Fear of Getting HIV Infection : A Case Study from Psychiatric Clinical Practice

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Clinical Presentation

A 35 year old, married, truck driver referred to the psychiatric outpatients department for complaints of headache, palpitation, restlessness, lethargy, poor appetite and abdominal pain for more than 6 months. Patient was constantly worried about his symptoms, and their seriousness. History revealed about sexual contact with commercial sex worker with use of condom. Initially he was worried of acquiring Human Immunodeficiency Virus (HIV) for which he had undergone multiple testing. Results were negative. Despite the negative test results, he was very much distressed and not able to convince himself for being healthy. There was no history of cough, sore throat, prolonged feverwith chills or rigors, and evening rise of temperature, burning micturition. Intensity of symptoms fluctuate. Patient had undergone various investigations including testing for HIV infection several times from different pathological laboratories, but results were within normal limits. Patient occasionally consumes alcohol. Pre-morbidly the patient was well adjusted to life; however history suggested that during his early adolescence, he used to feel anxious and worry on trivial issues. He would also worry for minor issues related to health. In past whenever he became sick, he would become very apprehensive and undergone various investigations and would be assured with very difficulty even all findings were within normal limits. His academic and work performances were also affected because of this behavior.

There is history of depression in his mother and it was treated adequately by a psychiatrist. On mental status examination, patient was found conscious, co-operative, well-oriented to time, place and person. He was having predominantly anxious mood, pessimistic view about future and had preoccupations of having HIV infection. His general physical examination and systemic examinations were within normal limits.

Clinical investigations

The body mass index (BMI) score was 24.5. All routine blood investigations were within normal limits. He was nonreactive for Hepatitis C antigen, HIV 1,2 and was western blot test- negative.

After clinical evaluation the patient was diagnosed with 'Somatisation Disorder' according to International Classification of Diseases, 10th edition (ICD-10).

Management

Both non-pharmacological andpharmacological measures started simultaneously. Patient was first counselled about his illness and his irrelevant apprehensiveness and worries about symptoms. Hewas explained about safe sexual practices and avoidance of risky behaviours.

Psychological interventions had focussed on issues of stress and use of appropriate coping skills to handle it. Patient was given proper rationales and facts to clear his queries and myths. Progressive muscular relaxation exercises sessions were taken.

Pharmacological treatment continued with antidepressant (Escitalopram 10 mg at night time) and anxiolytic agent (Clonazepam 0.5 mg/day in divided doses).

Outcome

After several sessions of relaxation exercises and psychotherapy, feedback was taken from the patient. He reported significant improvement in his symptoms and was able to cope with stress. Frequency and intensity of various somatic complaints also decreased. After one month of therapy, there was a noticeable improvement in mood and substantial decrease in other symptoms like headache, palpitation, excessiveworry etc. He was adhered to the treatment till two months follow up.

Conclusion

In somatoform disorders, the major symptoms of presentation are physical symptoms, but evidences of obvious medical disorder that can explain those symptoms are not there. There are evidencesthat link physical symptoms with psychological factors or conflicts. Patients with somatoform disorder undergo significant psychological distress and use maladaptive coping methods to counter their distress. Substance abuse tendency is common in patients with somatoform disorders to get rid of somatic pain [1]. Knowledge about somatoform disorders is now accumulating which shows that it is a treatable condition, particularly in the early stages before its illness-behaviour aspects have become embedded. In Somatoform disorder, cognitive behaviour therapy (CBT) and counselling are two good options to help with treatment [2]. A cadre of well-trained therapists who are knowledgeable in the principles and practice of CBT is required in both family practice and tertiary care settings, where most somatisation disorder patients are found [3].

References

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