PJP

CASE REPORT

SILENT SCREAMS: A CASE REPORT ON A MUSLIM MEDICAL STUDENT WITH BORDERLINE PERSONALITY AND MAJOR DEPRESSIVE DISORDER

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ABSTRACT

This is a case of a Muslim medical student who sought psychiatric consultation because of suicidal behaviors and declining academic performance, diagnosed with Borderline Personality and Major Depressive Disorder. It was later discovered that she had gone through various instances of physical, emotional and sexual trauma since she was a child. These histories of transgenerational trauma were explored throughout the course of evaluation, including how these experiences had affected her current condition.

KEYWORDS: *Depressive Disorder, Suicidal Ideation, Islam, Students, Consultation, Case Report*

INTRODUCTION

People use religion to cope with illness and other challenges. Thus, it can have a significant impact on human health and behavior (1). Islam is the second largest religion in the world. Islam, like other religions, has a diverse and multidimensional nature. In some aspects, Islam may be comparable to other religions, while it remains distinct in some ways. For the vast majority of its adherents, Islam is intertwined with all elements of human life (2).

According to the 2015 Census of Population by the Philippine Statistics Office, Islam is the second largest religious affiliation in the country, comprising 6% or 6,058,886 persons of the total population. This number is expected to increase by 35% in 2030. Even as the Islamic Community has been growing in size, plenty of them are hesitant to seek psychiatric consult. The reasons behind this include differences in faith and the understatement of Islamic values in the treatment options. Moreover, Muslims find it uncomfortable going to a mental health professional to preclude being in conflict with their religious principles (3).

Although there are Muslims who have positive attitudes towards mental health, the social stigma still remains strong, with concerns surrounding family and social standing, as mental illness is deemed as shameful (4). The concept that mental disorder is either a punishment from Allah or a demonological origin is still prevalent among Muslims (5).

Similarly, medical students may hold themselves from seeking help from a mental health professional because of stigma, fear of jeopardizing their career and pressures of training. Research has shown that medical students' mental health decline upon entering medical school and continues to remain poor throughout training (6).

Some studies suggest that compared to the general population, medical students experience greater rates of psychological distress and mental disorders (7). Adjustment to the medical school environment, the amount of workload, lack of sleep, irate patients, poor learning settings, debt and financial constraints, information overload, career development,

student abuse and personal life events are the usual stressors that dampen medical students' mental health (8). For medical students who go on hospital training, they have the added stressors of relational difficulties with supervising consultants, humiliation and bullying, ethical conflicts, exposure to death and human suffering (9). Last year, the pandemic brought about by COVID-19 became an additional source of stress to everyone, particularly healthcare workers and medical students (10).

The distress to medical students has profound effects. One of those is impaired academic performance. Assessments always give a great deal of stress and anxiety. Most studies suggest that anxiety has a significant correlation with poor performance (6). Cynicism, along with a decline in empathy and compassion, have been seen as in effect of distress. Other consequences of medical student distress include academic dishonesty, substance abuse and suicide. Depression and suicide are only some of the psychological morbidities commonly reported among medical students (11). In one study in the United States, suicide ranked higher as a cause of death in medical students compared to similarly aged members of the population (6).

CASE REPORT

An adult Filipino Muslim woman who was enrolled in medical school, sought online consultation due to feelings of depression and emotional emptiness. She was unmotivated to study and had difficulty maintaining sleep. She was a natural achiever, often excelling in class from the time she entered school. Despite her lack of friends, she was a consistent honor student and Dean's Lister.

Her parents met abroad. Her father was a high-ranking official while her mother was a salesclerk. To advance his courtship, her father sent food and money to her mother's family. Because they liked her dad, they persuaded her mother into marrying him.

She was the product of an unplanned but eventually wanted pregnancy. Her father was always unavailable and was unemphatic. She grew up watching her parents fight all the time. Her mother was threatening and would leave them for weeks as her mother was having an affair with her uncle which, almost led to divorce when her father found out.

She was the eldest of eight children, and she had seven brothers. At 10, she woke up to her second brother fondling her breasts. Weeks later, her third brother did the same.

At 14, her drunk uncle pointed a knife at her and held her hostage. She witnessed the same uncle fire three gunshots at her mother.

At 18, she caught her fourth brother taking a video recording of her while bathing. She also caught her fifth brother peeping while she was getting dressed.

Through it all, she did well in academics, and had no history of truancy or delinquency.

At 21, she failed the Licensure Examinations. Her mom berated her and called her an embarrassment to the family.

When she was 23, a friend forced her to drink alcohol. She woke up with him on top of her, kissing her and fondling her breasts forcibly.

Still, she became a registered pharmacist and landed a job immediately after, then she got into a relationship with a Catholic man, whose parents were supporting her financially so that they could both attend medical school without her parents' knowledge. When she was stressed, she would often "zone out," even in the middle of conversations or while at work. She stated that she did not know who she really was, and described a longstanding pattern of changing her hobbies, interests, style of clothing, based on whom she was with. She alternated between believing that her partner was the best thing that ever happened to her, impulsively buying him extravagant presents, planning sweet surprises, and then thinking that he was no good for her, lashing out, yelling and throwing things at him. Immediately after doing so, she would regret and panic at the thought of him leaving her.

History of Present Illness

One year and one month prior to consult (September 2019), her father was rushed to the hospital in critical condition due to complications from his Chronic Obstructive Pulmonary Disease (COPD) and Liver Cirrhosis. She wanted to go home, but her mom advised her against it due to her class schedule. She felt guilty and viewed herself as an insignificant medical student and daughter due to her inability to care for her ailing father. She had

enthusiasm for school and began missing classes. She cried constantly and frequently complained of fatigability. She ate and slept less as she continued to worry about her father.

One year prior to consult, she lashed out at her boyfriend. He hit her on the chest, and she retaliated by grabbing his phone and throwing it, at which point he twisted her arm and pulled her neck. Unable to resist, he pushed her to the bed, stripped her naked and had sex with her, despite her initial refusal. She eventually gave in but immediately regretted it the next day. She persisted in skipping classes. She spent days crying in her room. She felt guilty about what happened and panicked at the thought that he would leave her for it. She did not eat and thought of killing herself. She assumed she was worthless not only as a daughter unable to help her critically ill father, but also as a girlfriend. When her boyfriend returned from school, she slashed her thighs in front of him. She threatened him that if he broke up with her over her anger the night before, she would do more. She had a hard time falling asleep and even when she was awake at night, she lacked motivation to study. Additionally, she avoided interactions with her classmates.

Eleven months prior to consult, she threatened that she would break up with her boyfriend after they got into a fight about old text messages between her and a classmate, giving back the ring he gifted her when they first became a couple. He shoved the ring into her mouth, forcing her to swallow it. He only stopped when her lips started to bleed. When they reconciled, she told him that she did not actually want to split up; she merely wanted to test whether he would stop her. She blamed herself for causing the fight. She began failing some of her exams, all the while her father's condition in the province remained unchanged, adding to her misery. She continued to find it difficult to sleep at night. She lost weight noticeably because of her decreased appetite. She constantly had feelings of worthlessness and low energy.

In the succeeding months, she repeatedly threatened her boyfriend against leaving her by means of self-harm. As her father's health continued to decline, she pondered on hanging herself. She still had a hard time sleeping. There were times she wished she would not wake up anymore. She started losing more weight. Even as she tried attending classes, her inability to concentrate resulted in further decline in her grades.

Seven months prior to consult, she was informed by her parents of an arranged marriage. Her dad wanted her to marry the man that could support their family. She felt that was being seen as means to an end. However, because the enhanced community quarantine, she was unable to go home. Because the wedding did not take place, her parents were required to repay the bridal money. She felt guilty, knowing that they were already facing financial difficulties. She continued to cry frequently, had lack of appetite and difficulty falling asleep. She persistently had suicidal thoughts.

One month prior to consult, she observed that she had missed her period for three months. She got excited at the thought that she might be pregnant. Ultrasound examination revealed polycystic ovaries. She was disappointed upon realizing that she was not pregnant and that she might have difficulty getting pregnant.

Two weeks prior to consult, she received a call from her mother letting her know that her father's condition had turned for the worst. He had been coughing out blood and was bed ridden. He could not even sit up without having shortness of breath. She advised her mother to bring her father to the hospital, but her mother chose to keep her father at home, as she was afraid that he might contract the corona virus disease. Still with above symptoms, and unable to attend classes, she contemplated on killing herself, which prompted consult.

Physical and neurological examinations were essentially normal. Her past medical history showed consult with an Obstetrician-Gynecologist in August 2020 due to irregular periods. Her substance history revealed she was a non-smoker, tried drinking alcohol once, and denied use of illicit substances. She had a positive family history for hypertension, chronic obstructive pulmonary disease, liver cirrhosis (paternal side), and depression (maternal aunt). Diagnostic tests included Complete Blood Count, Urinalysis, Chest X-ray, 12-Lead Echocardiogram and Thyroid Function Tests, which were all unremarkable. Her Transvaginal Ultrasound revealed normal sized ovaries with polycystic ovarian morphology.

Throughout the course of outpatient follow-up, her issues revolved around her poor self-esteem, mistrust towards others, fear of abandonment, and repeated history of abuse. Along with these were her concerns regarding the fact that she could not open up to her family about seeking psychiatric consultations because her family deemed this as shameful and a disgrace.

Given the data, differential diagnoses included Depressive Disorder due to Polycystic Ovarian Syndrome, Persistent Depressive Disorder, Bipolar Disorder, Post-traumatic Stress Disorder, Complex Post-traumatic Stress Disorder, Dependent Personality Disorder, and Histrionic Personality Disorder. Her final diagnosis was Borderline Personality Disorder and Major Depressive Disorder.

Biopsychosocial-Spiritual Formulation

Her family history of Major Depressive Disorder has genetically predisposed her to a mood disorder. To add to that, she had a history of sexual assault, which heightened her vulnerability to develop both a depressive and borderline personality disorder. There has been substantial data proving that sexual assault in childhood and adolescence may result in a neurobiological sensitivity that predisposes people to react to stressors as adults by developing a major depressive episode. This occurs 10 times more in women than in men (12).

Furthermore, sexual abuse or assault in the younger years may trigger the stress response and stimulate increased activity in corticotropin-releasing factor (CRF) containing neurons, which have been identified to be stress responsive and excessively active among depressed individuals. These cells can become hypersensitized in certain persons, responding intensely to even mild stressors. The amygdala, hippocampus and the prefrontal cortex play precarious roles in conditioning and extinction of memories of traumatic fear. Stress-induced fear and anxiety are regulated by the prefrontal cortex through inhibitory effects on amygdala output and processing. Trauma induces changes in the structural and functional brain regions involved in emotional regulation and cognitive processing. A reduction in volume of the prefrontal cortex, hippocampus and the amygdala has been documented among individuals who suffered traumatic adverse life events.

These lasting changes brought about by trauma result in an imbalance between these brain regions, characterized by hyperactivity of the amygdala and hypoactivity of the prefrontal cortex and the hippocampus (13). The hyperactive amygdala, poorly controlled by the prefrontal cortex causes enhanced attentiveness to predominantly negative and threatening social stimuli (14). Increased and prolonged amygdala responses along with decreased activity of the hippocampus and the prefrontal cortex causes the hypervigilance, emotional dysregulation, disturbed interpersonal relationships and misplaced trust, which are particular susceptibilities seen in patients with Borderline Personality Disorder (15).

This patient started from a developmental base of an absence of an emotionally fulfilling relationship with her father and mother. From an attachment perspective, disrupted attachments and emotionally mis-attuned, threatening, unstable or unpredictable caregivers provide fertile soil for the development of disorganized internal working models, basic mistrust toward others, negative views of self, which were noted in this case. Additionally, her history of multiple sexual assaults and physical abuse made her feel betrayed by the people who were supposed to protect her. This instigated in her the inability to conjure memories of good attachment figures that could provide models for self-soothing such that as an adult, she necessitated an actual instead of an internalized presence of another person to help regulate her affect when in distress. Unable to do so, she resorted to impulsive behaviors such as cutting. Constantly feeling that she was merely a means to an end—her parents' way of obtaining financial support, her brothers' and friend's means of obtaining sexual satisfaction, her boyfriend's family's means of getting her boyfriend to go into medical school, and her boyfriend's means for sexual satisfaction. She was also constantly conflicted between loving and hating not just her parents, but her brothers and everyone else who had done her wrong. To avoid this conflict, she employed the defense mechanism of splitting. Children like her who grew up with unstable attachments view themselves as unlovable and their mothers as undependable and abandoning, thus having a poor sense of identity. This poor sense of identity lead to negative core beliefs about herself

beliefs are activated, automatic thoughts are elicited and cognitive distortions arise such as her all-or-none thinking, overgeneralization and labeling. Consequently, she grew up with chronic feelings of emptiness and a sense of longing that was reactivated in adulthood whenever she was in a situation involving loss or the possibility of loss. The effects of these losses were magnified when they occur in adult life. This brought her intense fear and insecurity; that she had to go through great lengths just to avoid being abandoned or deserted.

From a social and spiritual standpoint, she grew up within the Muslim culture, guided by Islam, which could have helped form her identity. Instead, she was conflicted between the principles of her religion against the beliefs of her Muslim tribe. She got into a relationship with a Christian who promised to convert to Islam eventually. Deeming it would be agreeable to her family and her religion, she intended on making it known to her family. Yet, her mother did not accept the idea as their Maranao tribe prohibits them from being in a relationship with someone who does not belong to the same tribe as theirs even if the boyfriend is a Muslim too. The fact she did not comply with her tribe's rules, led her to believe that she was bringing shame to the family.

The stigma that her family had about mental health also posed as a conflict for her, as she was unable to get the much-needed support from her family. Their current financial constraints were another source of struggle for her. She had to rely on the good graces of her boyfriend's family to sustain living in Manila and studying medicine, which was similar to how her parents got together. The combination of these factors contributes to her present psychopathology.

On the other hand, her above average cognitive functioning, her adherence to treatment and medications, absence of any substance use and her motivation to fulfill her dream of becoming a doctor protected her and kept her well.

Treatment Plan

Given the formulation, the treatment plan included maintaining therapeutic alliance with the service user by cultivating rapport and confidentiality.

Psychoeducation was done to help her understand the course of illness and its impact as well as set pharmacotherapy and psychotherapy goals. To ameliorate the depressive symptoms, cautious pharmacotherapy was done by addressing the decreased serotonin using escitalopram 10mg/tab once daily at bedtime. Selective serotonin reuptake inhibitors (SSRIs) mechanism of action involves increasing the functional connectivity of the pre-frontal limbic system via modulation of amygdala activity in response to negative stimuli.

Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT) skills were also employed as both have been found to attenuate amygdala hyperactivity at baseline, which could improve emotional regulation. With her borderline personality traits, boundary setting was emphasized. She was asked to record her thought, which is a standard CBT procedure to make patient aware of her automatic thoughts, using the two-column technique. Thought recording helps the patient recognize the effects of underlying automatic thoughts and its relations as well as to understand how the relation between situations, thoughts, feelings and behaviors apply to her own experiences. She was able to identify cognitive distortions such as All or Nothing Thinking, Overgeneralizing and Labeling.

Mindfulness, self-soothing techniques and basic distress tolerance skills were demonstrated. Long term goals include an in-depth understanding by the patient of how her past trauma affects her present self and how these impact her symptoms through Psychodynamic Psychotherapy with the aim of providing a secure base, from which to explore both herself and her relations with all those with whom she has made or might make, an affectional bond.

The absence of psychotic symptoms and substance abuse indicated a good prognosis for this case; however, having a comorbid personality disorder, poor family and social support, were negative prognostic factors that need to be taken into consideration during therapy.

DISCUSSION

The complexity of Borderline Personality

Disorder (BPD) persists despite the abundance of validated studies, scholarly journals, internet sources and articles that attempt to explain it. BPD is a diagnosis characterized primarily by emotional dysregulation, as opposed to the more typical symptoms of mental illness. And at a time when psychiatry is grounding each severe mental disorder in neurobiology, BPD disorder presents us with an enigma and a clinical dilemma. Primarily manifested with emotional dysregulation rather than signs more commonly associated with mental illness, the disorder frequently goes undiagnosed ore misdiagnosed (17).

Considered to be the most common personality disorder, with a reported lifetime prevalence of about 1.7 percent and an 8.3-fold higher all-cause mortality compared to the general population; making it a rather relevant public health concern. Although controversial, it appears that females are more frequently diagnosed than males in clinical settings, with a four-to-one ratio (18). BPD is distinguished by severe functional impairment, with a suicide rate that is 10-50 times higher than the general population (18). They are frequently treated for coexisting conditions such as major depression, anorexia or bulimia or substance abuse. In addition to suicide and substance abuse, it is linked to other public health issues such as domestic violence and sexual assault (19).

And how should all of these symptoms be interpreted? How do we explain the intricacies of the patient's case? Does her brain condition exist "alone" and require pharmacological treatment? Are her problems a direct effect of the recurrent and chronic child maltreatment she endured? Are these answers mutually incompatible or do they all contribute to a full comprehension of her problem?

This complexity is reflected in the tortuous history of the idea of borderline personality disorder. Adolph Stern coined the word "borderline" in the 1930s to characterize a situation on the gray line between neurosis and normality (20). For many years, "borderline" was a vague term. It did not become an official diagnosis until the 1970s, when John Gunderson investigated and categorized a group of people who had been incorrectly labeled with schizophrenia (21).

In 1980, "borderline personality disorder" was included in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (22).

In 1993, Marsha Linehan introduced dialectical behavior therapy (DBT) as an effective treatment (23).

In 1994, DSM-IV was released, providing the diagnostic criteria for Borderline Personality Disorder (24).

Through the years, even among specialists, we will find a variety of perspectives and interpretations that are sufficiently divergent to remind us of the legendary blind men studying an elephant, each persuaded that a part was the whole. Similar to other psychiatric diseases, the most widely accepted etiopathogenetic theory for BPD posits that this disorder was caused by the interplay of biological and psychosocial variables (25).

Psychologically, the psychoanalyst refers to "splitting" and "distorted object relations," but the cognitive behaviorist refers to "faulty schema" and "an invalidating environment." Psychodynamic theories may suggest that the development of "mistrustful inner working models" in relation to insecure attachment patterns predisposes a person to regard others as untrustworthy and rejecting. Children who are exposed to these unfavorable situations are therefore incapable of identifying, regulating and tolerating emotional responses, and they oscillate between high emotional lability and emotional restraint (25).

As with other mental diseases, there is a consensus that BPD is associated with abnormalities in multiple biological systems and brain structural features, which involved the HPA, amygdala and prefrontal cortex (26).

The concept that early traumatic experiences contribute to the development of borderline personality disorder (BPD) is gaining scientific support. Multiple studies indicate that BPD is more likely to have its origins in early childhood trauma than in genetic susceptibility (7). Some writers hypothesized that difficulties with affect modulation mediated the association between childhood trauma and BPD (27).

been: What qualifies as trauma? Although some people with BPD, such as this patient, have experienced severe traumatic experiences in her past. What perplexed many of us, even until now is that she did not fit the diagnosis of PTSD nor complex PTSD, as many with this condition, do not.

The definition of trauma is always extremely tricky.But what use are these labels or definitions for the children and their families trying to make sense of the difficulties? And even if this experience does not fit the textbook definition of trauma, studies have shown they can leave lasting marks on the brain and heighten the risk of developing mental health disorders.

Hence there lies the diagnostic issues among PTSD, complex PTSD and BPD. One of the most major issues of contention is the enormous overlap between this BPD and PTSD or trauma-related condition. While trauma exposure is common in the histories of BPD patients, it is not a requirement for diagnosis, as it is for PTSD and cPTSD (17, 28, 29).

One of the major unanswered questions is why some people develop BPD or other illnesses, such as complicated PTSD, depression, or drug abuse, such as complex PTSD, depression, or substance use—but not others. What elements contribute to resilience or vulnerability is yet unknown. Those who acquire BPD may have grown up in what Linehan refers to as "traumatic invalidating environment," where a person feels devalued by those around them (30).

A handful of clinical research groups around the world are now working on integrating a focus on these adverse experiences into interventions for BPD. Psychotherapy is frequently the initial treatment option for borderline personality disorder. Randomized controlled studies have demonstrated the efficacy of two psychotherapy approaches: psychoanalytic/psychodynamic treatment and dialectical behavior therapy. Regulatory bodies have not yet authorized any drugs for the treatment of BPD (31).

However, up to 96% of BPD patients take at least one psychotropic drug. Nonetheless, according to a recent systematic review and pharmacotherapies for the treatment of BPD is limited.

Antipsychotics, anticonvulsants and antidepressants of the second generation were unable to reliably lessen the severity of BPD. Anticonvulsants may ameliorate particular BPD symptoms, such as rage, aggressiveness, and emotional lability, according to data with a low level of certainty, however the evidence is primarily restricted to single trials.

Antipsychotics of the second generation had minimal influence on the severity of particular BPD symptoms, but they alleviated patients' overall mental symptoms (32).

Borderline Personality Disorder (BPD) is one of the most misunderstood, misdiagnosed and stigmatized condition, despite public attempts to eliminate the stigma associated with mental illness. Our individuals demonstrate extraordinarily complex interpersonal behaviors that trigger unfavorable responses from others. Perhaps these findings just reflect a very human response to these patients' complex and aberrant behaviors, a conclusion relevant to our treatment.

Therefore, we must continuously remind ourselves that the diagnosis, rather than the label, is not the problem; rather, it is finding a solution for all of this with empathy, validation and compassion.

PATIENT PERSPECTIVE

After going through psychotherapeutic sessions, the patient began to understand what was going on within herself; while before that, patient mostly questioned herself, as to "why I am the person that I am." She blamed herself most of the time and at some point, patient became angry with herself too. Knowing that the traumatic experiences that happened were not her fault. All her life, she had been in constant battle with herself--how should I act, how should I react, and what to say or how to express myself. I always felt that something was wrong with me. My upbringing, relationships with people and certain experiences contributed in shaping the person that she is.

Consulting a psychiatrist, opened my eyes and broadened my perspective. Since then, .

whenever I am overwhelmed with all my problems, in school, financial, with my dad's illness or with my boyfriend's infidelity, I remember what my psychiatrist told me before, that it is okay to be angry or sad whenever someone does me wrong or when something does not go the way I planned. So, I did. I have learned not to suppress my feelings and I let myself feel all those feelings to allow myself to understand my feelings, my thoughts, and the situation. I think psychotherapy helped me a lot. The assignments and journals I did before gave me a better way of looking at things in a different light and putting everything in the right perspective. I honestly do not think I would be like this if I did not receive any help, both in terms of the medication and psychotherapy.

CONCLUSION

It is said that the goal of medical education is to produce knowledgeable, skillful, and professional physicians. However, there are parts of the training curriculum that may inadvertently take a toll on the mental and emotional health of medical students. Poor mental health does not only disrupt students' lives but it may also have detrimental effects on patients' care in due course. The medical students' quality of life may eventually affect the quality of care rendered to their future patients.

Strategies to reduce medical student distress may involve creating a nurturing learning environment with the aid of faculty mentoring programs, institution-sponsored social events to reduce stress and prevent or alleviate burnout. Programs that offer assessment, psychological support and counseling is considered an effective approach to support medical students grappling with their mental health. According to a study done in 2019, "merely identifying the mental distress of a student does not seem to contribute to reducing the psychological morbidity; it is crucial to provide personalized support to the stressed students once they are recognized."11 Stress management workshops should be included in the curriculum to educate students on adaptive coping, conflict processing, and empathy are also helpful. Lastly, promoting good health with exercise, adequate sleep may also be beneficial (6). In addition, this case gives us the realization that it is imperative to be familiar with Islamic morals for us to provide therapeutic treatments that are congruent with them.

For example, their belief that health is a gift from Allah may encourage consistent follow-ups and medication adherence. With the awareness of their fasting practices during Ramadan, the dosing of medications may be adjusted towards their eating times. In addition, psychiatrists should have basic understanding with their dietary restrictions. The chance that certain drug ingredients may be derived from pork products should be discussed with patients.3 When it comes to psychotherapy, Muslims are more likely to go to a religious leader (Imam) than a mental health professional.16 Group therapy may be problematic as disclosing private matters in a group setting may be difficult, more so when there are members of the opposite sex within the group.

Generally, psychodynamic approaches are not acknowledged as Islam gives emphasis on the community, recognizing their character in religious teachings, culture, and family (3).

As a result, the American Psychiatric Association (2019) suggested that assessment and treatment recommendations for Muslim populations must include employing culturally sensitive therapeutic interventions, considering building specialized, culturally, and religiously congruent clinics, recognizing Muslim patients' vulnerabilities, seeking cultural and religious sensitivity trainings, engaging with the local Muslim community, working with community and faith leaders, creating collaborative care models, and addressing potential language barriers.

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WAR WITHIN SELF: THE ROLE OF EARLY TRAUMA EXPOSURE IN BORDERLINE PERSONALITY DISORDER AND DEPRESSIVE DISORDERS”

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This artwork portrays the patient, Maj's tumultuous journey in life. The dark blue color in the background, represents the sadness that overshadowed her childhood experiences. Maj is wearing a green sari. We perceive her to have several gray clouds hanging over her head - each haze representing the terrible circumstances in her life; connected with a chain - signifying how these experiences are connected and together have a major impact on the patient.

Those who are screaming in silence will eventually be found and we, psychiatrists will be here to listen. We may not be able to alter the past, but we can always act on the present and facilitate the reshaping of the future. Even in one’s darkest moments, there are pockets of light. Despite these adversities, there is always someone there to help, and thus there is always hope.

The woman in white is the psychiatrist with pink clouds above her. The rose color symbolizes love, comfort and vitality that the doctor can provide for the patient. Rose color also represents tranquility and progress, which signifies the hope for a healthier and brighter future for the patient through the psychological support of her therapist. Inside the pink veils are the biological, psychosocial and spiritual interventions orchestrated by the psychiatrist.