Evolving Illness, Shifting Perspectives: Childhood Psychosis Through the Lenses of Family Therapy and Individual Therapy

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CASE HISTORY

The Lombardo family,* presenting for family therapy, comprised five members: Dave, a 46-year-old white male employed as an investment manager; Caroline, a 47-year-old white female working as journalist; Ryan, their 10-year-old son in fourth grade; John, their 8-year-old son in second grade; and Nick, their 7-year-old son in first grade. The couple had been married for 13 years. The family came to five sessions to complete the intake process, meeting in different configurations. In the final intake session, with the entire family, the therapist provided feedback and recommendations for treatment. Following the intake and over the next several months, the family continued weekly sessions, in the following sequence: a session with the children only, followed the next week by a session with either the entire family or the parents only, followed the next week by a session with only the children again.

The family was referred to family therapy by Nick's individual therapist, Dr. A, who for the past year-and-a-half, had been treating Nick in individual play therapy and with medication management for an emerging mental illness, marked by psychosis, depression, and anxiety. Nick had been hospitalized psychiatrically on an inpatient unit for the first time three months prior to the initiation of family therapy.

Couple's Individual, Relationship, and Family History

Caroline was the second of five siblings, from an Italian Catholic family. She described her father as "debonair" and devoted to supporting the family, but she also noted that he was a traveling salesman and "hardly around." Caroline's mother worked as a waitress and was mostly around in the evening hours. Because Caroline's parents worked such long hours, Caroline served much of the time as the caretaker for her siblings during her teenage years and young adulthood. Each of her siblings suffered from severe mental illness. Her older sister had bipolar disorder with psychotic features (with childhood onset), alcohol and benzodiazepine abuse, multiple hospitalizations, and two suicide attempts. Her three other siblings also developed significant mood disorders and substance dependence. Caroline described loving her parents and family deeply, and was invested in helping her siblings throughout her life. In addition to the history of mental illness in her immediate family, her maternal great-grandfather and first cousin had completed suicides by hanging. She mentioned that one of her brothers once said to her, "Caroline, you must be the saddest one of us all," referring to the burden that she has had to bear.

Caroline has suffered episodically from depression and anxiety as an adult, and experienced postpartum psychosis following the birth of her second child, John. Caroline first entered into family therapy when she was six years old; she noted that therapy had always been an important part of her life.

Dave grew up with both his parents and an older brother. He described his childhood as "pretty typical" and denied any family history of psychiatric illness. His father worked a white-collar job for a manufacturing company, and his mother was a college professor. He was always interested in music, and still plays guitar in a band with his older brother. He denied any personal or family history of psychiatric illness or substance abuse.

The couple was introduced to each other at a party twelve years earlier, through mutual friends. With a warm smile on her face, Caroline recounted how she fell in love with Dave's "zest for life" and his "sense of frivolity." Dave followed this

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up with a statement that "Caroline is an amazing and wonderful person." They married a year after they met, and Ryan, their first child, was born less than two years later. Caroline described the significant impact that raising children has had on her; in particular, she discussed the postpartum psychosis that she experienced following John's birth, in which she reported hearing incessant, menacing voices coming from next door.

Caroline was well educated. She held multiple degrees, including a master's degree in journalism. At the time of the initial family consultation, she was working as a writer for a women's health magazine. Dave led a successful career in the financial industry, but as a result of a national financial crisis three years earlier, he experienced a brief period of unemployment. He then joined a different company, whose business has continued to grow.

Caroline and Dave had been in couple's therapy in the past, which Caroline stated was to help them improve their communication and navigate the challenges of balancing work and family life. Caroline found therapy useful, whereas Dave stated, "I'd always end up becoming good friends with the therapist, but I honestly don't think it really did anything for me."

Caroline noted that the reason for seeking family therapy this time was due to the significant marital conflict regarding their conflicting approaches to Nick's psychiatric illness. Caroline, who had been the children's primary caregiver since their eldest, Ryan, was born, reported that she had become increasingly frustrated with Dave's minimizing the extent of Nick's illness. She often found herself in the role of having to "defend the doctors," a position she found burdensome; she wished, instead, that Dave would either defer to her and be a supportive presence, or become more educated about the situation, as she felt that she was. Of note, however, was that up to this point, both Dave and Caroline reported that Dave had never personally witnessed any psychotic behavior in Nick. An example of the tension that resulted from their different perspectives occurred when Nick was hospitalized psychiatrically three months prior to our initial meeting. Dave rhetorically asked in an inpatient family meeting, "Doesn't anybody here realize that he's missing school?" Caroline felt that it was obnoxious to pose such a question—and to imply that capable treaters would keep Nick in the hospital without psychiatric justification. Another irritant in their relationship was their different use of humor. Caroline complained that Dave often deflected his feelings with humor that contained a sarcastic edge. For example, when asked how he managed his emotions, he quipped in a pseudo-quivering voice, "I don't have a heart."

Children's History

VIA DR. A, NICK'S INDIVIDUAL THERAPIST Nick presented to treatment a few months after first reporting that he heard voices in his head telling him that he was bad, warning him that he was going to die, and instructing him to hurt others. At the time, he reported that one of the voices had the same name as his brother yet was distinct from his brother. Nick had urinated on the floor a few times and reported that the voices had instructed him to do so. Nick had also grown fearful of caretakers, including his mother and camp counselors, whom he thought were plotting to hurt him. He worried about choking on his food and so avoided eating, which led to significant weight loss. He frequently spoke about death, expressing worries that he or others would die or be killed, and reported that the voices inside his head threatened to kill or hurt him.

Nick was born full-term via a normal spontaneous vaginal delivery with no perinatal complications. His mother started citalopram 10 mg daily during her third trimester of pregnancy to prevent severe postpartum depression with psychotic features that she had experienced following the birth of Nick's older brother, John. Indeed, she did not experience a postpartum mood episode following Nick's birth. As an infant, Nick demonstrated hypotonia and had delays in fine and gross motor functioning and also in language development. He was evaluated by developmental medicine and received speech therapy at the age of two for expressive language delays. Social milestones were also significantly delayed. From a young age, Nick had a tendency to isolate, and he did not often ask for others or seek shared enjoyment. He also had a lack of age-appropriate friendship formation and socialization. He demonstrated heightened sensitivity to loud noises and exhibited some hand flapping in toddlerhood. Nick and his parents independently denied any history of physical, verbal, emotional, or sexual trauma.

Nick was diagnosed with unspecified psychotic and anxiety disorders, and an extensive medical workup was initiated. The workup was notable for slightly elevated prolactin. A neurology evaluation led to a diagnosis of familial spastic diparesis, thought to account for his developmental delays. EEG and MRI were normal. Neuropsychological testing was significant for features of a pervasive developmental disorder and for anxiety, depression, and psychosis. His anxiety significantly improved over the course of his first year of treatment with weekly play therapy and low doses of citalopram and aripiprazole.

Despite this decrease in anxiety, exacerbation of his psychotic symptoms occurred in the fall of 2011, about one year after initial evaluation. The precipitant appeared to be a fire drill at school, which caused extreme fear and escalated to a recurrence of his initial symptoms. He also expressed pervasive feelings of sadness, had thoughts of hurting himself, threatened to kill his mother, and exhibited aggressive, disorganized, and hypersexualized behaviors. This downward course led to his first psychiatric hospitalization, where he was ultimately stabilized with a combination of risperidone, lamotrigine, and clonazepam. A family therapy referral was initiated in the winter of 2012 following this hospitalization. In addition to being in conflict over the understanding and treatment of Nick's symptoms, his

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parents requested the family intervention to help Nick's two brothers understand and cope with his illness and symptoms.

Via Dr. B, the Lombardos' family therapist Ryan, the eldest brother, was a good student and popular with his peers. He was an excellent athlete and particularly excelled at baseball. He was enrolled in public school in their affluent suburb. Psychologically well-adjusted, he was well aware of his younger brother Nick's psychosis. In the initial intake, Ryan voiced concern about Nick and worried that Nick was going to be teased in the years to come due to his mental illness.

John, the middle brother, was also very bright, excelled academically, and attended the same school as his brothers. He had occasional behavioral problems in school, getting into verbal arguments with select peers. Throughout the initial intake, John was mildly hyperkinetic and attempted to draw humorous characters (e.g., he drew a picture of a whimsical superhero shaped like a taco with a cape, aptly named "Taco Man"). He appeared to pay little attention to the interview. When questioned directly about Nick's illness, he attempted to be funny, declaring, in a goofy tone, "I'm afraid Nick's going to die!"

Treatment History I: Individual Play Therapy with Dr. A

Over the course of almost two years, Nick was treated with a combination of medications and weekly individual play therapy, which for six months was observed by child psychiatry fellows through a one-way mirror. Doing crafts was a common theme of play; it involved using paper to make objects like swords, books, and costumes. Nick also gravitated toward drawing scripted cartoon characters, playing ball, building forts, and pretending to die or to sleep. His play was often characterized by challenges to the frame of therapy: he would run out of the room and back in, in a version of hide and seek. At other times, he went into the observation room and tapped on the mirror connecting it to the therapy room: he was delighted and mesmerized when the therapist would localize Nick's vibrations on the glass and tap back, mirroring his movements.

At times when Nick was less well, his play became more disorganized, aggressive, and sexualized. During these sessions, his thoughts were difficult to follow; he would appear afraid much of the time; and he frequently used the term "chicken" as both a name for characters and a nonsensical answer to questions. In therapy, Nick and his therapist worked on identifying and describing feelings, and on self-regulation and connectedness. He became increasingly able to identify and express feelings such as excitement, sadness, and worry with words as opposed to physical gestures. He brought up sexual words and themes that he thought were "gross" or "confusing" (e.g., asking the therapist to close her eyes and typing "boob" on the computer), but he was increasingly able to avoid running out of the room right after expressing himself. He typed messages, including "I hate you" and "I like you," and became more able to tolerate positively expressed emotion from the therapist (such as "I like you, and "I like our time together") without becoming aggressive or running out of the room.

Treatment History II: Family Therapy with Dr. B

During the initial meeting with Caroline and Dave, they described their exuberant courtship as well as the strains on their marriage since becoming parents. Caroline remembered the excitement and optimism she felt when, early on, she watched Dave perform with his jazz band on stage. Dave described an appreciation for Caroline's work ethic and dedication to any endeavor to which she committed herself, whether it was her attending night school to earn a master's degree or her meticulous planning of interesting weekend trips for the two of them.

As that session progressed, however, Caroline recounted the strain that having children had on their relationship and her career. Prior to having children, she was in a position to be a lead editor for a major national newspaper. However, because she wished to be the primary caregiver of her children, she felt she had no choice but to put aside some of her career ambitions. Although she did not regret this decision, it had been a difficult one and "permanently changed" the course of her career. She also noted that she had decided to take a leave of absence at the time of Nick's first hospitalization to assist more with his care.

This initial couple's session concluded with Caroline expressing her hopes that family therapy could help support their family in the face of Nick's illness. By contrast, Dave expressed ambivalence about attending family therapy. On the one hand, he wanted to be supportive of his wife by attending because "she finds therapy helpful." On the other hand, he confessed that it felt like just "another thing I've gotta do" in an already busy schedule.

In the initial session with the entire family, Caroline reported that she had always been open and had encouraged the boys to be open about their feelings, in general, but also, in particular, around Nick's mental illness. Caroline was by far the most talkative member of the family and much more enthusiastic about the potential benefits of family therapy. Dave described that he felt a great deal of stress around providing for the family financially. He felt most comfortable expressing feelings of anxiety and stress related to work.

Meeting with the three boys alone, the therapist noted that they were a lively and generally cooperative group, who readily included Nick in their play. While they initially looked to the therapist to help moderate board games, they were able, with a little encouragement, to negotiate games on their own. During the play, they often talked about music. John played guitar and was a big fan of the Beatles. Nick played drums. Ryan used to play guitar but gave it up in favor of athletic endeavors. He now spoke about musicianship with a disdainful tone.

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Following the initial set of sessions, the therapist met with the entire family to give feedback and recommendations for therapy. The therapist noted that much of the conflict that Caroline and Dave experienced as a couple was shaped not only by differences in their direct experience of Nick's mental illness, but also by their experience of mental illness (or lack thereof) in their respective families of origin. He noted that humor had served as somewhat of a double-edged sword in the family. At its best, it created a lighthearted atmosphere, but humor also played a destructive role when it suppressed expressions of sadness and other painful emotions.

Ongoing family therapy was recommended, with three primary goals: (1) to develop a healthy way to talk about Nick's illness, (2) to ensure that John and Ryan were provided adequate room to develop as individuals, and (3) to help Caroline and Dave create a family system in which they could discuss their challenges and collaborate as a team despite their differences in parenting styles. A plan for treatment was offered in which there would be meetings with the boys every other week, and in the intervening weeks, alternating sessions with the couple alone or with the entire family. The therapy was arranged this way for several reasons. Observing the sibling subgroup repeatedly over time would provide a playful forum in which the boys might more freely express feelings about their family. It also could provide a unique perspective into their relationship with Nick, and vice versa. Parent sessions were important, as a number of subjects, such as Nick's mental status and parenting disagreements, would be more appropriately discussed in the absence of the children. In addition, sessions with the entire family were important to assist the family in functioning as a whole.

Although the initial consultation began in January, regular family sessions did not get under way until late May. This delay was primarily due to conflicts around scheduling and cancellations due to Dave's work-related obligations. During the summer, sessions with the boys involved a mix of physical activity (e.g., Monkey-in-the-Middle), computer time (e.g., humorous YouTube videos), and collaborative board games. The more physical the activity, the more likely it was that physical altercation would occur—most often between Ryan and John. At times, particularly around use of the computer, Nick would become tearful if he perceived that his brothers were not being fair to him. When the therapist asked the older boys about their experience of Nick's behavior, John would say things like, "I hate him! He's disgusting!" and would describe how Nick exposed his buttocks to people and pushed his breasts together. John spoke in an exasperated tone, conveying contempt for Nick. His tone was like that of a stand-up comedian, doing a routine on his annoying little brother. He sought to convey distress, but not in a vulnerable way. This posture contrasted with that of Ryan, who tended to respond minimally and appeared uncomfortable being asked about Nick.

In the other sessions (i.e., those with the couple alone or with entire family) that took place during the summer, Caroline asserted that she was the only parent with whom the kids would discuss their feelings, and she complained that Dave's approach had contributed to this imbalance. Caroline might go up to their bedrooms to say goodnight, and then learn how the children were "really doing," whereas Dave would notice it was getting late and loudly declare, "Go to bed!" This would signal the end of his communication to them for the night. Dave defended his style of parenting by emphasizing the things that he did with the children, like coaching baseball and going on outings. He also acknowledged, however, that he was not the fun-loving dad that he imagined he might be and that he often was angry and testy when he interacted with the kids. Both John and Ryan complained that "all Dad does is yell" and that they "can't really talk to him."

Toward the end of the summer of 2012, the family entered into another crisis. Caroline reported that Nick was becoming increasingly hypersexual, groping her breasts and taunting her. She said that Nick had grabbed the crotch of one of Ryan's friends in the car and also inserted his penis through a key ring on his mother's purse. She also observed that Ryan and John were irritated and embarrassed by Nick's inappropriate behavior.

Another stressor at this time was the news that Caroline's company was planning to eliminate her job, although the parent newspaper company had created a job for her in Philadelphia. Included in this move would be a higher salary: however, if she was unwilling to accept this position, she would be laid off. After some deliberation, in which she considered commuting during the week, she ultimately decided not to accept the position.

Shortly after quitting her job, September arrived, and a new school year began for the boys. Caroline began putting forth great efforts to obtain services for Nick at school. Still, she experienced significant resistance from the school, whose reported position was that Nick had been receiving adequate services and that he was not nearly as impaired as his mother believed him to be.

With the beginning of the school year, Nick continued to become more symptomatic and was unable to attend school. He grew increasingly fearful and disorganized, questioning whether he was real or whether his mother was real. This significant exacerbation of his psychosis and anxiety ultimately led to a three-week inpatient psychiatric hospitalization spanning late September and early October, during which he was stabilized with risperidone and citalopram. The period just prior to and following the hospitalization was notable for a significant shift in Dave. During this period, he increasingly acknowledged that he was experiencing Nick's behavior as abnormal. He described Nick as clingy and noted that it was challenging to spend a whole day with him.

During Nick's hospitalization, the therapist continued to keep in touch with Caroline via phone, but the family did not come to sessions during this time, choosing instead to spend the evenings with Nick at the hospital. Shortly after

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Nick's discharge from the hospital in mid-October, the couple had a particularly intense session focused on their experience of Nick's hospitalization. Caroline described how, early on, she became overwhelmed by feelings of sadness and hopelessness, lamenting that Nick, only a young boy, had become so perpetually sad and fearful. This prompted her to envision a grim future in which she imagined a teenage Nick becoming emotionally tortured and suicidal. She wondered what sort of life he had to look forward to, leading her to entertain the idea of not intervening if he were to become suicidal as an adolescent. She described having these "horrible thoughts" as she commuted back and forth to the hospital to visit Nick. In this context Caroline also discussed the suicide by overdose, just a year earlier, of her cousin, a young adult female whom she greatly admired. Caroline also anticipated "the burden" that her other sons would face in having to assist with Nick's care as they grew into adulthood.

When Dave was asked about his way of managing his emotions during the hospitalization, he paused for a moment and said, "I guess I deal with it by concentrating on what has to be done now." Dave described how he chose not to spend much time contemplating the future because there was so much that needed to be done "right now" just to fulfill his responsibilities as a husband and father. However, he poignantly acknowledged how painful it was both to see his child locked up in a hospital and—at the same time—to acknowledge that it was appropriate in this situation. Dave also noted that Nick, despite his misfortune, was also fortunate to be a part of their family and that he could have been much worse off in many other circumstances. Caroline noted that, in contrast to her experience of Dave during Nick's previous hospitalization, she perceived Dave to have become more understanding of her sadness. Furthermore, she appreciated Dave's ability to remain centered and focused on the moment at hand. She felt that Dave helped to lift her out of the despair that she had been experiencing early in Nick's hospitalization. These perceptions and feelings marked a major shift in their relationship.

As the session shifted to a discussion of their other children, Caroline and Dave expressed concern that Ryan had been spending more and more time at the home of one of his peers and that he seemed to be avoiding home lately. At a subsequent session in early November, Caroline reported that Ryan had been expressing feelings of sadness to her, and she encouraged him to talk to the therapist about those feelings at the next family meeting. That evening, while meeting individually with the therapist, Ryan mentioned that he wanted to have "my own counselor." When asked why, Ryan said that he had been feeling sad over the last two months. And just recently, on the day after his birthday—when he did not get the laptop computer that he wanted—he had had thoughts about death for the first time in his life. A referral to individual therapy was forthcoming.

At around the same time, Caroline reported that John had become interested in biographies. Among the books he read was the biography of rock 'n' roll legend, John Lennon, who was tragically shot and killed by a former fan, Mark David Chapman. While reading this book, John asked his mother, "Doesn't Nick have the same mental illness as Mark David Chapman?" Caroline responded with reassurance that Nick was a different person than this man he was reading about and that they did not have the same mental illness. The therapist counseled Caroline to reassure John that Nick had never been violent before and that nothing suggested that he would be violent in the future.

Against this background, the therapist wondered if family therapy was adequately addressing Ryan's and John's emotional needs. At the following session, the therapist decided to encourage affective expression through play and introduced an expressive play intervention, called the "family photograph," in which each member of the family—like a photographer—is instructed to arrange each family member into characteristic positions for a family photograph. The "photographer" was also asked to provide "thought bubbles" (as in a comic strip) for each family member. Ryan's image was unsettling. He asked his younger brothers to get on the ground like dogs and positioned them so that they were sniffing each other's backsides. Nick's thought was, "He smells yummy," and John's was, "Payback stinks!" He instructed Caroline to cover her eyes, whereas Dave was asked to look the other way. Both John and Nick created photographs and thought bubbles with similar themes of sexuality, bathroom humor, and aggression.

Caroline's utilized the exercise to express anger, sorrow, and frustration. She positioned Ryan at the computer, stating, "I'm focused on this game. I hate everyone!" She positioned Nick with one hand on himself and one hand on John, stating, "Sexy, sexy!" She instructed John to make a frustrated expression, stating, "I can't stop him. Stop him! Stop him!" She asked Dave to put his face in his hands, thinking, "I'm tuning this all out until this bubble game ends."

Finally, Dave moved each child into position for a traditional pose, with each person facing the camera. Then, he asked everyone to put a big smile on his or her face and to make the rock 'n' roll symbol (the sign of the horns) with his or her hands, and declare, "Rock 'n' roll!"

After the activity, the therapist and family discussed the experience. The emotions displayed in this session were raw and unsettling—especially to Caroline. She commented, "This is exactly what dinner is like!" In the following session, the therapist attempted to change the negative tone conveyed in the photograph exercise (and apparently also present at dinners): each family member was asked to think of one thing that he or she admired or appreciated about every other family member. For five nights, a different member would take a turn at the exercise. The hope was that by creating a deliberate space for expressing positive feelings about family members at the dinner table, it could help to offset the omnipresent aggressive, sexualized, and resentful emotions that had become so common.

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Formulation

The Lombardo family was an engaging family of five whose youngest member, Nick, had been struggling with an evolving, severe mental illness with psychotic and affective components. On the whole, this family had many strengths and showed resilience in the face of challenging circumstances. However, Caroline and Dave had experienced significant marital conflict regarding Nick's mental illness; a contributing factor was the contrasting experience of each in their respective families of origin.

The marital conflict around managing Nick's illness was not the only source of tension for Caroline and Dave. Caroline complained that she was the only parent who made the effort to engage the children on an emotional level, and she felt lonely at times. As Nick's illness had evolved over time, however, it was noticeable that Dave's gradual acceptance of Nick's illness enabled him to be a more effective partner to Caroline.

In the course of family therapy, the Lombardo family demonstrated that despite Nick's illness, they were beginning to find ways to relate to one another. Still, the challenge of helping them feel cohesive and supported continued in the midst of great unknowns. The brothers' individual responses to Nick's illness were also evolving and often showed signs of distress. Individual therapy and space within the family was needed for Ryan and John to feel supported. As a family unit they were slowly developing a common language to talk about painful feelings.

Family therapy continued to be important in supporting Dave and Caroline in their evolving role as parents. Despite their sometimes disparate ideas on parenting strategies, they also experienced the comfort and strength that come from being able to work together. Furthermore, the Lombardos' future work in family therapy will provide a forum for ongoing exploration of emotional challenges that they face. Ultimately, the hope is that this treatment will help them experience joy and connectedness as a family and also individual growth for each of them.†

QUESTIONS TO THE CONSULTANTS

1. What kind of language might be useful so the family can talk together about Nick's developing mental illness?
2. What is the role of play in the treatment of Nick?
3. How does one modify the treatment approach to a family when one member has psychosis? How does the psychoeducational model developed by William McFarlane and others for working with families with mental illness inform the work with the Lombardo family?
4. How can a family therapist help to foster individual growth in family members amid the demands of an individual with severe mental illness?
5. When a child decompensates, what are effective family interventions? What are some goals for a family during a hospitalization? Are there specific things that should be attended to for the nonhospitalized members of the family?

† The case history was prepared by Daniel Greene, MD, and Andrea Spencer, MD.

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Like many families with a child who has a chronic mental illness, it is not surprising that this particular family is experiencing a pattern of unrelenting crisis. Families in this particular situation may intermittently need to depend on the resources of either inpatient psychiatric units or residential psychiatric programs. As a general rule, it is true that care should be provided in the least restrictive setting possible. That being said, children who are prone to severe emotional dysregulation and physical aggression may not always be able to be safely contained within their homes. For these children, inpatient hospitalization may be necessary for safety and containment, as well as for more careful diagnostic assessment. As one can easily imagine, a child like Nick has complex psychiatric needs that sometimes far exceed what can reasonably be provided in an outpatient provider's office in either a 50-minute psychotherapy session or a time-limited psychopharmacological assessment. Medications designed to treat symptoms of depression or severe mood dysregulation are often deployed in crisis situations, occasionally without consideration of certain psychosocial difficulties or complex family dynamics that contribute to the severity of symptoms.

Given that inpatient psychiatric work is often challenging and arduous, it is not surprising that most parents and families struggle to manage at home the special needs of a mentally ill child. This child's needs may ultimately take precedence over the needs of other members of the family, especially in the context of frequent psychiatric emergencies. Although certainly not intentional, the special needs of a mentally ill child can have an erosive impact on family cohesiveness, creating conflict between siblings and a growing sense of hopelessness and despair for parents. Family work is not generally thought of as a primary treatment goal in inpatient psychiatric settings, but it can be critical to the well-being of the identified patient and also to the family overall. Much research suggests that families that have high degrees of expressed emotion often struggle to manage mentally ill children, and encounter a higher rate of symptom relapse compared to families that have low degrees of expressed emotion.[1–3] Inpatient or residential psychiatric hospitalization can be an effective intervention to break this cycle and provide some valuable psychoeducation in the moment—not only about the specifics of particular psychiatric illnesses but also about more effective means of coping and strategies for behavioral management.[4] In Nick's case, the hospitalization would provide an opportunity to work more intensively with Nick's father around his understanding (and misunderstanding) of his son's mental illness, potentially enhancing his motivation for meaningful participation in treatment. And it would also provide an opportunity to work with Nick's mother around her experience of "burnout" and emotional

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over-involvement, both of which can be seen, at least in part, as a result of her husband's more emotionally reserved, problem-focused interpersonal style.

Given the time-limited nature of much inpatient or residential treatment, providing resources that enable families to continue, post-discharge, with this very important therapeutic work is essential. Inpatient hospitals tend to be intimately familiar with resources in the community that may not be well advertised or accessible. For example, inpatient clinicians can make referrals to somewhat obscure and scarce resources (i.e., in-home family therapy or family stabilization teams that provide home-based, post-acute, follow-up mental health services). The clinicians can also serve as a direct interface with commercial insurance companies, advocating for payment for these resources or for the provision of special, single-case agreements that would allow families to use their insurance to pay for a service that would otherwise be financially prohibitive. In the case of children who are unable to live safely in their communities and who require more intensive, 24-hour psychiatric care, inpatient and residential psychiatric units can also help facilitate longer-term residential treatment.

In the particular case of Nick, given his pattern of severe emotional dysregulation and serious behavioral issues, shorter-term residential psychiatric care could be a viable resource within which to reevaluate his diagnosis, deploy psychotropic medications in a safe and evidence-based manner, and, perhaps most importantly, provide Nick's family with a respite from the ongoing turmoil in their home. Another critical goal is to help Nick's family to process and manage the complicated grief that they are likely experiencing as a direct response to having a mentally ill child. An important function of residential or inpatient psychiatric hospitalization is to provide a safe and well-controlled potential space within which to discuss matters of emotional expression, conflict, and grief, and to consider the likely impact that these matters have on each family member.[5–7] A well-informed residential team would also prioritize helping Nick's family to maintain a sense of hope and compassion for Nick.

Although his behaviors may sometimes be frustrating and upsetting to his siblings (who are understandably too young to have a more nuanced and balanced sense of mental illness), they should understand as best they can that Nick's behaviors are in many ways a function of his chronic mental illness and therefore at least partially beyond his control. Helping younger siblings to develop a better understanding of chronic mental illness and to create a language to describe this experience can often help them to advocate for their own needs so that they are not left to feel either ignored or neglected. In the case of Nick and his family, the older brother's request for individual therapy could potentially enable him to receive the support that he needs to feel validated and heard while also broadening his understanding of Nick's chronic illness. By the same token, individual psychotherapy for Nick's brothers might help to minimize problematic sibling interactions that likely contribute to chaos and disruption in the household. It is not uncommon to see siblings experience their own grief process over the chronic illness of a brother or a sister, although inquiries about siblings are rarely made during inpatient or residential psychiatric hospitalizations. Siblings' time constraints and complex school and work schedules also present a challenge in efforts to involve them in family sessions in inpatient or residential settings. Nonetheless, childhood mental illness invariably involves the entire family, whether that is a family of origin, an extended family, or a family of choice. Working in a collaboratively compassionate way to manage the special needs of these children is ultimately critical so as to reduce unnecessary harm and to ensure the best prognosis.

Nick's case is a common example of the growing mental health crisis for children in the United States. Nationally, only 7000 child and adolescent psychiatrists are available to care for some 15 million mentally ill children and adolescents.[8] Likewise, providing services for mentally ill children and their families is a grossly undervalued service that is focused nationally in specific socioeconomic strata, thereby making it practically nonexistent in impoverished communities or those distant from an academic teaching facility. It is critical to recognize the importance of inpatient and residential psychiatric services, not only as medically necessary for the special needs of mentally ill children but also for vitally important therapeutic family interventions. These interventions often enable suffering families to remain intact and to maximize the strengths of mentally ill children while minimizing these children's emotional and psychiatric vulnerabilities.

Corinne Cather, PhD

Family intervention is considered one of the most powerful interventions for adults with schizophrenia,[9] though less is known about family therapy with psychotic children. Meta-analyses show that family interventions with adult patients reduce relapse by approximately 50%.[10] Family interventions accomplish this result by harnessing the family's resources to manage the disorder (for example, by improving medication adherence in first-episode psychosis),[11] by decreasing family stress and improving the family's functioning as a whole, and by decreasing *expressed emotion*—a high degree of criticism or emotional over-involvement in the family[12]—which has been consistently demonstrated to increase relapse risk. Expressed emotion tends to be low in the prodromal phase and to increase over time with the diagnosis of a primary psychotic disorder. This mutability of expressed emotion suggests that it is not a static family trait but rather a modifiable reaction to the stress, frustration, and sense of loss associated with a family member's illness.[13]

Behavioral family therapy is a model of family intervention that has demonstrated efficacy in reducing relapse for adults with severe mental illness. Its key elements include psychoeducation plus training in communication skills, problem solving, and goal setting.[14] Historically, this form of

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therapy has been implemented in single-family models, often but not always including the patient in all sessions. McFarland and colleagues[15] pioneered multifamily group models for treating young adults with first-episode psychosis. In this multifamily model of behavioral family therapy, several families (including patients) attend a semi-structured group focused on psychoeducation, problem solving, and developing a support network. These are closed groups, with approximately six families who meet for up to two years. A key benefit of the multifamily model over the single-family model is its "built-in" peer support network. Although the multifamily group model has not been adapted for families with children (versus young adults) who have experienced psychosis, it has been used for children diagnosed with mood disorders and with externalizing disorders.[16,17] In both of these cases, the multifamily groups have been reformatted as separate, parallel groups for the children and parents. The use of separate groups is a means of addressing the different needs and capacities of children and parents for psychoeducation and for skills training—issues that also require consideration in the present case. In this family, the therapist needs to be sensitive to the possibility of overloading the children with information or "parentifying" their role in Nick's treatment. For example, it would not be appropriate to include the children in sessions focused on content that is primarily the parents' responsibility, such as the detection of early warning signs of relapse and promoting collaboration with the treatment team.

Family psychoeducation typically covers a number of topics, including symptoms and diagnosis, the role of medication, the stress-vulnerability model of psychosis, the role of the family in treatment, and relapse-prevention planning. In the present case, psychoeducation could help the family develop a shared vocabulary to discuss Nick's symptoms and disruptive behavior while also improving the family's understanding of psychotic symptoms and helping them become more sympathetic to Nick's experience.

Whereas family psychoeducation may require an intervention of six to nine months for the parents Caroline and Dave, the children Ryan and John need be present only for selected family psychoeducational sessions. In addition, the parents could participate in the peer-taught, 12-week Family-to-Family Program provided in communities nationwide by the National Alliance for Mental Illness. This program has been demonstrated to benefit in various ways the participating family members of individuals with diverse mental illnesses: improved family and community functioning, increased knowledge about symptoms, and greater acceptance of the mental illness.[18]

Adapting psychoeducational materials to children requires adjusting language and using comprehensible analogies. The analogy of "dreaming while awake" can explain how a person can come to believe things that are not true (in Nick's case, the belief that his mother may not be real) and the concept of senses playing tricks might help the siblings and patient understand more about the experience of hearing voices. Command hallucinations and threatening voices can be described as "imaginary bullies." Topics for psychoeducation include the role of medication, effective coping strategies for stress, positive social support, and the benefit of enjoyable and meaningful activities, all of which could be discussed as means of helping to keep Nick well. In this way, family psychoeducation can also foster hope of recovery and begin to help the patient and family members consider age-appropriate self-management strategies regarding Nick's illness and its consequences for the family.

Once the entire family has a basic knowledge about Nick's symptoms and disruptive behaviors, the family would participate in communication-skills training. Typically, this module begins with expressing positive feelings. Although it is important that Nick's siblings do not feel responsible for managing Nick's illness, the criticism and maladaptive behavioral and communication patterns between Nick and his middle brother John need to be addressed. Rather than accepting John's judgmental attitude ("I hate him! He's disgusting."), the therapist could coach John about expressing negative feelings and making a request (e.g., "When you act like that, it makes me feel grossed out, and I would rather you did not do this in front of me."). Training in communication skills might also be used to develop skillful responses for Nick and his brothers to any teasing (a concern expressed by Nick's older brother).

Whereas behavioral family therapy with adult patients and their families tends to focus problem solving on goals identified by the entire family, work specifically with child patients will most likely also include parent management training (or contingency management) for behaviors that the parents, but perhaps not the child, identify as problematic. The use of these techniques requires an analysis of behavior from a learning theory perspective. The clinician considers whether and how target behaviors are being modeled and reinforced. How are family members reacting to Nick's aggressive and sexually inappropriate behaviors? It seems that his middle brother may be sending Nick a mixed message about these behaviors—on the one hand, criticizing him for the behaviors, and on the other, modeling similar behavior and perhaps even egging him on at times. Are the boys being exposed to movies with sexual or aggressive themes, or are they witnessing such behavior? If yes, the therapist would work with the parents to evaluate whether withdrawing these influences would affect Nick's behavior. Nick's mother seems to be communicating that she is not only unhappy with the disruptive behaviors of the two older boys ("This is what it's like during dinner time.") but also somewhat powerless to change those behaviors. Some of Nick's father's stress may also be related to his experience of powerlessness in the family. Parent management training would be helpful here, both to develop a behavioral plan to address the older sons' problematic behaviors and to problem-solve around how to increase wanted behaviors (e.g., by creating an environment that makes

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Nick's older brother feel comfortable inviting friends over to the house).

Because it is important for family functioning that individual family members develop as individuals, they are encouraged from the very beginning of behavioral family therapy to identify personal goals. In the Lombardo family, such goals might include working as a consultant, being a good athlete or a better listener, or exercising three times a week. Family members would be asked to employ problem-solving/goal-setting strategies to make progress on these goals throughout the course of therapy. An advantage of this intervention is that it takes the focus off of the identified patient; it may also, as a bonus, help to produce an empathic understanding of how difficult it is to change.

Steven Ablon, MD

In this description of a complex and creative family therapy intervention, individual therapy for Nick was also extremely important. With a history of childhood psychosis and psychiatric hospitalizations, Nick entered into weekly psychodynamic play therapy and achieved major gains. Although the effectiveness of psychodynamic play therapy with psychotic children is not as well documented as with neurotic children, it is an important intervention.[19] Psychodynamic play therapy facilitates the working out of early developmental difficulties that persist and that interfere in a major way with the child's life. It is effective in dealing with problems of affect management and self-esteem, and with ego vulnerabilities.[20]

Many writers have pointed out that play is therapeutic in its own right.[21] It helps organize disparate parts of the self, especially dissociated personae, and in this way provides a vehicle for ego growth. A central aspect of play therapy is providing a therapeutic environment in which the therapist is the child's steadfast companion in psychological explorations, while the therapist also maintains a lively self-reflective capacity.[22] Play is an innate brain function. It is the language of children, and they go about playing with a therapist—and choosing the most expeditious way of dealing with their struggles—without being consciously aware of doing so. Therefore, it is important not to interfere with the child's unique play signature.

The therapeutic action of play can be understood in various ways. Particular attention has been focused on the repetition and mastery of trauma and conflict through transforming passive experiences into active ones. Freud[23(p35)] observed, "In the case of children's play we seemed to see that children repeat unpleasurable experiences for the additional reason that they can master a powerful impression far more thoroughly by being active than they could by merely experiencing it passively." But numerous other views of the play's therapeutic action have been presented: it provides opportunities for abreaction and catharsis of overwhelming affect; the elaboration of fantasies, wishes, and fears in play involves problem solving and mastery similar to the process of dreaming and telling the manifest content of dreams;[24] play, like dreams, facilitates an appreciation of the nuances and transitions involved in reality orientation; and the freedom from superego constraints during play enables the child to try on various roles, including ones prohibited by social norms or the child's conscience.

Play in the therapeutic setting allows the child to bring forward and explore feelings that are most troublesome and important. In this process, the child expands an organizing aspect of the psyche and brings order to the chaos of preconscious and unconscious affect as it is worked on and explored in symbolic terms in play. This assimilation of affects and experience, past and present, into an organizing aspect of the mind, has a powerful therapeutic impact. A therapeutic situation that allows the child to use play for symbolic organization and synthesis of affects is aimed at resuming the progressive development of the child. This process is extremely difficult and taxing for the therapist. A position of neutrality is difficult to maintain: the therapist is interested in allowing the play to expand; the child is "encouraged to continue";[25(p151)] but even as this process continues, the therapist is struggling to understand what the child is trying to communicate.

The therapist needs to see both the defense and the communication in the child's play and to tolerate the powerful affects that emerge in the play and in the relationship. These affects include anger, sadness, helplessness, humiliation, worthlessness, sadism, intense sexuality, and dependence on the therapist, and they raise taxing countertransference stresses. This was certainly clear in Nick's treatment, and his therapist worked effectively with these feelings and pressures. Difficulty sitting with these painful affects can lead to defensive efforts such as intellectualization, premature intervention, manipulation, limit setting, and other activities that bring closure to the child's explorations. Establishing and maintaining a therapeutic situation depends on the therapist appreciating the child's painful affects and trying to help the child bear them. That is what occurs when the therapist does not intervene to avoid such affects, but it also depends on other factors—for example, how the therapist responds to events in the therapy that diverge from play in that they have real consequences outside that process. Included here would be acts that would endanger the therapist or the child, or that would do damage to the office. Also included would be the child's failure to comply with time constraints, such as refusing to leave at the end of an hour. In Nick's therapy it was important to attend to the therapeutic frame. For example, the therapist needed to set limits on his aggression and helped him play in the office as much as possible. In Nick's therapy these interventions were not difficult. Fortunately, our child patients are forgiving of our struggles such as inattentiveness or insensitivity, or our efforts to interpret, based on our own needs to understand, to feel valued, or not to feel helpless.

In Nick's situation, he was overwhelmed by sexual and aggressive feelings and was able to play them out, present them in symbolic form, and provide additional organization

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for their representation. An important part of his play therapy involved the relationship with his therapist, which provided the structure and containment within which he could safely explore and master these issues. For example, he was able to work on deep issues of ambivalence. He wrote on the computer the word "'boob"; then he wrote that he hated his therapist and, after that, that he loved her. In this way he was able to organize these extremely powerful feelings in relation to his therapist and to the early mother-child relationship and the breast. At other points in the therapy, Nick was able to work on early issues of object constancy and object permanence. He would go to the other side of the observation mirror and, with his therapist, would tap out a rhythmic dialogue and also touch fingers to each other against the mirror. In this way Nick reworked early issues of attunement. At other times he would leave the office, come back playing hide-and-seek, and, by losing his therapist and finding her, rework powerful issues of trauma, bonding, attachment, and loss. This interplay helped him with his fear of death. In acting out different personae, he was able to integrate them, which reduced his states of dissociation and the need for internal voices representing parts of himself.

Treatment of a family member with psychodynamic play therapy can be combined in a productive way with other modalities such as family therapy, psychopharmacology, and psychoeducational efforts such as school and community consultations. Despite a strong family history of psychopathology and many struggles in different aspects of the family structure, the improvement of one member such as Nick, who is having an especially difficult time, frees other members in their development and adaptation. The effectiveness of psychodynamic play therapy also helps underline the hope, well grounded in theory and practice, that children such as Nick will continue in their development and will have a reasonable opportunity for a successful, rewarding life. With psychotherapeutic and developmental help, children with severe difficulties often can harness their developmental progressive forces in the direction of health and successful adaptation. In Nick's treatment over a period of one-and-a-half years, he demonstrated substantial improvement, which one would expect to continue. More important, it was very helpful for this family to see the gains and to experience hope for Nick's future.

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