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CASE STUDY

Trauma, emotions, and adolescence: A transdiagnostic approach to treat severe dysregulation using emotion-focused therapy

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Abstract: Adolescence is an age of varied concerns and widespread challenges whether intrinsic factors such as hormonal changes, self-esteem issues or body image concerns, or, extrinsic factors like peer pressure, meeting familial expectations or cyber influence. Congruent to the same, this clinical case examines the clinical presentation of a 16-year-old female with severe emotional dysregulation, interpersonal difficulties, anger outbursts, and significant psychosocial adversity. Assessment using clinical interviews, standardized rating scales, and projective tests indicated features suggestive of Bipolar I Disorder (Mixed Episode) and emerging personality pathology. The case was conceptualized using the transdiagnostic model of Emotion-Focused Therapy (EFT), emphasizing the role of early relational trauma, emotional avoidance, and maladaptive coping. Intervention focused on grounding techniques, emotional processing, and developing adaptive emotional responses. The therapy approach significantly improved affect regulation, interpersonal functioning, and overall psychological well-being. The case highlights the importance of comprehensive assessment and culturally sensitive, trauma-informed interventions in adolescent mental health care in the Indian context.

Keywords: *Emotional dysregulation, Emotion-focused therapy, Adolescence, Trauma-informed interventions*

Introduction

Adolescence represents a critical developmental period characterized by major changes in biological, psychological, and social aspects, often accompanied by heightened vulnerability to the onset or exacerbation of mental health challenges [1]. Navigating the complexities of identity formation, relationships with peers, academic pressures, and familial expectations can be demanding, and for some, this period is marked by substantial psychological distress. The challenging clinical presentations that emerge in this case are severe emotional dysregulation, marked shifts in mood, and significant interpersonal difficulties. Understanding the intricate interplay of these aspects is crucial for accurate diagnosis and effective intervention. If such presentation in adolescents remains undiagnosed or untreated, it poses significant difficulty for the person in regulating oneself and dealing with their personal and social life effectively. It also affects the internal sense of self-direction and self-worth. Affected persons may experience impairment in building and maintaining meaningful interpersonal relationships. Further, if the presentation remains chronic it may lead to manifestation of severe psychological disorders.

The challenges inherent in diagnosing complex adolescent presentations are well-documented in the literature. Differentiating normative adolescent turmoil from emerging psychopathology, particularly when symptoms overlap across diagnostic categories, requires careful consideration [4]. For instance, the emotional lability, impulsivity, and interpersonal difficulties observed in the patient necessitate a careful

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evaluation of potential mood disorders, such as Bipolar Disorder with mixed features, alongside considerations of emerging personality pathology, characterized by traits like negative affectivity and difficulties in self-identity and interpersonal functioning [6], [9]. Furthermore, the profound impact of developmental trauma and cumulative stressors on both mood regulation and personality development is increasingly recognized, adding another layer of complexity to the diagnostic and etiological understanding [10]. Existing research highlights the detrimental effects of experiences like bullying and familial invalidation on adolescent mental health trajectories (e.g., [2], [3], yet detailed case studies illustrating the confluence of these specific factors i.e. trauma, potential mood disorder features, and personality vulnerabilities remain valuable for informing clinical practice.

Therefore, the primary aim of this paper is to present a comprehensive case study of the patient, utilizing data gathered from clinical interviews, informant reports, mental status examination, and a battery of psychological assessments (including projective tests, objective personality inventories, and symptom rating scales). This study seeks to: (1) detail the multifaceted clinical presentation and developmental history of the patient; (2) explore the potential interplay between past traumatic experiences, ongoing stressors, and current symptomatology; (3) elucidate the diagnostic considerations, specifically examining the evidence for Bipolar I Disorder (Mixed Episode) versus enduring personality patterns like Negative Affectivity or Borderline features, as suggested by the assessment; and (4) discuss the implications of the assessment findings for tailored therapeutic intervention, highlighting the need for an integrated approach.

This paper seeks to enhance understanding of the diagnostic challenges and therapeutic requirements of adolescents experiencing severe emotional dysregulation amid substantial psychosocial adversity. It highlights the importance of comprehensive, multi-method assessment for clarifying complex symptoms and informing effective, evidence-based treatment strategies.

Case description

The patient, 16-year-old female, presented with an acute exacerbation (approximately 2.5 months) of longstanding psychological distress with chief complaints of labile affect, episodes of uncontrollable anger, dysphoria, vengeful thoughts alternating with periods of elevated mood, over-talkativeness, disinhibition, and inappropriate laughter along with anxiety (restlessness, rapid heartbeat, cold hands), heightened interpersonal sensitivity, and occasional prosody of speech. The patient reported long-standing emotional difficulties, which started in middle school, wherein severe emotional harassment by a teacher in 7th grade, followed by feeling criticized by her mother compared to her sister, rejection by her only friend in 9th grade, and later bullying and inappropriate physical contact at a new school. These experiences led to chronic low self-esteem, social withdrawal, and difficulty managing her feelings. The recent emergence of these overly happy and uninhibited periods, combined with her ongoing distress and episodes where she lost control (screaming and struggling to breathe), prompted her to seek psychiatric help and psychotherapy. The patient was admitted to IPD for a period of 2 and a half weeks, post which she has been taking regular therapy sessions in the OPD.

Assessment

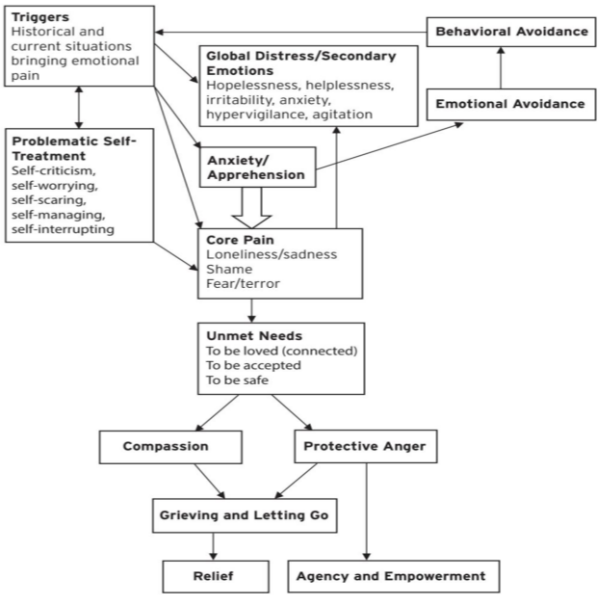
The first four sessions (excluding the therapy sessions-total 16) focused on exploring case history through a semi-structured clinical interview, covering developmental background, family dynamics, interpersonal relationships, academic and occupational functioning, and psychiatric history. A Mental Status Examination (MSE) was concurrently conducted through observation and interaction, evaluating the client's appearance, speech, mood, thought processes, cognition, and insight. Diagnostic indicators such as the Hamilton Anxiety Rating Scale (HAM-A), the Hamilton Depression Rating Scale (HDRS), Young Mania Rating Scale (YMRS) were administered using structured interviews to evaluate symptoms of anxiety, depression, and mania, respectively. Projective tests such as the Rorschach Inkblot Test (RIBT), Draw-A-Person Test (DAPT), and Sacks Sentence Completion Test (SSCT) were used to explore unconscious conflicts, personality dynamics, and emotional functioning. The Millon Clinical Multiaxial Inventory–III (MCMI-III),

a self-report inventory, was also administered to assess personality traits and clinical syndromes aligned with DSM criteria. These tools collectively contributed to a multi-method, multi-domain assessment essential for differential diagnosis and treatment planning.

General Behavioral Observation

The patient was kempt and tidy. The rapport was established with ease. The patient was cooperative towards the examiner and testing situation gradually. The attention could be aroused and sustained, and she completed the tests well. The patient did not face much difficulty in understanding instructions and performing assessments. She initially denied cards 3 and 7 from the Rorschach inkblot test in the first attempt during administration (screaming and looking at them with hands shaking); however, after a few minutes, she resumed giving responses for the cards.

Case Formulation



Note. From "Transforming Emotion Schemes in Emotion Focused Therapy: A Case Study Investigation," by S. McNally, L. Timulak, and L. S. Greenberg, 2014, *Person-Centered & Experiential Psychotherapies*, *13*(2), pp. 136, 142 (https://doi.org/10.1080/14779757.2013.871573). Copyright 2014 by Taylor and Francis. Adapted with permission; and "Emotion-Focused Therapy: A Transdiagnostic Formulation," by L. Timulak and D. Keogh, 2020, *Journal of Contemporary Psychotherapy*, *50*, p. 3 (https://doi.org/10.1007/s10879-019-09426-7). Copyright 2020 by Springer. Adapted with permission.

Figure 1: Model of Emotion-Focused Therapy

Source: McNally, Timulak & Greenberg, 2014

The transdiagnostic model of Timulak and Keogh [7] is relevant in understanding the causation of patient's symptomatology. It proposes triggers combined with problematic treatment of oneself, leading to global distress entailing, in the current case, irritability, helplessness, agitation and anxiety. This anxiety leads to behavioral and emotional avoidance , presented as suppression of anger as well as social withdrawal.

Beneath this anxiety lies the client's core emotional pain, which includes feelings of loneliness, 'my friends call me weird' , shame, ' the teacher will humiliate me again', and fear, ' I won't go back to school'. These emotions are often rooted in unmet relational and safety needs such as the need to feel loved, accepted, and safe, which may have gone unfulfilled in early life as reflected by mother's punitive parenting style, public humiliation towards her by her teacher or significant past peer relationships entailing bullying as reported by the patient.

In an attempt to manage these vulnerable emotions, the patient resorts to emotional and behavioral avoidance. This might involve withdrawing from meaningful connections and numbing emotional experiences altogether. Unfortunately, these avoidance strategies prevent her from engaging with their

emotions in a healing and constructive way, thereby reinforcing the cycle of distress. Thus, presently, the lability of affect is explained by the patient as a way of uncontrollable expression of anger which she was not able to in the past, and 'heightened sensitivity'.

Therapeutic work involves helping her access and validate these core emotional experiences and unmet needs. When emotional safety is established, the client can begin to connect with adaptive responses, such as self-compassion and protective anger. Compassion allows the client to soften their inner critic and soothe emotional pain, while protective anger empowers them to establish boundaries and assert unmet needs. As these responses are integrated, the client can begin the process of grieving past hurts and letting go of emotional burdens.

Through this emotional processing, the client experiences relief from chronic distress and a renewed sense of personal agency and empowerment to help patient's concerns of helplessness. Therapeutic goals focus on disrupting maladaptive self-treatment patterns, building tolerance for core emotional experiences, meeting unmet needs through adaptive responses, and fostering healing through grieving and emotional integration. Externalization of self critical comments was also incorporated in the same.

The current case also saw expansive behaviour (dancing in the inpatient department, singing songs in the outpatient department), grandiose ideas of becoming a singer (agency and empowerment), ' will you come to my concert?', and regressive voice changes alongwith silly laughing when addressing certain pleasurable activities like going to the mall or singing (letting go). Access to media and internet led to a certain amount of exasperation and hyper sexualization of events, also seen in the assessments conducted.

Case conceptualization using the transdiagnostic model of Timulak and Keogh [7] for the current case can thus be as follows:-

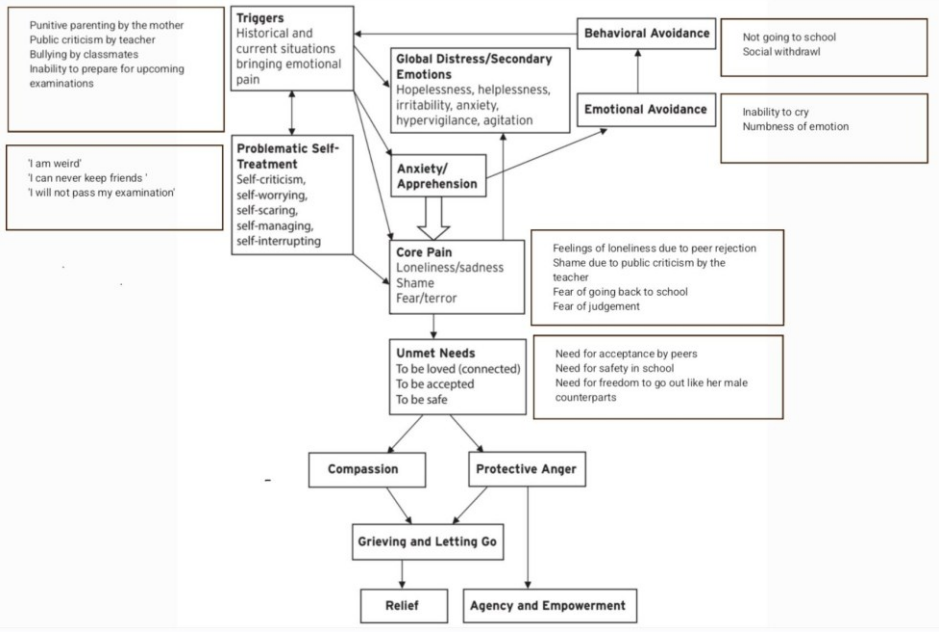


Figure 2 Case Conceptualization of the patient

Psychotherapy

Structure and Content

The therapy sessions were organized at a hospital setting in the inpatient department for 6 days and outpatient for 9 days after the patient was discharged. X was accompanied by her father. Adequate measures were taken to ensure the confidentiality of the obtained information.

The patient was psychoeducated about crisis management techniques along with the objectives of emotional focused therapy. The sessions were of 1 hour duration, which were provided weekly.

In addition, the therapy also incorporated grounding techniques, distress tolerance skills, and modulating emotional dysregulation. Parental psychoeducation in terms of gains as well as expressed emotions was provided. Parental skill training for using grounding techniques was also provided.

Goals

As decided collaboratively with the patient, the short term goals were stabilization, providing space for ventilation and inducing relaxation. The long term goals involved forming a narrative of emotional pain, insight building and overcoming behavioural and emotional avoidance.

Therapy Process

Initial phase

Psychoeducation

The parents as well as the patient were provided with psychoeducation to help them understand the emotional difficulties. It was explained that emotional lability, anger outbursts, crying spells, and regression were not simply acts of defiance or immaturity, but were understood as expressions of deeper emotional pain and unmet needs. These behaviors were described as maladaptive secondary emotional responses that had likely developed as ways of coping with underlying primary emotions such as sadness, fear, or shame. The patient's anger was explained as a defense against feelings of vulnerability or emotional hurt due to humilation by the teacher, while crying spells were seen as expressions of unacknowledged emotional pain, such as loss or rejection by peers. Regression behaviors were framed as an attempt to seek safety or comfort when she felt overwhelmed or emotionally threatened. Parents were reassured that these responses were common and were encouraged to respond with empathy, curiosity, and emotional validation. It was emphasized that, through support and therapeutic intervention, the adolescent could be helped to identify and process core emotions, and to gradually develop more adaptive emotional responses, such as healthy assertiveness and self-compassion (Figure 2).

Forming a therapeutic alliance

A strong therapeutic alliance was intentionally fostered with the patient by creating a safe, non-judgmental, and emotionally attuned space where their experiences were consistently validated. Efforts were made to build trust through genuine curiosity, empathy, and consistent emotional presence, allowing the patient to feel seen and understood. The therapist adopted a collaborative stance, gently exploring the patient's emotional world at their own pace while affirming their strengths and resilience. By attuning to their emotional needs and respecting their autonomy, the therapeutic relationship became a secure base from which deeper emotional exploration and healing could begin.

Grounding training

Grounding techniques were introduced to the patient to help manage episodes of emotional overwhelm and enhance their capacity for present-moment awareness. One key grounding strategy provided was the 5-4-3-2-1 technique, which was practiced in the initial sessions in the IPD. The patient was guided to focus on their immediate environment by identifying 5 things they could see, 4 things they could touch, 3 things they could hear, 2 things they could smell, and 1 thing they could taste (or imagine the taste of). This sensory-based exercise was framed as a way to anchor the patient in the present moment, she was especially during intense emotional states such as anger, anxiety, or dissociation. The technique was presented as a practical and accessible tool that could be used independently, and the patient was encouraged to practice it regularly to strengthen their emotional regulation skills outside of therapy. The parent (father) was also trained to do practice when needed with the patient.

Affective modulation and expression

Empathic holding - A soothing acknowledgement of the current experience was presented to the patient in a soothing voice while maintaining a close contact, ' I understand you feel rejected because your friend

won't talk to you and that makes you feel sad', ' You cannot understand whom to be angry at and it is making you uncomfortable so you feel like shouting'.

Grounding and regulating

Instructions to orient the patient to the present physical space as well as their emotions were given while building on empathetic holding 'you're sitting on the bed, holding the bed sheets and they feel soft and smooth in your hands'.

Clearing a space task

Through the practice of focusing, an experiential task was carried out by identifying markers of overwhelming and uncontrollable emotions. She was made to focus inward and describe the bodily aspects of the feeling along with naming and linking it to the current situation. An effort was made to externalize the feeling by 'putting it aside' and the practice was repeated.

Middle phase

Overcoming avoidance

To help the patient overcome emotional avoidance, the two-chair technique for self-interruption was introduced to address the internal conflict where one part of the self interrupts or blocks the expression of vulnerable emotions. The patient was invited to enact a dialogue between two parts of themselves: the "Interrupter"—the part that avoids or shuts down emotional experiences—and the "Experiencer"—the part that holds the underlying emotional pain. In the Interrupter chair, the patient expressed the thoughts or behaviors used to block feelings, while in the Experiencer chair, they were supported in exploring the emotional impact of being silenced or shut down. Through this dialogue, the patient was able to give voice to their core emotions, articulate unmet needs, and express how the Interrupter part may have developed as a protective mechanism. Over time, the goal was for the Interrupter to soften or transform, and for the Experiencer to gain permission to feel and express emotion freely. This process allowed the patient to move through avoidance and toward deeper emotional healing and integration.

Access and transform emotional pain

In therapy, the patient was gently guided to access their core emotional pain through a safe and supportive environment, the patient was encouraged to move beneath surface-level distress (anger outbursts and crying spells) and begin to explore the underlying primary emotions of sadness, fear, and shame. These emotions were carefully accessed through empathic reflection and experiential techniques, such as imagery and two-chair dialogues, which helped the patient articulate the unmet needs embedded in their emotional pain (the need for connection with peers, acceptance, or safety at school). Once these core emotions were fully accessed and expressed, the patient was supported in generating adaptive emotional responses.

This included cultivating self-compassion in response to shame and protective anger in response to past invalidation or emotional injuries. As a result, emotional pain that had previously been overwhelming or avoided was gradually transformed, allowing the patient to experience relief, a greater sense of agency, and emotional integration.

Interpersonal learning for EFT

Interpersonal effectiveness was addressed by emphasizing the importance of emotional awareness and authentic expression in relationships. The patient was supported in identifying how unmet emotional needs (connection, acceptance, safety), were often masked by anger outbursts, withdrawal, or regression in interpersonal situations. The patient was guided to recognize and express their core emotions in a clearer, more constructive manner. Role-plays were used to help the patient practice setting boundaries and communicating needs with assertiveness and emotional honesty, rather than through reactive or avoidant behaviors. By fostering self-awareness and emotional clarity, the patient began to experience increased confidence and agency in their relationships, enhancing their ability to navigate interpersonal challenges with both vulnerability and strength.

Final phase

Consolidation of changes

Through role plays and hypothetical situation setting, the patient's overcoming avoidance as well as adaptive reactions were practiced.

Relapse prevention

Relapse prevention for the patient focused on helping them recognize early warning signs of emotional dysregulation and re-engagement in avoidance strategies. Using Emotion-Focused Therapy principles, the patient was guided to develop increased awareness of their emotional triggers, patterns of problematic self-treatment (self-criticism or emotional suppression), and the internal cues that signaled a return to maladaptive coping. Together, a personalized plan was developed that included grounding techniques like the 5-4-3-2-1 method, compassionate self-dialogue, and continued use of adaptive emotional responses such as protective anger and self-soothing. The patient was encouraged to reflect on past therapeutic gains and to draw on moments of emotional resilience as evidence of their capacity to cope. Emphasis was placed on viewing setbacks not as failures, but as opportunities to re-engage with their emotional process, supported by strategies discussed in therapy and, when needed, seeking support through trusted relationships or further therapeutic contact.

Summary of Psychological Testing Results:

Draw a Person Test (DAPT)

The patient showed a need for control or detachment from emotional or physical realities along with heightened curiosity or preoccupation with sexual themes. Feelings of inadequacy and expansive representation suggested the patient may be attempting to overcompensate for perceived deficiencies through self-aggrandizement or exaggerated self-importance. The patient may have a strong desire to assert themselves or prove their sense of control and autonomy. The patient tends to suppress their impulses or engage in self-restraint, possibly to the extent of emotional or social withdrawal. The patient may tend to withdraw from their environment, potentially due to difficulties in coping with external stimuli or a perceived lack of emotional resources to engage with the world effectively. There is also possible unresolved sexual issues or an overactive interest in sexuality reflecting neurotic tendencies around sexual expression or body image. Underlying feelings of vulnerability or a desire to project strength and control were noted. Ambitious or driven nature, possibly with a desire for control over one's environment, along with unresolved anger or distrust, contributing to the subject's social or interpersonal struggles. Feelings of dependency and helplessness, pointing to a potential need for support or a reliance on others to navigate challenges, were also noted.

Rorschach Psychodiagnostics

Cognitive Findings of RIBT-(based on Information processing, mediation & ideation)

The patient consistently views the world negatively, allowing this pessimism to permeate her thoughts and fostering doubt and a belief in inevitable failure. Instead, she likely integrates fleeting thoughts into a pre-existing, negative framework of thinking as a defense mechanism. Furthermore, when faced with stress, this patient has a strong inclination to escape into fantasy rather than confront reality, more so than typical individuals. Her thought processes are likely significantly impaired, and this level of impaired conceptualization often results in poor reality testing. Her thinking tends to be disorganized, contradictory, and frequently characterized by flawed judgment. While she does engage in some self-reflection, which could promote a more accurate self-perception, her overall self-image is tainted by negative self-attributions, leading to a more pessimistic view of herself. This difficulty in processing information accurately seems to be a pervasive issue, not just limited to ambiguous situations, suggesting a deliberate defensive distortion of reality. She may also frequently disregard social norms to prioritize her own desires, increasing the likelihood of unusual or inappropriate behaviors. She tends to process information with minimal effort,

which could indicate a lack of self-assurance or an unwillingness to engage in new experiences. This patient also demonstrates a consistent approach to processing new information and may set unrealistically high goals, increasing the potential for failure and subsequent frustration. Her scanning habits are characterized by haste and randomness, often causing her to miss crucial details, leading to flawed decisions and actions. Finally, she experiences notable difficulties in shifting her attention, and while her processing quality is generally adequate, it can sometimes decline in effectiveness or maturity.

Personality Findings of RIBT- (based on control and stress tolerance, affect, self perception and situation related stress)

The patient appears to be suffering from emotional deprivation, possibly stemming from a long-standing unmet need for closeness that exceeds typical interpersonal boundaries. She is currently overwhelmed by intense emotions that disrupt her thinking and can lead to impulsive actions. She tends to oversimplify complex or ambiguous situations by denying their existence and demonstrates inconsistency in problem-solving and decision-making, as well as in managing her emotions, which can fluctuate between overcontrol and inappropriate lack of control.

Furthermore, this patient often blends her feelings with her thoughts when trying to cope. While somewhat adaptable and occasionally willing to use a more logical approach to decision-making, she is currently experiencing distress and actively avoids emotional stimuli, feeling uncomfortable when dealing with emotions, which leads to social withdrawal. She strongly avoids emotional confrontation, suggesting a lack of trust in her own ability to cope using emotional experiences as a guide. This indicates the presence of significant, generalized anger that impacts her attitude towards her surroundings and can interfere with decision-making, coping strategies, and the ability to maintain meaningful relationships. Her psychological makeup appears less complex than expected, and she struggles behaviorally in complex emotional situations. She is often confused by emotions or emotional situations, experiences feelings more intensely than others, and this confusion can be disruptive, making it harder to resolve issues and increasing her distress. She is likely experiencing increased demands due to situational stress, which may lead to less organized decisions and behaviors. This mild to moderate stress is causing psychological disruption, affecting both her thinking and emotions, and she feels considerable discomfort due to a sense of helplessness related to her current situation, resulting in significant emotional confusion.

Interpersonal findings of RIBT (based isolation index and interpersonal interest)

The patient assumes a more passive, though not necessarily submissive role in interpersonal relations. The patient may prefer to avoid responsibility for decision making and is less prone to search out new solutions to problems, or initiate new patterns of behavior, especially when the possibility exists that others will assume the necessary responsibilities.

The patient is more conservative than might be anticipated in close interpersonal situations, especially those involving tactile exchange. The patient is more likely to be concerned with personal space, and much more cautious about creating or maintaining close emotional ties with others.

The patient has a strong interest in other people, but the patient does not understand people very well. This lack of understanding can often lead to unrealistic expectations concerning relationships and/or social blunders that alienate others.

The patient is unsure about her integrity in interpersonal situations and is prone to become defensively authoritarian as a way of fending off perceived challenges to the self that arise in those situations. The patient may be regarded by others as rigid or narrow-minded and, as a consequence she often has difficulties in maintaining close relations, especially with those who are not submissive to them.

Millon Clinical Multiaxial Inventory (MCMI-III)-

MCMI-III indicate deep-seated feelings of inadequacy and sadness, leading to social withdrawal and a lack of assertiveness. Possible difficulties in forming close relationships due to eccentric behaviors and mistrust. It also suggests challenges with emotional regulation and interpersonal relationships.

(Avoidant-112, Depressive-99, Dependent-100, Masochistic-100, Schizotypal-111, Borderline-97, Paranoid-100, Anxiety-97, Bipolar Manic-95, Major Depression-109, Delusion Disorder-90).

Sacks Sentence Completion Test (SSCT)-

The patient generally views themselves favorably and possesses a solid sense of identity. The results in areas of guilt feelings, past, future, and goal-related items reflected a balanced approach to emotional experiences, with room for deeper exploration or development in these areas. Findings show signs of emotional ambivalence in relationships, particularly with family members and the opposite sex. There may be unresolved issues from the past and a need for emotional security from relationships or those who have provided care.

Hamilton Anxiety Rating Scale

16 indicating mild anxiety

Hamilton Depression Rating Scale

16 indicating mild to moderate depression

Young Mania Rating Scale

A score of 23 suggests the presence of mild manic symptoms.

Overall, the testing indicates substantial psychological distress with significant cognitive distortions, severe difficulties in emotional regulation and personality functioning, and marked impairments in interpersonal relationships. The findings suggest difficulties with reality testing and potential for maladaptive behaviors under stress.

Therapy Outcome

The assessments conducted post-therapy indicated significant improvement.

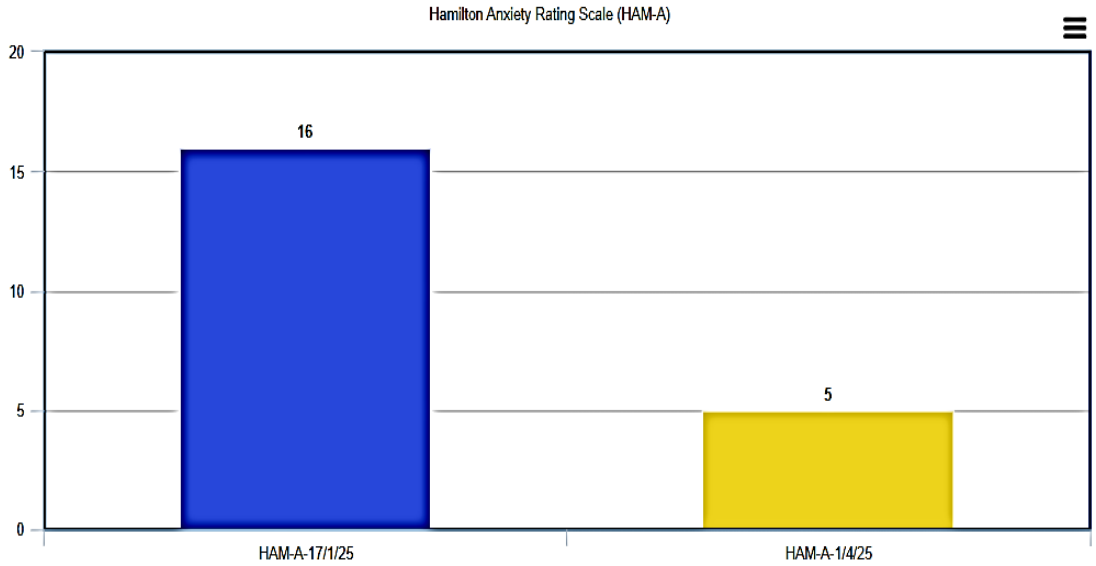


Figure 3 Patients' anxiety levels as measured by HAM-A

Figure 3 showing patient's anxiety levels, as measured by the Hamilton Anxiety Rating Scale (HAM-A), showed significant improvement. The pre-test score on January 17th was 16, indicating Mild Anxiety. By the post-test on April 1st, the score had reduced to 5, which falls within the normal range.

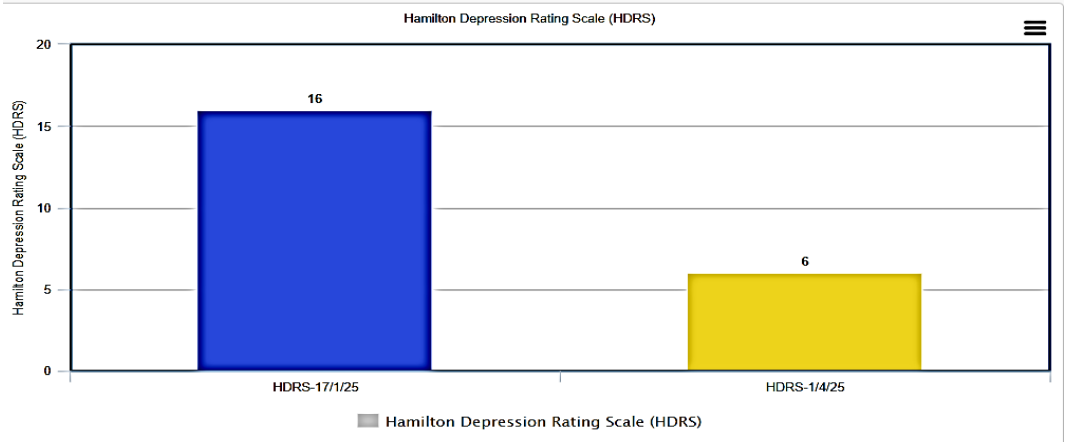


Figure 4 Patients' anxiety levels as measured by HDRS

Figure 4 showing patient's anxiety levels, as measured by the Hamilton Depression Rating Scale (HDRS), showed significant improvement. The pre-test score on January 17th was 16, indicating Mild Anxiety. By the post-test on April 1st, the score had reduced to 6, which falls within the normal range.

Therapist's Reflection

The EFT techniques were provided to the patient with some modifications with respect to the sequence of the components, however, the core elements remained the same as in the manual. Since the patient was an Indian adolescent from a lower socio-economic strata, the analogies used to make her understand the techniques were modulated to her culture and age.

The patient could understand and practice emotional regulation techniques by understanding the underlying causes of behaviours deemed inappropriate by her peers and how unmet needs could lead to such consequences. She could further externalize through clearing a space task and approach the emotions that were being avoided in the past.

She reported significant improvement using grounding techniques. Additionally, on a trip during the middle phase of therapy, the parent also reported performing 5-4-3-2-1 technique when the patient reported feeling apprehensive in a crowd followed by box breathing exercise.

Overall, the patient as well as the informant, i.e., father, asserted significant improvement concerning shouting impulses, emotional regulation, and conduction of appropriate social behaviour (Figure 4).

Barriers and Challenges Faced in Therapy

Diagnostic vagueness-Symptoms involved shouting attributed to anger, grandiose behaviour, regressive behaviour entailing voice changes but with no criteria for dissociation being met. Further, mood dysregulation varied from time to time depending upon primary gains. Violent outbursts in the OPD setting entailing hitting hands on the tables and kicking the almirah were also followed by guilt during the episode wherein she was apologizing as she was hitting the furniture. No derealization or depersonalization was reporther, rather the patient asserted wanting to control said behaviour while it was happening but failing to do so. This intact reality orientation led to further investigation into primary gains and voluntary components of the symptomatology (Figure 3).

Boundary setting-In her initial admission to the emergency department of the hospital, she reportedly hugged and wrote a ‘love letter' to her attending doctor. This was followed by wanting to hug and kiss attending doctors and therapists and asserting a desire to ‘kiss’ them. Frequent compliments were also observed wherein a voice change with a regressed child like tone was noted. Repeated requests to take

pictures were also made. Boundary setting and social norms were reinforced regularly and the therapists were mindful of not providing her with any positive reinforcement or gains with respect to these desires.

Violent outbursts-The therapeutic process was hindered by regular outbursts in the inpatient and outpatient department when she had a reality orientation of her desires (I want to do a concert) was emphasised.

Tertiary gains of mother-As reported by her father, when the patient has an episode of shouting and uncontrollable anger, her mother has similar symptoms of shouting, mood dysregulation and weakness. For the same, they were psychoeducated about expressed emotions.

Faith healing-Due to cultural beliefs and coercion by community members, the patient was taken to a religious place for 'jhaad phuk', which led to an episode entailing possession as described by her older sister. However, no similar episodes were reported before or after the same. This also led to an increased need for awareness among parents about mental health and its management.

Conclusion and Future Implications

This case study highlights the multifaceted nature of adolescent emotional dysregulation arising from cumulative psychosocial trauma and developmental vulnerabilities, presented with overlapping affective and personality symptoms. A transdiagnostic, emotion-focused therapy approach allowed for the exploration and transformation of core emotional pain, resulting in notable clinical improvement in affect regulation, interpersonal functioning, and overall distress levels. However, the therapeutic process was not without challenges, diagnostic ambiguity, boundary testing behaviors, regressive tendencies, and socio-cultural influences, such as faith healing and family dynamics involving secondary and tertiary gains, posed significant barriers to therapeutic progress. These issues required sustained clinical vigilance, consistent psychoeducation, and reinforcement of therapeutic boundaries. Despite these hurdles, the intervention was effective in facilitating emotional insight and behavioral change. This case underscores the need for comprehensive, culturally attuned, and trauma-informed mental health care tailored to the developmental needs of adolescents in the Indian context. It further calls attention to the importance of clinician adaptability, family engagement, and systemic awareness in navigating complex therapeutic landscapes.

The case underscores the clinical utility of transdiagnostic frameworks, such as Emotion-Focused Therapy, in managing adolescents presenting with complex affective and personality-related symptomatology. There is a pressing need for trauma-informed assessment and intervention protocols within adolescent mental health services, particularly for individuals with histories of bullying, abuse, or emotional invalidation. Culturally sensitive adaptations of psychotherapeutic techniques are essential when working with Indian adolescents from diverse socioeconomic backgrounds, to enhance therapeutic alliance and effectiveness. Parental psychoeducation and involvement must be integrated into treatment plans, especially in cases where family dynamics contribute to the maintenance of emotional dysregulation or reinforce maladaptive behaviors. Clinicians must remain vigilant about boundary-setting and therapeutic neutrality, particularly in cases involving regressive behaviors, transference, or testing of social norms by the adolescent. The case highlights the impact of community beliefs and mental health stigma, such as faith healing practices, on treatment continuity and calls for public mental health awareness initiatives targeting caregivers and community stakeholders. Finally, the importance of comprehensive, multi-method psychological assessment is reinforced as a foundation for accurate diagnosis and individualized, evidence-based treatment planning in adolescent care.

Declaration of Conflicting Interests

There are no potential conflicts of interest regarding this article's research, authorship, and/or publication.

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Statement of Informed Consent and Ethical Approval

Informed consent from the parent and assent from the adolescent were obtained for assessment, therapeutic work, and publication. Ethical approval for the study was provided by the Department of Clinical Psychology of the Shree Guru Gobind Singh Tricentenary University.

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