Searching for Change Mechanisms in Emotion-Focused Work With Adolescents and Parents: An Example From Multidimensional Family Therapy

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Disconnection and disengagement are frequent characteristics of interactions between parents and adolescents who present with substance use disorders. Excessive blame, defensiveness, and recrimination characterize day-to-day interactions within these families. Developmental psychopathology research reveals both short- and long-term effects of negative emotional patterns between parents and adolescents on the young person's development, as well as on the parents' functioning and their parenting practices in particular. Persistent expression and experience of negative emotions are also associated with poor treatment outcome, as they act as barriers to treatment engagement and change. This article demonstrates how research-based knowledge can guide therapeutic strategy and how emotions can be transformed in an empirically supported, family-based treatment: multidimensional family therapy. Transcripts with commentary from an adolescent, a parent, and from family therapy sessions illustrate emotion-related interactional transactions and interventions.

Keywords: multidimensional family therapy, change mechanisms, emotion-focused interventions, adolescent, parents

Multidimensional family therapy (MDFT) is an evidence-based treatment for adolescents and young adults presenting substance use disorders (SUD) and delinquent behaviors (Boustani, Henderson, & Liddle, 2016; Liddle et al., 2001). MDFT takes into account the critical, well-documented role of the family in a child's development and has been found to be an effective treatment for clinically referred youths (Tanner-Smith, Wilson, & Lipsey, 2013). Using a multidimensional assessment and intervention framework (Liddle, 1994),

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therapists assess mutually influencing domains of intrapersonal and interpersonal functioning within and outside of the family. Individual sessions with the youth and the parent, in combination with family sessions, offer unique assessment and intervention opportunities. Assessment is guided by knowledge about both risk and protective factors. These include attempts to understand each identified influence contextually and in reciprocity with other influences. For example, drug use can derive from many mutually influencing factors related to the individual, the family, and circumstances, and from a cascade of negative experiences (Liddle, Rowe, Dakof, Ungaro, & Henderson, 2004). Overall treatment and intervention goals derive from the assessment and take into account empirical research on normative adolescent development and developmental psychopathology (regarding nonadaptive functioning and symptom development over time).

Change occurs via multiple pathways (such as work on core beliefs or emotional clarification and expression), in different units (individual, parental, familial, and extrafamilial), and through different mechanisms (e.g., new experiences of self and others, skill development; Liddle, 1994). Multiple therapeutic alliances, with the youth, parents, other family members, and potentially, school and juvenile justice officials, are foundational. Treatment is organized in stages, based upon knowledge of what is considered normal cognitive and emotional development of the youth. Each stage represents one of several targets for assessment, intervention, and change, and the therapist will not progress to the next stage until the therapy has been through the previous stage. The three stages structuring MDFT aim to (Liddle, 2005): (a) build therapeutic alliances and the foundation for therapy; (b) take action and make changes in the four domains (individual, parental, familial, and extrafamilial); and (c) seal the changes and guide the family members to create a healthy internal relationship. MDFT lasts between 4 and 6 months.

Intervening in dynamic and reciprocal interactions in real time (during sessions) is a major challenge: An adolescent's behavior provokes reactions from the parent and in turn parenting practices influence the adolescent's behavior and provoke reactions (Stice & Barrera, 1995). "Anger is all around" is a metaphor that could

describe the negative emotional climate in a family with an adolescent presenting a SUD. Excessive blame, defensiveness, longstanding resentment and recrimination predominate early-stage conversations of most families (Liddle, 2005). Parents' and adolescents' interactions are disconnected and disengaged. When these negative exchanges persist, family members are less motivated to achieve a solution, pessimistic about treatment, hopeless about change, and easily dissatisfied with therapy (Diamond & Liddle, 1999). Thus, the likelihood of noncompliance and early dropout increases (Patterson, 1982). Clinically, chronic negative emotional expression during sessions maintains the memories of negative experiences of each other, reduces flexibility in problem-solving, lowers expectancies for change, and has been associated with poor treatment outcome (Robbins, Alexander, Newell, & Turner, 1996). Thus, therapists need to work on reconnecting the family members. This means moving from an emotional climate full of negative emotions to an emotional climate with increased positive emotions. Indeed, decades of studies conclude that the parent–adolescent relationship quality influences the development and prevention of risky adolescent health behaviors and protects against a variety of externalizing and internalizing problem behaviors, including SUD (Blustein et al., 2015; Donovan, 2004; Keijsers, 2016; Riesch, Anderson, Pridham, Lutz, & Becker, 2010). No factor seems to influence adolescent adjustment more than the quality of family relationships (Garnefski, 2000; Kaminski et al., 2010), specifically the young person's "feeling of connectedness with parents and family" (Blum & Rinehart, 2000, p. 31).

This article presents an analysis and a clinical illustration of emotional reconnection—a major component of MDFT. Our aim was to develop further understanding of emotional reconnection (see Liddle [1994] for a detailed explanation of working with emotions in MDFT). We illustrate *why* and *how* to work on the experience, expression, and transformation of negative emotions between parents and their adolescent, with an emphasis on how anger as a core emotion can become central intrapersonally and interpersonally and is an important disruptor of the desired therapeutic process. First, we present the impact of negative emotional experience and expression in family interactions on adoles-

cent development and on parenting. Second, we explain and illustrate how negative emotions (e.g., anger) can be transformed into more adaptative emotions within family interactions.

It is important to keep in mind that the therapeutic process and change is multidimensional. Throughout the article, this multidimensional aspect of therapy and therapy's broader objectives (e.g., work on emotion regulation) are highlighted, and some other techniques used in therapy are described. However, the aim of the article is to focus on a specific element of the therapeutic process—one specific component of the work on anger—and to focus on how to connect the family members through vulnerability, namely, to find productive emotions.

Emotional Climate and Expressivity in the Family: Consequences on Parents and Adolescents

Emotional Patterns Between Parents and Adolescents: Reciprocal Influences

The quality of emotional patterns between parents and their adolescent has major consequences on adolescent development and on the functioning of the parent. Socialization is a two-way process that affects the parents' and their adolescent's behavior (Willoughby & Hamza, 2011).

Consequences of emotional patterns between parents and adolescents on the adolescent's development. A negative parent–child relationship hinders the adolescent's acquisition of fundamental psychological skills, particularly emotion regulation and social interaction skills, both linked to SUD and other problem behaviors. Children who have had long-term exposure to negative emotion in the family are less competent in peer relationships and can exhibit poor socio-interactional skills (Mesurado, Vidal, & Mestre, 2018). Relatedly, there is an association between excessively reactive parenting (harsh, irritable, and angry) and negative outcomes such as SUD (Beatty, Cross, & Shaw, 2008). Conversely, parental expression of positive emotions is associated with adaptive developmental outcomes in children: prosocial behavior, social competence, understanding of emotion, positive emotionality, and quality of the parent–child relationship (Eisenberg et al., 2003; Resnick et al., 1997).

The tripartite model Morris, Silk, Steinberg, Myers, and Robinson (2007) suggests that children learn emotion regulation through observing and modeling parenting practices, and through the emotional climate in the family. When parents regularly demonstrate high levels of anger toward their children, children are less likely to observe and learn effective emotion regulation responses (Morris et al., 2007). An essential component of children's successful development is learning how to regulate emotional responses and related behaviors in socially appropriate and adaptive manners (Eisenberg, Spinrad, & Morris, 2002). Developmental psychopathology studies have highlighted the role of emotion regulation in development and have linked difficulties in regulating negative emotion—primarily anger and sadness—to emotional and behavioral problems (Frick & Morris, 2004; Silk, Steinberg, & Morris, 2003), including SUD (Boden, Gross, Babson, & Bonn-Miller, 2013). SUD may result from avoidance or poor management of emotional reactions (Estévez, Jáuregui, Sánchez-Marcos, López-González, & Griffiths, 2017), meaning that drug use can serve to regulate negative emotion (Kober, 2014). In families, this means that negative emotional transactions between parents and youth could also reinforce SUD by maintaining a state of negative emotion (like anger or sadness). Indeed, emotional patterns characterized by negative emotion may activate or maintain dysfunctional emotion regulation strategies in youth, as negative emotion and stress are well-known to increase drug use, craving, and relapse (Sinha & Li, 2007). Thus, disrupted parent–child interactions are associated with difficulties in affect regulation which in turn maintain SUD in the adolescent.

Consequences of emotional patterns between parents and adolescents on parental functioning. There is a bidirectional association between parenting and children's disruptive behaviors during adolescence. If young adolescents engage with deviant peers and behaviors, they pull away from closeness with their parents, and parental effectiveness and engagement declines (Coley, Votruba-Drzal, & Schindler, 2008). Excessively reactive parenting is then thought to develop partly in response to increases in children's challenging behaviors (Patterson & Fisher, 2002). Over time, adolescents' and parents' negative feelings toward

each other have a reciprocal relationship—the more negativity adolescents feel, the more it leads to negative feelings in their parents, and vice versa (Kim, Conger, Lorenz, & Elder, 2001). A long-term program of observational clinical research established the escalation hypothesis in Patterson's coercive family process model. Once an aversive interaction is produced in the parent–adolescent relationship, aversive reactions expressed from one party to the other tend to gradually intensify (Patterson, 1982; Patterson, DeBaryshe, & Ramsey, 1989). The escalation of negativity between both parties beyond a certain threshold can lead either to overt violence, to separation, or to both (Kim et al., 2001). It can also lead to harsh parenting and a breakdown in communication between the parents and the adolescent. On the contrary, positive emotions, especially those coming from parents, such as love or trust, have been linked to healthy development and to good quality parent–child relationships (Dix, 1991). Parents who express positive emotions are generally authoritative parents (warm yet firm), and parents who express negative emotions may be more authoritarian (cold and firm) in nature (Halberstadt, Crisp, & Eaton, 1999). In the field of addiction, several studies suggest a decreased risk of substance use among adolescents whose parents had an authoritative parenting style and an increased risk for adolescents whose parents had permissiveness/indulgence, neglectful/unengaged, or authoritarian parenting (Cablová, Pazderkovà, & Miovsky, 2014; Davids, Roman, & Leach, 2017). In fact, among other aspects, there is a "family-centered process" in the prediction of problem behavior (Willoughby & Hamza, 2011). A warm relationship between parents and their adolescent may facilitate voluntary disclosure, which in turn predicts fewer problem behaviors like SUD.

Negative Emotional Patterns Between Parents and Adolescents: Psychotherapeutic Consequences

Negative emotions are generally considered to be the primary focus of assessment in therapy. Some authors implicate these negative emotions as a "root cause" of client problems that represent a barrier to treatment and a predictor of therapy dropout and poor outcome (Diamond & Liddle, 1999; Doane, Hill, & Di-

amond, 1991; Sexton & Schuster, 2008). Process research has shown that if negative interactions among family members are allowed to escalate and at least some small change does not begin early on, deleterious disruptions to treatment occur (Heatherington, Friedlander, & Greenberg, 2005). Thus, a change in how emotions are handled individually and interpersonally can be viewed as a major goal of therapy (Greenberg, 2004). Successful work with emotion fosters self-efficacy, motivation, and functional individual and family processes that work together with cognitive and behavioral interventions (Rowe & Liddle, 2018).

Emotional reactions in the parent–adolescent relationship fuel hostility and resistance in the behavioral realm (Diamond & Liddle, 1999). Thus, parents will not be able to change educational behaviors or practices if their emotional involvement is low (Dix, 1991; Patterson & Chamberlain, 1994) and if they remain in a negative emotional stance toward their adolescent. Longitudinal studies have shown that when parents perceive their adolescents as becoming more negative over time, they also feel increasingly less effective about their parenting (Lipscomb et al., 2011), which increases the risk of disengagement from therapy. On the contrary, positive emotions are associated with positive treatment outcomes because they favor increased problem-solving abilities by making thought processes more flexible, creative, and efficient (Fredrickson, 2001). However, this does not mean that positive emotions are functional and negative emotions are dysfunctional. According to the seminal work of Greenberg (2004), it is the adaptative function of emotion that is essential, more than its positive or negative valence (Greenberg, 2004). For example, for ongoing participation in treatment, expressions of disappointment increase compliance with requests for help, whereas expressions of anger undermine compliance (Van Doorn, Van Kleef, & Van der Pligt, 2015).

In the context of family therapy with an adolescent presenting SUD, negative emotions, and more specifically anger, are predominant, play a critical role, and could be considered as a core element in clinical change. This is because anger breaks the communication and relational bond between the parents and the adolescent and can generate aggressiveness all around. On a related note, parenting practices and more

specifically negative parenting behaviors are as-
sociated with several adolescent symptoms, in-
cluding SUD. Substance use can ultimately be
understood as ineffective emotion regulation,
and negative emotional patterns between the
parents and the adolescent generate negative
emotions in each party which activate this mal-
adaptive behavior. Working on the emotional
climate is an indirect way of working on sub-
stance use. There is a therapeutic need to restore
or enhance positivity in parent–adolescent emo-
tional expression, and direct modification of the
emotional climate and expressivity between
parents and adolescent is therefore essential.
MDFT change mechanism studies have demon-
strated the malleability of these adverse intra-
family transactions (Diamond & Liddle, 1999;
Schmidt, Liddle, & Dakof, 1996). Hence, on
this basis and per the developmental psychopa-
thology literature, chronically negative parent–
adolescent exchanges represent a primary ther-
apeutic change target.

Next, using descriptions from a clinical case
study, we explain how emotions are targeted for
change in a comprehensive family-based ap-
proach.

Working With (Negative) Emotions in MDFT: Intervention Levels for Emotional Reconnection

Because of the adolescent's SUD and its fre-
quent correlates inside and outside of the family
(lies, robbery, etc.), one important characteristic
of these families' interactions is impairment in
communication. When the family enters the first
treatment session, tension is usually high in the
room and anger is omnipresent. Both implicitly
and explicitly, blame, criticism, and recrimina-
tion dominate the interactions: The parents are
angry at their teenager. Typically, the adoles-
cent either attacks his or her parents in return by
harshly defending himself/herself, or remains
mute, pretending to ignore the conversation
while boiling inside. Anger tends to override the
other emotions. There is a sense of being stuck
in a dead end or in quicksand. Here, anger can
be seen as a maladaptive emotional state that
blocks the process of change. In this context,
how can the therapist create a therapeutic pro-
cess? In this section, we describe a step by step
process to promote change. The therapist seeks
to facilitate a new dynamic that includes expe-

riential processing of each of the family mem-
bers' overwhelming experience of anger. Work
with the different units—the adolescent, the
parent, and the family—is divided into three
levels: (a) reconnection to core adaptive emo-
tions; (b) preparation of enactment; and (c) en-
actment and beginning the healing of attach-
ment injuries.

The case presented involves Gerard, 16 years
old, and his mother. Gerard has only met his
father twice in his life, when he was a small
child. The mother is a single parent who has
brought her son up alone. She works full time.
Gerard was referred to therapy for cannabis and
video game use. This segment illustrates the
highly combustible nature of negative emo-
tional exchanges between mother and son.[1]

Mom:	The way I understand Gerard's situation? The only thing he's interested in is doing what he wants, which means doing noth-ing! He spends every day doing nothing, smoking cannabis and playing video games, seeing his friends who also do nothing. Do you think that this is real life?
Gerard:	[Stays silent, looks up to the sky and sighs]
Mom:	And see (motioning to her son), I cannot say anything. It does not matter anyway, he just wants me to say nothing and accept everything without say-ing anything.
Gerard:	That's it. Leave me alone, you always say the same thing, you're boring. I do not want to talk to you and I do not even want to see you. I have nothing to do here [at the treatment cen-ter] and all this is useless.

It is clear from this extract that hostility and
blame are present on both sides. Although not
immediately apparent, these interaction patterns
typically include emotional disconnection and

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[1] The case material in all clinical exchanges has been
deidentified and changed to comply with the American
Psychological Association's code of ethics.

disengagement. Here, the mother is critical, harsh, and judgmental. She blames her son for his behavior and is angry and disappointed. Gerard rejects the conversation, declares to be bored, and shows annoyance. This common in-session deadlock, which can be hurtful both personally and interpersonally, is addressed with an intervention referred to as a "shift intervention" (Diamond & Liddle, 1996, 1999), a protocol used to resolve in-session negative family interaction stalemates. When effective, it moves the conversation from the parent blaming the adolescent to the adolescent disclosing feelings about attachment disruptions or failures. In MDFT, parenting relationship interventions are designed to reduce the emotional distance between the parents and the adolescent, to repair the attachment relationship, and to reduce excessive conflict and negative affect (Liddle, 1994). Decreasing the negative emotional charge can reconnect family members and create motivation and opportunities for family members to interact in new ways. Therapists must develop confidence and skill in this method. It helps when the parents realize how parenting practices and a family environment of continued connectedness and support contribute to decreased adolescent drug taking (Schmidt et al., 1996; Steinberg, Fletcher, & Darling, 1994).

Clinical dysfunction can be understood multidimensionally (Newcomb, 1992), and we have found it beneficial to conceive of treatment along similar lines. However, transaction-targeted change efforts are supported directly within the sessions with the young person and the parent. These direct attempts to shape relationships sometimes include out-of-session homework (Kazantzis et al., 2016)—an "activity the client carries out between sessions, selected together with the therapist, in order to aid progress toward therapy goals" (Kazantzis, Petrik, & Cummins, 2012, p.3). In out-of-session homework, family members are asked to reflect on session conversations and if possible, continue to discuss them between sessions. Interventions of this sort are complemented by individual work with the young person and parent, during which processing of previous discussions and planning for new ones can be helpful. The therapeutic objective of improving the parent–adolescent relationship takes time (MDFT lasts about 6 months but can take longer depending on the difficulties encountered by the family), can be difficult to achieve, and can require many interventions. Still, our outcome and therapy process results are encouraging, and these findings are related to the creation of positive therapeutic alliances with the parent and the young person (Hogue, Liddle, Dauber, & Samuolis, 2004; Jackson-Gilfort, Liddle, Tejeda, & Dakof, 2001; Robbins et al., 2006).

Encouraging an adolescent to disclose and share intimacy can be a difficult task. It becomes even harder when the adolescent is blamed for things by his parents and may feel undervalued, ashamed, guilty, unloved, and angry. Consequently, what psychotherapeutic action can be activated and promoted? Because therapeutic change cannot occur in this specific emotional atmosphere, the therapist needs to implement change by working with the family but also with each member separately. It is known that adolescents react negatively to therapist insincerity and pretense but respond well to authenticity (Bolton Oetzel & Scherer, 2003). Authenticity and empathy are undoubtedly the best qualities necessary to create and maintain value in the therapeutic bond but also in the parent–therapist relationship. Thus, therapist empathy and cultivation of trust are valued as contributions to the bond with the patients (Campbell & Simmonds, 2011). How can the therapist set the ideal contextual, personal, and interpersonal conditions to allow for this transition from blame to the disclosure of feelings about attachment disruptions or failures?

Assessment of the family interaction is a difficult task when the parent–adolescent conflict occurs in a dysfunctional way. Hostile interactions and symmetrical escalation do not allow the therapist to intervene in a constructive way. In these circumstances, most of the time, the therapist has to interrupt the session, invite the members of the family to agree that they strongly and vehemently disagree, and temporarily meet the family in subsystem settings. In families trapped in a parent–adolescent conflict (Benítez, Abascal, Garrido, & Escudero, 2019), it is first necessary to establish a feeling of safety in the therapeutic system, protect vulnerable members of the family, and build the multiple therapeutic alliances by facilitating emotional connection with each of the family members (Escudero & Friedlander, 2017).

When the family's emotional climate becomes milder, the therapist can help punctuate

the patterns of emotional interactions and their dysfunctional nature. The process of helping each family member to identify how he is coping with and what his emotional regulation strategies are in the family conflict (Duriez, 2017) helps them shed light on how the family as a whole is regulating different kind of emotions. We believe that this individual and collective endeavor has better outcomes when emotional processes are investigated more deeply in individual sessions. In MDFT, there is a constant interaction between individual sessions with the parent and adolescent alone and sessions with the parent(s) and adolescent together. Thus, individual sessions serve as a foundation for the work in joint sessions (even if they also function independently and have value in and of themselves).

Working With the Subsystems: Deconstructing the Anger and Gently Helping Vulnerability and Pain Emerge

Enactment is a clinical method and a minichange theory in MDFT (Liddle, 2005). Technically, enactment is first prepared individually with the members of the subsystems—adolescents and parents—and second is activated in the presence of the whole system (Bonnaire, Bastard, Couteron, Har, & Phan, 2014). Change is therefore pursued by working in the here and now.

In this section, we describe the family's emotional interaction processes, going into detail specifically regarding the deconstruction of anger, and gently helping vulnerability and pain emerge. We also describe how working with the subsystems favors this process of anger deconstruction and emergence of vulnerability, in parallel with the family sessions. To promptly interrupt the dead-end anger dynamic, the parents and the adolescent are seen separately to understand what lies behind the anger. Nevertheless, as suggested before, the emotional tone is also worked on in family sessions.

In individual sessions, the patient's emotions are discovered/constructed to reach individual vulnerability. Step by step, the therapist helps the adolescent progress from experiencing anger to becoming more familiar with his or her vulnerability, as pain slowly emerges. From a strategic point of view, this is a way to get around the dead-end explosive rise in the paren-

t–adolescent conflict. Anger is maladaptive and dysfunctional in this situation but also represents a defensive stance, an emotion hiding things that are below the surface. Once the adolescent is more in touch with his feelings, he becomes ready to encounter his parents. The parents and the adolescent must connect to their vulnerable selves in order for them to speak more sincerely. Focusing on and using emotions is one way of working on the underlying process (Liddle, 1994) and identifying the core conflict in the family.

Furthermore, a successful shift intervention is based on the therapist's ability to evoke softer, more vulnerable or empathic feeling states (Diamond & Liddle, 1996; Liddle, 1994). By changing the way parents are communicating, the therapist's interpersonal objective is to develop or enhance empathy between the parents and their adolescent. The MDFT therapist favors a process within the adolescent and within the parent, and then within the family together (Liddle & Rigter, 2013). Several treatment steps are necessary to reach deeper emotions. The MDFT therapist needs to work through each level of the emotion to activate the more adaptive one (see Figure 1). The therapist must draw the attention of the subsystem to the background or subdominant emotions, which are frequently present in the room nonverbally, in the tone of voice or manner of expression (Greenberg, 2004).

Working with parents: Reconnection to the parent's self. With the parents, the therapist aims to enhance feelings of parental love and emotional connection, underline parents' past efforts, acknowledge difficult past and present circumstances, and generate hope (Liddle, 2016b), while alleviating family burden. Parents can improve parenting if they better understand the adolescent's experience and feelings. This will increase their emotional and behavioral investment in their adolescent. Specifically, the main goal with parents is to temper the parents and transform the anger toward their adolescent ("T" denotes the therapist).

> Mom: As usual, there is a big conflict about his internship. When I started talking to him about searching for an internship, he became haughty, disrespectful. He started to bend his chest, in a
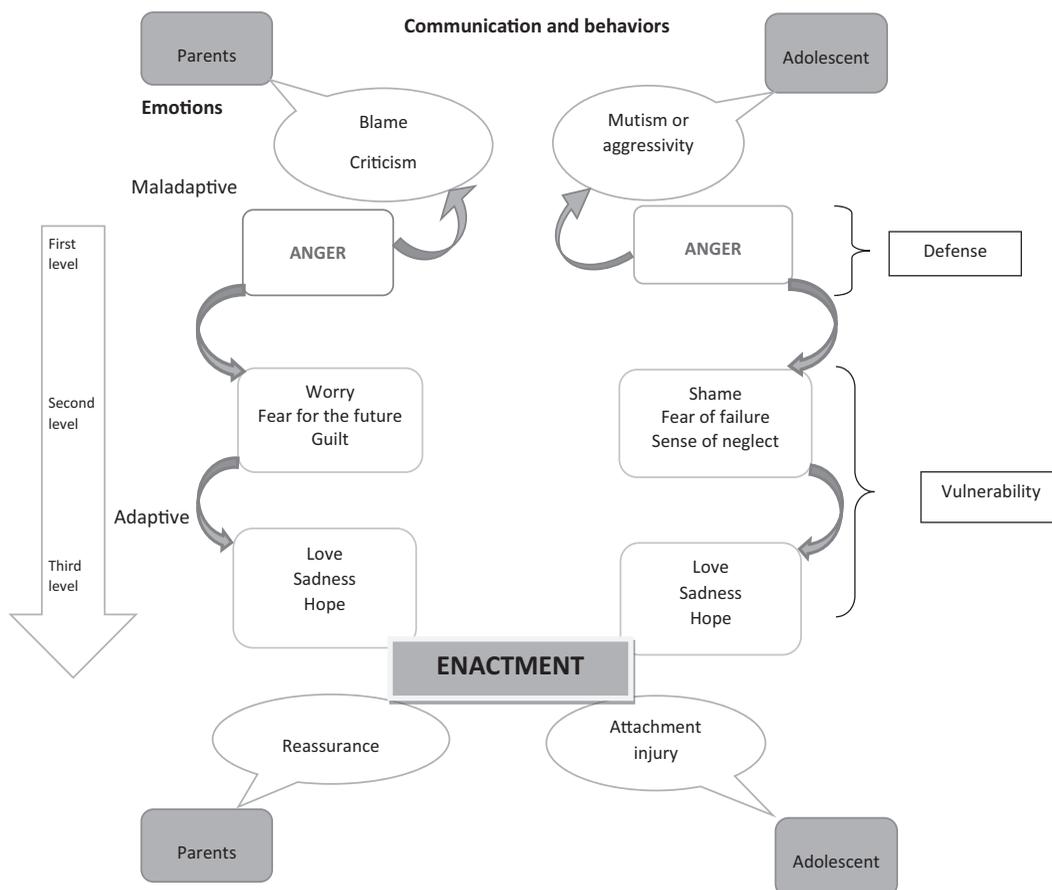
Figure 1. Emotional processing of anger: Treatment levels for exploring and transforming parent–adolescent dysfunctional interactions.

very aggressive way (. . .). He is going nowhere.

T: It is so difficult to see him doing nothing, it is so annoying.

Mom: Of course it is difficult, how can I handle it?

T: It's as if it's unbearable to see him doing nothing and ruining his life. You did so much for him during all these years, trying to help him, all alone.

The therapist assists and guides the mother by understanding the family history and the parents' psychological functioning. The therapist's empathic validation of past and current suffer-

ing provides the parent with a sense of being understood. This promotes a sense of safety, and gradually the client can move from one emotion to another more adaptive one (Elliott, Bohart, Watson, & Greenberg, 2011). The therapist uses attuned responses that try to communicate understanding of the parent's message (Elliott et al., 2011). Through empathic validation and exploration of what the parents went through, the therapist reaches and connects with the parent's self, which can then allow a potential engagement–reengagement with their child. In our example, this method accesses certain emotions, first fear for the future and then commitment and love.

Mom: We get nothing for nothing, life is not easy you know. If he has

no internship, he has no training, so, nothing.

T: Uh-huh . . . and there is this prospect of another year lost and it is so tough because . . .?

Mom: (beginning to cry) But I do not care. I do not care. I cannot stand it anymore. I think it has exceeded all limits. I am fed up. (. . .)

T: Yes, it is too difficult, it is so difficult. And it's as if you want to finally feel sure, relieved about his future. Is that right?

Mom: I am terribly afraid that he will not construct his life. I cannot stand that it's a mess . . . The only thing that matters to me is for him to be on the right track and be safe. That way, if something happens to me, I know he will have built something and he will be safe at that level.

T: It is so important for you to be serene that everything will be all right for him, that you, as a mom, did the right thing for him to do well in his life . . . And maybe he is not aware of these feelings, he is just feeling like a bad teenager who does nothing and like someone who never does anything good. Since he is so convinced of that, he does nothing. It is as if he is saying to himself "I am a failure, okay, so why would I bother doing things."

By following the path of the mother's internal experience step by step (Elliott et al., 2011), the therapist guides her through her anger. When the mother begins to feel kindness and love for her son, she is renewing the attachment relationship and the possibility of mentalizing her child's mind (Bateman & Fonagy, 2006). She can better imagine what it feels like for him to be mad at her and where that emotion comes from. By meeting her son's mind, she can feel reciprocity. She can imagine how the problems that arise may express the child's internal mind (Sorensen, 2005) and create new meaning. Us-

ing emotions as a barometer of functioning and as a roadmap to negotiate important issues, the MDFT therapist reframes situations, messages, and people (Liddle, 1994).

The process of changing from one emotion to another one (in this case example, anger against Gerard becomes fear for him) favors the reconnection of the mother to her son and allows the therapist to help the mother change her perception of the current situation (Rowe & Liddle, 2018): Gerard is not a "lazybones," he is suffering and in difficulty. At that point, the therapist and the mother can explore the underlying reasons for her fear for him beyond the current situation. Here, the mother says: "If I die, then he has nothing . . . and I know what it's like to have nothing." By exploring her thoughts and their associated emotions, the therapist helps the mother explore the history of her relationship with her attachment figures. MDFT is mostly a present-centered therapy and deals with daily issues. However, in this clinical case, there is a necessity to explore past attachment issues. As described by Boszormenyi-Nagy and Spark (1973), the transgenerational model refers to recurring transactions with the family of origins (in this case, a nonfostering and very absent mother with whom she is no longer in touch). The dialectical back and forth movement between current and past relationships—the mother's own history of attachment injury and her relationship with Gerard—has three important effects. First, it brings awareness of the influence and resonance of her own history on the relationship with her son and on her parental practices. Second, activating her own unresolved attachment needs brings better understanding of her son's feelings (Gerard was born of rape and does not really know his father). Finally, it helps prepare the mother to hear what her son has to say. Our concern here, in the parent–adolescent dyadic relationship, is the fragile restoration of trustworthiness (Boszormenyi-Nagy & Krasner, 1986) to allow dialogue. Reinforcing a mutual feeling of trust helps the dyadic relationship pull away from ambivalence.

Working with the adolescent: Active guidance to emotional awareness and verbalization. Because of the strong relationship between emotion regulation and SUD, one of the main therapeutic goals with young patients is to work on emotion, the interoception of emotion

(Critchley & Garfinkel, 2017), emotion awareness, and emotion regulation strategies. Given the continuous interplay and reciprocal influences between behavior, cognition, and emotion, the therapist focuses on this complex process and uses relevant techniques within and outside of sessions. For example, a "consumption log" can be used with the patient and contributes to a functional analysis (Dattilio & Epstein, 2005). In the consumption log, the patient is asked to note down each time a substance is used and think about their cognitions and emotions associated to it, to enhance awareness of the interplay or reciprocal dynamic between thoughts, emotions, and behaviors (here, substance use).

Family sessions provide material to work with in individual sessions during which it is easier to go over what has been said together and help the patient to become aware of the internal processes implicated in their interpersonal interactions. For example, the therapist can explore clinically relevant cognitions by asking Gerard "What went through your mind when you said to your mother 'Leave me alone, you always say the same thing, you're boring'?". Indeed, emotion signals cognition, and usually this provides relevant cognition (often automatic thoughts) to target for change (Tompkins, 2019). The downward-arrow technique could be used to explore underlying emotions and cognitions (Dattilio, 2010; Tompkins, 2019). The use of Socratic questioning (Beck & Dozois, 2011) can also help the adolescent internalize the process of self-questioning, which enhances cognitive change (alternative thoughts and new meanings; Okamoto, Dattilio, Dobson, & Kazantzis, 2019).

In previous sessions, we looked for an event (an attachment injury; Johnson [1996]) that may have created a relationship trauma or major conflict and impaired the bond between the parents and the adolescent. Indeed, for adolescents with poorer pretreatment attachment histories, research suggests the potential value of giving additional focus to alliance building, maintenance, and repair (Zack et al., 2015). The therapist attempts to help the adolescent clarify and express these issues, and then to prepare to discuss them with his parents in a new way—a more competent and more readily receivable way (Rowe & Liddle, 2018). The MDFT therapist focuses on the adolescent's concerns to reduce the adolescent's negativity, promote his engagement in treatment, and increase the possibility of a more meaningful conversation with the parent(s; Diamond & Liddle, 1999; Liddle & Diamond, 1991).

G: There was a big fight last night and this morning with my mother.

T: What happened?

G: It's about registration for my school for next year. My mom asked me to do stuff and I did it. She asked me to do my resume so I did it. (. . .) The next day, she comes home from work and she yells at me. And why? Because apparently I did not do what I had to do.

T: And what did you have to do?

G: Well nothing, she did not tell me to do anything. She made the registration file on her side and then she yelled at me because she did it and not me. And then there was the fight.

T: Uh-huh . . . and you, how did you take what she told you?

G: Me? I do not understand and I do not give a shit. I told her, you can yell, I do not care.

T: As if it was so unbearable to hear her shout and not be able to speak to her and to understand what's was going on . . .

G: Yes . . . but . . . and you know I think that it is a good thing that I have bought barbells because . . .

T: (stopping him) G I think it is important to stay on this subject because I think it is very important for you.(. . .)

G: It happens so often that now, I do not care anymore.

In this segment, the therapist did not allow the adolescent to drift from one topic to another. The therapist refocuses attention on emotionally relevant topics when Gerard tries to change the subject (Dattilio, 2010). A more directive stance

was taken. The therapist slows down the process because the adolescent speaks very quickly. The therapist tries to connect the adolescent to what he is feeling about the situation. By doing so, the therapist helps the adolescent stay focused on what is important. The adolescent is contained, to decrease avoidance. Anger, like substance use, keeps the adolescent away from his primary emotions and thus, away from his important needs. The main goal in working with emotion is to foster emotional awareness and help the patient to become aware of his primary emotion (i.e., his primary adaptive emotion; Greenberg & Pascual-Leone, 2006). The processing of these emotions in a secure therapeutic environment leads the adolescent to experience them as less dangerous and more acceptable than he previously imagined (Narkiss-Guez, Zichor, Guez, & Diamond, 2015).

Once the recognition and symbolization of emotions is put into words, the therapist helps the youth reflect on his emotional experience in order for him to be able to make narrative sense of his experience and promote its assimilation into his ongoing self-narrative (Greenberg, 2019). Reflection "creates new meaning and new narratives to explain experience" (Greenberg, 2019, p. 128). Indeed, language contributes to organize, structure, and assimilate the individual's emotional experiences and the events that may have generated the emotions (Pennebaker, 1995).

T: What do you feel when she yells at you?

G: I do not listen to her, I do not listen, I think of something else. And sometimes she says something important but I do not listen and after she yells at me louder because I didn't listen. But for me it is just someone who is yelling at me so I do not give a shit about what the person is saying. But I do not care [shakes his hands and seems disappointed].

T: It sounds as if it is so difficult, so unbearable that you need to switch off. Is that right?

G: Mmm.

T: And what do you need from her at this time?

G: To not scream anymore, it's simple. If she wants to bitch about me, no problem but she needs to talk to me, not yell at me.

T: What you really need from her is for her to talk to you.

G: Yes, because when she yells, I yell in return. Either I yell either I switch off.

T: It is like it hurts you so much, it touches you so much that you cannot stand it.

G: I cannot stand it anymore because it reminds me of when I was placed in a shelter.

T: Right. Anger is associated with going to the shelter.

G: Of course, because it is my fault if I was placed in a shelter. At that time, I was angry all the time, I was aggressive all the time and it is my fault if I was placed in a shelter. (. . .)

G: Many times when my mother yells at me . . . I always think that either she did not love me because I was not desired, she did not want me [G was born of a rape] and this is why she was yelling at me, either it is as if she feels resentment toward me.

T: [First person talking, as the adolescent's self] I always feel like she didn't love me.

G: Always . . . But it is the past and it is not important, it is old stuff.

T: Does she know about this? Because it is so important . . .

In this segment, the therapist explored the "cognitive–affective sequences" that generate unhealthy emotions or bad feelings (Pascual-Leone & Greenberg, 2007). The therapist explores (via empathic exploration) and activates/reactivates old emotional wounds (core

emotion) individually with the adolescent. Indeed, in this case anger is an example of a secondary emotion, also called a nonproductive emotion. Through the process of changing emotions (Greenberg, 2015), the maladaptive emotional state (anger) is transformed by activating more adaptive emotional states (guilt and feeling unloved). Exploring what "yelling" means for Gerard, in other words, is a way of exploring the cognitions associated with this emotion but also of exploring the other emotions activated when his mother is yelling at him. For the adolescent, guilt and feeling unloved represent painful ways of perceiving and experiencing himself. In MDFT, emotional reorganization, defined as creating a healthy emotional alternative in the face of dysfunctional feeling and belief (Greenberg & Paivio, 1997), is not worked through with the patient. The MDFT therapist encourages the adolescent to enact it in vivo, which involves talking to his parent(s) about these painful feelings in therapy.

Enactment or the Experiential In-Family Session: From Level 1 to Level 3

In this therapy, the first endeavor is for the adolescent and their parent to successfully transform their state of mind from anger to a more positive subjective emotion (Fredrickson, 2001). The parents and adolescent need to shift from a behavioral or problem-solving focus to an attachment focus (based on the epigenetic model of relationship development; Wynne, 1984). The transformation of their emotional personal process can be reached through individual and family sessions. These preparation sessions include (a) a personal immersion in the emotional domain and (b) a rehearsal of the enactment session that will come subsequently. In MDFT, change is synergetic and determined by multiple factors. It is a result of several ways of working within and outside of the therapy sessions. Individual sessions represent one component among multiple pathways of change (using emotion awareness, emotion regulation, cognitive restructuring). In this paragraph, we will focus on one aspect and mechanism of change in a family session.

The therapist's stance is active during this preparation and then acts almost like an orchestra conductor in the enactment sessions. The therapist guides and aims to enhance the relationships during the parent–adolescent session. The aim of the parent–adolescent interaction module is to modify the in-session patterns of family interaction through enactment. This entails helping the family members to discuss and solve problems in new ways (Liddle, 2016b). To have constructive discussions—both problem-solving and relationship healing—the parents and the adolescent must be able to experience discussions about daily issues without excessive blame, defensiveness, or recrimination (Liddle, 2016b). Problem-solving aspects of their day-to-day lives, school, curfew, and so forth, are essential. Nevertheless, negotiations concerning these important topics cannot be undertaken without changing the negative emotional climate between the parents and the adolescent. This means that an atmosphere of love and commitment must be reestablished. This long and difficult therapeutic process will produce motivation to negotiate and discuss issues reasonably, even after very conflictual and hurtful events have occurred (Rowe & Liddle, 2018). More importantly, this will allow the adolescent to express his or her attachment injuries and in return, with the therapist's help, this will enable the parents to meet the attachment needs of their child. Resolving parent–adolescent stalemates involve transforming the nature and the tone of the conversation in sessions (Liddle, 2016a). A successful enactment relies upon the work carried out previously with the subsystems. The therapist guides the parents and the adolescent together through the different levels of the emotional process. Enactment being experiential, the parent and the adolescent have to go through each level of the emotional process (see Figure 1). Patients have to feel the emotion and experience the consequences in the "here and now" parent–adolescent interaction.

The excerpts that follow demonstrate three steps in the psychotherapeutic intervention concerning Gerard and his mother. Each step will be described after each excerpt. The transcription of this family interview corresponds to a session occurring after more than 6 months of therapy.

> Mom: You stole some cigarettes again in my bedroom and for you there is no problem!! I am fed up. You are constantly stealing from my home, money from my wallet,

cigarettes from my bag, that plus that, plus that . . . I pay for all of it.

G: (trying to speak but mom is yelling).

Mom: And then, you would also have me pay for the holidays. At some point, I cannot do everything, that's what I told you last week.

G: I told you that it was a mistake to pay for the holidays for us. You said that we were punished, why do not you keep your word.

T: We need to stop now because we can find many examples of all that. If I let you talk together like this, I know that there will be many examples [pause]. But, it is this tone of anger and reproach that dominates all the time [therapist speaks more slowly to slow down the process]. All the time. It is so difficult to talk through all this anger. Why it is so difficult?

[Silence from Mom and Adolescent]

T: What makes discussions so tense? [pause] In addition, you blame each other in the same way. Everyone blames the other for feeling nothing about the other. You, G, you say that she doesn't care about you, and you, Mom, you say that he doesn't care about you.

G: Once, we quarreled. And at the end of the argument, she said, no worries, now it will be every man for himself. She's not interested in us anymore, she is only interested in herself. I said okay.

T: And how do you feel about that? Are you okay with that?

G: No I am not. But I will not talk about that anymore.

T: But how do you feel about that?

G: I am disappointed.

T: You feel disappointed. Is it like it hurts?

G: I can understand that she is fed up. But saying that, everyone for himself, no. We all need to make efforts and that's it.

T: And what would these efforts be?

G: To talk to each other.

T: Right.

First level.   At first, the therapist listens to a short, dysfunctional interaction between the parent and the adolescent. The therapist lets the anger express itself in the parent–adolescent interaction. Thereafter, the therapist halts the discussion and underlines what has been happening in the interaction (blaming, yelling). He slows down the process and highlights the mirror interactions. The therapist briefly reminds everyone about the interpersonal work carried out in individual sessions, so that everyone begins to connect to the emotions that were activated in previous individual sessions. This process stops the anger (dysfunctional interaction) and activates the second level of emotion (fear). The idea is to help the parent and the adolescent each connect with their internal vulnerability.

T: There are so many things in each of you, so many things underneath that remain unsaid. If all these things are not put into the open and discussed, I think it will be difficult to change this anger and change anything. The anger is present all the time. The anger guides your discussions all the time and jeopardizes your discussions.

[Silence from both G. and mom, both looking at each other]

T: [sighs and then speaks slowly] You do a lot of things that move you away from each other. Currently, in things you both say, you suffer from an alleged indifference for one another. There is this fear of being far from each

other, of losing one other. But at the same time, in everyday life, the way you talk to each other, the way you behave with each other, just keeps you away from each other, even if that's the thing you dread the most.

Mom: In life, there are priorities. In his life there should be priorities. There are things that I cannot listen to until these priorities are made.

T: Okay but maybe these priorities are not made because there are other blockages.

Mom: Ok. What?

T: It's not for me to say.

Mom: I'm talking about your priorities. No, of those I have for you. Because they are not your priorities and this is a problem relating to your placement/internship. Yes, I consider that your training next year is your priority. (. . .)

T: Why it is so important for you?

Mom: My biggest fear is . . . for the past three years, he has started the year but not finished it. And we are almost at the end of the year.

T: I feel panicked that . . .

Mom: The start of the school year will come and nothing will happen for him? That would not be possible.

T: And tell him what you are panicked about. Which is precisely why this topic is a topic of enormous tension. Could you tell him what you are panicked about?

Mom: No training, nothing to do. It's been three months that he has been at home doing nothing [Starting to get tears in her eyes].

T: I'm so scared that you're not doing anything . . .

Mom: Yes, it is not possible.

T: There you are, you go back to anger. But what is behind the anger?

Mom: He does not take charge of his own life.

T: And why do you want him to take charge?

Mom: I want him to build a future, to build his life.

T: Why is it so important to you that he builds his life?

Mom: That he has a job, that he earns his own money. And there, we go back to the same thing; if I disappear tomorrow, what will he do?

T: Tell him. My fear is that if I die tomorrow . . .

Mom: (crying) You have nothing in your hands.

T: And what do you feel when you say that?

Mom: It scares me [crying].

T: It scares me. And it feels like it's killing me.

Mom: He must do something. It's urgent. He has already been held back a grade, he . . .

T: It's dramatic for me G, to imagine you with nothing next year. It hurts me so much. If something happens to me, this idea is unbearable to me. [to the mother] Tell him.

Mom: We already said that.

T: Never mind, tell him here.

Mom: I'm trying to put things in place so that, in fact, the day I disappear (starts crying again), you have something. I have money at the bank but it will not be enough if you do not start your life. If

you have no training, no job, you
will be lost.

T: And what do you feel?

Mom: It's so painful. I do not want you
        to find yourself without anything,
        to find yourself lost because you
        no longer have your mother. You
        know, it is possible.

G: No . . .

Mom: Yes it is possible, you know it.
        You have to build your own life.
        You need to wake up. I am all
        alone.

T: [Talking from the mother's point
        of view] And I would like to feel
        relief about your future. I would
        like to be serene for you, feel that
        you are on the pathway of inde-
        pendence. Right?

Mom: Yes.

Second level. During this second part of
the session, the therapist helps the mother tran-
sit from the expression of anger to the expres-
sion of her worry and her fear for the future and
helps her talk to her son in the first person with
that emotion. The therapist actively guides,
coaches, and shapes increasingly positive and
constructive family interactions (Liddle,
2016b). The therapist orients the session toward
the underlying preoccupations, worries, and
feelings. The therapist encourages the parent to
reflect upon their fear in the presence of their
child, therefore softening their attitude.

In the next extract, the mother's tone is more
emotional. She is in a more vulnerable place
and therefore in a more productive place. Our
aim is not simply to reframe or reinterpret the
conflict. Rather, our objective is to create a new
in-session content/affect focus that can circum-
vent stagnant, unproductive dialogue (Diamond
& Liddle, 1999). Indeed, the use of in-session
affective and cognitive shifts in one family
member produces a shift in the other family
member.

T: G, when your mother says that,
        that something could happen to
        her, what is happening with you?

You are shaking your head, what
does that mean?

G: What I understand is that she
        wants me to be independent, so
        that she can take care of some-
        thing else.

T: Woaw . . .

Mom: [very surprised] Take care of
        what?

T: Could you be more clear and ex-
        plain to your mother how you
        received what she just told you?

G: [shrugs his shoulders but says
        nothing]

T: Is it almost like she is saying,
        you want to get rid of me? Is that
        right?

G: [stiff on his chair]

T: As if I wanted the "G subject" to
        be closed and that's fine. I did
        my job and then I can move on.

G: I think that she is waiting for me
        to be independent, to take charge
        of my life and thus have less
        worries. That's what I feel.
        Maybe I'm wrong but it's not a
        big deal.

T: Yes it is a big deal. Because if
        you see things like that, if you
        feel that way, I do not think it
        helps you move forward.

Mom: Suddenly, I understand your re-
        sistance much better. But G, it's
        just to take a breath, to be less
        worried about you.

T: What is going on, G? It looks
        like you are sad.

G: [tears are rolling down his face]

T: What is going on for you? You
        are sad. What is making you sad
        like that? What is hurting you
        like that?

G: [wipes his tears on his shirt]

T: I know it's difficult. But what do the tears say, G.? I think they have been there for a long time, and that they are very important.

G: [crying] I do not know.

T: I feel like you want to get rid of me. I'm your weight, your burden. You want to get rid of your load and then you will be relieved. Is that what you feel about what your mother said?

G: I always think that.

T: I always think that I am your burden, that I am in the way.

G: [crying again]

T: I have always felt like I am the one you did not choose. Is that what the tears say?

G: Yes.

T: Tell her G.

G: This is what I see. Three quarters of the problems you have are because of me.

T: [To the mother] What do you feel when you hear G saying that?

Mom: The only time I could call him my weight is when he does bullshit but it has nothing to do with that.

T: [pointing at G] talk to him, tell him those things.

Mom: Things do not happen all at once Gerard. Adolescence is a difficult time. It's a time when you make your choices, you make your decisions, which are not always the same as mine (. . .) But, your existence Gerard, your existence I chose. I wanted you. You are my child. [Mom begins to cry]. And that will never be challenged. I never questioned it. The adolescence period is not easy but apart from that, I love you. It's not

because you are doing bullshit and I'm angry about something, sometimes about several things, that it changes how I feel about you and my love for you. Sometimes I may have expectations that are a bit too high. Maybe you do not feel capable when I ask you. But it is not because you are a weight. You are not my weight (. . .). I will always love you. I am very proud of you. I am proud of who you are. Of course I did not have a calm child. So much the better!

T: And about getting rid of him?

Mom: It will happen, it will happen that you will leave the house one day, and I think that I will be the most depressed about it. But I wish for you that you leave the house one day, it's for your personal construction. I just wish sometimes that it would take you less time. But you are a golden boy. You are very sensitive, you have a great awareness of things. You are a great guy. (. . .)

T: How does it feel G to hear that from your mom?

G: It feels good.

Third level. During this third part of the session, the mother talks to her son with a more adaptive emotion (fear for his future). This creates an emotional shift in the adolescent. Gerard attunes himself to this and begins to talk from a more adaptive level of emotions as well (see Figure 1, Levels 2 and 3). The mother's shift of emotional tone allows the adolescent to change his attitude and express himself differently. That is what gives access to the adolescent's inner world. Thus, the adolescent experiences and expresses his suffering, his old wounds, and his specific attachment failure. The adolescent softens and can talk from a vulnerable stance. The therapist guides the (re)activation and expression of more vulnerable emotional states such as sadness, feeling rejected, and unloved. Just as in experiential therapies (Greenberg,

2004), the therapist perceives, identifies, names, and amplifies patients' emotions during the session. Thus, discussion becomes an experiential moment (Diamond & Liddle, 1999) and allows parents' expression of love and pride toward their child (Level 3).

When core conflicts are identified, when family members talk to each other with more adaptive emotions, the shift gives parents a new perspective and experience of their adolescent. This helps revive parents' empathy toward their child, empathy for the difficult experiences of their adolescent, for their suffering, and encourages adolescents to identify and express a wider range of emotions and concerns (Diamond & Liddle, 1999; Liddle, 2016a). From this position, the parent become more respectful and receptive to their adolescent's own experiences, feelings (suffering), and memories (Gerard is the result of a rape, does not know his father, and thinks that his mother did not desire his birth). This in-session shift of attention and emotion makes new conversations possible between the parent and the adolescent. The parent is able to support and reassure the adolescent (e.g., "But, your existence Gerard, your existence I chose. I wanted you. You are my child. And that will never be challenged. I never questioned it"), creating a new system of meanings that favors different feelings, thinking, and actions on the part of both mother and adolescent (Weingarten, 2003). Indeed, emotions are essential to effective parenting. The parent can then respond to their child's attachment needs. When invested in the interests of children, emotions elicit sensitive, responsive parenting (Dix, 1991).

From there on, the therapist can become less directive in the session. The process moves from a very directed sequence to a more open-ended exploration, once the resolution of the impasse (not necessarily the problem) has been achieved (Diamond & Liddle, 1999). The therapist becomes less content-directive and focuses more on coaching the emotional process. It is now important for Gerard to be able to tell his mother what he expressed in the individual session, namely, that he thinks his mother wants to get rid of him because she did not choose to become pregnant, did not desire his birth, and regrets his coming into the world. He thinks that he represents a weight for her.

Positive emotions are important as a representation of an "outcome" of a specific therapeutic change mechanism or as a means of accomplishing other therapeutic processes (Sexton & Schuster, 2008). Indeed, this therapeutic change (transforming negative emotional patterns of interaction) is necessary but not sufficient in the therapy. From now, the parent and adolescent are able to discuss and solve everyday life issues without blaming each other and can begin to find new ways of problem-solving (i.e., Stage 2 of the therapy: request for change). Working on emotions provides a way of acquiring new strategies of emotion regulation and thus has an indirect impact on the consumption of substance (which has this function of emotion regulation). Furthermore, in the family session, the mother was able to respond to Gerard's attachment needs and reassure him. However, this is not enough to change some of Gerard's psychological processes. Individual work must be a continuation of family work and work in parallel with it. Family work does not replace and does not exclude individual work, which remains essential.

Conclusion

Overwhelming anger as part of the parent–adolescent conflict is a dominant characteristic of early-stage conversations of most families with adolescents presenting addictive disorders. Negative emotions, especially anger, have a deleterious effect on different domains of the adolescent's self, parents, family, extrafamilial relationships, and the environment. They contribute to the maintenance of substance use. Furthermore, anger is a primary barrier to change and creates therapeutic stalemates. In MDFT, the therapist facilitates change in the parent–adolescent relationship directly through enactment. As a technique, enactment gives an ecological picture of existing family relationships and shapes new kinds of family interactions (Liddle, 1995). Thus, in the first stage of MDFT, the therapist works on family members' emotional reconnection. Parenting interventions in MDFT are designed to reduce the emotional distance between the parents and the adolescent and reduce excessive conflict and negative affect. Anger needs to be transformed into a more adaptive/primary emotion. This interactional

change allows passage to Stage 2 of the therapy to work on parental practices and the SUD.

This article describes and illustrates one pathway of MDFT's work with the adolescent's and parents' emotions, and patterned, chronic emotional exchanges as a critical target of change. Through this clinical case, we demonstrated intrapersonal and interpersonal aspects of the putative change process through the deep exploration and deconstruction of anger. Highlighting the model's multidimensional philosophy and method, we described how the clinician's work with different subsystems (the adolescent and parent separately) complements the family sessions where the parent–adolescent interaction is shaped, gently but quite directly.

Anger is seen as a secondary or maladaptive emotion (Greenberg & Safran, 1989) that has detrimental consequences on communication and behavior. Beyond anger, more vulnerable and unacknowledged emotions can be found. Relationship-related feelings of fear and sadness become easily assessible, and perhaps paradoxically, are used as personal and interpersonal motivators for change. By going through these emotions, the parents and the adolescent are more tempered and can exchange on a more adaptive level. Themes related to acceptance and forgiveness find their way into a treatment that uses emotion in the ways we have discussed. In the presented clinical case, one of the main goals was to alter the mother's critical and aggressive stance and encourage a more vulnerable, and inquisitive stance toward her own and her son's behavior. The mother's emotional relaxation promoted an expanded expression on the adolescent's part. The work broached the sensitive area of perceived attachment slights and evoked mother's reassurance and expression of unconditional love. According to contemporary evidence-supported approaches including MDFT (Sexton & Schuster, 2008), emotions and the increase in the capacity to experience and express positive emotions (Fredrickson, 2001) are crucial elements in successful therapeutic change.

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