Benenzon's Music Therapy Model

Introduction
First of all I would like to thank you for the honor of inviting me to this World Congress. Even though English is not a language I master I will read in English and I will do my best to put meaning through.

I hope to be useful for the development of Music Therapy. I have been reflecting on my sixty years of life and the reason why I am here to tell you how I structured my theoretical and practical approach to Music Therapy. I have understood that after all, my theory is absolutely in keeping with my history of life and with my training as a human being and as a professional as well.

My theoretical model is not based on only one cause. There is a series of simultaneous causes and it is not based on a single ideology either. On the contrary, there are simple and complex interwoven structures of thought based on all that I have watched and experienced in my own clinical practice and in the practice of others while acting as a supervisor. Considering my history of life I must acknowledge as one of the factors that conditioned it, the fact of being an only child because my younger three brothers and sisters died at birth. The reason for their death was the Rhesus-factor-problem, whose mechanism and prevention were unknown at that time.

My father was a learned physician with a great general knowledge. My mother was a singer. They made up a firm solid couple and they traveled very much. I stayed alone for long periods accompanied by a relative or a nanny.
This experience led me to live and to recreate a world, in which music began to play a very important role. At the age of five I started to learn the piano. Even though I achieved a very good command of this instrument, I now know that my skill was more that of an improviser and of a creator than of a performer of the instrument. That is why I continued studying harmony, counterpoint, fugue and composition. I composed several pieces of music, and one of them comprised choir, orchestra, percussion and magnetic tape, which means that I felt free while recreating the sound-music language.

But this was not my only means of expression. I also painted and made sculptures.

I am sure that these first experiences of a lonely life lacking in understanding because of what had happened to my brothers and sisters were a determining factor in my predisposition to study the fetal psychic system and particularly the states of isolation of the human being.

I can remember a long conversation with my father before choosing my professional career. I told him how deeply I wished to be a musician and a composer, although I also liked medicine. My father told me about the human gratifications of being a physician. I then promised myself that if I chose medicine as a professional career, I would never give up music and I would try to integrate it in any possible space in my profession.
I must admit that when I finally decided that psychiatry was my medical vocation, then I realized that I could integrate music (my companion in loneliness) with my profession.

Later, when I became fascinated by the study and research of childhood autism, its relationship with the fetal psychic system and the application of Music Therapy in these cases, and in cases of coma I closed the circle of my own history of reissuing the unknown factors of my lonely childhood and that of my brothers and sisters who died at birth.

Now I want to show you two figures which are the explanation of my theoretical model, which I shall describe in detail in the Track. You will see that each of its foundations were development stages in my professional training, which integrated my clinical experience.

Let me classify them as follows:

a) psychological aspects

b) sociological and anthropological aspects

c) musictherapeutic aspects

a) Psychological aspects

As soon as I decided to work as a psychiatrist I began a long personal experience of group psychotherapy, which was later replaced with personal psychotherapy and eventually with psychodrama. This long experience enabled me to confirm Freud’s deep study of psychoanalysis. The most important thing was to understand that psychoanalysis was not an invention of the
imagination of a man. It was the permanent and real watching of the human psychic system.
This led me to conceive the human psychic system based on the presence of the unconscious, the preconscious and the conscious, the concept of primary and secondary process, which features each of them and the permanent moving energies that are the dynamic system, including the pleasure principle, which is the discharge of these energies as a communication expression.

When I began to work in a general hospital, I realized that I had to adapt my theory to a special situation, for patients would probably come only once to see me and I would never see them again. That is why I learnt short psychotherapy techniques, and to manage interviews in a practical way and I began to study other ideas and techniques: Jung, Ruesch, Palo Alto, Watzlawick, Bateson, Hall, Winnicott and Lorenz among others.
All of them enabled me to coin more powerfully the concepts I would define later: the archetypes, the collective unconscious, the imprinting, the transitional object, the nonverbal context and the analogical communication.
At the same time I was introduced to the fetal psychic system by Dr. Rascovksy.
I started to work in an ambulatory institution for autistic children and later, I would devote an important part of my time to the foundation of therapeutic communities which offered permanent stay to autistic adults.
This was the beginning of my experience of thirty years trying to understand autism and the family group. Among other authors I read
Kanner, Bettelheim, Tustin, Clancy, Rimland, Lovaas, Mahler, Bowlby, Shopler.

The important thing is to understand that I had a well defined background but I was open to learn and to understand that all the other theories and techniques had a reason and, above all, they had chances of success. I had to find my own, adapted to my personal characteristics.

b) The sociological and anthropological aspects

The daily work with autistic people and their families and above all, my own evolution while these children grew up, my conception of a therapeutic community for the future, its organization and its management led me to the concept of isolation.

The ideas of Fernand Deligny and his community for autistic children and the ideas of Francoise Dolto contributed to make more human my conceptions and approach to these patients. I became aware that isolation is one of the most serious illnesses of man at the beginning of the new millenium. That’s why I founded the Permanent Assembly for the Study and Research of Isolation, because I realized that it is not only the most serious social illness, which causes several others, e.g. depression. It is also the most denied illness by man. If you want to know my bibliography regarding this topic, I would only mention one: Antoine de Saint-Exupery: „The Little Prince“: „What is essential is invisible to the eyes.“, „Words are a source of misunderstanding.“

And now, let’s continue with the

c) musictherapeutic aspects:
I started to work at the psychiatric hospital in Buenos Aires without any knowledge about Music Therapy. This was in 1961. I formed groups of very serious schizophrenic patients and together with them and a colleague, we listened to recorded pieces of music chosen by ourselves and we shared a kind of dialogue, which we roleplayed. I call this my empiric period of passive Music Therapy. Later I repeated these experiences with other patients who suffered other pathologies and finally all these led me to develop a projective sound test similar to Rorschach's sound sheets. In the same period, at the Di Tella Institute in Buenos Aires, whose director was Alberto Ginastera, and together with a group of physicians, specialized in psychodrama, we underwent experiences of listening to electronic music.

This was also the time when I studied in depth the cases of musicogenic epilepsy. This means that I was interested in all the effects of music on the human being. I was influenced by the organicist, mechanical and cause–effect ideas, which were interwoven with the ideas about the free association in psychoanalysis throughout words or music effects as well. These experiences enabled me later to define clearly that this had nothing to do with Music Therapy.

Music Therapy needs the presence of a minimum of two people, who want to relate and to be linked through the use of all the codes of the nonverbal context. A music phenomenon and a person are not a musictherapeutic event.

Finally I understood that in these first experiences music was just a means of improving the environment and my mood. It made me feel more comfortable to share the space with another person.
Further I also understood that the use of recorded music is a defense against the relationship, it is like the introduction of an uncontrollable element which gets you away from the body. That is why my model contradicts the musical pharmacopoeia. My model is not commercial because it requires the active intervention of the music therapist's own body, by interrelating with the patient or with the group of patients. I am a defender of active Music Therapy as the only representative one. After I graduated as a physician I decided to find out everything available about Music Therapy at the time. A curious but happy event was that the "Asociación Psicoanalítica Argentina", which was very orthodox at that time, didn’t let me pursue the didactic psychoanalyst career if I insisted on the application of Music Therapy. This event strengthened even more and definitely the deepening in this discipline. But this sort of identification of myself with the orthodox psychoanalysis was the reason for the NAMT’s resistance against my ideas in those days. I traveled to London, where I met Juliette Alvin and her work. She taught me the importance of knowing the language of music and the importance of the instrument as a mediating object. She used the cello and this had an impact on me which gave me the freedom to think of any kind of instrument. Then I travelled to Geneva and I met E. Willems. The dialogue with him was very rich. All my thoughts about the fetal psychic system interwove with his philosophy of musical education.
In New York I learnt of Asthuler's idea about the ISO, a Greek word meaning equal, which he used as a formula to make empathy with the mental tempo features of the patient with whom he was trying to communicate. This was my platform for starting to develop the idea of the sound identity principle (ISO), because I understood that the only possible way to open communication channels between the patient and the music therapist is to become aware of the personal sound identity and of the patient's sound identity. I also understood that Freud and his followers couldn't stop thinking of images and words. That is why I decided to leap into the void, which was necessary in order to redefine a new way and I conceived the idea that it is not necessary to transform the energies into words or to switch from the analogical to the digital to make the unconscious conscious.

The nonverbal code is more than enough to establish conscious communication and to recreate the symbols between two or more people. I discovered that the nonverbal code and not the word is the element that produces the emergency of transference.

I ascertained this in clinical application. It was also the reason for the enormous resistance of psychologists, which I call "the resistance against the nonverbal context" that has deep roots in psychological training and has unconscious and social components.

On the other hand, I got to know the experiences of Patricia Stokoe and Maria Fux with movement, body expression and dance therapy. Movement and space began to be part of the ISO and nowadays it has become a multisensory concept.

In Paris I met Martenot, Tomatis and Pierre Schaefer and very soon I was fascinated by the thoughts and works of Xenakis with the
"estocastica", Varese and John Cage. They all helped to make the concepts of music and sound object more flexible and and could become contingent. I got free from musical structures and could accept the world of multiperception. You don’t need an ear to feel the sound, you need a whole body to vibrate, to gravitate, to move and to reply.

Rojas Bermudez and Winnicott brought me closer to the conceptualization: the intermediary object as the element which enables the transmission of communication energies between two people. In this context it is possible to think of the body-sound-musical instrument and differentiate it from other forms like the transitional object, the encapsulated object, the defensive object, the cathartic object, etc.

In my opinion, the three Music Therapy definitions I have worked out throughout these 35 years’ work with Music Therapy show clearly the evolution of my thoughts.

In 1968 I defined Music Therapy as follows: “A scientific specialization which deals with the study and research of the sound-human being complex, regardless of whether it is a musical sound or not, and which tends to find diagnostic methods with therapeutic effects.” The definition in 1978 was: “Music Therapy is a paramedical discipline which uses sound, music and movement in order to produce regressive effects and to open communication channels to achieve through these processes the rehabilitation and recovery of the individual for society.”

Nowadays my definition is: “Music Therapy is a psychotherapy which applies sound, music, movement and body-sound-musical instruments in order to develop, to elaborate and to reflect about a
link or a relationship between musictherapist and patient or group of patients with the purpose of improving the patient’s quality of life and to achieve his rehabilitation and recovery for society.”

This last definition and, particularly, the mention of Music Therapy as a psychotherapy developed in the nonverbal context, is the most resisted and controversial definition. However, that is what it is.

Finally, the time comes to train professionals in Music Therapy and this is also the reason for the existence of supervision.

My psychoanalytical training showed me clearly that if you don’t undergo the same experience you are going to submit your patient to, you will not be able to understand all the phenomena occurring in the relationship, and this is a virtue of all psychotherapies and consequently, of Music Therapy as well. Freud stated that “every blind spot in the analysis of an analyst will be a blind spot in the analysis of his patient.”

In my opinion, every blind spot in the recognition of the musictherapist’s ISO will be a blind spot in the recognition of his patient’s ISO:

That is the reason why I have developed Didactic Music Therapy. It consists in experiences which need a special methodology, enabling the musictherapist to have a personal experience in a musictherapeutic process facing his own conflicts with the nonverbal and becoming aware of his ISOS and his intermediary objects. But probably the most risky fact is to learn the way to regression and the return to the prospective.

This becoming aware achieved by the nonverbal communication leads us almost at once to our mother-child and father-child relationships and the fact of recognizing and reviving them throughout
the transference and the countertransference in the nonverbal is the most resisted aspect in the musictherapeutic act. This is what Didactic Music Therapy teaches and trains people in. I have had 950 groups along these years in different countries and regions of the world. I learnt a lot from them and I want to thank my disciples for all they allowed me to learn.

By watching and making a multiperceptive reading of these experiences I discovered the totemic phenomenon which held in itself all the other watched phenomena. The totemic phenomenon is the possibility for the patient to revive and to repeat countless times the most archaic rituals of mankind in his evolution in the frame of a musictherapeutic process and together with the musictherapist. That is why supervision is an essential technique for the musictherapeutic training.

The musictherapist, who is involved with his whole body in his work, is not able to elaborate and to clarify by himself the phenomena, which will happen to himself in the bipersonal relationship. Supervision showed me that it is the only tool which helps to avoid the burn-out, the acting-out, the narcissism and the omnipotence of the musictherapist, caused by the use and the experience in the nonverbal. Supervision makes it possible to keep the ethics of our profession. The patient and the musictherapist undress in front of the nonverbal. Supervision facilitates possible freedom, respect for each other and non-invasion.

I began to speak and to teach from this platform. “The ethics of non-invasion, the ethics of listening, the ethics of non-acting, the ethics of
the professional secrecy of the nonverbal. This is not passivity on the part of the musictherapist; it is respect to the other. In supervisions I always insist that the musictherapist is unable to wait more than 30 seconds before he replies with imitations or with some echo of the patient's expression. The musictherapist cannot listen. Lastly I understood that Music Therapy is a work out process along time.

In a world which runs fast and is full of images, the well understood and non commercial Music Therapy is one of the few philosophies to counteract and to face the XXI century. This is not profitable but this is the way of Music Therapy. It is not a profit-making profession, it is a vocation and a pleasure to do something for another person in a personal, direct and engaged way. This is invaluable.

On this occasion I want to thank publicly all those who taught me, who have been my patients, my students and my disciples. To all of them who are going to speak during this Congress about my model: Gabriela Wagner, Ofelia Herrendorf, Emerenziana D'Ulisse, Alfredo Raglio, Gianluigi Di Franco, .....Perez,..... García, Carmen Ferrara, Lia Rejane, Cleo Correia, .....Negreiro, because they have all made an invaluable contribution.

Thank you very much.