Psychosocia : Journal of Applied Psychology and Social Psychology
E-ISSN : 3031-2442
Volume. 3 Issue 2 April 2025
Page No: 90-101

Dissociative and Hallucination as Main Symptoms of Borderline Personality Disorders: A Case report

Aaliyah Yusmadewi[1], Ahmad Misbahul Ulum Fatwa[2], Isna Meirilla Zahara Al Makka[3], Illa Billah[4], Muhammad Istio Hadi Al Imron[5], Ariyani Sri Suwarti[6], Hafid Algristian[7]
Universitas Nahdlatul Ulama Surabaya, Indonesia[123457]
Rumah Sakit Radjiman Wedyodiningrat Lawang, Indonesia[6]
Correspondent: dr.hafid@unusa.ac.id [7]

Received : March 22, 2025
Accepted : April 28, 2025
Published : April 30, 2025

Citation: Yusmadewi, A., Fatwa, A, M, U., Zahara, I, M., Billah, I., Imron, M, I, H, A., Suwarti, A, S., & Algristian, H. (2025). Dissociative and Hallucination as Main Symptoms of Borderline Personality Disorders: A Case report. Psychosocia : Journal of Applied Psychology and Social Psychology, 3(2), 90-101. https://doi.org/10.61978/psychosocia.v3i2

ABSTRACT: Borderline Personality Disorder (BPD) is a complex psychiatric condition often accompanied by dissociative symptoms and hallucinations. These symptoms are not merely comorbid features but appear to be integral aspects of the disorder's pathology. This case report presents a 20-year-old female patient with a history of childhood trauma and persistent emotional distress, who exhibited dissociation and auditory hallucinations as primary clinical features. Approximately 75–80% of individuals with BPD experience dissociation, while 30–50% report hallucinations, particularly under emotional stress. In this case, dissociative states such as depersonalization and amnesia preceded hallucinatory experiences, suggesting a causal link. The patient demonstrated episodes of memory loss, out-of-conscious behavior, and auditory command hallucinations, which significantly impaired her functioning. These symptoms were exacerbated by academic pressure and unresolved trauma. The interplay between dissociation and hallucination highlights the importance of trauma-informed, emotion-regulation-focused interventions. Clinicians should assess these symptoms systematically, as their presence may indicate a more severe clinical profile and the need for integrative therapeutic strategies.

Keywords: Borderline Personality Disorder, Dissociation, Auditory hallucinations.

INTRODUCTION

Borderline Personality Disorder (BPD) is increasingly recognized as one of the most complex and debilitating psychiatric conditions, with far-reaching implications for individuals, families, and health care systems. The disorder is characterized by a pervasive pattern of affective instability, identity disturbance, chaotic interpersonal relationships, and marked impulsivity that often leads to self-harming behaviors and recurrent crises (W. M. Association, 2013; Chapman et al., 2022)

Traditionally, clinical and research attention has focused on mood dysregulation and interpersonal dysfunction as central diagnostic markers. However, emerging evidence underscores the importance of dissociation and psychotic-like symptoms, such as hallucinations, in shaping the clinical course, severity, and treatment outcomes of BPD. These phenomena, although not explicitly listed as core diagnostic criteria, may be fundamental to understanding the disorder's heterogeneity and prognostic variability.

Dissociation in BPD has been conceptualized as a maladaptive coping mechanism that develops in the context of overwhelming affect and early trauma. It encompasses a range of phenomena including depersonalization, derealization, amnesia, and identity fragmentation (Al-Shamali et al., 2022). Far from being transient and benign, dissociative experiences have been associated with greater symptom severity, impaired therapeutic engagement, and increased suicidality. Epidemiological studies report that between 75% and 80% of patients with BPD experience dissociative symptoms at some point in their lives (Alfieri et al., 2024). Neurobiological research has revealed that dissociation correlates with altered fronto-limbic connectivity, particularly reduced functional integration between the amygdala and prefrontal cortex, resulting in impairments in affect regulation and autobiographical memory consolidation (Krause-Utz et al., 2021). These neurocognitive disturbances may account for the fragmentation of self-experience and vulnerability to perceptual anomalies observed in many BPD patients.

Hallucinations, particularly auditory verbal hallucinations (AVH), constitute another critical but often overlooked domain of psychopathology in BPD. Studies have found that between 30% and 50% of individuals with BPD report hallucinatory experiences, most commonly in the form of voices delivering criticism, commentary, or direct self-harm commands (Schulze et al., 2016; Slotema et al., 2018). Although such symptoms may superficially resemble those found in psychotic disorders such as schizophrenia, their phenomenology and contextual triggers differ. In BPD, hallucinations are often stress-dependent, rapidly fluctuating with affective intensity, and closely tied to interpersonal conflicts or trauma reminders. Neuroimaging evidence suggests that BPD-related hallucinations may arise from hyperactivity in the auditory cortex coupled with diminished top-down inhibitory control from the dorsolateral prefrontal cortex, thereby impairing reality monitoring and leaving individuals vulnerable to perceptual distortions (Schulze et al., 2016).

The interplay between dissociation and hallucinations represents a particularly important area of inquiry. Several studies have described a dynamic and bidirectional relationship between these two domains: dissociative states may undermine reality monitoring and continuity of consciousness, thereby creating fertile ground for hallucinatory experiences; conversely, the distressing and alienating nature of hallucinations may reinforce dissociative withdrawal, creating a vicious cycle of psychopathology (Celban & Nowacki, 2024). Clinically, this dynamic interplay appears to predict greater severity, higher suicide risk, and increased treatment resistance (Yen & Gagnon, 2022). The present case reflects this cyclical pattern, with dissociative episodes preceding hallucinatory experiences and hallucinatory content intensifying dissociative withdrawal. Understanding this relationship is essential for accurate diagnosis and effective treatment planning.

The etiological role of trauma provides a unifying framework for interpreting these phenomena. There is substantial evidence that childhood adversity, including emotional neglect, physical abuse, sexual abuse, and exposure to domestic violence, is disproportionately common among individuals with BPD and strongly predicts both dissociation and hallucinatory experiences (Barnow & Arens, 2020). Trauma models propose that dissociation arises as a defensive strategy to manage overwhelming affective states when no other coping strategies are available, while hallucinations represent intrusive, fragmented re-experiencing of trauma-related material (Meares, 2020). These mechanisms align with the biosocial developmental model of BPD, which emphasizes the interaction of genetic vulnerability, invalidating environments, and maladaptive coping strategies in shaping psychopathology (Crowell et al., 2019). The patient in this case, with a history of exposure to parental violence and maternal criticism, exemplifies this developmental pathway.

Clinical misdiagnosis represents another significant challenge. Hallucinations in BPD are often misinterpreted as signs of schizophrenia, leading to inappropriate pharmacological interventions and neglect of psychotherapeutic approaches. Conversely, dissociative symptoms are sometimes dismissed as malingering or dramatization, rather than recognized as core elements of psychopathology. Such misdiagnoses may delay effective treatment, exacerbate stigma, and undermine therapeutic alliance. Case-based analyses such as the present report are therefore critical in raising clinician awareness and refining diagnostic frameworks.

Treatment implications are substantial. Over the past two decades, structured psychotherapies such as Dialectical Behavior Therapy (DBT), Mentalization-Based Therapy (MBT), Schema Therapy, and Transference-Focused Psychotherapy (TFP) have demonstrated efficacy in addressing core features of BPD (Bateman & Fonagy, 2019; Linehan, 2014; Stoffers-Winterling et al., 2020). However, dissociation and hallucinations present unique barriers to therapeutic engagement. Dissociation can interrupt attention and memory during sessions, impairing skill acquisition, while hallucinations may provoke acute distress that destabilizes treatment progress. Accordingly, integrative, trauma-informed approaches are required. DBT skills such as grounding, mindfulness, and distress tolerance may help stabilize patients, while trauma-focused modalities such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR) may address underlying traumatic memories once basic stabilization has been achieved (Barnicot & Crawford, 2019). Pharmacological interventions may provide symptomatic relief for severe hallucinations or comorbid affective disorders, but current evidence suggests limited long-term efficacy, and psychotherapy should remain the cornerstone of treatment (Paris, 2020).

Beyond clinical management, this case contributes to ongoing debates about the nosological boundaries of BPD. Should dissociation and hallucinations be regarded as peripheral comorbidities, or as central features that deserve explicit recognition within diagnostic systems? Some researchers advocate for dimensional models that incorporate trauma-related dissociation and psychotic-like symptoms as definitional features of severe BPD (Sharp & Wall, 2021). Others argue for maintaining current categorical frameworks while emphasizing clinical training in differential diagnosis (Gunderson & Links, 2020). Regardless of stance, there is growing consensus

that ignoring these symptoms risks underestimating severity and missing opportunities for intervention.

In conclusion, dissociation and hallucinations in BPD deserve greater clinical and research attention. They complicate diagnosis, intensify functional impairment, and heighten risk, particularly for suicidality. This case study seeks to enrich understanding by documenting the lived experience of a young woman whose BPD symptomatology was dominated by these phenomena, situating her trajectory within current theoretical and empirical knowledge. By integrating descriptive clinical data with contemporary research, the report highlights the necessity of systematic screening, trauma-informed care, and further investigation into the neurobiological and therapeutic mechanisms linking dissociation and hallucinations in BPD(Çörekçi & Erermiş, 2022; Raine & Chen, 2024). Ultimately, acknowledging these symptoms as central rather than peripheral may enhance diagnostic clarity, guide more effective treatment, and foster more compassionate, individualized care for patients living with this complex condition.

METHOD

The case was analyzed using a descriptive clinical approach. Data were gathered through structured clinical interviews, including the Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD), psychiatric observation, and patient self-reports. Dissociative symptoms were further assessed using the Dissociative Disorders Interview Schedule (DDIS). Informed consent was obtained from the patient prior to the collection and publication of clinical information. Ethical approval for the case report was granted in accordance with institutional guidelines. The data were interpreted qualitatively, with attention to the temporal relationship between trauma exposure, dissociation, and hallucinatory episodes. Particular emphasis was placed on identifying how dissociation may have functioned as both a defense mechanism and a risk factor for perceptual disturbances.

RESULT AND DISCUSSION

Case Presentation

The patient, a 20-year-old female college student, presented with a chronic history of dissociative and hallucinatory symptoms. Her symptoms began at age five after witnessing domestic violence perpetrated by her father against her mother. By age seven, she experienced significant academic pressure from her mother, leading to anxiety, insecurity, and feelings of inadequacy. Dissociative symptoms such as depersonalization, emotional numbness, and amnesia began to emerge in elementary school. By fourth grade, she reported both auditory and visual hallucinations—hearing crying voices of children and mothers, and receiving commands to harm herself.

In junior high school, these symptoms temporarily subsided but returned during high school, particularly in isolated environments such as stairwells. During hallucinatory episodes, she exhibited dissociative behaviors like striking her head to silence the voices. At one point, she found scratches on her phone without recollection of the act. In college, the patient developed panic attacks, sleep disturbances, and decreased appetite. She reported peer bullying, auditory hallucinations commanding self-harm, and episodes of fugue-like behavior where she lost awareness of her actions. Despite seeking help, the responses from healthcare services were unsatisfactory. She coped by writing in her journal and confiding in a boyfriend. However, her trauma history and high academic demands continued to exacerbate her psychological condition.

This case highlights the complex and often underappreciated role of dissociation and hallucinations in Borderline Personality Disorder (BPD). Although diagnostic systems such as the DSM-5-TR emphasize affective instability, impulsivity, and interpersonal dysfunction as the primary features of BPD (American Psychiatric (A. P. Association, 2022), the presence of dissociative phenomena and psychotic-like symptoms such as hallucinations complicates clinical presentations, contributes to greater severity, and raises challenges for both diagnosis and treatment. By situating this case within the broader scientific literature, several important themes emerge regarding the nature, etiology, and management of these symptoms in BPD.

Dissociation as a Central but Overlooked Phenomenon

Dissociation is increasingly recognized as a prevalent and impairing feature of BPD, despite its relative absence from official diagnostic criteria. Research indicates that approximately 75–80% of BPD patients experience dissociative symptoms, with manifestations ranging from transient depersonalization and derealization to severe amnesia and identity fragmentation. In the present case, dissociation appeared in early childhood as a defensive response to exposure to domestic violence and maternal criticism. This supports trauma-based models suggesting that dissociation originates as a protective mechanism in the face of overwhelming affective states when other coping strategies are unavailable.

Neurobiological studies strengthen this conceptualization. Dissociation has been linked to altered connectivity between the amygdala and medial prefrontal cortex, impairing affect regulation and memory integration (Krause-Utz et al., 2017). Functional imaging also implicates the insula and hippocampus, regions associated with interoception and autobiographical recall. These disruptions may explain the fragmentation of self-experience and continuity observed in the patient, who frequently described feeling detached from her body and unable to recall her own actions. Thus, dissociation should not be regarded as a peripheral feature but rather as a central dimension of BPD that interacts with core affective and interpersonal difficulties.

Hallucinations in BPD: Similarities and Distinctions from Psychosis

Hallucinations, particularly auditory verbal hallucinations (AVH), are another underappreciated symptom cluster in BPD. Prevalence studies suggest that 30–50% of BPD patients report hallucinatory experiences, with voices often characterized by critical or commanding content (Minarikova et al., 2022). The present case exemplifies this pattern, with the patient reporting critical voices and commands to self-harm during periods of interpersonal stress and academic pressure.

The phenomenology of hallucinations in BPD differs significantly from that seen in schizophrenia. In BPD, hallucinations are typically stress-contingent, episodic, and rapidly fluctuating, often resolving when emotional intensity subsides (Niemantsverdriet et al., 2022). By contrast, hallucinations in schizophrenia are more persistent, less tied to external triggers, and often accompanied by broader cognitive and negative symptoms (McCutcheon et al., 2020). Neuroimaging research suggests overlapping but distinct mechanisms: BPD-related hallucinations are associated with hyperactivity in the auditory cortex and hypoactivity in the dorsolateral prefrontal cortex, impairing reality monitoring, while schizophrenia involves more widespread disruptions in dopaminergic pathways (Schulze et al., 2016).

Clinically, this distinction is crucial. Misdiagnosis of hallucinations in BPD as evidence of schizophrenia may lead to inappropriate treatment, such as long-term antipsychotic medication, while neglecting trauma-focused psychotherapies that are more effective in addressing the underlying causes. The patient's experience of being initially misclassified as having a psychotic disorder mirrors broader concerns about diagnostic accuracy and underscores the importance of contextualizing hallucinations within the framework of stress and trauma.

The Dynamic Interplay Between Dissociation and Hallucinations

Perhaps the most salient finding from this case is the cyclical and bidirectional relationship between dissociation and hallucinations. Dissociative states—particularly depersonalization and amnesia—were observed to precede hallucinatory episodes. This temporal relationship supports models suggesting that disruptions in consciousness and identity integration inherent in dissociation lower the threshold for perceptual anomalies. Once hallucinations emerged, their distressing and alienating content further intensified dissociation, creating a self-perpetuating cycle of psychopathology.

This dynamic has important clinical implications. Patients caught in this cycle are at elevated risk of suicidality, as hallucinations often carry self-harm content while dissociation impairs the ability to regulate emotions or seek help effectively (Faisal et al., 2022). The cycle also contributes to treatment resistance, as dissociation undermines memory and engagement in therapy, while hallucinations destabilize emotional regulation. Recognizing this interplay allows clinicians to tailor

interventions that disrupt the cycle by simultaneously targeting both dissociation and hallucinations.

Trauma as the Common Etiological Ground

The unifying role of trauma provides an essential framework for understanding the co-occurrence of dissociation and hallucinations in BPD. Numerous studies have documented the association between childhood trauma—including physical, sexual, and emotional abuse—and both dissociative phenomena and hallucinations (Zanarini, 2020). Trauma disrupts the hypothalamic-pituitary-adrenal (HPA) axis, sensitizing stress responses and impairing neural circuits responsible for emotion regulation. Over time, these neurobiological adaptations manifest in maladaptive strategies such as dissociation and in perceptual distortions resembling psychotic symptoms.

In the present case, early exposure to domestic violence and maternal invalidation served as key developmental risk factors. This aligns with the biosocial model of BPD, which posits that emotional vulnerability interacts with invalidating environments to produce chronic dysregulation. The patient's symptoms thus illustrate how trauma operates not only as a distal risk factor but also as a proximal trigger for symptom activation.

Implications for Clinical Assessment

The findings highlight the urgent need for systematic screening of dissociation and hallucinations in patients with suspected or confirmed BPD. Standardized tools such as the Dissociative Disorders Interview Schedule (DDIS) (Ross et al., 1989) and the Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD) (First et al., 2016) should be routinely employed in clinical practice. Clinicians must move beyond narrow symptom checklists and inquire specifically about perceptual disturbances and dissociative experiences, which patients may otherwise conceal due to fear of stigma.

Training is critical in this regard. Many clinicians remain insufficiently familiar with dissociation and its manifestations, leading to misinterpretation as malingering or dramatization. Similarly, hallucinations in BPD may be prematurely pathologized as psychotic, leading to unnecessary pharmacotherapy. Improved training and awareness can reduce diagnostic errors and promote more effective treatment planning.

Treatment Considerations

The management of dissociation and hallucinations in BPD requires integrative, trauma-informed approaches. Dialectical Behavior Therapy (DBT) remains the most empirically supported intervention for BPD, with robust evidence for reducing suicidality and improving emotion regulation (Linehan, 2014; Barnicot & Crawford, 2019). DBT skills in distress tolerance, mindfulness, and grounding are particularly useful in addressing dissociative states. For hallucinations, DBT's emphasis on emotion regulation may reduce stress-induced triggers, while grounding techniques can re-anchor patients during perceptual disturbances.

Trauma-focused therapies such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR) may be indicated once patients have achieved sufficient stabilization. These modalities can help process traumatic memories underlying both dissociation and hallucinations, reducing their recurrence and intensity. Importantly, trauma-focused work should be introduced cautiously, as premature exposure to traumatic content may exacerbate symptoms.

Pharmacological interventions remain controversial. While antipsychotics may provide temporary relief from hallucinations, systematic reviews suggest limited efficacy in BPD, and side effects may outweigh benefits (Slotema et al., 2018). Selective serotonin reuptake inhibitors (SSRIs) may be considered for comorbid depression or anxiety, but they do not directly target dissociation or hallucinations. Current consensus recommends prioritizing psychotherapy, with medications used only as adjuncts for severe or refractory symptoms.

Broader Clinical and Research Implications

This case contributes to broader debates about the conceptualization of BPD. Should dissociation and hallucinations be regarded as peripheral features or as core components of the disorder? Some scholars advocate for revising diagnostic criteria to reflect their high prevalence and clinical importance. Others propose dimensional models of personality pathology that would better capture the full spectrum of BPD symptoms, including trauma-related and psychotic-like phenomena (Gunderson & Links, 2020).

From a research perspective, further longitudinal studies are needed to clarify the developmental pathways linking trauma, dissociation, and hallucinations. Neurobiological investigations using functional imaging could elucidate the mechanisms by which stress and trauma disrupt connectivity in brain circuits, leading to both dissociation and perceptual anomalies (Schulze et al., 2016). Treatment research should explore integrative protocols that combine DBT skills training with trauma-focused therapies, assessing their impact on both dissociation and hallucinations.

Summary

In sum, this case underscores the clinical importance of dissociation and hallucinations in BPD. Far from being peripheral, these symptoms significantly shape the disorder's trajectory, severity, and treatment response. Dissociation undermines identity cohesion and memory integration, while hallucinations amplify distress and suicidality. Together, they create a self-reinforcing cycle rooted in early trauma. Recognizing and addressing these phenomena is essential for accurate diagnosis, effective treatment, and improved outcomes.

CONCLUSION

This case report highlights the importance of recognizing dissociative symptoms and hallucinations as clinically significant and interacting features in individuals with Borderline Personality Disorder (BPD)(Matthew, 2020). These symptoms can severely impair emotional regulation, identity cohesion, and daily functioning, especially in patients with histories of trauma and emotional stress. Given the observed interplay—where dissociation may precede and even trigger hallucinatory experiences—clinicians should routinely screen for both symptoms during diagnostic evaluations.

From a clinical perspective, incorporating trauma-informed approaches such as Dialectical Behavior Therapy (DBT) and grounding techniques may prove essential in managing this symptom overlap. Structured intervention plans that target both dissociation and hallucination should be prioritized in therapeutic settings. Additionally, mental health professionals must be equipped to identify early warning signs of perceptual distortions that may arise from dissociative states.

Future research should focus on developing integrated treatment models that specifically address the dynamic relationship between trauma, dissociation, and hallucinations in BPD. Longitudinal studies examining the neurobiological underpinnings and treatment outcomes of these symptoms will be vital in improving care strategies for this complex patient population.

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