MUSIC THERAPY, INTUITION AND COUNTERTRANSFERENCE

MUSICOTERAPIA, INTUIÇÃO E CONTRATRANSFERÊNCIA

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Abstract - The aim of this study is to present theoretical content about countertransference. The paper discusses the origin of countertransference, as well as contemporary music therapy perspectives through a music-centered approach and plurimodal. The paper will present how the countratransference was initially thought, the difference between countertransference and intuition and how countertransference can be thought in terms of music therapy.
Keywords: music therapy, intuition, countertransference.

Resumo - O objetivo deste estudo é o de apresentar conteúdo teórico acerca do fenômeno contratransferencial. Desde a origem do conceito passando por algumas perspectivas de musicoterapia contemporânea e chegando a uma perspectiva clínica musicocentrada e plurimodal. O artigo apresenta como a constratransferência foi pensada inicialmente, a diferença entre contratransferência e intuição e exemplos de como se pode aplicar este entendimento em musicoterapia.
Palavras-Chave: musicoterapia, intuição, contratransferência.

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Introduction

There is no therapy if therapeutic relationship is not established. A healthy therapeutic relationship requires safety and grounding. This allows the internal world of a human being to be unfolded and treated in order for them to achieve personal objectives for better quality of life and improved health. Relationship is a fundamental subject that has been studied and discussed in several therapeutic areas including music therapy. As a music therapist, I am interested in reflecting about the phenomena involved in relationships that have to do with people, health, and therapy, as well as music.

In dealing with relationship in therapy, one deals with phenomena called transference and countertransference. Although these two phenomena can be thought of in terms of specific characteristics, they are interdependent because they have to do with the therapeutic relationship[2]. They are inseparable; however, this paper will focus solely on the phenomenon of countertransference and its implication in music therapy practice.

Origin of countertransference

In 1910, Freud (Etchegoyen as cited by Chazan, 1998) described countertransference as the result of the patient's influences over the unconscious feelings of the doctor, reinforcing the necessity for the doctor to submit themselves to personal analysis.

Along the century this concept has been developed. After Freud, the phenomenon was discussed by Theodor Reik in 1924 and by Wilhelm Reich in 1933. Both theorists understood that the analyst's reactions would come in form of intuition. In the 50's Paula Heimann and Heirich Racker (id.) considered countertransference as intuition. Countertransference for them was not a

MUSICOTERAPIA

[2] Schapira, Diego. Personal communication through e-mail (11/30/2009).

normative or attitude of the superego, but was an important tool for psychoanalytic technique.

For them, countertransference was not anymore a “danger” that should be avoided in the therapeutic process. Racker (Etchegoyen as cited by Chazan,1998), in 1953, considered Reik and Reich’s intuitions as a contratransferential product, pointing out that the ability of the analyst is to listen their own countertransference since countertranference is the intuition of the analyst.

Freud (Etchegoyen as cited by Chazan, 1998) in 1916/17, stated three different characteristics of transference: 1) that it was a serious obstacle, 2) a helpful instrument, and, 3) an area where it is possible for the client to transform themselves.

Based on this model, Racker wrote that countertransference operates in these three forms: as obstacle (danger of blind spots of the therapist - distortion), as an instrument to identify what is happening with the patient and as the area where the patient can achieve a rich and different experience from the one he had previously in his/her life" (ibid.).

Countertransference and Intuition

1n 1997, I began my internship at the Nordoff-Robbins Center for Music Therapy in New York under Dr. Kenneth Aigen’s supervision. As part of my internship, I studied a series of lectures that were given by Paul Nordoff in the year of 1974, called *Talks on Music*. These lectures became, years later, the book entitled *Healing Heritage* (Robbins & Robbins, 1998) which has been a great influence for me in terms of the way I understand and apply music and music as therapy. In addition, at that time I had the opportunity to study clinical cases with Clive Robbins. Among several concepts that were important at the Nordoff-Robbins Center, “clinical intuition” was relevant to me. It was also a challenge to understand.

What would be the possible differences between intuition and countertransference? Currently, I consider countertransference to be the intuition of the music therapist. In other words, intuition is the countertransference of a trained therapist. It is complex and, as mentioned by several theorists, has to do with the way the therapist feels and perceives transference being projected from the patient and how the therapist responds to it.

Countertransference in Music Therapy Practice

Kenneth Bruscia (1998) wrote a self-inquiry article in order to answer his question about what is "to be there" for his client. He described his experience of "being there" in four different levels: sensory, affective, reflective and intuitively.

Therefore, it is important for the therapist to expand, center, and shift their consciousness to three experiential spaces: the client's world, the therapist's personal world and the therapist's world as a therapist. He considered this ability as freedom to move consciousness wherever needed or desired.

Racker influenced the British music therapist Mary Priestley. Based on this model about countertransference Mary Priestley (1994) described some of its types. The therapist's:

- own transference is regarding their transference distortion their relationship to the patient;
- complementary identification is caused by the therapist identifying with the patient's internal objects that they have projected onto the therapist;
- concordant identification is those psychological contents that arise in the analyst by reason of the empathy achieved with the patient and that really reflect and reproduce the latter's psychological contents.

Priestley called these concepts countertranference, c-countertransference and e-countertranference.

Scheiby (1998), defined musical countertransference as:

> the sound patterns that reflect or evoke feelings, thoughts, images, attitudes, opinions, and physical reactions originating in and generated by the music therapist, as unconscious or preconscious reactions to the client and his or her transference. The medium through which these countertransferences are conveyd is the music played in the session (SCHEIBY, 1998, p. 214)

Relationship in Music Therapy

In music therapy, there is a dynamic of the relationship that is established among a music therapist and co-therapist, patient and music. The music, produced by the therapeutic relationship, becomes an entity in the music therapy room. The relationship between the therapist´s music and the client´s music creates another entity, which is the music of the relationship. The three agents (therapists-music-client) look for contact and form the Triangle of Carpente and Brandalise[3] (2001, p. 11)

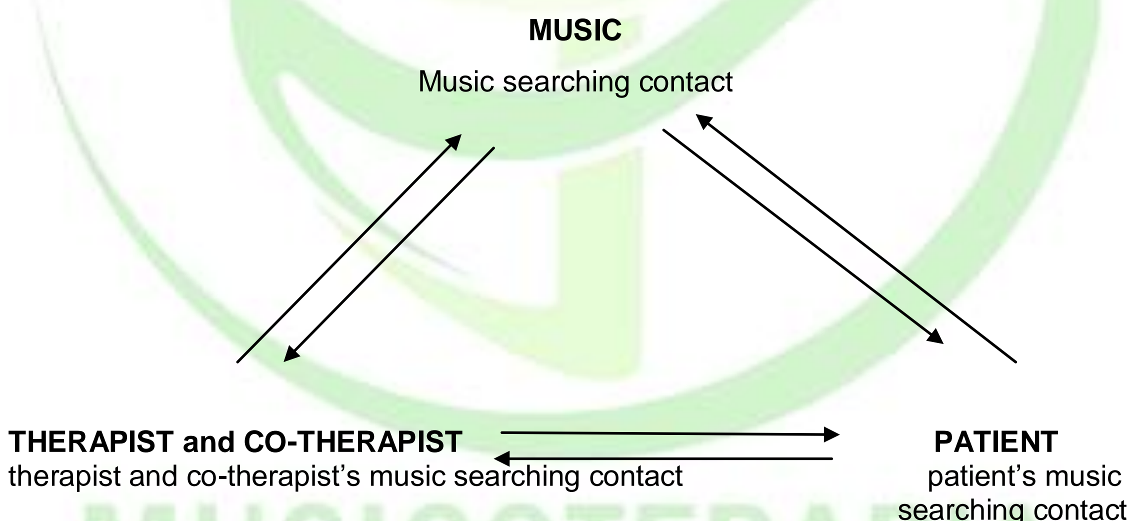

Figure 1: Triangle of Carpente and Brandalise.

[3] The "Triangle" was created by my North-American colleague John Carpente and I in the year of 2000 for the 10th Brazilian Conference on Music Therapy (Porto Alegre, Brazil).

Figure 1 illustrates one of the main characteristics of the music-centered music therapy model proposed in book entitled *Music-centered Music Therapy* (2001): the re-placement of the agents (therapist-music-client) involved in the music therapy dynamics. The entity of music is no longer placed "between" therapist and client but is one of the vortexes of the triangle. Each agent is of equal importance. Client and therapist are not living the creative experience through music but *in* and *with* it.

The philosopher of music Victor Zuckerkandl (1973) stated that tones have dynamic qualities. When a tone relates to another in a system it begins to demand. The tones have "needs" that ask to be accomplished (p. 19). In *Healing Heritage*, Nordoff (1998) wrote that tones have inherent ascending and descending directions. In other words, the tones "want" directions, from the person who is dealing with them, based on the musical scale where they are (p. 13). Looking at music from this anthropomorphized lens, music "wishes" contact. Music, which "asks" to be completed, in a similar way as the other agents involved, will also bring a "need" for communication. Figure 1 shows the two-side arrows from agent to agent in the clinical dynamics. Therefore, the dynamics of music-centered music therapy present the necessity of relationship (communication) between the three agents, forming the Triangle.

These ideas support the phenomena of transference and countertransference in music therapy, related to the relationship among therapist, client and music. Projections occur in a particular dynamic. The South American Plurimodal theorists, call these projections “pluri-objectal” which means feelings in music therapy are projected, from therapist and client, onto therapist and client again but also onto music. There is pluri-objectal transference and pluri-objectal countertransference.

The music therapists Diego Schapira and Mayra Hugo (2005), among other music therapist in South America, have been developing a model called “Plurimodal Approach”. Its name refers to two dimensions: theoretical and practical. Regarding the theoretical dimension, it is "plurimodal" because it is not inscribed in a rigid way within any of the well known music therapy

theoretical models. They have considered concepts from different thinkers and different theoretical frames that they found useful and valuable. In its practical dimension, according to the authors, it is plurimodal because it considers all the lines of action as equally important and it does not use any technique, procedure or resource exclusively.

Among the 11 pillars of the Plurimodal Approach (SCHAPIRA & HUGO, 2005), I will cite three:

1. Considers that during the music therapy process, the same defense mechanisms that appear in an analytical psychotherapeutic process unfold.
2. Conceives the concept of music therapy transference.
3. Adheres to the concept of musical countertransference.

Vignettes and Reflections about Countertransference in my Clinical Practice

Example #1: Countertransference being an obstacle

In the beginning of my career as a clinician I had a challenging time trying to understand and manage my negative feelings towards some members of some of my patients' families and it obviously reflected on the way I could facilitate their therapeutic processes. I work with each of my patients understanding that they belong to a bigger system (family, school, neighborhood, city, and so on) and that it is important for me to help them and their family to achieve a harmonious way of living.

In many instances, I could notice efforts of sabotage being made by family members. There are different forms: arriving late for the 30 minute session, not coming for a meeting (some fathers have difficulties in coming, mothers very often are the ones who come), and being late with the payment. Even though I understood that sabotage was part of the process, I had great difficulty calling those people for a meeting to talk about the treatment for their children. And my feelings of frustration towards them became a significant

obstacle in terms of being able to fully support some of my clients' processes. With personal therapy and supervision, I was able to improve this understanding and find clinical ways to intervene.

Example #2: Countertransference as an important tool for connection

In the first music therapy session of N., a 5 year-old autistic boy. my co-therapist and I were waiting for him. We already knew that he was non-verbal and that the parents had received a recommendation for music therapy because N. had interest for sounds and for different types of music.

When N. arrived with his family he seemed to be extremely shy, walking towards the music therapy room very close to his mother, not looking directly at us. Based on my countertransference, I decided that the "hello/opening of the session" would come first from one of the puppets we have in the room called "Fulgêncio" (see Figure 2).

Fulgêncio was a puppet previously created for one of our clients and he became popular because various clients began to interact (verbally and musically) with him. Fulgêncio became the mayor of the City of the Puppets that we had in the music therapy room (see Figure 3).

Figure 2. Fulgêncio is a character created by one of my co-therapists (Tiago Lewis) for one of our autistic clients.

MUSICOTERAPIA

Figure 3: City of the Puppets.

For N., Fulgêncio, the mayor of the city, lived in this building on the left and because his session was early in the morning the opening was to take him to Fulgêncio's building for him to wake Fulgêncio up, to say hello and then, begin the music experiences by starting with a hello song.

I consider Fulgêncio himself and the clinical interventions, made through him, a product of our countertransference. Fulgêncio and his representation became a supportive form as a result of the way I noticed our patient coming to the session. We operated Fulgêncio as a bridge to invite our client for creative-musical experiences.

Example #3: Countertransference an important tool for clinical response

In my work, I use many music therapy techniques: free and oriented musical improvisations (or referential and non-referential improvisations), composition, re-creation, performance of musical plays, and listening. I am a guitar player and I always work with a co-therapist who is a keyboard player. Our main goal is to meet the person where they are musically, understanding that it is a representation of where this person is in the world.

THE CREATION OF A RADIO STATION (as the symbolic representation of the structure of the session).

F.P. initiated his music therapy process with me when he was 14 years old. F.P. is autistic and extremely talented musically. He can hear and identify each tone that is played on any instrument. I used different music therapy techniques with him, as he loved pre-composed songs as well as composition and improvisation. My main therapeutic objective, after several sessions, was to structure the sessions differently in order to offer him more independence and also ground our musical interactions in a different way. Therefore the process of music therapy would offer him more independence to meet his needs and make bright musical insights. F.P. loved city news, cultural attractions of the city, and movies premiers. In one of his sessions I could give form to this countertransferential feeling and proposed the creation of a radio station called by his last name. And, supported by this radio station, he would be able to insert any news, music, creations, interviews, etc. that he wanted. It has been 12 years from that moment and the Radio Station still exists as the structure of his sessions. However, it has expanded. His radio now operates in different continents, playing music from different cultures. F.P. has learned to use this structure to ground the expansion of his therapeutic creations, and consequently, to ground the expansion of his world.

Example 4: Countertransference of the co-therapist splitting the therapeutic team

One music therapy intern was initiating his internship in one of the facilities I used to work. It was his first session, as my co-therapist, with a group of eight functional autistic adolescents. The session went nicely but when it was over one of the clients, G.M., came directly to my co-therapist and asked him an important question: “do you like soap operas?” Soap operas in Brazil are very popular and for G.M. they are very important. He remembers details about characters, music, cities, etc. I heard G.M. asking my intern and I immediately looked at both of them. My intern very rapidly responded “No” to G.M. I could see G.M.’s face expression transforming so I intervened by saying to G.M. that

it was not exactly like that and that we would explain in the next session. I had to talk with my intern first.

In supervision we began trying to understand the response my intern gave to G.M. We found that soap operas for my intern were something that he felt used to break the fluency of his relationship and communication with his family. He told me that he yearned for nice and quiet dinners with his family but it was impossible since the TV was always on showing soap operas.

When G.M. asked him that question he had this strong negative feeling towards soap operas and could not think about G.M., the question and the importance of everything to G.M. in that particular clinical situation.

In reality, G.M. was trying to make contact with this new person, guitar player, singer, and music therapist intern. For G.M., people need to like soap operas mainly those that are very important for him. So, in the second session, led by my intern, he was prepared and had understood the previous situation. As soon as the session started G.M. came to him and asked again the same question. Then, my intern could respond that he did not watch a lot of TV because the lack of time. G.M. accepted that explanation.

I understand the work of therapist and co-therapist as a team (one of the Triangle of Carpente and Brandalise's vortexes). It is important that the team is united, having a similar understanding about the patients' conditions and philosophy of work in terms of being able to be coherent facilitating the patients' processes towards better quality of life. In this situation, my intern's countertransference made the team split and GM perceived that and tried to fix it bringing elements like tension and questions.

Conclusion

Countertransferential phenomena were always part of my practice as a music therapist. I always relied on it to explain some moments in therapy, especially those that are challenging to explain. How can questions like "why did I do some intervention?" or "based on what I felt that the client was shy?" be

answered precisely? It makes sense to think about intuition as the countertransference of the music therapist. Metaphorically thinking, countertransference is a kind of control panel of how everything is going in the session and along the process and how to be there for our clients. Countertransference should be understood as a tool to hear the clients' needs, to better respond to their demands, and to perceive their sounds or music.

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