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# CULTURALLY COMPETENT CASE FORMULATION IN ADOLESCENTS: LESSONS FROM AN ADOPTION DISCLOSURE CRISIS

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## Introduction

Self-injurious behaviour in adolescents frequently indicates deeper emotional and cultural struggles that conventional diagnostic methods may not address. This educational article examines a clinical case of a 13-year-old Malay girl (AI) experiencing Major Depressive Disorder and self-injury following the unexpected revelation of her adoption. The case illustrates why culturally aware, comprehensive case assessment is essential. The article presents the Biopsychosocial (BPS) 4P framework; examining Predisposing, Precipitating, Perpetuating, and Protective elements as an efficient tool for incorporating identity-related trauma, family confidentiality patterns, and community-oriented cultural values into effective clinical planning. This methodology is crucial for suitable evaluation, addressing diagnostic uncertainty, and implementing trauma-sensitive treatments such as Dialectical Behaviour Therapy (DBT) in family-focused, non-Western environments. The case offers three essential clinical insights for addressing complicated adolescent mental health issues in diverse cultural settings.

## The Clinical Challenge: Moving Past Symptoms Lists

The global prevalence of non-suicidal self-injury (NSSI) during adolescence highlights the need for effective, context-specific assessment strategies [1]. Though NSSI is a known risk factor for suicide, it often functions primarily as a maladaptive coping mechanism used to regulate intense emotional pain and distress [2].

In multicultural settings, the presentation of such distress is significantly shaped by local sociocultural norms. In Malay culture, a strong emphasis on family reputation, hierarchy, and community identity often discourages the overt expression of conflict or negative emotion. This creates a psychological environment where sensitive issues like adoption are frequently hidden to preserve family stability, unintentionally setting the stage for profound identity crises when such secrets are exposed. The utility of the BPS-4P model lies in systematically dissecting these intersecting layers of vulnerability.

## Clinical Scenario: Identity Trauma and Relational Rupture

AI, a 13-year-old Malay girl, presented to the Child Clinical Psychology service with severe, persistent depression, social withdrawal, passive suicidal ideation, and repeated self-harm (cutting) following the unexpected discovery of her adoption status. The trauma was amplified by the revelation that her biological mother was her adoptive mother's youngest sister—a complex relationship fact that fractured her core sense of self and relationship dynamics.

The crisis intensified during the COVID-19 Movement Control Order (MCO), amplified isolation, academic pressure, and escalating conflict with her adoptive mother. Objective screening revealed internalizing and externalizing problems in the clinical range, confirming a severe manifestation of distress.

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**The Educational Framework: Implementing the Biopsychosocial 4P Model**

The BPS-4P method serves as an educational resource for practitioners, progressing from simple symptom description to a comprehensive understanding of mental health conditions. Using this framework with AI's situation offers valuable insights into intervention targets:

*Predisposing Factors (Vulnerability)*

These factors established the underlying risk long before the crisis. For AI, these included the fundamental adoption history (early separation, genetic history gaps) and a substantial cultural expectation. The imperative to maintain family unity and obedience in her Malay context predisposed her to internalize, rather than express, deep-seated distress, increasing her psychological vulnerability to betrayal-related cognitions [3].

*Precipitating Factors (Triggers)*

These are the immediate stressors that disrupt the balance. The unexpected disclosure was the primary precipitant, creating a sudden, traumatic loss of her perceived identity and trust. This crisis was magnified by situational stressors, including the social isolation of the MCO and academic demands, which reduced access to protective resources and heightened family tension.

*Perpetuating Factors (Maintaining the Illness)*

These are factors sustaining the depression and self-harm cycle. Key perpetuating factors included maladaptive coping (self-harm as an emotion regulator), severe negative cognitive patterns (hopelessness, self-blame, resentment toward the biological father), and, significantly, the ongoing familial mistrust and reluctance of the adoptive parents to address the initial trauma. The unresolved family secret prevented emotional repair, continually reinforcing AI's sense of isolation and betrayal.

*Protective Factors (Strengths)*

These factors served as a therapeutic entry points. AI's strong sibling bond, established school involvement, and capacity for insight (her ability to articulate her internal conflict) were vital resources utilized in the treatment phase.

**Clinical Implications for Intervention**

AI's clinical journey underscores three critical lessons for clinical practice in multicultural adolescent settings:

1. Acknowledging Identity Trauma and Relational Rupture: Diagnosis (Major Depressive Disorder) was insufficient. AI's self-harm was a symptom of a relational rupture—a non-verbal, extreme attempt to communicate silent grief and exert control over an unstable internal narrative. Clinicians must recognize that NSSI in this population often requires a trauma-focused lens that addresses the loss of identity and broken attachment rather than just managing mood symptoms.
2. Incorporating Cultural Understanding in Family Engagement: The family's initial avoidance of the adoption topic reflected their own cultural distress over failing to preserve family reputation. Effective engagement required sensitive psychoeducation to reframe the secrecy not as guilt or wrongdoing, but as a cultural coping strategy that unfortunately led to psychological consequences for AI. This intervention opens the way for open communication.
3. Selecting Trauma-Informed, Skills-Based Therapy: The treatment combined individual and family modalities:
    - Individual Therapy (DBT-A Principles): Dialectical Behaviour Therapy (DBT), adapted for adolescents, was utilized to replace NSSI with effective emotion regulation skills and distress tolerance techniques, specifically targeting the dysregulation stemming from the betrayal trauma [4].
    - Trauma-Focused Work: This component focused on processing the sense of betrayal and helping AI integrate her complex life story—the core of her identity conflict [5].
    - Family Psychoeducation: Work focused on helping the family develop a new, non-pathologizing, and open narrative around the adoption to repair trust and rebuild the relationship.

**Key Takeaways for Practice**

This case highlights the following principles for clinicians working with complex adolescent presentations:

1. Emphasize Formulation Over Diagnosis: The BPS-4P formulation is essential for connecting symptoms to meaningful life events and socio-cultural context.
2. Recognize Cultural Masking: In community-oriented settings, self-harm may represent the only permissible outlet for distress that is otherwise culturally suppressed.

 

3. Proactive Identity Work: Proactive, structured life-story work in adoptive families, especially those embedded in high-secrecy cultures, may mitigate future psychological distress.

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