

The significance of triadic structures in patients undergoing therapy for psychosis in a psychiatric ward

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Case Thirteen

**THE SIGNIFICANCE OF TRIADIC STRUCTURES
IN PATIENTS UNDERGOING THERAPY FOR
PSYCHOSIS IN A PSYCHIATRIC WARD**

Susanne Metzner

ABSTRACT

The significance of triadic structures is shown with the example of a young schizophrenic patient undergoing psychodynamic therapeutic treatment. The author presents a triadic structure model that serves as the basis for theoretically reflecting upon a multilateral transference situation in a multidisciplinary treatment team of a psychiatric ward.

INTRODUCTION

In psychodynamic psychiatry, music therapy is one component of the clinical treatment concept fitted to the personal needs of each patient. This coordination occurs in the interplay between what the multidisciplinary treatment team offers as therapy, on the one hand, and the use of this by the patient who shapes his or her therapeutic environment and forms therapeutic relationships, on the other hand. Therapy, following a psychodynamic approach, pays special attention to this interrelationship and the resulting social network in the ward, because it is seen as a reenactment, which provides insight into the intrapsychic and interpersonal real-life situation of a patient. An understanding of this can help to locate and activate resources as well as to treat disorders.

Dyadic and triadic structures comprise the smallest components of this complex social network. In this chapter, I will focus on the significance of triadic structures in the inpatient treatment of individuals with psychotic disorders and illustrate these structures with the help of a case vignette.

My presentation begins with the description of my first encounter with this patient. This is followed by a theoretical introduction to the triadic structure model, which I have developed. Finally, I will analyze a significant musical scene, taken from individual music therapy with this patient in the context of the hospital treatment, in relationship to the biography and present life circumstances of the patient and the psychotic symptomatology. My descriptions and interpretations, which are of a rather subjective nature, are written in italics.

BACKGROUND MATERIAL

Casuistry: My First Encounter with Ms. K.

I make an appointment with Ms. K., a twenty-three-year-old, much younger and quite girlish-looking patient with long blond hair, for Friday, which I write down for her on a note. Ten days ago she was admitted to our psychiatric ward in an acute psychotic condition. She had the delusion that her father had been shot by her ex-boyfriend with whom she had broken up a couple of weeks before. During the first few days after admittance she was in a condition best described by the old-fashioned term "mentally deranged." For four or five days now she has been more responsive with the help of neuroleptic treatment. In the meantime, she takes part in the day-to-day routine of the ward. The patient is now offered further psychotherapeutic help through individual music therapy. The fact that I have the time to take on another patient fits nicely with my spontaneous interest in this young woman.

As I enter the patient's room on the Friday in question, her mother quickly moves away from her and says: "Oh, music therapy, I already thought that was some kind of mistake." Everything goes so fast that I don't even have time to say hello and introduce myself.

It seems to me that the patient leaps up from her bed very suddenly in order to follow me to the music therapy room, which is located on the first floor of the building. I am worried about her circulation because she looks very pale. However, Ms. K. says that everything is okay and starts to walk off.

She hesitates at every door through which we must pass. At the door to the ward she says that this must be a mistake, she doesn't want any music therapy after all. I am surprised, pause for a moment, and wait for the patient to move either in one or the other direction. Forward or backward? She goes forward and comes with me to the music therapy room.

In this first session, I confine myself to giving the patient information about music therapy. It seems to me that this rather objective level of communication gives the best support to this hesitant patient who is still in danger of regressing. Although I act very cautiously, the situation between us remains depressingly nontransparent. The sluggishness of her verbal, as well as gestural-facial, reactions makes me feel as if I were in a dense fog which swallows up everything. The only thing that is clear, in the end, is the patient's declaration that she does not want any further treatment other than medication. I tell her that I respect this decision for the moment and that I will ask her next week again in case she changes her mind in the meantime. So there doesn't seem to be anything left to discuss, and it seems to be time to part. But all of a sudden it is difficult to end the session. The patient finds it difficult to part? detach herself? And I have the feeling as if I have to break off something by force.

After the session, I become aware of a very unpleasant, all-embracing feeling, which I cannot put into words. It is not easy to get it out of my thoughts.

At the beginning of the following week, I want to address the music therapy question once more, as promised. However, during the doctor's rounds the patient is so sleepy that I am not able to reach her on this occasion, nor am I able to do so on two further attempts. A few days later, my student, doing practical training, runs into the patient's father in the ward by chance. He mistakenly takes her to be the responsible music therapist and asks her about music therapy for his daughter. My trainee doesn't know how to react because she is not informed about the current state and, in particular, because she is interested in conducting the treatment herself. She puts him off until later, which does not leave him in too happy a state.

Nothing seems to be alright anymore. Nobody knows who wants what from whom, and I have the desperate wish to be able to start over from the beginning.

At this stage of development Ms. K. is willing to begin music therapy.

Where do we meet if we do not meet? With this ambiguous question, Deuter (1995) pinpoints the predicament which seems to be so typical of the treatment of psychotic patients. This does not only concern the meeting between patient and therapist but also a disturbance in interpersonal contact, in which the concerned persons either are unable to reach each other on an emotional level or meet each other in a state of high vulnerability, which leads to fear and defense reactions. In our case, this concerned more than two persons, for example, different members of the treatment team and/or members of the family.

In not all cases are the latter involved as strongly as in the case of Ms. K. From her family we obtained a wealth of information—some of it was given intentionally and some unintentionally—about the relationship structures in the family, to which I will refer later. This is not typical of our therapeutic work: What happens more often is that our psychodynamic understanding, as well as what we do in therapy, must rest solely upon the conclusions we draw from the reenactments in the ward and our own countertransferences.

TREATMENT

Excursus: On Multidisciplinary Teamwork

In the multidisciplinary, psychodynamic treatment of psychiatric patients in general, and psychotic patients in particular, each team member involved in the treatment relates not only to the patient concerned, but also to the other team members who all have equal rights. Thus, multidisciplinary teamwork is not simply based upon the sum of different therapeutic processes, rather it involves the use of a specific method which places particular emphasis on working on, and with, the relationships of the concerned staff.

Although I let the term "equal rights" slip into the above formulation in passing, I am not denying the fact that there is a hierarchical structure that has evolved over time in the hospital workplace. Neither do I want to deny that there are differences in qualifications and competencies between staff members. Multidisciplinary teamwork in a psychodynamic treatment concept, where members enjoy equal rights, means that one must be willing to reflect upon the relations within the team and, among other things, to think about one's own use of power.

Therefore, the interdisciplinary treatment of patients in a psychiatric hospital is more than the sum of various therapeutic processes. It encompasses the work on and with the relations of the professional staff. Thus, the mutual task is to examine the emerging constellation of multilateral relations with the patient. In this connection, attention is paid not only to the transference relations between the respective patient and the individual team members, but also to the relations

that are transferred to other team members. What is so special about this perspective is that whatever happens in the team, or between different therapists, during treatment is taken into account to the same extent as whatever happens during the different therapeutic sessions. To formulate this in somewhat stronger terms, this means that the team lets the patient have an influence on the relations between the team members.

From what has been said so far, it follows that I, as a clinical music therapist, relate not only to the patient, but also to my colleagues who are involved in the treatment of this patient. In this process, I pay close attention to how our professional relationships are influenced by the mutual treatment of a patient. This approach is based upon a triadic structure model, which I have developed for the systematic analysis of multiperson relationships and for the formulation of hypotheses about possibly disturbed triadic relationship experiences of a patient, who—through his or her reenactments—asks us to help him or her come to terms with these problematic experiences.

The Structure of the Triad

In the attempt to examine the structure of the triad, the first important thing to do is to free oneself from thinking in dyads, for example, considering a triad either merely a dyad plus another interaction partner (AB+C) or a series of three dyads (AB, BC, CA). Rather, a triad has a structure that is produced by triadic interaction forms. Although quite a large number of such interaction forms exist, they can be reduced to three triadic interaction modes. These three interaction modes together make up the internal structure of the triad. Thus, triangulation—understood as both an intrapsychic and interpersonal triad-forming process—does not take place by extending a dyad by a third interaction partner nor by joining three dyads, but in multiple interrelations between three interaction partners. *In the following section, I will describe the three main triadic interaction modes in more detail.*

Triadic Interaction Modes

Triadic Interaction Mode I:

Each Interaction Partner Relates to Two Objects.

This interaction mode is acquired during early childhood and consists of various elements. Prerequisite for this interaction mode is that the subject is able to relate to two distinguishable objects. Already, a newborn baby is able to differentiate

between his or her mother and other persons. As if to express this relatedness, the subject uses eye movements: This is connected with casting one's eyes in the direction of one person and looking away from the other, with an alternation between foreground and background. In the course of time, representations are formed on the basis of the experience that an object, which momentarily is not in one's field of vision, has not really disappeared. This interaction mode is different when, for example, the voice or—at a later point—words are used. In his or her imagination a subject turns to two or more objects simultaneously and connects them, joins them together. A conversation between three individuals is a highly complex phenomenon: Because each person relates to both of the others, looks and words between the involved parties wander back and forth, overlap with each other, and sometimes proceed in opposite directions. The basis for this is a psychic structure which comprises the "either-or" and the "both . . . as well as. . ."

Triadic Interaction Mode II:

Always Two Objects Together Relate to a Third One.

This statement expands upon what has already been said above and describes a triadic interaction mode in which the elements' mutuality (self with other) and counterposition (self versus other) are combined with one another.

The experience of mutuality includes the subjective experience of the individual that another person shares the contents of his or her feelings. Stern (1986, p. 179) believes that the first signs of this ability in the development of the child become evident starting in the seventh month. If an individual is certain that the other person feels, thinks, or acts the same as him or her at a given moment, then he or she experiences both himself or herself as a perceptual unity and the "we" as such a unity. In a triadic interaction, two who are united together in a "we" relate to a third. They confront a third with their mutuality, who, alone from this opposite position—merely by his or her presence—shapes the interaction process and influences the mutuality of the two others. In a well-functioning triad, the mutuality of two against a third party is not structurally fixed. However, changes do not occur very quickly because this second interaction mode needs some time to become established. It has a certain tendency to perpetuate itself, as shown by the results of social research.

Triadic Interaction Mode III:

Each of the Involved Relates to the Relation Between the Two Others.

The statement made here refers to a triadic interaction mode, which was already mentioned before in connection with the influence of a third on the mutuality of two others. This is now extended and put into more precise terms, because the relation between two encompasses more than the aspect of mutuality. The kind of relationship between two objects influences the position that a third party can take toward it. Abelin (1975) describes that the young child initially experiences him or herself as being between the parents and internalizes the relationship between the parents in the course of individuation.

If the relationship between two persons is disturbed, then a third person has only limited possibilities to take a position toward it. The interaction attempts he or she undertakes, which do not meet with a response, must be defended against. Consequently, such forms of interaction appear as a substitute, which are geared toward maintaining the defense reaction.

On the Developmental Psychological Prerequisites

Father, mother, and child—these three terms first of all indicate biologically-based positions in a triangle. Triad and dyad develop from originally biological basic prototypes of relationships between parents and children. The formation of a dyad is preceded by the physical connectedness of mother and child during pregnancy. The triad, on the other hand, has its origin in the act of procreation, which marks the beginning of parenthood for a man and a woman. Before a child is born, structural preforms of relationships between parents and child already exist. However, the individual developmental course of these three positions is inextricably linked with unconscious fantasies, prescribed role expectations, and socially determined evaluations. Triadic structures are also relevant if a child does not grow up in the traditional nuclear family, which is more common nowadays.

Whereas the parents or, as the case may be, the respective adult significant others use their ability of triangulation in their relation to the child right from the start, the child develops this capacity only in the course of his or her development. This means that the child grows into already existing structures. In this process, dyadic and triadic structures become superimposed and influence one another.

Already during the first year of life, the developing child finds out how it is to experience him or herself in relation to two objects which have something to

do with each other. In the course of the further development of self and object representations (via transitional objects, Winnicott, 1971), the child also experiences that a third person relates to the relationship between him or her and another person. At that moment, when he or she understands what it means to have the feeling "both of us," the child also recognizes the dyad's boundary. Consequently, the development of the dyadic relationship depends upon this close interaction process with a third person. In other words: The existence and relatedness of this third person, which has a counterposition to the dyad or which surrounds the dyad from the start, induces the development of interpersonal abilities in the dyad.

This approach has a direct influence on the concept of the so-called "early disorder" and its treatment. In the case of a disorder which is rooted in disturbed early relationships, the influence of the mother cannot be considered as a singular force, but must be seen and analyzed in the context of the triad.

Triadic Disorders in the Development of Schizophrenic Illness

From the viewpoint of the psychology of self and object relations, psychotic disorders can point back to deficit situations and disturbed interactions experienced very early in life. The clinical manifestation almost always indicates the inability to triangulate, which stems from a fragmentation of the triad or a specific form of splitting of the triad. It is not always the case that the family situation is extremely burdened, marked by deficits, or perhaps even hopeless, in which the child has been neglected with respect to his or her mental, physical, or social well-being. Even in the seemingly intact families of schizophrenic patients, one can very often find a triadic structure characterized by a relationship between the parents which left no room for the child. The parents live in a relationship in which they are not able to mutually relate to the child. One example is a relationship characterized by extreme dependency: If both parents are constantly fighting with each other, they do not relate to two objects at a time, rather, they ignore the needs of the child. If they live in a symbiotic relationship, then they reciprocally gratify their dependency needs and shift their hostile impulses from the relationship between themselves to the one with the child. Under such circumstances, the development of the dyadic mother-child, and the respective father-child, relationship is disturbed as well.

The triadic structure model provides information about the extent of the disturbance. The child is not able to relate to two objects either because the objects are not sufficiently distinguishable or because they are incompatible. The parent, in most cases both of them, does not relate to two objects, namely the other parent and child. Moreover, the parents do not mutually relate to the child. On the other hand, the child cannot experience a mutual relatedness with one

parent toward the other parent, because neither parent would be able to form a mutual relationship with the child without seriously threatening the adult relationship. As a consequence, the child cannot relate to a (mature) parental relationship. He or she is forced to internalize a parental relationship which is characterized by dependency and open or latent destructiveness.

Sometimes these pathological structures in the primary family become virulent only in the further course of development of the child. I am talking about that point in time when the main focus no longer is solely on the needs of the child and their satisfaction (as during the first months of life), but when the child's own will starts to emerge—when he or she has to reconcile his or her grandiose ambitions with the perceived limitations of the real world, both his or her own and those of his or her objects. The stubborn child, who in the crisis of the “*rapprochement-phase*” (Mahler, 1975) is clinging at one time and domineering at another, no longer meets the ideals of his or her parents. This, in turn, taxes their ability to deal with ambiguous feelings toward their child. The less successful the parents are in smoothing out these conflicts in their relationship with one another and maintaining their confidence in the mental healthiness of their child, the deeper the parents get into a crisis with their child. If they are not able to accept the narcissistic defeat, and bear the disappointment of not having a perfect child and not being able to create a perfect world for him or her, interpersonal constellations evolve in which the integration of omnipotence and powerlessness, and the development of more mature object relations, are blocked.

Especially if the relationship between the two parents is dominated by the myth that aggression is destructive, retaliation is unconsciously demanded of the child. A child in this position draws the conclusion that his or her developmental needs are destructive and that he or she is responsible for preventing the emotional breakdown of his or her parents by attempting to compensate for the retaliation wishes (Benjamin, 1990). In extreme cases, the child needs a justification for his or her mere existence.

The failure of the process of individuation in early childhood is reactivated during adolescence, when the already existing psychic structures are reorganized once more. In particular, events such as final examinations, moving away from home, and similar experiences make great demands on mental stability, which can trigger the initial manifestation of a psychosis.

Casuistry: Multidisciplinary Psychodynamic Therapy of Triadic Disorders

In a psychodynamic approach to therapy, the aim is to reconstruct the disturbances that are responsible for the symptoms and reenactments of the

patient and to restore interaction forms. If, in this process, triadic interaction forms are also considered, a certain therapeutic perspective will result, in which there is room for a third party in one's imagination, in other words, for persons who also have contact to the patient. This means, as already explained above, the willingness to closely examine the relationships between the involved individuals and to also consider one's own emotional feelings in reference to the third party in the countertransference analysis.

With help of the example of Ms. K.'s treatment, I will show which position I, as music therapist, took in the social network which the patient set up around herself, and illustrate what value music therapeutic material has for understanding the patient. But first I must mention the fact that Ms. K. broke off the treatment so that it was not possible to bring therapy to a satisfactory close.

A Scene from the Music Therapeutic Process with Ms. K.

In music therapy, I work with free improvisation and verbal discussion. The only therapy session during which we played music was the third one (of a total of five). At that time I made the following notes:

(. . .) In the music therapy room we soon start playing. A few plucked notes on a one-string Indian instrument, the gopiphant, come from the patient. After a while I find a heartbeat rhythm on a low register clave and am inwardly happy about it, because it provides such an unobtrusive support for her and for me. But suddenly the tables are turned, and I have the feeling that the heartbeat is dissolving. It is both an unpleasant and inexplicable feeling. How can a heartbeat be dissolving?

Then, in our mutual playing I have the feeling as if a chick were hatching out of its egg. Mother hen answers from outside the eggshell. But the short dialogues quickly cease. Afterward, the patient tells me that at this moment she was afraid of doing something wrong.

Ms. K. tries out some other string instruments and eventually returns to the gopiphant. She has not yet found out how to modulate the notes on the single string. I am on the cello. A soft, enchanting, but icy music emerges, which I find fascinating. Like frost patterns in a window.

If one assumes that schizophrenic illness is the result of a dyadic relationship disturbance, then one would not spontaneously think that a triadic disturbance comes to light in the musical interactions described above. But the expression "the heartbeat gives support to her and to me" implies that there is a third entity which could provide support to both, if only it had not dissolved. The whole thing becomes clearer if one imagines that the expressions refer to an early

developmental stage, in which mature representations have not yet been formed and the "other" is perceived not so much as an object than a living substance. This living substance is disintegrated. In other words, it is as if the emerging relatedness, or even the core relatedness, as described by Stern (1986), was being dissolved once more. After this, it seems for a while that patient and therapist go on in a more reassuring manner with this interaction between unhatched chick and hen. But only for a short period, then this attempt to get in touch with each other fails as well: The patient develops fear.

What exactly could be so threatening in this scene? Apparently the eggshell does not provide any protection for further development. Further, it is not a symbol for the stabilizing third entity in the relationship between hen and chick. Rather, it is the fear of doing something wrong which at least saves the fragile self from dissolving or from being disintegrated. The price which has to be paid for keeping up the self-feeling is that the interaction, and its further development, freeze, in other words, come to a halt.

Despite this freezing, I, as a therapist, have the feeling that I am on the right track in the therapy with this patient. My colleagues share this feeling. The assistant medical director and the ward doctor have family discussions together with the patient and both of her parents. This triggers numerous dynamics in the family situation. Many members of the nursing staff devote a lot of attention to the patient. One staff member helps the patient write a curriculum vitae consisting of several pages. In art therapy, a number of interesting works are produced that provide valuable information, such as a fragile, weary-looking chicken made of clay and a picture of the patient's name, hardly discernible from a background of curlicues and floral patterns of creeping and climbing plants.

All staff members had a special interest in the patient, all had "adopted" her, and all had the feeling that they were doing everything really well. It would have been only natural for rivalry to come up in our team. But this did not happen; we were hardly aware of one another. A relationship situation developed in which rivalry was completely missing and in which we were more or less content with filing away our detailed reports in the records without exchanging any information with one another. We did not personally meet with each other, neither in the concrete nor in the figurative sense. The knowledge of the patient's biography and the careful analysis of the therapeutic scenes helped us to understand the reenactment of the patient as well as our countertransferences.

The Patient's Biography—Facts and Interpretations

Ms. K. was an adopted child. Her birthmother was twenty years old and single when she became pregnant. She only noticed that she was expecting a child when she was seven months into the pregnancy. What a diffuse body feeling this

woman must have had. The only explanation is that she must have misinterpreted the movements of the baby as digestion problems. Referring back to the music therapeutic scene, one can say, "The chick in the egg could give as many signs as it wanted, these expressions of its existence were simply misunderstood." The birthmother was pressured by her mother to give the child up for adoption because she had not yet finished her vocational training. One week after birth, the baby was already adopted by the K. family, which is unusually fast under German law.

Mr. and Ms. K., both teachers, already had a biological son and wanted to adopt another child because there are so many unwanted children in the world. The parallels to our behavior in the treatment team are obvious. On the basis of these countertransferences one could suppose that the adoptive parents were driven by the desire to improve the fate of another person with all their might, and so to become the better parents.

The child was difficult right from the start. As a baby she cried for hours, and it was not possible to soothe her. As soon as she was able to talk, she asked her parents if they really loved her. She was still a bed wetter as a schoolgirl. In spite of all these difficulties, her parents did not stop trying to give her their best and also to seek therapeutic help. Everything indicates that the parents tried as hard as they could to reject the narcissistic defeat in connection with the fact that they were not able to create a perfect world for their child. So, the ambiguous feelings—more than understandable for parents in this situation—had to be split off. It seems that this inevitably resulted in the parents not being able to give their daughter one thing, namely a secure feeling of belonging. She saw her existence altogether as a big mistake, and as a little girl she never ceased asking her parents if they truly loved her. This must have hurt the parents very deeply because they really loved this child. But in view of their ideals of good adoptive parents, they could not allow themselves to be "hit" by this question. The little girl was not able to develop a feeling for the reality of this parental love and had to feel guilty because of this.

After finishing school, our patient contacted the adoption agency in order to obtain the address of her birthmother, which she received. She met her birthmother and hoped to find a good friend in her. However, she was forced to realize that her birthmother saw her as the lost daughter and—much too late—tried to bind her too closely to herself. Ms. K. wanted to get out of this situation, but she was afraid of hurting this mother and so she made no decisions—neither for nor against this relationship. This was the situation at the time of treatment. However, almost two more years passed before the first manifestation of psychosis. During this period, the patient had started to study teaching in order to take up the same profession as her parents. She had also moved into her own

apartment, but she did not manage very well on her own, became more and more isolated, and neglected herself.

DISCUSSION AND CONCLUSIONS

I already mentioned that a striking feature of the multidisciplinary treatment of Ms. K. was that no rivalry existed. In discussions with the family it became apparent that rivalry was also missing in the relationship between the adoptive parents. They gave the impression of being a harmonious married couple, who not only had the same occupation, but also had dedicated themselves to the same goal of becoming adoptive parents. From the perspective of another person they merged to form one whole, in which there was no room for anything that was different.

Especially for the adoptive daughter it must have been difficult to find herself as a different person. On the one hand, she was the planned baby of the adoptive parents; on the other hand, she had originally not been expected by her birthmother, who was not even aware of the fact that she had started to exist, and was exceptionally fast in giving her consent to the adoption. Therefore, the adoptive parents had all the more reason to feel that they were the better parents. From the beginning, doubts, contradictions, and a latent rivalry between birth and adoptive parents hovered over the child's existence. All of this did not get any more concrete when the now grown-up daughter expressed her wish to contact her birthmother. The adoptive parents did not only approve of this undertaking, they even arranged to meet with the birthmother themselves. They described this as being a harmonious meeting, but this harmony seems to have been icy. In this, we saw the repeated failure of the patient to discover the reality of the relationships. As in the music therapy session, the dialogue ceased, and everything remained undecided. The relations in the parent generation did not give the teenage daughter the support she needed—they did not serve as a springboard from which she could take the crucial step toward individuation. It was not possible for her to create her own individual life, the same as in music therapy where she did not find out that it was possible to modulate the note on the string of the gopiphant.

In a situation characterized by separation, namely breaking up with her boyfriend, the patient decompensated psychotically. Various things come together in the delusion that her ex-boyfriend had shot her father: the desperate search for the missing father, the desire to get out of an unresolvable relationship situation with the help of a third person, and the latent fear of her own destructive anger.

This is how far we had gotten in understanding the psychodynamics of the patient. We started to question the one-sided success of the pharmacological and sociotherapeutic treatment and to exchange our thoughts about the interaction process in the team. This evoked the resistance of the patient. To get out of this dilemma she followed the strategy that attack is the best means of defense. After two and a half months she was well enough to have herself discharged from the hospital against the doctor's advice. She argued that it would be better for her to continue therapy in a day clinic. Unfortunately, she never appeared there.

Although I referred to this end of therapy before as the breaking off of treatment, I would like to suggest a different interpretation, although it cannot be confirmed without the help of the patient and information about her further development. The analysis work in the team, which had just started but was quickly increasing in intensity, brought the reality of relations into play, so that the patient was able to use them as a springboard to find her own way. We, who had been used by her as parent figures, were simply left behind together with our relations.

REFERENCES

- Abelin, E. L. (1975). "Some Further Observations and Comments on the Earliest Role of the Father," *International Journal of Psychoanalysis*, 293-302.
- Benjamin, J. (1990/1993). *Die Fesseln der Liebe*. Frankfurt, Germany: Fischer TB-Verlag.
- Buchholz, M. B. (1993). *Dreiecksgeschichten*. Göttingen, Germany: Vandenhoeck & Rupprecht.
- Deuter, M. (1995). "Beziehungsformen in der musiktherapeutischen Arbeit mit psychotischen Patienten." Unveröffentl. Manuskript, 22 Seiten.
- Heltzel, R. (1996). "Der psychoanalytische Beitrag zur stationär-psychiatrischen Versorgung," Vortrag vom 27.1.1996 in Berlin, unveröffentl. Manuskript.
- Lempa, Günther (1995). "Zur psychoanalytischen Behandlungstechnik bei schizophrenen Psychosen." *Forum der Psychoanalyse* 11, 133-149.
- Mahler, M. S., Pine, F., & Bergman, A. (1975/1996). *Die psychische Geburt des Menschen*. Frankfurt, Germany: Fischer TB-Verlag.

Metzner, S. (1999). *Tabu und Turbulenz. Musiktherapie mit psychiatrischen Patienten*. Göttingen, Germany: Vandenhoeck & Ruprecht.

Stern, D. N. (1986/1992). *Die Lebenserfahrung des Säuglings*. Stuttgart, Germany: Klett-Cotta.

Winnicott, D. W. (1971/1985). *Vom Spiel zur Kreativität*. Third edition. Stuttgart, Germany: Klett-Cotta.