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Perceived Criticism in the Treatment of a High-Risk Adolescent

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Abstract

Perceived criticism (PC) is a construct that plays a key role in family relationships of persons with psychiatric disorders. It can be assessed in a brief and simple way using the Perceived Criticism Measure. PC ratings made by patients about their caregivers predict adverse clinical outcomes including increases in symptoms and relapse across a broad range of psychiatric diagnoses. Although research supports the concurrent and predictive validity of PC, the measure is not widely used in clinical practice. Here, we describe the construct of PC and review evidence supporting its clinical utility. We then illustrate how criticism and perceptions of criticism can be addressed in a clinical context, describing a family focused treatment approach used with a depressed adolescent at high risk for bipolar disorder.

Keywords

expressed emotion; families; treatment; criticism; mood disorders; adolescence

It has long been clear that the family environment is of tremendous importance with respect to understanding the course and outcome of psychiatric disorders. Notably, expressed emotion (EE), a measure of critical, hostile, or emotionally overinvolved attitudes held by caregivers (e.g., parents, spouse) toward a family member with a psychiatric disorder, is a reliable predictor of relapse or other poor clinical outcomes across a range of disorders. High family levels of EE are associated with worse clinical outcomes among patients with schizophrenia, depression, bipolar disorder, anxiety disorders, posttraumatic stress disorder, eating disorders, and substance abuse problems (Hooley, 2007). EE is also a reliable predictor of course of illness in pediatric psychiatric samples (Peris & Miklowitz, 2015).

One problem that has hampered the use of EE in clinical settings is that the construct is hard to measure. The semistructured Camberwell Family Interview takes between 60 and 90 minutes to administer (see Hooley & Parker, 2006). Moreover, the interview must be recorded for later rating by a coder who has been trained to detect criticism through the changes in voice tone that occur when the respondent is speaking about the patient. Coding of the full interview takes approximately 2–3 hours, and each relative requires his or her own interview. This is clearly more time than the average clinician can devote to an assessment of

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single family. Not surprisingly, researchers have sought to develop shortcuts to EE assessment.

One such shortcut is the Five Minute Speech Sample (FMSS; Magaña et al., 1986). Here, the relative is asked to talk about the patient for 5 uninterrupted minutes. A trained rater then listens to the recorded speech sample and rates the content of the relative's remarks, taking note of critical comments and evidence of overinvolvement. Coding takes much less time than coding of the Camberwell Family Interview (around 20 minutes). The FMSS, which is frequently used in studies of children and adolescents, has demonstrated predictive validity with respect to depression and, to a lesser degree, schizophrenia (Peris & Miklowitz, 2015). However, the FMSS has a steep learning curve, and trained coders are few. There is also evidence that the FMSS has low sensitivity for EE; it tends to underidentify high EE relatives when compared to the standard EE interview ratings.

Perceived Criticism

The Perceived Criticism Measure (PCM; Hooley & Teasdale, 1989) is another alternative. The PCM is designed to provide a simple assessment of a family member's criticism *from the perspective of the patient*. In this respect, the PCM is unlike the traditional EE interview or the FMSS. After identifying the person who is most emotionally important to him or her (usually a parent, spouse, or partner), the respondent simply rates, using a 10-point scale ranging from 1 (*not at all*) to 10 (*very critical*), how critical he or she thinks this person is of them. The measure also includes an item (again rated on a 1–10 scale) that asks how upset the respondent becomes when criticized. Rating the PCM requires no special training and takes less than a minute.

The advantage of the PCM lies in its ability to quickly identify people at risk of relapse or other poor clinical outcomes. Like EE, PC appears to be a predictor of relapse across a wide range of disorders. In the original study using the PCM, Hooley and Teasdale (1989) found that *every* depressed patient who rated his/her spouse 6 or higher on the 10-point PCM experienced a symptom relapse within 9 months of leaving the hospital. In sharp contrast, every patient who rated his or her spouse a 2 or lower remained well. The link between PC and relapse was also replicated in a subsequent study with depressed outpatients although a slightly different cutpoint (3 or lower) was used. Higher PCM ratings are also associated with more rapid time to relapse in patients with substance abuse problems. Moreover, in adolescents and young adults at high risk for psychosis, PC predicts increases in positive symptoms (for a review, see Masland & Hooley, 2015). The measure performs best when it references a person with whom the patient or client is currently living (Renshaw, 2008).

Is PC Just Another Measure of Psychopathology?

Although it might be expected that patients' ratings of their relatives' criticism might reflect nothing more than the patient's own psychopathology, this does not appear to be the case. In depressed patients, ratings of PC are stable across illness and recovery periods, with high test-retest reliability (Hooley & Teasdale, 1989). Negative mood inductions also do not change PC ratings in any appreciable way (Gerlsma, de Ruiter, & Kingma, 2014). PC is

unrelated to neuroticism (Masland, Hooley, Tully, Dearing, & Gotlib, 2015), and across two separate samples, Masland, Drabu, and Hooley (2017) found no significant correlations between PC and a wide range of psychiatric variables, including sensitivity to criticism (being "thin-skinned"). Demographic variables such as gender, education, or race/ethnicity are also unrelated to PC (Masland & Hooley, 2015; Renshaw, 2008).

Objective and Subjective Criticism

One reason why PC is such a strong predictor of clinical outcomes may be because it measures how much criticism is "getting through" to individuals (see Hooley & Teasdale, 1989). In other words, the validity of the PC rating may stem from its ability to pick up objective *and* subjective experiences of criticism. With regard to the former, PC does tend to be modestly correlated with EE when the latter is assessed through the Camberwell Family Interview although this is not always the case. When spouses are asked to rate how critical they are of the patient, their ratings are moderately correlated with the ratings of spouses' criticism made by the patients themselves (Chambless, Bryan, Aiken, Steketee, & Hooley, 1999; Chambless & Blake, 2009). Observer's ratings of how critical relatives are during a problem solving interaction with the patient also correlate significantly with PC ratings made by patients (Chambless & Blake, 2009). Importantly, available evidence suggests that PCM is measuring perceptions of destructive as opposed to more constructive forms of criticism that are genuinely designed to be helpful (Renshaw, Blais, & Caska, 2010).

As the above-mentioned correlations suggest, however, associations between PC and independent assessments of criticism are far from perfect. Much variance in PC remains unexplained. This suggests that there is subjectivity in the measurement. Smith and Peterson (2008) have referred to the overperception of criticism in close relationships (perceiving more criticism than is objectively present) as c*riticality bias*. Criticality bias has been shown to be positively correlated with negative attributions that patients make about their relatives' behavior. In other words, patients' interpretations of the causes of their relatives' behavior play a role in determining whether or not the relative is perceived as being critical.

PC and Clinical Outcome

In all probability, PC ratings are telling us something about a person's experience of what it is like to be in a relationship with the individual who is the target of the PC rating. But why is this necessary to know? First, and as noted earlier, PC is a valid predictor of clinical outcomes. Clinicians need to be able to identify patients at greatest risk of doing poorly. The brevity of the PC measure makes it valuable in research or clinical contexts where time is limited.

Second, PC ratings may provide a quick and useful indicator of a patient's current relational problems and life difficulties, highlighting important targets for intervention. In adolescents receiving their first treatment for early onset schizophrenia, not only were higher levels of perceived criticism significantly correlated with poorer interactions within family; they were also significantly correlated with having problems with peers, and having a worse quality of life overall (von Polier et al., 2014).

Higher levels of PC may also be marking vulnerability to criticism at the level of the brain. Recent neuroimaging research shows that when people with high PC ratings are exposed to real-world criticism from a family member, they show higher and more enduring amygdala activity. Relative to low PC scorers, high PC scorers show reduced and less prolonged activation in the dorsolateral prefrontal cortex (DLPFC; Hooley, Siegle, & Gruber, 2012). The amygdala and DLPFC are key brain areas involved in emotion and emotion regulation. They have been implicated in depression and other disorders. The finding that neural responding to criticism is different in high versus low PC scorers is therefore quite important. It suggests that the PC measure may provide a rapid means of identifying people whose brains–due to genetic liability, early experience, or both–are taking more of a "hit" from criticism. Over time, and in the absence of intervention, it is possible that being repeatedly challenged in this way may take its toll at both the neural and emotional levels. Indeed, other forms of psychological stress have been proposed to create neurotoxic processes that become autonomous with time.

Finally, there is evidence that PC may be identifying people who have difficulty engaging inhibitory control over negative information. Using a nonclinical community sample, Masland and colleagues (2015) have demonstrated that people high on PC show cognitive processing biases consistent with the DLPFC findings just described. Specifically, people who rate their key relationship as high in PC have more difficulty exerting attentional control over negative emotional information when given a cognitive task that requires them to disengage their attention from a negative emotional face. These findings suggest that negative emotional information may be *stickier* for individuals high on PC. In other words, PC may help us identify people who have more difficulty shifting their attention away from negative emotional stimuli.

Taken together, these findings suggest that PC may be an important variable for clinicians to measure. For many reasons, assessing PC and targeting criticism in the context of the family environment makes a great deal of clinical sense. Approaches designed to reduce criticism and the perception of criticism may have the potential to reduce the heat of the emotional climate in the family and provide benefits for patients and relatives alike. Chambless and colleagues (2017) have recently shown that higher levels of PC predict worse treatment outcomes in patients with panic disorder. As a result of their findings, they argue that interventions should involve a more specific focus on perceptions of criticism.

In the sections that follow we provide a clinical example and illustrate how PC can be used in the context of family-based treatment designed to help an adolescent at risk for bipolar disorder. The approach illustrates the use of family-focused therapy (FFT), an evidence-based therapy for bipolar disorder in adults and adolescents consisting of sessions of psychoed-ucation, communication enhancement training, and problem-solving skills training. Numerous trials have found that the combination of FFT and pharmacotherapy is more effective than usual care or brief treatment and pharmacotherapy in reducing symptom severity and enhancing functioning in patients with or at risk for bipolar disorder (Miklowitz & Chung, 2016).

Case Illustration

Presenting Problem and Client Description

James (a pseudonym, with all subsequent identifying information altered), age 13, who went by "JJ" to his family and friends, was in a special education school for children with "emotional and cognitive disorders." His Individual Educational Program (IEP) mandated that he be in relatively small classrooms with other children with special needs, which in his case included children with autism spectrum, psychotic, and severe attention deficit hyperactivity disorders (ADHD). James complained bitterly about his school and the low functioning of the other kids who went there. His own school performance was inconsistent, even though he tested in the high IQ range (111 Full Scale score).

James came from a middle class family that lived in a rural area. His mother was a real estate agent and his father owned a business. He had a 21-year-old sister who had a developmental disability (low IQ) and had been diagnosed with bipolar disorder at age 13. His sister lived in the home but in her parents' estimation was not stable enough to attend family sessions. JJ received FFT with his mother (Mrs. A) and father (Mr. A). His own diagnoses included major depression (current and past), ADHD, and oppositional defiant disorder.

During the first family session, JJ's father began with a list of all of the things JJ had done in the past several months to "destroy the family atmosphere." These included inconsistent school performance, staying up too late playing video games, being irritable, especially when asked to interrupt his game-playing; being grumpy at the dinner table; getting into altercations with kids at school in situations where he felt insulted or left out; and more generally, "poisoning the atmosphere wherever he goes." JJ responded by intermittently crying and cursing at his father. In the next session, conducted just with JJ and his mother, JJ cursed loudly and repeatedly jumped out of his chair when his mother spoke, threatening to physically hurt her with pieces of cardboard, pens, or other implements he found in the therapy room.

Despite this behavior, JJ showed some insight into his problems. He complained bitterly that his father "is always after me to do better … he never tells me I'm doing good enough." He spoke articulately about feeling stigmatized by attending a school for emotionally disturbed kids. His conflicts with his mother centered on her apparent inability to get things done to help him, whether it be getting extensions on his homework due dates, not being willing to put him in another school, or her lack of success in getting his father to be less critical.

Case Formulation

JJ came from a family that was rated as high in expressed emotion by the FMSS method. Both parents made critical comments and showed evidence of high emotional overinvolvement when they were asked to speak about JJ. Use of the PC measure and a family interaction sample pointed to bidirectional family processes–criticisms from parents were met by counter-criticisms from JJ in recursive fashion. On the 10-point PC measure, JJ rated his father a 7 out of 10 on the amount of criticism his father expressed toward him; he rated his distress in response to his father's criticisms as a 7 out of 10. JJ rated his mother's

criticality as a 3 out of 10. Both parents rated themselves as low in criticism (ratings of 2–3) and did not feel that JJ was critical of them. Rather, they viewed him as just “oppositional” and “impolite.”

The family was asked to complete a 10-minute problem-solving discussion with no clinical staff members in the room. They chose a common topic, conflict over video games. In the direct interaction, Mr. A. lectured JJ about his behavior. These lectures often became long and critical harangues that no one could interrupt. JJ fought back at first, justifying himself and pointing out ways in which his father had missed positive things he had done. As the interactions progressed, JJ lay down on the couch on his back and started kicking at the prints on the wall. His mother and father both told him to “stop, you’re being disrespectful” but this seemed to increase his behavior. By the end of the 10-minute discussion, JJ became withdrawn and lay curled up on the floor, no longer willing to interact with the clinician or his parents. It resembled a “learned helplessness” process.

After the baseline evaluation, the family clinician proceeded with the following goals: (a) to encourage the parents, and especially the father, to recognize the underlying biological bases of JJ’s disorder and the degree to which his aversive behaviors might not be fully under his control; (b) to encourage both parents to recognize JJ’s hypersensitivity to critical comments and decrease the frequency of negative communication; (c) to increase the frequency of positive communication from both parents toward the child and the child toward parents; (d) to assist the father in framing his positive feedback in ways that didn’t put pressure on JJ; (e) to help JJ recognize his emotional reactions when others (his parents and peers) said or did things that made him feel rejected and to try to distinguish his reactions from their intentions.

Course of Treatment

Given the salience of disordered communication in this family, and the lack of acknowledgment of JJ’s disorder in his parents’ formulation of his problems, the clinicians offer the family a 12-session course of FFT for youth at high-risk for bipolar disorder (FFT-HR; Miklowitz et al., 2013). The program comprised four sessions of family psychoeducation (recognition and early intervention with prodromal signs of mood episodes; recognizing and attempting to reduce the impact of stressors); four sessions of communication enhancement training (directed exercises to practice expressing positive or negative feelings, active listening, making requests for changes in others’ behaviors, and communication clarity); and four sessions of problem-solving skills training. JJ also met with a psychiatrist who prescribed risperidone (a second generation antipsychotic medication), lamotrigine (Lamictal, an anticonvulsant mood stabilizer), and Vyvanse (a CNS stimulant for ADHD).

Treatment began with the assumption that JJ had fairly severe depression and anxiety that would have amplified the meaning of any criticism he perceived from his parents. At first, it was hard to ignore his oppositionality. He seemed to become offended very easily and could become unreachable early in the session if the clinician did not set limits on his parents’ critical comments early and repeatedly. Psychoeducation about mood disorder helped to normalize his behavior and relate it to probable biological and genetic underpinnings, such

as their family history of depression and bipolar disorder. However, discussion of his mood disorder sometimes increased JJ's resistance to treatment. It was not surprising why: He felt stigmatized by the diagnosis in his home and school life. Moreover, most of the people he knew who had mental illnesses (his older sister, several of his schoolmates) had led unfortunate and isolated lives.

The treatment quickly moved into a communication training phase. JJ was clever in the communication/role-play exercises. He learned the steps of *active listening* and *positive requests for change* very quickly. He responded especially well to the exercises involving *expressing positive feelings about specific behaviors*. Not only did he appreciate his parents' acknowledgment regarding his attempts to be a good student or be cooperative at home, but the exercises also allowed him to express appreciation toward his mother, whom he recognized had been working hard to find him the right school.

A key moment in this treatment occurred in the sixth session, when the FFT clinician asked the father to express positive feelings about something JJ had done in the past week. The clinicians gave Mr. A a handout listing the components of the skill (look at the person, say what s/he did that pleased you, how it made you feel), which he had seen before in earlier rehearsals. This time, however, Mr. A's difficulties became more obvious. He praised JJ for his recently improved school performance, adding a "tail" of implicit criticism at the end: "Now that you've got Ms. Brooks in math you'll be able to do much better than you have been doing." JJ bristled at this aspect of his father's message, explaining that Mr. A's constant references to the future meant that JJ's performance was always going to be under a microscope.

The clinician coached the father to express the same positive sentiments without any reference to the future. Leaving off the tail at the end was difficult for Mr. A, who wondered why one would give a compliment without encouragement to "keep it up." The clinician assisted him with different ways to wrap up the compliment, as illustrated below:

> Clinician: Dad, can you tell JJ what he did in this past week that you appreciated? And JJ, all I want is for you to listen, like we talked about, and then you can tell us how your dad did with the skill.
>
> Father: Um, well … let me think for a minute. I guess he did really well with his homework and the Spanish test ….
>
> Clinician: Can you tell him directly?
>
> Father: Sure, uh, JJ, I want you to know I was very impressed with your effort in Spanish this week. I could tell it was important to you, and you know how proud I am when you do well. So, I really appreciated that, and, and … now that you've got the tutor and those tapes, I think there's no reason you can't keep doing that well and really shine like I know you're able to.
>
> Clinician: Good. JJ, can you tell us what you liked or didn't like about what your dad just said? JJ: (pauses) I didn't. He got into telling me about what he expects, and how I never end up living up to it.

Father: (surprised) When did I do that?

Mother: You always do that, honey. I can see you going in that direction.

Father: But I don't understand what I said that was wrong. (looks again at handout)
Clinician: JJ, if I may, I don't think your dad said anything about you not living up to his expectations. But I do think you get kind of upset when he adds anything about the future.

JJ: (nods emphatically) Yeah, it's that. He doesn't have to do that. It's like, the next time I take a test he'll be watching me and then I won't do well, and then he'll be all freaked out.

(silence)

Father: OK, but what should I say instead?

Clinician: I think the rest of what you said was good. JJ, how would you like him to finish it up?

JJ: (defensive) I dunno.

Clinician: What can he end it with?

JJ: (rolls eyes) How about just "You did good"?

Clinician: OK, dad, would you be willing to try it again, but this time don't go into the future, just end it with "You did good"?

Father: OK, seems kinda artificial, but I'll try …. JJ, I was very impressed with your effort in Spanish, I was really proud that you did as well as you did on that midterm test, and so, uh … good job.

Clinician: Nice! JJ, what about that time?

JJ: (noncommittal) It was better.

Mother: I think this is great. I just wish we could do this at home.

Mrs. A. was aware that her husband often felt disappointed in JJ, although she tended to add "digs" such as "sometimes I think he just doesn't like JJ." In a parent-only session, she said that she thought her husband's reactions derived from his own history of depression and difficulty pleasing his own father. Mr. A. did not entirely agree, feeling that JJ's behavior needed to be judged harshly if they were to see any changes.

The clinician worked with the parents to set up a positive behavior point system to reward JJ's daily behavior. Points were allocated for certain good behaviors (e.g., getting his homework done, getting to bed on time) but also for the absence of negative behaviors (e.g., getting through an evening without cursing at one of his parents, limiting his video game time). Although JJ seemed enthused about the plan, Mr. A. had some resistances to it, believing that JJ was being rewarded for behavior that he should be doing anyway. The clinician explained that because of his mood disorder and difficulties with attention and motivation, JJ needed more immediate rewards to carry out his parents' daily expectations, with the plan to discontinue the point system when these behaviors became more automatic.

For JJ, later segments of the treatment involved learning to label his emotions, whether positive or negative. Instead of the pervasive “good” or “bad” emotions he described at the beginning of treatment, he was increasingly able to identify more nuanced states such as anxiety, threat, guilt, anger, sadness, or, on the upside, feeling “super excited,” or “amped up.” Use of these terms in communication and problem-solving exercises was of considerable help when he tried to explain to either parent why he had reacted negatively to a seemingly neutral exchange. They were also useful when the family began to discuss JJ’s prodromal symptoms of mania and depression.

Outcome and Prognosis

At the end of treatment, JJ’s behavior was considerably more stable. His relationship with his father was growing: They spent more time together on weekends doing activities they both enjoyed (playing in the park with a drone and building a replica of a “Quidditch pitch” in their backyard). JJ still became withdrawn when he felt he was being criticized, but he was more able to observe that his mood swings sometimes came about from overreacting to his peers’ or parents’ comments. He reported being less depressed and anxious at the end of treatment. As is usually recommended in the continuing care of children with bipolar disorder or high-risk conditions, JJ continued to take mood stabilizers to reduce his chances of developing a new episode of mania or depression.

Clinical Practices and Summary

Based on JJ’s rating of his dad as a 7 on the PCM, and the fact that both of his parents met criteria for being high in EE on the FMSS, we would consider JJ to be at high risk of a poor clinical outcome at the outset of treatment. Although we might consider that the difference between JJ’s PC rating of his father and Mr. A.’s rating of his own behavior to reflect hypersensitivity to criticism or a “criticality bias” on JJ’s part, it also seems apparent that Mr. A. was more critical of JJ than Mr. A acknowledged. Although the father’s comments were well intended and made in the service of improving JJ’s school performance, it is clear that these comments reminded JJ of his inability to live up to his father’s expectations. This created stress for JJ, reinforcing his feelings of failure as well as triggering acts of aggression toward his parents and peers.

JJ’s relationship with his mother was less characterized by criticism. It was, however, characterized by emotional overinvolvement. His mother met the EE criteria for overinvolvement based on her self-sacrificing behaviors (e.g., missing work to stay home with JJ if he became anxious about school). She also made occasional statements indicating questionable emotional boundaries (“when he hurts, I hurt”). This feature of their relationship came up in treatment as well. For example, Mrs. A showed a tendency to take her son’s side whenever there was a conflict with anyone at school.

Some children or teens with mood disorders have increased resilience because of the presence of protective factors. These can be manifest in the child (e.g., good social skills) or the environment (e.g., supportive parents or other relatives, strong friendships, good financial resources). Some adolescents seem to have a native ability to “reframe” negative interactions (e.g., “Dad just wants me to do better; he’s not saying those things to be mean”).

In contrast, in youth who are less resilient–because of increased genetic vulnerability, loss experiences, or trauma–parental criticism can trigger feelings of self-hatred and hopelessness. For these youth, criticism is more “penetrant” and may become magnified in either importance or perceived frequency or both. The nature of the association between parental criticism and psychiatric symptoms may also change over time; in adolescents, there appears to be a bidirectional association.

Criticism and the perception of criticism are both important targets in the FFT approach and similarly formulated treatments for schizophrenia, such as behavioral family therapy. FFT does not assume that parents should always refrain from criticizing their children; indeed, circumstances may necessitate pointing out problematic behaviors and the effects these behaviors have on other people. Instead, FFT takes a contextual approach and assumes that the course of childhood mood disorders will be partly a function of the degree of conflict and criticism in the family (Miklowitz & Chung, 2016).

FFT attempts to modify the impact of criticism and negative family interactions in a number of ways. First, this approach seeks to teach parents and offspring how to balance praise with criticism. There is also a focus on encouraging family members to make criticisms as behaviorally specific as possible. It is important for the recipient to know which of his or her behaviors are being critiqued and how often they occur in the judgment of the person making the criticism. FFT strives to help parents (and other family members) understand that some of the negative behaviors that they regard as problematic are related to their offspring’s vulnerability to illness and not fully under volitional control.

Finally, efforts are made to teach children to consider the possibility that some of their parents’ critical comments are in the service of improving relationships or enhancing their functioning in the school environment. When youth are older (often, late adolescence), they can begin to understand that their parents have their own emotional vulnerabilities that are triggered by factors sometimes unrelated to the offspring’s behavior.

Concluding Comments

Research is limited on the role played by criticism in the pathways to clinical improvement with family intervention. Currently, there is evidence that perceived criticism is a moderator of the efficacy of treatment for panic disorder; patients who rate their closest relative as more critical do less well. In contrast, several studies suggest that criticism is a moderator of the effects of FFT in bipolar spectrum disorders but in the opposite direction: Patients from families rated high in EE show greater improvement in FFT than patients from families rated low in EE (Kim & Miklowitz, 2004; Miklowitz et al., 2009, 2013). Despite these divergent findings, PC ratings might be used to identify families who are most in need of clinical services.

Interestingly, in the only study to examine PC as a mediating variable, patients who were at high clinical risk for psychosis rated their mothers as less critical after FFT or after a much briefer psychoeducational intervention. The degree of reduction in PC was related to the severity of positive psychotic symptoms at 12 months (O’Brien, Miklowitz, & Cannon, 2015). Taken together, these findings highlight the importance of criticism and perceived

criticism as treatment targets in individual-, couple-, and family-based interventions for patients with severe psychopathology.

There is no rigid or prescribed protocol for modifying criticism in the context of the family environment. Rather, a variety of cognitive and behavioral approaches can be used. Most patients are quick to acknowledge the role that criticism from others plays in their emotional lives. Moreover, disorders like bipolar disorder may amplify the meaning of criticism. For example, fMRI studies indicate that children with bipolar disorder may interpret neutral faces as negative. This “negativity bias” has also been seen in schizophrenia and other disorders such as borderline personality disorder.

Most family members are aware of how criticism can make a challenging situation even worse. It is also important to stress that criticism and reactions to criticism can be addressed even in the absence of a formal family intervention, such as through individual cognitive behavioral therapy or interpersonal therapy. We hope that the illustrations provided here will encourage clinical practitioners to consider the role of criticism, and perceptions of criticism, in the patients that they treat.

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