Models of Response to Client Anger in Music Therapy

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ARTICLE INFO

Article history:
Received 31 March 2009
18 September 2009
Accepted 20 September 2009

Keywords:
Anger
Music therapy
Experience
Qualitative
Model

ABSTRACT

Anger is an emotion that is commonly addressed in therapy situations, and particularly in music therapy since music, by its nature, is evocative of emotion. This qualitative study examines music therapists' experience of and response to client anger utilizing a multiple instrumental case study design. Descriptive narratives of clients' expressions of anger during sessions were collected from 29 board-certified music therapists working with a variety of populations in a number of different settings. The narratives were analyzed through a process of hermeneutic phenomenological reflection, then compared and grouped according to similar aspects and reanalyzed. The results of these analyses revealed four groupings of therapists' responses, the division of which is primarily based on the therapists' intent, and which are described as models of response. They include the Redirection Model, the Validation Model, the Containing Model, and the Working-through Model. The models are compared by similarities and differences, and their usefulness in relation to clinical application is discussed.

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Introduction

Anger is an emotion that is often addressed in therapy. Given that music is evocative of emotion, music therapists may frequently encounter clients who are expressing strong emotions like anger during music therapy sessions. This study examined how music therapists experience and respond to client expressions of anger within the music therapy session. Is each therapist's experience of client anger entirely individual, and does this lead to unique responses? Or do music therapists experience their clients' expressions of anger in similar ways, and does this lead to similar ways of responding? If they respond in similar ways, can these responses be categorized in some manner that will reveal identifiable models or prototypes? To this end, the study was designed around the following research questions:

1. How do music therapists experience their clients' expressions of anger within the clinical setting?
2. And, how do they respond to their clients' expressions of anger within the clinical setting?
   (a) Are there characteristic ways in which music therapists respond to their clients' expressions of anger?
   (b) If so, can these responses be categorized?

For the purposes of this study, “anger” was defined as a strong experience of belligerent displeasure, manifested physiologically, emotionally, cognitively, and/or behaviorally, often resulting, consciously or unconsciously, from the perception of a wrong, injury, or injustice. The study focused on the therapists' experiences of their clients' expressions of anger, their understandings of those expressions within the context of the clients' sessions, and their subsequent responses. The therapists' own personal emotional feelings were described as part of their experience of their clients' expressions, as well as their rational thoughts and interpretations, and their behavioral responses to their clients during these expressions. In this way, the therapists' experiences could be understood in a holistic way. So, in the context of this study, the “therapist's experience” was defined as the totality of the therapist's thoughts, feelings, responses, interpretations, and understandings of the event as remembered and re-experienced in the present.

Related literature

Anger is a complex phenomenon having many descriptive aspects that might be influenced by numerous factors. It has been studied in terms of gender differences (Cox et al., 2004; Newman, Fuqua, Gray, & Simpson, 2006), as state and trait anger (Rice & Howell, 2006; Stimmel, Rayburg, Waring, & Raffeld, 2005), and as anger-in and anger-out expression styles (Alkhadher, 2004; Linden et al., 2003). It has also been studied in terms of its correlates, such as depression (Boergers, Spirito, & Donaldson, 1998; Stein, Apter, Ratzoni, Har-Evan, & Avidan, 1998), powerlessness and external locus of control (Carmony & DiGiuseppe, 2003), shame and guilt (Lutwak, Panish, Ferrari, & Razzino, 2001; Tangney, 1991), frustration (Frick, 1986), and pessimism (Alkhadher, 2004). These studies are helpful in understanding specific aspects of anger, but none pro-
vides a comprehensive picture of the emotion that can illuminate how client anger might be understood within the clinical setting.

A large majority of the literature considers anger from the cognitive-behavioral orientation, which conceptualizes the emotion as behaviors that are the result of the interaction of thoughts and behavior patterns. Cognitive–behavioral interventions that focus on anger reduction and management have been explored with numerous client populations including child and adolescent client groups (Goodwin, 2006; Humphrey & Brooks, 2006; Stern, 1999), individuals with learning disabilities (Willner, Jones, Tamsy, & Green, 2002), individuals with mental retardation (Rose, Loftus, Flint, & Carey, 2005), various forensic groups (Jones & Hollin, 2004; Taylor, Novaco, Gillmer, & Thorne, 2002; Vannoy & Hoyt, 2004), individuals who are assaultive to their spouse or partner (Eckhardt, 2007), those with trauma-related disorders (Wiseman, Metzl, & Barber, 2006), individuals with traumatic brain injuries (Gongora, McKenney, & Godinez, 2005), those with attentional disorders (Miranda & Presentacion, 2000), and those with driving anger or road rage (Deffenbacher, Filetti, Lynch, Dahlen, & Oetting, 2002). These interventions have also been used with mental health client populations who are experiencing anger as a part of their symptomatology, including those suffering from depression (Leung & Slep, 2006), with anxiety disorders (Erwin, Heimberg, Schneier, & Liebowitz, 2003), with symptoms of both depression and anxiety (Martin & Dahlen, 2005), substance abusers (Lin, Enright, Krahn, Mack, & Baskin, 2004), as well as with children who are demonstrating early psychiatric symptomatology (Snyder, Stoolmiller, Wilson, & Yamamoto, 2003). The intent of many of these studies is to identify best practice in anger treatment and management, but the actual focus of the studies is rarely on exploring the clients’ expressions of anger in the clinical setting, or on understanding how therapists understand their clients’ expressions of anger and how that understanding leads to intervention choices. Additionally, Glancy and Saini (2005) note that most of the research literature focuses on cognitive–behavioral interventions for anger issues while many other types of interventions are currently in practice; for example, psychodynamic, psycho-educational, experiential, treatment within substance abuse counseling, etc. They highlight the fact that the relative lack of rigorous testing of other types of treatment interventions for anger hinders the ability to determine whether cognitive–behavioral therapies should be considered “best practice,” or simply one of a variety of choices in treatment interventions.

A few studies have examined anger from other clinical orientations. Of particular interest in these studies is the recognition of the role of the therapist in the therapeutic process, including the ability to set aside personal discomfort to facilitate the client’s use of anger within the therapy session (VanVelsor & Cox, 2001), and use of transference and countertransference as a means of resolving anger (Wiener, 1998). Similarly, in studies that have examined anger as a relational process, the therapists’ role as an active participant in the therapeutic process has been found to facilitate the client’s ability to gain understanding of emotions and behaviors within the different contexts in which they are experienced (Dalenberg, 2004; Roffman, 2004).

The music therapy literature specifically related to anger is limited. While anger is rather frequently mentioned in the literature, it has rarely been the focus of study. Anger has been studied in relation to music styles (Gowensmith & Bloom, 1997), and has been used as an indicator to compare music therapy interventions to those of other therapeutic modalities (Cevasco, Kennedy, & Generally, 2005). These studies do not examine the nature of anger itself, nor do they look at the role that anger might play within the context of the music therapy session. A number of articles and book chapters discuss anger within the presentation of case materials related to specific music therapy approaches, including Analytical Music Therapy (Priestley, 1994; Scheiby, 1991, 1998), the Bonny Method of Guided Imagery and Music (Borling, 1992; Pickett, 1995; Rinker, 1991; Schulberg, 1994; Ventre, 1994), and Nordoff–Robbins, or Creative, Music Therapy (Aigen, 1999; Nordoff & Robbins, 1977; Robarts, 1998; Rolvsjord, 1989). Some have mentioned anger in describing the use of specific music therapy methods, mostly notably including song writing (Bailey, 1984; Cohen, 1994; Freed, 1987; Lindberg, 1995; Robb, 1996) and improvisational drumming (Sutoroff, 1994). Again, these articles and chapters focus on other aspects of music therapy treatment, such as specific methods or the overall process of therapy. Their descriptions of clients with anger issues and their treatment do, however, allow the reader to make their own interpretations of the therapists’ understanding of their clients’ anger and how this led to their choices of response.

In summary, though there is quite a bit of literature related to anger, the information that it provides is not focused on understanding client anger as a phenomenon or on understanding how the therapist experiences those expressions and makes clinical choices in response. It does illustrate the subjective nature of anger and the many different presentations in which it may appear, lending support for taking a qualitative approach in studying anger. The music therapy research literature offers little that specifically focuses on examining clients’ expressions of anger or on how therapists make choices in responding to those expressions, though case materials do provide opportunities for the reader to make inferences about this. This study was intended as a beginning step into an exploration of the phenomenon of client anger and how music therapists respond to their clients’ expressions of anger.

Method

Participants

Participants for this study were board-certified music therapists in the USA selected from the Member Sourcebook of the American Music Therapy Association (AMTA, 2006). The aim of sampling was to recruit therapists who had varied experiences of and responses to client anger in order to understand the phenomenon in as complete a manner as possible within the confines of this study. After the study’s review and approval by the Institutional Review Board, a total of 115 invitation e-mails were sent to potential participants, resulting in 29 fully completed questionnaires. The 29 participants represented both genders, a range of years of clinical experience, and varied levels of education. They identified numerous clinical orientations to which they ascribed, and they indicated that they work with a variety of client population groups in different settings. The demographics for these participants are shown in Table 1.

Design

This study used a multiple instrumental case study design in which the case served as a unit of data. In a multiple instrumental case study design, the researcher begins with a specific question or theme, and the cases are studied in order to reveal insight into that particular theme (Smeijsters & Aagaard, 2005). The specifics of each therapist’s experience were collected by means of a questionnaire, which was quasi-phenomenological in nature. On the one hand, the questions were mostly open-ended, and carefully designed to encourage the participants to place themselves back into an experience in the past, and to relive the events as they described them. On the other hand, the written format and the specificity of certain questions unavoidably imposed some structure upon the participants’ responses. A phenomenological approach typically uses in-depth, open-ended interviewing to understand participants’ experiences, but a semi-structured...
questionnaire format has been successfully used to retrieve similar kinds of qualitative, experiential information from numerous participants (O’Callaghan, 2001). An approach that allowed the collection of information from a larger number of participants was more advantageous for bringing about some insight into the therapists’ experiences of client anger and their subsequent responses and whether these experiences and responses are completely individual or if patterns exist.

The cases, as units of data, were examined through a process of hermeneutic phenomenological reflection in which each case was explored in terms of its meaning in relation to the whole phenomenon (Kenny, Jahn-Langenberg, & Loewy, 2005). The individual cases were analyzed individually to gain understanding of the essence of the participants’ experiences of client anger and the responses that they made. They were then analyzed horizontally to understand similarities and differences in the participants’ experiences and responses in the form of a variable-oriented qualitative analysis using a cross-case approach (Bruscia, 2005). Because the experience of anger is a subjective phenomenon, comparisons could only be made by first understanding the individual experience of each participant. The exploration of similarities and differences was focused on revealing any underlying patterns of response that were inherent in the data and which might be considered a model or prototype of therapist response to client anger.

Epoché

My interest in therapists’ experiences of client anger grew out of events and situations in my own clinical practice that caused me to begin asking myself and others questions about the nature of client anger and various theoretical understandings of anger and other emotions within the context of therapy. These questions, the answers I received from others about them, and the additional questions that those responses raised for me created certain preferences and biases that I bring to this study. I clearly prefer a creative and expressive approach to exploring, understanding, and working through strong emotion within the context of therapy. In my own personal experiences with therapy, it has always been the approaches that actively involved me in an exploration of my own thoughts and feelings (naming, expressing, exploring, etc.) that have been most effective. I have experienced these types of approaches as being respectful of me as a complex creature, more than a sum of my parts, and more than a learned response. I also have some bias regarding behavioral approaches, largely because, in my own clinical experience, I was referred clients with notable anger issues when the behaviorally based therapists and psychologists at my hospital had reached an impasse in progress with these clients. My tendency is to believe that these impasses were related to a certain amount of ineffectiveness in the others’ responses to the clients.

These preferences and biases created certain expectations that I held in regard to this particular study. In general, I expected to find that music therapists would report a very wide variety of experiences of and responses to their clients’ expression of anger. I also expected to find that models of response would reveal themselves within the participants’ descriptions, and I suspected that these models would in some way reflect certain orientations or clinical approaches. The identification of these biases and expectations hopefully allowed me bracket them, to set them aside, and to be fully open to any and all insight that the data had to offer.

Data collection

Data for this study were collected from participants using a researcher-designed questionnaire (Appendix A). After initialing an informed consent page and answering demographic questions, each participant was asked to describe one event in their clinical work in which they experienced a strong expression of anger from a client. The questionnaire was intended to assist the participants in re-living a past event in the present in order to describe that event; and the questions were designed to stimulate the participants’ memories of different aspects of that event. The questionnaires were made electronically accessible through an online link. Providing the participants with opportunity to write their responses allowed them time to describe the event with their client in a manner that most closely reflected their experiences, as well as allowing them to participate in the data collection process with the least amount of inconvenience to them. The written responses allowed me, as the researcher, to gain as accurate an understanding of the participants’ experiences as possible.

Data analysis

Each of the 29 questionnaires was examined as a single case with the intent of developing a phenomenological description that allowed for deeper understanding of the individual experiences and responses of the participant. The participant’s responses were read multiple times with notes made as to my understanding of the event that was being described in the questionnaire. Each participant’s responses were then formed into a descriptive narrative using as many of the participant’s own words as possible and reflecting my understanding of the event. This narrative was then returned to the participant for verification, and any corrections, additions, or deletions made by the participant were incorporated into the narrative. Member checking continued until each participant verified that the narrative fully represented their experience of the event they had described.
The completed narratives were read several times as a whole group to get a broader sense of how individual cases fit into that whole. Then, the individual narratives were analyzed again. Specific aspects that helped to define the essence of each participant's experience were highlighted and coded. As each narrative was reanalyzed in this way, coding was adjusted on previously analyzed cases to reflect my increased understanding of both the individual narratives and the data group as a whole. This process continued until all narratives had been reanalyzed, coded, and the coding across all narratives adjusted accordingly.

The cases were then analyzed as a group of data, with the intent of understanding similarities and differences that might reveal underlying patterns. The coded segments gleaned from the analysis of the individual narratives provided the means for the horizontal, across-case analysis. Cases with similar codes were grouped together and examined. The individual cases in each group were again revisited and interpreted until one general description fitting all cases in each grouping was derived from the separate interpretations. In this way, understanding of the original cases led to new ways of interpreting and understanding the larger phenomenon of therapist response to client anger, and the new ways of understanding the larger phenomenon allowed for deeper understandings and new interpretations of the processes involved in individual therapists’ responses to client anger.

The questionnaire asked the participants to provide a number of additional demographics and other descriptors, including participant's and client's ethnic backgrounds, participant's and client's religious affiliations, notable differences in age between participant and client, etc. In examining this data, no evidence was found that these factors correlated in any way with the models that these factors could be correlated with the experiences described by the participants in any discernable way. There was also no indication that these factors correlated in any way with the models that were derived from the data. While these types of factors must necessarily have some influence on the manner in which a therapist experiences, thinks about, and understands the process of therapy, these questions are beyond the scope of this study. Therefore, these parts of the data were removed from final analysis.

Results

The analysis of the individual cases resulted in codes that were descriptive of various aspects of the participants' experience of and response to their client's expressions of anger. Two of these aspects were directly prompted by the structure of the questionnaire: the thoughts and feelings of the therapist and the active response of the therapist. Others were aspects of the experiences that were revealed in the interpretation of the cases: the target of the client's anger; the therapist's understanding of the meaning of the client's anger; and the outcome of the specific event. These aspects and the corresponding cases are shown in Table 2.

The thoughts and feelings described by the participants fell into three categories. Twelve of the participants described feeling fear in response to the clients' expressions of anger, and having worry about the safety of those present at the time. Feelings of fear included experiences such as feeling “terrified,” “afraid,” “paralyzed,” and descriptions such as “my heart was pounding and my hands got all clammy.” Safety concerns were expressed in ways such as feeling “fear for my safety because [client] was a lot bigger than me,” and feeling “concerned about making sure that the rest of the group were not hurt or negatively affected by [client’s] rampage.” Nine participants described feeling angry and frustrated themselves. For example, one participant described feeling “frustrated about being unable to find a way to connect with [client].” Another described her anger as “disgust for the parents, who were sitting in the session but were talking with each other, incapable of dealing with the intensity of their child's emotion and seemingly oblivious that their arguing had stimulated [client’s] temper tantrum.” The remainder of the participants described less emotionally charged feelings about their clients' expressions of anger, including surprise, understanding, and even positive feelings about the expressions. For example, one participant felt “it was a breakthrough for [client] to learn how to express these types of emotion,” while another felt “relieved . . . that the song had prompted a response that led to me and [client] working together to deal with his anger in a productive manner.”

The types of active responses made by the participants in response to their clients' expressions of anger fell into four groupings. Seven participants used redirection in response to their client's anger. Redirections included verbal redirection, musical redirection, and modeling. Six participants described remaining present with and allowing the clients' expressions of anger. For example, one participant “allowed [client] to have some time hid- ing . . . and then encouraged [client] to express her feelings, giving her permission to do so in her own time and giving her [options] . . .” Eight participants encouraged their clients' expressions of anger and either musically or verbally contained those expressions. One of these participants told the client that she would “be there for her no matter what,” and that “she could be as angry as she needed to be for as long as she needed.” She then gave the client a drum to hit instead of hitting and kicking the door. Six participants either verbally or musically reflected the clients' expressions and encouraged exploration of the feelings. For example, one participant described “listening and empathizing” with the client's

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Common aspects among cases.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspect</td>
<td>N</td>
</tr>
<tr>
<td>Target of client's anger</td>
<td>12</td>
</tr>
<tr>
<td>Anger towards therapist</td>
<td>8</td>
</tr>
<tr>
<td>Generalized anger</td>
<td>9</td>
</tr>
<tr>
<td>Thoughts and feelings of therapist</td>
<td>12</td>
</tr>
<tr>
<td>Fear; concern about safety</td>
<td>7</td>
</tr>
<tr>
<td>Anger; frustration</td>
<td>9</td>
</tr>
<tr>
<td>Surprise; understanding; positive feelings</td>
<td>8</td>
</tr>
<tr>
<td>Understood meaning of client's anger</td>
<td>21</td>
</tr>
<tr>
<td>Active response of therapist</td>
<td>25</td>
</tr>
<tr>
<td>Redirection behavior</td>
<td>6</td>
</tr>
<tr>
<td>Allowing; remaining present; receiving</td>
<td>8</td>
</tr>
<tr>
<td>Encouraging; verbally or musically containing</td>
<td>6</td>
</tr>
<tr>
<td>Verbally or musically reflecting; exploring</td>
<td>6</td>
</tr>
<tr>
<td>Nonopportunity for active response</td>
<td>7</td>
</tr>
</tbody>
</table>

Note. Aspect refers to the categories of aspects found to be common among cases. N is the total number of cases. Cases refers to the specific numbers assigned to the cases.
expression and “reflecting to him [my understanding] of what he was expressing.” The group was then encouraged to discuss as a whole the client’s feelings and their own similar feelings, and they wrote a song together about this. Two participants were unable to make an active response to their clients due to the circumstances of the event: one client was immediately removed from the group by support staff who were present; the participant in another case was injured by the client’s outburst and left the session for medical care.

Each participant described the client’s expression of anger in a manner that revealed the target of the anger: anger towards the therapist; anger towards others; or, generalized anger. For example, in one case the client directed his anger at the therapist: “... [client] rose from his chair, paced the floor, and moved to put his hands around my neck.” In another, the client was angry with hospital staff: “... [the client] felt he had been hospitalized too long and that he was being ‘jerked around’.” In nine cases, there was not an apparent target for the clients’ expression of anger. For example, in one case, “… [client] began drumming louder and faster until the others in the group stopped playing. [Client] began crying and cursing.”

Each participant was asked to describe the specific event, the residual feelings from the event, and whether or not that event had an impact on the therapeutic relationship with the client. From these descriptions it was possible to infer if the specific event concluded positively, negatively, or neutrally. In 16 cases, the outcome was positive, with increased trust and a strengthening of the therapeutic relationship specifically noted by many of these participants. For example, one participant related that working through the anger in that particular session led to “continued engagement in the therapy process at a deeper level than [client] had previously offered.” Another stated that “There is greater trust” that [client] can work it through and that I am strong enough to remain with him while he does.” Seven cases resulted in a negative outcome from the specific event, including the therapist’s termination of the client from services, inability to make progress with the client, and the client’s refusal to return to music therapy. In the remaining six cases, the specific events described by the participants did not necessarily have either a positive or negative conclusion, but were simply occurrences within the process of the music therapy session.

In each individual analysis, the specific details of the event described by the participant and the manner in which the participant made meaning of the event suggested a particular understanding of the client’s expression of anger. These understandings fell into two groupings. In the first grouping, it seemed as though the participants understood their clients’ expressions as behaviors. In these eight cases, the combination of the participants’ descriptions and their active responses suggested that they understood the anger as a behavior that either needed to be extinguished or replaced by some other behavior. For example, one participant indicated that her active response was to “[follow] the protocol established in his behavior plan” which included “leaving the session when [client] expressed anger.” The other 21 cases fell into the grouping in which participants seemed to understand their clients’ expressions as emotions that required resolution of some kind. For example, one participant stated, “I felt that it was an important step for [client] to get in touch with and express these feelings.” Another related, “I was thinking about what I needed to do to support [client] in expressing his anger—validating it, amplifying it, etc.” This aspect, the therapist’s understanding of the meaning of the client’s expression of anger, became the first division for grouping cases in the horizontal analysis.

As the data as a whole were examined horizontally according to the common aspects (therapist’s experience, therapist’s active response, therapist’s understanding of the client’s anger, target of the client’s anger, and the outcome of the specific event), some natural groupings began to reveal themselves. Initially, as indicated above, two groupings were identified based on the participants’ understood meaning of their clients’ anger. The first grouping, which understood their clients’ anger as behaviors which required change, seemed to stand on its own without further re-grouping. The second grouping, which understood their clients’ anger as an emotion that required resolution, was further divided. This division was based upon the participants’ active response to the clients’ expressions, which resulted in an additional three final groupings that stood on their own. Because each of these groupings could be generally described in a unique fashion, I determined that they constituted models of response. The two cases mentioned previously in which the participants were unable to actively respond to the clients’ expressions of anger were not included in these final groupings since the participants’ active responses were a critical aspect of the horizontal analysis. The four models and their general descriptions are as follows:

1. The Redirection Model: As the client expresses anger, the therapist recognizes this expression as a behavior that should be redirected. The therapist uses verbal skills and behavior management techniques to extinguish or recondition the presenting anger behavior and to encourage and reward a more acceptable or desired behavior.

2. The Validation Model: As the client expresses anger, the therapist recognizes this expression as an emotion that requires recognition and validation. The therapist allows the client’s expression and validates the emotion by staying present with and receiving the expression.

3. The Containing Model: As the client expresses anger, the therapist recognizes this expression as an emotion that requires recognition and validation, but also recognizes the need to effectively contain the expression in order to maintain safety and to increase the therapeutic effectiveness of the expression. The therapist provides options that validate and encourage the client’s expression of anger, but that channel it into a safe and manageable format.

4. The Working-through Model: As the client expresses anger, the therapist recognizes this expression as an emotion that the client needs to acknowledge, and/or through which the client must move to reach resolution or insight. The therapist uses verbal and/or musical skills to reflect the client’s expression and to encourage further exploration and expression by the client.

The groupings of cases by model are shown in Table 3. Table 4 shows the descriptive aspects of the cases grouped by model.

### Model 3: Therapy Groupings

<table>
<thead>
<tr>
<th>Model</th>
<th>N</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redirection Model</td>
<td>7</td>
<td>1, 5, 7, 15, 16, 19, 20</td>
</tr>
<tr>
<td>Validation Model</td>
<td>6</td>
<td>2, 3, 6, 14, 22, 29</td>
</tr>
<tr>
<td>Containing Model</td>
<td>8</td>
<td>4, 9, 11, 12, 18, 24, 25, 27</td>
</tr>
<tr>
<td>Reflection Model</td>
<td>6</td>
<td>8, 10, 13, 17, 21, 23</td>
</tr>
</tbody>
</table>

**Note.** N refers to the number of cases included in each model. Cases refers to the specific number assigned to each case. Cases 26 and 28 are not included as they did not fall into one of these models.

**Discussion***

**Comparison of models***

The first division that was made was between the cases in which the therapist understood the client’s expression of anger as a behavior, and those in which the therapist understood it as an emotion that was expressing a need. This understanding of what the client’s
anger meant and how it could be understood within the process of music therapy is the primary difference between the Redirection Model and the three other models. It is no surprise, then, that the responses made by the therapists in the Redirection Model are significantly different than those made in the other models. One difference is that the therapists using the Redirection Model did not enlist the help of music in any significant way in addressing the behaviors of the clients. In the other three models, while some therapists used verbal interventions to respond to their clients, most also used music in conjunction with verbal intervention, or used music as the primary response to the client's expression. The other significant difference between the Redirection Model and the other three models is that the therapists' stance in relation to the client was somewhat distanced. Because they were redirecting a behavior, the therapists did not actively engage the client in the sharing of their feeling of anger, nor did the therapists report feeling empathetic. In the other three models, the therapists did engage the clients in sharing their feelings, and in many instances they empathized with the client, thus taking what might be described as a more personal stance, or one in which they were more personally vulnerable to the clients.

In the Validation, the Containing, and the Working-through Models, the therapists understood their clients' expressions of anger as emotions that expressed certain kinds of therapeutic needs. In all three models, the therapists chose very similar actions: verbally supporting, encouraging, directing and redirecting, and/or validating the clients' expressions; improvising to musically support, contain, reflect, and explore the clients' expressions; using songwriting to identify, express, and explore emotions and their meanings, and to examine ways to cope with those emotions; and, in some cases, utilizing the group as support for the clients' expression, and to verbally and musically explore common experiences of the emotion. They also chose various combinations of these actions.

While the therapists in each of these three models made similar, or in some cases the same, choices of specific action in response to their clients' expressions of anger, it was their intended outcome by making those choices that differentiates the models. For example, in a case from the Validation Model, the therapist used instrumental improvisation to allow, encourage, and receive the client's expression of anger. In a case from the Containing Model, the therapist used instrumental improvisation to contain and manage the client's expression of anger while still encouraging and receiving the clients' expression. In both cases the therapist used drum improvisation, both allowed and received the emotional expressions of the clients; but, in the Validation Model case, the therapists' intent was for the client to identify and own his own emotions, while the intent of the therapist in the Containing Model case was for the client to release the emotion in a safe and functional manner.

The Redirection Model and the Containing Model are notably different based on how the client's anger is understood. In one specific way they are quite similar, however, in that the therapists' concern was to interrupt behavior that was unsafe or dysfunctional. In both sets of cases, client's expressions were such that the therapists described feeling concern for the safety of the client, of themselves, and/or of others in the group, and they responded in ways to stop the concerning behavior. The difference is that the intent of the therapists in the Redirection Model was to stop the expression and change or extinguish the behavior, while the intent of the participants in the Containing Model was to redirect the behavior while still allowing and encouraging the expression. The therapists in the Containing Model cases describe some behavioral interventions, such as verbally redirecting specific behaviors and outlining consequences for actions. They also provided other means for allowing and channeling the emotional expression, such as providing a drum to hit instead of the doors and walls, or using assaultive words to write lyrics to a song instead of directing them at other people. In the Redirection Model, participants describe using only behavioral techniques and verbal intervention without choice for further expression and exploration by the client.

The Validation Model and the Working-through Model are quite similar in many ways, including the understanding of the expression of anger as something that is necessary and useful, and in the therapist's choice of response that encourages that expression. These two models differ from the others in that there is no intent by the therapist to curtail the expression of emotion in

Table 4
Case aspects according to model.

<table>
<thead>
<tr>
<th>Case aspects</th>
<th>Models</th>
<th>Redirection N</th>
<th>Validation N</th>
<th>Containing N</th>
<th>Reflection N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger towards therapist</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Anger towards others</td>
<td>–</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Generalized anger</td>
<td>1</td>
<td>1</td>
<td>3</td>
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<tr>
<td>Thoughts and feelings of therapist</td>
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<tr>
<td>Fear; concern about safety</td>
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<td>6</td>
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<tr>
<td>Anger; frustration</td>
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<td>–</td>
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<tr>
<td>Surprise; understanding; positive feelings</td>
<td>1</td>
<td>5</td>
<td>–</td>
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<tr>
<td>Understood meaning of client's anger</td>
<td></td>
<td></td>
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<tr>
<td>Behavior requiring change</td>
<td>7</td>
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<tr>
<td>Emotion requiring resolution</td>
<td>–</td>
<td>6</td>
<td>8</td>
<td>–</td>
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<tr>
<td>Active response of therapist</td>
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<tr>
<td>Redirect behavior</td>
<td>7</td>
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<td>–</td>
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<tr>
<td>Allowing; remaining present; receiving</td>
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<td>6</td>
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<tr>
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<td>–</td>
<td>–</td>
<td>8</td>
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<tr>
<td>Verbally or musically reflecting; exploring</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>6</td>
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<tr>
<td>Outcome of event</td>
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<td></td>
<td></td>
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<tr>
<td>Positive</td>
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<td>6</td>
<td>6</td>
<td>3</td>
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</tr>
<tr>
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<td>5</td>
<td>–</td>
<td>–</td>
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Note. Case aspects refers to the aspects common to all cases. N refers to number of cases.
any way. Instead, the expression is recognized and received by
the therapist, and further expression is allowed and often encour-
gaged. Again, what separates these two models is the therapist’s
intent in responding. In the Validation Model, therapists tended
to describe responses that encouraged the client to continue their
expression of anger. They described validating those expressions by
verbally expressing acceptance and understanding, by encouraging
the clients’ continued expression through both verbal and instru-
mental means, and they used discussion, improvisation and song
writing to assist the client naming and accepting the emotion. The
therapists in the Working-through Model tended to also describe
responses that encouraged the clients to continue to express their
anger, while also using verbal and instrumental means to reflect
and instrumental means to intensify and amplify the client’s active
experience of the emotion in order to stimulate further exploration
of the emotion. The intention of these therapists was to allow the
client’s experience and exploration of the emotion to bring about
insight and resolution. Perhaps the difference between these two
models can be described as facilitating an individual’s express-
ion of human emotion as normal and valid as opposed to assist-
ing an individual in reaching a resolution to an experience of an
emotion.

Differences among cases within models

In the process of comparing the data, the cases seemed to fall
quite naturally into the groupings that led to the description of
models of therapist response to client anger. However, the dif-
fences between cases within the same model seemed to be
equally as notable, and to have implications that are as important
as the similarities. These differences included the demographics
of the participants, the target of the client’s anger in each case,
and the individual case outcomes. The apparent lack of relation-
ship between these aspects and any specific model are particularly
important because they do not reflect the descriptors that music
therapists often use to describe and evaluate clinical work: clinical
orientation, clinical method, level of education of the therapist,
etc.

Demographic differences. The collection of demographic infor-
mation from participants was intended primarily to ensure that a
sufficiently wide variety of experiences and responses were
collected from participants to understand the phenomenon of ther-
apist response to client anger as thoroughly as possible within
the confines of this study. These demographic descriptors were
not included in the case descriptions that were used as the pri-
mary data, nor were they used as the basis for any grouping of
cases. After the case groupings were determined and the models
had been described, I did examine the demographic descriptors of
each grouping of cases in order to determine if any particu-
lar descriptor appeared to be associated with any model. No such
associations were apparent, even though I had originally suspected
that models of response might be related in some way to clinical
orientation and/or levels of education. It seems important to high-
light this point: assumptions about the manner in which a therapist
responds to client anger cannot be made based on descriptors such
as level of education, years of experience, or clinical orientation.
This would suggest that, while there appears to be describable pat-
tterns in therapists’ responses to client anger, these responses are
not necessarily related to factors that are as simplistic as demo-
graphics.

Target of client’s anger. Differences were noted in the target of
clients’ anger in the case groupings for the Validation Model, the
Containing Model, and the Working-through Model. In all three
of these groupings, the participants described both themselves and
others as targets of their clients’ anger, as well as describing clients’
generalized expressions of anger. In other words, all potential tar-
gets of a client’s anger were represented within the cases for each
of these models. This would suggest that the manner in which a
therapist responds to a client’s expression of anger is not necessar-
ily based upon the target of that expression. Those therapists who
were the target of their clients’ anger did not respond in one par-
ticular manner, and neither did those whose clients directed their
anger towards others, etc. Additionally, since there were multiple
targets for clients’ expressions of anger in all these groupings, and
each grouping was made based in part on the participants’ under-
standings of the clients’ anger, then the manner in which a therapist
understands the meaning of a client’s expression of anger is not ne-
essarily related to the direction of the client’s expression. So, the
target of a client’s anger does not seem to affect how a therapist
will understand that expression, or how a therapist might choose
to respond to it.

The cases from which the Redirection Model was derived were
different from the other models in this regard. In six of the seven
cases, the participants described themselves as the target of their
clients’ expression of anger, with one case in which the client’s
anger was described as a generalized expression; however, this
may simply be coincidental. There is nothing in the participant’s
descriptions that would suggest that they understood their clients’
anger in a particular way because of the targets of that anger, or that
they chose their manner of response because of that target. Partici-
pants in other models also described themselves as targets of their
clients’ anger or described their clients’ anger as generalized, and
yet they understood those expressions differently and responded
to them in multiple ways.

Participants’ personal feeling. Participants in all models largely
reported less than comfortable feelings that they experienced while
their clients expressed their anger, including feelings such as fear,
concern, frustration, and anger. Some described uncertainty in their
own thoughts, feelings, and responses, wondering if they under-
stood the clients’ intentions or meanings, or questioning their own
abilities to effectively respond, or if they had made the right choice
in responding to the client. Only a few indicated that they felt
positive feelings or were pleased in response to the angry expres-
sions. In these cases, the positive feelings of the participant were
related to their understanding of the client expression as an inte-
gral part of the client’s therapeutic process. So, while a therapist’s
personal thoughts and feelings in response to a client’s expres-
sion of anger may be in some way related to the manner in which
she/he understands that expression, it is not predictive of any one
specific choice the therapist will make in responding to that expres-
sion.

The exception to this was in the cases when the client’s anger
included behavior that was immediately dangerous to self or oth-
ers. In these instances the participants first acted to ensure the
safety of those involved in the session. The Containing Model par-
ticularly reflects this necessity in the therapist’s attempt to place
boundaries around the client’s expression of anger so that it can be
safely managed and channeled; however, regardless of the model
one might use to respond to client anger, safety must always be a
priority in immediate choice of action.

Clinical outcomes. I had originally suspected that certain ways
of responding to client anger would generally have better or worse
clinical outcomes. In examining the outcomes of the cases for each
model, it seems that such conclusions should not be drawn. The par-
ticipants in the Validation and the Containing Models described no
negative clinical outcomes; however, in both the Redirection and
Working-through Models, both positive and negative outcomes
were described. The Redirection and the Working-through Mod-
els differ from each other in the manner in which the participants
understood the meaning of their clients’ anger (i.e., as a behav-
ior to be changed or extinguished, and as an emotion that need
to be expressed and explored, respectively), and in the subse-
quent manners in which they responded to those expressions. The Working-through Model and the Validation and Containing Models are similar in terms of the participants’ ways of understanding their clients’ anger (i.e., as emotions that need to be allowed and expressed). So, one cannot generally attribute positive or negative clinical outcomes to the therapists’ understandings of the meaning of clients’ anger, nor to the therapists’ choices of response to those expressions. Additionally, other aspects of the cases, such as the target of the client’s anger, or the personal thoughts and feelings of the participant, seemed to be in no way related to the clinical outcomes of the case events.

This has several implications. First, it is simply not possible to identify one “correct” way of responding to client anger. All four models of response were effective in some cases, and ineffective in other cases. Therefore, successful outcome in responding to client anger cannot be ensured by the use of a specific model of response identified in this study. A large majority of existing literature about anger has focused on cognitive-behavioral interventions as best practice for responding to client anger; however, this study would suggest that responding to the client’s anger from only one approach will be inconsistently effective.

Secondly, if specific aspects of a client’s expression of anger (e.g., the target of the client’s expression, or the personal feelings of the therapist about the client’s expression) do not necessarily lead to a positive or negative clinical outcome, then a successful outcome must be attributable to something more than a simple combination of aspects. More likely, successful outcome is a result of the therapist’s choice of response in relation to the complete context of the event, including the client’s means of expression, the therapist’s understanding of that expression, the therapist’s own thoughts and feelings, the nature of the therapeutic relationship between client and therapist, and environmental factors (e.g., the treatment space, the available equipment, and the presence of others). This is reflective of a systems approach to understanding the phenomenon of anger, where the experience of anger is influenced by and influenced upon all parts of the system in which it is imbedded (Robins & Novaco, 1999).

Additionally, if successful clinical outcome is a result of the interaction between the therapist’s choice of response and the whole context of the client’s expression of anger, then it would be ineffective for any given therapist to respond to client anger by using only one model of response. The models of response do not describe the clinical orientation or therapeutic stance of therapists. Instead they describe different clinical responses available to any given therapist based upon the context of the immediate event of client anger. This recalls the “menu” concept of treatment intervention discussed by DiGiuseppe (1999). Though his “menu” of treatment referred to combinations of modalities for treating anger, a parallel can be drawn between this and the models of response identified in this study. The four models reflect the need of the client and the unique context of her/his expression of anger.

A parallel can be drawn between this and the models of treatment referred to combinations of modalities for treating anger. A model of response identified in this study. The four models reflect the need of the client and the unique context of her/his expression of anger. A model of response identified in this study. The four models reflect the need of the client and the unique context of her/his expression of anger.
Appendix A.

A.1. Anger questionnaire

1. For descriptive purposes, please indicate if you are:  
Male  
Female

2. What is your race?  
African-American  
Asian  
Native American  
Hispanic/Latino  
Other: please specify

3. Please indicate your ethnic background.  
[open response box]

4. Please indicate your country of origin.  
[open response box]

5. If you have a religious affiliation, please indicate what it is.  
[open response box]

6. What is your level of education?  
Bachelor’s degree  
Master’s degree  
Doctoral degree

7. For how long have you been a professional music therapist?  
Less than one year–five years  
Six years–ten years  
Eleven years–nineteen years  
Twenty or more years

8. Please indicate the client population with which you most often work.  
Humanistic  
Behavioral  
Cognitive-behavioral

9. Please indicate the setting in which you most often work.  
[open response box]

10. What was the client’s gender?  
Male  
Female

11. What was the age of the client at the time of the incident?  
[enter years]

12. Were you and the client significantly different in age? If yes, by how much?  
No  
[please specify if you were older or younger and by how many years]

13. What was the client’s race?  
African-American  
Asian  
Native American  
Hispanic/Latino  
Other: please specify

14. Please indicate the client’s ethnic background if you know it.  
[open response box]

15. Please indicate the client’s country of origin if you know it.  
[open response box]

16. If the client had a specific religious affiliation, please indicate what it was.  
Don’t know  
None  
[open response box]

17. Please describe what you remember about how the client expressed her/his anger, including any and all details that you are able to recall.  
[open response box]

18. Please describe your thoughts and feelings while the client was expressing this anger.  
[open response box]

19. Did you do anything to respond to the client as s/he expressed this anger?  
[open response box]

20. Did you experience any residual feelings about the client’s expression of anger after the conclusion of that session? If yes, how did you deal with those?  
[open response box]

21. Did this event have any influence on the manner in which you responded to this client in later sessions? If yes, please describe what changed.  
[open response box]

22. Did this event have any effect upon the therapeutic relationship between you and the client? If yes, please describe what was different.  
[open response box]

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