vacation after vacation, sunbathers may expose themselves almost exclusively to ultraviolet A. Although they may obtain a tan without burning, they nevertheless suffer cutaneous damage similar to that from ultraviolet B.⁸ And, unlike what happens after ultraviolet B irradiation, their recurrent exposure to ultraviolet A gives them very little protection against further damage from ultraviolet radiation.⁹ Furthermore, other disorders largely exclusive to ultraviolet A may occur—such as photosensitisation by drugs and creams¹⁰; unusual freckling¹¹; fragility and blistering of the skin¹²; and many photodermatoses (most merely annoying but some potentially life threatening),¹³ to which perhaps one in five people are susceptible.¹⁴

What should be done? Must we avoid sunscreens altogether and return to a more natural existence, seeking instead clothing and trees for shelter? Perhaps not—although this might be a more sensible approach—for help now seems at hand. Sunscreens that more effectively block ultraviolet A are being developed.¹⁵ These contain either absorbent chemicals (which carry a risk of irritation or allergic contact sensitisation) or, more effective if not quite vanishing, formulations of inert reflectant particles such as titanium dioxide. As yet, however, no agreement has been reached over how to measure the efficacy of such sunscreens,¹⁶ and the matter is currently the subject of heated scientific and commercial debate and disarray. Until further advances are made the product packs on retailers' shelves will convey this confusion to the consumer by their varied and uncertain terminology. Though perfection

has yet to be attained, come summer and the next vacation, choosing a cream combining a high sun protection factor with good protection against ultraviolet A seems well worth while.

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Phobias and related anxiety disorder

Treatment with behavioural exposure can be quick, inexpensive, and effective

About one in 10 people develop an anxiety disorder some time during their lives (A Weizman *et al*, world congress of biological psychiatry, Philadelphia 1985).¹ Agoraphobia, other phobias, obsessive-compulsive disorder, and post-traumatic stress disorder cause much misery and handicap to sufferers and their families. They consume many health care resources, even though less than half the sufferers found in community surveys have sought help for their problem (A Weizman *et al*, world congress of biological psychiatry, Philadelphia 1985).¹

The diagnosis is easily missed but is quickly revealed by a few judicious questions. One is "Do you avoid things that most people wouldn't mind for fear of discomfort; if yes, what things?" Red, excoriated hands in a compulsive handwasher may be misdiagnosed as allergic dermatitis; the truth springs from briefly inquiring into undue washing and fear of dirt. Palpitations and dizziness in agoraphobic panic may be misattributed to heart or ear disease for failure to ask, "Do your symptoms occur mainly in public places (street, crowds, shops, buses, trains, and auditoriums)? and do you avoid these places because they cause fear or panic?" Intermittent depression frequently complicates anxiety syndromes and may mask the underlying disorder.

Untreated anxiety disorders often continue for decades and are present for an average of nine years before treatment is sought.^{2,3} This delay is partly due to sufferers' slowness to seek help because of fear of stigma and partly to them and their doctors not knowing that effective treatment is available.

Most anxiety disorders improve with treatment by behavioural exposure.² It is reliable and cost effective, and its benefits usually continue to follow up at six years.⁴ During

treatment the patient is persuaded to confront the hitherto avoided situations that bring on his or her typical fear, panic, or the urge to wash or check. Remaining in those situations, enduring the resultant discomfort, leads to gradual habituation over the next hour or so. Using an exposure manual⁵ the patient plans and carries out such exposure exercises as daily homework until the situations are tolerated easily with minimal discomfort, records these exercises in an exposure homework diary, and brings this to the clinician for discussion at intervals. Exposure may also have to be to avoided thoughts ("listen for at least an hour daily to a Walkman tape recorder on which you have recorded discomfiting thoughts").

Improvement usually appears within days, and the exposure programme can be completed within weeks or months, depending on the size of the problem. Relatives can help to monitor the exposure programme, praise progress, and learn to withhold the addicting reassurance that makes matters worse. About three quarters of sufferers offered behavioural treatment complete it,² a compliance rate better than in much other treatment. Most completers benefit—with much reduced distress, avoidance, family burden, and demand on health care resources. Sufferers become able to resume care of their children and home and to work again.

The key is regular self exposure with some guidance from a clinician. Little is gained either by accompanying the patient during exposure⁶⁻⁸ or by teaching relaxation.² A fashionable addition to exposure is cognitive therapy, which teaches patients to change irrational automatic thoughts. Such thoughts decline anyway during exposure without cognitive therapy, and whether outcome is enhanced by adding cognitive therapy to exposure therapy is still debated.

Patients with anxiety disorder who consult doctors seem more likely to get a psychotropic drug than psychological treatment. Though side effects may be troublesome, an antidepressant drug is a useful aid to exposure therapy when depression complicates the picture.³ Whether particular drugs fit particular anxiety syndromes is much debated. Benzodiazepines are probably best avoided as their effects are limited, and they may reduce benefit from exposure.⁹ Relapse is usual on stopping psychotropic drugs but not on stopping exposure therapy.

Many self help groups give information and support for anxiety disorders. A lay group in Bath helps sufferers improve with self exposure (C Bonham-Christie, European Association of Behaviour Therapy, Paris 1990); spread of its self exposure format to other groups could relieve many sufferers. In controlled studies with follow up, self exposure for phobias was as effective when guided by a manual⁵ or a computer program as by a psychiatrist,¹⁰ and depression¹¹ and obesity¹² responded as well to guidance from computers as to guidance from psychologists. Early work suggests that obsessive-compulsive disorder is helped by computers.¹³ Some forms of care could be extended economically by making well tested self help manuals and computer programs more widely available—for example, in general practitioners' surgeries, other clinics, and self help groups. Effective self help aids can

ease the load on clinicians. Perhaps pharmaceutical and other companies might market such aids, diversifying to become therapy companies.

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Stephen Lock retires

Achievements with the BMJ but also internationally

Stephen Lock, who has been with the *BMJ* for 26 years—16 of them as editor, left the journal last week. Anyone who wants to begin to understand how Stephen changed the journal should look at an issue from 1974 and one from 1990. The new design (introduced in 1988) stands out; but the many changes in content over the previous 10 years or so were more important.

Readers tell us that in the past two decades the *BMJ* has become a more interesting, enjoyable read; what Stephen did was to balance the research papers with more journalistic sections—personal views, medicine and the media, book supplements, Minerva, and, most recently, the expanded news. With Stephen as editor the *BMJ* defended the abortion legislation; covered topics such as nuclear warfare, alcohol, and housing; and campaigned for medical audit and for better financing and organisation for the NHS. Timing has been one of his key talents: repeatedly he has highlighted issues before they have become of major importance. Stephen introduced the very popular Christmas edition—a mixture of humour, history, and culture—with a new cover each year commissioned from an artist he chose. Recent readers of the *BMJ* may not realise that only in the past 15 years has this issue come to be full of illustrations from classic and modern artists and of good writing about all sorts of subjects—reflecting Stephen's own interests. And the research articles that bring music and medicine together have been another pointer to his tastes—he gives his first recreation in *Who's Who* as “as much opera as possible (before Stockhausen).”

Yet while broadening the appeal of the *BMJ* to general readers Stephen also made important changes to the reviewing system for research articles. He introduced the “hanging committee” (taking its name from the committee at the Royal Academy that decides which pictures to hang in the summer exhibition), which each week assembles two clinicians and

two in house editors to decide the papers to accept from those recommended by our outside referees. He pioneered the referral of all papers chosen by the hanging committee to a statistician—and most weeks nowadays the hanging committee includes a statistician.

Stephen has also been active internationally, having taught medical writing all over the world and being a former president of the European Association of Science Editors. Most important of all, he was one of the founders of the International Committee of Medical Journal Editors (the Vancouver group), which has had a profound impact on medical journals everywhere. It was no mean feat to bring together editors from around the world in a relaxed, informal forum where they could speak their minds. Probably because of its informality the group has achieved much with references, ethics, statistics, and editorial standards.

Research into the processes of scientific publishing is still in its infancy, but Stephen has been one of the leaders of this development. His analysis of the whole concept of peer review and how it works in practice, published in 1985 as *A Difficult Balance*,¹ was recognised around the world as a major contribution to the academic discipline of scientific editing.

That, indeed, though less obvious to most readers than the changes in the *BMJ*, may be Stephen Lock's most lasting achievement; he has encouraged, stimulated, and helped his contemporaries in scientific editing to make their profession one with established ethics, guidelines, and standards.

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¹ Lock SP. *A difficult balance: editorial peer review in medicine*. London: Nuffield Provincial Hospitals Trust, 1985.