the total duration of symptoms was 6.2 weeks (range 3–22). The premorbid personalities of patients included obsessional (8), anxious/hysterical (6) and others (6); and in the rest we could detect no abnormality. Only half the patients had some form of mental disorder: obsessive-compulsive disorder (4), depressive illness (2), schizophrenia (2), and various anxiety syndromes (4), including panic disorder.

The clinical course varied considerably: less than half (11) showed complete remission of symptoms after simple reassurance or a couple of sessions of supportive therapy. At the end of three months, only five patients had persistent symptoms of AIDS panic. The most distressing symptoms were severe anxiety syndromes and depression (suicidal symptoms in five), and in four there was evidence of delusions or hallucinations. Seven patients required no specific treatment apart from reassurance in the out-patient clinic, 11 were seen regularly for supportive therapy, seven received benzodiazepines, two antidepressants, and two neuroleptics.

Detailed analysis has been submitted for publication, but the findings described above show that AIDS panic has a more complex aetio-pathogenesis than that suggested by Jacob *et al*. It illustrates the dangers of making sweeping generalisations about clinical phenomena which have many and varied contributions from constitutional as well as environmental factors.

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Not a Case of Pseudo-AIDS

SIR: *Case report*. A 30-year-old married serviceman presented with the complaint that he believed that he had AIDS. He had no previous psychiatric history and presented to his GP complaining of vague physical symptoms which he ascribed to AIDS. He denied any homosexual contact or any heterosexual contact outside marriage. He claimed that he had been exposed to risk of infection with the human immuno-deficiency virus in a fight with an unknown assailant. The history was not suggestive of AIDS, and there was no clinical evidence of the syndrome. Despite reassurance he presented on several further occasions with the belief that he had AIDS. He was therefore eventually referred for AIDS counselling and testing.

While awaiting counselling the patient again presented to his GP and on this occasion admitted to symptoms of depressive illness with lowered mood, sleep disturbance, loss of interest, and tearfulness. His GP made a diagnosis of depressive illness and started treatment with doxepin. Approximately one week later the patient's mood appeared to be lifting. He did not appear over-concerned about AIDS. However, before the negative results of testing were received, the patient hanged himself, having put his affairs in order and having taken precautions against discovery.

This patient was managed by his GP, who made a diagnosis of depressive illness and initiated treatment with antidepressants. Unfortunately the patient killed himself early in treatment. The point in question is the significance of the initial presenting symptoms of fear of AIDS and whether this man represented a case of 'pseudo-AIDS' as described by Miller *et al* (*Journal*, May 1985, **146**, 550–551).

Miller presented two cases of pseudo-AIDS, one with an anxiety neurosis and one with a depressive illness. It has long been recognised, however, that the content of psychopathology can be influenced by current themes. What is important in patients who present with concern about AIDS in the absence of the disease is not so much AIDS, but the underlying illness which gives rise to the symptoms. We should concentrate not on the question of AIDS, but on making the correct diagnosis. The significance of the presenting symptom of worries about AIDS is not that there is a specific pseudo-AIDS syndrome but that we should be aware that we may see large numbers of patients in whom AIDS figures as the content of the phenomenology. This is not something which is specific to AIDS, but is a result of the fact that AIDS is the most important new disease which we have to face in this century and is a major part of the public consciousness at this time, being prominantly portrayed in the media. We need to be aware, not only that the fear of AIDS may give rise to psychopathology, but, perhaps more importantly, that the psychopathology of illness may be coloured by the collective fear of AIDS which exists and which is likely to grow in the wake of the government's publicity campaign. We are likely to see patients who are suffering from a wide variety of psychiatric illnesses all presenting with worries about AIDS.

Miller states that there is a clear need for clinicians to be alerted to the likelihood of psychiatric complications arising from fear of AIDS in their homosexual patients. It appears likely that this advice is correct, but already out of date in one important aspect: AIDS is no longer purely a disease of homosexuals and drug addicts. Growing numbers of cases are arising as a result of heterosexual transmission. It is important that we remember that a wide range of psychiatric illnesses in heterosexual patients may also present with fear of AIDS.

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