cent were referred with the intention that behaviour modification might be useful in conjunction with other treatments. The reasons for referral in 3 per cent of cases was unclear.

For each patient the main psychiatric diagnosis was obtained from the medical notes at the time of referral. These diagnoses are rank-ordered in the Table.

Main psychiatric diagnosis of 115 patients referred for behaviour modification

Diagnosis	N	Diagnosis	N
Anxiety state	37 (32%)	Alcoholism	3 (3%)
Agoraphobia	15 (13%)	Behaviour disorders	3 (3%)
Other phobias	14 (12%)	Hysteria	3 (3%)
Sexual problems	13 (11%)	Schizophrenia	2 (2%)
Personality disorders	12 (10%)	Depression	2 (2%)
Obsessional states	6 (5%)	Other	5 (4%)

Full desensitization or relaxation alone (Goldfried, 1971) formed 80 per cent of all the treatments, with operant conditioning technique and aversion therapy accounting for only 4 per cent and 2 per cent, respectively. For 12 per cent of their referrals the clinical psychologists considered that either psychotherapy or counselling (admittedly not clearly distinguishable) was a major part of the treatment.

We kept records of the amount of time taken up by treatment. Six months after the end of the survey 96 of the 115 patients had completed treatment. These 96 had an average of 11 treatment sessions each with 87 per cent of the sessions lasting one hour. A minority of patients (15) were seen for over 20 sessions.

Discussion

Generalizations from one hospital group are clearly unwarranted, but if the one studied here is at all representative behaviour modification would seem to have established itself, albeit modestly, as one of the possible range of treatments offered within the National Health Service.

In this survey it appears that the patients referred by the psychiatrists as potentially able to benefit from behaviour modification mainly have problems of the kind treated by Wolpe (1958) in his original work. The predominance of desensitization and relaxation techniques is obviously related to the kinds of patients referred, but one cannot be certain of cause and effect here since it is quite possible that psychiatrists, knowing that certain techniques are frequently used by clinical psychologists, will refer patients who they think will benefit from those techniques. We have the impression that since our survey was completed a wider variety of techniques If this is so it reflects the widening variety of problems tackled by behaviour modification techniques which are reported in journal articles at the present time.

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BRITISH ACADEMY OF PSYCHOPHARMACOLOGY

DEAR SIR,

I have just learned of the proposal, by an eminent group of neuropsychopharmacologists in the United Kingdom, to form a British Academy of Psychopharmacology (*Journal*, **124**, 1974, 508). Such a proposal has much merit, as anyone who has followed this field closely is well aware of the great contributions made by British investigators. The United Kingdom has more than enough highly qualified persons to constitute such a group.

The American College of Neuropsychopharmacology, now in existence for fourteen years, has provided a common meeting-ground for the exchange of ideas among the many disciplines which this field embraces. Our membership is limited to 185 Fellows and 35 Members and Scientific Associates. Our small membership, deliberately kept so as to keep the meetings relatively informal, has limited the privileges of membership to residents of North America. The formation of a British Academy of Psychopharmacology would provide a formal channel of communication between English-speaking neuropsychopharmacologists on both sides of the Atlantic. Many of us, but by no means all, are also members of the Collegium Internationale Neuropsychopharmacologicum, whose biennial meetings provide only a limited exchange of information between workers in North American countries and those in the United Kingdom.

So we welcome the formation of the British Academy of Psychopharmacology and fully expect it to thrive.

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