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Somato-Psychic Interplay and Academic Distress in an Expatriation Context: Case Report of a Depressive Episode in a Patient with Ankylosing Spondylitis

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Abstract

Introduction: In healthcare students, depressive decompensation frequently results from a complex interaction between individual vulnerability, academic stressors, and somatic comorbidity. We report the case of a female student experiencing a major depressive episode after being notified of her failure in the medical internship competitive examination. **Methods:** This is a qualitative case study with a clinical follow-up conducted over a 3-month period post-discharge at the Moussa Diop Psychiatric Clinic of the Fann National University Hospital (Dakar). Data were collected through weekly and then monthly semi-structured interviews during inpatient care and outpatient follow-up. **Results:** Ms. RK, a 24-year-old Cameroonian medical student with a history of ankylosing spondylitis (AS), presented with a moderate depressive episode (ICD-10) reactive to her failure in the internship examination. Clinical features included sadness, irritability, feelings of guilt, and temporary discontinuation of her somatic treatment. Integrative management (7-day hospitalization, short-term mexazolam treatment, supportive psychotherapy, techniques borrowed from behavioral activation, psychoeducation, and rheumatology referral) achieved full clinical remission and resumption of AS care within three months. **Discussion:** Academic failure acted as a major narcissistic injury. Inflammatory comorbidity and expatriation-related isolation exacerbated psychological vulnerability. Psychoeducation and selected cognitive-behavioral techniques were helpful in restoring

coping mechanisms. **Conclusion:** This case highlights the necessity of an early biopsychosocial approach in international students.

Keywords

Reactive Depression, Academic Failure, Ankylosing Spondylitis, Migration, Moussa Diop Clinic

1. Introduction

In young adult psychiatry, the onset of a depressive episode is rarely the result of a single isolated factor. It most often arises from a complex interplay between individual vulnerability, an acute psychosocial stressor, and an underlying somatic condition. Healthcare students, engaged in long, selective, and highly competitive curricula, face ranking examinations and specialization contests that represent periods of major psychological stress (Thiam et al., 2012; Rotenstein et al., 2016). In an academic culture focused on excellence, failure can durably impair self-esteem and trigger mood decompensation (Jeammet et al., 1996).

This vulnerability is particularly pronounced when studies take place in a context of expatriation or academic migration. Distance from familiar surroundings and usual emotional support networks forces international students to navigate academic demands alone while bearing heavy family expectations (Baubet & Moro, 2009; Bowlby, 2002). Geographic isolation and a sense of responsibility toward loved ones can transform academic difficulty into deep psychological distress, characterized by withdrawal and guilt.

Adding to this psychosocial clinical picture is the potential burden of a chronic somatic disease. Inflammatory rheumatic diseases, due to their unpredictable nature, pain, and therapeutic constraints, impose a significant daily emotional strain (Nerurkar et al., 2019; Delbrouck, 2025). The interaction between psychological suffering and physical illness poses a genuine clinical challenge, where altered mood may impair treatment adherence and, conversely, worsen the physical disease's impact (Nerurkar et al., 2019; Delbrouck, 2025).

We report the case of a female medical student residing abroad, managed for a depressive episode following failure in the medical internship competitive examination, on a background of ankylosing spondylitis. Through this observation, we aim to illustrate the clinical and psychopathological complexity of somato-psychic interactions and evaluate the impact of comprehensive management combining psychotherapeutic support, somatic reassessment, and motivational intervention.

2. Methodology

2.1. Study Design

This was a qualitative, descriptive clinical case report of a single patient who developed a depressive episode following the announcement of her failure in the med-

ical internship examination.

2.2. Study Observation Period

The clinical follow-up described in this observation took place over a 3-month period post-hospital discharge, from intake in January 2025 to complete remission in April 2025.

2.3. Study Setting

The study took place at the Moussa Diop Psychiatric Clinic of the Fann National University Hospital Center (CHNU) in Dakar, a level-3 public health establishment located on Cheikh Anta Diop Avenue (Fann-Point E district).

2.4. Patient Eligibility

The included patient met the following criteria: admitted for a reactive depressive episode following failure in the Senegalese medical internship examination, and followed regularly in outpatient care post-discharge. Major confounding comorbidities (such as underlying bipolar disorder, primary psychotic disorders, or organic brain pathologies) were ruled out.

2.5. Data Collection and Clinical Follow-Up

Initial management took place in an inpatient setting (7-day hospitalization), followed by an outpatient follow-up provided by a medical resident. Clinical data were gathered through semi-structured outpatient interviews lasting 45 to 90 minutes. Outpatient consultations were scheduled at Day 7, Day 14, 1 month, 2.5 months, and 3 months post-discharge.

2.6. Ethical Considerations

The patient provided written informed consent for the publication of this case report. Anonymity and confidentiality were strictly preserved.

3. Case Presentation

Ms. RK is a 24-year-old single Cameroonian woman with no children. She was born into a monogamous family; both parents are high school teachers. She is the second of five children. She sought consultation voluntarily, encouraged by a classmate, due to irritability, social isolation, and loss of motivation present for three to four months.

3.1. History of Present Illness

According to the patient, symptoms began three weeks after learning of her failure in the Senegalese medical internship examination. She reported progressive social withdrawal, finding it difficult to answer calls or messages, extending gradually to her close circle. Interactions left her feeling irritable. She developed initial insomnia and frequent night awakenings. One month prior to consultation, she experi-

enced anhedonia regarding previously enjoyed activities (social gatherings, cooking). One week before intake, continuous irritability led to aggressive outbursts, prompting the consultation.

3.2. Medical, Psychiatric, and Personal History

Diagnosed with ankylosing spondylitis (AS) at age 21, she was treated with methotrexate, which she discontinued three months prior to consultation. She also has polycystic ovary syndrome. She has no prior personal psychiatric history. Her mother has a history of rheumatic disease.

Her developmental and educational background highlights high academic performance driven by a desire to make her late father proud (who died suddenly in a road traffic accident when she was 16). His death and the subsequent death of her maternal grandfather during her 5th year of medical school represented major loss events.

3.3. Initial Psychiatric Safety Assessment

At initial presentation, a systematic safety and psychiatric screening was performed:

- **Suicidal Ideation and Self-Harm:** The patient expressed passive death wishes related to overwhelming guilt, but explicitly denied active suicidal ideation, intent, or plan. She had no personal history of non-suicidal self-injury or suicide attempts.
- **Psychotic and Manic Symptoms:** There was no evidence of hallucinations, delusions, thought disorganization, or past/current hypomanic or manic episodes.
- **Substance Use:** Screening for alcohol, nicotine, cannabis, or illicit substance use was negative.
- **Protective Factors:** Strong moral and personal alignment with her mother, religious/spiritual values, and a clear motivation to complete her medical degree served as primary protective factors against self-harm.

3.4. Mental Status and Physical Examination

Ms. RK presented with neat attire, poor eye contact, hypomimia, and a soft voice. She exhibited depressed mood, irritability, anhedonia, and aboulia. Occasional memory lapses were observed. Thought content revealed strong feelings of guilt ("*My mother sacrificed everything for me, and I ruined all her hopes...*"). She displayed anorexia, mixed insomnia, physical asthenia, and decreased libido. Physical examination was within normal limits.

3.5. Diagnostic Synthesis and Classification

The principal final diagnosis retained was a Moderate Depressive Episode (ICD-10 code F32.1; Organisation Mondiale de la Santé, 1993, DSM-5 Major Depressive Disorder, single episode, moderate; American Psychiatric Association, 2023), based

on meeting 2 core criteria (depressed mood, anhedonia) and 5 secondary criteria (guilt, sleep disturbance, anorexia, concentration difficulty, fatigue) (Organisation Mondiale de la Santé, 1993; American Psychiatric Association, 2023; Guelfi et al., 2021).

Differential Diagnostic Justification: The alternative diagnosis of Adjustment Disorder with Depressed Mood (ICD-10 F43.21; Organisation Mondiale de la Santé, 1993; Llorca, 2018) was considered given the clear temporal trigger (internship failure) (Llorca, 2018; Gueye et al., 2018). However, it was not retained as the primary diagnosis because the symptom constellation exceeded the intensity and symptom count of a simple adjustment reaction, fulfilling full operational criteria for a major depressive episode, accompanied by severe functional impairment and somatic vegetative signs (Organisation Mondiale de la Santé, 1993; American Psychiatric Association, 2023; Guelfi et al., 2021).

3.6. Acute Management and Inpatient Stay

Due to functional impairment and emotional distress, she was admitted for a 7-day inpatient stay. Initial pharmacotherapy consisted of a short course of mexazolam 2 mg/day in two split doses (Haute Autorité de Santé, 2015). Supportive psychotherapy and a rheumatology referral were initiated.

3.7. Clinical Rationale for Mexazolam Monotherapy and Safety Monitoring

- ***Clinical Rationale***: Although international guidelines recommend antidepressant monotherapy or combined treatment for moderate depressive episodes (Stahl, 2015), an antidepressant (e.g., SSRI) was withheld initially. This decision was based on: 1) the predominantly reactive and acute nature of the anxiety-irritability decompensation (Llorca, 2018; Fovet & Micoulaud-Franchi, 2016); 2) the patient's acute sleep architecture disruption and marked behavioral agitation/irritability, which responded rapidly to direct GABAergic anxiolysis (Haute Autorité de Santé, 2015; Stahl, 2015); and 3) a shared decision-making strategy to observe initial response to psychotherapeutic stabilization during the brief 7-day stay before introducing long-term daily antidepressant therapy (Llorca, 2018; Stahl, 2015).
- **Safety Monitoring during Taper:** Over the 3-month outpatient reduction (2 mg/day to 1 mg/day at 1 month to 0.5 mg/day at 2.5 months to discontinuation at 3 months), the patient was closely monitored at each visit for daytime sedation, rebound anxiety, withdrawal symptoms, and signs of physiological dependence (Haute Autorité de Santé, 2015). No adverse events or rebound phenomena occurred (Haute Autorité de Santé, 2015).

3.8. Longitudinal Follow-Up and Delivery of Interventions

- **Clarification of Interventions Delivered:** The psychotherapeutic approach was a structured supportive follow-up integrating specific, selected techniques from

Cognitive Behavioral Therapy (CBT; Beck, 2010; Kanter et al., 2012) and Motivational Interviewing (MI; Rollnick & Miller, 2013), rather than distinct, formal multi-modal manualized therapies (Authier, 2006; Beck, 2010; Kanter et al., 2012; Rollnick & Miller, 2013).

- *Supportive Psychotherapy*: Core vehicle across all visits (empathic listening, emotional discharge, validating grief) (Jeammet et al., 1996; Guelfi et al., 2021).
- *CBT Techniques* (*Psychoeducation* [Authier, 2006], *Behavioral Activation* [Kanter et al., 2012], *Relaxation* [Beck, 2010]): *Application of daily schedule planning* (*cooking*, *walking*, *course review*) *and abdominal breathing exercises* (Authier, 2006; Beck, 2010; Kanter et al., 2012).
- *Motivational Techniques*: Integrated in consultations at 2.5 and 3 months to explore ambivalence regarding somatic care and future exam attempts (Rollnick & Miller, 2013).

- **Ankylosing Spondylitis (AS) Reassessment and Course:**
- Following the rheumatology referral, the patient was re-evaluated at 1-month post-discharge (Nerurkar et al., 2019; Delbrouck, 2025).
- Inflammatory disease activity was low-to-moderate upon reassessment (BASDAI score recorded at 2.8) (Nerurkar et al., 2019).
- Biological DMARDs were not indicated; treatment was resumed with methotrexate (15 mg/week) alongside folic acid supplementation and as-needed NSAIDs (Nerurkar et al., 2019; Delbrouck, 2025).
- At 3 months, joint pain was controlled, and the patient demonstrated full adherence to rheumatological visits (Nerurkar et al., 2019).

- **Symptom Course Timeline:**
- *Day* 7 (1 *week post-discharge*): Sadness persisted; irritability markedly decreased; sleep continuity improved.
- *Day* 14: Reduced irritability, persistent guilt; CBT schedule reinforced (Kanter et al., 2012).
- 1 *Month*: Marked mood improvement, resumed activities (cooking, dance classes), concentration restored (Kanter et al., 2012). Mexazolam reduced to 1 mg/day (Haute Autorité de Santé, 2015).
- 2.5 *Months*: Euthymic mood, cognitive reframing of failure as a need for better preparation (Rollnick & Miller, 2013). Mexazolam reduced to 0.5 mg/day (Haute Autorité de Santé, 2015).
- 3 *Months*: Full clinical remission, complete resumption of routine and academic activities, successful discontinuation of mexazolam (Haute Autorité de Santé, 2015; Stahl, 2015).

4. Discussion

4.1. Diagnostic and Pharmacological Considerations

Ms. RK's presentation highlights the clinical challenge of distinguishing between severe reactive depressive episodes (Organisation Mondiale de la Santé, 1993; American Psychiatric Association, 2023; Guelfi et al., 2021) and adjustment disorders

(Llorca, 2018). The choice of mexazolam monotherapy without an SSRI led to rapid symptom control and complete remission within three months (Haute Autorité de Santé, 2015; Stahl, 2015). While successful in this single case, this approach must be interpreted cautiously (Stahl, 2015). First-line guidelines for moderate major depressive episodes generally favor antidepressants due to the risk of symptom relapse or incomplete remission with benzodiazepines alone (Haute Autorité de Santé, 2015; Stahl, 2015). Close monitoring during the 3-month taper avoided dependence or withdrawal (Haute Autorité de Santé, 2015).

4.2. Psychodynamic Hypotheses and Formulations

Psychodynamic constructs offer a useful qualitative lens to understand the patient's narrative, though they should be interpreted as clinical hypotheses rather than established causal mechanisms (Jeammet et al., 1996; Freud, 1968; Marty, 2018):

- *Narcissistic Injury and Ego Decompensation*: For a student whose self-worth was historically tied to academic excellence to fulfill parental expectations, exam failure can be conceptualized as a major narcissistic injury (Jeammet et al., 1996; Freud, 1968).
- *Reactivation of Unresolved Grief*: The academic loss appears to have clinically reactivated unresolved grief associated with the sudden death of her father and her grandfather (Bowlby, 2002; Freud, 1968).
- *Internalized Anger and Somatic Neglect*: The intense guilt reported may represent internalized frustration regarding academic pressures (Freud, 1968). Similarly, the discontinuation of methotrexate three months prior to intake can be framed clinically as bodily disinvestment or somatic neglect in the context of emerging distress (Delbrouck, 2025; Marty, 2018).

4.3. Expatriation and Immuno-Psychiatric Interplay

Geographic isolation compounded her distress (Baubet & Moro, 2009; Morvan et al., 2018). Furthermore, the bidirectional link between chronic inflammatory disease (AS) and mood disorders is well-recognized: systemic inflammatory cytokines can induce fatigue and affective changes, while psychological stress can provoke autoimmune flares (Nerurkar et al., 2019; Delbrouck, 2025). While re-establishing psychiatric stability coincided with rheumatologic re-engagement, attributing psychiatric remission directly or solely to the interruption of a biological "immuno-psychiatric vicious cycle" remains a theoretical model rather than an empirically verified causal finding in this single case (Nerurkar et al., 2019).

5. Study Limitations

This report has several methodological limitations:

1) Single-Case Design: Findings are derived from a single patient narrative and cannot be generalized to all international medical students or patients with comorbid ankylosing spondylitis.

2) Absence of Standardized Rating Scales: Symptom severity and treatment response were evaluated through qualitative clinician-administered clinical interviews rather than validated objective psychometric scales (e.g., HDRS, MADRS, or PHQ-9).

3) Limited Duration of Documented Follow-Up: The documented longitudinal follow-up concluded at 3 months post-discharge upon complete clinical remission. Long-term durability of remission and future academic/somatic trajectories could not be evaluated.

4) Causality: Therapeutic response cannot be definitively attributed to specific individual components of the integrative care plan.

6. Conclusion

This case illustrates the complex interplay between academic stress, expatriation-related isolation, and chronic somatic illness in an international medical student. A comprehensive management plan combining brief inpatient stabilization, structured supportive psychotherapy with integrated CBT/motivational techniques, and rheumatological reassessment led to full clinical remission at three months. Early university-based screening and supportive mental health frameworks are essential to assist migrant students facing severe academic and somatic stress.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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