We present the case of a 25 year-old caucasian male (L.A.), a 6th year medical student, with a known psychiatric history of major depression disorder and a recently diagnosed demyelinating disease, admitted to “Prof. Dr. Al. Obregia” Clinical Hospital of Psychiatry for 9 days between May 25th until June 3rd 2016 for: depressed mood, diminished pleasure in almost all activities, insomnia, overall anxiety and restlessness, fatigue, diminished ability to learn or concentrate, recurrent suicidal ideation with a specific plan and four suicide attempts in the last month, symptoms which had intensified in the last four months despite following adequate treatment. We present the challenges of discerning between symptoms of depression and maladaptive personality traits in relation to the suicidal ideation and behavior.

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BACKGROUND

Diagnosing maladaptive manifestations and personality traits may sometimes represent a challenge when the diagnostic approach is influenced by Axis I and III episodes and disorders, biographical background and other confounders, such as suicidality. Any diagnostic approach in the given context is particular because of the stigmatizing character, impaired self-perception and poor control of the maladaptive personality traits (18,19).

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The patient was first diagnosed with major depressive disorder in 2012 at 21 years old when he attempted suicide by ingesting approximately 75 mg of midazolam. At that time, the patient recalls presenting

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Ward as recommended. From the last week of April 2016 until admission to our ward, the patient's mood worsened and his suicidal ideation became more prominent and he attempted to end his life using a different approach every week (saphenous minor venesection, ingestion of approximately 500 ml of whiskey and 40 mg of clonazepam, ingestion of 300 ml then 600 ml of antifreeze, buying a cable for the purpose of hanging himself). He was admitted voluntarily to our ward for the symptoms stated above.

The patient is a 6th year medical student, single, has one older sister to whom he has a close relationship. The patient is a moderate smoker (about 10 cigarettes per day), drinks alcohol occasionally and does not take any other medications except the psychotropic treatment mentioned above. From his family medical and psychiatric history we retain that his father has a history of major depressive episode with psychotic features and an attempted suicide. He denies having any allergies or serious adverse reactions to the treatment taken so far. He lives in a student accommodation campus and has a room mate to whom he is not very close, but for the last 3 months he returned to live with his parents in his hometown, practicing commute to attend to the university.

PSYCHIATRIC EXAMINATION performed on 25.05.2016 revealed a conscious andcooperant patient, oriented in time and space, autopsychic and allopsychic oriented, visual and psychic contact a bit difficult to start and maintain, a sad facies and slow and scarce gestures. The patient appers to be his stated age, his overall appearence and hygiene are appropriate. His motor behaviour appears to be slightly slowed down, his speech is slow and hesitating, making many pauses as if he cannot seem to find his words. His discourse, although interrupted by many pauses, is coherent and the patient uses many psychiatric terms to describe his symptoms, admitting that he has read a lot about his psychiatric condition. The rhythm and flow of thoughts is slow and he states that “for the past year I am experiencing thoughts and images about killing myself” “when this toughts reoccur, that is when I start to think about things” “I try to concentrate or learning and told us that his son “used to concentrate and maintain, a sad facies and slow and scarce gestures. He denies having any perceptual disturbances in the past or at the time of examination. The patient describes his mood or suicidal ideation did not improve during the first two days but he was able to sleep properly. During 26th May we talked to his sister who came in the office and gave us more information about the patient's past psychiatric history and recent neurological findings, confirming what the patient had told us. She was aware of his suicidal attempts but did not gave them much importance at that time, but is now very worried that he might do something to risk his life. She described the patient as being a very reclusive person, spending his time reading books, watching movies and listening to music (“he has very specific tastes” “he is attracted especially to philosophy and psychology, he watches movies with a profound philosophical and spiritual meaning, listens to weird music”), has very few friends, having a distant relationship with their parents, especially with their father. She remembers that this was not always the case, his regular visits to psychiatrists and distant behaviour started from 2012 when he first complained of having difficulties focusing on academic related activities. His childhood and adolescence were “normal, but he always was a bit more eccentric, he was a bit of a rebel in high school”. The same day we contacted the patient's parents who confirmed the overall description of their daughter, his father adding that his academic performances decreased progressively starting from the second year of medical school, that he complained of feeling useless and having difficulties concentrating or learning and told us that his son “used to read a lot about depression and its treatment and because of that he would get into conflicts with his psychiatrist and insist on changing the treatment”. He also mentioned that “this idea of his, having electroconvulsive therapy, first
appeared in December 2015 but we tried to convince him that this idea was a bad idea. His mother seemed concerned that the patient doesn’t give much attention to the demyelinating disorder and “he says it can’t be multiple sclerosis because the blood results were negative”. On the 27th May we added clozapine 50 mg per day to the treatment (increased to 100 mg per day on 29th May), increased trazodone to 300 mg per day and halted the tiapridam. After having more information from his family, we revisited our psychiatric interview and insisted more on the suicide attempts demanding a more detailed description of the events. The patient was now unsure of what “he remembers doing” every time and says that “it might not have been as much alcohol and Rivotril as I said” “I do not know exactly how much antifreeze I drank” “maybe it was not antifreeze, it was something else in those bottles” “maybe I fantasized a bit the events”. When asked to describe his personality traits and asked if he was ever given a diagnosis of personality disorder, the patient remembered a mention of schizoid personality disorder given by his first psychiatrist as a secondary diagnosis, but he feels “it did not accurately describe my state and I did not agree with it. I felt belittled by it”. The suicidal ideation was still present but not at the same intensity as before, the patient was able to sleep but felt sedated in the morning.

On the 30th May, we added amisulprid 400 mg per day which we increased the next day to 600 mg and continued this treatment for the rest of his hospitalization. Clozapine was stopped the day before discharge. During this time he had a few appointments with the ward’s clinical psychologists who gave us her conclusions: the patient has a depressive mood and background anxiety, suicidal ideation, is anhedonic and lacks motivation, has no future plans and perspectives and apparently he dismisses his neurological pathology but a great deal of anxiety can be detected from his attitude towards this subject. The interviews and psychological tests revealed maladaptive personality traits consistent with mixed personality disorder (schizoid personality disorder traits: flattened affectivity, emotional coldness and detachment, few close relationships, solitude; borderline personality disorder features: chronic feelings of emptiness, dissociative symptoms which the patient has remembered having in high school, recurrent suicidal behavior and gestures; obsessive-compulsive personality disorder traits: rigidity and stubbornness, inflexibility, pride). During the last days of hospitalization, the patient said his mood started to improve and had less prominent autolytic ideation and he noted a slight improvement in his attention. He described feeling better, he was able to resume work on his thesis, being capable to keep them under control and they are not as intrusive and distressing. His psychiatrist has prescribed him a month ago duloxetine 60 mg per day and trazodone 150 mg per day and has discontinued clonazepam with no notable benzodiazepine withdrawal syndrome. The patient went to several psychotypana sessions (which he abandoned eventually), he trained himself into relaxation techniques and mindfulness and even tried a few sessions of magnetic transcranial stimulation of which he said had no notable effects. He says he is still struggling to “become his old self”. Regarding his neurological follow-up, he decided to ask for another opinion and is now taking a new set of imagistic, immunologic and genetic tests.

**DISCUSSION**

In the described patient, psychiatric and somatic factors have contributed to his disorder and suicidal behavior. Maladaptive personality traits played a great role in addition to the persistent depressive disorder, to the suicidal behavior the patient displayed. The newly diagnosed demyelinating disorder (possible multiple sclerosis) only adds to the burden the patient had to deal with, depression, anxiety and suicidality being correlated to it (1). At admission, the patient presented with the symptoms of a major depressive episode (2) which had been present at the current intensity for at least one month and lead to attempted suicide (parasuicidality) and had a significant outcome on his overall functioning. Treatment-resistant depression (TRD) is a common clinical occurrence among patients treated for major depressive disorder. In managing TRD, 3 pharmacotherapy strategies are in clinical use: optimization of antidepressant dose, augmentation/comboination therapies, and switching therapies (3) all of which the patient underwent. Although electroconvulsive therapy is an indication in severe treatment-resistant depression (4,5), we carefully examined the patient and his multiple co-morbidities and decided that enhancing the current treatment would be a better approach. The most accurate current estimates of lifetime suicide risk are from a national study of suicide risk (6) which found an absolute lifetime risk for men with unipolar mood disorder of 6,67%. Reported prevalence of positive lifetime history of suicide attempts among psychiatric patients with mood disorders varies widely between studies and settings, but has been found in regionally representative samples with both out- and inpatients to be 30% to 40% in major depressive disorder (7). Prospective clinical cohort studies of patients with mood disorders (8, 9) have found risk factors for completed suicide to include male sex, family history of suicide, previous suicide attempts, hopelessness, suicidal ideation, psychotic symptoms, comorbid personality disorders, alcohol dependence or misuse, and anxiety disorders. The described patient presented with autolytic thoughts and behaviors which did not conclude in an outcome, the patient stating that his intention was to get rid of the burden of the ongoing distress and feelings of emptiness.
and uselessness. Non-suicidal self injury (NSSI) is an especially important risk factor for suicide. Findings are interpreted in the context of Joiner's interpersonal-psychological theory of suicide; specifically, NSSI may be a uniquely important risk factor for suicide because its presence is associated with both increased desire and capability for suicide (10). The frequency, duration, and severity of suicide-relevant cognitions will determine the probability that a person will engage in a suicidal act (11).

Clozapine is a useful last-resort medication for several approved indications and off-label uses. In addition to the official, evidence-based indication for treatment-resistant and refractory schizophrenia (12) clozapine is FDA-approved for suicidality in schizophrenia (13). Clinically reported, but unapproved, uses are among others, severe borderline personality disorder and treatment-resistant depression (14).

Patients with personality disorders are at higher risk than the general population for many (axis I) psychiatric disorders. Mood disorders are a particular risk across all personality diagnoses. Our patient presented features from A,B and C personality clusters (schizoid, borderline and obsessive traits). Among the list of comorbid psychiatric disorders: major depression, anxiety disorders, substance abuse, suicide ide, eating disorders (15,16) . By using one of the dimensional models (the 5 factors or Cloninger’s & factors model) of personality, one can find more complex correlations between normal personality, pathological traits and Axis I disorders (17).

Regarding suicidality, when analyzing different personality disorders, clusters A and C present with suicidal ideation, ruminations and representation related to the preparation of the act itself (all present in the case of our patient), whilst cluster B dominants include suicidal behavior with a high or low survival risk (18, 19).

Demyelinating disorders, such as multiple sclerosis (MS), are associated with a wide range of psychiatric comorbidities (depression, anxiety, alcohol and drug abuse, bipolar disorder, psychosis, personality disorders), especially depression and anxiety each of which affect more than 20% of the population (20). The high prevalence rates for depression in MS raise the question as to whether or not patients with MS might then be at increased risk of suicide. Findings of a study following 140 patients attending a Canadian MS clinic (21) reported a lifetime prevalence for suicidal intent of 28.6% (40 patients) and nine (6.4%) had actually attempted suicide. The patient complained of impaired learning ability and attention deficits. Demaree and DeLuca (22) noted that the relation between depression and cognitive impairment is best established for severe depression and primarily in relation to information processing speed and working memory. Arnett and colleagues have also reported that cognitive impairments in patients with MS seem to be closely correlated with mood and negative self-evaluations but less so with the vegetative symptoms of depression (23).

Due to the inconsistency between history and objective findings (notably, the lack of scoring after supposed venesection, the possible exaggeration of the other suicide attempts), the dramatical or atypical presentation (the patient request for electroconvulsive therapy), the lack of authenticity of the patient's behavior, his status of medical student, we revisited the possibility of factitious disorder imposed on self. Malingering patients do not have adequate coping mechanisms, presenting traits or even a comorbidity with a personality disorder (borderline, narcissic, hystirionic) or with depressive disorder (24).

Taking into account the long psychiatric history (both axis I and II disorders) of the patient and the prominent suicidal ideation, we dismissed this diagnosis. In the same line of thought, the differential diagnosis of simulation came to mind, but was dismissed because there was no evident secondary benefit.

CONCLUSION

The scope of this article was to highlight the important role of carefully revising psychiatric symptoms and personality features in any patient who presents with suicidal ideation and a history of multiple non-lethal suicide attempts. In this specific case we had to ponder the psychological and biopsychological contributions of the possible multiple sclerosis diagnosis on the overall mental and physical state of the patient. We must draw attention on always considering simulation or a factitious disorder when our clinical intuition and evaluation indicate it. In the attempt of comprehending the suicidal phenomenon, we must integrate a dimensional assessment of personality and evaluate possible Axis I comorbidities.

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