to a small figure. As long as we remain in ignorance on these points, however, it is almost impossible to form any accurate judgment of the outcome of the "experiment". In my *Handbook of Abnormal Psychology* (1960) I discussed at some length desirable and necessary criteria for outcome assessments, and Lazarus (1961) has demonstrated how such procedures can be objectified in the case of phobic disorders.

I feel that it is justifiable to conclude from Marks and Gelder's review that when an outdated and experimental type of behaviour therapy is applied to phobic patients by inexperienced novices without any training in behaviour therapy, and the outcome compared with traditional methods by means of a subjective estimate of unknown reliability, it is found that at no point is behaviour therapy inferior, and in relation to phobias other than agoraphobia it is superior. We would not at any point have considered these early self-training results worthy of exhumation, and the studies examined by Marks and Gelder were certainly not designed to prove or disprove any claims on behalf of behaviour therapy; it is surprising and welcome to find that even under these conditions behaviour therapy did no worse, and in some connections rather better, than traditional methods of therapy. Certainly the result suggests that a similar study, using up-to-date methods and a highly reliable method of assessment, carried out on the performance of trained and experienced behaviour therapists, would show very much better results. One such experiment is in progress at the moment in my Psychology Department, and preliminary results seem to bear out this prognosis.

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DEAR SIR,

In their retrospective study of the effects of behaviour therapy (*Journal*, July 1965, pp. 561–573) Drs. Marks and Gelder concluded that this technique produced results which were equal to (and in certain cases, better than) those yielded by conventional psychotherapy. Their report may, however, give rise to certain mistaken impressions. I feel that they do not stress sufficiently the fact that in the majority of their cases the type of behaviour therapy administered consisted of an early, rudimentary procedure (practical re-training). Professor Wolpe, whose results are discussed in their paper, virtually discarded this method more than ten years ago in favour of ideational desensitization and other lesser techniques. A direct comparison between the Maudsley results and those of Wolpe, Lazarus and others is therefore neither feasible nor fair. As I have attempted to argue elsewhere,* the clinical and experimental results so far available are, in the main, consistent with Wolpe's findings. Furthermore, the few patients in the Marks and Gelder series who received "Wolpeian" treatment appear to have responded rather better than those treated by practical re-training.

I understand that Drs. Marks and Gelder are currently assessing the effectiveness of the Wolpeian technique, and their findings on this topic are awaited with interest.

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* RACHMAN, S. (1965). "The current status of behaviour therapy." *Arch. gen. Psychiat. (Chic.)* (in the press).

DEAR SIR,

We do not appear to disagree fundamentally with Dr. Snaith. We accept that patients with agoraphobia differ in many ways from other phobic patients and this is precisely why we divided our group in this way. We are continuing to examine these differences in further case material, but think it premature to conclude that anxiety neurosis underlies all agoraphobias.

Many advocates of behaviour therapy still maintain that *all* neuroses are collections of maladaptive learned responses and that all can be treated by deconditioning. This may be true only for certain neurotic syndromes. For this reason, like Dr. Snaith, we consider that results in different neurotic syndromes should be reported separately.

Professor Eysenck asks about the "considerable