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A Case Report of Psychological Counseling for a College Student with Depression, Anxiety, and Self-Injury Behavior Triggered by Family-of-Origin Issues

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Abstract: *This report details the case of a college student, Xiao An (pseudonym), who presented with moderate depression, mild anxiety, and self-injury behaviors, all rooted in family-of-origin issues. The client reported persistent low mood, anhedonia (diminished interest), low self-worth, strained family relationships, and engagement in self-harm and social avoidance. The counseling process followed a progressive model: "Establishing a Therapeutic Alliance—Problem Assessment —Cognitive Restructuring — Behavioral Intervention." Techniques such as active listening, causal chain analysis, identification of automatic thoughts, and alternative behavior training were employed. Outcomes included alleviation of emotional symptoms, clarification of familial role boundaries, and development of preliminary emotion regulation strategies. The client demonstrated significant improvement in emotional stability, a reduction in self-harm behaviors, and gradual enhancement of self-worth. However, deep-seated family trauma, emotional blunting, and motivational deficits warrant continued intervention. This case offers practical insights for counseling interventions addressing psychological distress stemming from family-of-origin issues among college students.*

Keywords: *College Student; Family-of-Origin Trauma; Moderate Depression; Mild Anxiety; Psychological Counseling; Cognitive-Behavioral Intervention*

1. Introduction

College students are in a critical stage of psychological maturation. The family of origin, as a primary and early developmental environment, profoundly shapes an individual's self-perception, emotion regulation, and social adaptation capacities through its relational patterns and parenting styles [1]. It serves not only as the individual's initial living environment but also as a crucial context for learning communication styles and establishing intimate relationships [2]. Dysfunctional family dynamics, characterized by parental marital discord or extreme parenting practices, can predispose individuals to states of loneliness and emotional detachment. Consequently, this vulnerability often manifests as clinical concerns such as depression, anxiety, and low self-esteem, with self-injury representing a severe maladaptive coping mechanism[3, 4]. Therefore, implementing systematic and effective psychological counseling interventions for college students experiencing distress due to family-of-origin issues is of significant practical importance.

2. Case Overview

2.1 Demographic Information

The client, Xiao An (pseudonym), is a 21-year-old female, majoring in liberal arts in her third year of undergraduate studies. Her family of origin includes her parents and a younger brother approximately five years her junior. Her father, an entrepreneur with a strong and domineering personality, held extremely high expectations for his children's academic achievement, particularly for the client as the eldest daughter. His primary mode of emotional expression was criticism and negation. He had a history of long-term extramarital affairs and was largely absent in his familial role.

Her mother, a homemaker with a fragile and codependent disposition, inverted the parent-child dynamic by making her daughter her primary source of emotional comfort. This occurred within an

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environment of **entrenched son preference**, where the brother was indulged, and the client was thrust into a parentified role. She internalized the belief that her worth was transactional, contingent upon **being unfailingly dutiful** and **academically outstanding** to secure a fleeting sense of recognition from her father.

The parental relationship had long been discordant, creating a tense and oppressive family atmosphere. From a young age, the client was entangled in parental conflicts and became her mother's primary emotional confidante, assuming the roles of a "surrogate spouse" and a "parentified child." This resulted in chronic emotional repression and feelings of injustice and resentment stemming from the stark contrast between her brother's "privileges" and her own "burdensome responsibilities."

The client has no significant history of physical illness and no family history of mental illness within three generations. She was recently diagnosed with "moderate depression and mild anxiety" at another hospital due to emotional and behavioral issues, however, a brief treatment course was discontinued shortly after its initiation due to her father's objection.

2.2 Chief Complaint and Personal Statement

Chief Complaint: "Persistent low mood, anhedonia, anxiety, and worry for over a year, accompanied by self-injurious behaviors, with recent exacerbation." Personal Statement: The client was diagnosed with "moderate depression and mild anxiety" at a hospital one year ago. She discontinued medication after one week due to family opposition and a self-perceived correlation with her menstrual cycle. Recent academic pressure and family conflicts have exacerbated her emotional distress, leading to self-harm behaviors including punching walls, banging her head, and scratching her arms with nail clippers, albeit reporting a "lack of pain sensation." She feels "unworthy" of her friends' kindness and feels uncertain about the future. At home, her father engages in extramarital affairs and imposes extremely high expectations on her, frequently criticizing and negating her. The client perceives herself as the cause of her parents' frequent arguments and feels responsible for consoling her mother and maintaining family harmony, resulting in profound internalized suppression.

2.3 Counselor Observations

The client was neatly dressed, mentally alert, and coherent in speech. She was cooperative during communication but exhibited a low mood, becoming easily agitated and tearful when discussing family relationships. She demonstrated intact insight and a strong desire for help.

2.4 Psychological Assessment

Pre-counseling assessment utilized the Symptom Checklist-90 (SCL-90)[5], the Self-Rating Anxiety Scale (SAS)[6], and the Self-Rating Depression Scale (SDS). The SCL-90 results indicated significantly elevated scores on the depression, anxiety, interpersonal sensitivity, and hostility factors compared to the norm. The total score exceeded 160, suggesting suboptimal psychological health. The SAS and SDS standard scores were 68 and 65, respectively, indicating moderate anxiety and mild to moderate depression.

3. Problem Analysis and Assessment

Based on the collected clinical data, the client's issues are analyzed as follows:

3.1 Emotional Disturbance

Clinical presentation is consistent with moderate depression and mild anxiety, characterized by pronounced low mood, anhedonia, sleep disturbances, and somatic symptoms (e.g., hand tremors, headaches, numbness).

3.2 Self-Injury Behavior

The primary functions of her self-injurious behaviors (e.g., punching walls, scratching arms) are to release internal distress, counteract emotional numbness, and engage in self-punishment, representing maladaptive coping mechanisms.

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3.3 Self-Perception and Family System Issues

①Profoundly Low Self-Worth: The client's core beliefs center on themes of worthlessness and being a burden (e.g., "I am worthless," "I am a burden to others"). These beliefs manifest as a chronic and pronounced feelings of undeservingness, which permeate both her interpersonal relationships and her ability to accept personal or material gains.

②Parentification and Role Confusion: Within the dysfunctional and discordant parental subsystem, the client was forced into the role of a "surrogate spouse" and emotional caregiver for her mother. This resulted in the chronic suppression of her own emotional needs and a confused sense of identity, trapped between the roles of a child and an adult.

③ Unresolved Familial Trauma: The father's long-standing extramarital affairs, combined with his pattern of chronic emotional invalidation and excessively high demands, represent a significant and unprocessed source of psychological trauma, which continues to fuel her present-day distress.

4. Counseling Approach

4.1 Theoretical Framework

Grounded in Cognitive Behavioral Therapy (CBT)[7], which posits that the client's emotional and behavioral difficulties stem from negative automatic thoughts and core beliefs about herself, others, and the future. By identifying, evaluating, and modifying these cognitions, her emotional and behavioral patterns can be effectively improved. Additionally, Motivational Interviewing (MI)[8] techniques were integrated to address the client's ambivalence towards "getting better." Role Clarification and Emotion Regulation strategies were also employed to address family-related dynamics.

4.2 Counseling Goals

Short-Term Goals: ① Establish a safety agreement to reduce and eliminate self-injurious behaviors; ② Learn emotion regulation techniques to alleviate anxiety and depressive symptoms; ③ Identify and challenge core beliefs related to "low self-worth."

Long-Term Goals: ① Foster a healthy self-concept and enhance self-worth; ② Clarify personal roles and boundaries within the family system to reduce psychological burden; ③ Establish positive interpersonal relationship patterns to strengthen social adaptation skills.

4.3 Counseling Setting

Sessions were conducted once weekly, each lasting 50 minutes, via face-to-face counseling at the University Mental Health Center. A total of 6 sessions were conducted.

5. Counseling Process

The counseling process was broadly divided into three stages:

Phase 1 (Sessions 1-2): Relationship Building, Risk Assessment, and Behavioral Intervention

The first session focused on active listening and unconditional positive regard to establish a safe and trusting therapeutic relationship. A "No-Self-Harm Agreement" was collaboratively developed and signed with the client. The second session prioritized assessing triggers for self-harm (e.g., conflicts with her father, internal self-critical thoughts) and co-creating an "Alternative Behavior List" (e.g., squeezing a stress ball, running, journaling, mindful breathing). The aim was to replace self-injury with safer, adaptive behaviors.

Phase Two (Sessions 3-4): Cognitive Restructuring and Role Clarification

The third session guided the client to identify her automatic negative thoughts (e.g., "I am a burden to others," "I am unworthy") through specific life events (e.g., friends showing concern, replacing personal belongings) and to learn to decouple these thoughts from objective facts. The fourth session focused on the family system, employing "causal chain analysis" to help the client recognize that her parents' arguments stemmed from their own marital communication patterns, not her actions or

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responsibility. This facilitated her gradual disengagement from the "surrogate caregiver" role and supported her return to an appropriate filial role.

Phase Three (Sessions 5-6): Emotion Management, Motivation Enhancement, and Future Orientation

The fifth session addressed exam-related anxiety and associated negative thoughts, while affirming the client's progress in utilizing alternative behaviors for emotion regulation. The sixth session explored the client's underlying ambivalence and conflicting mindset of "not wanting to get better," uncovering that she equated "recovery" with "losing a sense of control" and "prematurely assuming full adult responsibilities." Through empathic reflection and guidance, the counselor helped reframe the goal as "returning to a normative developmental path" and assisted in developing short-term, actionable personal plans to strengthen her intrinsic motivation for change.

6. Evaluation of Counseling Outcomes

6.1 Scale Assessment

Post-counseling, the SCL-90 total score and scores on key factors (depression, anxiety, interpersonal sensitivity) showed significant reduction compared to pre-counseling levels, falling within or below the normal threshold. SAS and SDS standardized scores decreased to 55 and 53, respectively, indicating that anxiety and depression levels had reduced to below the mild severity range.

6.2 Client Self-Assessment

The client reported increased emotional stability, reduced sensitivity to environmental sounds and social interactions, and a significant decrease in both the frequency and intensity of self-harm urges. She actively employed coping strategies such as squeezing a stress ball and journaling to manage emotional crises. She stated, "Although thinking about family matters still makes me sad, I no longer feel completely overwhelmed as before. I know it's not solely my fault."

6.3 Therapist Assessment

Cognitively, the client developed a preliminary ability to identify and challenge some of her negative automatic thoughts. Behaviorally, her self-harm was effectively controlled, and she established healthier coping mechanisms. Emotionally, while she still exhibited strong reactions to topics related to her family of origin, she demonstrated improved awareness and some capacity for regulation. The short-term goals were largely met, laying a foundation for long-term growth.

6.4 Follow-up

A telephone follow-up conducted six months after the conclusion of counseling revealed that the client's emotional state remained generally stable. Self-harming behaviors had not recurred. The client was adapting well to academic life and had formed more profound friendships with her peers.

7. Discussion and Reflection

The strengths of this case include: First, rapidly establishing a trusting therapeutic relationship and implementing safety interventions early in the process effectively prevented the escalation of self-harm behaviors. Second, the flexible application of CBT techniques, interpreting the client's "low self-worth" and self-injury through the lens of unmet emotional needs, made the interventions more targeted and meaningful. Third, addressing the client's ambivalence towards change enhanced her engagement and the overall effectiveness of counseling.

Limitations of this case include: Constrained by the limited number of sessions, the depth of processing the family-of-origin trauma was insufficient. The counseling did not fully guide the client in expressing and processing underlying emotions like anger and disappointment toward her father. If conditions permit, subsequent interventions could incorporate deeper techniques such as the empty chair technique or narrative therapy. Furthermore, family interviews—a crucial pathway for understanding and intervening in the family system—were not feasible due to practical constraints, which somewhat limited the comprehensiveness of the counseling outcomes.

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In summary, for depression, anxiety, and self-harm behaviors stemming from complex family-of-origin issues, an integrative counseling model primarily based on CBT, supplemented by other techniques, can effectively alleviate symptoms, promote cognitive shifts, and create favorable conditions for further personal growth and trauma processing.

8. Conclusion

This case systematically presents the emotional and behavioral troubles of Xiao An caused by issues in their family of origin and the intervention process, highlighting the importance of providing targeted psychological support to college students. As the initial foundation for an individual's psychological development, the family of origin's internal conflicts and dysfunction often have a lasting impact on an individual's self - identity, emotional regulation, and interpersonal patterns. Counseling practices indicate that an integrated intervention strategy based on cognitive - behavioral therapy, combined with motivation enhancement and role clarification, can effectively alleviate the client's surface symptoms and support their cognitive reconstruction and behavioral change.

However, the repair of deep - seated trauma and long - term psychological growth still require a long - term, stable professional relationship and systematic support. In future work, the possibility of family involvement should be further explored, and attention should be paid to enhancing the client's psychological resilience and self - care ability, so as to promote their transition from "symptom relief" to "personality growth" and truly achieve psychological independence and integration. This case also provides a reference intervention framework and reflection direction for college psychological workers in dealing with similar complex family - of - origin issues.

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