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The importance of an eclectic psychodiagnostic and psychotherapeutic approach in the treatment of adolescents with psychosomatic and dissociative symptoms – a single case report

Pomen eklektičnega psihodiagnostičnega in psihoterapevtkega pristopa pri obravnavi mladostnice s psihosomatskimi in disociativnimi simptomi – prikaz primera

Abstract

An increase in psychosomatic and dissociative complaints has been observed in the adolescent population due to their rapid physical, cognitive and psychosocial development, which leaves them prone to mental disorder. Psychosomatic and dissociative symptoms affect the overall functioning of the adolescent. This case study aims to illustrate the psychological assessment of, and therapeutic approach with a 14-year-old Slovenian schoolgirl presenting with psychosomatic and dissociative symptoms. Treatment may differ from child to child and must be based on an individualized assessment of the child's needs and stage of development. The eclectic psychotherapeutic approach (CBT, TA, mindfulness, EMDR) used is described in this article. At the beginning of the therapeutic process, the participant reported struggling with headaches as well as experiencing weakness in her legs and losing consciousness 3-4 times a week. Such episodes occurred predominantly at school, where she had experienced trauma as a result of bullying by her peers. Medical examinations did not reveal any identifiable physical causes for these symptoms. At the beginning of the therapeutic process, the participant rated the pain intensity as 7/10 on the VAS scale. After 6 months of psychotherapy (15 sessions), she reported no longer having pain and no longer losing consciousness. At the follow-up sessions four and

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eight months after the end of the therapeutic program, she confirmed that she no longer had any symptoms.

Keywords: adolescents, psychosomatic and dissociative symptoms, eclectic psychotherapeutic approach.

Povzetek

V populaciji mladostnikov je prisoten trend večanja psihosomatskih in disociativnih simptomov. Zaradi hitrega telesnega, kognitivnega in psihosocialnega razvoja, so mladostniki ranljiva populacija in dovzetni za razvoj duševnih motenj. Psihosomatski in disociativni simptomi vplivajo na splošno delovanje mladostnika. Namen študije primera je ponazoriti psihološko oceno in terapevtski pristop pri 14-letni slovenski šolarki s psihosomatskimi in disociativnimi simptomi. Zdravljenje se lahko razlikuje od otroka do otroka in mora temeljiti na individualizirani oceni otrokovih potreb in njegovi razvojni stopnji. V prispevku opisujemo eklektičen psihoterapevtski pristop (VKT, TA, čuječnost, EMDR). Udeleženka je vstopila v terapevtski proces in poročala, da je 3-4 krat na teden imela občutek, da ima šibke noge in izgublja zavest, tožila je o glavobolih. Zdravniški pregledi so ovrgli morebitne organske vzroke. Ti napadi so se pogosteje pojavljali v šoli, kjer je doživela travmatično izkušnjo ustrahovanja s strani vrstnikov. Na začetku terapevtskega procesa je udeleženka ocenila intenzivnost bolečine s 7/10 na lestvici VAS. Po 6 mesecih psihoterapije (15 srečanj) je poročala o izkušnji, da nima več bolečin in ne izgublja več zavesti. Na sledenju (štiri in osem mesecev po koncu terapevtskega programa) je prav tako poročala o tem, da je simptomatika povsem izzvenela.

Ključne besede: mladostniki, psihosomatski in disociativni simptomi, eklektičen psihoterapevtski pristop.

1. Introduction

Adolescence is defined as a transitional phase between the ages of 10 and 19. It is generally perceived as a period of life relatively free of major health issues (National Research Council et al., 2009). Due to their brain development (Dehestani et al., 2023; Holz et al., 2023), adolescents experience rapid physical, cognitive, and psychosocial development (Li et al., 2023) and are at increased risk for developing mental health issues. Around 20% of adolescents suffer from a mental health problem at an early age (11-14 years), most commonly depression or anxiety (Silva et al., 2020), which rises to 48.4% by the age of 18 (Scheiner et al., 2022).

An increase in psychosomatic and dissociative complaints has been observed in the adolescent population (Bulut et al., 2023; Högberg et al., 2023), highlighting

the need for a deeper understanding of the underlying causes and effective strategies for intervention and support are needed (Bulut et al., 2023). A psychosomatic disorder is a mental condition characterised by physical symptoms for which there is usually no medical explanation (Berezowski et al., 2022). The most common symptoms are headaches, stomach aches, and general bodily discomfort. Dissociation refers to a disturbed integration of conscious awareness, emotions, memories, body representation, and motor control (*Diagnostic and Statistical Manual of Mental Disorders,* 2013). In extreme cases, dissociation manifests as complete sensory disconnection, including loss of motor control and impaired speech perception and production (Schauer & Elbert, 2010).

High levels of perceived stress, difficulties in coping with stress, and less adaptive emotion regulation strategies such as suppression are considered risk factors for psychosomatic disorders (Buli et al., 2024; Sumter & Baumgartner, 2017; Teixeira et al., 2022), while dissociative disorders in adolescents are more likely to be associated with stressful, traumatic life events such as psychological or physical abuse in peer or family relationships (Abdelbaseer Mahmoud et al., 2022; Dell'Osso & Rossi, 2020).

A larger proportion of female adolescents complain of physical health problems (Zouini et al., 2019) which may be linked to their higher reported rates of mental health issues compared to male adolescents (Ohannessian et al., 2017). They most frequently report generalized anxiety, panic disorder, social anxiety, depression (Ohannessian et al., 2017) and headaches (Zouini et al., 2019). Both female and male adolescents report that all types of supportive relationships based on reciprocity, understanding, and respect have a positive impact on their mental health (Landstedt et al., 2009), while negative psychosocial factors are associated with increased physical and mental health complaints (Kerekes et al., 2021; Zouini et al., 2019). Another important part of adolescents' lives that can affect mental and physical health is the school environment and the perceived stress associated with it. Murberg & Bru (2004) defined four main dimensions of school stress: (i) difficulties with peers at school, (ii) worries about academic performance, (iii) pressure related to school work, and (iv) conflicts with parents and/or teachers.

When adolescents with dissociative and psychosomatic disorders are correctly diagnosed, they usually respond well to specialized psychological treatments (Brand et al., 2009; Li et al., 2023; Woolard et al., 2024). The results of a meta-analytic study (Woolard et al., 2024) describe psychotherapy as the most commonly used treatment method, but it is rarely used alone (Bhide & Chakraborty, 2020; Woolard et al., 2024).

A growing number of psychological treatments, such as cognitive behavioral therapy (CBT), psychoanalytic therapy, family-based treatment (FBT), and mindfulness techniques have been used to treat psychopathology in children and adults (Li et al., 2023; Woolard et al., 2024). On the other hand, the number of case studies describing the effects of other therapeutic approaches and techniques such as EMDR is increasing (Paauw et al., 2019; Woolard et al., 2024).

There is still a lack of empirical clinical research on children and adolescents who experience dissociation. Because they experience a variety of different types of trauma and dissociation can present with a wide range of severity, treatment may differ from child to child and must be based on an individualized assessment of the child's needs and developmental level (Woolard et al., 2024).

1.1. Current Case Study

This case study provides valuable insight into the experience of dealing with psychosomatic and dissociative symptoms in a 14-year-old Slovenian schoolgirl who had had a traumatic experience. The study describes the psychological assessment and diagnostic process and the therapeutic process in which various psychotherapeutic approaches and techniques (CBT, mindfulness, TA, EMDR) were used.

It was hypothesised that the participant would report a significant decrease in symptoms as a result of the eclectic therapeutic approach.

2. Method

2.1. Participant

"Brina" (a pseudonym; pseudonyms and other non-identifying details have been used to protect the client's confidentiality. These changes do not affect the validity of the case study or any crucial variables) was a 14-year-old Slovenian schoolgirl.

At the time of the first meeting, she was in the eighth (out of nine) grade of elementary school. She had always been an excellent pupil. School was very important to her, and she worked hard to succeed. She also attended a music school where she learned to play the piano.

She described her social life as "satisfactory". She had a good friend with whom she met in the afternoons and felt safe enough to trust her and talk about her problems. At school, she did not feel safe with her classmates.

She lived in a family of 4. She had a sister who was 5 years younger and reported satisfactory, supportive family relationships.

2.1.1. Presenting Complaints

At the first outpatient session (May 2022), Brina reported frequent sensations of leg weakness, headaches, and episodes of losing consciousness. These symptoms had occurred 3-4 times a week for a year and a half (since January 2021), sometimes several times a day, most frequently at school. She described these episodes in terms of "sudden feelings of lifting, weak legs, dizziness, light-headedness, weakness in the body, and unconsciousness". Most of the time, she remained unconscious for a few minutes (2-4 minutes) and did not need medical help. After regaining consciousness, she felt intense pain in both legs. She described the pain as "sharp cutting" and rated pain intensity as 7/10 on the VAS scale. The pain subsided after about 10 minutes and usually disappeared after two days. The examinations by a neurologist and an endocrinologist showed no notable findings, and the episodes were defined as psychosomatic symptoms. The patient said that the episodes did not elicit significant emotional reactions. She had learned to recognize them and tried to respond appropriately, adopting a static position or seeking help from others. She said that she was happy and in a good mood most of the time. She did not report emotional fluctuations or difficulties related to mood regulation.

2.1.2. History

Brina and her mother mentioned two stressful situations. The first was in November 2020 when she had herpes zoster and facial paralysis. The second event was in March 2021, when her classmates made fun of her, including on social media, where they posted a false image of her as disabled. This constituted a traumatic event for her. After this experience, she found it difficult to go to school and constantly felt that she was not accepted.

Her mother revealed Brina`s strong desire to have a sibling. After the birth of her sister, Brina began to behave as if she were the baby`s mother (e.g. feeding the baby with a bottle, changing diapers). Her mother tried to set boundaries and teach her that she was a child and not responsible for the baby. After that, her mother began to notice changes in their relationship. Before the baby was born, they had a good bond; after that, Brina started to isolate herself and she stopped talking to her parents about her problems.

2.2. Procedure

The participant was treated in an outpatient setting in a Slovenian hospital. The case description is an example of good practice from a study approved by the hospital's Medical Ethics Committee. Additionally, the participant and her parents gave written consent for Brina's results to be included in the study.

The participant, accompanied by her parents, had her first outpatient session

at the hospital in May 2022. Initially, she was examined by a specialist in physical and rehabilitative medicine and a clinical psychologist, who is also a certified Transactional Analysis psychotherapist and the research leader.

During the first consultation, a basic medical history was taken. In June 2022, we conducted an in-depth clinical-psychological examination and then provided feedback to her and her parents. We recommended admission to further psychotherapeutic treatment. Brina was very motivated to engage in the psychotherapeutic process, and her parents were supportive.

The therapeutic process took place from January to June 2023. We met weekly for 60 minutes. In total, the patient had 15 therapy sessions and two follow-ups. The first follow-up took place after five months (October 2023), and the second nine months after the end of the therapeutic process (February 2024). At both follow-ups, we reassessed pain symptoms (FOPQ-C, PCS-C and VAS). The participant and her parents signed a consent form permitting the anonymous use of the research results and data obtained during the study.

2.3. Instruments

After an unstructured clinical interview, the clinical psychologist conducted an in-depth psychological assessment, which helped to define Brina's functioning and her pain characteristics more precisely. The following psychodiagnostics instruments were administered:

The Wechsler Intelligence Scale for Children - 3rd edition (WISC-III) (Chorpita et al., 2000);(Wechsler, 2014); Slovene version: Boben et al., 2001. It is used for the individual assessment of children's intelligence based on four factor-based indices: verbal comprehension, perceptual organization, attention span and processing speed. It is suitable for children aged 6.6 to 16.6 years.

The Revised Children's Anxiety and Depression Scale (RCADS) (Chorpita et al., 2000) The RCADS is a 47-item self-assessment questionnaire developed to assess the frequency of various symptoms associated with anxiety and low mood in young people aged 8 to 18 years. It provides total scores for anxiety and depression as well as individual subscales (separation anxiety, social phobia, generalized anxiety, panic, obsessive-compulsive symptoms, and depression). Participants respond on a four-point Likert scale ranging from 0 ('never') to 3 ('always').

The Personality Assessment Inventory for Adolescents (PAI-A) (Clinical Applications of the Personality Assessment Inventory, 2010); Slovene version: Rigler et al., 2015. The PAI-A is an objective personality self-assessment questionnaire designed to collect information on critical clinical variables in adolescents aged 12–18 years. It comprises 264 items on a 4-point scale. It yields 22 independent scales:

- Four validity scales (inconsistency, infrequency, negative impression, positive impression)
- Eleven clinical scales (somatic complaints, anxiety, anxiety-related disorders, depression, mania, paranoia, schizophrenia, borderline traits, antisocial traits, alcohol problems, drug problems)
- Five treatment scales (aggression, suicidal ideation, stress, lack of support, treatment rejection)
- Two interpersonal scales (dominance, warmth)
- It can be completed individually or in a group, on paper or via an online application.

The Rorschach Inkblot Test (Ro.p.) (Exner Jr., 2003)

This semi-structured and standardized personality test is used for individuals aged five years and older. It contains ten inkblot cards: five are black and white (or shades of grey), two are two-colour, and three are multicolour. The Rorschach test provides information about a person's stress management mechanisms, thought processes, emotional responses, self-image and interpersonal functioning.

Fear of Pain Questionnaire – Child Version (FOPQ-C) (Simons et al., 2011); Slovene version: Horvat Rauter & Groleger Sršen, 2023.

This is a self-report questionnaire designed to assess pain-related anxiety in children aged 8 to 17 years. Participants rate each of the 24 items on a 5-point Likert scale ranging from 0 ('strongly disagree') to 4 ('strongly agree'). The total score can range from 0 to 96 points. A score of up to 34 points is defined as mild fear of pain, between 34 and 50 points as moderate fear and over 50 points as severe fear of pain.

The Pain Catastrophizing Scale – Children's Version (PCS-C) (Crombez et al., 2003); Slovene version in progress.

The protocol was validated on individuals aged 8 to 18 years. It contains 13 items measuring heightened negative cognitive and affective pain reactions, assessing three dimensions: rumination, magnification and helplessness. Each item is rated on a 5-point Likert scale from 0 (not at all) to 4 (extremely). The PCS-C total score ranges from 0 to 52; a score above 30 indicates a clinically relevant degree of catastrophizing.

The Visual Analogue Scale (VAS) (Delgado et al., 2018)

The VAS is a simple tool used to measure pain intensity. The numerical values range from 0 to 10, with 0 indicating no pain, 1 to 3 indicating mild pain, 4 to 7 indicating moderate pain and 8 to 10 indicating severe pain.

3. Results

3.1. Presenting Problems and Mental State Exam

The following table summarizes the results of the psychological assessment. The results of the assessment of personality traits, for which the diagnostic instruments (PAI-A and Ro.p.) have several subscales, are given descriptively.

Table 1
Assessment results.

Test	Result	Description
Wechsler Intelligence Scale for Children (WISC-III)		
Verbal Scale	IQ = 118	High average
Performance Scale	IQ = 129	superior
Anxiety and Depression Inventory (RCADS)		
Separation anxiety	T = 46	average
Generalized anxiety	T = 33	average
panic	T = 65	clinically elevated
Social phobia	T = 46	average
Obsessive-compulsive symptoms	T = 47	Average
Depressive symptoms	T = 40	Average
anxiety	T = 47	Average
Anxiety and depression	T = 46	Average
Pain Catastrophizing Scale – Child Form (PCS-C)	Raw score = 15	Not significant
Fear of Experiencing Pain Questionnaire, form for children (FOPQ-C)	Raw score = 23	Not significant
Visual Analogue Scale (VAS)		
Minimal	0	Low
Maximal	7	High
average	3	moderate

The participant has verbal skills in the high average range and superior non-verbal skills (WISC-III).

There is a tendency toward a positive-presentation (RCADS, Ro.p and PAI-A). The orientation toward physical symptoms is clinically elevated, which is reflected in an increased level of concern about health and adjustment symptoms. Specifically, she reports functional disability due to symptoms related to sensory or motor dysfunction. She tends to be quite rigid. Changes in routine, unexpected events, contradictory information cause her stress. She simplifies more complex propositions. She is mainly unique in her perception, as she gives only a few

typical answers and thus logical connections. Atypical and less adequate perceptions of situations are expressed more strongly than in the reference group. Her style of dealing with stress is avoidant, which means that a more intense inner experience is avoided, simplified and supressed. Stress is also harder to recognize, and she can appear less stressed than it actually is. She employs the defense mechanisms of intellectualization and rationalization. She tries to control her emotional expression, and while overwhelmed, impulsive outbursts may occur. The presence of less conscious anger is indicated. Interest in other people decreases, and the quality of existing relationships deteriorates. She finds it difficult to build deeper relationships.

3.1.1. Pre-existing Vulnerabilities

According to the psychological assessment, Brina's poor stress coping skills and her avoidant stress coping style — which prevented her from connecting with, recognizing, and expressing her feelings — were the main reason Brina could not process the traumatic events or express herself and her feelings in relationships. Instead of talking about her anger, she compartmentalized it, rendering it unconscious.

3.1.2. Activating Events

Brina experienced two highly stressful, possibly even traumatic, events. She dealt with facial paresis, and just four months later, she was mobbed by her peers.

3.1.3. Perpetuating Factors

Brina's coping style and the daily interactions with her classmates were the main factors that caused her feelings of panic and loss of consciousness.

3.1.4. Protective Factors and Strengths

Firstly, from the perspective of intrapersonal protective factors and strengths, Brina's high intellectual abilities must be highlighted, as they helped her to understand her education and gain insight into her behavioural patterns quickly. She was also highly motivated to make changes in her life, which is why she attended sessions regularly, was curious about herself and her aims, and practiced what we did during sessions at home as well and shared her observations during the subsequent sessions. Secondly, Brina's family served as an important environmental protective factor. They were supportive, enabling her to attend the therapeutic sessions regularly, and were present at the sessions when needed.

3.2. Course of Treatment and Assessment of Progress

The results of the clinical-psychological assessment of the participant confirmed weaker stress-coping skills and difficulties in building interpersonal relationships despite her high intellectual and cognitive abilities. She has problems with emotion regulation, especially in social situations, where she perceives others as

critical towards her. As her emotions intensify, she loses the ability to cope with them. They exceed her window of tolerance and trigger loss of consciousness.

After the psychological assessment, we provided the adolescent and her parents with feedback and education on the test results and advised her to seek psychotherapeutic treatment. Brina was highly motivated to work on her issues, so we agreed to include her in the psychotherapeutic treatment, which took place regularly, every week at the hospital. We combined an eclectic approach of CBT, TA, EMDR and Mindfulness.

The introductory sessions in January and February 2023 were mainly used to build a therapeutic relationship. Erskine's Keyhole model (Erskine et al., 1999) helped us to build a relationship in which we focused on her relational needs. The participant responded particularly well to validating her emotions, as this enabled her to get in touch with them and realize that they were present and valid.

Session 1 focused on orienting Brina and her parents to therapy, psychoeducation about her symptoms and the ABC model of functioning (Young, 2020). We explained the impact of context and situation on psychological processes (thoughts, emotions, behavior) with the help of monitoring (King & Boswell, 2019). She reported having a lack of such insight. Together with her parents, we explained two examples from her everyday life.

Table 2
Example of monitoring.

Situation	Thoughts	Feelings	Body, behaviour
Playing the piano	"I am doing OK." "I am playing my favourite song."	Happiness (80%) Pride (20%)	Relaxed (90%) Tension in muscles in hands (10%)
After collapsing at school.	"Something is wrong with me!" "Everyone is looking!" "They think I am crazy!" "It would be better not going to school!"	Shame (70%) anger (20%) disappointment (10%)	Headache and pain in legs (60%) Dizziness (20%) Anxiety and helplessness (20%)

Home practice required monitoring similar to the example above for one week until the next session.

Session 2 focused firstly on her homework review. According to the TA approach in her monitoring and descriptions of peer relationships, some of her script beliefs were involved (Hargaden & Sills, 2013; Hay, 2017). For example: in describing losing consciousness again at school – beliefs about herself ("I am not good enough." "I am not valuable.") and about others ("Others are

better than me." "Others are not trustworthy."). Before monitoring, she didn't have insight into her self-critical tendencies. Afterwards, she became aware that self-criticism was a pervasive and deeply impactful pattern in her daily functioning She began to feel ashamed, and she noticed an intensification of her pain symptoms. Using the functional model of ego states, she illustrated an inner dialog between the Critical Parent, and the Adapted Child (Hargaden & Sills, 2013; Hay, 2017). From her story, we learned that self-criticism had significantly intensified symptoms which she had not previously connected to emotional processes. Subsequently, we educated the participant about chronic pain mechanisms and introduced some TA concepts (Functional Model of Ego States, Drivers, Injunctions) (Erskine et al., 1999).

Home practice included continued monitoring, with a focus on the internal interaction between the Critical Parent and Adopted Child ego states.

Sessions 3-5 focused on emotions. Through monitoring, Brina reported improved insight into her cognitive and behavioural domains, though she continued to struggled with recognizing her emotional and somatic responses. The concepts of inner and outer contact and interruptions of contact are presented in the self-relationship model. This model identifies the cognitive, affective, behavioural, and physiological domains and the interpersonal space of contact with others (Erskine & Trautmann, 1996). According to this model, Brina was accustomed to establishing contact via the cognitive and behavioural domains. She frequently described experiencing "a mess in the head", and being overwhelmed with negative thoughts about herself and others, which resulted in pain symptoms, avoidance behaviours and dissociative symptoms. The aim of these sessions was to strengthen her affective domain. We focused on specific peer interactions in which she reported feeling discomfort but lacked awareness of the psychological processes leading up to loss of consciousness. With EMDR, we introduced the safe-place exercise to help enhance her sense of internal safety. Her safe place was a fantasy beach, where she felt relaxed, calm and strong. She described these feelings as centred in her chest and described them as pleasant.

We introduced mindfulness practices by first explaining the technique, then linking it to insights gained through monitoring – namely, that script beliefs and interpersonal dynamics intensified her pain. As she increasingly encountered situations that exacerbated her symptoms, we agreed that she would attend to self-criticism and its corresponding physical manifestations. When she noticed this pattern, she was to focus on that moment and try to respond to self-criticism with self-compassion, acknowledging it as a part of herself (Žvelc et al., 2011). She recognized the internal communication between

the entrenched Critical Parent ego state and its effect on the Adapted Child ego state. These observations caused her distress as she felt unsure of how to interrupt the entrenched dynamic. At this point, we began to integrate creative approaches more intensively.

Home practice included mindfulness, monitoring and observation of the interaction between her Critical Parent and Adapted Child ego states. Special attention was placed on increasing her awareness of emotional responses.

Sessions 6 and 7 focused on her observations— especially those at school, when she often felt judged or ridiculed by her classmates. In those moments, her script beliefs (Hargaden & Sills, 2013) about herself ("I am not good enough." "I am not valuable.") and about others ("Others are better than me." "Others are not trustworthy.") intensified. She recognized very intense mix of anger and helplessness that escalated rapidly, overwhelming her to the point of fainting. The reaction was connected to crossed transactions: she experienced her classmates as speaking from the Parent Ego state, while she shifted into her Child ego state.

We introduced the concept of crossed transactions as a source of relational conflict, in contrast to parallel transactions, which support healthy communication. She was able to describe the stepwise escalation of her inner processes:

Step 1: a stressful situation triggers her script beliefs leading to a basic feeling of anxiety.

Step 2: she anticipates a fainting episode.

Step 3: she starts to feel dizzy, develops a headache, becomes overwhelmed by racing thoughts; the world around her slows down, but her internal experience becomes rapid and intense; she has difficulty breathing.

Step 4: The world starts to go black, and she loses consciousness.

She recognised that she had felt this way when she was mobbed by her peers. We included interventions based on Erskine's Keyhole Model (Erskine et al., 1999),particularly normalization and emotional validation. A strong connection emerged between these past emotional memories (bullying) and her current responses—suggesting that the earlier experiences reinforced maladaptive coping strategies and contributed to dissociation. Brina felt helpless about her ability to impact these responses.

We began exploring what she would need in such situations; what internal or external resources might give her a sense of agency. She identified relational needs, (Erskine & Trautmann, 1996) especially: safety, feeling accepted, and being close to someone who could help her to calm down. We explored the kinds of external and internal stimuli that could help her regulate these intense feelings. We recommended the STOP technique and taught her a deep breathing method

(Exner Jr., 2003). The STOP technique is a cognitive-behavioral tool designed to manage overwhelming emotions, impulsive reactions, and maladaptive patterns of behavior (Bakker, 2009).

Because Brina expressed a strong need for an external stimulus, we used a creative approach to identify something tactile that could help her ground herself She chose a small, very soft object that she could hold in her hand during moments when she sensed an impending loss of consciousness. We tried to strengthen her Adult Egostate through this object.

Home practice focused on applying the STOP technique, deep breathing, and using the symbolic grounding object during stressful situations.

Sessions 8 and 9 were dedicated to the implementation of techniques in her everyday life and to strengthening her Adult Ego state. In those two sessions, Brina reported an important decrease ina symptoms. In a 14-day period, she had 10 episodes where she felt she was about to lose consciousness. She started to breathe, she was mindful, in touch with her feelings that were overwhelming her, but she was able to take the soft, small object to feel a sense of safety and strength in herself. In 9 cases, she was able to overcome the feelings, calm down, and prevent the loss of consciousness. She felt less pain in her legs (5/10 on VAS). Brina reported dealing with intense feelings of anger. With the affect bridge technique (Watkins, 1971), she recognized that an important part of her anger was directed toward her mother. She was ashamed of that, because of her loyalty to her parents. With the help of validation and normalization, she gave herself permission to speak about her experiences with her mother. Because of her work, the mother was often not present. Brina missed her a lot. When the mother came home, Brina saw her being tired, without energy. She needed her so much and cherished the moments when they played the piano together. But Brina had decided, even as a younger child that she wouldn't ask her mother to do that, because she might worsen her bad mood. While talking about this, tears were pouring down her face. In the Drama triangle, Brina was used to slipping into the role of Rescuer and Adapted Child Ego state (Karpman, 1971). We educated her about anger and the Drama triangle and explained some reactions that could come from her Adult Ego state. She expressed an intense need to talk with her mother, so we agreed to invite her to our next session.

Home practice required continuing the implementation of all the strategies we had worked on up to that point (monitoring; awareness of her anger; recognizing Ego states, STOP technique; breathing, symbol, mindfulness).

Session 10 included the meeting with her mother. We encouraged Brina to talk about her relational needs. She was able to tell her mother how much she misses her and that she would like to spend time with her. She especially wished

to play piano with her again. At least once a week, she would like to spend time together. She also talked about her experience of her mother as often tired and without energy— factors that led her to avoid her mother and behave more like an adult. She recognized and talked about the »Be strong driver! «. On the other hand, her mother talked about her feeling of helplessness connected with her unsuccessful attempts to strengthen her attachment with Brina. She experienced Brina as inaccessible, which made her feel not good enough.

The mother also talked about the decrease in Brina's symptoms.

Home practice required spending time with her mother in a special activity (playing piano) once a week. We agreed that her mother would be the one who schedules this time each week.

Sessions 11 and 12: Brina was happy because in the last weeks, she was able to prevent all the symptoms. On the other hand, she felt helpless when she came in touch with her Critical Parent. Although she recognized all the parts of the Functional model of Ego States, she did not know how to intervene during the interaction between the Critical Parent and the Adapted Child. We practiced the two-chair technique (Irarrázaval & Kalawski, 2022) to help her feel more authentically connected to herself and more self-compassionate. She sat on one chair in the role of the Critical Parent and on the other in the role of the Nurturing Parent. She came into contact with harsh criticism and prohibitions (e.g., "You are not worthy!", "You are not capable!" and "*You do not deserve it!*"). As she moved from one chair to another in the role of the Nurturing Parent, she came once again into contact with her repressed needs. She reported that she needed closeness, acceptance, and security. She also reported spending time with her mother as agreed upon in session 10. It was nice, but although she feel that her relational needs were not being met, when she was alone away from home.

Home practice required spending time with her mother in a special activity (playing piano) once a week.

Session 13 was a session with both parents, who reported important positive changes in Brina's behaviour and functioning – she had not had a collapse in quite some time. She seemed more relaxed and spoke about herself. They were especially grateful that she started to express anger.

Home practice required continuing all the learned practices.

Sessions 14 and 15 focused more on evaluating our work and setting plans on how to respond if the symptoms return. At the final session, Brina completed the pain questionnaires again, reporting a PSC-C of 5 and an FOPQ–C of 6, indicating a significant reduction in pain symptoms. On the VAS scale, she rated her maximum pain intensity as 2/10 during stressful situations, while in general she experienced no pain at all.

3.3. Complicating Factors

The main complicating factor was the delay between the beginning of Brina's symptoms and the beginning of psychotherapeutic treatment. Psychosomatic symptoms can emerge suddenly or develop gradually, often in response to chronic stress or emotional strain. Their intensity and duration may vary. Over time, if stress or unresolved psychological issues persist, psychosomatic symptoms can worsen. The longer the psychological stress continues, the more likely the body is to manifest physical symptoms. This is because the body and mind are deeply connected, and prolonged stress can disrupt the balance of the nervous system, hormones, and immune system. Early diagnosis and timely inclusion in treatment are therefore crucial (Fava, 2024).

3.4. Access and Barriers to Care

Several barriers exist in the treatment of children and adolescents with chronic pain, psychosomatic and dissociative symptoms. In our country, healthcare workers often lack sufficient knowledge about chronic pain (Pico et al., 2023) since this is an underdiagnosed condition, it is inadequately treated by health professionals. To this aim, a systematic review was carried out based on a search of the electronic literature databases (PubMed and Web of Science and may fail to recognise its psychological origins. Brina experienced symptoms for nearly two years before being referred to a clinical psychologist and receiving appropriate care.

Barriers to treatment may also be internal and come from the patient. Low psychological flexibility and comorbid mood disorders may hinder the recognition of the body-mind connection. These clients may attribute their pain solely to physical causes (i.e. the body without the mind). Brina had more external than internal barriers. She demonstrated insight, openness, and a capacity to gradually change her behavioral patterns.

3.5. Follow-Up

Two in-clinic follow-up sessions (October 2023 and February 2024) were conducted to determine how well the therapeutic effects were being maintained, parcitularly regarding Brina's experiences of pain and losing consciousness.

Table 3
Follow-up results.

Test	Score			
	Beginning	End	Follow-Up	
	May 2022	June 2022	October 2023	February 2024
The Pain Catastrophizing Scale – Child Form (PCS-C)	28 Not significant	5 Not significant	2 Not significant	1 Not significant
The Fear of Experiencing Pain Questionnaire, form for children (FOPQ-C)	23 Not significant	6 Not significant	3 Not significant	3 Not significant
Visual Analogue Scale (VAS)				
Minimal	0 (low)	0 (low)	0 (low)	0 (low)
Maximal	7 (high)	2 (moderate)	0 (moderate)	0 (low)
Average	3 (moderate)	0 (without)	0 (without)	0 (without)

At both follow-ups, Brina completed psychological questionnaires (PCS-C, FOPQ-C), rated her pain on the VAS scale, and shared updates about her everyday life. In stressful situations (schoolwork, tests), she rated her pain intensity is as1. The most intense pain (moderate, rated 4) occurred during periods when her script beliefs were reinforced). However, she was able to manage those situations effectively. Most of the time, she was without pain, although she continued to struggle with negative script beliefs. She actively worked to adress them through self-compassion. Progress was steady. She returned to the clinic for another follow-up in March 2024, six months after the previous one. The trend of improvement continued. The PRM specialist physician re-evaluated her and confirmed that the outcome has been positive.

4. Interpretation

This case study has provided evidence for the effectiveness of an eclectic psychotherapeutic approach for treatment of psychosomatic and dissociative symptoms in adolescents. Eclectic psychotherapy is a flexible therapeutic approach that integrates techniques from different psychological theories to tailor treatment to the individual needs of each client. This method allows therapists to draw from multiple modalities such as cognitive behavioural therapy (CBT), psychodynamic therapy, and humanistic approaches and select the most effective interventions based on the individual‘s specific problems

and preferences (Li et al., 2023; Woolard et al., 2024). The mechanisms of these symptoms are comprehensive and include both individual experiences and environmental influences.

Modic and Žvelc (2021) discuss the application of an integrative psychotherapeutic approach that combines mindfulness and compassion-oriented strategies. This approach emphasizes the importance of adapting therapeutic methods to the unique needs of each client, depending on the problem, treatment goals, and the person's expectations and motivation. Our case study describes how the psychotherapist adapted to Brina's needs using various strategies from CBT, TA, mindfulness and EMDR (Paauw et al., 2019; Woolard et al., 2024).

Although we describe the effects of the different therapeutic approaches, we must emphasize the strong therapeutic alliance (Woolard et al., 2024) established between our participant and the psychotherapist (researcher). Through the description of the psychotherapeutic process, we can sense the bond between the subjects that helped Brina to gain confidence. She felt safe in the therapeutic relationship and was able to trust the therapist and slowly get in touch with and share her emotions.

Brina's case is an excellent example of how education can help patients to understand their inner processes, to recognise them and gradually influence them. She learned to understand her internal processes and her reactions to her environment. Brina was also able to become aware of and understand the split between her Child's and Parent's ego states, especially between her Critical Parent and Adapted Child. Through several CBT techniques (ABC model, STOP technique) (Li et al., 2023; Woolard et al., 2024), TA techniques (like the two-chair work and the Keyhole model approaches) (Hargaden & Sills, 2013; Hay, 2017), and the process of mindfulness, we decontaminated her Adult ego state and strengthened her self-compassion (Žvelc et al., 2011). The whole process helped her understand her symptoms as reactions to the stressful environment and trauma caused by her peers, and to prevent it.

On the other hand, this case study also shows the importance of family-based treatment (FBT) (Li et al., 2023; Woolard et al., 2024). FBT involves the family in the treatment process and aims to improve family dynamics and support the individual's recovery. The goal is not only to treat the symptoms themselves (in our case, Brina's pain and dissociation), but also to improve family dynamics and communication. We met with the whole family but focused intensively on the relationship between Brina and her mother, as she described it as unsatisfactory. The meetings with both of them helped to improve their relationship.

Psychosomatic, dissociative and pain symptoms are increasing in the population of children and adolescents. Therefore, it is important for professionals

to be aware of the symptoms and to be able to treat them effectively. For these patients, a safe environment is of great importance. Empathic inquiry is an essential therapeutic approach in TA that can help therapists establish a good therapeutic relationship (Erskine et al., 1999). Children and adolescents with such problems are particularly often not understood by others because there is a myth that young people are too young to be ill. It is essential to give them space and time to share their experience. Therapists should listen carefully, validate, and normalize their feelings. CBT is the most evidence-based therapeutic approach, it is not the only one (Woolard et al., 2024). A combination— the power of the eclectic approach, which enables us to attune more accurately to the patients and their needs— is of great importance. The main recommendation to clinicians and students is not to be afraid of eclecticism and to learn different approaches.

The study provided valuable insights, but its limitations should be recognized. First, the study is a case study. It is valuable for describing the therapeutic process, but it allows for subjective conclusions. Second, the study provides evidence for the potential effectiveness of different therapeutic approaches, such as CBT or TA, but the research design does not allow for a direct evaluation of these approaches. Additionally, the study uses self-report and clinician-performed assessments. However, the inclusion of objective measures such as physiological markers or neuroimaging could provide a more comprehensive understanding of the interplay between psychological factors and psychosomatics. In future studies, this could be included, along with a larger sample size.

5. Conclusion

Despite its limitations, the case study highlights the eclectic psychotherapeutic approach to the treatment of an adolescent with psychosomatic and dissociative symptoms. There is a dearth of such studies. We believe that an eclectic approach, whichintegrates different therapeutic approaches and techniques, is beneficial.

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