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Childhood Abuse, Neglect and Dysfunctional Family: A Case Report of a Patient with Depression and Borderline Traits

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A B S T R A C T

Ms. S.A, 16.5 years old, girl, 9th grade student, came to the outpatient department at Benazir Bhutto Hospital with the presenting complaints of sadness, irritable mood, reduced interest in his usual activities, reduced appetite, poor concentration, sleep problems, disturbed interpersonal relationships, affective instability, feeling of emptiness, impulsivity and suicidal ideation. The patient was referred to the trainee Clinical Psychologist for psychological assessment and management purposes. History revealed child abuse, neglectful parenting, madrassa and school transitions and family psychiatric illness as major factors for illness. History of present illness, subjective rating of symptoms, and mental state examination were used for informal assessment. For formal assessment, the Beck Depression Inventory (BDI) was used and Beck Suicide Intent scale was used. HTP and Borderline Zanarini scale was used for personality assessment. On the basis of this assessment, the patient was diagnosed with Major Depressive Disorder, Moderate, recurrent episode comorbid with borderline personality trait. Management plan was proposed accordingly which included sleep hygiene principles, progressive muscles relaxation, mindfulness exercise, activity scheduling, master and pleasure technique, triple column technique, examining the evidence, pie chart, cost benefit analysis, distraction techniques and relapse prevention and Dialectic behavior therapy

Keywords: Child abuse, neglectful parenting, school and madrassa transitions, genetic predisposition

Introduction

Major Depressive Disorder (MDD) is marked by persistent low mood, anhedonia, appetite and sleep disturbances, and suicidal ideation. In this case, the patient presented with these symptoms, along with affective instability, impulsivity, and unstable relationships, meeting DSM-5-TR (2022) criteria for MDD with borderline personality traits. These symptoms emerged following multiple psychosocial stressors, including school transitions, financial hardship, childhood sexual abuse, and family discord. Stressful life events have long been associated with the onset of depression (Gan & Gibb, 2025). Psychodynamic theory suggests that symbolic losses may trigger depressive symptoms (Comer, 2018), while cognitive models highlight guilt and rumination as central features (Beck, 2008). Appetite loss, insomnia, and fatigue are consistent with MDD's somatic profile (McKeough et al., 2025). Suicidal ideation, as reported by the patient, underscores the need for prompt intervention (Comer, 2018). The presence of early-onset interpersonal instability and trauma history further supported the diagnosis of borderline personality traits. Childhood abuse and insecure attachments are significant contributing factors.

Previous studies suggested that childhood trauma is significant predisposing factor for the development of borderline personality disorder (BPD). Moreover, insecure attachment and maladaptive emotion regulation might be related to childhood abuse and neglect (Peng et al., 2021). Females may be biologically more vulnerable to BPD due to heightened cortisol responses and sensitivity to rejection (Domes et al., 2009). Ongoing family dysfunction and unresolved guilt perpetuate emotional dysregulation and suicidality (Kietzman et al., 2025)

Case Study

S.A. is a 16.5-year-old female who was referred for psychological assessment and intervention due to persistent symptoms of low mood, fatigue, irritability, disturbed sleep and appetite, impaired concentration, and recurrent suicidal ideation. These symptoms had been present for approximately seven months and were reported to have intensified following academic setbacks and the termination of a romantic relationship. She belonged to a nuclear family with limited financial resources and a notable psychiatric history, her mother had a diagnosed psychiatric illness, and her siblings had been diagnosed with Obsessive-Compulsive Disorder and Bipolar I Disorder, respectively. S.A. disclosed multiple traumatic experiences, including incidents of childhood sexual abuse perpetrated by a cousin and a friend's father, as well as incestuous abuse by two of her elder brothers. Her familial environment was characterized by emotional neglect; she reported feeling disconnected from her mother, unsupported by her father who was described as emotionally unavailable and preoccupied with religious obligations, and conflicted relationships with her sisters. These dynamics contributed to a pervasive sense of

insecurity and emotional isolation within the home. Academically, she had encountered considerable instability, including frequent school changes, bullying, maladjustment at a religious seminary she was compelled to attend, and academic failure when her desire to pursue A-levels was dismissed. Over the preceding two years, S.A. exhibited increasing emotional dysregulation, impulsive behavior, engagement in high-risk sexual activities, and brief episodes of substance use. These behaviors suggested difficulties in identity formation and emotional regulation. Although she demonstrated some level of insight and a desire for change, she remained burdened by feelings of guilt, helplessness, and low self-worth. Overall, her clinical presentation was indicative of complex trauma, significant depressive and anxiety symptoms, and emerging personality pathology. These appeared to be rooted in chronic emotional neglect, cumulative traumatic experiences, and unstable interpersonal relationships. During the initial session, a mental status examination was conducted to assess the patient's current functioning. S.A. appeared as a neatly dressed adolescent female with appropriate eye contact. Her speech was clear, coherent, slow, and low in volume. She displayed a sad affect consistent with her reported mood. Her posture was low, and she showed signs of agitation when discussing her difficulties. Suicidal ideation was expressed. Attention, concentration, and memory (recent, immediate, and remote) were intact, though her reaction time was slow. There was no evidence of obsessions, compulsions, delusions, hallucinations, depersonalization, or derealization. She was oriented to time, place, and person, and demonstrated intact judgment, abstract thinking, and insight into her condition.

Beck Depression Inventory (BDI):

The Beck Depression Inventory was administered to assess the severity of depressive symptoms. The patient obtained a raw score of 25, which falls within the moderate depression range (19–29). This score indicated the presence of moderate depressive symptoms requiring clinical attention.

Suicide Intent Scale:

The Suicide Intent Scale was used to evaluate the intensity of the patient's wish to die at the time of assessment. The patient scored 17, indicating a low level of suicide intent. However, another qualitative report noted a score of 28, suggestive of medium suicide intent, highlighting the necessity for targeted interventions to mitigate suicide risk.

Zanarini Borderline Scale:

The patient's score of 7 on the Zanarini Borderline Scale, below the cutoff of 8, suggested the presence of mild borderline personality traits.

House-Tree-Person (HTP) Test:

The house drawing reflected impulsivity, rumination about the past, regression, anxiety, and a strong need for love and protection. The tree depicted openness to new experiences and people, alongside dependency, personality instability, and depressive tendencies. The person drawing revealed internal conflicts through omitted body parts, lack of ambition and achievement, aggressiveness both internal and external, a self-centered attitude, and emotional instability.

Results

The assessment results for the patient provided a detailed understanding of her psychological and cognitive functioning. Her performance on the Beck Depression Inventory indicated moderate depressive symptoms, with a raw score of 25. The Suicide Intent Scale results showed low to medium suicidal intent, emphasizing the need for careful monitoring and intervention. The Zanarini Borderline Scale revealed mild borderline personality traits. Projective testing using the House-Tree-Person (HTP) test reflected significant emotional distress: the house drawing suggested impulsivity, rumination, and anxiety; the tree indicated personality instability, dependency, and depressive tendencies; while the person drawing revealed internal conflicts, emotional instability, and aggression. These findings collectively suggest emotional instability and moderate psychological distress.

Table 1–Assessment results of patient S.A

Test	Raw Scores	Range	Interpretation
Beck Depression Inventory	25	Moderate	Moderate depression
Suicide Intent Scale	17-28	Low to medium	Low to Medium Suicide Intent
Zanarini Borderline Scale	7	Mild	Mild Borderline Traits

Based on these results, along with observations, clinical interview, and DSM-5-TR criteria, the patient was diagnosed with Major Depressive Disorder, Recurrent Episode, Moderate (F33.1), with comorbid borderline personality traits.

Discussion

In the present case, parental neglect due to mother's psychiatric illness and father's unavailability, sexual abuse by cousins and brothers, and her gender were the factors that played the role of predisposing factor. From a psychoanalytic perspective, the patient's rejection of family life, unhealthy home environment, and weak ego strength may be attributed to early childhood experiences that have shaped her personality trait and interpersonal relationships. According to Freud's psychoanalytic theory, personality development is influenced by unconscious conflicts that arise during the psychosexual stages of development, which can result in the formation of maladaptive defense mechanisms and personality traits (Freud, 1915). In this case, the patient has

experienced trauma or neglect during their early childhood, leading to the development of insecure attachment and difficulties in identity formation (Bowlby, 1969). Furthermore, the patient's regressive themes and low self-esteem may reflect unresolved developmental conflicts related to their sense of self and self-worth (Erikson, 1950). In the current case, it was evident as the patient had faced severe paternal neglect and abused which impaired her normal ego development and made the patient unable to form a normal self-identity. From a behavioural perspective, the patient's adjustment difficulties and limited social contact may be attributed to learned behaviours and environmental factors that have influenced their behaviour and emotional regulation. According to the principles of classical and operant conditioning, behaviour is shaped by environmental stimuli and reinforcement contingencies, which can lead to the development of maladaptive patterns of behaviour (Skinner, 1963). In this case, the patient may have learned to avoid social contact due to negative reinforcement experiences, such as rejection or criticism, bullying from others, which have reinforced their maladaptive behaviour. As, the patient was always made feel inferior in her class and Jamia and she started comparing herself with others. Moreover, the patient's emotional dysregulation may be attributed to deficits in behavioural self-regulation skills, such as mindfulness and emotion regulation (Linehan, 2015).Research suggests that experiencing sexual abuse during childhood can increase the risk of developing borderline personality disorder (BPD) in adulthood. Studies have found that individuals with BPD are more likely to have a history of childhood sexual abuse compared to individuals without BPD (Zanarini, & Frankenburg, 1997).It is quite evident in the case of this patient. Individuals with BPD often experience intense negative emotions, which they have difficulty regulating. This emotional dysregulation is a risk factor for suicidal ideation and behaviour (Manson, 2024). Researches have also found that individuals with BPD who engage in self-destructive behaviours, such as self-harm and substance abuse, are at greater risk for suicidal ideation and behaviour (Reichl,& Kaess, 2021) or this case, patient had severe problems in emotional regulation which may be attributed to her multiple suicide attempts. The patient's development of Borderline personality disorder can be traced back to her disposition of emotional dysregulation and inaccurate expression in the form of anger, crying which was in turn responded by neglecting. This pervasive invalidation of her emotions from the significant figures in patient's life increased her emotional vulnerability (in the form of higher sensitivity to rejection and using to maladaptive ways to react in face of stress.

The management plan for the patient was structured into ten therapy sessions using a cognitive-behavioral approach. The first session focused on building rapport, providing psychoeducation on depression and anxiety, and emphasizing the importance of medication adherence. The second session introduced the ABC model to help the patient understand the connection between thoughts, emotions, and behaviors. The third session targeted cognitive restructuring using a dysfunctional thought record and the triple-column technique to challenge negative thinking patterns. Sleep disturbances were addressed in the fourth session through the use of a sleep log and sleep hygiene principles, followed by relaxation exercises such as deep breathing and progressive muscle relaxation in the fifth session to aid stress reduction and emotional regulation. The sixth session emphasized behavioral activation by identifying pleasurable activities and implementing an activity schedule. Interpersonal difficulties were explored in the seventh session through assertiveness training and role-playing exercises. The eighth session focused on suicidal ideation by conducting a cost-benefit analysis of self-harm, introducing thought diffusion strategies, and developing a crisis safety plan. Relapse prevention strategies were introduced in the ninth session, highlighting early warning signs and coping mechanisms. Finally, the tenth session reviewed overall progress, discussed self-help strategies for future well-being, and set long-term goals to maintain stability and resilience. This structured and gradual approach ensured a comprehensive intervention tailored to the patient's psychological needs. Initially, the prognosis appeared poor due to the patient's resistance, lack of insight, and deeply rooted negative self-beliefs. However, as therapy progressed, she gradually developed awareness, engaged more actively, and adopted healthier coping strategies. Her ability to challenge negative thoughts and regulate emotions improved over time. With continued therapeutic support, her prognosis became more favorable, indicating potential for long-term emotional stability.

Conclusion

This clinical case involves a comprehensive DBT treatment plan to address depression and borderline personality disorder. The treatment plan consisted of four primary modules: Mindfulness, Distress Tolerance, Emotional Regulation, and Interpersonal Effectiveness (Linehan, 1993). Initially, the patient participated in mindfulness training to develop present-moment awareness and reduce emotional reactivity (Kabat-Zinn, 2003). Distress tolerance techniques, such as deep breathing and progressive muscle relaxation, were introduced to help the patient manage emotional crises (Linehan et al., 2006). Emotional regulation strategies, including identifying and labeling emotions, was taught to reduce mood intensity and duration (Gross & Munoz, 1995). Finally, interpersonal effectiveness skills, such as assertiveness and boundary-setting, were practiced to enhance relationships and reduce conflict (Linehan, 1993). Research has consistently demonstrated the efficacy of DBT in reducing symptoms of depression and borderline personality disorder, improving emotional regulation, and enhancing quality of life (Kliem et al., 2010; Verheul et al., 2003).

Limitations of the Study

1. Multiple family members with psychiatric conditions limit the patient's support system, affecting long-term recovery.
2. Time constraints and resource limitations hindered access to all relevant indigenous literature on depression, similar to challenges faced in research on depression among Pakistani women.
3. The treatment primarily concentrated on psychological and emotional aspects, without addressing biological, hormonal, or neurological factors, limiting a holistic understanding of the patient's condition.

4. Past trauma and inappropriate relationships within the family complicate the case, requiring a trauma-focused approach that may take time to show progress.
5. The patient's impulsive behaviors (substance use, unsafe sexual activity) pose challenges to maintaining engagement and ensuring safety in therapy.
6. Financial constraints and lack of strong social support further hinder access to resources and long-term recovery.
7. Given the emotional instability and unresolved trauma, the patient is at high risk of relapse, requiring ongoing therapy and follow-up.
8. Cross-cultural comparative studies and interdisciplinary approaches should be considered to address limitations in both research and therapeutic interventions for patients from diverse backgrounds.

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