group are more difficult to follow up, and may have constituted a significant proportion of the 12 who were not followed up in Sydney. In both the endogenous and the neurotic group 17% were always incapacitated by their illness or committed suicide. Yet when the London criteria were applied, only 9% and 12% in the respective groups had a very poor outcome. The poor outcome group in Sydney, therefore, appears to have been underestimated.

It is interesting to note that both groups have come up with findings that contradict their previously firmly-held but opposed beliefs about the endogenous-neurotic dichotomy. Both groups used a neurotic-endogenous classification for the cohort. When the Sydney group reclassified their cohort using DSM–III criteria they found that their sample covered the entire range of depressive illness from major depressive illness to adjustment disorder. The same spread of diagnoses may apply to the London cohort. This highlights the heterogeneity of both the samples, and casts doubts on the conclusions they make. It would, therefore, be a pity if these papers stimulated more wasteful research into the validation of the endogenous and neurotic categories.

Both studies clearly show us that a significant proportion of depressed patients do poorly in the long term. The findings of two major studies conducted in the pre-treatment era (Lundquist, 1945; Rennie, 1942) are broadly similar to those of the present studies. We wonder why it is that, almost 50 years later, with innumerable treatment methods at our disposal, we are still faced with such a dismal outcome for depression. Are we not using these therapeutic tools appropriately, or are they of no use in ameliorating the poor long-term outcome? It is unfortunate that neither of the current studies have attempted to correlate outcome with treatment. There is clearly a need for further long-term prospective studies into the outcome of depression and the effect of different treatment methods, both short and long-term, on prognosis. We hope the findings of these studies will stimulate further research into this rather neglected and difficult area.

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AIDS hypochondriasis

SIR: Todd (*Journal*, February, 1989, **154**, 253–255) describes five cases of unwarranted concerns about AIDS, "which cover a wide range of psychopathology". In several of the non-psychotic cases, there are similarities with cases of primary hypochondriasis (DSM–III–R; American Psychiatric Association, 1987), a diagnosis which has not been considered. Examination of these similarities may improve the understanding of the processes involved in such cases.

In a cognitive-behavioural formulation of primary hypochondriasis, it has been suggested that the central feature is the persistent misinterpretation of innocuous bodily sensations as indications of physical illness (Salkovskis & Warwick, 1986; Warwick & Salkovskis, 1989). As in these examples, the bodily sensations involved may be the result of a wide range of conditions, such as anxiety states, trivial physical disorders, or normal bodily variations. The resultant erroneous perception of threat to health inevitably leads to anxiety. This anxiety will be associated with a variety of other clinical features, such as avoidance, reassurance seeking, and guilt, and may resemble phobic or obsessive-compulsive states. In this view, the misinterpretation is the primary problem, and the other clinical features should be regarded as secondary phemonena, rather than "symptomatic of an underlying psychiatric disorder".

Consideration of hypochondriasis along cognitive-behavioural lines also has important implications for treatment, which are clearly illustrated by the results of Dr Todd's cases 3 and 5. Clinical experience suggests that some patients who are labelled 'poorly motivated' in fact experience high levels of anxiety, which may make them reluctant to carry out exposure treatments. It is likely that successful treatment of such cases will need to include *direct* attention to the beliefs and misinterpretations responsible for this anxiety, along with treatment directed at *secondary* symptoms. A cognitive approach may help such patients to correctly attribute their sensations and hence facilitate exposure and response prevention. Dr Todd rightly makes the point that these cases often do not respond to simple reassurance, yet case 3 "required repeated reassurance between outpatients appointments". In both hypochondriasis and obsessive-compulsive disorder it is recognised that the provision of repeated reassurance can reinforce and prolong the patient's fears (Warwick & Salkovskis, 1985). Reassurance can take the form of unnecessary physical consultations, examinations,

and investigations. Once the patient's physical state has been thoroughly evaluated, none of these should be repeated without clear clinical indication. Successful treatment should teach the patient alternative methods of dealing with their concerns. Case 5 illustrates both these points successfully. The use of cognitive techniques and hyperventilation control will undoubtedly have helped this man to make more accurate interpretations of the cause of his symptoms. He sensibly refused the HIV test, for which there was no clear indication, and hence did not reinforce his anxieties.

Presentations of this type are not peculiar to AIDS. Any illness receiving publicity is likely to be associated with unnecessary concern in some individuals, other examples being syphilis or cancer. However, Dr Todd's AIDS cases serve as a timely reminder that the classification of unnecessary concerns about *all* illnesses is confused and needs clarification. It is often possible to diagnose both hypochondriasis (a somatoform disorder) and an anxiety disorder in the same case. There are no clear guidelines as to which diagnosis takes precedence, although the recent addition of an arbitary six-month duration as a criterion for DSM–III–R hypochondriasis will lead to this diagnosis being made less frequently. However, the principles of the management of the disorder should always be used where appropriate in the treatment of cases of unwarranted somatic concern.

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Journal contents page

SIR: I was dismayed to find that the contents page for the Journal is no longer provided on the back cover, but inside where it is less easily glanced at. I am not aware that advertising revenue is particularly required – I believe that the Journal makes quite a lot of money for the College – and I hope the Editorial Board will revise its decision in placing the contents page inside the Journal. If it doesn't, I think it would be fair for advertisers to know that many readers will never look again at the back cover! If the purpose of the change is to facilitate binding, which certainly applies to only a small number of the published copies, perhaps a provision of a contents list for binding might be dealt with by a different means, as the needs of the general readership of the Journal are surely paramount. I hope my comments may invite some debate on this small but important unannounced matter.

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SIR: I do hope the experiment of having the list of contents on the third leaf of the Journal will end soon. Surely the front or back cover has become popular for good reason, namely ease of reference. I don't believe advertising revenue should be allowed to alter this. Perhaps, if it is unavoidable to have an advertisement on the back cover, it could be done in such a way as to allow removal of it to reveal the list of contributors.

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I am sorry that Drs Wrate and Lambert do not approve of the change to the back cover. As Dr Wrate says, the present arrangement is much more convenient for those subscribers who bind their journals. However, I agree with Dr Lambert that the new sequence of pages at the front of the issue doesn't seem to be the best possible, and a different version is now being tried. A comparison of other leading monthly journals shows a great diversity of arrangements, but most have advertising on the back cover when they can get it.

I am dismayed by Dr Wrate saying he is "not aware that advertising revenue is particularly required", in view of the enormous efforts made by the Journal staff to produce a financial surplus, which is essential to keeping the College going. I would suggest a careful look at the Annual Accounts for recent years. The alternative would be an enormous (and in the end, self-defeating) increase in subscription rates.

HUGH FREEMAN

Editor, British Journal of Psychiatry