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"HUMAN IMMUNODEFICIENCY VIRUS (HIV)/ ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) DELUSIONAL DISORDER" – A CASE REPORT

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ABSTRACT
There is paucity of data on HIV/AIDS delusional disorder. Thus, the aim of this case report is to create awareness on this disorder and its treatment outcome.
The patient is a 42 year old female who was referred from Adult PEPFAR (Presidential Emergency Plan for AIDS Relief) clinic to the Mental Health clinic because of repeated visits to the PEPFAR to request HIV test. A diagnosis of HIV/AIDS delusional disorder was made and she was started on treatment including psychotherapy. After nineteen weeks of treatment, the delusion had completely abated and she had insight. The repeated presentation by an individual for HIV test should raise the suspicion of the presence of HIV/AIDS delusional disorder.

Introduction:

When an individual holds the belief that he or she is infected with HIV/AIDS in the absence of evidence and despite contrary evidence, such an individual is said to suffer from HIV/AIDS delusional disorder[1,2]. There is paucity of research on the subject and it appears there has been no prior report of HIV/AIDS delusional disorder in Nigeria, though HIV/AIDS delusion has been reported as occurring in other psychiatric conditions[3]. The quick recognition of the condition is important. Therefore, the aim of this study is to create awareness on this disorder, raise the clinical index of suspicion and comment on its treatment outcome.

KEYWORDS: *HIV, AIDS, Delusion, Delusional Disorder*

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Case report:

We report a 42 year old employed single mother of one who was referred from Adult PEPFAR (Presidential Emergency Plan for AIDS Relief) clinic to the Mental Health clinic. She was referred because of repeated visits to PEPFAR to demand that she should be tested for HIV/AIDS and started on HIV/AIDS treatment even though prior HIV tests have been negative and she did not have features or risk factors for HIV/AIDS.

Nine months prior to presentation she came to believe she was infected with HIV/AIDS. She was on admission for road traffic accident (RTA) at the time in a private hospital. She claimed she began to observe that the members of the team treating her were behaving strangely towards her. She thereafter concluded that their behaviour was because the staff had discovered that she was HIV positive (even though no HIV test

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was done for her at the private hospital). There was no loss of consciousness or injury to the head from the RTA. Upon discharge she thereafter moved from one facility to the other where she requested HIV tests that were always negative. She was never reassured by these negative results; instead she concluded that she was being deceived, her true HIV status was being kept away from her in a bid to deny her treatment; so that she should die from the infection. She made contact with the few men she had had sexual intercourse with in the past and told them she was HIV positive and that they needed to go test themselves. They all reported to her that they were HIV negative but this did not reassure her. She also severally tested her daughter believing that she may have infected the daughter. The daughter's tests were all negative. Eventually, she was referred for psychiatric evaluation.She had no prior history of mental illness and no known family history of mental illness. She did not use psychoactive substance and her medical history was unremarkable. Assessment of her mental state showed a well dressed lady who was crying (on account of persistent refusal by medical teams to offer her treatment for HIV/AIDS), non-bizarre delusion of being infected with HIV/AIDS and a lack of insight. Other aspects of her mental state were normal. Thorough physical including neurological examination did not show any abnormality.

A diagnosis of HIV/AIDS delusional disorder was made and she was started on tablet risperidone, injection flupenthixol decanoate (because it was doubtful whether she would comply with oral medication) and supportive /cognitive behavioural psychotherapy. After seven weeks she began to entertain doubt about her HIV status and nineteen weeks after commencement of treatment the delusion had completely abated and she had insight.

Discussion:

A delusion is a "fixed belief that is not amenable to change in the light of conflicting evidence". It is a belief based on wrong conclusion that is held on to firmly in the presence of contrary evidence and such belief is not compatible with the individual's culture, education or social background[1]. A delusional disorder describes a psychiatric illness characterised by delusions involving situations that are possible, such as being infected, having a disease, poisoned, love or spouse infidelity (non-bizarre delusions). The delusion should persist for at least one month[1]. Genetic, biochemical and psychological factors have been postulated as aetiological factors of delusional disorders[4-6]. Generally, it is commoner in females and the mean age of onset is 40 years, but ranges from 18 to 90 years[4,7,8]. The diagnosis is predicated on the presence of persistent non-bizarre delusions (if mood or other psychotic symptoms are present, they are related to the delusion and are fleeting) that is not attributable to the use of a medication, substance or general medical condition[1]. Other features include self-reference, irritability, aggressiveness and depression[9]. The patients are usually well groomed without evidence of disintegration of personality or daily activity. They may seem eccentric, odd, suspicious or hostile. Mental Status Examination is usually normal except for delusion. If abnormality of the mental status occurs it is usually consequent upon and in keeping with the delusion. The patient lacks insight and thus they are usually first seen by other medical specialists before psychiatrists[10]. It should be noted that patients who have delusional disorder should be assessed for suicidal and homicidal tendencies since they are at risk of these complications[11]. Delusional disorders must be differentiated from such disorders as Hypochondriasis. The patient who has hypochondriasis is usually able to doubt, at least for a short while, their conviction of being ill when presented with reassuring data for example negative HIV test result. In Mood disorder with psychotic symptom, delusion of having HIV/AIDS may occur. But the mood disorder is of longer duration than the delusion and the delusion usually remits with treatment of the mood disorder. While

in schizophrenia there is prominence of other psychotic symptoms, the delusions may be bizarre and usually there is psychosocial disruption. In Factitious Disorder and Malingering the patient enjoys primary or secondary gain from having the delusion[12].

Many clinicians consider delusional disorder to be resistant to treatment[13], but this may not be entirely correct. Treatment includes the use of antipsychotics, antidepressants, electroconvulsive therapy and psychotherapy[5,14-22]. Although delusional disorder is primarily a psychotic illness requiring antipsychotic, antidepressants often have a role because depression or depressive symptoms often accompany the delusion[22]. Admission should be considered if the nature of the delusion puts the patient at risk of violence, suicide or homicide. The antipsychotics that have been used include pimozide, olanzapine, risperidone, clozapine and haloperidol. Antidepressants that have been used include the selective serotonin reuptake inhibitors and clomipramine. Munro and Mok[23] who reviewed 209 articles published from 1980 to 1994 had sufficient grounds to assert that delusional disorder has an acceptable measure of good prognosis when properly treated. They further stated that response to treatment was positive regardless of the content of the delusion. It has been reported that in cases that do not respond, non-adherence to the prescribed drugs is a common and significant factor to be considered[24]. The mark of successful treatment may be a better social adjustment rather than abatement of delusion. Manschreck and Khan reviewed 134 cases of delusional disorders published from 1994 to 2004[22]. They classified outcome into three groups which included recovered, improved and no improvement based on symptomatology at follow-up. A patient who had no symptom at follow-up was described as recovered while one whose symptoms had not changed was identified as a case of no improvement. They thereafter reported that 49.3% recovered, 40.3% improved while 10.4% had no improvement. They stated clinical implications thus: “Pessimism about whether delusional disorder can be treated is not consistent with the evidence in the recent literature; and overcoming potential adherence issues and addressing the dysphoric nature of the illness also appear essential to achieving treatment success”. It is worthy of note that they observed no significant difference in outcome among pimozide, other typical and atypical antipsychotics.

Most delusional disorders are often preceded by an identifiable stressor, coping and coming to terms with such stressor is essential to successful treatment. Factors portending a good prognosis include; high level of occupation, good social and functional adjustment, female sex, onset before age 30, sudden onset, short duration and presence of precipitating factor[25]. Those who have a high level of occupational attainment, good social and functional adjustment are more likely to be able to cope with the stresses that often precede the onset of delusional disorder. They are also more likely to be able to access resources that may prove useful to their recovery. Female patients are more likely to enjoy more social support than males. Generally, sudden onset psychotic illnesses are more likely to readily draw attention and therefore more likely to present early for treatment. Short duration is likely to imply that complications and or comorbidities have not set-in while it is expected that if precipitating factors is identified and removed or ameliorated, the delusional disorder may abate. Younger patients may have more resources at their disposal.

Conclusion:

The repeated presentation by an individual for HIV test should raise the suspicion of the presence of HIV/AIDS delusional disorder. This will facilitate prompt referral to psychiatric facility where appropriate care

can be provided for the patient.

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