given (1) in fantasy or in practice, (2) individually or in groups, (3) at varying speeds, (4) with anxiety heightened or lessened, (5) with or without 'psychodynamic' cues present, (6) with frightening cues which are relevant or irrelevant, (7) with differing durations of sessions and (8) of intersession intervals, (9) with differing intervals between fantasy and *in vivo* flooding, (10) with fantasy flooding sometimes imposed externally by the therapist and sometimes abreacted spontaneously by the patient, (11) with differing endpoints of a given session (is it best to end on a good note?), (12) by tape-recorder or by a live therapist, (13) with or without coping instructions, and the nature of these.

As work proceeds doubtless other minutiae will also appear potentially relevant. Generalizations about 'flooding' will only become accurate when the relevant conditions have been dissected out in detail. Some of these conditions are undergoing investigation in many centres, and from these useful generalizations should eventually become possible. Meanwhile, reports of exposure research will be interpreted more easily if they specify the experimental condition in more detail, including these 13 variables. Workers in the field need to develop an agreed vocabulary for describing research on exposure treatment.

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DEAR SIR,

We agree with many of the points made by Dr. Marks, but wish to clarify some differences:

(1) We defined, at the beginning of our paper (p. 446), those factors which we considered 'non-specific'. Encouragement to practise counter-phobic behaviour was included in these because it seems to be common to many different approaches to treatment. Our conclusion merely states how much effect might be attributable to the sum total of the components which we defined.

(2) We do not say there were no important differences between treatments during the *in vivo* phase; on the contrary, difference did exist in '. . . the hierarchy levels used and degree of anxiety tolerated' (p. 448). Thus, patients were vigorously encouraged to tolerate greater anxiety and more difficult situations during flooding than in desensitization, although we did not continue verbal flooding during practice sessions.

'(3) Dr. Marks states that *in vivo* exposure is 'much more therapeutic' than exposure in fantasy. There is no unequivocal evidence for this, since studies such as Stern and Marks (1973), like our own, use designs in which interaction between treatment phases is possible and even to be expected. For example, it may be that agoraphobic patients improve rapidly during *in vivo* treatment only after previous exposure in fantasy (p. 460). We are carrying out research to test this, by comparing *in vivo* practice given alone with combinations of fantasy and *in vivo* treatment.

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DEAR SIR,

The suggestion of M. G. Gelder *et al.* in their paper that revision of the current explanations of desensitization and flooding is needed prompts me to write this letter.

While this letter is neither a criticism nor an endorsement of behaviour therapy, I would refer to Locke (1971), who believes that behaviouristic procedures contradict every major premise of behaviourism, and to Wilkins (1971), who asserts that the effectiveness of the procedure is not due to the mutual antagonism between muscle relaxation and anxiety but rather to social variables involved in the patient-doctor relationship and to cognitive variables, including expectancy of therapeutic gains, information feedback of success, and so on.

If one accepts these views, considering the therapeutic results are favourable, one has to assume that perhaps the behaviour therapists are doing the right thing for the wrong reasons.

After sifting the accumulated wealth of material and both observing and carrying out behaviouristic therapy, I have come to the conclusion that perhaps desensitization and flooding are based on certain and