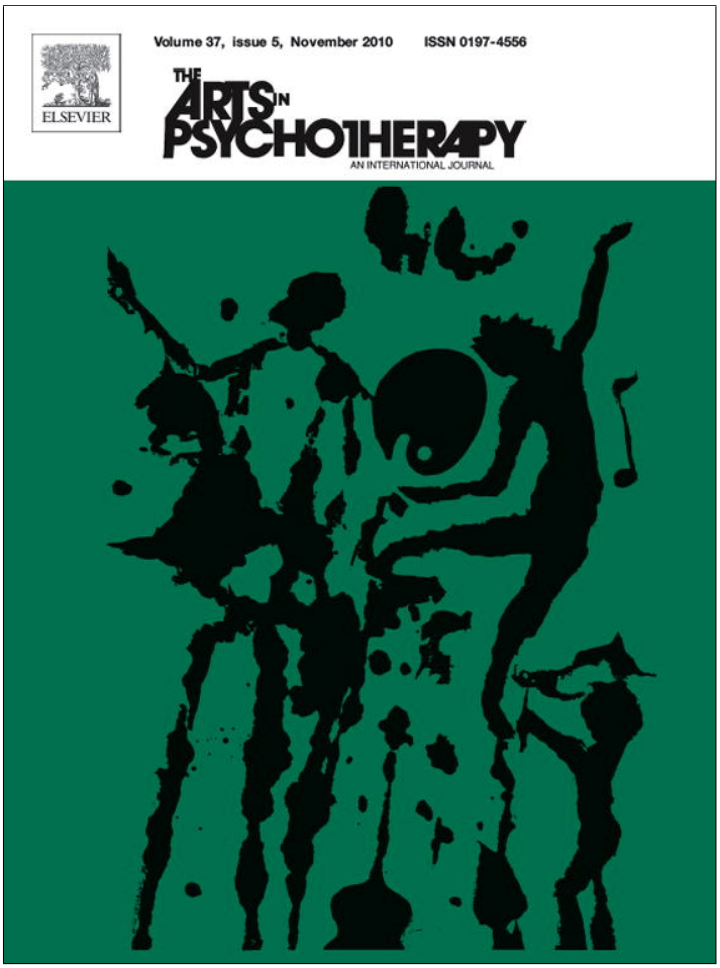

(This is a sample cover image for this issue. The actual cover is not yet available at this time.)

The Arts in Psychotherapy 38 (2011) 169–177

Contents lists available at ScienceDirect

The Arts in Psychotherapy

Aggression in music therapy and its role in creativity with reference to personality disorder

Jonathan Pool, MA[a,*], Helen Odell-Miller, PhD[b]

[a] Anglia Ruskin University, Cambridge, UK
[b] Music and Performing Arts Department, Anglia Ruskin University, Cambridge, UK

ARTICLE INFO

Keywords:
Aggression
Creativity
Personality disorders
Music therapy

ABSTRACT

This article describes a project that explored the relationship between aggression and creativity in music therapy. It examines the role of aggression in psychological growth and how music therapy might have a unique role in channelling aggression. An exploratory qualitative study included a mixed methods approach of a case study and thematic analysis of interviews. It included three interviews with three experienced music therapists who were asked about their experience of aggression in music therapy. The case study supports the evidence gathered in the interviews, and describes short-term individual music therapy treatment with a man with a personality disorder diagnosis and a history of extremely aggressive behaviour. The study suggested a strong link between aggression, affect and body movement. Gathered information and results from interview analysis showed that aggression and creativity share important similarities in areas of mastery and control, affect and emotion, and action and intention. Conclusions of the study showed that music therapy can sometimes provide a context for safe exploration of aggression and deeper feelings. It can also enable the individual to sublimate negative emotions through appropriate expression.

Introduction

The purpose of this exploratory qualitative study was to gain a deeper understanding of the link between aggression and creativity, and to examine the role of music therapy in working with aggression. The study included a mixed methods approach (Wheeler, 2005) of a case study and thematic analysis of interviews with a small purposeful sample (Wheeler & Kenny, 2005) of three experienced music therapists asking about their experience of aggression in music therapy. The casework and some of the research work was carried out by a trainee music therapist with supervision from an experienced music therapist, and both author researchers have worked on the mixed methods project and data analysis. It aims to inform the thinking processes of music therapists in helping patients[1] to better understand, experience and use aggression constructively.

The case study with a man with personality disorders was undertaken by a music therapist while training in a unit for people with this disorder. As such, the context was informed by the National Institute for Health and Clinical Excellence (NICE) consultation guidelines, to which the unit multidisciplinary team contributed at the time of the study. The case study was of a man exhibiting anti-social and avoidant personality disorder with borderline traits. For this diagnostic group there is not always an implication of cause, and it is characterised by 'a pattern of instability of interpersonal relationships, self-image and affects, and by marked impulsivity'.[2] Although a large number of outcomes have since been reported through the final NICE guideline for Borderline Personality Disorder, published after this study, individual psychological interventions are reported to have little effect upon symptoms compared with treatment as usual. There is little music therapy research evidence reported for this population in the NICE guidelines, and worldwide it is an area which needs more research. Currently, a European Collaboration between music therapists researching music therapy for people with personality disorders is preparing a large international study. Some case reports and anecdotal evidence have shown positive outcomes (Hannibal, 2003; Nygaard Pedersen, 2003; Odell-Miller, 2007), and this study is a small contribution to the existing literature.

Aggression is a common reason for referral to the arts therapies (Odell-Miller, 1995). 40% of referrals given by mental health

* Corresponding author. Tel.: +44 1483272449.
E-mail address: jonathan.pool@hotmail.co.uk (J. Pool).

[1] The word patient is used to refer to clients/patients/users within music therapy treatment.

[2] NICE guidelines scoping document section 3. http://www.nice.org.uk/nicemedia/live/.

0197-4556/$ – see front matter © 2011 Elsevier Inc. All rights reserved.
doi:10.1016/j.aip.2011.04.003

care professionals in Odell-Miller's survey were aggression-related or cited aggression as the reason for referral. In her paper on art therapy and children who behave aggressively, Nissimov-Nahum (2008) stated that childhood aggression is a widespread problem. Other articles have focused on treatment of aggression and anger in music therapy (Bensimon et al., 2008; Jackson, 2010), in the arts therapies (Smeijsters & Cleven, 2006) and in psychodynamic psychotherapy combined with movement (Twemlow, Sacco and Fonagy, 2008).

A typical aim of music therapy in treating aggression is to reduce challenging behaviour (Derrington, 2005). Performing and song-writing can be stabilising factors in exploring and developing a sense of self (Baker, Kennelly, & Tamplin, 2005; Derrington, 2005). Others have discussed the relationship between a developing sense of identity and creativity (Storr, 1972; Winnicott, 1971). Music therapy enables people to experience themselves in a safe environment, by providing a psychological and musical space and another mind (the therapist's) to increase the capacity for insight into themselves and their behaviour. Arts therapies focus strongly on emotions and behaviour (Smeijsters & Cleven, 2006). Many psychological treatments enable aggressive expression by the patient, especially when aggression is suppressed or presented inappropriately. This suggests that aggression may be something with which we must learn to live, rather than hide, and that we must learn how to use it constructively in order to fulfil the needs of the individual within the boundaries of society. For these reasons, we decided to examine further the nature of aggression in music therapy.

Defining aggression and creativity

A comparison of two definitions of aggression from psychology (Geen, 1990) and psychoanalysis show in each case an acknowledgement of the complexities of aggression, the importance of developing its meaning beyond simple destructive behaviour, and Geen (1990) emphasised the importance of the role played by emotions in acts of aggression. One emergent theme from the comparison is the intention to harm, which can be linked to the aggressor's need for mastery, omnipotence, control of the object or self-preservation. Freud (1920) saw aggressiveness as a sign of resistance and implied that the arousal of aggression; including locating, uncovering and getting hold of it; was an important part of treatment. Geen (1990) suggested that affective aggression is motivated mainly by the intention to harm, and can be linked to patterns of activity in the central nervous system, whereas instrumental aggression is motivated by concerns more important to the aggressor than the harm-doing itself. This physiological link suggests a bodily arousal and explains why strong affective states may be aroused by playing music, which can activate the music-maker at physical, emotional and expressive levels.

Creativity reflects the ability to bring something new into existence Barron (1965) and Winnicott (1957) linked this to the infant's experience of creating the world from which 'action' and 'doing' arise. He suggests that impulse-doing involves action with meaning, requiring a mind to bear it; and reactive-doing involves reactions, reflexes and behaviours that may hold little or no meaning for the individual. Omnipotence is a requirement of creativity and there must be a belief that it is possible to create something. In the infant's experience this process is facilitated by the caregiver who adapts to the infant's needs. So, there seem to be some areas of overlap between the aspects of aggression and those of creativity: mastery, affect, and action. In music therapy it is possible to explore the relationship between aggression and creativity through making music in a relationship that involves physical, intellectual and emotional expression.

Mastery

Psychoanalytic theory is helpful in thinking about mastery. Freud (1910) had regarded aggression as an urge for mastery, which is about doing something intentionally with greater thought and experience, and with improved timing, technique and efficiency of effort. This requires confidence in one's ability. The patient's compulsion to repeat is linked with aggression and attempts at mastery of these experiences. This process may provide the ego with satisfaction of its vital needs (Freud, 1930).

Klein (1952) viewed aggression as a destructive impulse that has relevance to mastery in the area of omnipotence. In the absence of the mother, the infant believes her to be suffering or damaged, perhaps due to the infant's destructive impulses. The mother facilitates the reparative function of the infant's omnipotence by providing the illusion that he or she can revive her. The mother's confidence in this ability to recreate gives the infant greater confidence in his or her objects, to internalise them and become more self-reliant, and aggression can be experienced as benign, manageable and available for sublimation. In music therapy, mastering aggression and emotions through an omnipotent relationship and repetitive experiences may be explored through musical play, as discussed by Aigen (1991) in the case study of Will. Here the exploration of expressive extremes decreased Will's need to gain mastery through destructive social interactions. Through the use of structured and pre-composed songs, Will began to show sudden, uninhibited expressions of aggression, elicited by the safety of the musical context, which led to an increasing capacity to self-regulate. His fighting at school diminished considerably, and he expressed a need for Aigen to play in a more separate way, showing his diminishing need for omnipotence.

Drawing on psychoanalytic theory, John (1995) draws attention to the process of sublimation by describing the process where the patient uses pre-verbal exchange to deal with rage and overwhelming emotions and can communicate and discharge into a containing holding object. Here, rage can be mastered and brought under conscious control. Patients, defence mechanisms may be seen through perseverative playing when a patient defends against pain brought to the surface in therapy. Perseverative playing is observed when the patient plays in a set rhythm, usually regular patterns, but with no flexibility or apparent awareness of other people's music (Bruscia, 1987).

Mastery is linked to the feeling of self-confidence. Twemlow et al. (2008) suggest that as practitioners of martial arts become more advanced they show better control of anxiety and hostility. They also suggest the need for a mentor to contain the destructive aggression during training towards mastery of the martial art, which suggests similarities to the function of a therapist.

Emotional development and affect

In psychoanalytic theory, aggression is often viewed as integral to emotional development (Winnicott, 1950). There is a stage of concern in emotional growth when the infant begins to appreciate the personality of the mother, which represents the beginning of a more complex psychological life. Through emotional development, often through creative play, aggression can be linked with the establishment of a clear distinction of what is the self and what is not the self (Winnicott, 1957, 1971). In order for a child to express aggression in a healthy way – finding relief and experiencing it as finite disposable and useable – he or she must be able to experience its form – having a beginning, a development and an end. As the aggressive impulse is suppressed, so also are other impulses along with creativity.

In music therapy improving a patient's ability to play is an important part of the treatment as inhibited creativity may indi-

cate a patient's needs and difficulties (Pavlicevic, 1997). Authentic autonomy is a unique state of being which helps a person be subjectively creative while having confidence in the authenticity of images. Without a coherent sense of self, children are unable to play. The suppression of aggression may be due to the infant having to adapt to the caregiver due to a failure by the latter to contain the child's aggression. Austin (1991) presented a music therapy case of a woman who adapted to her family's needs in her early childhood: her own emotional needs not being met. In early treatment Sara resisted attending therapy. Through musical improvisation Austin (1991) located the root of this resistance in Sara's fear about being dependent. Sara's later expression of aggression in the music led to expressions of feelings of vulnerability at the isolation she felt from her feelings and her real self.

So, in music therapy, communication and the expression of the self through playing occurs in the mutual 'transitional' space between, and created by, the therapist and the patient, at the interface between the internal world and external reality (Winnicott, 1971). Taken seriously, the child is empowered to find his or her niche, but if not, this constructive expression is experienced as having no place in the real world, which may lead to a loss of 'ability to be aggressive at appropriate moments, whether in hating or in loving' (Winnicott, 1957, p. 237). Music therapy may be effective in treating patients with aggression problems due to the ability of music to access feelings non-verbally through improvisation. It may also be suitable if the injury has occurred at a non-verbal level (Austin, 1991). The patient can be enabled to express aggression in a constructive way and is held by the therapist while working on this in the music. In this safe environment he or she may learn to express and regulate aggression (Smeijsters & Cleven, 2006). The therapeutic relationship provides a safe, containing context for destructive aggression as suggested by Twemlow et al. (2008).

Action

The arousal of the stress response by the hypothalamus is stimulated by the amygdala and regulated by the cerebral cortex which judges whether a situation is threatening. However, the amygdala may initiate the stress response before the cerebral cortex has examined the situation (Sprenger, 1999; Storr, 1968). The body contains a system that initiates aggression and this system is in the service of the emotions and emotional memory. This suggests a link between emotional processing and memory and the bodily expression of aggression. According to Skaggs (1997), and Smeijsters and Cleven (2006) the physical nature of music making, for example drumming, may evoke deep emotions through bodily arousal and, due to its orientation to action using parameters such as dynamics, tempo, rhythm and form, music is able to contain emotional experience. 'The therapeutic process is possible because the change of expression in the art form is experienced as a change of vitality affects' (Smeijsters & Cleven, 2006, p. 39). Twemlow et al. (2008) postulated that the safe exploration of affect is possible owing to a complex interaction of the mind and body in a contained social context.

So, the cerebral cortex plays a major role in mediating the cognitive processes regarding the arousal of aggression by regulating, altering and developing the expression of aggression within socially appropriate boundaries. In relating this to music therapy, it is important to consider sublimation. Priestley (1994), a music therapist, listed it among the ego defences, defining it as 'the healthy, alternative conscious channelling of instinctual energies of sex or aggression.' During music therapy treatment, freed id energies may find their way into new interests and creative pursuits which have symbolic significance' for the individual (Priestley, 1994, p. 171). Symbolisation is very important in sublimation as it provides meaning for the action. Segal (1957) differentiated between two types of symbol formation: the symbolic equation where confusion exists between what is the part of the ego being projected and what is the object; and the symbol proper which 'is felt to *represent* the object' and used to 'displace aggression from the original object' in order to 'lessen the guilt and the fear of loss' (Segal, 1957, pp. 167–168).

Bensimon et al. (2008) argued that very loud group drumming enabled soldiers suffering from Post Traumatic Stress Disorder (PTSD) to discharge their rage. During the treatment the soldiers were able to express rage spontaneously while also being able to play basic and complex rhythmic patterns during group improvisations. Drumming aroused bodily effects and facilitated emotional release (Bensimon et al., 2008). He suggested that through controlling the rhythm, tempo, dynamics and timbre of their playing the patients learned to gain self-control, and this brought a sense of satisfaction, relief and empowerment. In his research Bensimon explained that through drumming, the patients became able to discuss their experiences and feelings, and were able to use the music to sublimate their aggression after these conversations. He linked the use of basic rhythmic patterns with the need to provide inner stability and a sense of control (Bensimon et al., 2008).

Odell-Miller (2002) described the treatment of a man with issues of aggression and somatisation, which seemed to stem from emotional deprivation in childhood. The patient was helped to find symbolic meaning in his external world through the therapist's and group members' acceptance and understanding of freely expressed music, which reflected the more obsessive aspects of his personality. At times he would play loudly and chaotically. One example of his aggression being understood and contained symbolically was that in the first year of his treatment, during the last minute of a session, the patient struck the drum next to the therapist so loudly that it startled her. This experience was used by the therapist to verbally reflect back an understanding of the strength of his aggression, which all had experienced in the group. In the subsequent session he talked about his fears about not being able to sustain relationships. This seemed an important symbol of what he was trying to contain. As the treatment progressed the patient was increasingly able to talk about his fear of affection and, thus, his fear of his own destructiveness in relationships, particularly with his mother. His music and behaviour were at times omnipotent, annihilating and angry, and he became able to think about the effect of this behaviour on other members of the group. Through music therapy, the patient was able to express his rage and sublimate his aggression so that he could uncover greater meaning behind it and gain a deeper sense of self. The emergent themes of mastery, affect and action discussed above lead to the research questions raised in the following study.

Main questions and methods

The main questions for the study were:

- What is the function of music therapy in relation to aggression?
- How can music therapists use creative experience to enable patients to express themselves constructively to promote psychological health?

The methodology used was qualitative with a mixed methods approach (Wheeler, 2005) of a case study and a thematic analysis of interviews using a purposive sample of three music therapists. The data analysis draws on thematic analytic methods using Interpretative Phenomenological Analysis (IPA) (Smith & Osborn, 2003). This approach supported the observational, philosophical and phenomenological study of this topic.

The case study was of a young man with a personality disorder diagnosis and a forensic history of violence. Destructive aggression had featured strongly in Charles' life and the music therapy

work focussed on channelling his aggression and experiencing it constructively. The intention of the descriptive case study was to explore his relationship with aggression and to describe and explain it in terms of psychoanalytically informed thinking and music therapy with reference to creativity.

The semi-structured interviews were used to gather information about three music therapists' experiences and thoughts about aggression in their own practice. The interviews were guided by a schedule while allowing freer exploration of arising areas of interest (Smith and Osborn, 2003). The same questions were asked in the same order for each interview – providing continuity and structure – while allowing for the interview to include any relevant areas that the interviewer may not have considered. The interview schedule was constructed with the overall aim of the study as its focus: 'An exploration of aggression in music therapy with specific reference to its role in creativity.' The broad range of issues for discussion was identified and consisted of the respondents' views of aggression, the role of aggression in the music therapy process and the link between aggression and creativity. The questions were designed to concentrate on these areas and the schedule constructed so that the interview would begin generally and become more specific and focussed later on. The following questions were constructed and planned in the sequence given:

1. What do you understand by the term 'aggression'?
2. How do you understand aggression in relation to your own music therapy practice?
3. What do you consider to be the function of music therapy in working with aggression?
4. Do you think that there is a link between aggression and creativity in music therapy? Please give reasons for your answer and use anonymous vignettes, if possible.

The respondents' answers were recorded using an audio recording device, where possible, and transcribed immediately following the interview to reduce inaccuracy in the transcription. The selection of respondents was based on the following:

1. The respondents should be experienced music therapists. Choosing music therapists who had at least ten years experience and who were also clinical supervisors ensured this.
2. The choice of respondents should reflect the breadth of theoretical and clinical understanding of music therapy. This was determined by the diversity in training and background between individual respondents.
3. The respondents should be available for interview.

Respondents who met the criteria for selection and were working in and around the Cambridge area were invited for interview. This was to ensure availability. The data produced from the interviews was analysed thematically using IPA (Smith and Osborn, 2003) to evaluate the experience of aggression of three music therapists. Themes were elicited from their thinking about its role in the promotion of psychological growth and its relationship with creativity. These emergent themes were grouped into clusters defined by topics that arose from the literature review. Findings are later discussed in relation to the case study with reference to the literature. A summary of this work leads to conclusions, linking the case study and interview results. Ethical procedures were followed within the relevant organisation.

Case study

The case study is based upon a real case but details are changed for reasons of confidentiality, and consent was gained to write about the work while protecting anonymity. It illustrates how a man used music therapy to explore his aggression, to begin to uncover the source of his aggressive behaviour and to sublimate it. It reveals a link between aggression and creativity, showing how suppressed aggression is bound up with the ability to be creative. It supports Winnicott's (1950, 1957) suggestion of the bond between aggression and creative living, Freud's (1920) thinking on resistance and the compulsion to repeat, and Klein's (1952) concepts of the paranoid-schizoid and depressive positions with reference to sublimation.

Background

Charles, one of four siblings, had lived with his natural parents until the age of eight. He had experienced emotional and mental abuse from his alcoholic father who was physically abusive towards Charles' mother. When his parents separated, Charles recalls being beaten by his mother and all blame being directed towards him. As a child he attended counselling, in which he felt blamed for difficulties in the relationship between his mother and stepfather. Themes that emerged from his case notes were: persecution, judgement, humiliation and being used. Charles had a history of violent and alcohol-related offences including very serious violence towards his family resulting in him stabbing a male family member. He had repeatedly attempted suicide and had self-harmed. His contact with the psychiatric service had been characterised by his reluctance to talk about himself and his emotions.

Diagnosis

Charles was assessed two years before attending individual music therapy using the Structured Clinical Interview (SCID-II) (First et al., 1997), which closely follows the language of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV Axis II) Personality Disorders criteria (American Psychiatric Association, 2000). From this it was concluded that he had reached the threshold for two personality disorders: avoidant and anti-social. The psychological treatment service that cares for him uses a Cognitive Analytic Therapy (CAT) (Ryle, 1995) model and psychotherapeutic services. CAT is a talking therapy that focuses on helping a patient understand and analyse his or her own dysfunctional processes, or limited ways of relating, in order to learn new and healthier ones. It is designed as a brief intervention, but may occur over longer periods (Ryle, 1995).

Referral, therapeutic aims and setting

Charles was referred for individual music therapy by the consultant psychiatrist in discussion with a senior music therapist, clinical psychologist and the team. The referral aimed to assess whether group music therapy would be suitable for his needs, as he had motivation in the area of music, and also seemed to need an outlet for emotional expression. The consultant had discussed with him the idea of using the short-term treatment as preparation for the music therapy group and also in order to focus on an achievable task. The use of short-term work in this way was usual in this team. It was also considered that making an audio CD as part of the therapy might counteract Charles' feelings of shame. The physicality of music therapy was also discussed at the referral stage – this aspect of making music would be useful in helping Charles' self-expression. A male trainee therapist was chosen to work with him as he seemed to lack a healthy male role model and also it would give Charles the opportunity to have a safe relationship that might draw out some similar feelings he had for male family members. The multi-disciplinary setting for people with personality disorders included a large experienced team of psychotherapists, psychol-

ogists, social workers, probation workers, an art therapist and an occupational therapist. A high level of awareness of the dynamics of the work, including possibilities for splitting and projections within the team as a result of the high level of self-harm and disturbance amongst the population existed. Therapists attended supervision and case discussions, and the multi-disciplinary team (Twyford and Watson, 2008), while not focussed upon in this study, was of prime importance in the context of any therapeutic work, specifically close communication with case managers and significant figures for each patient. The emphasis at the time upon CAT allowed for examination of reciprocal roles and close attention to patient's individual diagrams.

Treatment

Charles attended 10 weekly individual music therapy sessions over a period of three months. These sessions were 50 min in duration, held at the same time each week. The sessions took place in a well-equipped music room in a hospital, which he visited only for his music therapy sessions.

Initially, Charles seemed amiable and shy. He suppressed his emotions, which found expression in outbursts of extreme violence in his life. So it was important to help him find satisfaction in safely expressing his anger. This might lead to strengthening his sense of identity, through a feeling of being heard, and to more vulnerable emotions being expressed, which seemed to be at the root of his aggression.

The music therapy approach used in the treatment was a Psychoanalytically Informed Approach (Hughes, 1995; Odell-Miller, 2001, 2003). In this approach the use of musical improvisation and talking is informed by psychoanalytic thinking drawing on the work of Winnicott (1957, 1971), Klein (1948, 1952) and Freud (1920, 1930) focussing on the musical relationship in the here and now rather than psychoanalytic interpretation with the patient. (Although, interpretation and unconscious meaning are sometimes the focus if appropriate to the patient's process.) The treatment addressed Charles' use of aggression. Clinical supervision was essential in thinking about how both he and the therapist related to, and handled, his aggression. The treatment may be conceptualised as having three phases: first – establishing boundaries, safety and identity; second – holding, containment and Charles beginning to master his aggression; and third – separation, ending and loss. Each session took on a ternary form in which the first and third parts involved talking and the middle section involved mainly musical improvisation.

Phase 1: Establishing boundaries, safety and identity

Here, the therapist's reliability was established, and strategies were discussed for safely handling his aggression when he felt threatened during the sessions. Themes that emerged here were fear of being judged or humiliated, trust, suppression of loud playing and internal conflict about expressing emotions.

Charles was very impressed by the variety of instruments in the room, particularly the drum kit. He had never played a real drum kit before and appeared excited about it but his fears about being judged were stopping him from doing so. Charles was similarly ambivalent about having music therapy and being judged by the therapist – an experienced musician. The therapist felt that Charles was avoiding confrontation with him, so, initially chose not to play the drums and, instead, played the bass and electric guitar. Charles considered drumming to be something constructive that he did well and that promoted his individuality.

For three weeks, Charles' music showed excessive control and emotional flatness. He seemed detached and avoidant in the music. The music would become trancelike and he seemed to be avoiding expressing his emotions. When the therapist tried to introduce some emotional content and challenge his controlled, trancelike music he would play glissandi or scalar runs up and down the bars of the xylophone and fast, unconnected motifs across the therapist's music as if resisting the emergence of his emotions. In supervision, the trancelike nature of the music was discussed and also the decision by the therapist not to play any drums. The therapist was also avoiding Charles' anger. Perhaps Charles was projecting his fear of his own anger onto the therapist, resulting in trancelike music.

Charles often complained of having headaches on arriving for music therapy. He attributed them to be side effects of his medication. However, these headaches may have been an indication of some psychological conflict connected with Charles' therapy. The third session represents a milestone in this part of his treatment. He took a decisive movement in his overall care plan and made his first decisions in the process of writing and playing music about his feelings. He was beginning to master/take control of his overall treatment and had been trying to deal with his problems with and reasons for drinking. He spoke of realising the magnitude of this task and the therapist's main role in this phase was as the provider of the holding environment and containment in music therapy. During this session the therapist decided to play the conga drums. Charles needed to experience his aggression as benign, and the therapist had to allow aggressive feelings to emerge. The therapist thought that he should challenge this feeling in his counter-transference of the fear of Charles' aggression, so he decided to play in, what seemed to be, Charles's territory. It was the first time the therapist had played any type of drum with him and perhaps showed him that the therapist was prepared to face his violent feelings and, in doing so, allow him to see his feelings as something manageable.

Charles sat at the drums and played a simple rhythm pattern, which the therapist matched. Then he played a drum roll on the snare drum that increased in loudness and tempo. The therapist matched this and then, on Charles' cue on the crash cymbal, both broke into a vibrant, dynamic and congruent rhythm. Their individual rhythms fitted together in a sort of weave, creating a larger, more complex pattern. There was a sense of individuality and partnership in the music. The piece developed with some copying and matching (Wigram, 2004), and each took turns to lead while the other supported. Copying and matching techniques are intended to empower the patient with a sense of control while either reflecting back the patient's material, as in copying; or playing music that is compatible with some aspect, quality or element of the patient's material, as in matching. Towards the end of the piece the therapist played the bass drum and gong. Charles signalled the end by using a long drum fill and they ended together. Afterwards he seemed energised and immediately exclaimed: "Wow!" The therapist asked him about his headache and he said that it had disappeared. Were these headaches connected to some internal conflict he was having about suppressing and expressing his emotions?

Phase 2: Holding, containment and learning to master aggression

In session four Charles brought an important theme for him, for the music for his CD recordings: *taking risks*. He seemed to need permission to play loudly. Being 'good' seemed important to him and this meant not doing anything that might annoy or anger others. The gong was useful for Charles to explore his anger and to release his emotions from this suppression of them. While striking the gong, he talked about his worries about making too much noise. His worries about upsetting others with his loud music were an expression of his fear that his emotions were intolerable to others and so had to be suppressed and controlled. Charles liked the gong because it reminded him a film called *The Clash of the Titans*. As a child he had watched it repeatedly despite being frightened by it. The part

he found most frightening was when the Kraken was released from its dungeon under the sea. Perhaps the gong represented taking a risk and releasing the Kraken (his destructive emotions) from its underwater dungeon (the unconscious). The music of this phase was characterised by loud, aggressive rhythms. The pieces began to grow in duration, and form and emotional content began to emerge in the music. In one piece, Charles played the gong and bass drum while the therapist played the piano, starting loudly with explosive 'bursts'. Through the jointly created music, form was applied to his expression and the piece ended more softly as if some sense of satisfaction had been attained in the music through sublimation. Charles and the therapist managed to end this piece together. Following this improvisation, he spoke of his ambivalence towards his mother. Meeting her aroused strong, negative feelings he had about himself, whereas avoiding her brought feelings of guilt about hurting her. As the treatment progressed, Charles became more confident in the therapeutic relationship. It was agreed all the music from the sessions would be recorded, reviewed in the ninth to present him with a CD in the final session.

Phase 3: Separation, ending and loss

In this phase Charles and the therapist were finding it difficult to bring the work to an end. Themes that seemed to emerge in conversations were not finding one's niche in the world, isolation and loneliness, and Charles' problems with alcohol. He spoke about using music to escape from his life and it is possible that Charles was using music as a substitute for alcohol. His music seemed reflective and thoughtful. He allowed more space in the music and his melody seemed smoother and less detached from the therapist's music. Pieces had more form and both players seemed to move between being together and being separate in the music. The therapist felt that there was an overall sense of the enjoyment of playing together and an awareness of each other's music, and improvisations were longer with greater variety and range in expression. Charles seemed reluctant to end pieces/sessions and occasionally, the music would regress back to the emotional flatness of the first phase. He seemed to avoid experiencing vulnerable and painful feelings when they emerged.

During the final session Charles found it too difficult to express sadness at the loss of the relationship with the therapist. He joked that it was a shame that he would not be able to take any more time off work to attend music therapy. He seemed to avoid the pain of loss by showing aggression and became more able to confront and show anger towards the therapist musically. He discovered the slap stick and smiled as he used it in a sideways motion as if punishing someone. He played the demos on the keyboard to amuse himself, and the therapist felt shut out. Perhaps this was his way of showing his anger towards the therapist for not continuing the treatment. This was a more appropriate way of expressing anger and, through music therapy Charles had explored some of his aggression and had begun to develop a firmer sense of self. He had found safer ways of expressing anger and had had some experience of showing vulnerability in a safe environment.

Charles casually said that he was not committing properly to Alcoholics Anonymous meetings. (This is a fellowship of people who meet to support each other in facing and recovering from alcoholism.) Charles said that he was happy to put himself in situations that he knew would put him at risk of relapsing into drinking again. Initially, this seemed to be a sort of attack on the therapist for ending the relationship. However, on reflection the therapist thought it was an expression of the fear of not knowing what would happen after music therapy ended. Behind this casual bravado lay feelings of loss. The therapist presented Charles with a CD in the final session. When the music was reviewed in the ninth session, he seemed surprised by the amount of music that he wanted to keep. It seemed that the CD was very effective in building his sense of self-worth.

Case conclusion

It is suggested that Charles suffered a deprived and abused childhood in which he had learned to adapt to his environment by suppressing his emotions. This seemed to limit his sense of self and identity, and created a sense of persecution from the outside world. Through music therapy he began to experience that his own destructiveness and, hence, his feelings could be held and adapted to by another person. He managed to express aggression without losing control and this led to the expression of other, more vulnerable, emotions such as shame, embarrassment and pain. The CD served to counteract his feelings of shame and humiliation by embodying the success of his creative ability to express himself through music.

The interview results

The outcome of the music therapists' interviews and thematic analysis resulted in fifteen main themes grouped into four theme clusters. The clusters were: origins of aggression, mastery, emotional development and action. Table 1 gives an overview of the main themes in their clusters. A cross in the corresponding column represents the emergence of the themes in the respondents' answers. The anonymity of the respondents was retained, so they will be known as respondents 1, 2 and 3. The theme-based clusters developed from the results of the interview analysis are described below with comments regarding the interview content.

Origins of aggression

Aggression seems to be rooted deep within the psyche of the individual. Its nature seems to be primitive, finding expression in many forms. Self-preservation, protection, and reactions to frustration and anxiety are linked to aggression. A context is needed for aggression to emerge, which respondents identified as the presence of a bad object, and group participation (which seems to draw out aggression through envy, territorial thinking and shame).

Mastery

Mastery involves aggression in the practiced use of internal and external objects. All respondents implied the need for the patient to feel omnipotent to begin mastery of their aggression and internal world. The survival of the object was stated as paramount in the development of the individual's experience of aggression. Play and illusion were described as methods for practicing the use of objects, leading to internalisation of the concept of the external world as interesting and bearable. This theme is linked to repetitive practice required in the gradual shift from omnipotent thinking towards a sense of reality. The properties of music, i.e. dynamics, form, tempo, rhythm, helped contain, modulate and regulate the patient's affective state.

Emotional development

Emotional development involves the individual's understanding of aggression and its meaning while creating a concept of self in relation to the outside world. Aggression is used in managing the shift towards self-reliance, becoming autonomous and establishing identity. The use of words, containment and an understanding psychodynamic attitude were stated as tools for helping the patient to gain insight in understanding aggressive behaviour. All respondents implied that aggression existed in healthy development and

Table 1
Clustered themes from interviews.

Themes in clusters (clusters underlined)	Respondent		
	1	2	3
Origins of aggression			
Primitive and innate in condition of life	X		X
Context/relationship – requirement for aggression to emerge	X	X	X
Mastery			
Omnipotence	X	X	X
Play and illusion – methods for internalisation of concept of world as bearable	X		X
Musical properties – shaping and adding form to affective state	X	X	X
Emotional development			
Self-reliance	X		
Meaning – requirement for development of sense of self	X	X	X
Aggression in healthy development	X	X	X
Object's survival of aggression	X	X	X
Patient's use of aggression as indicator of patient's needs	X	X	X
Action			
Motility and aggression	X	X	
Aggression arousal through music		X	X
Music therapy – appropriate form of expression of aggression	X	X	X
Sublimation of aggression in creative action	X	X	X
Use of music used as a defence	X	X	X

in creativity. Creative activity was suggested as enhancing the patient's concept of self. All respondents implied that the object's survival of aggression was essential in emotional development and that the therapist's survival led to the patient experiencing his own aggression as benign, tolerable and not destructive. Respondents also suggested that the type and use of aggression by the patient could be considered an indicator of the type of emotional disturbance present.

Action

In music therapy, embodiment is commonly employed in the act of making sound and can evoke body movements. The individual may perceive his own aggression as destructive and powerful, and therefore, suppress or sublimate its expression. Respondents considered aggression to be linked to body movements and capable of arousal through music. All respondents stated that music therapy is an appropriate form of expression of aggression and that it seems to reduce aggressive behaviour, particularly through drumming and improvisation as a means of channelling aggressive energy. Respondents agreed that aggression is a common reason for referral to arts therapies, and mentioned sublimation of aggression in music therapy. Through sublimation, the destructive behaviour is transformed into something creative. In music making, links may be made between the act, the thought, the emotion and its meaning. All respondents stated that action with meaning may become sublimated, but that action without meaning may only be discharged or acted out. They also considered that music might be used as a defence against pain or intimacy in the therapeutic relationship. The patient might play familiar songs, repetitive patterns or without emotional expression in order to defend against the pain or risk evoked by the therapeutic relationship.

Discussion and conclusions

This study of the links between aggression and creativity in music therapy suggests important areas of congruence in affect, action, mastery, context and meaning. Music therapy provides a suitable and adaptable environment in which to explore these concepts. The function of aggression for the patient in music therapy is partly in providing the energy and intention to be creative in exploring and developing a sense of self. Musical expressions of aggression in a holding environment can lead to the emergence of more vulnerable feelings, which may be the cause of the aggressive behaviour.

The need for a context for aggression to emerge is implied by the notion of the intention to harm (Geen, 1990; Laplanche and Pontalis, 1973). This view was supported in the interview data, in which respondents identified group or individual music therapy as a suitable context for this to explore object relations. Kernberg acknowledges the arousal of aggression to destroy the bad object, avoid pain or motivate the object to satisfy the patient's needs (Kernberg, 1992). Without a context in which to explore his personality safely, Charles and others with similar problems might suppress aggression and unmanageable emotions through self harm, by excess drinking, for example. Music therapy can provide a relational context and, through creative activity, Charles was able to play, improvise and express himself. This supports Winnicott's (1957) assertion that an individual's experience of aggression influences the expression or suppression of other emotions. The context is also created by the therapeutic alliance and the knowledge that both patient and therapist have entered into a relationship that addresses aggression in the process.

Aggression is activated and driven by affect (Kernberg, 1992). The respondents suggested that aggressive energy is channelled in music making. Musical expressions of aggression in a containing environment can lead to the emergence of more vulnerable feelings, which may reveal the root of the aggressive behaviour (Winnicott, 1957). Charles began to explore difficult feelings he had about significant and longstanding relationships as his music therapy progressed and he became more able to use music to express himself.

Storr (1968), Sprenger (1999) and Geen (1990) support the interview results suggesting that aggression has strong physiological, neurological and psychological origins, and is controlled by a dynamic relationship between emotions and cognitive processes. Aggression is regulated by a dynamic process and can be sublimated. Therefore, patients can learn to sublimate aggression creatively in music therapy. The case study showed that Charles became more able to explore his inner world and the therapeutic relationship by learning to express his aggression creatively in the music.

The information gathered suggests that using body movements may be key in working with destructive aggression (Bensimon et al., 2008; Smeijsters & Cleven, 2006; Twemlow et al., 2008). Charles mainly chose drumming to express himself. His use of the gong seemed to be connected with the conflict between his fear of his

own destructiveness and his desire to release it. In music therapy, it is possible to explore the appropriate expression of destructive feelings and thoughts and sublimate them in creative activity. Sublimation requires meaning and a balance between primitive and obsessional expression. Connections are made between the act, the thought, the emotion and meaning; linking emotional, cognitive and physical ways of being. Charles used music to discharge his aggression primitively in loud drumming and also to resist emotional expression by playing repetitively. By expressing aggression, he started to gain insight and became more able to show vulnerability and sublimate his aggression. Giving meaning to aggressive behaviour is fundamental in promoting psychological growth (Twemlow et al., 2008). All interviewees emphasised the adaptability of the therapist's music to enable experience of aggression as manageable and meaningful. Insight into behaviour is often achieved verbally. However, the patient may not be able to express a painful experience or feeling verbally in early stages of treatment. Therefore, musical interaction is a very suitable medium for working at a non-verbal, emotional level. Working musically at a non-verbal level through the use of techniques including matching, synchronising, reflecting and grounding (Wigram, 2004) can provide the foundations for the verbal aspect in gaining insight.

Mastery of aggression involves greater experience through repetition, leading to an improved ability to handle it and reduced anxiety in contexts that contain potential for aggression to emerge (Twemlow et al., 2008). Repetition is necessary in working with a concept or feeling in order to find psychological satisfaction (Freud, 1930), and play is an important factor in this for internalising concepts of the self and the external world (Winnicott, 1971). Repetition featured highly in Charles's creative output. He often returned to the same instruments, for example the gong and bass drum; with which he associated feelings of destructiveness; using them to explore these feelings. The object's survival and the patient's omnipotent thinking are essential for building confidence and self-reliance. Through the therapist's survival of the patient's aggression, the patient experiences this aggression as finite, manageable, and available for sublimation.

The interviews and case study suggest giving the patient control in music therapy in order to empower and encourage confidence. The results of the study support this notion through the emergence of themes of self-reliance, meaning, and constructive use of aggression in becoming assertive. Charles' increasing ability to express aggression and to assert his wishes beyond the sessions suggests that he was developing his sense of self through music therapy. He seemed to gain a sense of empowerment through taking responsibility for his treatment.

There were some limitations to this small study, which used a small literature review and the case study was designed around a 10-week individual music therapy treatment of a young male. A limited period of time in which to gain deeper insight into the patient's aggression may have limited his use of creative activity in exploring his aggression. A longer period of treatment would be likely to produce material richer in content. For a study of aggression and creativity it may also have been interesting to include a female subject of a similar age for comparison. The interviewer was not present at all the interviews, but the topic guide and questions were specific and prepared beforehand.

The clusters of themes in Table 1 provide useful viewpoints in thinking about sublimation of aggression through creativity. In thinking about the origin of aggression the practitioner might consider the patients' relationship to the therapist or group as providing the context for aggression to emerge. Providing this context may be necessary to promote the patient's mastery of aggression via shaping and adding form to expression. In considering the emotional development of the patient the therapist should reflect on the patient's need for autonomy in order to establish identity. Uncovering the meaning and the therapist's survival of aggressive behaviour are important factors in the development of the sense of self. It is also important to consider the types of musical instruments available with regard to the arousal of aggression through body movement. Some patients may benefit from the opportunity to play loudly on a drum while others might find this over-stimulating. However, if a patient plays without emotional expression, this may indicate the suppression of emotions, which may be explored through eliciting emotional expression. Encompassing the treatment, therapists should consider their own responses to aggressive behaviour. This will enable clearer thinking and a more psychodynamic attitude towards the patient's aggression. This attitude will inhibit a reactionary, self-preservative response by the therapist and enable appropriate responses and adaptation to the patient's needs.

This article offers ways of thinking about aggression in music therapy and suggests a strong link between aggression and creativity. It proposes that through movement in music making with a music therapist to contain aggression as it emerges the patient can be enabled to sublimate their aggression, and that an increase in creativity may be an indicator of therapeutic progress and successful mastery of aggression.

References

Aigen, K. (1991). Creative fantasy, music and lyric improvisation with a gifted acting-out boy. In K. Bruscia (Ed.), *Case studies in music therapy* (pp. 109–126). Gilsum, NH: Barcelona.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders*, Fourth ed., Text revision. Washington: American Psychiatric Association.

Austin, D. S. (1991). The musical mirror: Music therapy for the narcissistically injured. In K. Bruscia (Ed.), *Case studies in music therapy* (pp. 291–308). Gilsum, NH: Barcelona.

Baker, F., Kennelly, J., & Tamplin, J. (2005). Songwriting to explore identity change and sense of self-concept following traumatic brain injury. In F. Baker, & T. Wigram (Eds.), *Songwriting: Methods, techniques and clinical applications for music therapy clinicians, educators and students* (pp. 116–133). London: Jessica Kingsley.

Barron, F. (1965). *New directions in psychology II*. London: Holt, Rinehart & Winston.

Bensimon, M., Amir, D., & Wolf, Y. (2008). Drumming through trauma: Music therapy with post-traumatic soldiers. *The Arts in Psychotherapy*, *35*(1), 34–48.

Bruscia, K. (1987). *Improvisational models of music therapy*. Springfield, IL: C. Thomas.

Derrington, P. (2005). Teenagers and songwriting: Supporting students in a mainstream secondary school. In F. Baker, & T. Wigram (Eds.), *Songwriting: Methods, techniques and clinical applications for music therapy clinicians, educators and students* (pp. 68–81). London: Jessica Kingsley.

First, M., Gibbon, M., Spitzer, R., Williams, J., & Benjamin, L. (1997). *Structured clinical interview for DSM-IV Axis II personality disorders (SCID-II)*. Washington: American Psychiatric Press.

Freud, S. (1910) *The standard edition of the complete psychological works of Sigmund Freud (1886–1939)*, under the general editorship of James Strachey in collaboration with Anna Freud, assisted by Alix Strachey and Alan Tyson, 24 volumes, (1953–1974). London: The Hogarth Press.

Freud, S. (1920). Beyond the pleasure principle. In S. Freud (Ed.), *The essentials of psycho-analysis* (pp. 218–268). London: Penguin.

Freud, S. (1930). Civilisation and its discontents. In S. Freud (Ed.), *Civilisation, society and religion* (pp. 243–340). London: Penguin.

Geen, R. (1990). *Human aggression*. Buckingham: Open University.

Hannibal, N. (2003). A woman's change from being nobody to somebody: Music therapy with a middle-aged speechless, and self-destructive woman. In S. Hadley (Ed.), *Psychodynamic music therapy: Case studies* (pp. 403–413). Gilsum, NH: Barcelona.

Hughes, M. (1995). A comparison of mother infant interaction and the client therapist relationship. In T. Wigram, B. Saperston, & R. West (Eds.), *The art and science of music therapy: A Handbook*. Chur, Switzerland: Harwood Academic Publishers.

Jackson, N. (2010). Models of response to client anger in music therapy. *The Arts in Psychotherapy*, *37*, 46–55.

John, D. (1995). The therapeutic relationship in music therapy as a tool in the treatment of psychosis. In T. Wigram, B. Saperston, & R. West (Eds.), *The art and science of music therapy: A handbook* (pp. 157–166). London: Harwood Academic.

Kernberg, O. (1992). *Aggression in personality disorders and perversions*. New Haven: Yale University Press.

Klein, M. (1948). On the theory of anxiety and guilt. In M. Klein (Ed.), *Envy and gratitude and other works* (pp. 25–42). London: Virago.

Klein, M. (1952). Some theoretical conclusions regarding the emotional life of the infant. In M. Klein (Ed.), *Envy and gratitude and other works* (pp. 61–93). London: Virago.

Laplanche, J., & Pontalis, J. (1973). *The Language of psychoanalysis*. London: Karnac Books.
Nissimov-nahum, E. (2008). A model for art therapy in educational settings with children who behave aggressively. *The Arts in Psychotherapy*, *35*(5), 341–348.
Nygaard Pedersen, I. (2003). The revival of the frozen sea urchin: Music therapy with a psychiatric patient. In S. Hadley (Ed.), *Psychodynamic music therapy: Case studies* (pp. 375–389). Gilsum: Barcelona.
Odell-Miller, H. (1995). Why provide music therapy in the community for adults with mental health problems? *British Journal of Music Therapy*, *9*(1), 4–10.
Odell-Miller, H. (2001). Music therapy and its relationship to psychoanalysis. In Y. Searle, & I. Streng (Eds.), *Where analysis meets the arts* (pp. 127–152). London: Karnac Books.
Odell-Miller, H. (2002). One man's journey and the importance of time: Music therapy in an NHS mental health day centre. In A. Davies, & E. Richards (Eds.), *Music therapy and group work: Sound company* (pp. 63–76). London: Jessica Kingsley.
Odell-Miller, H. (2003). Are words enough? Music therapy as an influence in psychoanalytic psychotherapy. In L. King, & R. Randall (Eds.), *The future of psychoanalytic psychotherapy* (pp. 153–166). London: Whurr.
Odell-Miller, H. (2007). *The practice of music therapy for adults with mental health problems: The relationship between diagnosis and clinical method*. Unpublished doctoral dissertation. Aalborg, Denmark: Aalborg University.
Pavlicevic, M. (1997). *Music therapy in context: Music, meaning and relationship*. London: Jessica Kingsley.
Priestley, M. (1994). *Essays on analytical music therapy*. Phoenixville: Barcelona.
Ryle, A. (1995). *Cognitive analytic therapy*. London: Wiley.
Segal, H. (1957). Notes on symbol formation. In E. B. Spillius (Ed.), *Melanie Klein today: Developments in theory and practice. Mainly theory*. London: Routledge.
Skaggs, R. (1997). Music-centered creative arts in a sex offender treatment program for male juveniles. *Music Therapy Perspectives*, *15*(2), 73–78.
Smeijsters, H., & Cleven, G. (2006). The treatment of aggression using arts therapies in forensic psychiatry: Results of a qualitative inquiry. *The Arts in Psychotherapy*, *33*, 37–58.
Smith, J., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 51–80). London: Sage.
Sprenger, M. (1999). *Learning and memory: The brain in action*. Virginia: Association for Supervision and Curriculum Development.
Storr, A. (1968). *Human aggression*. Middlesex: Pelican.
Storr, A. (1972). *The dynamics of creation*. London: Secker and Warburg.
Twemlow, S., Sacco, F., & Fonagy, P. (2008). Embodying the mind: Movement as a container for destructive aggression. *American Journal of Psychotherapy*, *62*(1), 1–33.
Twyford, K., & Watson, T. (2008). *Integrated team working: Music therapy as part of transdisciplinary and collaborative approaches*. London: Jessica Kingsley.
Wheeler, B. L. (2005). Overview of music therapy research. In B. L. Wheeler (Ed.), *Music therapy research* (2nd ed., Vol. 1, pp. 3–19). Gilsum, NH: Barcelona.
Wheeler, B. L., & Kenny, C. (2005). Principles of qualitative research. In B. L. Wheeler (Ed.), *Music therapy research* (2nd ed., pp. 45–58). Gilsum, NH: Barcelona.
Wigram, T. (2004). *Improvisation: Methods and techniques for music therapy clinicians, educators and students*. London: Jessica Kingsley.
Winnicott, D. (1950). Aggression in relation to emotional development. In D. Winnicott (Ed.), *Through paediatrics to psychoanalysis: Collected papers* (pp. 204–218). London: Karnac.
Winnicott, D. (1957). *The child, the family, and the outside world*. Oxon: Routledge.
Winnicott, D. (1971). *Playing and reality*. Oxon: Routledge.