Behavioural Psychotherapy, 1987, 15, 101–103

Correspondence

To the Editor,

Cognitive therapy of obsessive-compulsive disorder: treating treatment failures. *Behavioural Psychotherapy,* 1985, 13, 243–255.

In this article, Salkovskis and Warwick describe the apparently successful use of a treatment based on Beck's cognitive therapy to potentiate *in vivo* exposure in an obsessional with "overvalued ideation". They argue that cognitive-behavioural interventions may be useful as adjuncts to more "traditional behavioural treatments".

Whilst the development of new strategies in the treatment of obsessional disorders is commendable, we offer the following reservations concerning their article. Firstly, as Kendall and colleagues point out (Kendall and Bemis, 1983; Kendall and Kriss, 1983), there is a logical as well as an historical affinity between specific cognitive-behavioural approaches and particular kinds of disorder, e.g. rational restructuring and anxiety, cognitive treatment for depression, self-instructional training and impulsivity. They refer to the trend that is evident amongst advocates of cognitive-behavioural models to claim an "expanded terrain" of appropriate patient populations, without careful assessment of cognitive errors, deficits or absences that may have aetiological significance in the disorder to be treated. Currently popular, but arguably inappropriate, extensions of strategies may result in inaccurate generalizations about the value of the treatment approach. Beck's cognitive therapy for depression for instance, was not developed from subjects with "overvalued ideation".

More fundamentally, however, we feel that there are alternative explanations for Salkovskis and Warwick's treatment outcome. It is likely that their agglomeration of "cognitive" techniques *viz.* consideration of evidence for and against automatic thoughts, examination of thoughts of worthlessness, the advantages and disadvantages of engaging in obsessional behaviour, etc., in actual fact contain elements of *imaginal exposure* to feared consequences. They themselves stress that their strategy was to tackle the thoughts that resulted from the initial intrusive thoughts, i.e. those concerning the feared consequences of handling the handcream (pp. 247–248). Steketee, Foa and Grayson (1982) state that with obsessive-compulsives who have fears of future harm that cannot be produced in reality, imaginal exposure to fears of future

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catastrophes needs to be added to *in vivo* exposure. It is therefore plausible that the subsequent compliance with *in vivo* exposure and facilitation of habituation in Salkovskis and Warwick's patient was made possible by the reduction of anxiety following the (unintended) imaginal exposure. This explanation appears to us to be more likely than the "cognitive" one they offer, especially since they state that during "cognitive" therapy the patient continued to have "overvalued ideation".

Cognitive therapists claim to be implementing new strategies whereas a closer inspection of what they do often reveals procedures which are not entirely different from those of well established treatments. To quote Ullman (1981): "It is what we do that should be evaluated, not what we call ourselves or our efforts".

Another factor which could account for the improved response to the behavioural intervention is that of spontaneous or drug induced changes in mood state (Beech and Liddell, 1974). According to Salkovskis and Warwick's description, the unsuccessful behavioural intervention took place in the setting of a severe depressive episode, whilst the subsequent more successful procedure was correlated with the remission of the same. We cannot simply assume that the cognitive-behavioural intervention gave rise to the subsequent improvement in mood state (although a possibility): in the absence of further evidence it remains at least equally likely that the potentiation described was consequent upon affective change rather than *vice versa*.

In the light of Latimer and Sweet's (1984) recent review in which empirical comparisons between behavioural versus behavioural plus cognitive interventions provided little justification for the inclusion of a formal cognitive component, caution would seem prudent in the face of the currently fashionable "cognitive" emphasis.

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