The Triangle of Vitality: A Strengths-Based Psychodynamic Framework

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Introduction

Davanloo's central dynamic sequence, the triangle of conflict (TOC), and Malan's triangle of persons (TOP) guide the metapsychology of Intensive Short-Term Dynamic Psychotherapy (ISTDP). Therapists' psycho-diagnose intrapsychic conflicts to develop treatment plans for patients across broad spectrums of resistance and anxiety tolerance thresholds. Understandably, emotion-focused clinicians pay much attention to unconscious resistance and its multitudinous permutations. However, to what extent do clinicians attend to the patient's most healthy conscious and unconscious developmental aspirations and potentials? During a confrontive "head-on collision" intervention with a patient, Davanloo often referred to a "freedom" that is waiting for the patient on the other side of their resistance (Davanloo, 2000).

What is the essence of this freedom, and how would it manifest concretely in an individual's life? Furthermore, how does ISTDP metapsychology conceptualize post-traumatic growth and post-unlocking growth? Should we rely on changed scores on validated instruments, subjective observation, or the patient's report? ISTDP can enhance its efficacy by integrating a strengths-oriented psychodynamic framework to psycho-diagnose patients' strengths and inherent healing capacities. This article introduces a framework I refer to as the *Triangle of Vitality: I Am, I Can, I Will* (see Figure 1 below). This paper will succinctly outline the inspiration for the Triangle of Vitality (TOV), elucidate each of its dimensions, and subsequently analyze a therapeutic case to demonstrate the TOV's clinical applicability. The limitations and suggestions for integrating the framework into clinical practice and supervision will be discussed.

FIGURE 1. THE TRIANGLE OF VITALITY

CONFLICT OF INTEREST STATEMENT
The author, David M. Rudesill, asserts that he has no personal or financial conflicts of interest.

ACKNOWLEDGMENTS
I wish to express my gratitude to mentors and ISTDP supervisors whose courage, kindness, integrity, and humanity have guided my journey: David Wolff, John Rathauser, and Jon Frederickson. I am particularly appreciative of Diane Byster for serving as both my supervisor and teammate, as well as for her steadfast confidence in my capacity to achieve and actualize my full potential. I acknowledge Althea Horner and Habib Davanloo; the TOV would not exist without your monumental contributions. I thank friends and colleagues who provided critical feedback on the TOV framework: Matthew McCall, Chris Giolli, Brian Sparks, and Johannes Ermagan. I am grateful to Mr. Thomas Hesslow and the JCI for creating an international community that encourages innovative ideas and viewpoints. I am appreciative of supervisees who offered feedback on the pedagogical and clinical utility of the TOV. Finally, I am grateful to my wife, Elizabeth, for her love and support throughout this entire process.

Genesis of the TOV

I will briefly share a personal note about the genesis of this framework. The inspiration originated approximately 20 years ago, prior to my career as a mental health professional, during a particularly challenging period in my life. During that period, navigating each day felt like an act of survival; I had become disconnected from my positive attributes, creativity, and vitality. Amidst the pervasive hopelessness, a mantra emerged in my consciousness: "I Am, I Can." It was both simple and profound, reiterating a fundamental aspect of existence in conjunction with the emotions I was experiencing regarding significant life challenges. The mantra served as a tangible reminder that, contrary to the fallacious belief in my powerlessness, I retained the ability to make choices. I recited the mantra daily, and it significantly benefited me. Approximately two decades later, while perusing Althea Horner's "The Wish for Power and The Fear of Having It," I encountered a chapter titled "I Am, I Can, I Will" and was astonished. Horner elucidated the psychodynamic and developmental aspects I had instinctively encountered two decades prior. This framework originates from personal and professional experiences as a therapist and supervisor and is inspired by the brilliance of Althea Horner and Habib Davanloo.

Definition of Vitality

The term "dynamic" derives from the Greek word "dynasthai," - signifying the ability to possess power. Thus, any esteemed psychodynamic psychotherapy should aim to empower patients and address barriers to the experience or capacity to express intrapsychic power. Why vitality? Webster's dictionary offers definitions for vitality: "the power giving continuance of life, present in all living things" and "the state of being strong and active, energy." 20th-century French philosopher Henri Bergson (1907) posited that vitality – what he called "Élan Vital" – was an impulse that drives the evolution of life and human creativity. Energy, creativity, strength, and power are all antonyms to the kinds of descriptors patients use when describing anxiety and depression. Resistance and its associated clinical symptoms significantly deplete the patient's energy essential for healing and growth. Therefore, vitality is suggested as a contrasting antithesis to clinical suffering and symptomatology.

It is axiomatic that resistance (all the defenses/behaviors that arise in the therapy situation) is both the maladaptive source and expression of a patient's suffering. Resistances reveal and express how a patient learned to bond and survive in sub-optimal attachment environments, hiding critical elements of their identity, developmental capacities, and will. For example, the defense of self-criticism reveals how, as a child, a patient may have identified with a critical parent to manage the conflict of feeling anger towards that parent whom they also loved and relied upon for survival. In the present, the patient's unconscious habit of redirecting anger and aggressive impulses upon themselves may drive symptoms of anxiety, depression, and a characterological pattern of people-pleasing. Taken altogether, it is a perfect recipe to deplete and exhaust a person rather than make them feel vitalized and capable of action and growth. We now come upon what resistance and clinical symptoms obscure: the Triangle of Vitality: I Am, I Can, I Will.

The "I Am" Domain: Waxing Vitality

Buddhist psychoanalytic author Mark Epstein asserted that an individual must possess a self prior to transcending it (2007). When childhood attachment is sufficiently adequate, individuals experience authenticity:

"A man or woman who feels real knows not only what he or she feels but also has access to other aspects of experience as well. Such individuals know what they think, what they feel, what they want, and what they perceive. They also know what they can do and are able to pursue goals and aims" (Horner, 1999, p. 30).

The I Am is the base of the TOV and reflects Ms. Horner's description: a subjective internal experience of self in which intermingling feelings, impulses, dreams, wishes, and needs feel real to the individual and unlock domains of capacity and will. The I Am functions akin to a hard drive with boundless storage capacity, wherein intricate and conflicting experiences can be assimilated and harmonized to facilitate intrapersonal and interpersonal development. Knowing what one truly feels, with whom, and why – and without anxiety or defense overwhelming this awareness – is a core expression of the I Am. The I Am is not a static concept but an expression of how one can move towards self-actualization, or what Baxter Magolda (2001) calls "self-authorship." Self-authorship theorist Robert Kegan describes it as "an internal personal identity that can coordinate, integrate, act upon, or invent values, beliefs, convictions, generalizations, ideals, abstractions, interpersonal loyalties, and intrapersonal states. It is no longer authored by *them* [italics added]; *it* authors them and thereby achieves a personal authority" (Keegan, 1994, p.185). From a classical psychoanalytic viewpoint, Karen Horney's detailed depiction of child development elucidates the fundamental nature of the I Am domain of the TOV:

"You need not, and in fact cannot, teach an acorn to grow into an oak tree, but when given a chance, its intrinsic potentialities will develop. Similarly, the human individual, given a chance, tends to develop his particular human potentialities. He will develop then the unique *alive forces* [italics added for emphasis] of his real self: the clarity and the depth of his own feelings, thoughts, wishes, interests; the ability to tap his own resources, the strength of his will power; the special capacities or gifts he may have; the faculty to express himself, and to relate himself to others with his spontaneous feelings" (Horney, 1950, p. 17).

The I Am is the foundation from which these "alive forces" energize the domains of capacity (I Can) and will (I Will). Psychotherapy serves as a means to cultivate and realize the I Am. This paper will go on to give more concrete examples of how therapy can achieve this. Now, we will examine how, in the face of attachment trauma, the I Am is eclipsed by anxiety and survival strategies (resistance).

Anxiety and Resistance: Waning Vitality

ISTDP therapists receive training in identifying and clarifying the myriad defenses that were adaptive in childhood and that drive the patient's symptoms and problems. Later in life, tactical defenses like hypothetical speech, eye gaze avoidance, physical barriers, vagueness, and smiling can all be unconscious "tactics" to maintain relational distance, including with the therapist (the transference). Character defenses such as compliance and defiance, people-pleasing, and self-attack are enacted in relationships – including the transference relationship – and fundamentally "hide" the patient, rendering them unavailable for collaborative relational closeness. All these behaviors, which therapists call defenses, are the root cause of dysregulated anxiety, feelings, and behaviors. Collectively, resistance often engenders a sensation of impostorism in an individual. Nevertheless, the sensation of "feeling" like an imposter does not constitute an emotional expression but rather an insight into the experience of depression and anxiety when resistance has eclipsed the I Am.

Althea Horner described defenses as constructing a false self, a prepositional self that "is an identity that is based on reactions to the other person, a self that takes its cue from that person. The false self both enables connection to the other and protects the true self from the other (Horner, 1989, p. 77)." An anxiety-laden and defended "I Am" confines the patient, reducing them to a mere pawn in the world, compelling them to be pleasing *to*, withdrawing *from*, complying *with*, accommodating *for*, and defying *against* people. There is no freedom from these prepositional positions. Each of these character defenses guarantees emotionally taxing and unrewarding pseudo-connections with others, covering up an authentic "I Am." While resistance was once adaptive to save a person's life, over time, they may be left feeling alienated and unreal:

> "They describe themselves as feeling fraudulent, not knowing what they think, feel, want or believe. They complain of lack of spontaneity, no pleasure in what they do or achieve, no sense of really being alive. Although they may seem to fare in superior style in the world, from their point of view none of it has any meaning for them. Upon scrutiny, one can see that they live their lives as reactors rather than as initiators; their entire identity seems to be carved out of a characteristic adaptation to the external world (Horner, 1999, p. 31)."

Children and adolescents who are psychologically "poisoned" by punitive or domineering influences from caretakers may develop a belief that they are not authentic or lack the agency to act independently. They unconsciously employ psychological defenses to endure attachment trauma; however, these defenses also "block" (a term frequently utilized by patients) access to a genuine experience of self and others. "Access to the real rather than the reactive self is the sine qua non for being, and without it loving and intimacy are impossible" (Horner, 1999, p. 11). The extent of anxiety and syntonic defenses surrounding the I Am will inversely correlate with the patient's capacity for authentic self-contact and potential for loving intimacy with others. When unconscious anxiety and defense consistently govern an individual's existence, the TOC – not the TOV – emerges as the prevailing triangle in their life. This brings us to our subsequent domain of vitality, I Can.

The "I Can" Domain

What could be more delightful than a child, adolescent, or therapist in training when they proudly exclaim, "I can do it; I can do it on my own!" When an individual's sense of self is nurtured and supported by significant others (caretakers, friends, clinical supervisors), they feel empowered to undertake calculated risks, explore, and engage in play, approaching new experiences with the belief that the risk itself is rewarding: "I Can!" The practice of "nervous system flossing" (a term used by Dan Siegel during UCLA grand rounds in 2014) will assist individuals in confronting and managing their anxiety by progressively engaging in risk-taking and enduring uncertainty regarding the results of their endeavors. This illustrates how repeated experiences of "I Can" will strengthen reserves of "I Am," enhancing vitality and fortifying the individual to endure life's unavoidable pains and losses.

Common early developmental examples of I Can include children taking their first steps, toileting on their own, tying shoes, putting on clothing, etc. Later in life, the I Can may manifest in passionate exploration of a particular school

subject, sport, or musical instrument. With the support of others during this exploration, the adolescent will recognize their potential to eventually attain competence and progress towards mastery of significant undertakings in their life. The positive emotions derived from perceiving oneself as competent replenish the TOV.

Acquiring and honing skills in psychotherapy is very challenging. Many therapists have thought, "I *cannot* do this!" Therapists may defend against threats to self-esteem by idealizing ISTDP and devaluing other forms of therapy and idolizing or pleasing their supervisors (Brightman, 1979). Trainees often lack awareness, just like patients, about how unconscious anxiety and resistance cover up their I Am. Clinical supervisors might unintentionally relate to trainees (perhaps when trainees become anxious or use defense) *as though* they are children, infantilizing or devaluing them due to their unconscious conflicts or supertransference reactions (Teitelbaum, 1990). When clinical supervisors continually relate to a trainee *as though* they're helpless, dangerous, or hopeless, the trainee may falsely perceive that their supervisor holds the objective truth about them and begin to behave in ways that align with their supervisor's views, thereby cutting themselves off from their I Am. When trainees become alienated from their potential because of unwittingly accommodating or submitting to a clinical supervisor, they will struggle to truly learn and metabolize any metapsychology. Moreover, detached and alienated from their I Am, they can only offer a detached or alienated psychotherapy, rather than a genuinely relational psychotherapy, damning both client and trainee to further suffering.

Children psychologically amputate key aspects of themselves to adapt and preserve an insecure attachment. Such behavior comes at the expense of intrinsic developmental strivings. When one is dominated, abused, or neglected by important others, the "I Am" may be covered up and eclipsed by the image of someone else. Then, the power potential of "I Can" is eclipsed with "I Cannot" or "I Will Not" (Horner, 1999). When the TOC predominates the psychological landscape of a person's life, expressions of capacity are stifled by anxiety and resistance, obstructing access to I Will, the subsequent dimension of vitality.

The "I Will" Domain

"Will is an expression of the life force that drives the universe and, thus, the patient in her life task of self-creation" (Frederickson, 2021, p.118). The I Will represents the intersection of the I Am and the world. Will reflects *consciously articulated intention*, a revelation of both oneself (I Am) and one's felt capacity to achieve (I Can). Will is the precursor to actions that we *feel capable* of achieving. Examples may be, "I will pursue a career in mental health, so I will apply to a graduate program in counseling psychology." "I will tell the person I have loving feelings for how I feel and what I need." As Althea Horner puts it, "A consciously articulated intention requires a sense of existence [I Am] and of the capacity for mastery [I Can]" (Horner, 1989, p.79). Unsurprisingly, successfully willing one's intentions into being will bolster vitality in both the I Am and I Can domains. An example of this could be when a child who has been successfully supported in learning to practice and play chess declares their will to enter a local tournament. Their will is being marshaled for the purpose of cultivating something that vitalizes them and supports their burgeoning sense of self.

The water wheel requires a flow of water to operate, just as psychotherapy cannot be effective if the patient's conscious or unconscious desires are obstructed by resistance. Patients subjected to domination or abuse, characterized by high authority and punitive parental styles, may find it challenging to consciously assert and disclose their will to rely on others and pursue healing. "The patient's choice was to fuse with the abuser's will or lose his love. This soul murder could also be called will murder" (Frederickson, 2021, p. 119). Patients will lack conscious awareness of their volition when it is unconsciously attributed to others, including the therapist. Their will may be covered with survival statements such as, "I will not!" or "I will *if you say so*!" or "Is this the *correct* way to do therapy?" When the I Am is blocked with syntonic resistance, patients can only marshal a pseudo-will in the forms of compliance/defiance, withdrawing, ruminating, projecting, and other forms of resistance. This fosters a psychological state that is profoundly disempowering, stressful, and isolating – the antithesis of vitality.

In summary, physiological anxiety and behavioral resistance – both manifestations of attachment trauma – hinder the development of intrinsic vitality that underpins one's sense of self (I Am), capacity for mastery (I Can), and ability to consciously articulate intention (I Will).

A Case Example

Let us analyze a case to clinically consider how anxiety and resistance obscure and obstruct access to the dimensions of the TOV. To do so, we'll analyze statements made by a client before and after turning against his resistance. Lastly, we will consider how the therapist's interventions target both the TOC and TOV.

The patient, "H," is a 30-year-old Caucasian male reporting persistent symptoms of depression, at times "double depression" since childhood, generalized anxiety, intermittent substance abuse (alcohol and marijuana), confusion and anxiety regarding his sexual identity, difficulties with emotional closeness, and engaging in self-destructive behaviors (allowing men to objectify and use him sexually and drinking to excess regularly).

The patient's anxiety was initially discharged into both smooth (reporting nausea and migraine headaches) and stri-

ated (reporting intermittent tension headaches) muscles. In terms of resistance, the patient presented with defenses to emotional closeness (DAEC), tactical defenses, and some regressive defenses. Taken altogether, the resistance included eye gaze avoidance, vague and hypothetical speech, rumination, passivity, detaching, weepy tears, self-attack, acting out (sexually), and substance abuse.

After 30 sessions of ISTDP therapy, the patient stated he was finally ready "to process deeply buried emotions with his brother," who, as a child, repeatedly coerced the patient to perform sex acts on him and, at times, a neighbor boy.

The following transcripts illustrate sessions preceding and succeeding the patient's confrontation of his resistance and the profound processing of repressed emotions linked to trauma. During the first session, the patient exhibits signs of unconscious resistance, primarily towards emotional intimacy. As a result, his TOV is initially eclipsed by the TOC. In the follow-up session, the patient discusses positive changes in himself and in his life after facing his resistance and embracing complex, mixed feelings and impulses toward his brother. An analysis of the TOC and TOV will follow the transcripts.

Session 1: Working with Syntonic Resistance and Unlocking the Unconscious

Patient: "It kind of feels like a whole new set of blocks; blockers are coming up to kind of keep me from feeling any of these emotions."

Therapist: "Well, I think that the blockers that are coming up keep people out. And I know they don't happen intentionally, but [snaps fingers] they happen. The distancing, the detaching, the wanting to shut down, and the wanting to go away––all these different behaviors allow you to become further away from what you might be feeling inside a close relationship."

Patient: "Mmmhmm." [Patient sits for several seconds and then takes a deep, striated sigh.]

Therapist: "You take a sigh; I can see you thinking some things over. What do you notice feeling inside at the moment?"

Patient: [The patient says nothing, averts his eye gaze, and starts to withdraw inward, away from the therapist.]

Therapist: "You're slowing down; notice how you go slow?"

Patient: [Nods] "Yea."

Therapist: "What feelings are coming that make you want to kind of go slow and shut down? What do you notice? What feelings are coming up here [gestures towards himself]? Together?"

Patient: [Another striated sigh, then his eyes move away to the side of the room.]

Therapist: "You notice how quickly your eyes go away from mine?"

Patient: [Nods]

Therapist: "If you keep your eyes on mine, what feelings do you notice coming up?"

Patient: "Like a sincerity...almost like an honest truth... being able to stare down... [trails off]."

Therapist: "These are some thoughts, though. These are some thoughts you have about the experience. If you look to your body, what feelings are coming up here with me?"

Patient: [Another big, striated sigh.]

Therapist: "Another sigh. Some feeling is coming up inside."

Patient: "I guess some frustration and some anger."

Therapist: "Mmhmm, but with whom?"

Patient: "I guess it's with you because of...just the..."

Therapist: "You guess?"

Patient: [With a big smile and a laugh] "...the prodding..."

Therapist: "You say "you guess" though. So, some anger with me. How do you physically experience that anger with me?"

Patient: [appearing somewhat detached and flat] "I mean, I feel it in my arms and...some tense, some tension throughout my body."

Therapist: "My question to you right now is: can you give yourself the full freedom of this anger right now? Because by looking at your face, I can see that – I really appreciate your honesty, I really do. You're doing something difficult in letting me know how you feel because of my questions – but I sense there's a part of you that's in pain, almost tormented over letting me know how you feel. I also sense that there's a part of you that wants to slide into tears again. Now, can you hold onto your anger with me? Can you hold onto the feeling inside and give yourself full freedom to feel it? It's so important. How often do you allow yourself this kind of honesty in your life?"

Patient [sighs] "Not that honest, [corrects himself] not that often."

Therapist: "This is why it's so important; this is why it matters so much. You know all the other ways it typically goes, or could go, or has gone in the past, but if you really allow yourself to fully hold on to this anger that's come up with me."

Patient: [Big Sigh]

Therapist: "There's a rising power in you, and really what we're looking at is giving you power in your life."

Patient: [Nods in agreement].

Therapist: "How do you feel when you are really able to declare your feelings over me asking these questions?"

Patient: I mean, it feels great; it feels really good to be in the full force of this anger [a fist has formed]."

Therapist: "Yes. Yes."
Patient: [Sighs] "Wanting to really express it."
Therapist: "So, if you give yourself the freedom in thought and fantasy, if this anger were to come out at me, how would it go in thought and fantasy?"
Patient: [Big sigh, then sitting and waiting]
Therapist: "If you don't slow down, if you don't hold back, if you don't move away. How does it go, if you really focus it at me?"
Patient: "I mean, I...I hold my hands up [tentativeness in his voice and body, voice quieter and weepy tears rising up]... being able to... punch you in the face."
Therapist: "Well, let's slow down for a moment because there are tears that are wanting to shut this down, this whole operation. Notice that?"
Patient: [Nods].
Therapist: "Because you have in that fist, and you have in that body of yours an immense potential for great power and strength."
Patient: [Nods]
Therapist: "I think that these tears that want to come up really castrate your power and strength. Just at the moment when you want to jump off the bench and get into the game... of your life."
Patient: [Feelings of pain and grief start to break through.]
Therapist: "These tears want to come up and shut you down again, shut you down, put you down. Has it not been too much of that?"
Patient: [With feelings of pain and grief moving through, the patient appears much more focused now, looking intently at the therapist].
Therapist: "I encourage you to really hold on to it and give yourself your total honesty with the emotion, with the anger, your anger that's come up. If you like?"
Patient: [Big sigh]
Therapist: "How do you notice feeling it toward me?"
Patient: "I feel the pain. I feel it, like a rush coming through my whole body. An anger coming through my fists and into my hands [both hands activated and in fists now]. As I grit my teeth, I'm just getting more and more angry."
Therapist: "Good, so if you let it, if you don't ratchet down on it, in thought and fantasy you let the full force of this power inside you come at me, how does it go?"
Patient: "I picture punching you in the face [jaw gritting], breaking your jaw."
Therapist: "Which hand? How do you swing?"
Patient: "With my right hand, and then I punch you on the left side with my left hand, like an uppercut."
Therapist: "What else? If it goes on?"
Patient: "And then, I keep punching you in the head with my right, and then my left, then my right again..."
Therapist: "Punching my head..."
Patient: "I see you kind of hanging there still on your two feet [big sigh, right hand moving rhythmically]...
Therapist: "What else? If you really let loose?"

Several minutes later

Patient: "I take the neck, and I hold it in a headlock."
Therapist: "You say, "the neck." Whose neck?"
Patient: "Your neck. So, you can't breathe anymore..."
Therapist: "Strangling, strangling my throat until I can't breathe?"
Patient: "Mmhmm."
Therapist: "Does that kill me?"
Patient: "Mmmhmm. Then slowly... I can see you struggle with, like, your last breath."
Therapist: "Does my body go to the ground?"
Patient: [Nods]
Therapist: "Can you look to the body? Can you look and see the body?"
Patient: [Nods]
Therapist: "If you look to the body – not my eyes – but to the body that you've killed there. Ribs cracked and fractured..."
Patient: [Taking very deep sighs as large waves of emotion rise up, moving towards an unstoppable breakthrough.]
Therapist: "Stay with it, stay with it, stay with the body, look at what you've done. Can you look at what you've done? The face crashed in with the hammer, ribs smashed..."
Patient: [Strong waves of guilt, grief, and pain breakthrough]
Therapist: "Whose body is lying there right now?"
Patient [makes a guttural vocalization]. "It's... it's my brother's body."
Therapist: [soft tone of voice] "Ok. There's a great wave of feeling; just hold on to it. Let it come, let it come."
Patient: [face contorting as waves of guilt, grief, and pain go through, wringing his hands in his lap]
Therapist: [soft, slow, and encouraging tone] "Don't fight it back; let it come."
Patient: [feelings moving through in waves, sobbing deeply]
Therapist: [soft, rhythmic tone] "It's ok, stay with it. Give yourself the freedom of this feeling too. Hold on to it, however much is there. It may go very deep; allow yourself the depths...of all your feelings."
Patient: [The full force of his guilt, grief, and pain breaks through. The patient sobs and wails uncontrollably. This goes on in various waves of emotion for around 20 minutes.]

The session ends with a period of consolidation in which the therapist and patient make important links between the nature of the resistance that arose in the session and how he historically handled mixed feelings towards his brother and other important attachment figures. Focus was directed towards understanding how the patient's defenses contributed to his presenting symptoms and problems. As an adult, the patient repeatedly reenacted the original trauma by seeking out men to sexually objectify and use him, recycling a sense of alienation and purgatory as though he only existed to gratify others sexual sadism. Taken as a whole, the resistance, combined with guilt-fueled re-enactments of trauma, eclipsed his triangle of vitality.

The follow-up session offers several examples of multi-dimensional structural change and the ascension of the TOV as the dominant triangle. The patient communicates dystonic awareness of the resistance, its function, and cost and reports *consciously* making choices to bolster his sense of self, capacities, and will.

Session 2: Processing the previous session

Therapist: "Tell me more about the work you feel you'd like to accomplish; my sense is our last session really was very significant in terms of your awareness of your own blockers [the patient's own term for his defenses] has greatly increased."

Patient: "Definitely, definitely in the moment. Because I can stew on those things. If I am angry or frustrated, *now* [patient emphasizing the present moment] why hold off on explaining it to somebody, or at least sharing it till later?"

Therapist: "Yeah."

Patient: "You know, because then it's just going to build up; it'll get worse and worse."

Therapist: "Absolutely. It festers."

Patient: "And it usually does, yeah. Um, with this new realization and seeing my blocks come up, um, it has helped me feel a little more comfortable in my own body day by day. Especially without the stress of work because of summer break, I was really able to redouble my efforts on myself."

Therapist: "Wow."

Patient: "Yeah, I can focus inwards; I don't have to worry about anything else for the time being."

Therapist: "Yeah. Wonderful."

Patient: "Yeah, um. Just little things like before I'd hesitate to give my father a kiss on the head, on the cheek, or something; now, I just go in for it. Because that's how I want to express my love to him."

Therapist: "Mmhmm."

Patient: "And that makes me feel a warm feeling inside. Just a little choked up to express it that way."

Therapist: "Beautiful. You have a deep love for your father. And you are letting yourself be loving in a less inhibited way. That's beautiful."

Patient: [Nods in agreement.] "Yeah. And as much as I can't read his mind, I can't read his emotions, so all I can do is express my feelings to him as much as I can."

Therapist: "Mmhmm."

Patient: "So, that's what I've been trying to do. Noticing those guards come up when I would want to do that [in the past] was like a person was talking in my head saying, "You don't want to do that, because then he [the patient's father] might do this or that." Now it's like, "Who cares?!"

Therapist: "That could go on ad nauseum."

Patient: "It usually does. And then I would go home regretting it and feel guilty about it. It just spirals downwards."

[A few moments later]

Therapist: "It's just absolutely striking how much more keenly attuned you are to your feelings and what pulls you away from your feelings."

Patient: "Yeah. I can – thank you for that – I can really see it, and I can feel it."

[A few moments later]

Therapist: "I'm struck by how much of a fighter you are; there's a real force of determination within you to achieve what you want and be emotionally free in the way you want. Perhaps you've gotten to a point of no return where you can see all the ways you've gotten in your way, that it cost you a lot in the past, and you don't want to do that anymore."

Patient: "And it's funny you should use the word 'fighter, because ever since our last session, I just feel a little stronger."

Therapist: "I'm not surprised. The power you really had to hold on to. So, that's resonating for you? Tell me more about how you've been feeling stronger..."

Patient: "I mean stronger in not just feeling angry, but like, *owning it now*. Stronger in really feeling my own path, my own sexuality. Being freely comfortable in expressing my likes and dislikes towards men. Especially in, like, public."

Therapist: "Mmhmm."

Patient: "When I express any sort of topic with friends about being gay or anything else, it now feels so freeing for me, and I just feel so strong [big striated sigh] expressing it."

Therapist: "Very pleased to hear that. You've described up to

this point, sort of, really having an inner debate in terms of your sexual identity and being comfortable, and it's really, again, you've fought to declare who you are and who you're attracted to. Even to be okay and comfortable within yourself. What I hear you saying is that there's been a shift."

Patient: "Yeah. Really for myself, the shift is inwards. I'm giving myself permission that it's ok, that I can go on with my life, you know, dressing up the way I want, or going out the way I feel. Especially, I just feel good––even to go out at night––it's not like I'm dressing in some kind of flamboyant way; I just feel good."

Therapist: "Yeah."

Patient: "I remember those voices, those apparitions making me feel guilty, because, um, either a friend saying something or people looking at me, not specifically judging me. But then, I was judging myself. So, I turned all those eyes, which just happened to be glancing in my direction, into different voices. I'd make up this whole script and dialogue of anger and guilt and frustration and just mean things. But! That's just me saying all of that! So that's not there; it's not as strong anymore, and I can just shut it down."

Therapist: "Wow."

Patient: "It's like, no! I feel great about myself, and I'm just going to go out and have some fun."

Analysis of the TOV and TOC

Table 1 below showcases central statements articulated by the patient during both therapy sessions. The summary statements demonstrate transitions from the TOC to the TOV. The reader will observe clear manifestations of vitality in the left column and of syntonic resistance in the right column.

TABLE 1. SUMMARY STATEMENTS THAT HIGHLIGHT TRANSITION FROM TOC TO THE TOV

	DIS-IDENTIFIED WITH RESISTANCE	IDENTIFIED WITH RESISTANCE
I Am	"I feel angry and really own it now; I feel my own path."	"I don't know what I feel...Internal blockers keep me from feeling all these emotions."
	"I'm comfortable now expressing my likes and dislikes [as a gay man]."	"I don't know who I'm attracted to or what I want; I'll just go with the flow."
	"I'm giving myself permission to be who I am."	"I only exist to service and please other people."
I Can	"All I can do is express my love to my father as best as I can."	"I'm not sure I want to do that since I don't know how he'll respond."
	"I can go on with my life dressing up the way I want or going out the way I feel."	"Better to stay in or tone it down tonight; otherwise, everyone will judge me."
	"If I'm angry or frustrated with someone, why hold off on explaining it to someone?"	"I get so anxious thinking about what others might think about me. What if they judge or abandon me?"
I Will	"Kiss my father on the forehead and tell him I love him because that's how I want to express my love."	"When I try and read his mind or guess at what he wants, he doesn't want affection from me anyways. Why bother?"
	"I will come out as gay to my friends and family."	"How can I know if anyone will accept me? What if they judge or reject me? Better to wait until I'm more ready."
	"I will pursue that teaching job as an elementary school teacher."	"I don't think I'm ready. What if I fail? Other applicants are probably more qualified anyways..."

Interventions to target the TOV

Below are some of the interventions used during the 1st session. Let us examine the particulars, as diction is significant, highlighting the words in bold:

- "Can you **hold** on to that feeling inside and **give yourself** the full freedom to feel it?"
- "Are you **willing** to face these feelings here together?"
- "Do you **want** to face these feelings together so you can feel more **capable**?"
- "How often do you really **allow yourself** this type of honesty in **your** life?"
- "I encourage you to **give yourself** your total honesty."

The interventions underscore each aspect of the TOV by both implicitly and explicitly addressing the patient's conflicting desires for increased individuation, capability, and autonomy. They emphasize the patient's right to choose and implicitly deactivate the notion that the therapist can make the patient do anything (the omnipotent transference). They also communicate a spirit of firm encouragement and belief that the patient is capable of change, but that only they – and no one else – can walk through their inner doors.

was hesitating to give my father a kiss on the head or the cheek; now, I just go in for it. Because that's how I want to express my love to him." These statements are thematically different than when the patient was more identified with resistance and struggled to marshal a consciously articulated will that authentically reflected himself.

A multitude of sessions preceded this pivotal breakthrough session. The processes of restructuring syntonic defenses and anxiety discharge pathways (transitioning from smooth to striated muscles) were essential and often repetitive, while prompting the patient to confront and viscerally engage with repressed emotions and impulses. The iterative process of restructuring anxiety and defenses was essential to the development and elevation of the TOV; it is not solely focused on achieving a significant breakthrough.

The patient began treatment in a state of syntonic defense, which perpetuated symptoms of depression and anxiety, blocking access to the TOV. Through collaboration and over time, the patient comprehended the function and cost of his resistance while gradually confronting and experiencing previously repressed emotions and impulses. This process progressively shifted the patient into a more *authentic* and *empowered* experience of themselves (I Am), experiencing their *capacity* to change and grow over time (I Can) as they *chose* to turn on defenses and embrace their feelings and real-world needs (I Will). The multidimensional structural change transitioned the patient from pain and suffering to empowerment and potential, from TOC to TOV. Within a year of this session, the patient emailed to communicate that he had, "for the first time," established a stable and emotionally rewarding romantic relationship with a man and was very happy.

"This process progressively shifted the patient into a more authentic and empowered experience of themselves (I Am), experiencing their capacity to change and grow over time (I Can) as they chose to turn on defenses and embrace their feelings and real-world needs (I Will)."

Clinical Themes

Multiple themes emerge when we examine the patient's statements in the context of disidentification from resistance. A theme of I Am is evident in assertions about strength and genuine self-connection: "I mean stronger in not just feeling angry... but like, owning it now." I'm stronger in really feeling my own path, my own sexuality. Being freely comfortable in expressing my likes and dislikes towards men."

The subsequent theme is his employment of the phrase "I Can" as a declaration of newfound empowerment and realism: "All I can do is express my feelings as best as I can." "Yeah, I can focus inwards; I don't have to worry about anything else for the time being.

Finally, the patient expresses statements that indicate the emergence of consciously articulated intention and volition: "I'm *giving* myself permission now; I love who I am." "Before, I

Figure 2 on the next page depicts the operation of the TOV in conjunction with the TOC. By superimposing the TOC onto the TOV, the correlation between the triangles becomes evident. When patients confront anxiety-laden and previously repressed emotions and impulses, it fosters a more authentic connection with themselves (I Am) and others. Physiological anxiety triggered by unconscious emotions perpetuates

avoidant behaviors, fostering a sense of helplessness versus empowerment. Confronting and expressing previously suppressed emotions, wishes, and dreams enhances the patient's sense of competence. Ultimately, automated defenses activated by unconscious emotions and anxiety hinder a patient's ability to consciously express their authentic self (I Am).

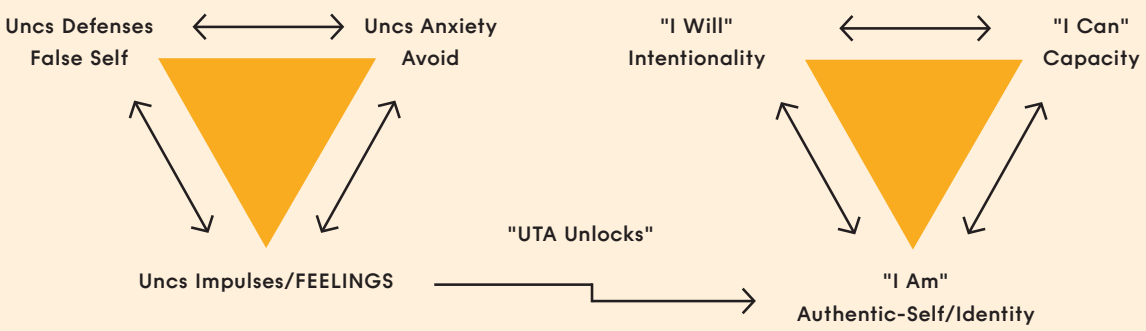
This framework aims to aid therapists and supervisors in clinically analyzing what anxiety and resistance conceal: vitality. The TOV is founded on my personal and clinical experience, substantiated by numerous case studies. Nevertheless, the framework is constrained by the absence of qualitative or quantitative research support. Moreover, there are intrinsic limitations in defining and quantifying psychological concepts that are non-physical entities. Defining the I Am presents a paradox, as it embodies a concept that evolves and transforms continuously, both moment to moment and throughout one's lifetime. The qualitative definition intentionally allows for variability, which could complicate future research endeavors. However, additional research and testing are required to confirm the framework's validity.

In closing, I've presented here a strengths-based framework, the Triangle of Vitality, which is intended to complement ISTDP's triangle of conflict and triangle of persons in psycho-diagnosing capacities and strengths. The TOV is instrumental in analyzing how particular patient resistances obstruct specific domains of vitality, as illustrated in the case of a man whose resistances hindered his TOV. I also discussed how ISTDP therapists can think about tailoring interventions (forms of pressure, challenge, and head-on collision) in ways that target the patient's domains of vitality by honoring their autonomy, capacity, and freedom to act.

"Vitality is a subjective emotional state that emerges organically when cultivated, leading to developmental dimensions that foster resilience, the capacity for love, and enduring maturation and growth: I Am, I Can, I Will."

Clinical supervisors will benefit from viewing their supervisees as highly capable, separate, autonomous beings, despite grappling with unavoidable anxieties, counter-transference responses, and obstacles to mastering a highly intricate therapeutic model. Belief in the potential for vitality is a prerequisite for its actualization in all clinical contexts. Finally, I propose that vitality is a subjective emotional state that emerges organically when cultivated, leading to developmental dimensions that foster resilience, the capacity for love, and enduring maturation and growth: I Am, I Can, I Will.

FIGURE 2. THE RELATIONSHIP BETWEEN THE TRIANGLE OF CONFLICT AND THE TRIANGLE OF VITALITY



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