REFERENCE

TOKSVIG, S. (Ed.) (1965). *Swan on a Black Sea: A Study in Automatic Writing*. London: Routledge.

BEHAVIOUR THERAPY

DEAR SIR,

A clinician even vaguely familiar with the literature and practice of "behaviour therapy" cannot help but be dismayed at an article like that of Marks and Gelder in your July 1965 issue, "A Controlled Retrospective Study of Behaviour Therapy in Phobic Patients". Although one must be impressed by the care exercised in matching treatment and control patients in terms of deviant behaviour, age, and so forth, there is absolutely no control in terms of actual treatment. To be specific, on p. 564 the authors point out that the behaviour therapy patients often received as wide a variety of ministrations as relaxation-hypnosis, systematic desensitization, barbiturates, and, yes, two E.C.T.s and one leucotomy. How can one overlook this utter disregard of the most elementary and basic criteria of experimental design? All the numbers in the world (e.g. duration of treatment, outcome of treatment on a five-point scale, etc.) are meaningless as a result.

A further criticism is in the use of the term "behaviour therapy" to refer to Meyer and Gelder's technique of gradual *in vivo* exposure or "practical retraining" as they call it. It is especially puzzling to see this unjustified generalization of the phrase "behaviour therapy" in the same article which, in its first paragraph, points up the widely differing nature of psychotherapeutic techniques which are subsumed, for better or for worse (and, in my opinion, for worse) under the rubric of behaviour therapy or conditioning therapy. I have myself been involved in a treatment programme quite similar, in parts, to Meyer and Gelder's (Lazarus, Davison, and Polefka, 1965); we never considered our successful therapy as any sort of vindication of "behaviour therapy", however.

Let me commend Marks and Gelder for their emphasis on the importance of non-desensitization or non-practical retraining factors in treating even relatively simple neurotic disorders. After controlled experimental studies have established the actual conditioning bases of "behaviour therapy techniques" —and this kind of work has only just begun, references below—we will do well to examine any "non-learning" factors of which, I suspect, most practitioners considering themselves behaviour therapists are keenly aware. Arnold Lazarus of South Africa has stressed these non-specifics for several years now. On the other hand, it seems premature to *assert* that learning principles cannot be found to account for aspects of therapy which go beyond the desensitization couch or the syringe loaded with apomorphine.

Ambitious attempts at evaluating various therapies are surely to be encouraged and reinforced. However, it is misleading to publish articles which are so unsatisfactory on methodological grounds. As a fellow "behaviour therapist", I can only hope that investigators like Drs. Marks and Gelder will be more careful in specifying the referents of their terms.

GERALD C. DAVISON.

Veterans Administration Hospital,
Palo Alto,
California.

REFERENCES

DAVISON, G. C. (1965). "The influence of systematic desensitization, relaxation, and graded exposure to imaginal aversive stimuli on the modification of phobic behavior." Unpublished doctoral dissertation, Stanford University, Stanford, California.

LANG, P. J., LAZOVIK, A. D., and REYNOLDS, D. J. (1966). "Desensitization, suggestibility and pseudotherapy." *J. abnorm. Soc. Psychol.* (in press).

LAZARUS, A. A., DAVISON, G. C., and POLEFKA, D. (1965). "Classical and operant factors in the treatment of a school phobia." *Ibid.*, **70**, 225–229.

DEAR SIR,

Dr. Davison's comment on the design of our study misses the point. It was a retrospective inquiry; we collected all the phobic patients who had received behaviour therapy in this hospital from 1960 to 1963. Since we found that it had been customary clinical practice to use behaviour therapy as part of a wider plan of treatment (which sometimes included drugs and occasionally E.C.T.) we collected a control group, with similar clinical features, who had received a similar amount of drugs and E.C.T. The one patient who had a leucotomy and behaviour therapy was matched by a similar patient who had had a leucotomy but no behaviour therapy. Comparison of the two groups revealed the contribution of behaviour therapy over and above that of the other treatments.

The design undoubtedly shows the effect of an active treatment: for example, it shows up the useful effect of behaviour therapy in less severe phobias, and of modified leucotomy in severe agoraphobia (to be published). We cannot accept, therefore, that our findings result merely from poor design.

Dr. Davison has decided that practical retraining should not be called behaviour therapy. Unfortunately he has not provided his definition of the