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Contents: Hospital Anxiety and Depression Scale/Pseudo-AIDS, AIDS panic, or AIDS phobia/Self-inflicted eye injuries/Paranoid psychosis and AIDS/Ganser syndrome/Age of onset in schizophrenia/Anthropology and psychiatry/The dopamine hypothesis, viral theory of schizophrenia, and season of birth/Barking mad/Screening for hepatitis B in the mentally handicapped/Maternity blues and post-partum euphoria/Characteristic plasma hormone changes in Alzheimer's disease/Down's syndrome with mania/Dopamine hypothesis of neuroleptic drug action/Lithium, psoriasis, abnormal glucose tolerance, and thyroid dysfunction/Disulfiram reaction during sexual intercourse/Prasad's syndrome/'Criminal Law and Psychiatry'.

Hospital Anxiety and Depression Scale

SIR: May I comment upon the correspondence (*Journal*, December 1987, **151**, 861–862) arising from the study of depressed mood after stroke and the use of our Wakefield Depression Scale. The observation that this scale was an unsuitable instrument for the study is certainly correct. In fact, the concept of 'depression' covered by that instrument is too broad, since it is composed of a wide spectrum of symptoms, including those of anxiety and of somatic reference. We have long considered it to be redundant, and now advocate the use of the Hospital Anxiety and Depression (HAD) Scale (Zigmond & Snaith, 1983). The HAD Scale was designed for use with patients suffering from physical illness, and is an improvement on other self-assessment instruments since it avoids items, e.g. insomnia and anorexia, which are as likely to result from physical illness as from mood disorder. The HAD Scale provides a clear separation, in its two subscales, between the constructs of anxiety and depression and its ability to do so has recently been upheld in a validation study (Bramley *et al*, 1988). The depression subscale concentrates on the anhedonic state, which we take to be the nearest clinical marker to the biogenic mood disorder likely to respond to physical treatment (Snaith, 1986). In fact, the need to detect this state in medical and surgical patients and to differentiate it from the wider concepts of demoralisation and grief was the impetus which led to our devising the HAD Scale. The scale has the further advantages of providing score ranges indicating different levels of morbidity, of having been translated into most European and many Asian languages, and finally of being freely available, with scoring device, from the Medical Sciences Liaison Services of Upjohn Ltd, Fleming Way, Crawley, West Sussex RH10 2NJ.

Finally, Dr Wade states that he is not aware of "any simple measure of depression which could be used in a large number of elderly people". I should therefore like to draw attention to another validation study (Kenn *et al*, 1987) in which the HAD Scale was presented for use in the elderly; bearing in mind the difficulty of completion of a self-assessment scale in people who have suffered strokes, become blind, or have some other handicap, the authors of that study have presented the scale as a clinician-administered scale.

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Pseudo-AIDS, AIDS Panic, or AIDS Phobia

SIR: Riccio & Thompson (*Journal*, December 1987, **151**, 863) appropriately indicate that the term 'AIDS-phobia' is a misnomer, and that the fear of AIDS may be part of the content of any psychopathology (affective, obsessional, schizophrenic, or delusional disorders). In general, one would agree that the fact that AIDS is the content or object is of little

significance in the diagnosis or treatment of the disorder, which should be carried out in the usual way, i.e. a common feature of the psychiatric illness, with AIDS concern as a symptom, is hypochondriasis.

However, to avoid missing the obvious, one must not exclude consideration of the possibility of genuine cause for concern, as instanced by two recent male patients who were pathologically preoccupied and terrified that they might have picked up the disease. The first was a basically anxious somewhat hypochondriacal individual aged 60 years, who acknowledged past passive homosexual activity, and the second, a known manic-depressive aged 45 years, confessed his involvement with a prostitute abroad early in 1987.

The first patient required ECT, but the second fortunately responded to conservative antidepressant therapy. Their affective disorders appeared to have heightened awareness of their past sexual contacts and possible consequences, rather than having caused the depression, which was not relieved by pre-test counselling and demonstration (fortunately) that they were HIV sero-negative.

Fenton (*Journal*, November 1987, **151**, 579–588) noted: "Individuals, not only those belonging to the high-risk groups, and known in some cases to be sero-positive but in others not, have developed a terror of and intense preoccupation with AIDS leading to multiple somatic complaints with a conviction of suffering from the disease". Perhaps, then, rather than the terms 'AIDS phobia', 'AIDS panic' or 'pseudo-AIDS', more apposite descriptive and diagnostically acceptable terms might be 'AIDS-concern' or 'AIDS-anxiety'.

Finally, from experience as a consultant AIDS counsellor, if psychiatry does indeed become a 'front-line' speciality in the management of AIDS victims, then provision for staff education (and allocation of financial resources) must be undertaken promptly, not least to minimise the number of 'secondary' cases of this AIDS-related condition among the caretakers.

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SIR: I refer to the letter from Riccio & Thompson (*Journal*, December 1987, **151**, 863) commenting on the earlier report by Miller *et al* (*Journal*, May 1985, **146**, 550–551). I wish to endorse their and others' views, particularly O'Brien's statement (*Journal*, July 1987, **151**, 127) that "What is important in patients presenting with excessive concern about AIDS, but without the disease, is not AIDS itself, but the underlying psychiatric state".

On reading the original report by Miller *et al*, I expressed my views (*Journal*, August 1985, **147**, 210) making this very point, adding: "Surely we need no further confusion in our already confusing and loose nosology. Do we call a depressive illness characterised in part by either hypochondriacal, overvalued or frankly delusional ideas of cancer (even if the patient has been recently in contact with a cancer victim) a 'pseudo-cancer' syndrome?" I included comments on the article by Miller *et al* that "What they actually describe, however, are two manifestations of psychiatric disturbance characterised *in part* by a fear of AIDS resulting in significant impairment but, contrary to the title of the article, they do not convincingly describe "the psychiatric symptoms resulting *from* a fear of AIDS", which they wish to refer to as 'pseudo-AIDS'. Both these patients were at high risk of contracting AIDS, and further I fear that the invention of a 'pseudo-AIDS syndrome', set against the backcloth of the difficulty of diagnosing AIDS itself in the early stages, might prejudice the diagnosis of AIDS where it actually exists".

It behoves us psychiatrists to be extremely prudent in our use of words, especially so when words might become labels, as labels not infrequently assume the quality of an entity. The history of psychiatry is replete with examples of how words have not clarified issues for us and our patients but have added to the problems which already existed!

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Self-Inflicted Eye Injuries

SIR: The article by Rogers & Pullen (*Journal*, November 1987, **151**, 691–693) was of much interest as a psychiatric curiosity. Essays such as this, emphasising descriptive psychiatry, are a welcome relief from the usual stuff these days, much of it on epidemiology, surveys, questionnaires, and reports on patients with heavy reliance on complaints and symptoms, i.e. subjective phenomena generated by and reported by patients. It seems to me that a complaint is different from a symptom. In descriptive psychiatry we need to emphasise objective evolution based on signs.

Symptoms and signs often seem to be confused, and may be lumped together. 'Symptom' is from the Greek (*semeion*) and 'sign' from the Latin (*signum*). Stedman's dictionary defines semiology (semeiology) as symptomatology, which may be not strictly