CLINICAL PERSPECTIVES

# The Triangle of Conflict: Applications of a Core Intervention From Manualized Psychodynamic Psychotherapy

Timothy Rice[a,*], MD, Michael A. Shapiro[b], MD, Leon Hoffman[c], MD

The accessibility of manualized youth psychodynamic psychotherapies[1-3] facilitates their use in hospital-based and community clinic settings. Implementation of their component interventions within a single patient encounter can expand their utility throughout the hospital, including in emergency departments, pediatric floors, and partial hospitalization and inpatient psychiatry services. Here, we share a core intervention drawn from one of these manualized works, Regulation Focused Psychotherapy for Children (RFP-C),[2] named the Triangle of Conflict.

In our manualized outpatient approach, this heuristic initially helps the child and adolescent psychiatrist (CAP) to listen and talk with a parent about their children's externalizing symptoms and, later on, in talking and playing with the children. RFP-C was shown to be effective in reducing symptoms of irritability and oppositional defiant disorder (ODD) in a randomized controlled trial (RCT) that included 43 subjects randomized to our active intervention or to a waitlist control.[4] Treatment completers saw a statistically significant reduction ($p < .001$) in their Oppositional Defiant Disorder Rating Scale (ODD-RS)[5] score, from an average of 18.89 (SD = 3.16) to 12.17 (SD = 4.73).[4] We have clinical reason to believe that the application of the Triangle of Conflict intervention beyond the outpatient setting is feasible and provides an important therapeutic option for youth whose attributes incline them toward expressive and/or insight-oriented work.

## THE TRIANGLE OF CONFLICT

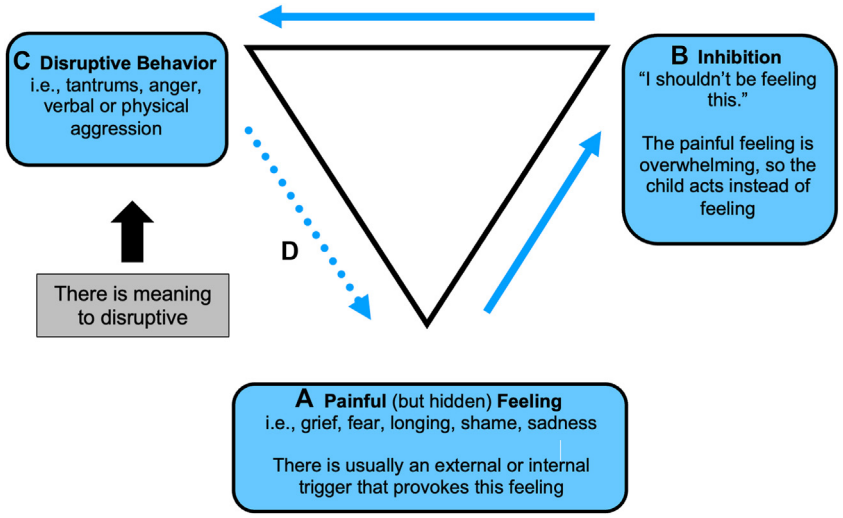
The Triangle of Conflict was originally described by Malan and incorporated by McCullough into the conceptualization of affect phobia in adults.[6] Affect phobia is literally a fear of feelings. The Triangle of Conflict (Figure 1) conceptualizes the disruptive behavior of irritable children as maladaptive protection against the emergence of painful emotions, which they avoid because of fear, shame, or guilt. These children hide from these feelings by the automatic emergence of disruptive behaviors.

## USE OF THE TRIANGLE OF CONFLICT WITH CAREGIVERS

When irritable children are exposed to a stimulus, which, for reasons of the specific child's history, endowment, and circumstances may be immensely painful, they experience intolerable affect. This affect is represented on the bottom vertex of the Triangle of Conflict. An unconscious internal signal is generated, "communicating" that the unpleasant affect needs to be kept out of consciousness. The right vertex depicts this signal. The end result is the child's expression of maladaptive behavior represented in the left vertex. This manifest behavioral disruption presents as a defense mechanism (DM), which is formulated as a product of an underdeveloped emotion regulation system.[7] The maladaptive behavior functions to keep the painful affect from consciousness, but has consequences.

**Diversity & Inclusion Statement:** *While citing references scientifically relevant for this work, we also actively worked to promote inclusion of historically underrepresented racial and/or ethnic groups in science in our reference list. While citing references scientifically relevant for this work, we also actively worked to promote sex and gender balance in our reference list.*

**FIGURE 1** The Triangle of Conflict




*Note: (A) There is typically an external situation or internal psychological conflict that triggers painful feelings for the child. (B) An automatic response occurs, as the child cannot allow themself to feel the painful feeling (inhibition) and instead the child becomes disruptive. (C) The disruptive behavior is a result of the child's need to ward off painful feelings. (D) This cycle continues if adults cannot identify what sets the child off and why these triggers are so upsetting to the child. The child needs the adult to recognize and acknowledge that there is meaning behind the disruptive behavior. Please note color figures are available online.*

Notably, the manifest maladaptive behavior is the salient manifestation observed by the parent, teacher, or CAP. By using the pictorial representation by the Triangle, the CAP can help the parent review the sequence of events prior to the child's explosive irritable behavior. The caretaker then becomes aware that the child may be responding to what the child, in contrast to most other children, experiences as a noxious stimulus, leading to painful feelings that need to be suppressed.

Consider this fictional example: A tired mother brings her disruptive 6-year-old daughter to the emergency department for "exploding without any reason." The parent demands an inpatient admission to "straighten her out." Through the Triangle of Conflict, the consulting CAP reframes the conversation to collaboratively work together to help the parent and the CAP understand the activities that precipitate explosions. The CAP learns that the mother's breastfeeding of the 6-year-old's newborn baby sister lights the fuse. The CAP draws on his knowledge of development and family systems to wonder aloud whether the 6-year-old's explosions protect her from directly experiencing the unacceptable feelings of envy, dependency yearnings at a stage of pushing for autonomous mastery, and a secret wish to get rid of her baby sister, with whom at times she can be quite tender. The mother becomes interested in considering these sides of her daughter that she had never previously considered, and herself clings less tightly to the demand for admission and becomes more open to the referral for outpatient care to further expand her understanding of her beloved girl.

## APPLICATIONS OF THE TRIANGLE OF CONFLICT

Irritable children with disruptive disorders are the most frequent recipients of behavioral health treatment.[8] They are challenging to parents, teachers, and CAPs alike. Alongside parent managing training, which has a strong evidence base for reducing disruptive behaviors inclusive of when the child is or is not directly involved in the treatment,[9] the Triangle of Conflict can also effectively reduce these behaviors while allowing for direct work with the child and educating parents to better understand their child. Use of the Triangle of Conflict enables parents and clinicians to understand the child's subjective experience, to appreciate the unmet emotional needs of children, and to formulate a therapeutic response.

By systematically addressing how the child uses maladaptive defenses to avoid painful feelings, children gradually are better able to tolerate those feelings, to regulate their emotions more adaptively, to develop a shared language about emotions of which they are unaware, and to decrease their disruptive symptoms. The active intervention strays from the nondirective quality of traditional psychoanalysis and provides agency in the CAP in addressing impairing behaviors with the time sensitivity that they require. It can also be integrated in a collaborative fashion with behavioral

approaches to care. In working with parents and teachers, the CAPs communicate the importance of developing greater awareness of the child's subjective experience of painful emotions. As a result, in place of knee-jerk punitive reactions to children's maladaptive irritable reactions, the adult develops a more reflective stance.

With a reflective stance, the adult begins tolerating their own feelings triggered by the disruptive behaviors, to notice the events that occur prior to the disruptive behavior, and to accept that disruptive behavior is a disguised expression of the child's painful emotional states. Adults are encouraged to be curious about how the events that trigger these feelings in the child may not provoke the same feelings in other children and adults but, for this child, may be particularly painful. This promotes modeling of a reflective and nonreactive stance for the child, which supplements the direct clinical work with the child.

In this way, the adult begins to imagine feelings that the stimulus provokes in the child, such as shame, guilt, anxiety, or fear, and to understand that the child's behavior could be a protective response to avoid their painful emotional experience, and that, for the child, the misbehavior is a safer expression than verbally expressing the painful and hidden feeling, for example, "It's easier to get mad than to show how vulnerable I feel."

## INPATIENT VIGNETTE THROUGH THE TRIANGLE

Use of the visual depiction of the process with caregivers helps to identify seemingly opaque triggers for the child's disruptive behavior. The Triangle helps the CAPs to identify frustrating and painful situations in the sessions. In another fictional example, an 8-year-old boy who was admitted to the hospital overnight for aggressive outbursts is encouraged to think about what happens before an explosion. In describing an antecedent, the boy tells a story that leads the CAP to suspect that the boy feels sad and lonely. The CAP asks the child curiously what happens to the sadness, and the boy insightfully responds, "When I get sad, I get mad." The CAP draws the Triangle of Conflict for the boy, and wonders if he's ever heard the expression "boys don't cry." The boy nods affirmatively and continues to nod when the CAP wonders if that's why it's easier to be mad than sad. The CAP suggests that if this can be shared with the boy's family, he might find it easier to show them when he is sad instead of having explosions. The child agrees, and a reflective family session effectively substitutes for what would likely have been prescription psychiatric medication targeting impulsive aggression.

The Triangle of Conflict is a portable intervention drawn from the traditions of psychoanalysis and incorporated into evidence-based manualized psychodynamic psychotherapies for children and adolescents. These efforts extend the reach of this predominantly outpatient tradition to all hospital settings. In the emergency department, pediatric ward, inpatient psychiatric unit, or community and hospital-based clinic, formulation of the genesis of the child's disruptive behavior through the Triangle's model anecdotally works. Teaching and direct clinical application increases accessibility to psychotherapeutic techniques, promotes health equity, and advances Accreditation Council for Graduate Medical Education (ACGME) requirements for child and adolescent psychiatry training of psychodynamic psychotherapy.[10] Future empirical studies in such settings will expand the evidence base for psychodynamic psychotherapy applications across the areas in which CAPs train and provide needed care.

## CRediT authorship contribution statement

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[a]Icahn School of Medicine at Mount Sinai, New York, New York; [b]Children's Hospital of The King's Daughters, Norfolk, Virginia; [c]New York Psychoanalytic Society and Institute, New York, New York.

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*Correspondence to Timothy Rice, MD, Icahn School of Medicine at Mount Sinai, 1090 Amsterdam Avenue 13th floor, Suite A Office 5, New York, NY 10025; e-mail: Timothy.Rice@mountsinai.org



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## REFERENCES

1. Midgley N, Ensink K, Lindqvist K, Malberg N, Muller N. Mentalization-Based Treatment for Children: A Time-Limited Approach. American Psychological Association; 2017. https://doi.org/10.1037/0000028-000

2. Hoffman L, Rice T, Prout T. Manual for Regulation-Focused Psychotherapy for Children with Externalizing Behaviors (RFP-C): A Psychodynamic Approach. Routledge; 2015.

3. Normandin L, Ensink K, Weiner A, Kernberg O. Transference-Focused Psychotherapy for Adolescents with Severe Personality Disorders. American Psychiatric Publishing; 2021.
4. Prout TA, Rice T, Chung H, Gorokhovsky Y, Murphy S, Hoffman L. Randomized controlled trial of regulation focused psychotherapy for children: a manualized psychodynamic treatment for externalizing behaviors. Psychother Res. 2022;32(5):555-570. https://doi.org/10.1080/10503307.2021.1980626
5. Hommersen P, Murray C, Ohan J, Johnson C. Oppositional Defiant Disorder Rating Scale: preliminary evidence of reliability and validity. J Behav Emot Disord. 2006;14:1-2.
6. McCullough L, Kuhn N, Andrews S, Kaplan A, Wolf J, Hurley C. Treating Affect Phobia: A Manual for Short-Term Dynamic Psychotherapy. Guilford Press; 2003.
7. Rice T, Hoffman L. Defense mechanisms and implicit emotion regulation: a comparison of a psychodynamic construct with one from contemporary neuroscience. J Am Psychoanal Assoc. 2014;62(4):693-708. https://doi.org/10.1177/0003065114546746
8. Loeber R, Burke JD, Lahey BB, Winters A, Zera M. Oppositional defiant and conduct disorder: a review of the past 10 years, part I. J Am Acad Child Adolesc Psychiatry. 2000;39(12):1468-1484. https://doi.org/10.1097/00004583-200012000-00007
9. Helander M, Asperholm M, Wetterborg D, *et al*. The efficacy of parent management training with or without involving the child in the treatment among children with clinical levels of disruptive behavior: a meta-analysis. Child Psychiatry Hum Dev. 2024;55(1):164-181. https://doi.org/10.1007/s10578-022-01367-y
10. Shapiro M. Psychodynamic child and adolescent psychiatry and the future of our field. J Am Acad Child Adolesc Psychiatry. 2022;61(6):739-741. https://doi.org/10.1016/j.jaac.2021.11.022