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AN APPROACH IN COUNSELING AND PSYCHOSOCIAL CARE FOR HIV POSITIVE PATIENT: A CASE STUDY

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Abstract
The patient Mr. M., who had the test result of HIV positive suffered from severe depressive disorder. It was found that the patient required intensive and phased counseling to manage his depression. The patient was involving in high risk sexual behavior and also had other behavior problems like addiction to alcohol. In addition the patient was malnourished. Counseling session started after establishing good rapport with the patient. The sessions helped the patient to understand the meaning of HIV positive and positive living. The patient was found to gain confidence when he understood the benefit of getting diagnosed for HIV at the earliest and also developed hope to live positively. Further the sessions in the department of psychiatry focused on safe behavior practices. Importance of condoms after becoming positive was shared and the patient accepted that he should not infect others and also he had to take care of his viral load count. Finally nutritional counseling was given to make him understand how nutrition could play a vital role in the disease progression. The patient's myth that nutritious food meant eating thrice a time rice and non-vegetarian food was cleared. Low cost nutritious food and methods of developing his nutritious food habits were focused. The counseling sessions helped him to come out of his fear of death and his worries about his illness and family. These efforts lowered his level of depressive disorder.

Key Words: HIV Patient, Depressive Disorder, Management.

INTRODUCTION

Mood influences much on a patient's outlook and perception of self and others and his environment. He experiences abnormally depressed mood which is a pervasive emotional tone. The symptoms affect all areas of functioning as they occur with history of a long term stress. The onset of depressive disorder begins in the ages of 30 years and the disorder may or may not have the psychotic symptoms of delusion and hallucination. The depressive disorder is a chronic disorder and is persistently present most of the days. The symptoms become worse when the day progresses on. It is commonly seen in women rather men with insidious attack (Kaplan, & Sadock, 1999). The patients can be sarcastic, nihilistic, brooding, demanding, and complaining with resistance of therapeutic interventions. The patients have changes in appetite and sleep patterns, low self-esteem, loss of energy, psychomotor retardation, decreased sexual drive, and obsessive preoccupation with health matters (Gelder et al, 1996; Hales, Yudofsky, & Talbott, 1999; Kaplan, & Sadock, 1999).

Moore, Vosvick, and Amey, (2006) reported that care giving demand, role captivity, and job conflict were positively associated with self-reported depression and suggested that work-related strains and role strains were associated with depression levels among caregivers (D'Cruz, 2004). The present study attempts to incorporate psycho social care of family members for the remission of depressive disorder in the patient.

OBJECTIVES

They were i) to use counseling strategy for the management of depressive disorder in HIV positive patient and to assess depression at follow up.

METHOD

Design

The patient with HIV positive, who was suffering from symptoms of severe depression for 2 months, came to the hospital. Antidepressants and anxiolytic drugs were administered and then it was decided that phased counseling would be suitable to treat the patient. The duration of the counseling was 15 sessions, each for 50 minutes session. Self report and family members' report were collected to understand the changing behavior of the patient, especially to increase confidence, practice of healthy habits and nutrition.

Measure

Depressive Status Inventory (DSI) (Zung, 1972). It provided a global measure of the intensity of depressive symptoms. It was a self-rated scale consisting of 20 items which were rated on either a 0-4 spectrum (0=none/absent and 3= severe). The total score consisted of the sum of the items of the inventory. Zung scores were interpreted as follows: <50, within normal

range; 50–59, minimal to mild depression; 60–69, moderate to severe depression; >70, severe depression. A severity index could be calculated by dividing the total score by 80 (the total possible).

Data were collected before, after and follow-up by using the scale to measure the level of depression of the patient. Before, after and follow-up scores were 71, 59 and 56.There had been remarkable reduction in depression in the patient.

Sample

The patient Mr. M. who had the symptoms of difficulty in breathing, fearfulness, sleep disturbance, feeling of hopelessness, not able to do work, loss of appetite, fear about future, suicidal ideas and palpitation, came to the hospital for treatment. He was a dhobi of 46 years old, and had two wives. His first wife had one daughter who got married. Second wife had two sons and they lived separately after their marriages. He also had multipartners who had high risk sex behavior. He reported of unsafe sexual practices. The patient developed initially fever, and tiredness. He also had loss of sleep and his appetite was also decreased markedly. He was advised by his friends to get tested for HIV and the test results showed positive status. After this, he developed problems which hindered his normal routine life. He started hopeless, helpless and worthless feelings. He had crying spells and suicidal ideas. He developed fear of death and stigma towards the disease. He did not have a similar episode in his remote past.

Personal history revealed that his developmental milestones were normal. His marriages were a non- consanguineous and arranged one and the second one was consanguineous. He had extramarital affairs and the habits of drinking alcohol and smoking. No history of mental illness, suicide, epilepsy, asthma, diabetes, and head injury, was reported in his family.

On mental status examination, he was aesthenic build, and fairly clean and tidy. He was cooperative while interviewing him. His talk was relevant and coherent with low tone. He had a fearful and depressed mood and a retarded psychomotor activity. He did not have the psychotic syndromes of delusion and hallucination. He had orientation to time, place, and persons. He had good immediate and long term memories but he had disturbed short term memory. He did not have the disturbances of judgment and insight. He had a good rapport with the therapist and the doctor. The diagnosis was done as HIV with depressive disorder because the symptoms met the criteria of depressive disorder (DSM-IV TR) (Kaplan & Sadock, 1999).

PHARMACOLOGICAL MANAGEMENT

The drugs -Cap. Prodep- 20mg 1-0-0, Tab. Dothip- 50mg 0-0-1, Tab. Rivotril- 0.5mg 0-0-1- were given to the patient by the psychiatrist for the entire period of treatment.

PSYCHOLOGICAL MANAGEMENT

Besides taking drugs, psychosocial care was given to the patient. It was a short term program oriented to the current problems and their resolution. To begin with, reading material on coping with depression was given. The focus of the therapist was to recognize the nature of the dysfunctional thinking. During the counseling / therapy session, mood shift helped the therapist to identify the automatic thoughts. Observing strong emotions such as irritability, anxiety and depression, the patient was asked to describe the thoughts that went through his mind just prior to mood shifts. He was instructed to recognize schemas (core belief or basic assumptions) on his own for psycho-education was used to explain the concept of schemas and their linkage to superficial automatic thoughts (Beck, 1995). After identifying schema, he had to do pro and cons analysis; it induced his to doubt the validity of the schema and to start think of alternative explanations. Modifying schema included examining evidence, listing advantage and disadvantage, generating alternatives and cognitive rehearsals. In cognitive rehearsal, he had to imagine various steps in meeting and mastering a challenging task and to rehearse various steps of it. The counseling session helped the patient to understand meaning of HIV positive and positive living. Behavioral intervention used to change dysfunctional patterns of behavior (e.g. hopelessness) to reduce troubling symptoms (e.g. intrusive thoughts) and to assist in identifying and modifying maladaptive cognitions (e.g. activity schedules) with mastery and pleasure when he engaged in each activity). A weekly log was employed in which he recorded what he did during each hour of the day and rated each activity for mastery and pleasure. The patient was found to gain confidence when he understood the benefit of getting diagnosed for HIV at the earliest and also developed hope to live positively. He reviewed the data in the next session with the therapist. In graded task assignment, a behavioral goal was broken down into small steps that could be taken one at a time to solve a part of the problem. The sessions focused on safe behavior practices. Importance of condom after becoming positive was shared and the patient accepted that he should not infect others and also he had to take care of his viral load count. Further nutritional counseling was given to him to make him understand how nutrition plays a vital role in disease progression. The patient's myths on nutritious food were addressed and he was advised to start of low cost of nutritious food

habits. He was instructed to stop dysfunctional behaviors e.g. crying spells and diverted them from intrusive thoughts by engaging activities such as play, physical activity. Role play was used as it could be a particularly powerful and useful technique to elicit automatic thoughts and to learn new behavior (Kendell & Panichelli-Mindel, 1995). The present research confirms the findings of earlier researches of Patrick et al, 2004; Kovacs, Rush, and Bech, (1981).

REPORT OF THE PATIENT

The patient was able to eat and sleep well and to do work. He did not make the complaints of difficulty in breathing, fearfulness, and sleep disturbance. He involved in pleasurable activities and handled situations successfully without much worry.

REPORT OF THE FAMILY MEMBERS

His sad emotion disappeared remarkably. Irritability that he showed with the family members and friends had changed. He had good relationship with others. He did not worry much and he was alert and energetic. He functioned effectively in social and occupational areas when compared to his past.

CONCLUSION

The counseling sessions helped him to come out of his fear of death and his worries about his illness and family. Changes in his cognition and behavior helped him lowered his level of depressive disorder.

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