Case Report

Persistent Somatic Pain Masking Psychiatric Distress in Borderline Personality Disorder and Major Depression: A Case Report

Zahra Ibadina[1], Margarita Maria Maramis[1], Elisabet Citradewi[1] and Isti Suharjanti[2]

ABSTRACT

Somatic pain without clear medical explanation is frequently encountered in clinical settings and may reflect underlying psychiatric conditions. This case describes an 18-year-old female with a history of borderline personality disorder and major depressive disorder who presented to the emergency department with acute headache accompanied by nausea, vomiting, and limb weakness. Neurological evaluation, imaging, and laboratory testing were unremarkable, and analgesic therapy produced minimal symptom relief. Persistent severe pain and repeated requests for medical reassurance contrasted with incongruent clinical observations. Psychiatric assessment revealed significant emotional distress associated with an interpersonal conflict. After transfer to the psychiatric ward, intensive psychotherapy incorporating supportive and mindfulness-based approaches resulted in gradual symptom improvement without changes in analgesic medication. This case highlights the importance of a psychiatric perspective in managing persistent somatic complaints and supports a multidisciplinary approach when symptoms exceed expected clinical findings or fail to respond to standard medical treatment.

Key Words: somatic symptoms, borderline personality disorder, major depressive disorder, pain perception, psychosomatic, multidisciplinary care

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INTRODUCTION

Somatic symptoms such as headache, dizziness, and fatigue are commonly encountered in clinical practice and often prompt urgent medical evaluation. Although many physical complaints are associated with identifiable medical conditions, a substantial proportion remain unexplained despite thorough diagnostic assessment.[1] Persistent somatic symptoms without corresponding physical findings may indicate underlying psychological distress or psychiatric disorders. The biopsychosocial framework conceptualizes pain as a multidimensional experience shaped by biological, emotional, and social factors, highlighting the importance of considering psychiatric contributions when symptoms are disproportionate to clinical findings or fail to respond to standard medical treatment.[1-3] Borderline personality disorder is frequently associated with altered pain perception, emotional dysregulation, and increased healthcare utilization.[4] Individuals with this condition may experience somatic symptoms that intensify during periods of psychosocial stress, complicating diagnostic clarity and treatment planning. Early recognition of psychiatric influences is essential in preventing unnecessary investigations and guiding appropriate multidisciplinary management.[5,6] This case illustrates the importance of psychiatric evaluation in the assessment of persistent somatic pain in a patient with borderline personality disorder and major depressive disorder.

[1.] Department of Psychiatry / Neurology[2], Faculty of Medicine, Universitas Airlangga, Dr. Soetomo General Academic Hospital Surabaya, Indonesia

Correspondence: Professor Margarita Maria Maramis, Department of Psychiatry, Faculty of Medicine, Universitas Airlangga, Dr. Soetomo General Academic Hospital, Jl. Mayjen. Prof. Dr. Moestopo, 47, Surabaya, Jawa Timur, 60286, Indonesia.
Email: mmmaramis61@gmail.com

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CASE PRESENTATION

Case Presentation: An 18-year-old female presented to the emergency department with a sudden onset severe headache accompanied by nausea, vomiting, and subjective right upper limb weakness. The symptoms had begun one week prior to admission and emerged during significant interpersonal conflict with her father. The patient had a history of major depressive disorder and borderline personality disorder with multiple previous psychiatric hospitalizations and regular outpatient psychiatric care. On admission to the neurology ward, intravenous analgesics, antiemetics,

and supportive medications were provided. Despite treatment, the patient continued to report severe headache, rating her pain intensity as 9 out of 10, and repeatedly requested medical attention throughout the day. Her subjective pain behavior appeared inconsistent with her physical appearance and facial expression, which showed minimal observable discomfort. Neurological examination, computed tomography of the brain, laboratory tests, and electroencephalography were unremarkable.

After three days of hospitalization, nausea and vomiting resolved, but her headache persisted unchanged. She expressed reluctance to be discharged, stating that she felt safer in the hospital environment. She demonstrated persistent reassurance seeking behavior and had difficulty accepting explanations regarding the absence of neurological pathology. A psychiatric consultation was requested, and the patient was transferred to the psychiatric ward. Intensive psychotherapy incorporating supportive techniques and mindfulness based cognitive behavioral approaches was initiated for four structured sessions. No changes were made to the patient's analgesic regimen. During treatment, emotional conflict surrounding her family relationship emerged as a significant trigger. As she engaged in psychotherapy, her headache gradually improved, and she demonstrated increased emotional regulation. The patient accepted discharge from inpatient care and continued outpatient psychiatric follow up without further somatic escalation.

DISCUSSION

Persistent somatic pain without clear medical explanation presents a frequent diagnostic and therapeutic challenge in clinical practice. Somatic complaints account for a substantial proportion of outpatient and emergency department visits, and many patients continue to report symptoms despite adequate medical evaluation and treatment.[2] A considerable portion of medically unexplained symptoms reflects underlying psychological or psychiatric distress. The biopsychosocial model supports the understanding that pain is influenced not only by sensory mechanisms but also by emotional regulation and interpersonal context. This framework is particularly relevant when symptom severity appears disproportionate to clinical findings or when persistent pain remains unresponsive to standard analgesic regimens.[2]

In this case, neurological assessment and imaging revealed no structural abnormalities to explain the patient's reported headache intensity. The persistence of severe pain despite adequate treatment, combined with repeated reassurance seeking and reluctance to be discharged, suggested contributions beyond physical pathology. Psychiatric evaluation identified psychosocial stress related to family conflict, which appeared to precipitate and maintain somatic symptom expression. In individuals with borderline personality disorder, emotional dysregulation, impaired stress tolerance, and altered pain perception may amplify physical symptoms and increase reliance on medical systems.[1,4] Pain may function as a manifestation of psychological distress or as a means of seeking safety and interpersonal support when internal coping resources are strained.[1,3,4]

Research has demonstrated a strong association between somatic complaints and psychiatric conditions such as major depression and personality disorders.[5,6] Individuals with borderline personality disorder may experience heightened sensitivity to internal states and difficulty interpreting bodily sensations, which may intensify symptom reporting.[1,3] Emotional conflict may lower pain thresholds or modify pain modulation pathways, including serotonergic, noradrenergic, and endogenous opioid systems, contributing to disproportionate pain responses.[1,4] Psychotherapeutic interventions targeting emotional regulation and interpersonal functioning have been shown to reduce symptom burden and decrease healthcare utilization.[1,2]

The improvement in symptoms following psychotherapy in this case, without changes to analgesic therapy, supports the role of psychological mechanisms in somatic pain persistence. This highlights the value of early psychiatric involvement when somatic symptoms appear inconsistent with objective findings. Multidisciplinary collaboration between medical and psychiatric teams can reduce unnecessary investigations, prevent iatrogenic risk, and guide patient centered treatment. Understanding the emotional context surrounding symptom presentation is essential for effective management, particularly in patients with personality disorders who may rely on somatic expression to communicate distress.

CONCLUSION

Persistent somatic pain can serve as an important indicator of underlying psychiatric distress, particularly when symptoms lack medical explanation or fail to respond to appropriate treatment. In individuals with borderline personality disorder, emotional dysregulation and altered pain perception may intensify somatic complaints and result in increased use of healthcare resources. This case underscores the need for early psychiatric assessment within a multidisciplinary care approach to improve diagnostic clarity, guide effective treatment strategies, and reduce unnecessary medical interventions. Psychotherapy focused on emotional regulation and coping skills may significantly reduce symptom severity and improve functioning. Recognizing when physical symptoms reflect psychological suffering is essential for optimizing clinical outcomes and preventing chronic disability.

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