capacity to synthesize this enzyme—though they do not entirely lack it—is not inconsistent with the Oxford report. Temporary suppressions of the already deficient enzyme, and the quantitative relationship between it and the substrate (gluten), could account for the episodic nature of multiple sclerosis; and in a population subsisting on a high gluten-containing diet the differences between normal subjects and heterozygotes in remission may be too subtle to be discerned by the immunological tests.—I am, etc.,

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Possible Retroperitoneal Fibrosis and Methysergide

SIR,—Following the initial report by Graham¹ of retroperitoneal fibrosis in two of 500 patients under prophylactic treatment with methysergide (Deseril) for various forms of severe recurrent migraine, Utz *et al.*² have recently described three cases of this condition in patients on long-term methysergide administration in varying dosage over 20 months, 22 months, and two years respectively. Utz *et al.* state: "A direct causal relationship between methysergide and retroperitoneal fibrosis has not been established by the presentation of these three cases."

The association, if there be one, is at present puzzling and is complicated by unpublished information from the United States which reports that, in cases treated with methysergide, symptoms and pyelographic changes suggestive of retroperitoneal fibrosis may disappear within a few days or weeks following drug withdrawal. Such patients have all been under continuous treatment with methysergide for eight months or longer.

Retroperitoneal fibrosis, a rare condition of uncertain aetiology, was first described by Ormond in 1948³ when methysergide was not available. It typically presents with persistent loin or flank pain and urinary symptoms of oliguria and/or dysuria. Impaired venous return and/or thrombophlebitis in lower limbs may be seen, and very rarely arterial insufficiency is described. In this event pyelographic evidence of hydronephrosis should be sought and renal function examined. If the patient is on methysergide therapy, drug withdrawal is mandatory.

It is advised, in view of this possible complication, that urinary tract dysfunction should form an additional contraindication to drug administration. Continuous methysergide administration should not at any time exceed six months without a drug-free interval of at least one month for reassessment. Review of patients already treated continuously for periods longer than this would be wise, and regular clinical supervision in all patients is recommended.

Investigations in experimental animals are being carried out to clarify this problem. In

the meantime we draw it to the medical profession's attention and request that any available information on this subject be brought to our notice.—I am, etc.,

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Behaviour Therapy

SIR,—The recent comparative analysis of the results of behaviour therapy by Drs. J. E. Cooper, M. G. Gelder, and I. M. Marks, appearing in the *B.M.J.* (8 May, p. 1222), provides a timely warning that some aspects of neurotic illness may be resistant to this treatment approach. Some of its more ardent protagonists have claimed that *all* neurotic symptoms are due to learning (or the failure to learn), which has led to overreaching claims for therapy based on learning theory. Such claims have aroused not only scepticism but also antagonism, and have endangered the wide acceptance of a therapeutic tool which is of undoubted value if applied selectively.

The condition called "agoraphobia," on which the authors have based much of their work, is a case in point. It is evident that this term, coined by Westphal in 1872 and meaning literally "fear of the market place" has led to much confusion. The term is generally applied to widespread fears of being away from a "secure" environment, and the suffix phobia places it squarely alongside other phobic conditions, such as animal phobias. The majority of "agoraphobic" patients suffer from generalized (=free-floating) states of anxiety, whereas the sufferers from true phobias as a rule do not. In most cases the symptoms of "agoraphobia" are best explained as a mere heightening of generalized anxiety in situations in which a patient already suffering from continuous anxiety and apprehension feels himself to be even more insecure; if this view is accepted it is clear that such a condition does not usually arise through "learned" mechanisms, and that a pure "unlearning" technique of therapy cannot be expected to succeed, except in so far as it incidentally provides environment and relationship, which tend to inhibit the generalized anxiety state.

Assessments of the results of behaviour (learning theory) therapy must concentrate on only those symptoms and syndromes which can fairly be thought to be learnt. There is much clinical material available on which to make such an assessment. The authors claim that "monosymptomatic" phobias are rare conditions; this is not my experience and I have recently found a dozen such patients to treat within the space of six months in a psychiatric service covering a population of less than 100,000.

One further comment: future assessments of behaviour therapy must include many more details of the actual technique. For instance, I have found that hypnosis as opposed to simple muscular relaxation based on Jacobson's techniques is a valuable adjunct and may even shorten treatment; not only can

the patient "imagine" the feared situation far more vividly under hypnosis, but instant calming can be produced by mere word of command as soon as tension is manifest. A further example: the authors give no details of their approach to the treatment of obsessional neurosis; yet there has been a recent suggestion¹ that behaviour therapy of this condition requires a two-pronged attack, not only to the compulsive behaviour, but also to the underlying anxiety-elevating factors; and that treatment of one without the other is likely to produce only a spurious and unstable improvement.—I am, etc.,

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REFERENCE

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SIR,—Drs. J. E. Cooper, M. G. Gelder, and I. M. Marks claim (8 May, p. 1222) to have conducted a controlled study of behaviour therapy in 77 patients manifesting various phobic and obsessional symptoms. However, "In addition, all patients were subject to the usual hospital influences and were given a variety of drugs, supportive interviews, and other treatments." The presence of so many variables which could have been controlled is surely undesirable.

The tone of the article suggests that the authors are sceptical of the value of behaviour therapy. Such an attitude cannot be criticized so long as it does not interfere with the methods employed. The fact that the above-mentioned treatments were not denied the patients suggests either poor design or lack of faith in the treatment on trial. As the influence of suggestion cannot be eliminated from either behaviour therapy or psychotherapy, neither being suitable for the double-blind control type of trial, perhaps the negative attitude in respect of behaviour therapy on the part of the authors accounts for the poorer results they obtained than did Wolpe.

An interesting minor theoretical point is raised by the question of training of behaviour therapists. In reply to Wolpe's criticism¹ of Cooper's earlier study²—viz., that the therapists were unskilled—the authors point out that similar results were obtained after treatment by both therapists with extensive knowledge of learning theory and by student psychologists and psychiatric registrars, and they "consider that the relevant skills are derived more from clinical experience in treating neurotic patients than from detailed knowledge of learning principles." Does this latter statement mean that all neurotic patients receive a form of behaviour therapy? If so, the controls are no longer controls.—I am, etc.,

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Abuse of Digitalis

SIR,—Please accept my heartiest congratulations on your leading article about the abuse of digitalis (8 May, p. 1208). What a pity somebody did not write it 20 years ago.