The Anatomy of Emotions in Family Therapy With Adolescents

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*Emotions in adolescence can be considered from a variety of viewpoints. Although it is
not uncommon to address this topic within nonclinical and clinical populations, exam-
ination of emotions in adolescence from a treatment or intervention perspective is more
unusual. This article discusses the emotions in adolescence literature from the vantage
point of a particular, empirically-tested family-based intervention model, multidimen-
sional family therapy. Addressing the contemporary challenge to specify how research
can influence practice, the article shows how research-based concepts guide formulation
of therapeutic strategy, as well as a therapist's in-session behavior. Transcripts with
commentary from a family therapy session focus on a core emotion-related problem with
clinical and many nonclinical adolescents and their parents—chronic, stable, quick-to-
escalate negative emotional exchanges between an adolescent and parent.*

As a fundamental core content area in the social sciences, emotion has mul-
tiple constituencies. Researchers understand the important role emotions play in
the development and everyday functioning of adolescents (Csikszentmihalyi
& Larson, 1984; Larson, 1989). Theory builders consider emotion a core
element in models of interpersonal relations (Kelley, 1984, p. 92) and
personality development across the life span (Izard, 1977; Malatesta, 1988).
Clinicians recognize how emotion is a primary communication system pro-
viding "action disposition information" (Safran & Greenberg, 1991, p. 7). As
an organizer of perceptions, actions, and personality, it is a guide to and target
of change in treatment (Sroufe, 1983).

This article works in two realms:

Perspective on the role of emotions in a particular kind of clinical work.
With its wariness of reductionism, the modern era urges us to consider

phenomena from a variety of perspectives. In the world of research, for
instance, new methodologies have been offered to complement traditional
inquiry methods (Liddle, 1992b; Hoshmand & Polkinghorne, 1992). Emo-
tion is a complex topic studied and discussed in a variety of ways. Therapy
contexts provide a unique perspective on emotions as aspects of develop-
mental processes (Bearison & Zimiles, 1986; Santostefano, 1986). Various
scholars have discussed why dysfunction can illuminate normal functioning
(Belsky & Vondra, 1989; Cicchetti, 1989; Kazdin, 1993). For Belsky and
Vondra (1989) "In the routine ebb and flow of life it is often difficult to
discern normal processes. Any dysfunction, by creating a perturbation in this
flow, reveals elements and/or relationships that might otherwise go unno-
ticed" (Belsky & Vondra, 1989, p. 192). Whereas the domain of developmen-
tal psychopathology endorses this perspective (Cicchetti, 1984; Sroufe &
Rutter, 1984), a context rich with information about development has re-
mained untapped. Treatment activities per se have not yet been included as
an arena within which to examine developmental processes of adolescence.
This article attempts to develop this uncharted territory. It discusses emotions
and interactional emotional processes from a clinical and family-based
treatment perspective. Formulations offered from this viewpoint might be
useful in theory construction and research with adolescents not evidencing
problem behaviors.

Research informs clinical interventions. Research and clinical practice
have not had the happiest of relationships. Studies show the lack of research
use in most clinicians' practices (Morrow-Bradley & Elliott, 1986). As part
of a new wave of discussion on this important topic (Forsyth & Strong, 1986;
Liddle, 1991a) and in accord with the premise, "The findings from basic
research provide the underpinnings for informed interventions" (Kazdin,
1993, p. 138), this shows how the emotion-in-adolescence literature guides
interventions within a treatment model for adolescent substance abuse and
behavior problems (Liddle, Schmidt, & Ettinger, in press).

EMOTIONS: THE CONTEMPORARY PERSPECTIVE

The study of emotions has blossomed in recent years. Several illustrations
of this specialty's robust condition could be invoked. These include: (a)
articulation of the complex nature of emotions over the life course (Campos,
Campos, & Barrett, 1989; Ford 1982); (b) cultural variations or similarities
of emotions (Mesquita & Frijda, 1992); (c) specification of developmental
processes and sequences in the emergence of emotions (Fischer, Shaver, &

Carnochan, 1989); (d) the fundamental role of emotions in psychotherapy (Greenberg and Safran, 1987); and (e) controversies concerning the interdependence (Fiske, 1982; Mahoney, 1984; Shantz, 1983) and temporal ordering of emotion and cognition (Lazarus, 1984; Zajonc, 1984). Given these developments, broad literature has emerged having significant clinical potential. As with much of the research literature, however, prototypes that will show how knowledge can be used in the clinical domain are rare.[1] More effort is needed in this area (Liddle, 1991a).

Emotion theories are increasingly comprehensive and they tend to emphasize person-environment transactions (Shaver, Schwartz, Kirson, & O'Connor, 1987). Previously neglected factors now have important roles in the generation of emotions. Consider the regulatory function of emotions in relationships. For Campos et al. (1989) "the emotional signals of another guide action and can generate a similar emotional state in the perceiver" (Campos et al., 1989, p. 396). In parent-adolescent relationships, in a life cycle period in which control issues often prevail (Smetana, Yau, & Hanson, 1991), emotions can be understood as behavioral influence strategies. Ideas about interpersonal influence have a long history in some clinical fields. For instance, they have been cornerstones of family therapy's conceptual foundation since its inception (Haley, 1963).

Emotional expression of one person can be contagious and transfer to another (Haviland & Lewica, 1987). In positive relationship sequences, this transfer effect may not lead to any difficulties, and it is probably experienced as satisfying. However, in clinical families the converse situation is more common. Negative emotion, particularly consistently negative emotional states or expressions of emotion, has deleterious effects on others and on relationship environments (Blechman, 1990; Pandina, Johnson, & Lebouvie, 1992; Wills, 1990). Marital quality, a core component of family life, is intimately tied to certain patterns of emotion expression. In fact, negative affect and expression is the most consistent and powerful discriminator of marital quality (Griffin, 1993; Gottman & Levenson, 1986); this is a conclusion reached across various methodologies, studies, and research settings (Griffin 1993; Schaap, 1984).

Although the goal-related clinical implications (i.e., reduce negativity) of these findings about the predictive utility of negative emotions in marital and family relations may be obvious, the means by which these goals are accomplished vary. Furthermore, realizing these goals with clinical populations of adolescents and their parents is challenging (Kazdin, 1991). That is, cognizance of the deleterious consequences of negative emotions may be helpful in a general way (e.g., induction of a positive attitude on the

therapist's part). However, the translation of this knowledge into a clinically useful formulation is difficult.

The contemporary emphasis on emotion action tendencies (Frijda, 1986) is an example of an area offering clinically helpful information that can be translated in a straightforward way. Action tendencies have been defined as "organized plans that cause a change in the person's relation to the appraised events" (Fischer, Shaver, & Carnochan, 1989, p. 117). Consider use of this idea in assessing the interpersonal microsequences clinicians target for change. If parents and adolescents are seen as showing emotions in terms of action tendencies, some key skills, such as case and session planning, can be enhanced.

EMOTIONS IN ADOLESCENCE

Emotions in Individual and Family Development

How are emotions central to individual and relationship development? Two areas have received considerable attention. A considerable body of research has demonstrated how attachment and autonomy highlight the basic role of emotions in adolescent development (Greenberg, Siegel, & Leitch, 1983; Hill & Holmbeck, 1986; Ryan & Lynch, 1989; Sessa & Steinberg, 1991; Silverberg & Steinberg, 1987). Once thought to be a process with relevance primarily for a single life cycle period (i.e., early years of a child's life), attachment has been reformulated to fit adolescence. During this stage parent-adolescent relationships are realigned. Although there is a leveling of hierarchy in the parent-adolescent relationship and conflict may increase, particularly during early adolescence, strong parent-adolescent attachment relations prevail. Close family relationships are related to numerous indicators of adolescent well-being (Steinberg, 1991; Youniss & Smollar, 1985). Concerning autonomy, parent-adolescent attachment relations are thought to be critical in providing a secure base (Bowlby, 1979) from which adolescents investigate and demonstrate psychosocial competency in novel environments (Greenberg et al., 1984; Grotevant & Cooper, 1983; Hill & Holmbeck, 1986; Kobak & Sceery, 1988; Papini, Roggman, & Anderson, 1991; Steinberg, 1991).

Systemic versions of emotions in adolescence can now be specified (e.g., emotions are relational processes). The relational processes which occur around parenting issues are important to parents and adolescents alike

(Csikszentmihalyi & Larson, 1984). Strong connections exist between parenting quality and a child's development (Darling & Steinberg, in press; Hauser, Powers, & Noam, 1991; Maccoby & Martin, 1983). Baumrind (1991) and Maccoby and Martin (1983) found a relationship between parenting style and many aspects of adolescent competence. Parental responsiveness—encouraging independence, individuality, and verbal give and take in the context of love and support—was highly related to positive adolescent emotional development. Similarly, Cooper, Grotevant, and Condon (1983) found effective adolescent functioning related to a family environment that balanced individuality (differentiated presentation of one's point of view) and connectedness (responsiveness to and respect for the views of others). In sum, an extensive literature underscores the role of parenting practices in children's emotional development (Collins, 1992; Dix, 1991; Youniss, DeSantis, & Henderson, 1992).

Negative Emotions and Problem Behaviors

Theory and data have converged to form a picture of the role of negative emotion and the development of problem behavior (Dodge & Garber, 1989). A major review underscored the "centrality of positive affect in the organization of prosocial behavior" (Collins & Gunnar, 1990, p. 393). Blechman (1990) described the relationship between mood of individual family members, their contact with each other while in these mood states, and individual and family functioning. Blechman believes that "family members who are often in good moods are primed for competence and shielded from psychopathology, despite cultural, biological, and socioeconomic handicaps" (p. 221). Similarly, Wills (1990) discussed how supportive relationships among family members influence the emotional states of adults and children, and how emotional states and processes affect the health status of family members (i.e., through stress buffering). Along these same lines, Carlson and Masters (1986) demonstrated how positive affect buffers children against some of the effects of negative affect. Ingersoll and Orr (1989), theorize that certain emotional patterns (e.g., being upset, lonely, tense, sad, nervous, problems sleeping and making friends, self-destructiveness) predispose adolescents toward risk behaviors. "It may be that individual styles of coping with social stresses are the primary moderating variables that increase or reduce the risk of engaging in problem behaviors" (Ingersoll & Orr, 1989, p. 405).

The regulation and expression of negative emotion have been critical topics in the clinical (Hooley, 1985; Koeningsberg & Handley, 1986; Leff & Vaughn, 1985) and research literatures for some time. Affective processing

ability has been linked to social competence in children and adolescents (Sroufe, Schork, Motti, Lawroski, & LaFreniere, 1984). The Gottman work with children and married couples emphasizes the link between negative emotion regulation and effective functioning (Gottman, 1983; Gottman & Levenson, 1984). Lindahl and Markman (1990) believe affect regulation to be a critical developmental task with couples and families. They hypothesized that a couple's ability to regulate negative affect in their marriage is linked to marital quality which itself is related to the parents' ability to regulate negative affect in their interactions with their children. Parents' emotion regulation ability in interactions with their children obviously plays a central role in a child's predominant affective tone.

Turning to family interaction, the predictive power of negative affect on parent-child interactions and child outcomes is well documented (Patterson, 1982). Frequent and intense negative emotional expression is connected to a variety of clinical problems including delinquency (Rutter, 1980) and drug abuse (Kandel, Kessler, & Margulies, 1978). The connection of emotion systems to the development of drug abuse is a core construct in a promising line of research by Pandina et al. (1992). Their early studies have found adolescents with an emotional profile of pervasive and persistent negative affectivity energized by a context of prolonged and heightened arousability to predict progression from experimental drug use to abuse.

Emotion regulation has also been discussed in terms of its adaptive functions, for instance, as a way of coping with negative self feelings or stress (Saarni & Crowley, 1990; Wills, 1990). Three critical factors influencing emotional regulation (temperament, cognitive development, and socialization) each with different implications from a target of intervention perspective are present in the case illustration to follow (Saarni & Crowley, 1990).

Emotions and Problem Solving

Clinical theory, in accord with empirical work by investigators such as Pandina et al. (1992), suggests that chronic negative emotion detours problem solving and over time erodes relationships (Minuchin, 1974). Forgatch (1989) believes that negative emotion can affect the problem-solving process in several ways. First, it may affect the representation of the problem, making solutions seem improbable. Second, negative emotion can impede the generation of helpful solutions because the person is too focused on negative experiences. Third, interaction can be affected by negative emotion because these emotions create a climate in which people are less motivated or able to achieve a solution. The clinical case to follow illustrates these processes. In a study with important clinical implications, Forgatch (1989) established a

strong link between negative emotion and ineffective problem solving with parents and their adolescents.

Emotions and Dysfunctional Family Patterns

Earlier eras of family therapy focused on overinvolved parent-adolescent relationships (e.g., Kaufman, 1985; Minuchin, Rosman, & Baker, 1978). Today in a trend which may be reflective of some societal processes (see postmodernism's charge of fragmentation; Gergen, 1991), increased attention is given to disengaged family systems. Research teams see patterns of parent-adolescent disconnection and disengagement in their clinical samples (Liddle, Dakof, & Diamond, 1991; Volk, Edwards, Lewis, & Sprenkle, 1989). These relationship problems, often characterized by intense negativity and long-standing resentments, have been found very difficult to treat (Doane, Hill, & Diamond, 1991; Liddle et al., 1992).[2]

EMOTIONS IN ADOLESCENCE:
A CLINICAL PERSPECTIVE

Multidimensional Family Therapy:
Background and Evaluation to Date

Considering emotions from a clinical intervention perspective requires specificity about the treatment model in question. Multidimensional family therapy (MDFT) is a family-based-treatment approach designed to treat adolescent drug abuse and behavior problems (Liddle, 1991c; Liddle, 1992d). With its roots in the family therapy of drug abuse tradition (Stanton & Todd, 1982), MDFT incorporates additional notions about the targets, mechanisms, and methods of change. This approach is empirically based, having been developed within the Adolescents and Families Project (AFP) at the University of California, San Francisco in 1985. On critical dimensions such as attrition and impact of treatment, results of this study were favorable for MDFT. MDFT was significantly more effective than two comparison treatments (multifamily treatment and group therapy for the adolescent) in engaging and retaining 73% of the adolescents and parents in a 5-month, 16 session treatment (Liddle, Dakof, Parker, et al., 1991). This finding is noteworthy because of a growing recognition in the treatment field that attrition should be considered a critical outcome variable in intervention studies (DeLeon & Jainchill, 1986; Szapocznik et al., 1988). Also when compared to the other conditions, MDFT provided the greatest decrease in

drug use from pre- to posttreatment (Liddle & Dakof, 1993). Adolescents receiving this therapy reduced their drug use from more than daily use of alcohol and marijuana and sporadic use of drugs such as cocaine, amphetamines, and hallucinogens to once a week use of alcohol or marijuana and no use of harder drugs.

Main Features of the Intervention Model

Core to this approach is the continuous interplay and reciprocally determining relationship between cognition, emotion, behavior, and environmental input and feedback (e.g., Bandura, 1978; Fiske, 1982; Greenberg & Safran, 1987; Lazarus, 1991; Mahoney, 1984; Shantz, 1983; Wachtel, 1977). MDFT uses an ecologically oriented (Bronfenbrenner, 1979), developmental psychopathology theoretical framework (Cichetti, 1984; Kazdin, 1989; Sroufe & Rutter, 1984). The adolescent development (Petersen, 1988) and parenting literatures (Schmidt & Liddle, 1992; Sigel, McGillicuddy-DeLisi, & Goodnow, 1992) inform the clinical formulations and interventions as well. Research demonstrates the common misconceptions about adolescents and their development (Offer, Ostrov, & Howard, 1981). With this in mind, therapists challenge their assumptions about adolescents and family relations during this life cycle period by learning contemporary research findings.

Problems have historical as well as contemporary influences, and both these aspects may be subject to attention in treatment. We have found that it is possible, contrary to what some have argued (Haley, 1963), to address a family's past conflicts within a present and problem-oriented therapy. Drug use and other problem behaviors are understood in terms of a network (individual, familial, peer, community) or multiplicity of influences (Brook, Whiteman, Nomura, Gordon, & Cohen, 1988; Pandina & Schuele, 1983). These problems are construed within a problem behavior or general deviance syndrome perspective (McGee & Newcomb, 1992). This framework details the correlated nature of individual problem behaviors and emphasizes their co-occurrence and covariation (Kazdin, 1982). Accordingly, interventions must be sufficiently comprehensive (Hawkins, Catalano, & Miller, 1992) and target several realms of functioning (Kazdin, 1982).

Consistent with other multisystems approaches (e.g., Henggeler & Borduin, in press), MDFT has a multidimensional assessment and intervention framework. It identifies different domains of personal and interpersonal functioning within and outside of the family for intervention. The approach assumes that change occurs via *multiple pathways* (e.g., cognitive restructuring, affective clarification and expression), in *different contexts* (individual, familial, and extrafamilial), and *through different mechanisms* (e.g., devel-

opment of a new cognitive framework and acquisition of new skills). For its treatment format, MDFT uses family sessions, subsystem sessions (marital or parental focus), and individual sessions (adolescent or parent[s] alone). Extrafamilial systems (probation officers, school personnel) are included extensively in treatment. Frequently this involvement takes the form of in-depth phone conferences between sessions. These telephone discussions (which also include scheduled phone conversations with the parent and adolescent during the week), are considered "sessions" in as full a sense as in-clinic interviews. The usual course of treatment extends 5 or 6 months and may include several sessions of varying lengths (in-clinic and telephone) per week.

A Common Problem Situation:
Escalating Negative Emotion

This article's clinical illustration examines one of the most difficult, and according to Doane et al. (1991) the most change resistant problem faced by clinicians—chronic, stable, and quick-to-escalate negative emotional exchanges between family members. Interactions of this kind have been identified from several theoretical perspectives and on the basis of research to be linked to the development of child and adolescent problems (Loeber & Stouthamer-Loeber, 1986).

Segment Introduction

The first segment gives a "baseline" level of a typical negative emotion exchange. It illustrates progress achieved during the session. The last vignette presented (Segment 6) occurred 30 minutes after the baseline segment. The segments show different clinical techniques. However, at a macrolevel, they are consistent in showing a single therapeutic strategy central to MDFT. Known as the *shift strategy*, this technique is used to change in-session impasses between parents and adolescents (Liddle, 1991b). We attempt to break these emotional stalemates by changing the focus of the discussion during the session. Frequently this involves moving the conversation to a more personal level. This method accesses certain emotions, such as parental commitment and love and adolescents' hurt feelings, while blocking at least temporarily others, like resentment (Diamond & Liddle, 1993). Emotions are targets of work as well as mediating variables. In this sense they are intervention foci that can potentiate entry into other domains of functioning. For example, focus on emotion may be helpful not only for motivation

enhancement but also to instigate intrapersonal or interpersonal processes that access and permit work in the cognitive or behavioral domain.

The case[3] involves a 16-year-old boy, Chris, the youngest of three siblings (who live outside the home). Chris lives with his mother. Although mother and father are separated, the father is involved in the treatment. Chris is currently on probation for drug possession and violence against school personnel.

All of the segments, from baseline to the final segment are presented in the order in which they occurred.

Segment 1 (Baseline):
Negative Emotion in Action

Mother: I'm sorry.
Chris: What? At least I admit when I'm wrong. You never do. F—— you.
Mother: Well, I don't remember it that way. What I remember . . .
Father: (to Chris) All right, all right, don't talk that way.
Chris: (to father in a very explosive manner sitting up in his chair, arms waving, finger pointing. Therapist sits forward with him ready to intervene.) Just shut up.
Chris: You don't live at my house, you don't have nothing to do with this at all. So, why don't you just leave. Just shut the f——up. You're never f———there, you're never f——— there.
Father: I'm supposed to be there.
Chris: Even when you lived there . . . you were never in anything. So, just shut up.
Father: I come here every Monday night.
Chris: You think I want you to be here? No.
Father: No, but I come here anyhow.
Chris: I don't want you to be here, so don't f——— lay that on me.
Father: I'm not laying it on you.
Mother: Chris, he is your father.
Chris: He never acts like it, never. He's my biological father, but he's never acted like my dad ever in my whole life. So, why should I now when . . . I don't need a father now. Why should I even want to.
Ther: Is that true?
Chris: When I was a kid I . . .
Father: I guess it is. If he says it is, I'll go along with that.

This segment illustrates two important points made by Safran and Greenberg (1991) in their discussion of the role of emotions in psychotherapy. First, it shows how "Emotions provide action disposition information" (p. 7), and second, how "Emotional responses are mediated by anticipated

interpersonal consequences" (p. 7). Cumulatively, negative emotions of this kind are developmental threats to the adolescent's self system (Grossman and August-Frenzel (1991). Therapists craft goals in relation to knowledge of this nature, as well as in relation to the model's developmental sensibilities. Therapists use these ideas to retrack normative individual and family developmental tasks.

The following passages give numerous examples of negative emotion in the life of the adolescent we present.[4] Some family treatment models emphasize process over content (Hoffman, 1981). In MDFT, however, we understand that the particular content of the discussion is critical to the elicitation and exacerbation of the intense, negative emotion. This understanding includes historically significant and contemporaneously enacted intrapersonal and interpersonal relationship themes. Themes of resentment about past hurts and the adolescent's nonacceptance of the parent's attempt to adopt a parental role are frequent in-session topics.[5]

Knowing about emotions as action tendencies (Fischer et al., 1989) gives a therapist confidence to intervene into a conversation progressing down a disastrous path. Therapy involves reinstitution of attachment between parent and adolescent. Changes in this relationship serve historically relevant (e.g., healing past resentments) and present-focused purposes (e.g., successful problem solving of everyday conflicts is one area in which the renegotiation of the parent-adolescent transition occurs). The emotions as action tendencies concepts compliment the overarching attachment and developmental emphasis.

Segment 2: Focus and Framing

Ther: Chris, right now, it seems to me, that it's sort of like your whole life with
  your father is flashing before you. You're mad at him for how many years?
Chris: I know, I shouldn't. I shouldn't think about it.
Ther: No, let me just—Is that wrong or right?
Chris: It's wrong. I'm not sayin' it's right. It is wrong.
Ther: No, I mean, is that accurate?
Chris: Yeah.
Ther: Right now, every inch of this guy is tight and really angry, right?

Addressing emotional reactions includes appraisal of events or relationships (Lazarus, 1991; Shaver et al., 1987). The therapist is intentional and precise in his or her characterization of the situation, choosing certain aspects of the drama for intervention. In MDFT, family members' understanding of emotional reactions is not an objective per se (although this may occur).

The characterizations, or in family therapy terms, creation of new realities (Minuchin & Fishman, 1981) or frames (Alexander, Barton, Waldron, & Mas, 1983), is a practical and at least temporarily useful accomplishment. They are also new in-session territories of operation. These frames are socially shared realities constructed in the public domain of in-session discussions. They are intended to serve as a more workable foundation within which new work on self and relationships occurs. In the previous sequence, first the therapist reestablishes the longevity of the problems presenting a historical "given" as a reason for why Chris's emotions would be so strong. This construction is preferable to pathological personality ascriptions that perpetuate beliefs about the other's incompetence and contribute to a chronic negative emotional tone. Then, the intensity of Chris's experience is acknowledged and named. The intent is to reduce the fears associated with this experience (father's and Chris's own concerns about his lack of control).

Chris: Yeah.
Ther: And angry at your father.

The interpersonal aspect and target of the behavior are also named.

Ther: (continues, to Chris) You have to help us figure this out. When you get like
  that, what's the best way to handle this?

This particular reality asserts two things. Challenging helplessness, first it asserts that something can be done. It aims to demystify and disprove the apparent inevitability of emotional reactivity and failed problem solving. Second, it declares that Chris can and should have some responsibility for communicating his concerns more effectively and helping to devise a plan. It is important to affect the adolescent's participation in treatment (i.e., autonomy and competence focus) in the presence of the parent. Accomplishing this counters a frequently heard challenge from parents about how some treatments require too little of the adolescent (e.g., parents say: "I can't do all the changing here," "Maybe I'll try again if I see that she is trying too," or "He's got to show me he wants to get better").

Chris: I usually just tune out and try to forget about it.
Ther: All right, but you know that that's no good. That's why you're here, Chris.
  (to father) As you know, you're trying to find a new Chris.

Although it may have clear adaptive functions (Wills, 1985) and represent this adolescent's emotion regulation strategy (Saarni & Crowley, 1990),

Chris's "tune out and forget" method is defined as ineffective problem solving. The thematic or "big picture" (Liddle, 1985) aspect of the work is invoked. This is an attempt, among other things, to help Chris express himself more effectively. Mastery and competence are important tasks of adolescence and are protective against the development of problem behaviors (Dodge, 1989; Newcomb, Maddihian, & Bentler, 1986). They are fundamental generic treatment goals. A therapist consistently makes basic assumptions explicit to the family and uses them to organize the work. In this situation we assume several things. First, Chris's problem behavior has included failed attempts to communicate about various aspects of his life. Second, related to this, Chris needs to express his concerns more effectively (Liddle et al., 1992). The therapist works within and between two levels of focus and change targets. Sometimes we work in a so-called big picture realm, emphasizing thematic representation of relationships. These might be broad level conclusions about one's son, daughter, or parent ("He's never been there for me," "I can't trust her after all she's put me through"). Particular day-to-day or past relationship events are the components of the big picture. These are the narratives about one's own and others' lives that are central to all therapies. They represent the recollected history and continuing events that have led to the conclusions portrayed in a big picture analysis.

The language in the previous sequence typifies how we frame problems. Because we both construe *and* construct our environment and interpersonal relations (Strupp & Binder, 1984), interventions must take into account these complimentary processes. The Safran and Segal (1990) interpersonal schema (internal model of relationships derived from experience) is also a clinically practical generic representation of self-other interactions. The interpersonal schemas of Chris and his father are intervention targets. Whereas we aim to reduce the problem behaviors of the adolescent, the relationship context (parenting, if we are referring to the father) is related to the adolescent's change.[6]

The quest to develop a "new Chris" has intrapersonal and interpersonal dimensions. It is important that the father recognizes Chris's changes and construe them positively. This begins[7] a cycle that can alter father's attributions, emotions, and behavior. In family treatment terms, the creation of new relational realities infers that the father's experience of his son changes when Chris's behavior can be different, even if only slightly, for a brief time, or on a less than consistent basis. We assume that these changed perceptions and feelings are ingredients in influencing family members' behavior toward each other.[8] The father's emotional reactions to and cognitive appraisal of Chris predicts future action on his part (e.g., it will maintain emotional

disengagement, his beliefs about Chris's inability to change, and feelings of incompetence as a parent). Hence, these areas are key intervention targets.

The call for a "new Chris" relates to how problems are recast in developmental terms. The concept of "possible selves" (Markus & Nurius, 1986) is useful in this regard. Metaphors of multiple aspects of self and reinvented selves (Cross & Markus, 1991) are common in clinical work (Mahoney, 1992). The new or possible selves metaphor can be an umbrella concept used to orient goals and structure therapy. We talk with adolescents about their "possible selves," trying to counter the narrow range in which they have defined themselves and have been defined by others.

Segment 3: Emotions Inform Theme Development

Ther: (to Chris) Let's try and figure one aspect of this out that I really don't understand. There's something weird that you do with him, that is, well . . . it's like egging him on to hit you. How do you understand that?

The therapist works with Chris to articulate an understanding of his behavior. This strategy embodies the constructivist's awareness. Defining this "reality" is an intentionally collaborative, meaning-making endeavor. The therapist realizes that specifying the "facts" of the story is a central therapeutic task.[9] Reestablishing some degree of attachment between father and son takes time and has several dimensions. Clinical families often reside in a chronic emotionally negative environment. MDFT uses multiple channels to change this multivariate network.

Chris: Well, okay, when I was a little kid, he used to hit me, and now, when I am older . . . and like he was gonna hit me or somethin', then I'd hit him, and then ah, I would say "Yeah, you won't hit me now." You say the only reason you don't hit me is cause you love me and you're afraid of child abuse. Why didn't you do that when I was a little kid when I *couldn't* hit you? Hit me now, go ahead, go ahead.

What ideas guide a therapist at a time like this? As we know, factors such as temperament, cognitive development, and socialization influence emotional regulation in adolescents (Saarni & Crowley, 1990). Perceptions of and attributions about one's own or another's temperament may be changeable. Indeed, temperament is now believed to be modifiable as well (Collins & Gunnar, 1990; Goldsmith et al., 1987; Matheny, 1989). Cognitive development may be less modifiable in treatment than other aspects of the

cognitive domain per se. Socialization practices (i.e., parenting) are standard intervention foci, as are an adolescent's perceptions about these practices.

In the previous sequence, movement can be seen between descriptions of the past and understandings about one's motivations in the present. Chris reveals his father's abuse of many years ago. Chris's challenge and its insight are profound. What his speech lacks in coherence is offset by its intensity.

> Ther: So it's like you're saying, "I'm paying you back." "I remember when you hit me when I was small."
> Chris: And now you won't. Yeah, you won't hit me now.

This theme of retribution or payback for another's past behaviors (Liddle & Diamond, 1991), is familiar in our clinical work. Working for forgiveness[10] is the clinical goal with persistent retribution themes. Some clinical researchers have termed material of this nature core conflictual relational themes (Luborsky & Crits-Cristoph, 1990). The conflict in Segment 3 is an example of how conflict among family members involves multiple aspects or layers of content (Vuchinich, 1987).

Using emotions as a barometer of functioning and a roadmap to negotiate important problem areas, a therapist reframes situations, messages, and people. We use the potentiating possibilities (i.e., progress in one realm sparks progress in another) for new relationship connections available within less emotionally labile cognitive sets. Conflict resolution has been found to vary as a function of the topic of discussion (Smetana et al., 1991). Our work suggests the content area pertaining to retribution and its antidote, forgiveness, to be a complex discussion topics and not amenable to simple solutions. However, given the emotion regulation difficulties when parent and adolescent discuss these sensitive matters and the well-established consequences of continued failure in this realm, these content areas remain a high priority in MDFT.

Segment 4: Working an Emotion-Related Theme— The Interrelationship of Empathy and Constructivism

> Ther: (to father) Ray, I know this is very ... this is horrible for you, I realize that you're goin' through hell right now.
> Father: Not really, I'm coming back.
> Ther: Okay. Good. When this guy says, I mean in essence, when he hits you, according to the best way that he has this stuff put together in his head, with every punch or with every kick he says, "This is a payback."

Identifying the retribution theme is only a first step. The following shows how these first-level constructions are transformed and worked in a session.

> Father: Yeah, it probably is.
> Ther: So how do you make sense of that?
> Father: I don't make any sense out of it.
> Ther: I mean he, it's sort of like "remember that time ..." (To Chris) How old were you?
> Chris: Young ...
> Father: Well, he's never said that.
> Ther: And he may never say it. But it's like ... this kick is for when I was 7, this punch is for when I was 8. He remembers ... some bad things have happened between you and him. That's what he's saying to you. He's saying, "That hurt me when that happened then." And he's saying, "It still hurts me now." (Pause). I'm not at all justifying what he's doing, but I am trying to make your son's language clear. (Pause). Many times, he speaks a different language than we speak. No?
> Chris: It's not a good language: that's what I was sayin'.
> Ther: Well, no, it's not ... (refocuses to father). Do you know what I'm saying, Ray?
> Father: Yes. I know what you're saying.
> Father: When he kicks you, literally kicks you, he says, he says "screw you," but he also says, "I'm hurt. And you hurt me. And I'm gonna hurt you back. And I'm a big boy now, really big."
> Chris: I'm not that big. He's bigger than me.
> Ther: (again to father) So see what I'm saying here? What I'm trying to get to the bottom of is, what is your son's way of talking, what is his language?

This passage reveals deeply felt emotions. The behavioral consequences or corollaries (depending on one's theoretical perspective) of these emotions have been disastrous and threaten the continuance of this relationship. As we have seen thus far, one pathway of change is the adolescent's behavior. However, another target in this sequence, the father, is equally important. Success here probably depends on interrupting the father's automatic negative emotional reaction to Chris. Negative emotional perceptions and reactions are difficult to change. A new experience of the other helps this process. A softening of positions (e.g., by focusing on one's negative anticipation) helps this to happen. In reaching Ray, we would use the language and ideas connected to his parental role. Knowledge about how parenting styles are related to child outcomes guides a therapist in asking about parenting practices and in interpreting everyday events. Dimensions such as adolescent participation in decision making (Smetana et al., 1991), development of the

responsiveness (Baumrind, 1991) or empathy (Dix, 1991) dimensions of parenting, or on the role of communication of respect to one's adolescent (Steinberg, 1990) are other examples of research literature with rich clinical implications. In this vignette, by establishing different meanings about Chris's behavior, the therapist tries to instigate processes that can "unfreeze" Ray's perceptions and feelings. With negativity lessened, Ray's view and interpretation of Chris's new behavior is more positive.

Particular words are chosen to discuss Chris's behavior. These are small steps in helping Ray take a less extreme stance toward his son. It is important to note a critical balance in this operation. This involves the distinction between creating alternative meanings of Chris's behavior and appearing to take a position that might be construed as excusing the problem behavior. The father's acceptance of the therapist's premises (i.e., the new meanings or frames) is critical to this process. The seriousness with which the problem behavior is taken must not in actuality or in appearance be diminished.

The payback theme is made more complex, softened, and perhaps made acceptable to the father when the emotions pertaining to the son's hurt are juxtaposed with (not substituted for or given precedence over) anger. The therapist interprets to father: "He says screw you, but he also says I'm hurt. And you hurt me. And I'm gonna hurt you back." The sequence also relates to a core dimension of MDFT—recasting how behavior is understood. Previous referral sources, Chris's probation officer, and Chris's parents attribute randomness to his behavior. Chris was frequently described as a time bomb just waiting to detonate, not an atypically used metaphor. Therapy involved challenging these dramatic notions. Although Chris's behavior is made more functional and understandable, it is still not defined as an acceptable response to his circumstances. Conceptually, this is consistent with research that seeks to understand the development of coordinated and reciprocal interactional responses or adaptations to aversive and distressing stimuli (Dodge, 1989, p. 339). This clinical intervention is also consistent with research that links temperament and interactional variables (Bugental & Shenuum, 1987). Temperament is understood within a context of intrapersonal factors and interpersonal interaction.

The generic metaphor of "language" destigmatizes past behavior and lessens negative emotionality around current and future behavior. We tell both adolescent and parent that their current way of trying to get what they want and expressing complaints are ineffective. Emotions are acknowledged, but one's way of addressing concerns is challenged. By asserting the possibility that theirs is indeed a message which has not yet been but deserves to be heard, we offer a structure for the delicate discussions to follow. Adoles-

cents in particular are then able to sign on to an agenda (and gradually, help craft it) which avoids a "fixing the teenager" definition of treatment.

Segment 5: Using an Out-of-Session Crisis to Work a Core Interpersonal Theme

This segment shows how a recent crisis between sessions is employed to work key themes. The therapist tries to revise the conclusions that have been drawn from the negative incident. The particular event between father and son is used to reintroduce and concretize a primary theme—belief and trust. Inherent in this theme's discussion is a prevalent treatment issue with parents and adolescents—the role of the family's past as an influencer of emotions and thoughts in the present. The literature deals with emotions as powerful organizers and predictors but it mostly omits the role of history. The clinical perspective can contribute to our understanding of emotions in this regard.

The incident that gets discussed in Segment 5 is important unto itself. This event is addressed with different goals in mind. These include the need for: (a) reattribution work, (b) a different emotional reaction, and (c) development of behavioral options for the future. However, the content of this incident, not unusually, also serves as an entré into related areas of work. The out of session event, despite its high emotionality, presents an opportunity to rework ineffective problem solving. Understanding negative emotion's inhibition of problem solving (see Forgatch, 1989; Patterson, Reid, & Dishion, 1992) establishes a useful mindset for clinicians entering interactions of this type.

Ther: So, part of what I'm getting at here, Ray, is that I want to clarify Chris's language. Do you think there's anything else that he's saying to you . . . in addition to what we have been saying?

Father: (to Chris) It's just that I don't believe what you were saying to me yesterday.

Chris: All right.

Father: (Sarcastically) That you owe some drug dealer $135.

Chris: Why do you think my mouth was bleeding for 4 days since I got hit, man. I won't pay him, I already had somebody take care of him, so it's no big deal now.

Father: Okay, but the thing is I don't have $135 I can loan you.

Chris: Yeah, it's all right.

Ther: (to father) Stay with what you were saying. See, you're on to something good.

Father: The fact is, I did not believe him.

Chris: All right.

Ther: Okay, he did not believe.

Father: Because you have conned me in the past. You've even admitted this.

Chris: When? Okay, I made . . .

Ther: (to Chris, who is becoming agitated. Therapist moves closer to Chris, puts arm around his shoulder.) Here, sit back. He's not finished.

Father: I am not sure what you . . .

Ther: (to Chris) Take a breath and . . .

Chris: Okay. That's cool. It's not because I take . . .

Ther: No, wait.

Chris: He was done talking.

Ther: No, he's not done talking. Wait. (The therapist offers an incomplete sentence for father to complete, as a way of drawing him back into the conversation.) You do not believe him because . . .

Father: Past experience.

Ther: Past experience.

Father: Yeah.

Chris: I . . .

Ther: (to Chris) Not yet. (to father) Keep going.

Father: That's, what I run my life on—past experiences.

Ther: Right.

Father: I make my decisions from past experiences.

Ther: Right.

Ther: Keep going.

Father: I thought that you were conning me again to buy some drugs, to tell you the truth.

Chris: All right.

Father: Since you *have* done it before.

Chris: Can I say something? All right, when I ask to go to a concert, you think I didn't even go to the concert. But I told you before that I would just use extra money, and why would I . . . after I've been trying hard . . . you want to give me a drug test right now so I can prove to you I didn't do no drugs? And I was scared, man. I didn't wanna come to you, man, because I knew what you were gonna say. You already kicked me out of the house. (Chris's mood is changing and he becomes more agitated and angry.) Only reason I came to you, I was scared. I'm sorry I stooped down to your low level because I was scared, but I was. I'm sorry I came to you, I won't come to you anymore . . .

Ther: (trying to slow the pace down and looking for a way to use the new details which have emerged) Okay, so that's interesting. That . . .

Chris: I don't like to admit I'm scared, but I was.

Ther: (to Chris) Do you understand what your father's saying? I mean, is that so unreasonable?

Chris has said important things. Later they will be used to stimulate further discussion on this topic. Here however, focus must be retained. The therapist

helps to complete a previously started point. It is important to help Chris understand and gain perspective on his father's statement. This task has obvious developmental intents. Even under usual circumstances, perspective taking may be difficult for adolescents. In a clinical population, this ability is often hidden. Its materialization is a prime goal. Next, with Chris's acknowledgement made (I don't like to admit I'm scared, but I was), the conversation is shifted to another dimension.

Chris: No. He . . .

Ther: That he said, "My first take on this was that this kid is conning me."

Chris: Yeah, I can understand that.

Ther: Okay, you can understand that, good. The thing that you said that was interesting is that you were afraid because . . .

Chris: I don't like to admit I was afraid, but I was.

Ther: Okay, why were you afraid? Because there are people that can be pretty weird when it comes to owing other people money, and you could get hurt, and these people would make it clear to you that you are gonna get hurt?

Chris: They already did.

Ther: Ray, I know you didn't hear it this way, but what this kid is saying . . . now admittedly, let's take this with a grain of salt, but let's say he's telling the truth right now. I want to get back to this thing of "what's Chris's language?" Okay? If he is telling the truth right now, his language is telling you, in not so direct a way, "I came to you for support." Let's assume, again, that he's telling the truth. He was fearful, he was afraid. He came to his father for a form of support and help, and in a sense, protection.

Father: And I let him down . . . again.

Ther: Is it possible that he is telling the truth about this?

Father: Oh, it's possible.

Ther: Where are you right this instant with this issue?

Father: I think he probably was telling the truth.

Ther: Really?

Father: But at the time, I didn't.

Ther: I know. But, I want you to think really deeply about this. I want you to really search your soul right now, this instant. I don't want you to be afraid to say, "well, 90% says 'truth,' but 10% . . . I'm still unsure." What do you think? Ninety-ten?

Father: (to Chris) Let's put it this way, I always *want to* believe you.

Ther: Yeah.

Father: I've always tried to believe that what he's saying is the truth.

Ther: Yes.

Father: But then I see the facts afterward and how things weren't true.

Ther: Right.

Father: So, I'd say . . . I'd say 80-20.

Ther: Okay. Very good.

Father: That I do believe him.

Ther: Good. See, this is an important lesson for Chris. He has to really hear many things that you're saying. But this one thing, I think it's very important for him to have an understanding of what your position was. Why shouldn't he understand that you will find it hard to trust, you who have been burned. When he was doing a lot of drugs and was really screwed up, he wasn't the same person that he is now; he was lying, he was kidding you, other people, himself most of all. But yesterday, that was an interesting event to try and make sense of it. I mean the tragedy of it was that, again, the language was so unclear. I really hear him saying, "I came to you for help. I was afraid."

Father: Yeah.

Ther: I think it's interesting that he did come to you.

Chris approached his father for help. It is this aspect of the story that is highlighted. The attachment/relationship aspects of the interaction get emphasized. Despite the fact that the event did not go well, the positive intentions are underscored. The conflict incident and the therapist's reinterpretation of it serve as an important foundation for future work. The segment also highlights how we try to modify extreme stances—the all or nothing thinking and feeling characteristic of parent-adolescent impasse (Diamond & Liddle, 1993).

Ther: It was a sneak attack. You must have reacted like, "I can't believe what I'm..." You probably reacted like, like a time machine thing, like you flashed back in time, you heard this before.

Father: Exactly.

Ther: You thought of half a dozen other incidents where this boy came to you and you got "taken to the cleaners." And you reacted. It was like this... (crosses his leg, and with his hand, hits the knee in a way to activate a reflex movement of the leg forward) if a person hits their knee like that, see, it jumps, it's a reflex. I have no control over my leg. You had no control in that moment when he asked you for the money, especially given the way that he asked you. The *way* he asked—it was absolutely terrible. Again, his language was lousy. If this guy had his thinking cap on, if he wasn't so upset about being hurt, or whatever he was upset about, he would have asked in a good way. See, he was stuck in the past, too. You were stuck in the past with that reaction, but he was stuck in the past, too. Because he couldn't get clear what was going on with him when he asked you that.

Interventions are multidimensional—isomorphic with the problems they try to change. Here we see an intentional mix of temporal, motivational, cognitive, and behavioral levels of work. Both father and son are portrayed

as having "relapsed" in the way each handled this event. Ray is challenged to not be a prisoner of his past perceptions and feelings about his son. Chris's challenge cuts to his timing and methods of accessing his father. Although simple to state, these processes are difficult to change. Conceptually, we are aware of intervening into an intersection of emotion appraisal, experiencing, and expression. Various researchers have described the predictability of these processes. For Shaver et al. (1987), "Once one of the basic emotions is elicited, its characteristic action tendencies, cognitive biases, and physiological patterns seem to arise automatically unless they are countered by self control efforts" (p. 1080). In the clinical situation described here, the self-control and interactional control mechanisms have not functioned for some time. It is this process that we seek to interrupt and replace.

The following sequence again employs the relapse frame as a schema for understanding and, perhaps more basically, a device to create empathy. The relapse frame is a platform upon which the working of change can occur.

Ther: So, where did the fight end between the two of you?

Father: You mean today?

Ther: So yesterday there wasn't any fight.

Father: No, wasn't any fight yesterday. Today's when we was comin' on the freeway. He was...

Ther: And that was about the money.

Father: ... goin' off about his hair and here stompin' the car and everything else, and then he, I don't know, I said something about...

Chris: Oh, I went, I went like this. I moved my hand and he goes, "Oh, here it comes again." I say, "Okay, you think it's gonna come?" Boom! And I did it. I shouldn't have did it, but that's how I felt, 'cause he acts like I was gonna do somethin' I wasn't gonna do.

Father: No, I said to quit stompin' on the car floor, is what I said.

Chris: Yeah, but then I went like this. Okay. I just thought, okay, maybe I was wrong. Maybe I went like this. You said, "Oh, here it comes again," and you backed up.

Father: But pullin' somethin' like that when I'm pullin' on the freeway, I'm lookin' for merging traffic.

Chris: I'm not sayin' it was... I'm sayin', even if we're stopped I shouldn'ta did it. I'm not trying to put myself right. I'm sayin' I'm wrong, but I'm just sayin' that's how it happened.

Ther: Okay, that's good. (pause) It's too bad things don't happen the way we really think they ought to happen. Things like change. Because we would like a world where when somebody says they're gonna change... (in order to reengage Ray in the dialogue, therapist looks to father, and again uses an incomplete sentence, cuing Ray to complete it.)

Father: They change, right?

Ther: (to father) They change. So today, you have to live through something that triggers some terrible things for you, really terrible things. It sends you back. See, he had a relapse today. When he goes off like this, gets angry, stomps on the car . . . (to Chris) You know what a relapse is?

Chris: Yeah.

Ther: It's like you got a flu. You're feelin' a little bit better. Then all of a sudden, you feel sick again. Okay, you know what it is. (Now to father). So, today, he had a relapse. But, you had a relapse too. Because your relapse is characterized by tremendous doubt about him. Right? What are the elements of the doubt? "He hasn't really changed." The most basic of it is he hasn't really changed. What else, that he can't change?

Father: No, I think he can change.

Ther: What else? When you . . . when you're in a relapse, you're really feeling bad, and he's just gotten finished giving you a good whack, you're in relapse, so what is it characterized by? What else?

Father: I don't know what you're gettin' at.

Ther: You didn't believe in him in that moment.

Father: I didn't believe in him when he kicked me in the arm?

Ther: Yeah, you didn't believe that he could be different, that he was gonna be different. Here's the same old Chris. He's just conned me out of money.

Father: No, what I was gettin' at is I've seen (pause), okay, now I'll tell you what I mean by a relapse.

Ther: Okay.

Father: I've seen this building up in him, when he got into the car. I picked him and his mother up. I left work and got there just in time, and soon as he get in the car, he starts "I hate this haircut. I hate this car. I don't like this haircut." And he's goin' on like this, and he's goin' on, and the next thing I know, here I'm . . . we finally . . . I was havin' trouble findin' where do you get on the highway. So, I finally figure out and I go around, and then all of a sudden he starts like this on the car, and he's really goin'. I mean that little car isn't that strong. He could put his foot through that thing, and what I said was "Okay, here we go again," 'cause I've seen this same . . .

Ther: Right. Okay, good.

Father: . . . the same routine, how it all builds up.

Ther: Okay, good.

Father: And it builds up, and then, then here I'm just lookin' to . . . in the mirror there so to see if I can merge on the drive and he . . .

Ther: So, what then?

Father: . . . and he blindsides me.

Chris: I'm not sayin' I was right, but this is how I felt. Okay, that's how I feel. I'm not sayin' I'm right at all. I'm not tryin' to, but I'm sayin' soon as he said "here we go again," I went "Oh, okay, he thinks it's gonna go again, might as well."

Ther: Might as well then, right?

Chris: Right.

This sequence relates to observations about the role of emotions in interpersonal events. For instance, if emotions are influencers "emotions have script-like properties that direct the organization of behavior" (Fischer et al., 1989, p. 123).

The Kelley (1984) concept of intersituational processes is also illustrated in this vignette. For Kelley, "By their very location, the intersituational processes must, like Janus, the god of doors and gates, face simultaneously in two directions, toward the just-ended and the about-to-begin" (Kelley, 1984, p. 92). This sequence shows the retrospective, present, and prospective implications of emotional expression in sessions. Knowledge of this kind helps the therapist broaden the discussion of the negative incident. The relapse notion is given a specific meaning. Each in their own way, both father and son contributed to the negative event. Chris returned to a problem way of dealing with feelings about his father. Ray is said to have relapsed, too. His negative beliefs about Chris were automatic, triggered in the heat of an escalating conflict. Ray's belief in his son's ability to change is, theoretically and in practical terms, important to Chris's change (see the concept of complimentarity in Minuchin & Fishman, 1981). Both father and son are organized by anticipated negative interpersonal consequences. The therapist interrupts the automatic nature of the processing ("schematic emotional memory mediates emotional responding," Safran & Greenberg, 1991, p. 8), as well as its pace, by developing different appraisals and responses.

In its concreteness, a specific incident helps track down, give new meaning to, and rework the emotions around a core relationship theme. Behavioral and emotional triggers are particularized. They serve as preventive cues in the future. In this situation, several subtexts lace the intervention. First, dealing with emotional events is possible (this is distinguished from control of one's emotions). Second, extreme positions can be avoided. Third, the consequences of negative events of this magnitude hurt everybody. Fourth, there are advantages for each in not letting negative interactions escalate.

Segment 6: In-Session Outcome

This segment occurs about half an hour after the baseline segment. In this session with an oversupply of negative emotion, the therapist played a central role in-between the communications of father and son (i.e., changing the flow of emotional negativity). A common way to do this is to change the working territory of the session. In these situations, a shift to a cognitive realm is not uncommon.[11] Here, a cognitive component to the work is illustrated through naming the intervention method. The therapist says that he is "translating"

for Chris. Providing a vehicle for continuity, an important treatment dimension, this method gives a communication shorthand for later work. It gives complex and emotional themes a reference point in future discussions.

The next segment shows something important about the nature of therapist and adolescent subsystem work. We are careful not to do the adolescent's or the parent's work for them. At the same time, particularly at the beginning of therapy with negative, escalating interactions, we cannot expect parents and adolescents to have the ability to bring up sensitive topics with great skill.

> Ther: I'm doing something that, ultimately, should not be needed, and I think, will not be needed—and that's *translating* for him. (To father) Do you know what he was telling you with his very *immature* behavior? One thing that he was telling you was that "You know Dad, it really sets me off when I hear your lack of *belief* in me."

The word *translating* labels an important stage-specific therapy operation. The therapist first attempts to help Ray shift his view about the event and about his son. Sometimes processing negative emotions yields more negative emotions. So when negative emotionality runs too high, we frequently begin work on important content of this nature from within the cognitive realm.[12] The therapist ascribes positive motivation to counter the narrow negative attributional set and emotional response of Ray to his son (also see Alexander et al., 1983).[13] This treatment establishes complex frameworks about each family member's behavior. From this base, emotions contextualize the past and provide motivation for the present and future.

> Father: Okay.
> Ther: Am I wrong?
> Chris: No.
> Ther: He seems like such a bully sometimes, but there are obviously other sides to him . . .
> Father: He has a very good side.
> Ther: A very good side, right?
> Father: Yes.
> Ther: (to father) It doesn't come out sometimes. He'll get better. But at *that* moment, what he basically says to you is "It shattered me that you didn't believe in me, that you thought the bad stuff was coming again." And then, from that point forward, he loses it, and gets into a very childish "Oh yeah, so you think it's gonna happen. I'll show you it's gonna happen." Then it's too late. But it's *very* interesting what he said. That should make you feel like your opinion *is* important to him. Certainly, your support and your belief in him *is* important to him. Is it not important to you?

This content elaborates the "translating" theme. Attachment theory and research inform this intervention. To Chris we stress the importance of his father's emotional connection to him. The final statement intensifies and focuses the issue, making sure the father and son understand the new meaning being developed. The therapist's statement to Chris, referring to Ray's belief in his son, "Is it not important to you?", creates a personally meaningful and interpersonal in-session experience. Again, the knowledge base of this intervention is the research demonstrating the continued importance of the parent-adolescent relationship to the adolescent, and the ways in which this relationship, when negative, adversely affects the emotional life of both adolescent and parent.

Referring to his father's overt expressions of concern, Chris says:

> Chris: It is . . . but a lot of times I act like it's not (i.e., I act like your support and belief are not important to me), and (I say) "f—— you, I don't care what you say." I really do care, the only reason I say that, because, you know, I feel like you don't (support or believe in me) so I just . . . I don't do what you want.

Here is a marker of progress as well as a foundation upon which future progress can be built. The son's response offers more complexity and directness than usual. Chris acknowledges the importance of his father's support and belief. He reveals something critical—sometimes he acts as if this relationship is not important "because I feel like you don't (support or believe in me)." Attributing rejection and disconnection to his father (a common interpretation), Chris protects against future hurt and disappointment.

> Father: You know I do care . . . right?
> Chris: Yeah, most of the time.

Again, the son's response is more complex and differentiated than usual. Chris acknowledges some of his father's support and positivity, but importantly, he does not withdraw his complaint and further, he expresses it in a productive way. As previous segments demonstrate, this topic generates reactivity and emotional negativity. Now, there is a new relational reality being fostered—the extreme, either-or stances of father and son have been modified. Their positions are becoming more complex. For example, they experience the possibility that negative and positive feelings can coexist. By retracing one's steps out of the negative emotional territory (e.g., cognitive constructs as mediators between negative emotion and action), the realm of emotions now is reentered under different circumstances. Father reiterates a clear statement of caring for Chris. This is important to note because, al-

though these segments showed how to "work emotion cognitively," MDFT is not a cognitive therapy model. A multidimensional approach addresses human functioning in its multiple realms.

Father: Sure I do.

Father stays in an interaction that is difficult for him. Both Chris's new "language" and his father's overt expressions of connection to his son are unfamiliar territory.

Referring to his previous statement ("Most of the time I do see that you care"):

Chris: I'm not gonna say always, because I don't feel like it's always.

Chris completes his differentiated statement of feedback to Ray. This constitutes a good moment in and of itself (i.e., an event with potential "curative" aspects), as well as something that we will resurrect later in other conversations. Good moments[14] (Mahrer, 1988) in therapy are not endpoints unto themselves but "way stations," returned to later for elaboration and further work. The emotions present in these good moments provide new experiences about how relationships might be and give new information about oneself and other family members. As is the case with other aspects of MDFT, these achievements are wholes and parts. They are constructive in and of themselves, and they evolve a new "base of operations" to further relationship progress later. These segments show how negative escalating interactions and relationship themes can become more complex and be dealt with directly and positively with a therapist's help.

CONCLUSION

Our understanding of emotions as intrapersonal and interpersonal phenomena can be enhanced by examining them within a clinical context. However, given some of its well-publicized history, recently the adolescent development field has not been a likely context for this examination. It was this specialty that suffered (Petersen et al., 1993) from the overgeneralization of clinical observations in constructing theories of normal adolescent development (Blos, 1962; Freud, 1958). However, two decades of research have sufficiently debunked the myths of adolescence in the professional (Feldman

& Elliott, 1990; Offer & Schonert-Reichl, 1992; Petersen, 1988) and lay literatures (Steinberg & Levine, 1990).

Perhaps this sets the stage for the pendulum of change to swing back toward consideration of clinical observations, and in particular, therapy contexts in theory building and basic research. If treatment material was accessed in this way, fresh insights for emotion's many constituencies might be available, particularly in light of some contemporary trends. The articulation of empirically developed family-based treatments for adolescents is one of these developments.[15] Additionally, the process research studies conducted on some of these models are specifying basic and clinically related areas germane to adolescent development researchers. The interdependence of emotion, cognition, and behavior is one of these areas of modern-day treatment process research (Liddle, in press).

Finally, the research-practice dialectic needs to become driven less by hyperbole, or to be syntonic with this article's content, by escalating negative emotion (Liddle, 1992). Then we can deepen our understanding of something we knew all along—not only can research affect practice, but practice can and should influence research as well (Kazdin, Siegel, & Bass, 1990; Stricker, 1992).

NOTES

1. Some exceptions include: Colarusso & Nemiroff (1987); Furman (1980), and Kendall, Lerner, & Craighead (1984).

2. Although this article focuses on adolescents, we cannot conclude this section on emotions and dysfunctional family patterns without mentioning the important role of emotions in parenting as a major determinant of the adolescent's emotions. In a comprehensive review of emotions in the parenting literature, Dix (1991) concluded, "perhaps more than any other single variable, parents' emotions reflect the health of parent-child relationships" (p. 4). Dix presented a systematic, clinically relevant framework for understanding emotion's role in parenting. His model emphasizes (a) child, parent, and contextual factors that activate parents' emotions; (b) orienting, organizing, and motivating effects that emotions have on parenting once aroused; and (c) processes parents use to understand and control emotions.

3. These particular sequences were chosen for this article because they are good exemplars of (a) the selected clinical problem, (b) the therapy interventions, and (c) the change process, as we currently understand it.

4. Although we have yet to analyze these data, our clinical research has been concerned with characterizing the emotional processes and characteristics of the adolescents we see in treatment. In our last study, for instance, we used the Millon Adolescent Personality Inventory to assess the emotional self-system of the adolescent.

5. Parenting is a complex area of the field, experiencing a renaissance of attention and systematic study (Dix, 1991; Sigel, McGuillicuddy-DeLisi, & Goodnow, 1992). Elsewhere, we

have described methods designed to help parents reclaim their parental role (Liddle, Dakof, & Diamond, 1991). Unfortunately, these assertions of parental responsibility frequently come in the role of increased attempts at control (i.e., introduction of more control attempts into a system of relationships that already has an overabundance in control issues and attempts). Not surprisingly, our research found these behaviors to be some of the very ones which lead to greater estrangement on the adolescent's part (Diamond & Liddle, 1993; Schmidt, Liddle, & Dakof, 1991).

6. A study by Szapocznik, Rio, and Kurtines (1989) has challenged one of family therapy's fundamental principles—that change in the family is necessary to change an individual symptom. I mention this here to acknowledge that, although our theoretical assertions encourage concepts like complimentarity (e.g., father's change is, at least in part, a function of change in his son), current treatment research seeks to substantiate or, if necessary, change these assertions.

7. Because this approach is representative of the broader class of systems interventions, it is important to note that the converse of this conceptualization also is possible (reminiscent of the multidirectional nature of change in intimate relationships). It is equally important for the son to begin to experience his father in new ways. Also, altering his father's emotional reactions to and negative predictions about his son's behavior (or even about Chris's lack of trustworthiness or probable unsavory motivations) are key to providing Chris with just such a new experience.

8. All change does not lie in the (self-reflexive) network of perceptions about self and other. Although it is this dimension of the change process which we emphasize here, various other contextual (e.g., extrafamilial, ecological) factors, as well as other intrapersonal factors not emphasized here, such as the role of skill development (communication, problem solving, cognitive and affective and general life skills), affect change. They are omitted because they do not embody the therapy model represented in the article.

9. This aspect of treatment relies on the interaction between individual sessions with the parent and adolescent alone and sessions with the parent(s) and adolescent together. In individual sessions, the "positions" of each person are discovered/constructed within the context of a supportive working alliance. These individual sessions are critical to, and serve as a foundation for, the work in joint sessions. At the same time, however, they also function independently and we understand them to have value in and of themselves. Change is understood in a multifaceted way, just as problems of adolescence (i.e., drug abuse) are also understood multidimensionally (Newcomb, 1992).

10. Forgiveness is a complex topic in life and clinical work. Our clinical model does not assume that forgiveness is or should be an all or nothing endeavor. There are degrees, stages, and multidimensional aspects of forgiveness. Forgiveness is less an event and more of a process which must be understood in a developmental, temporal context.

11. This basic intervention strategy known as a shift intervention (Liddle et al., in press) has been identified empirically through a discovery-oriented process research method (Diamond & Liddle, in press).

12. A phrase like "working in the cognitive realm" should not infer that it is possible to have the location of one's focus in the moment be exclusively within this domain. Intentions to focus communication within this or that realm, of course, do not always keep the focus there. Also, given the interdependencies of these realms, this initial intention hardly guarantees the kind of distinctions to be drawn and boundaries to be maintained in reality as is done in language.

13. A note on the "selection" or influence of content in a session. First, a general statement: It is possible to think about the relationship of content to process as one might construe the relationship of emotion to cognition (Haviland & Kramer, 1991). These pairs are inseparable

and exert synergistic action in relation to the other. In therapy, we are biased toward the development of certain themes over others. An important one when considering the general topic of emotions concerns the notion of belief in one's son or daughter (or one's parent). Adolescent problems have been in formation for some time. Given the formidable histories that accompany the human dramas we see in therapy, it is important to acknowledge and help the family deal with the influential but not always articulated relationship themes that seem to characterize family members' current circumstances. Focus on the notion of belief, and importantly, loss of belief (a corollary of trust) is an example of a core parent-adolescent relationship theme.

14. The "good moments" method seeks to answer the question: "Given certain in-session patient conditions or states, what therapist operations or methods are useful in helping to bring about what kinds of very good moments of in-session patient change, improvement, movement, progress, or process?" (Mahrer, White, Howard, Gagnon, & MacPhee, 1992, p. 252).

15. Examples include Alexander et al. (1983); Bry (1988); Henggeler et al. (1986); Joanning, Quinn, Thomas, and Mullen (1992); Liddle et al. (1991); Lewis, Piercy, Sprenkle, and Trepper (1990); Robin (1981); and Szapocznik et al. (1989).

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