https://doi.org/10.29309/TPMJ/2026.33.09.10458 www.theprofesional.com

ORIGINAL ARTICLE

Childhood trauma and its impact on Borderline Personality Disorder development and symptom severity: A study at Allama Iqbal Teaching Hospital, Dera Ghazi Khan.

Hafiz Shafique Ahmad[1], Mujeebullah Khan Doutani[2], Adeena Rasheed[3]

ABSTRACT… Objective: To examine the relationship between childhood trauma severity and borderline personality disorder (BPD) symptom severity among adult patients, and to explore the role of dissociation and attachment anxiety in this association. **Study Design:** Cross-sectional study. **Setting:** Psychiatric Outpatient Department, Allama Iqbal Teaching Hospital, Dera Ghazi Khan. **Period:** 11-08-2025 to 10 -02-2026. **Methods:** A purposive sample of 150 adults (18–45 years) diagnosed with BPD was included. Data were collected using a structured proforma assessing demographic variables, childhood trauma (types and severity), BPD symptom severity (DSM-5 criteria), dissociation, and attachment anxiety. Data were analyzed using SPSS version 26. Descriptive statistics, Pearson correlation, multiple regression, and logistic regression analyses were performed. **Results:** Most participants reported at least one form of childhood trauma, with emotional neglect and witnessing domestic violence being most common. Trauma severity showed a strong positive correlation with BPD symptom severity ($r = 0.58$, $p < 0.001$). Dissociation and attachment anxiety were also significantly correlated with trauma and symptom severity. Regression analysis indicated trauma severity as a significant predictor of BPD symptoms, with partial mediation by dissociation and attachment anxiety. Logistic regression showed trauma severity and sexual abuse significantly predicted self-harm behavior. **Conclusion:** Childhood trauma significantly contributes to the severity of BPD symptoms. Dissociation and attachment anxiety partially mediate this relationship. Trauma-informed and culturally sensitive interventions are essential for improving clinical outcomes in resource-limited settings.

Key words: Borderline Personality, Childhood Trauma, Symptoms Severity.

Article Citation: Ahmad HS, Doutani MK, Rasheed A. Childhood trauma and its impact on Borderline Personality Disorder development and symptom severity: A study at Allama Iqbal Teaching Hospital, Dera Ghazi Khan. Professional Med J 2026; 33(09):1787-1790. https://doi.org/10.29309/TPMJ/2026.33.09.10458

INTRODUCTION

Borderline personality disorder (BPD) is a severe psychiatric condition characterized by emotional instability, impulsivity, disturbed self-image, and unstable interpersonal relationships. Patients often present with intense mood swings, fear of abandonment, chronic emptiness, anger, and self-harming behaviors, leading to significant impairment in functioning and quality of life.[1] The disorder imposes a considerable burden on individuals, families, and healthcare systems, often complicated by comorbid depression, anxiety, and trauma-related conditions.[2]

Childhood trauma, including emotional, physical, and sexual abuse, neglect, and exposure to domestic violence, plays a critical role in the development of BPD. Early adverse experiences disrupt attachment formation and emotional regulation, leading to insecure attachment patterns and maladaptive coping strategies.[3] Neurobiological changes due to chronic stress further increase emotional sensitivity and impair impulse control, supporting a biopsychosocial model of BPD development.[4]

Emerging evidence suggests that trauma is not only associated with the onset of BPD but also influences symptom severity and clinical presentation. Dissociation and attachment anxiety are commonly observed in trauma-exposed individuals and may mediate the relationship between trauma and BPD symptoms.[5] However, data from under-resourced settings such as South Punjab remain limited.

1. MBBS, FCPS (Psych), Associate Professor Psychiatry & Behavioral Sciences, D.G Khan Medical College.
2. Balochistan Institute of Psychiatry and Behavioral Sciences, Bewary Road Quetta.
3. M.Phil Applied Psychology (BZU), PMDCP (GCUF), Pakistan.

Correspondence Address:
Dr. Hafiz Shafique Ahmad
Department of Psychiatry & Behavioral Sciences, D.G Khan Medical College.
drhshafiq@ymail.com

Article received on:
09/03/2026
Date of revision:
14/04/2026
Accepted for publication:
20/05/2026

Therefore, this study aims to explore these relationships in patients presenting to Allama Iqbal Teaching Hospital, providing locally relevant evidence to inform trauma-informed care practices.

OBJECTIVES

To assess the relationship between childhood trauma severity and BPD symptom severity, and to evaluate the mediating role of dissociation and attachment anxiety.

METHODS

This cross-sectional study was conducted at the Psychiatric Outpatient Department of Allama Iqbal Teaching Hospital, Dera Ghazi Khan, over a period of six months from 11-08-2025 to 10 -02-2026 following ethical approval (Ref No:008/332; Date:11-08-2025). A purposive sample of 150 patients aged 18–45 years diagnosed with BPD according to DSM-5 criteria was included. Patients with schizophrenia, bipolar I disorder, severe substance dependence, or inability to provide consent were excluded.[6]

Data were collected using a structured proforma including demographic details, trauma history (emotional, physical, sexual abuse, neglect, and household dysfunction), BPD symptom severity, dissociation, and attachment anxiety. Trauma severity and chronicity were also recorded.[7]

Data analysis was performed using SPSS version 26. Descriptive statistics summarized the sample characteristics. Pearson correlation assessed relationships among variables. Multiple regression evaluated predictors of BPD symptom severity, while logistic regression analyzed predictors of self-harm behavior. Mediation was assessed using stepwise regression models.[8]

RESULTS

Most participants reported exposure to at least one form of trauma, with emotional neglect and witnessing domestic violence being the most prevalent. The mean BPD symptom severity indicated a moderate to high clinical burden.

A strong positive correlation was observed between trauma severity and BPD symptom severity ($r = 0.58$, $p < 0.001$). Trauma severity was also significantly correlated with dissociation and attachment anxiety. Emotional neglect and sexual abuse showed the strongest associations with symptom severity.

TABLE-I

Sample characteristics and key study variables (N = 150)

Variable	Mean (SD) or n (%)
Age (years)	28.6 (6.2)
Gender (female)	96 (64.0)
Education (≥ graduate)	58 (38.7)
Family history of mental illness (yes)	62 (41.3)
Trauma severity index (0–30)	16.9 (6.7)
Number of trauma types (0–10)	4.1 (2.2)
BPD symptom severity total (9–90)	58.4 (12.8)
Dissociation score (0–20)	9.7 (5.1)
Attachment anxiety score (1–7)	5.0 (1.1)

TABLE-II

Pearson correlations among main variables (N = 150)

Variable	1	2	3	4
1. Trauma severity	—			
2. BPD symptom severity	.58**	—		
3. Dissociation	.49**	.46**	—	
4. Attachment anxiety	.41**	.39**	.28**	—

TABLE-III

Hierarchical multiple regression predicting BPD symptom severity (N = 150)

Model	Predictor	B	SE B	β	p
1	Age	-0.12	0.14	-0.06	.39
	Gender (female)	2.10	1.58	0.09	.19
	Education	-1.35	1.42	-0.06	.34
	Family history	3.05	1.54	0.13	.048
	Trauma severity	0.88	0.11	0.53	<.001
2	Trauma severity	0.63	0.12	0.38	<.001
	Dissociation	0.72	0.15	0.30	<.001
3	Trauma severity	0.54	0.12	0.33	<.001
	Dissociation	0.61	0.15	0.26	<.001
	Attachment anxiety	2.40	0.78	0.20	.003

Regression analysis demonstrated that trauma severity significantly predicted BPD symptoms even after controlling for demographic variables. Dissociation and attachment anxiety partially mediated this relationship, indicating their role in translating early trauma into clinical symptoms.

TABLE-IV

Logistic regression predicting self harm criterion (N = 150)

Predictor	B	SE	Wald	OR	p
Trauma severity	0.09	0.02	16.2	1.10	<.001
Sexual abuse (yes)	0.78	0.34	5.3	2.18	.021
Dissociation	0.10	0.04	6.5	1.11	.011
Gender (female)	0.26	0.33	0.6	1.30	.43

Logistic regression analysis revealed that trauma severity and sexual abuse significantly increased the likelihood of self-harm, with dissociation further contributing to risk.

DISCUSSION

The findings support existing literature highlighting childhood trauma as a central factor in BPD development and severity.[9-10] The strong association between trauma and emotional dysregulation underscores the importance of early identification and intervention. Dissociation emerged as a significant mediator, suggesting its role as a maladaptive coping mechanism in response to overwhelming stress.[11-12] Similarly, attachment anxiety reflects disrupted relational patterns rooted in early caregiving experiences. These findings have important clinical implications. Trauma-informed care, combined with therapies such as Dialectical Behavior Therapy and Mentalization-Based Therapy, may improve outcomes by addressing both emotional regulation and interpersonal functioning.[13-14]

CONCLUSION

Childhood trauma significantly influences the severity of BPD symptoms, with dissociation and attachment anxiety acting as key mediating factors. Integrating trauma-informed assessment and culturally sensitive interventions can enhance treatment effectiveness and reduce recurrence in vulnerable populations.

IMPLICATIONS AND FUTURE RECOMMENDATION

The study highlights the importance of routine trauma screening in patients with borderline personality disorder, as childhood trauma significantly influences symptom severity. The mediating roles of dissociation and attachment anxiety support the use of trauma-informed treatments, including DBT and MBT, with added focus on emotional regulation and grounding techniques. In resource-limited settings, there is a need for capacity building and clinician training in trauma-informed care. At the policy level, strengthening child protection and early intervention programs may help reduce the long-term burden of BPD. Future studies should use longitudinal designs to establish causal relationships between childhood trauma and BPD. The use of standardized tools and biological measures is recommended to improve assessment accuracy. Research should also focus on culturally sensitive approaches and evaluate the effectiveness of trauma-focused therapies in this population. Larger, multi-center studies across Pakistan are needed to improve generalizability and guide national mental health strategies.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

SOURCE OF FUNDING

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

REFERENCES

1. Leichsenring F, Heim N, Leweke F, Spitzer C, Steinert C, Kernberg OF. **Borderline personality disorder: A review.** JAMA. 2023; 329(8):670-9.
2. Powers A, Petri JM, Sleep C, Mekawi Y, Lathan EC, Shebuski K, et al. **Distinguishing PTSD and BPD.** J Anxiety Disord. 2022; 88:102558.
3. Bozzatello P, Garbarini C, Rocca P, Bellino S. **Risk factors in BPD.** Diagnostics. 2021; 11(11):2142.
4. Bozzatello P, Rocca P, Baldassarri L, Bosia M, Bellino S. **Trauma and early onset BPD.** Front Psychiatry. 2021; 12:721361.
5. Ford JD, Courtois CA. **Complex PTSD and BPD.** Bord Personal Disord Emot Dysregul. 2021; 8(1):1-10.
6. Tate AE, Sahlin H, Liu S. **BPD associations.** Mol Psychiatry. 2022; 27:1-8.

7. Goodman M, Yehuda R. **Trauma and BPD.** Psychiatr Ann. 2002; 32(6):337-45.
8. Schulze A, Cloos L, Zdravkovic M, Lis S, Krause-Utz A. **On the interplay of borderline personality features, childhood trauma severity, attachment types, and social support.** Borderline Personality Disorder and Emotion Dysregulation. 2022 Dec 19; 9(1):35.
9. Marchetti D, Musso P, Verrocchio MC, Manna G, Kopala-Sibley DC, De Berardis D, et al. **Childhood maltreatment, personality vulnerability profiles, and borderline personality disorder symptoms in adolescents.** Development and Psychopathology. 2022 Aug; 34(3):1163-76.
10. Erkoreka L, Zamalloa I, Rodriguez S, Muñoz P, Mendizabal I, Zamalloa MI, et al. **Attachment anxiety as mediator of the relationship between childhood trauma and personality dysfunction in borderline personality disorder.** Clinical Psychology & Psychotherapy. 2022 Mar; 29(2):501-11.
11. Smits ML, Luyten P, Feenstra DJ, Bales DL, Kamphuis JH, Dekker JJ, et al. **Trauma and outcomes of mentalization-based therapy for individuals with borderline personality disorder.** American Journal of Psychotherapy. 2022 Jan 1; 75(1):12-20.
12. Krause-Utz A. **Dissociation and BPD.** Bord Personal Disord Emot Dysregul. 2022; 9(1):14.
13. Kolthof KA, Voorendonk EM, Van Minnen A, De Jongh A. **Trauma-focused treatment.** Eur J Psychotraumatol. 2022; 13(2).
14. Békés V, Szabó D, Lévay EE, Salgo E, Unoka Z. **Moral injury and shame mediate the relationship between childhood trauma and borderline personality disorder, PTSD, and Complex PTSD Symptoms in Psychiatric Inpatients.** J Pers Disord. 2023; 37(4):406-23.
15. Fung HW, Wong MY, Lam SK, Wong EN, Chien WT, Hung SL, et al. **Borderline personality disorder features and their relationship with trauma and dissociation in a sample of community health service users.** Borderline Personality Disorder and Emotion Dysregulation. 2023 Jul 3; 10(1):22.

AUTHORSHIP AND CONTRIBUTION DECLARATION	
1	**Hafiz Shafique Ahmad:** Supervision, proof reading.
2	**Mujeebullah Khan Doutani:** Data collection, data entry, data analysis.
3	**Adeena Rasheed:** Methodology, literature review, results.