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Case Report

Integrated Trauma-Focused and Family-Based Intervention in a Young Woman with Recurrent Depressive Episode and Emotional Dysregulation: A Psychiatric Social Work Case Report

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ABSTRACT

Background: Dysfunctional family environments and adverse childhood experiences are important contributors to emotional dysregulation, depression, and self-harming behaviour. Family-focused interventions may improve family functioning and treatment outcomes. **Case Presentation:** This case report describes a 25-year-old woman with rheumatoid arthritis and hypothyroidism who presented with anger outbursts, self-harming behaviour, crying spells, traumatic flashbacks, and longstanding family conflict. Clinical assessment revealed significant impairment in family functioning and high levels of perceived expressed emotion. **Intervention:** The patient received pharmacotherapy, trauma-focused therapy, and Family-Focused Therapy (FFT). Progress was assessed before and after treatment using the McMaster Family Assessment Device and the Level of Expressed Emotion Scale. **Outcome:** After two months of intervention, improvements were observed in family communication, emotional support, behavioural control, and overall family functioning. The patient also reported reduced emotional distress, improved coping, and resumption of academic and creative activities. **Conclusion:** This case highlights the value of combining trauma-focused and family-focused interventions with pharmacotherapy to improve psychological well-being and family functioning in individuals experiencing emotional difficulties associated with dysfunctional family environments.

Keywords: *Family-Focused Therapy, Trauma, Family Dysfunction, Expressed Emotion, Depression, Case Report*

Family functioning is one of the strongest psychosocial determinants of mental health. Dysfunctional family environments characterised by criticism, emotional neglect, overinvolvement, inconsistent parenting, and poor communication have been associated with depression, anxiety, self-harm, trauma-related symptoms, and impaired psychosocial functioning. Exposure to adverse childhood experiences, including physical and emotional abuse, significantly increases vulnerability to emotional dysregulation and psychological distress in adulthood [1].

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Expressed emotion (EE), which includes criticism, hostility, emotional overinvolvement, and lack of warmth, has been identified as an important predictor of symptom severity, relapse, and poor treatment outcomes across several psychiatric disorders [2,5]. Individuals raised in high-EE environments often experience reduced self-esteem, impaired interpersonal relationships, and persistent emotional difficulties. Family-Focused Therapy (FFT) is an evidence-based psychosocial intervention aimed at improving communication, enhancing problem-solving skills, reducing expressed emotion, and strengthening emotional support within families [6]. When combined with pharmacological treatment [1,7] and trauma-focused interventions, FFT may improve clinical outcomes and promote long-term recovery.

The present case report describes a young woman presenting with emotional dysregulation and trauma-related symptoms in the context of longstanding family dysfunction. The report illustrates the role of trauma-focused therapy and Family-Focused Therapy in improving family functioning, reducing expressed emotion, and enhancing psychological well-being.

CASE PRESENTATION

A 25-year-old woman, Ms P, a student of Fine Arts, presented with severe anger outbursts and persistent distressing flashbacks of physical assault by her mother. She was the only child of her parents. Her father was employed as a station superintendent in the Indian Railways, and her mother was a homemaker. She belonged to an upper socioeconomic background. She also reported significant psychological distress related to her diagnosis of rheumatoid arthritis and a history of hypothyroidism.

The patient described recurrent self-harming behaviour, intense crying spells since 2016, and markedly disturbed sleep due to emotional distress. These symptoms were particularly prominent before university examinations and during stressful situations. Appetite was reported to be satisfactory.

Psychiatric Evaluation

During psychiatric assessment, Ms P appeared significantly distressed regarding her parents' overinvolvement and controlling behaviour. She expressed persistent worry about the future, accompanied by frequent crying spells. She described a longstanding pattern of maternal criticism, overinvolvement, and severe verbal conflict involving both parents, especially around issues of autonomy and personal boundaries.

Psychosocial and Family Context

The patient's parents had married against parental consent, and this reportedly contributed to longstanding relational stress and rejection of the mother by her in-laws. Chronic stress persisted within the family environment. The patient described punitive parenting from her mother and emotional disengagement from her father. Owing to frequent occupational transfers, the father was absent for substantial periods during her upbringing, leaving her primarily in the care of her mother.

Assessment of family functioning revealed substantial dysfunction in problem solving, communication, affective responsiveness, affective involvement, behavioural control, and general functioning. The patient perceived limited emotional support, irritability, intrusiveness, criticism, and both domestic and social stigma.

Mental Status Examination

On examination, Ms P appeared poorly groomed. Eye contact was intermittent. She was cooperative but visibly tense. Speech productivity was reduced. Affect was dysphoric. Social and personal judgement were impaired, and insight into her condition was partial (Grade II).

Case Formulation

The patient's emotional dysregulation and distress appeared to arise from the interaction of adverse childhood experiences, dysfunctional family dynamics, chronic criticism and overinvolvement, and medical comorbidity. Her presentation was further maintained by maladaptive communication patterns and high perceived expressed emotion within the family system.

Intervention

The patient received a multimodal treatment approach comprising pharmacotherapy, trauma-focused therapy, and Family-Focused Therapy.

- **Pharmacotherapy:** She was started on a low dose of sertraline for depressive symptoms, with gradual dose escalation according to tolerance [1,7]. During the two-month treatment period, medication was also tailored to address dissociative symptoms, and an antipsychotic was introduced, contributing to symptom reduction.
- **Trauma-focused therapy:** This intervention addressed traumatic core memories, the impact of punitive parenting, somatic flashbacks, hypervigilance, and internalised guilt, shame, and self-blame [4].
- **Family-Focused Therapy:** FFT was used to address maladaptive family dynamics, improve boundaries within the parental subsystem, strengthen communication, enhance family cohesion, promote adaptive interaction patterns, and improve the family's understanding of mental illness [3,6].

Outcome Measures

Progress was evaluated using the McMaster Family Assessment Device [3] and the Level of Expressed Emotion Scale before and after treatment.

McMaster Family Assessment Device (FAD)

Domain	Pre-test	Post-test	Interpretation
Problem solving	2.66	1.80	Improved ability to identify and resolve family problems collaboratively
Communication	2.44	1.50	Reduction in criticism, blame, and avoidance; better direct expression
Affective responsiveness	3.16	1.20	Improved recognition and validation of emotions
Affective involvement	3.57	2.00	Reduced overinvolvement; healthier emotional boundaries
Behavioural control	2.55	1.20	Better regulation, clearer rules, and more consistent expectations
General functioning	2.66	1.60	Reduced conflict and improved family cohesion

Level of Expressed Emotion Scale (LEE)

Domain	Pre-test	Post-test	Interpretation
Perceived lack of emotional support	37	19	Greater sense of support and reduced emotional distance
Perceived irritability	19	7	Marked reduction in tense and hostile interactions
Perceived intrusiveness	19	18	Mild improvement in boundary respect and autonomy
Perceived criticism	10	7	Reduced blaming and critical communication

RESULTS

Over a two-month period, the patient showed improvement in mood, anxiety, emotional regulation, and family functioning. Her low mood, fatigue, and distress gradually reduced. Family members developed a better understanding of her condition as a psychological and medical difficulty rather than a personal weakness, which appeared to reduce blame, criticism, and stigma within the household.

Structured family sessions improved communication patterns and promoted more supportive responses to the patient's distress. Emotional warmth, validation, and shared responsibility increased. The patient also resumed painting and other meaningful activities. Her mother reportedly began accompanying her during these activities, suggesting improved relational engagement. Although she continued to experience overthinking, she became better able to recognise and manage it.

DISCUSSION

This case highlights the importance of addressing both individual psychopathology and family dynamics in the management of emotional dysregulation. The patient's presentation was shaped not only by trauma-related experiences [4] and depressive symptoms [1,7] but also by persistent maladaptive family interactions characterised by criticism, overinvolvement, and poor emotional support [2,5].

The observed improvement supports the potential usefulness of integrating trauma-focused therapy with Family-Focused Therapy [6] in such cases. While pharmacotherapy may reduce core affective symptoms, family-based interventions may address relational patterns that maintain distress and dysfunction [3]. The reduction in perceived criticism and improvement in family communication suggest that modifying family processes can meaningfully contribute to recovery.

This case also underscores the role of psychiatric social work in identifying psychosocial stressors, assessing family functioning, and facilitating systemic intervention. A comprehensive biopsychosocial approach was central to treatment planning and outcome improvement.

CONCLUSION

This case report demonstrates that integrating pharmacotherapy, trauma-focused therapy, and Family-Focused Therapy may improve emotional regulation, reduce perceived expressed emotion, and enhance family functioning in individuals experiencing

psychological distress within dysfunctional family environments. Comprehensive psychosocial assessment and family-based intervention may be valuable components of treatment in similar cases.

REFERENCES

[1] American Psychiatric Association. Practice guideline for the treatment of patients with major depressive disorder. 4th ed. Washington (DC): American Psychiatric Association; 2022.

[2] Brown GW, Birley JL, Wing JK. Influence of family life on the course of schizophrenic disorders: a replication. *Br J Psychiatry*. 1972;121(562):241-258. doi:10.1192/bjp.121.562.241

[3] Epstein NB, Baldwin LM, Bishop DS. The McMaster family assessment device. *J Marital Fam Ther*. 1983;9(2):171-180. doi:10.1111/j.1752-0606.1983.tb01497.x

[4] Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14(4):245-258. doi:10.1016/s0749-3797(98)00017-8

[5] Hooley JM. Expressed emotion and relapse of psychopathology. *Annu Rev Clin Psychol*. 2007; 3:329-352. doi:10.1146/annurev.clinpsy.2.022305.095236

[6] Miklowitz DJ. Adjunctive psychotherapy for bipolar disorder: state of the evidence. *Am J Psychiatry*. 2008;165(11):1408-1419. doi:10.1176/appi.ajp.2008.08040488

[7] National Institute for Health and Care Excellence. Depression in adults: treatment and management (NICE Guideline NG222). London: National Institute for Health and Care Excellence; 2022.

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Conflict of Interest

The author(s) declared no conflict of interest.

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