SOMATIZATION DISORDER IN HIV SERONEGATIVE MEN - A REPORT OF THREE CASES

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Psychiatric morbidity among individuals at high risk of acquiring HIV infection has been reported in the form of anxiety, phobias and panic. We report three cases of seronegative men indulging in high risk behavior who continued to manifest somatization disorder despite the knowledge of their serostatus. Possible reasons and implications for future work are discussed.

Key words: HIV, high risk, somatization.

INTRODUCTION

Psychiatric morbidity in groups at high risk for HIV infection have been reported in the form of increased life time rates of anxiety, depression and substance abuse (Atkinson et al, 1988; Perry et al, 1990). A life time prevalence of major depression ranging between 25-35% in both homosexual men and intravenous drug users have been reported even in those tested negative for HIV. Similarly, prevalence rates of anxiety in the range of 15-20% have been documented in both seropositive and seronegative men (Williams et al, 1991). These rates are mainly from Western studies where the predominant high risk group consists of intravenous drug users and homosexual men. The possible reasons as to this increased psychiatric morbidity are the burden of social stigmatization and a sense of ‘separatedness’ experienced by both these groups (Atkinson & Grant, 1994).

There is still not enough literature from India on the psychological status of heterosexual men indulging in high risk sexual behavior except as isolated reports of AIDS phobia (Jacob et al, 1987) and anxiety disorders related to AIDS (Jacob et al, 1989). Three men who tested seronegative for HIV but continued to demonstrate symptoms suggestive of a somatization disorder are hereby reported. All case had been voluntarily tested for HIV with pre and post test counselling.

CASE REPORTS

Case I: This was a 23 year old unmarried educated male who had indulged in unprotected sex with multiple partners over the last two years. He reported no homosexual relationships, IV drug use or blood transfusions. Prior to the test he reported multiple aches and pains, easy fatiguability, indigestion and erectile problems for the last one year. It was the physical complaints which had prompted him to seek HIV testing. Physical examination revealed no findings and routine investigations were normal. The patient’s VDRL and HIV test were negative and this was communicated to him during post test counselling. Despite this, the patient continued to manifest a somatization disorder with some anxiety features even six months after the test result. Though he was not preoccupied by it, he reported occasional fears of having HIV infection despite the negative test results. Even one month after testing he continued to have features of an Undifferentiated Somatization disorder by ICD-10 criteria.

Case II: A 28 year old unmarried educated male who had indulged in multiple partner sex with commercial sex workers had a history suggestive of a sexually transmitted disease three years earlier. He wanted to undergo HIV testing because of decreased libido, lack of energy, headache and occasional erectile problems of two years duration and thought of these as symptoms of AIDS. His HIV test (by ELISA) and VDRL were negative and physical examination did not reveal any positive findings. Despite being reassured of a negative test, the patient continued to have features of somatization disorder even three months after follow up. He denied fears of AIDS or a feeling of being already infected in the follow up sessions.

Case III: The third patient was a 40 year old married engineer who had indulged in sex with multiple partners. He also reported that his spouse engaged in similar behavior. He wanted an HIV test because of decreased concentration, erectile problem, decreased libido, pain in the legs and back and easy fatiguability of five years duration. He gave a history of a genital sore four years ago which had been treated. The patient however continued to manifest symptoms amounting to a somatization disorder despite a negative HIV ELISA and VDRL.

All three patients reported sexual dysfunction, easy fatiguability and loss of libido as symptoms of
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AIDS when their knowledge regarding the same was enquired into. However, all three had adequate knowledge regarding transmission and risk behavior. They also reported feeling reassured regarding the test result except for occasional fears that they might still have HIV infection. This preoccupation was not enough to warrant a diagnosis of hypochondriasis.

DISCUSSION

These cases illustrate the occurrence of psychological morbidity among men at high risk of HIV infection. Earlier studies have found an equal degree of psychological distress in both HIV negative and positive groups (Pergami et al, 1994). One possible reason given by the authors is that though seronegative, this group continues to perceive themselves at risk. It has also been speculated that preexisting psychological difficulties might prompt these persons to seek HIV testing (Windgassen & Soni, 1987). All our cases gave a history of sexual dysfunction, which has been a reported finding in both STD patients and those infected with HIV (Catalan et al, 1981 & 1992).

Anxiety disorders in seronegative men have been reported as occurring in those with a premorbid anxious personality (Jacob et al, 1989), specifically manifesting as AIDS phobia or AIDS panic (Jacob et al, 1987). Though this phenomena was not a major finding in our cases, it cannot be ruled out completely as a cause of the somatization disorder. The fact that the presenting complaints of all three patients resembled what they thought were symptoms of AIDS indicate that fears probably continued. It is possible that their risk behavior and somatization were part of a common personality construct.

In order to discern the effect of life styles on psychological morbidity from those related specifically to HIV infections and testing, it is necessary to study individuals engaging in high risk behavior independent of HIV testing. Our cases also emphasize the need for continued counselling even in those who test negative for HIV but have a history of high risk behavior. Specific problems faced by heterosexual men and women engaged in high risk behavior have to be delineated and their psychosocial needs have to be addressed.

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