

Review Article

Somatic and Dissociative Symptoms in Borderline Personality Disorder

Victor M Aziz*

Consultant Psychiatrist at Swansea Bay University Health Board, Swansea, Wales. UK

*Corresponding author

Victor M Aziz, Consultant Psychiatrist at Swansea Bay University Health Board, Swansea, Wales. UK

Submitted: 24 July 2026

Accepted: 04 September 2026

Published: 07 September 2026

ISSN: 2373-9312

Copyright

© 2026 Aziz VM

OPEN ACCESS

Keywords

- Borderline Personality Disorder; Dissociative Symptoms; Childhood abuse; Trauma-informed care

Abstract

Individuals diagnosed with borderline personality disorder (BPD) often report experiencing physical ailments, even when there are no sufficient medical explanations. Research consistently shows that those with BPD exhibit increased dissociative symptoms, although these symptoms are generally not as severe as those found in primary dissociative disorders. Experiences of childhood abuse, neglect, and complex trauma are commonly associated with BPD symptoms, dissociation, somatization, and PTSD. Rather than indicating distinct physical problems, somatic symptoms in BPD patients appear to be closely linked to dissociation, trauma-related psychopathology, and emotional dysregulation. Dissociation may act as a maladaptive mechanism for coping with intense emotional experiences, with both physical and dissociative symptoms potentially reflecting trauma and PTSD symptoms. Studies suggest that reducing PTSD-related distress could lessen the severity of physical symptoms, highlighting the importance of comprehensive, trauma-informed care.

INTRODUCTION

Individuals diagnosed with borderline personality disorder (BPD) often express physical ailments even when there are no adequate medical explanations. These complaints can vary from chronic pain and gastrointestinal issues to more intricate manifestations such as psychogenic nonepileptic seizures (PNES). The intensity of somatic symptoms seems to escalate in correlation with the overall psychiatric load, which includes conditions like depression, anxiety, PTSD, and dissociation [1]. In primary care settings, patients with BPD frequently report pain-related concerns or several less severe physical complaints, which can result in increased healthcare usage or even polypharmacy [2]. Beyond their physical manifestations, individuals with BPD exhibit a range of symptoms stemming from their challenges in emotional regulation, such as difficulties in interpersonal relationships, suicidal tendencies, and self-injurious behaviour. In addition to the diagnostic criteria outlined in DSM-5 (APA, 2013) and ICD-11 [3], BPD patients often experience significant comorbidity, including depression, anxiety, and posttraumatic stress disorder (PTSD) [4]. Although this co-occurrence is well-recognized and documented in clinical practice, there remains a scarcity of empirical research concerning the relationship between BPD and the severity of somatic symptoms.

DISSOCIATIVE SYMPTOMS

Research consistently indicates that individuals diagnosed with BPD exhibit heightened dissociative symptoms, although these symptoms are typically not as intense as those observed in primary dissociative disorders. The DSM-5 categorizes transient, stress-related dissociation as a diagnostic characteristic of BPD. It characterizes dissociation as a “disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behaviour.” This includes dissociative amnesia, which refers to the inability to recall autobiographical information; depersonalization/derealization disorders involve experiences of feeling disconnected or alienated from one’s body, thoughts, or emotions, and/or perceiving one’s environment as hazy, surreal, or visually distorted [5].

Furthermore, transient and stress-induced severe dissociative symptoms are considered a criterion for borderline personality disorder and have been associated with maladaptive functioning and the severity of symptoms in certain disorders, including executive functioning in borderline personality disorder [6].

Dissociation symptoms are observed across numerous mental health disorders and are associated with an

increased illness burden and diminished treatment efficacy, not limited to those disorders characterized by significant dissociation. A meta-analysis revealed that the highest average dissociation scores were recorded in dissociative disorders (mean scores >35), followed by posttraumatic stress disorder, borderline personality disorder, and conversion disorder (mean scores >25) [7].

A major meta-analysis [8], indicates that dissociation is markedly more prevalent in individuals with borderline personality disorder (BPD) compared to other psychiatric conditions in general. Those diagnosed with BPD appear to exhibit greater levels of dissociation than individuals suffering from various psychiatric and personality disorders, although this does not extend to dissociative disorders or posttraumatic stress disorders. These results reinforce the notion that dissociation is not an exclusive core characteristic of BPD and further support the idea of a continuum of severity present within the psychiatric population.

Working memory and cognitive deficits, reduced pain perception, altered body ownership, substance abuse or sedative substance abuse, increased fantasy proneness, personality fragmentation, fearful attachment, dream anxiety, perceived stress and altered stress responses, increased cumulative body mass index, decreased water consumption, several neurological correlates, and altered gene expression were all linked to dissociation. With implications for BPD, pathological dissociation is associated with earlier and more severe trauma exposure, emotional dysregulation, and poorer treatment results in dissociative disorders and posttraumatic stress disorders [9].

SOMATIC SYMPTOMS

Somatoform Disorders are characterized by the existence of one or more enduring somatic symptoms that lead to distress across cognitive, behavioural, and emotional dimensions [10]. A significant finding is reported by Hüsing et al. [11]. While depressive symptoms, PTSD symptoms, and dissociation were all linked to persistent somatic symptoms in BPD, the decrease in PTSD symptoms during inpatient dialectical behaviour therapy (DBT) seemed particularly crucial for alleviating somatic complaints.

Frankenburg and Zanarini et al. [12], describes a strong association between persistent borderline personality disorder and poorer long-term physical health, less healthy lifestyle behaviours, and greater use of medical services. People whose BPD had not remitted (meaning they still met criteria for the disorder over time) were significantly more

likely than those whose BPD had remitted to experience: chronic pain and fatigue-related conditions (Chronic Fatigue Syndrome, Fibromyalgia, and Temporomandibular Joint Disorder); and metabolic and physical health problems (Obesity, Diabetes, Hypertension, Osteoarthritis, Chronic back pain, and Urinary incontinence). They were also more likely to engage in unhealthy behaviours such as heavy smoking, daily alcohol use, not exercising regularly, frequent use of sleep medications, and long-term use of pain medications. And they used more intensive medical services, including emergency room visits and medical hospitalizations. The broader implication is that ongoing BPD symptoms may affect not only emotional functioning but also stress physiology, self-care, impulse control, sleep, substance use, and engagement with healthcare, which together can contribute to worse physical health outcomes over time. Importantly, the study shows an association, not definitive proof that BPD directly causes these conditions. Factors such as trauma history, chronic stress, poverty, medication effects, and co-occurring mental health conditions may also contribute.

Findings from epidemiological studies regarding personality disorders and their connection to physical health and healthcare utilization [13]. In simpler terms: Personality disorders (PDs) are prevalent within the general population. Various research conducted in countries such as England, Wales, Scotland, Western Europe, Norway, Australia, and the United States has identified prevalence rates between approximately 4.4% and 21.5%, influenced by: how PDs were assessed, which specific PDs were considered, and the demographics of the populations examined. Initial evidence indicates that certain categories of personality disorders — particularly those classified in: Cluster A (traits of paranoia, schizoid, and schizotypal) Cluster B (traits of borderline, antisocial, narcissistic, and histrionic) may correlate with elevated incidences of physical health issues such as: Cardiovascular Disease Arthritis Additionally, the text mentions that individuals with PDs are likely to utilize healthcare services more often, particularly: primary care appointments, routine medical check-ups, and general medical services. Researchers propose that this trend may stem from a variety of interconnected factors: chronic stress, suboptimal health behaviours, higher prevalence of smoking and substance use, difficulties in emotional regulation, exposure to trauma, social instability, and an increase in medical symptoms or pain complaints.

Psychogenic nonepileptic seizures are episodes characterized by movements, sensations, or behaviours that resemble epileptic seizures; however, they lack a neurological basis and instead represent somatic

expressions of psychological distress. Individuals experiencing psychogenic nonepileptic seizures are often misdiagnosed and treated as if they have epilepsy. It is estimated that 5 to 10 percent of outpatient epilepsy patients and 20 to 40 percent of inpatient epilepsy patients experience psychogenic nonepileptic seizures. These individuals typically present with comorbid psychiatric disorders, with the most prevalent being depression, posttraumatic stress disorder, various dissociative and somatoform disorders, and personality disorders, particularly of the borderline type. A significant number of these patients have a history of sexual or physical abuse. Notably, between 75 and 85 percent of those affected by psychogenic nonepileptic seizures are women. These seizures generally onset during young adulthood [14].

Numerous studies suggest that individuals exhibiting greater dissociative tendencies tend to report an increased number of somatic symptoms. Modestin et al. [15], discovered that patients diagnosed with dissociative disorders reported significantly higher levels of somatic symptoms. Hüsing et al. [11], identified a significant correlation between dissociation and the severity of persistent somatic symptoms in individuals with borderline personality disorder. Collectively, these findings bolster the hypothesis that dissociation and somatization may serve as distinct manifestations of a common challenge in processing intense emotional experiences and fragmented unprocessed traumatic memories.

Modestin and colleagues et al. [15], sought to assess the prevalence of dissociative experiences and dissociative disorders (DDs) among a group of acute psychiatric inpatients, while also examining the relationship of these experiences and disorders with various sociodemographic, clinical, and historical factors. The study included 207 consecutively admitted psychiatric inpatients who met the criteria for participation. Each participant was evaluated using the Dissociative Experiences Scale (DES), the Structured Clinical Interview for DSM-III-R Personality Questionnaire (SCID-II PQ), the Parental Bonding Instrument (PBI), and the Frankfurter Self-Concept Scales (FS). Those patients who achieved a score exceeding 20 on the DES underwent further assessment with the Dissociative Disorders Interview Schedule (DDIS). Overall, 20% of the patients scored above 20 on the DES, and a diagnosis of a DD was established in 5% of the cases. Notable positive correlations were identified between DES scores and the frequency of items on the SCID-II PQ related to all types of personality disorders, particularly borderline, antisocial, schizotypal, and dependent disorders. Weaker correlations were observed between DES scores and PBI scores, as well as between DES scores and age. Clinical axis I diagnoses

did not significantly affect DES scores. Conversely, patients exhibiting a higher tendency towards dissociation tended to score lower on most FS scales. There was a notable trend indicating that patients with DDs reported a higher incidence of childhood abuse and expressed significantly more somatic complaints. Dissociative experiences appear to be as prevalent among Swiss inpatients as they are among North American inpatients; however, DDs and instances of childhood abuse were reported less frequently in the Swiss population. A correlation appears to exist between dissociation and somatization.

AETIOLOGICAL FACTORS

Multiple authors suggest that dissociation arises as an involuntary reaction to intense emotional experiences and in reaction to prevent trigger to post-trauma effect. Shutting down the emotion to help tolerate the trauma by impacting the parasympathetic nervous system may be considered maladaptive yet it is also a survival response. Within this context, dissociation serves as a temporary safeguard for the individual against emotional turmoil and self-soothing, yet it incurs drawbacks such as diminished emotional processing, interrupted memory and learning, compromised self-awareness, and a sense of lost control. As time progresses, frequent dissociation may lead to increased psychological distress and impairment [16-18].

Neurobiological research indicates that dissociative phenomena are likely to interfere with information processing, learning, and memory across various levels [19]. Dissociation has also been associated with physiological processes such as sleep and fluid intake, in addition to personality traits like fantasy proneness and suggestibility [20]. On a cognitive-emotional level, dissociation may serve as a learned automatic response aimed at reducing or avoiding unpleasant emotional states [21]. As a secondary effect, the experience of dissociation can itself induce stress, as it not only disrupts neurocognitive functioning but may also be experienced as a loss of control. Consequently, recurrent dissociation may diminish an individual's ability to monitor confidence, perceived control, and sense of self [22], potentially leading to an increased burden of disease.

There is substantial evidence indicating that dissociation negatively impacts affective-cognitive functioning (for instance, interference inhibition), body perception, and the response to psychotherapeutic treatment in individuals with borderline personality disorder. At the neural level, there is heightened activity observed in frontal regions (such as the inferior frontal gyrus) and temporal areas (including the inferior and superior temporal gyrus)

during tasks that provoke symptoms as well as during resting states [23].

Childhood trauma, encompassing physical, sexual, and emotional abuse, neglect, and ongoing invalidation, is one of the most significant aetiological factors linked to both somatic and dissociative symptoms in borderline personality disorder. Such traumatic experiences can exceed a child's ability to assimilate emotional and sensory experiences, resulting in dissociation as a means of protection. Over time, these dissociative reactions may become ingrained and continue into adulthood. Trauma can also lead to somatic symptoms due to the prolonged activation of stress-response systems and reduced mentalization capacity, which may cause increased bodily awareness, sensitivity to pain, gastrointestinal issues, fatigue, and various other physical symptoms that lack a medical explanation. The body may serve as a means to "express" psychological distress, particularly when emotions are challenging to recognize or manage [24].

Krause-Utz and Elzinga et al. [25], proposed that insecure or disorganized attachment relationships play a role in hindering self-development. Continuous invalidation and erratic caregiving can disrupt the integration of emotional states, memories, and self-representations. This fragmentation of the self is believed to be a root cause of dissociative symptoms, especially feelings of unreality, confusion regarding identity, and a lack of continuity in experience. Consequently, dissociation can be interpreted as a reflection of challenges in sustaining a coherent sense of self when faced with stress.

Across various studies, childhood abuse, neglect, and complex trauma have consistently been linked to symptoms of BPD, dissociation, somatization, and PTSD. The research conducted by van Dijke and colleagues indicates that disturbances in affect regulation related to trauma may elucidate the frequent co-occurrence of BPD and somatoform disorders. Consequently, trauma may serve as a common etiological factor that underpins both dissociative and somatic symptoms. Affect dysregulation is regarded as a fundamental aspect of both borderline personality disorder and somatoform disorders (SoD). Previous research has indicated a distinct correlation between early childhood psychological trauma and affect dysregulation, particularly in instances where the caregiver is emotionally, sexually, or physically abusive towards the child. However, the relationship between these factors and the concepts of under- and overregulation, particularly across different developmental stages, remains unclear. While an increased risk of exposure to childhood trauma or symptoms of complex post-traumatic stress disorder

(CPTSD) has been documented in individuals with BPD and SoD, trauma histories, dysfunctional affect regulation, dissociation, PTSD, and CPTSD have not been evaluated collectively in the context of BPD and/or SoD. Differentiating between inhibitory and excitatory states of experience may provide insights into the variations in dissociation and affect dysregulation both between and within patients diagnosed with BPD and SoD. Targeted interventions that focus on addressing overregulation in BPD or under regulation in SoD should be incorporated into evidence-based treatments specific to each disorder. Complex PTSD is notably prevalent in BPD and BPD with SoD, and it is differentially linked to the under- and overregulation of affect, contingent upon the nature of the traumatic exposure [26].

Dissociation in individuals with BPD is linked to altered activity in brain areas responsible for emotion regulation, self-awareness, memory, and threat detection. These areas include the amygdala, anterior cingulate cortex, medial prefrontal cortex, and parietal regions. Such abnormalities may hinder the effective integration of emotional and sensory information during times of stress. Studies indicate that dissociation related to stress is associated with modifications in cortico-limbic networks, leading to emotional overmodulation, diminished emotional awareness, and a sense of detachment from both bodily and psychological experiences [25-27].

MANAGEMENT

According to current standards, organized psychotherapy should be the mainstay of treatment for BPD. Treatment plans should be customized based on the patient's level of functioning, cooccurring disorders, symptom profile, and treatment objectives [28]. While drugs are used sparingly and primarily for certain target symptoms or concomitant diseases, psychotherapy is thought to be the primary remedy.

Somatic and dissociative symptoms in borderline personality disorder are interrelated and can profoundly affect an individual's emotional and psychological health. Dissociative symptoms, including depersonalization and derealization, are frequently associated with the fragmentation of self and the difficulty in sustaining a unified sense of identity. These symptoms may lead to instability in identity, yet they can also function as a protective strategy against excessive stress and conflict. Grounding techniques and specialized therapeutic approaches can assist individuals with BPD in managing these symptoms and in the process of healing their fragmented self. Although various factors influence the

baseline severity of physical symptom severity (PSS) in BPD patients, enhancements in PTSD symptoms seem to play a crucial role in alleviating somatic complaints during inpatient Dialectical Behaviour Therapy (DBT). This underscores the necessity of addressing PTSD-related distress in treatment to achieve more comprehensive symptom relief. Future studies should investigate the mechanisms that underlie this connection and evaluate whether focused interventions for PTSD within DBT or any therapy for BPD could improve outcomes for patients dealing with PSS [11].

There isn't a drug that has been approved especially for BPD. Some evidence indicates that the use of medication may correlate with the severity of dissociative symptoms in borderline personality disorder, although the nature and mechanism of this association remain ambiguous. The levels of antipsychotic and antidepressant medications show a significant correlation with dissociative symptoms in BPD, unlike in schizophrenia. The findings reveal that dissociative symptoms, as assessed by the Dissociative Experiences Scale, were significantly linked to antipsychotic medication ($P < 0.01$) measured in chlorpromazine equivalents and to antidepressant medication in fluoxetine equivalents ($P < 0.01$). This connection between medication and dissociative symptoms may be related to a crucial role of stress in BPD. The reduced activity in the anterior cingulate cortex (ACC) due to antipsychotic and antidepressant medications in BPD may diminish conscious awareness of conflicting stressful experiences, potentially leading to dissociative symptoms as measured by the DES [29]. The existing literature suggests that effective treatment should focus on addressing deficits in emotion regulation, dissociative symptoms, PTSD symptoms, and somatic symptom distress. Clinicians ought to explore various approaches, including Dialectical Behaviour Therapy (DBT), trauma-focused interventions, psychoeducation on mind-body interactions, and, importantly, the careful management of polypharmacy.

CONCLUSION

In individuals diagnosed with BPD, somatic symptoms are not merely isolated physical issues; rather, they seem to be significantly associated with dissociation, trauma-related psychopathology, and affect dysregulation. Dissociation may function as an ineffective coping strategy for managing intense emotional experiences, while symptoms of trauma and PTSD may exacerbate both dissociative and somatic expressions. Recent findings imply that alleviating PTSD-related distress could result in a reduction of somatic symptom severity, underscoring the

necessity for comprehensive, trauma-informed treatment strategies for those suffering from BPD.

Transparency Declaration

I confirm that the manuscript is an honest, accurate, and transparent account of the literature being reported.

Author Contribution Statement

The author contributed to the writing up of the article and its review.

REFERENCES

- Schmaling KB, Fales JL. The association between borderline personality disorder and somatoform disorders: A systematic review and meta-analysis. *Clin Psychol Sci Pract*. 2018; 25: e12244.
- Sansone RA, Sansone LA. Borderline personality and the pain paradox. *Psychiatry (Edgmont)*. 2007; 4: 40-46.
- World Health Organization: International Classification of Diseases for Mortality and Morbidity Statistics 11th Revision. 2018.
- Frías Á, Palma C. Comorbidity between post-traumatic stress disorder and borderline personality disorder: a review. *Psychopathology*. 2015; 48: 1-10.
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th ed. Washington, DC, American Psychiatric Association. 2013.
- Haaland VØ, Landrø NI. Pathological dissociation and neuropsychological functioning in borderline personality disorder. *Acta Psychiatr Scand*. 2009; 119: 383-392.
- Lyssenko L, Schmahl C, Bockhacker L, Vonderlin R, Bohus M, Kleindienst N. Dissociation in Psychiatric Disorders: A Meta-Analysis of Studies Using the Dissociative Experiences Scale. *Am J Psychiatry*. 2018; 175: 37-46.
- Scalabrini A, Cavicchioli M, Fossati A, Maffei C. The extent of dissociation in borderline personality disorder: A meta-analytic review. *J Trauma Dissociation*. 2017; 18: 522-543.
- Al-Shamali HF, Winkler O, Talarico F, Greenshaw AJ, Forner C, Zhang Y, et al. A systematic scoping review of dissociation in borderline personality disorder and implications for research and clinical practice: Exploring the fog. *Aust N Z J Psychiatry*. 2022; 56: 1252-1264.
- Henningsen P, Zipfel S, Sattel H, Creed F. Management of Functional Somatic Syndromes and Bodily Distress. *Psychother Psychosom*. 2018; 87: 12-31.
- Hüsing P, Löwe B, Biedermann SV. Persistent somatic symptom severity in patients with borderline personality disorder: Trauma-related symptoms as mechanism for improvement during inpatient dialectical behaviour therapy. *J Psychosom Res*. 2025; 194: 112151.
- Frankenburg FR, Zanarini MC. The association between borderline personality disorder and chronic medical illnesses, poor health-related lifestyle choices, and costly forms of health care utilization. *J Clin Psychiatry*. 2004; 65: 1660-1665.
- Quirk SE, Berk M, Chanen AM, Koivumaa-Honkanen H, Brennan-Olsen SL, Pasco JA, Williams LJ. Population prevalence of personality disorder and associations with physical health comorbidities and health care service utilization: A review. *Personal Disord*. 2016; 7: 136-146.

14. Alsaadi TM, Marquez AV. Psychogenic nonepileptic seizures. *Am Fam Physician*. 2005; 72: 849-856.
15. Modestin J, Ebner G, Junghan M, Erni T. Dissociative experiences and dissociative disorders in acute psychiatric inpatients. *Compr Psychiatry*. 1996; 37: 355-361.
16. Van der Hart O, Nijenhuis ERS, Steele K. *The Haunted Self*. New York: W.W. Norton. 2006.
17. Spiegel D, Lewis-Fernández R, Lanius R, Vermetten E, Simeon D, Friedman M. Dissociative disorders in DSM-5. *Annu Rev Clin Psychol*. 2013; 9: 299-326.
18. Bessel A. van der Kolk, Onno van der Hart, & Marlene N. Weisaeth (1996). History of trauma in psychiatry. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic Stress*. 1996; 47-74.
19. Frewen PA, Lanius RA. Neurobiology of dissociation: unity and disunity in mind-body-brain. *Psychiatr Clin North Am*. 2006; 29: 113-128.
20. Giesbrecht T, Lynn SJ, Lilienfeld SO, Merckelbach H. Cognitive processes in dissociation: an analysis of core theoretical assumptions. *Psychol Bull*. 2008;134: 617-647.
21. Michal M, Koechel A, Canterino M, Adler J, Reiner I, Vossel G et al. Depersonalization Disorder: Disconnection of Cognitive Evaluation from Autonomic Responses to Emotional Stimuli. *PLoS ONE*. 2013; 8: e74331.
22. Soffer-Dudek N. Dissociation and dissociative mechanisms in panic disorder, obsessive-compulsive disorder, and depression: a review and heuristic framework. *Psychol Conscious*. 2014; 1: 243-270.
23. Krause-Utz A, Frost R, Chatzaki E, Winter D, Schmahl C, Elzinga BM. Dissociation in Borderline Personality Disorder: Recent Experimental, Neurobiological Studies, and Implications for Future Research and Treatment. *Curr Psychiatry Rep*. 2021; 23: 37.
24. Vermetten E, Spiegel D. Trauma and dissociation: implications for borderline personality disorder. *Curr Psychiatry Rep*. 2014; 16: 434.
25. Krause-Utz A, Elzinga B. Current Understanding of the Neural Mechanisms of Dissociation in Borderline Personality Disorder. *Curr Behav Neurosci Rep*. 2018; 5: 113-123.
26. van Dijke A. Dysfunctional affect regulation in borderline personality disorder and in somatoform disorder. *Eur J Psychotraumatol*. 2012; 3.
27. Krause-Utz AD, Elzinga BM. Neurale mechanismen van dissociatie: implicaties voor borderlinepersoonlijkeitsstoornis [Neural mechanisms of dissociation: implication for borderline personality disorder]. *Tijdschr Psychiatr*. 2019; 61: 267-275.
28. Keepers GA, Fochtmann LJ, Anzia JM, Benjamin S, Lyness JM, Mojtabai R, et al. The American Psychiatric Association Practice Guideline for the Treatment of Patients With Borderline Personality Disorder. *Am J Psychiatry*. 2024; 181: 1024-1028.
29. Pec O, Bob P, Simek J, Raboch J. Dissociative states in borderline personality disorder and their relationships to psychotropic medication. *Neuropsychiatr Dis Treat*. 2018; 14: 3253-3257.