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MANAGING MAJOR DEPRESSION WITH BORDERLINE PERSONALITY TRAITS: THERAPEUTIC INSIGHTS

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Abstract
The co-occurrence of Major Depressive Disorder (MDD) and borderline personality traits presents clinical challenges marked by emotional instability and interpersonal difficulties. This case-based study examines a multimodal therapeutic approach combining cognitive-behavioral techniques with positive psychology interventions–such as strengths identification, gratitude, hope-building, and self-compassion. Psychoeducation and family involvement further supported communication and social functioning. The integrated approach led to improvements in mood stability, interpersonal skills, and self-efficacy. Findings highlight the value of strength-based, holistic models in treating individuals with MDD and borderline traits.

INTRODUCTION

Major Depressive Disorder (*MDD*) and Borderline Personality Disorder (*BPD*) are two familiar and disturbing mental issues that frequently coexist and provide significant diagnostic and management challenges. *MDD* is defined as persistent sorrow, loss of interest, changes in sleep and appetite, and impaired daily functioning (American Psychiatric Association [*APA*], 2022). In contrast, *BPD* is distinguished by widespread patterns of instability in interpersonal relationships, doubts in self-image, inconsistent mood, and impulsive behavior.

MDD is one of the leading causes of disability, affecting around 280 million people globally (World Health Organization [WHO], 2023). With research suggesting that approximately 34% of Pakistan's population suffers from depressive symptoms, the country's *MDD* load is dangerously increasing (Khan et al., 2021). Several factors, including socioeconomic stresses, political disruption, unemployment, poverty, and a lack of mental health education (Naeem et al., 2022), can contribute to Pakistan's increased *MDD* prevalence. The cultural stigma surrounding mental illness also hinders people from seeking quick treatment, exacerbating their symptoms (Mirza & Jenkins, 2020). Furthermore, a lack of mental health accessibility, particularly in rural regions, creates a disproportion between the need for psychological therapy and the available resources (Husain et al., 2021). Developing indigenous treatments and enhancing mental health care in Pakistan requires an understanding of the prevalence, etiology, and course of *MDD* within that culture.

Although *BPD* has been extensively studied worldwide, its cultural presentation, diagnosis, and management differ substantially depending on socio-cultural factors (Paris, 2019). Personality disorders are often misdiagnosed or misunderstood in South Asian countries, such as Pakistan, due to cultural stigma,

lack of information, and poor mental health resources (Husain et al. 2014). Family ties, collectivism, and strict gender standards contribute to emotional expression and interpersonal dynamics in Pakistani society (Rehman et al., 2017). These cultural standards might mask or exacerbate *BPD* symptoms, making clinical diagnosis difficult. Furthermore, emotional dysregulation and anger outbursts, which are commonly associated with *BPD*, may be viewed as moral or behavioral flaws rather than signs of a psychiatric disorder, particularly among women (Javed & Kadir, 2019). This cultural misperception may affect the course and delay in receiving treatment, allowing the prognosis to be unfavorable.

Given the lack of local research on *BPD*, it is essential to investigate how borderline personality traits get diagnosed in Pakistani society and how cultural factors influence both symptom expression and treatment-seeking behaviors. Studies show that individuals with *BPD* have a significantly higher risk of experiencing *MDD* compared to the general population, illustrating a clear link between both conditions (Zanarini et al., 2015). Generalized emotional disturbance, early life trauma, and challenges with identity development are believed to contribute to the overlap of these disorders (Bateman & Fonagy, 2019). Moreover, *MDD* in individuals with *BPD* is associated with a more complicated clinical course, increased rates of self-harm, and more severe symptoms (Stepp et al., 2012). Given the noteworthy comorbidity rates and clinical implications of this association, it is vital to further explore how borderline personality traits and severe depression are interconnected.

The goal of this study is to highlight the urgent need for accessible mental health care and public education, as well as to examine the psychological, social, and environmental factors that contribute to *MDD* and *BPD* in Pakistan. Understanding their relationship not only enhances diagnostic clarity but also facilitates the development of more effective, integrated treatment strategies for individuals suffering from both conditions.

Clinical Case Report

Miss N, a 22-year-old unmarried female, has an intermediate-level education. Among her four siblings, she is the eldest and comes from a nuclear family structure. Her mother is a housewife; her father works for a government factory in Rawalpindi. The family is in the middle-class socio-economic level and practices Islam. From the Outpatient Department (*OPD*), the psychiatrist referred her for a thorough psychological exam and treatment plan.

The patient arrived with a spectrum of psychological and behavioral complaints. She said she suffered regular weeping bouts and ongoing sleeplessness. Moreover, prevalent emotions of emptiness and loneliness dominated her complaints. She also displayed verbal and physical anger outbursts. She seemed agitated a lot, and her appetite had dropped dramatically. She also exhibited pseudo-suicidal conduct, meaning gestures or ideas of self-harm without real intention to follow through. These symptoms taken together contribute to major emotional pain, needing thorough examination and treatment. The patient's birth and development were normal; she experienced no postnatal illnesses or complaints concerning delayed milestones. She was admitted to school at the age of five, demonstrating proficiency as a student and acquiring knowledge rapidly. Her parents were pleased with her, despite various instances of scolding from both her parents. She was a compliant student, consistently excelling in all subjects. She had few friends, as her family preferred not to build friendships. She was stubborn, disapproving of her parents' involvement in the care of her younger siblings, yet they insisted that she also assume responsibility for them. She enjoyed playing with them but was reluctant to share her belongings with her younger siblings, particularly her sister. Her parenting was strict; however, it did not encompass frequent physical penalties. She was then admitted to college. She had limited friends there, although she was prohibited from socializing with them. She was average in her academic performance. She departed from college after finishing her intermediate school because her grandmother was gravely ill, and her mother requested her assistance in caregiving, as she was the eldest sibling and no one else was available to support the grandmother. She possesses a favorable familial psychiatric history, as her father is a diagnosed case of bipolar affective disorder. There is no record of suicide attempts, substance misuse, or forensic involvement. Her difficulties began at the age of 19, when she commenced assisting her grandma, resulting

in the cessation of most of her recreational activities. She stated that her family does not love her since they referred her to a maid's role, resulting in persistent feelings of loneliness and emptiness. She also indicated that no one loves her as they do her younger sister. She harbors no affection for her sister whatsoever. Initially, her demeanor was obstinate, and her mood was irritable; however, she did engage with others and partake in household responsibilities. Over the past month, as reported by the informant, her behavior has escalated to aggression. She has fled the home twice and has threatened her family, particularly her parents, with suicide, while frequently exhibiting excessive emotional distress. Her activity level is nonexistent, as she refrains from engaging in activities at home and remains isolated in her room.

Psychological Assessment

This case study used multi-dimensional screening and diagnostic tools to confirm the diagnosis and structure a solution-focused treatment plan for the patient. These tests were applied in multiple sessions by keeping the patient's comfort in mind. During the ***Mental State Examination (MSE)***, her mood was subjectively irritated and objectively low, and her voice was nearly a whisper. She was oriented to person and location but not to time. She experienced suicidal ideations, exhibited abstract thinking, demonstrated weak judgment, maintained some insight, and was preoccupied with domestic conflicts, often contemplating admission to alleviate her home situation.

The Beck Depression Inventory-II (*BDI-II*) (Beck et al., 1996), Hamilton Depression Rating Scale (*HAM-D*) (Hamilton, 1960; Zimmerman et al., 2013), and Patient Health Questionnaire-9 (*PHQ-9*) (Kroenke et al., 2001) were used to assess the patient and confirm the diagnosis of *MDD* through clinician-administered and self-report measures.

Psychological Tools	Scale Items	Score Ranges	Patient's Scores
BDI-II	21	0-13 (minimal) 14-19 (mild) 20-28 (moderate) 29-63 (severe)	31 (severe)
HAM-D	17	0-7 (normal) 8-16 (mild) 17-23 (moderate) ≥24 (severe)	25 (severe)
PHQ-9	09	5 (mild) 10 (moderate) 15 (moderately severe) 20 (severe)	15 (moderately severe)

Further, the McLean Screening Instrument for Borderline Personality Disorder (*MSI-BPD*) (Zanarini et al., 2003), the Structured Clinical Interview for *DSM*-5 Personality Disorders (*SCID-5-PD*) (First et al., 2016), and Borderline Personality Disorder Severity Index (*BPDSI*) (Arntz et al., 2003; Giesen-Bloo et al., 2010) were utilized to ensure a thorough and reliable assessment of borderline personality disorder (*BPD*) across severity measurement stages.

Psychological Tools	Scale Items	Score Ranges	Patient's Scores
MSI-BPD	10	0-10	9 (high)
SCID-5-PD	DSM 5 full Criteria	5 or more *DSM* 5 criteria	6 criteria
BPDSI	70	0-90	38 (high)

These tools not only assist in diagnosis but also guide treatment planning and track patient progress. Utilizing a combination of self-report inventories and clinician-administered interviews ensures a

comprehensive understanding of the patient's condition and needs (Manea et al., 2012).

Therapeutic Sessions

In the initial therapeutic sessions, the patient exhibited severe anxiety and emotional distress. She remained quiet, tearful, and visibly tense throughout the session. Her posture was stiff and uncomfortable, sitting at the edge of the seat while repeatedly glancing at the door with increased vigilance, indicative of hyperarousal and safety-seeking behavior. The patient avoided eye contact and only responded to general questions by briefly looking at the therapist before resuming weeping. Communication was limited to whispering style, reflecting significant emotional inhibition and fear. Considering her heightened anxiety and inability to verbalize her thoughts fully, the therapeutic focus for this session was placed on ***catharsis*** and ***deep breathing exercises***, both implemented with patience and support.

Emotional ventilation through catharsis was encouraged to allow the release of suppressed emotions, an essential first step toward calmness (Shapiro, 2019). Deep breathing, a core skill of behavioral therapy, was introduced to help regulate her autonomic provocation and reduce immediate anxiety symptoms (Ma et al., 2017). ***Empathetic listening*** was consciously applied throughout the session to create an inclusive and validating atmosphere. The patient expressed feelings of neglect and emotional invalidation within her home, reporting that no one listened to her and describing her mother as strict and unsupportive.

Cognitive reframing was gently led by recognizing her pain while offering alternative perspectives and hope for resolution. Additionally, ***positive psychology techniques***, such as ***instilling hope*** and transferring ***unconditional acceptance***, were subtly integrated to foster a sense of trust and safety (Seligman & Csikszentmihalyi, 2014). Despite her severe distress, the patient expressed relief by the end of the session, stating she felt "heard" for the first time.

Recognizing the importance of family dynamics in her emotional state, and with the patient's consent, a ***family session*** was scheduled for the following session. This decision was based on the need to psycho-educate the family regarding environmental factors and introduce systemic mediation. At the end of the session, considering the severity of her symptoms and her father's willingness for ample care, the patient was allowed inpatient treatment to ensure continuous monitoring and a structured therapeutic plan.

Further sessions, based on a structured family session with the patient's mother, address familial dynamics contributing to the patient's psychological distress. The session focused on ***psychoeducation***, aimed at enhancing the mother's understanding of nature and the course of her daughter's illness. The mother reported that the patient had exhibited irritability over the past three years, with a marked decline in cooperation and household participation in the past month. Through psychoeducation, the mother was informed about the clinical features of depression and borderline personality traits, highlighting that reduced enthusiasm, agitation, and withdrawal are symptomatic representations rather than deliberate attempts (Beck, 2011).

The mother was also encouraged to recognize the patient's inclination to depressive episodes due to her personality structure and environmental stressors. ***Cognitive-behavioral psychoeducation*** included reframing the mother's perception of the patient's withdrawal as a need for support rather than disobedience. The importance of empathetic listening, positive reinforcement, and flexible parenting approaches was highlighted. The mother acknowledged her strict parenting style and expressed a willingness to adopt a more compassionate and lenient approach toward all her children. This intervention aligns with s***ystemic therapy principles*** and positive psychology techniques, fostering positive family relationships and an emotionally supportive home environment (Seligman & Csikszentmihalyi, 2014).

Next session, the patient requested discharge from inpatient care. In response, an ***hourly activity schedule*** was collaboratively designed to promote structure, behavioral activation, and a gradual increase in engagement with daily tasks. ***Behavioral activation*** is an evidence-based cognitive-behavioral strategy to counter the depressive phase by encouraging patients to perform planned, rewarding activities (Martell et al., 2010). The schedule was carefully formulated according to the patient's

interests and resources, ensuring feasibility and devotion.

In addition, the patient was reinforced on the continued use of ***Deep Breathing Exercises (DBE)*** as a self-regulation tool for anxiety management. She was instructed to practice this whenever faced with restlessness or feeling keyed up, reinforcing behavioral techniques aimed at physiological calm and emotional control (Ma et al., 2017).

In the following therapeutic session, patient feedback regarding the previous week's progress was taken to assess compliance and challenges. The patient stated insomnia with occasional fatigue that hinders her motivation to adhere to the prescribed activity chart. She acknowledged making efforts to follow the schedule and noted partial improvements. Her mother corroborated her efforts, observing increased engagement with siblings, with frequent anger outbursts. This indicated that while emotional regulation was still developing, overall improvement in social interaction and behavioral participation was clear.

A thorough discussion was started in a session to empower the patient through ***autonomy and goal setting*** (a key technique in positive psychology interventions) aimed at raising intrinsic motivation (Seligman & Csikszentmihalyi, 2014). The patient expressed a desire to include outdoor activities in her routine. Based on this feedback and following ***behavioral activation*** principles, her weekly activity chart was modified to incorporate a one-hour evening walk in her neighborhood with her brothers. This adjustment aimed not only to increase physical activity but also to enhance social connectedness and mood regulation, aligning with positive psychology strategies that focus on building positive relationships and engaging in enjoyable activities. (Lyubomirsky et al., 2005). This session emphasizes goal refinement and collaborative planning.

The final termination session is directed at evaluating therapeutic outcomes, consolidating learned skills, and preparing the patient for self-maintenance. The patient presented with a euthymic mood, reporting minimal depressive symptoms, and demonstrated compliance with both pharmacological and psychotherapeutic interventions. A structured review of therapeutic skills, including emotion regulation, cognitive reframing, deep breathing exercises, and activity scheduling, was conducted to reinforce self-efficacy (Bandura, 1997). Additionally, ***gratitude reflection*** and ***strength identification*** designed to increase resilience and optimism were introduced in the termination phase to encourage ongoing psychological well-being (Emmons & McCullough, 2003). The patient reported satisfaction with her current routine, expressed hopefulness about her progress, and demonstrated readiness for therapy termination. The termination session concluded with ***positive reinforcement*** and a discussion of ***relapse prevention strategies***.

Follow-Up Sessions Report

In the first follow-up session, the focus was on ***strengths identification***, aimed at enhancing self-efficacy and hardiness (Wood et al., 2011). The patient was guided through ***reflective exercises*** to identify her core personal strengths, including empathy, creativity, and persistence. These strengths were then linked to past successful coping efforts, reinforcing her capacity for self-regulation and adaptive behavior. Additionally, ***cognitive-behavioral emotion regulation techniques*** were reapplied, with the patient practicing reframing negative automatic thoughts and using deep breathing exercises during heightened emotional states.

In the second follow-up session, a structured gratitude exercise was introduced to reduce depressive cognition and enhance positive effects (Emmons & McCullough, 2003). The patient was encouraged to maintain a daily gratitude journal, listing three positive events or supportive exchanges each day. Additionally, the session included ***guided role-playing*** to practice ***assertive communication*** and relationship repair skills, helping her manage interpersonal conflicts constructively to resolve *BPD* features of interpersonal sensitivity. The patient reported feeling more connected and less reactive on most occasions nowadays.

The third follow-up session focused on ***building hope and future orientation***, as patients with *MDD* and *BPD* often experience chronic hopelessness (Cheavens et al., 2006). A ***hope-mapping exercise*** was introduced, where she identified personally meaningful goals, defined realistic pathways to achieve them, and anticipated obstacles with coping

strategies. She was encouraged to visualize small successes and celebrate progress to strengthen optimism and motivation.

The final follow-up session emphasized ***self-compassion*** skills to address the patient's self-criticism and emotional dysregulation (Neff & Germer, 2013). Guided self-compassion meditations and ***self-kindness exercises*** were introduced, allowing the patient to respond to emotional pain with care rather than harshness and anger. Additionally, ***relapse prevention strategies,*** including reviewing early warning signs of mood deterioration, reinforcement of daily routines, and continued practice of gratitude and mindfulness exercises, were also revised. The patient expressed confidence in her ability to maintain psychological well-being and reported improved self-acceptance and emotional balance. The patient's family also expressed a high level of support in this regard.

Conclusion

Managing *MDD* alongside borderline personality features proposes a distinct clinical problem with the need for a patient-centered therapeutic outlook. This study emphasizes the significance of integrating cognitive-behavioral therapies with positive psychology methods to tackle the complex comorbidity of emotional dysregulation, interpersonal challenges, and chronic mood symptoms. Psychoeducation, behavioral activation, and emotional regulation techniques were crucial in stabilizing depression symptoms, while strengths-based therapies, gratitude practices, and hope-building exercises promoted resilience, self-efficacy, and positive affect. Likewise, familial engagement and systematic activity plans were key components in enhancing social functioning and fostering a nurturing home environment.

In summary, a holistic therapy paradigm that combines cognitive, behavioral, and positive psychology principles can markedly enhance results for individuals with major depressive disorders and borderline personality traits. Future research should concentrate on longitudinal outcomes and the enduring effects of these integrated therapies across varied groups to further substantiate their efficacy in clinical practice.

Ethical Considerations/Disclosures

Human Subjects: Consent was obtained from the participants in this study.

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REFERENCES

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.).

Arntz, A., van den Hoorn, M., Cornelis, J., Verheul, R., & van den Bosch, W. M. C. (2003). Reliability and validity of the Borderline Personality Disorder Severity Index. *Journal of Personality Disorders, 17*(1), 45–59. https://doi.org/10.1521/pedi.17.1.45.32751

Bandura, A. (1997). *Self-efficacy: The exercise of control.* W.H. Freeman and Company.

Bateman, A. W., & Fonagy, P. (2019). *Handbook of mentalizing in mental health practice* (2nd ed.). American Psychiatric Publishing.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II.* Psychological Corporation.

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond* (2nd ed.). Guilford Press.

Cheavens, J. S., Feldman, D. B., Gum, A., Michael, S. T., & Snyder, C. R. (2006). Hope therapy in a community sample: A pilot investigation. *Social Indicators Research, 77*, 61–78. https://doi.org/10.1007/s11205-005-5553-0

Emmons, R. A., & McCullough, M. E. (2003). Counting blessings versus burdens: An experimental investigation of gratitude and subjective well-being in daily life. *Journal of Personality and Social Psychology, 84*(2), 377–389. https://doi.org/10.1037/0022-3514.84.2.377

First, M. B., Williams, J. B. W., Benjamin, L. S., & Spitzer, R. L. (2016). *Structured Clinical Interview for DSM-5® Personality Disorders (SCID-5-PD)*. American Psychiatric Association Publishing.

Giesen-Bloo, J., Wachters, L., Schouten, E., & Arntz, A. (2010). The Borderline Personality Disorder Severity Index-IV: Psychometric evaluation and dimensional structure. *Personality and Individual Differences, 49*(2), 136–141. https://doi.org/10.1016/j.paid.2010.03.007

Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery, and Psychiatry, 23*(1), 56–62. https://doi.org/10.1136/jnnp.23.1.56

Husain, M. I., Chaudhry, I. B., Rahman, R. R., & Hamirani, M. M. (2021). Mental health services in Pakistan: Past, present, and future. *BJPsych International, 18*(2), 37–39. https://doi.org/10.1192/bji.2020.28

Husain, M., Chaudhry, H. R., Khan, M. M., & Ahmed, S. (2014). Psychiatric stigma and mental health services in Pakistan: The role of culture. *International Review of Psychiatry*, 26(5), 468–477. https://doi.org/10.3109/09540261.2014.924907

Javed, Z., & Kadir, M. M. (2019). Gender and mental health in Pakistan: A narrative review. *Journal of the Pakistan Medical Association*, 69(4), 580–584.

Khan, M. S., Ahmad, N., & Iqbal, N. (2021). Prevalence of depression and anxiety among Pakistani population: A systematic review. *Pakistan Journal of Medical Sciences, 37*(5), 1361–1366. https://doi.org/10.12669/pjms.37.5.3630

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Lyubomirsky, S., Sheldon, K. M., & Schkade, D. (2005). Pursuing happiness: The architecture of sustainable change. *Review of General Psychology, 9*(2), 111–131. https://doi.org/10.1037/1089-2680.9.2.111

Ma, X., Yue, Z. Q., Gong, Z. Q., Zhang, H., Duan, N. Y., Shi, Y. T., ... & Li, Y. F. (2017). The effect of diaphragmatic breathing on attention, negative affect and stress in healthy adults. *Frontiers in Psychology, 8*, 874. https://doi.org/10.3389/fpsyg.2017.00874

Manea, L., Gilbody, S., & McMillan, D. (2012). Optimal cut-off score for diagnosing depression with the Patient Health Questionnaire (PHQ-9): A meta-analysis. *CMAJ, 184*(3), E191–E196. https://doi.org/10.1503/cmaj.110829

Martell, C. R., Dimidjian, S., & Herman-Dunn, R. (2010). *Behavioral activation for depression: A clinician's guide*. Guilford Press.

Mirza, I., & Jenkins, R. (2020). Stigma and mental health in Pakistan. *International Review of Psychiatry, 32*(6), 561–572. https://doi.org/10.1080/09540261.2020.1760236

Naeem, F., Ayub, M., Gobbi, M., & Kingdon, D. (2022). Depression in South Asia: The need for culturally relevant psychological treatments. *Asian Journal of Psychiatry, 68*, 102965. https://doi.org/10.1016/j.ajp.2021.102965

Neff, K. D., & Germer, C. K. (2013). A pilot study and randomized controlled trial of the mindful self-compassion program. *Journal of Clinical Psychology, 69*(1), 28–44. https://doi.org/10.1002/jclp.21923

Paris, J. (2019). *Borderline personality disorder: Etiology and treatment* (2nd ed.). American Psychiatric Association Publishing.

Rehman, S., Mastor, K. A., & Mahmud, Z. (2017). The impact of collectivism and family relationships on mental health among Pakistani young adults. *International Journal of Social Science Studies*, 5(8), 96–103. https://doi.org/10.11114/ijsss.v5i8.2572

Seligman, M. E. P., & Csikszentmihalyi, M. (2014). Positive psychology: An introduction. In *Flow and the foundations of positive psychology* (pp. 279–298). Springer. https://doi.org/10.1007/978-94-017-9088-8_18

Shapiro, D. (2019). *Psychotherapy of neurotic character: The patient who sabotages himself.* Routledge.

Stepp, S. D., Pilkonis, P. A., Hipwell, A. E., Loeber, R., & Stouthamer-Loeber, M. (2012). Stability of borderline personality disorder features in girls. *Journal of Personality Disorders, 26*(5), 654–665. https://doi.org/10.1521/pedi.2012.26.5.654

Wood, A. M., Froh, J. J., & Geraghty, A. W. (2011). Gratitude and well-being: A review and theoretical integration. *Clinical Psychology Review, 31*(7), 890–905. https://doi.org/10.1016/j.cpr.2011.03.005

Zanarini, M. C., Frankenburg, F. R., Reich, D. B., & Fitzmaurice, G. (2015). Attainment and stability of sustained symptomatic remission and recovery among patients with borderline personality disorder and axis II comparison subjects: A 16-year prospective follow-up study. *American Journal of Psychiatry, 172*(10), 993–1002. https://doi.org/10.1176/appi.ajp.2015.14070855

Zanarini, M. C., Vujanovic, A. A., Parachini, E. A., Boulanger, J. L., Frankenburg, F. R., & Hennen, J. (2003). A screening measure for BPD: The McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD). *Journal of Personality Disorders, 17*(6), 568–573. https://doi.org/10.1521/pedi.17.6.568.25355

Zimmerman, M., Martinez, J. H., Young, D., Chelminski, I., & Dalrymple, K. (2013). Severity classification on the Hamilton Depression Rating Scale. *Journal of Affective Disorders, 150*(2), 384–388. https://doi.org/10.1016/j.jad.2013.04.028