Chapter 6

Repetitive negative thinking in eating disorders

Identifying and bypassing over-analysing coping modes and building schema attunement

Robert Brockman and Adele Stavropoulos

Abstract

Research into the cognitive behavioural treatment of eating disorders (EDs) has largely focused on the content *of cognitions and their relation to ED pathology. Yet recent research has demonstrated the relevance of negative cognitive* processes *in the experience of EDs (Smith, Mason, & Lavender, 2018); in particular, the repetitive, abstract and negative way in which individuals with EDs commonly process cognitions, termed Repetitive Negative Thinking (RNT). Theory and research suggest that RNT processes represent an important transdiagnostic maintenance factor across EDs, which may function to block emotional processing. We review a body of research that outlines the potential importance of RNT processes to ED pathology, and present a schema mode conceptualisation of RNT in which high levels of RNT are conceptualised as maladaptive coping (mode) behaviour. Specific therapeutic strategies for bypassing RNT coping in schema therapy (ST) are discussed, including a process-focused approach to building schema attunement.*

At its core, schema therapy (ST) aims to provide deep emotional schema change through the facilitation of *corrective emotional experiences* (Farrell & Shaw, 2017). In general, much research has focused on the *content* of negative self-beliefs and their links with eating disorder (ED) pathology (Waller, Ohanian, Meyer, & Osman, 2000; Waller, 2003). This research has supported the advancement of prominent theories and treatment models that aim to address the core negative cognitive theme thought to be at the heart of all ED presentations: *the over-valuation of body shape and weight and their control* (Fairburn, 2008). While this line of enquiry has focused on negative cognitive *content*, research has demonstrated the relevance of negative cognitive *processes* (e.g. rumination, worry) as central to the experience of EDs (Sassaroli et al., 2005; Rawal, Park, & Williams, 2010). One study found clients with anorexia nervosa (AN) to have significantly higher levels of worry and rumination compared to anxiety disorder groups (Startup et al., 2013). A meta-analytic study by Smith and colleagues (Smith, Mason, & Lavender,

2018) reported consistent associations between rumination and all forms of EDs, and concluded that while the content of ED cognitions may be important, it may be that the repetitive, abstract, and negative way in which individuals process these thoughts could be the most influential feature of ED cognitions. Taken together, these studies indicate that negative thinking *processes* may be an important transdiagnostic maintenance factor across EDs (Smith et al., 2018). These negative processing styles have been termed *Repetitive Negative Thinking* (RNT) (Ehring & Watkins, 2008). This chapter outlines the potential importance of RNT processes to ED pathology, before discussing how to conceptualise and treat ED cases from a ST perspective where high levels of RNT may present as a threat to emotional processing.

Worry has been defined as 'passive, repetitive thoughts about future negative events with an uncertain outcome' (Papageorgiou & Wells, 2004). Such thoughts are often associated with increased anxiety. In contrast, rumination refers to a cognitive process in which one repetitively focuses on the meaning, causes, antecedents, and consequences of negative emotions (Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008). This process tends to be rather passive. When ruminating, people tend to fixate on their problems and associated distress as a covert mental behaviour, reducing their tendency to take overt action to remediate, and potentially disconnecting them from sources of reinforcement. Worry and rumination have been conceptualised as distinct in both thought content (worry involves themes of anticipated threat, rumination focuses on past loss or failure) and temporal orientation (worry is future and rumination past oriented; Papageorgiou & Wells, 2004). However, evidence suggests that worry and rumination appear to share more similarities than differences. Both are repetitive, difficult to control, negative in content, predominantly verbal, and are relatively abstract strategies implemented in response to an initial thought intrusion (Watkins & Moulds, 2005).

In light of these findings, Nolen-Hoeksema & Watkins (2011) proposed a transdiagnostic model, in which rumination and worry reflect the same underlying cognitive process: Repetitive Negative Thinking. RNT is defined as self-focused repetitive thinking that is prolonged, negative in content, and difficult to control (Watkins, 2008). Multiple findings support this model, namely that worry and rumination have been found in individuals with either a mood or anxiety disorder and do not differ depending on the disorder (McEvoy, Moulds, & Mahony, 2013). Additionally, RNT has been found to have more predictive utility for depression and anxiety than rumination or worry individually (Spinhoven, Penelo, de Rooij, Penninx, & Ormel, 2015). Furthermore, treatment specifically targeting RNT has been found to reduce both symptoms of anxiety and depression, providing evidence for the clinical utility of the construct (Nolen-Hoeksema & Watkins, 2011). Thus, despite evidence that rumination and worry are distinct processes, theory and evidence suggest RNT to be the overarching construct underlying both cognitive strategies, which can be differentiated mostly by content and time orientation.

Repetitive Negative Thinking and emotional processing

RNT processes such as worry and rumination have been hypothesised to be problematic for cognitive behavioural treatments because they tend to have the effect of blocking *emotional processing.* First, Processing Mode Theory (Watkins and Teasdale, 2004) suggests that incoming emotional information can be processed via two distinct modes, an abstract analytic (AA) or concrete experiential (CE) mode. The AA mode indicates analysing a situation based on its general causes, consequences and importance through focusing on the past or future. In contrast, the CE mode implies directly processing a situation though specifically experiencing one's emotional state, physical sensations and environment in a way that is both problem and present focused.

Processing Mode Theory proposes that these two processing styles produce distinct functional effects on memory, with the AA mode being maladaptive and CE being adaptive. The CE is adaptive because the abstract overgeneralised memories involved in AA evoke less vivid imagery than concrete specific memories, reducing activation of underlying emotional structure of memory and impeding the natural emotional processing of negative events (Foa & Kozak, 1986). Furthermore, abstract thoughts are less detailed or contextualised than concrete thoughts, promoting poorer elaboration and problem solving (Watkins & Teasdale, 2004).

This account of RNT as representing an AA processing style that blocks emotional processing is also consistent with the hypothesis that worry and rumination may function as a form of emotional avoidance. Borkovec and colleagues (Borkovec, Alcaine, & Behar, 2004) propose an avoidance model of worry which suggests that worry is a verbal-linguistic regulatory strategy that functions to reduce experiencing the full impact of the fear imagery associated with anxiety. From this position it is argued that worry is a predominantly verbal-linguistic process, and that such verbal articulation and elaboration of feared material leads to less sympathetic nervous system activation than engaging in processing of cognitive imagery, which can lead to increased emotional processing, and for some individuals, the feeling of being overwhelmed (Shearer & Tucker, 1981). Worry is thus characterised by abstract thinking, which produces less vivid and frequent images, and is thus less likely to evoke somatic responses (Borkovec & Ruscio, 2001). It is thus proposed by this model that this abstract, verbal linguistic regulatory strategy is reinforced by avoidance of more intense negative emotions inherent in processing imagery. Taken together, these theories and the empirical results that support them, suggest worry and rumination each function as a form of experiential avoidance; because focusing individuals on the verbal content of distressing material limits its emotional impact and gives a sense of control (Moulds, Kandris, Starr & Wong, 2007).

Repetitive Negative Thinking: A schema therapy perspective

It is clear from the above review of the literature that (a) RNT is a transdiagnostic maintenance factor for psychopathology commonly seen in individuals with EDs, and (b) that RNT may be problematic to psychological interventions because it serves as a form of avoidant coping, blocking *emotional processing*. This is entirely consistent with the ST perspective, whereby avoidant attempts to cope with intense emotions and images are conceptualised as *maladaptive coping modes* (Arntz, Bernstein, & Jacob, 2012). From this perspective, coping modes produce some relief from intense emotional states (e.g. *Vulnerable child* (*VCh*), *Angry Child* (*AnCh*)), and cope with external (e.g. work pressure) and internal demands and expectations (e.g. *Inner critic*/*Parent modes*) and are thereby maintained via an avoidance function (Jacob & Arntz, 2012). Further, the theory suggests that such coping states, while potentially useful in some contexts (e.g. during stressful circumstances in childhood), may come at some long-term cost in terms of not being able to meet their own needs, and maintaining early maladaptive schemas (EMS) (Young, Klosko, & Weishaar, 2003). Through the lens of ST, RNT may be viewed as a form of maladaptive coping, either as a part of the repertoire of a broader coping mode (e.g. *Perfectionist-Overcontroller* (*OC*) mode, *Detached Protector* (*DetPr*) mode), or as a coping mode in and of itself (e.g. *Over-analyser mode*; Stavropoulos, Haire, Brockman, & Meade, in preparation). As such, addressing RNT will involve explicitly formulating this process as a part of a maladaptive coping mode, and then applying strategies to bypass the coping mode and connect to the core emotional modes where the schemas can be accessed for *emotional processing* – this is the hallmark of schema treatment (Arntz, Bernstein, & Jacob, 2012). Stavropoulos and colleagues (in preparation) suggest a functional name for RNT modes of processing, 'over-analysing' which can be viewed as a part of a broader coping mode, or which may be formulated as an isolated mode. Stavropoulos and colleagues (in preparation) suggest that this '*Over-analysing mode*' may be defined as

> a focus on the verbal-linguistic processing of past and/or future events (in the form RNT), at the expense of attending to the experiential and emotional features of present experience. The over-analysing mode functions to block the emotional processing of threat schemas, which may result in the maintenance of EMS/ modes (e.g. *VCh* and *AnCh*).

Strategies for bypassing RNT and 'over-analysing' coping behaviour in schema therapy

The core management of coping modes within ST largely involves 'bypassing' coping modes or behaviour so as to engage more fully with emotions, where emotion-focused, and limited reparenting techniques may be successfully applied (Arntz, Bernstein, & Jacob, 2012). We argue that in some EDs (e.g.

AN), this behaviour may be best understood as a feature of the *Perfectionistic-OC* mode. However, it is also possible to conceptualise this behaviour as its own stand-alone coping mode in cases with over-analysing (mental) behaviour but no signs of overt perfectionistic behaviour. Such decisions are likely to be made pragmatically, in consultation with the client, as to what fits best with their experience. What follows is a series of techniques designed to facilitate the goal of bypassing over-analysing coping behaviour that may be blocking the potential for emotional processing within ST sessions. These techniques may also be useful for addressing other coping modes that may serve a similar avoidant function (e.g. *DetPr*).

Education and empathy for the functional role of over-analysing coping

Treatment of any coping mode involves educating and empathising with the client, about the understandable functional role of the coping mode, both in the past, perhaps as a child, as well as currently as an adult. We have found that clients with strong coping modes are more likely to soften their stance if the coping mode feels understood and appreciated. Here, the client's autonomy to give up (or keep) the coping mode intact should be central to the therapy. Clients who feel that a part of them is being attacked are likely to retreat further into their coping mode/s. It is from this position of empathy for the coping mode that the client may feel safe to tolerate and engage in some discussion of the pros and cons of their coping style.

Use of the pros and cons technique

Spend a session really evaluating both sides of the coping mode, considering its adaptive value, both past and present. You can do this using a whiteboard, and can extend this into chair dialogues, offering the client a chair for both sides. This will often lead to a dialogue between the coping mode and the healthy side. For the therapist, it is also important to deeply acknowledge the functionality of the coping mode, so the client may feel safe to explore how the coping mode leads to problems, or blocks your client from getting their needs met. Helping the client stand back and evaluate both sides of the coping mode, how it may work to protect, but ultimately block their needs, tends to trigger a *Healthy Adult* (*HA*) perspective in the session. It is from this position that the client can make an autonomous choice about whether to address the coping mode, and ultimately, engage in the therapy. The goal is to activate and then to 'do a deal' with their *HA* mode. While there is often ambivalence, there is nearly always at least one side of the client wanting flexibility over the coping mode. You will need to get autonomous permission from your client to either reduce, or gain flexibility over the coping mode, or else attempts to bypass the coping may prove unsuccessful, and therapy will likely stagnate (Roediger, Stevens, & Brockman, 2018).

Labeling the coping mode in session

Gently point out and label the coping mode. This builds mode awareness, helping the client to identify cues that they are in a particular coping mode. Mindfully noticing that one is in a coping mode is generally incompatible with being in a coping mode, and reinforces more of a *HA* 'observing' stance in the session, at least temporarily. Over time, clients may learn to recognise themselves going into coping positions without prompting, evidence of progress in building their own *HA* mode.

THERAPIST: I'm just noticing we are getting into that analysing thing again… searching for the answer on why this happened to you [*ruminating*]…I wonder if we could focus on how you really felt at that moment [*attunement, focus on emotions*].

Schema attunement: Building a healthy adult relationship with emotions using the therapy relationship

Schema attunement is potentially the most important intervention strategy the schema therapist has to offer; perhaps even 'the glue of schema therapy' (Roediger et al., 2018). A key skill of any therapist is the ability to listen and empathise. ST strives however to go beyond a standard level of therapeutic skill to provide a much higher level of understanding and attunement, where the therapist is able to communicate to the client the feeling of a deep understanding of the client's 'internal reality'. Erskine (1998) defines attunement as a two-part process that starts with (1) empathy; being sensitive to and identifying with another person's sensations, needs, and/or feelings *and* (2) communicating that understanding to the other person to create the feeling of *resonance.* This has several clear implications within ST for the relational style and skills required of the therapist trying to implement 'Limited Reparenting' strategies. Firstly, the communication of attunement validates the client's needs, feelings, and experiences, laying a foundation for healing the failures of previous interpersonal experiences (Erskine, 1998). Secondly, orientating the client towards their emotional experiencing in this way also lays the groundwork for emotive interventions as it communicates the importance of emotion-focused work, and starts to help the client share, experience, and ultimately tolerate smaller, more manageable amounts of emotional pain. In our experience, problems in the application of emotive techniques can often be traced back to a poor capacity for attunement on behalf of the therapist and/or the client. Therefore, the level of felt attunement between the therapist and client may be a good indicator of readiness for emotion-focused interventions. Finally, attunement aids the therapist's formulation of the specific underlying schemas and needs driving the clinical presentation. Without a high level of attunement, the therapist risks applying

limited reparenting and rescripting techniques in a way that does not specifically target or connect with the relevant underlying schemas or needs. As described, a high level of attunement sets so much of the groundwork for ST that it can be thought of as the 'glue' of ST, a necessary skill/condition that relates to and underpins all four broad ST intervention strategies (limited reparenting, experiential, cognitive, behavioural). A focus on emotional attunement is particularly important in ED populations who often struggle to connect to emotions, and who have for some time now been associated with alexithymia (Cochrane, Brewerton, Wilson, & Hodges, 1993). What follows next is an approach to building schema attunement based on a stepped process outlined by Roediger et al. (2018).

A process-based approach to building schema attunement

1. Focus on specific episodes of distress

Spend a good portion of the session focusing on understanding the client's recent emotional experiences or 'triggers'. This will often be aided with homework such as schema or mode monitoring sheets which will provide you with a prompt about a client's recent relevant triggering experiences. For some clients that are extremely avoidant or who withdraw into over-analysing, finding such episodes of distress may be difficult as they may make little contact with everyday life. For these clients, setting some very mild and scaffolded behavioural pattern-breaking tasks (e.g. socialising, eating meals around others) upfront may be necessary in order to produce some emotions to work on in therapy.

We have found it useful to structure ST sessions such that the first 15–20 minutes of the session are spent discussing any recent triggering experiences. This can often be combined with a check in of any homework tasks, which themselves are often felt to be emotionally triggering. Use this first third of the session to try and attune to relevant experiences. It is usually helpful to slow things down during your attempts at attunement and ask for very specific episodes as people who over-analyse tend to speak quickly and relay quite broad narratives that invariably gloss over the emotional content of any triggers (e.g. quickly linking from one episode to the next).

THERAPIST: So Jackie, you are saying that you have been feeling very upset this week, can you tell me about a specific time when you were feeling this way?
JACKIE: Yes on Monday I felt terrible all day.
THERAPIST: Can you tell me about a specific moment you were feeling upset on Monday, Jackie, perhaps when it was most upsetting for you?
JACKIE: When my mother was being her usual self!

THERAPIST: What exactly was it, Jackie, that was upsetting about the way she was treating you?
JACKIE: It was just her being her usual self, …but it was the look she gave me, it was 'that look' again.
THERAPIST: That look…
JACKIE: A look of disapproval…Like I've disappointed her again.

2. Tune in to the emotional response

This should be done by enquiring as to the nature of the emotional reaction to the triggering event in terms of emotion labels (e.g. 'I felt sad') and/or related bodily sensations (e.g. 'I felt it in my throat').

THERAPIST: And how did you feel when she gave you this look?
JACKIE: I felt anxious…like pressure.
THERAPIST: and where could you feel this pressure or anxiety building up [*in your body*]?
JACKIE: In my head…like a headache.
THERAPIST: [*summarising the understanding so far, and empathising*]: OK, so let's see if I am understanding this right so far…she was screaming at you and giving you the look, and this led to you feeling intense anxiety and a kind of pressure in your head, like a headache?
JACKIE: Yes.
THERAPIST: That does sound hard [*also communicating empathy with facial gesture*].
JACKIE: Yes.

3. Uncover underlying schema/s and needs

In ST, it is important to attune not only to the feelings, but also the underlying schemas and needs driving the distress. In most cases, episodes of distress can be understood in terms of the activation of specific schema/s and needs. Take an enquiring stance to continue questioning about the meaning of the trigger and feeling for them, using cognitive techniques such as downward arrowing and Socratic questioning.

THERAPIST: OK, and I could easily assume why you were feeling that way, but I'd like to check with you. What did it mean to you that she was giving you the look in that way?
JACKIE: I've disappointed her yet again.
THERAPIST: And what would that mean if you disappoint her?
JACKIE: I am a bad daughter. [*activation of emotions becomes evident*]

THERAPIST: Ah… OK, I think I'm starting to get it. Did it kind of feel like you're 'not good enough' again? [*Therapist checks the emerging understanding.*]

JACKIE: Yes, of course. She always makes me feel that way, especially with the look.

THERAPIST: Does that feeling of 'not good enough'…does it capture all of the pressured feeling or is there something else too? [*Therapist checking to see if there are other schemas at play.*]

JACKIE: No that is it, I'm a disappointment to her; nothing I do is ever good enough!

4. Summarise understanding, empathise, and link to historical origins

Tentatively summarise your understanding so far for the client, based on your line of enquiry. Do so, and repeat steps 1–3 as necessary until the client reports a high degree of resonance. Once the client communicates this resonance, offer some empathic statement/s and look for opportunities to link to relevant childhood experiences, making such links explicit.

THERAPIST: OK, so I think I'm starting to get it now, you were hanging out with mum, and like usual, she started picking at you and criticising, but it was 'the look' that really got you feeling anxious, and pressured, and like once again nothing you do is ever 'good enough'. Is that right?

JACKIE: Yes.

THERAPIST: And this makes a lot of sense to me that you would react so strongly, because it's not the first time you have been treated this way. This is kind of like all those other times she would pressure and criticise you growing up, right?

JACKIE: Yes.

THERAPIST: I'm really sorry to hear this Jackie, because I don't think you deserve this from your mother, but at the same time I'm really glad that you shared this with me, I feel like I understand you a lot more, particularly about the relationship between you and mum, and how she has a way of making you feel 'not good enough' so easily.

5. Intensify attunement

If necessary, you may ask the client to close their eyes to increase the level of emotional experiencing, including any bodily sensations. This may be necessary in cases where the coping mode is strong, and the level of emotional activation is low. For clients who can easily process and talk about their emotions, or those that become too easily overwhelmed, this may not be necessary.

6. Move into experiential techniques

High levels of attunement will on most occasions be very validating and reinforcing for clients, but also represent an opportunity to skilfully bridge into experiential techniques.

THERAPIST: This issue of feeling 'not good enough' seems really important for you at the moment Jackie, I'm wondering if it would be a good use of our time if we focus on this feeling or theme of 'not good enough' for some imagery work?

Therapist balance matrix. The matrix in Figure 6.1 represents two important dimensions the schema therapist must be aware of, in order to remain flexible and sensitive to clients' needs from moment-to-moment. One reason that clients become stuck in maladaptive coping is often because they have been overly triggered by negative emotions (e.g. *VCh, Inner Critic (Parent) modes*), and may have started feeling overwhelmed, leading to a strong coping response. This pattern would be represented at the top of the vertical axis. In these cases, careful management of scaffolding emotion focused tasks may be necessary to slowly build efficacy to deal with disturbing emotional content. That is, if the work is pitched 'too high' in terms of the level of emotional activation, you will likely find it more difficult to bypass the coping mode. Conversely, at the bottom of the vertical axis, a strong coping mode such as over-analysing may represent a pre-emptive protective strategy to avoid activation of any negative emotions. In these cases, it could

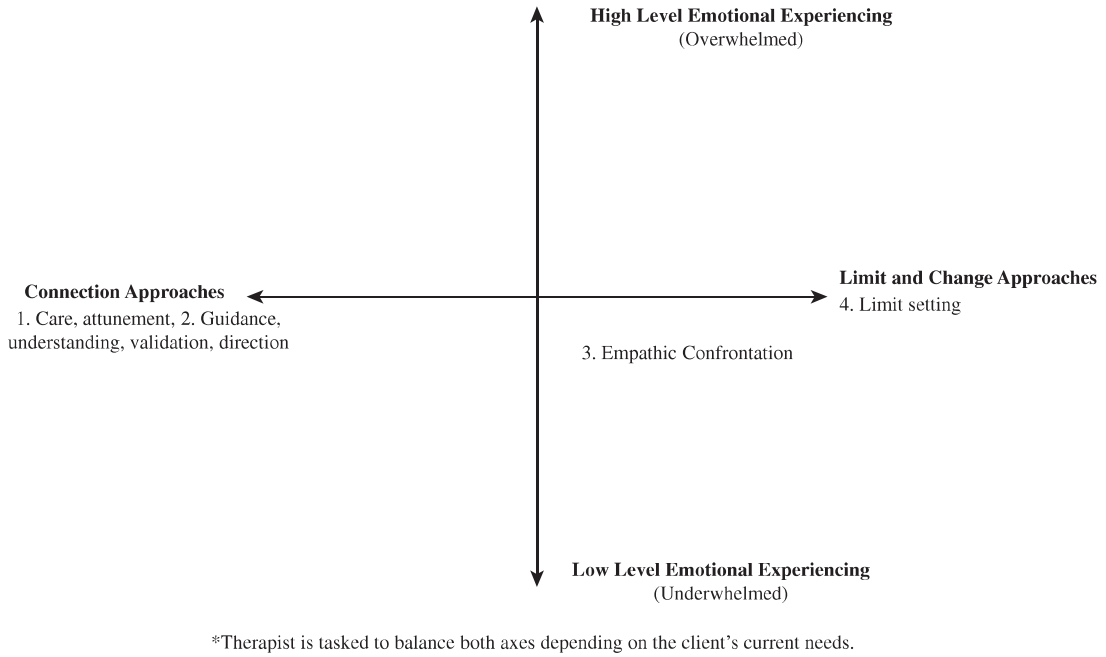

Figure 6.1 Therapist balance matrix

be that the therapist needs to purposely make the sessions more experiential (e.g. by focusing on imagery techniques).

The horizontal axis serves to keep therapists aware that they will also need to balance connection tasks (e.g. care, guidance) with the tasks of empathic confrontation and setting limits. Just as a good parent will find a balance between these approaches, given the child and situation, so too the schema therapist will need to find the right balance. For clients that are over-analysing, some mild empathic confrontation may be necessary to bypass.

THERAPIST: I know it feels more comfortable to explain all of the detail – it's that Over-analyser mode again, but I think it is important to, just for a moment, focus on how you felt in that situation.

This may open up more opportunity to switch to the connection leg on the left of the horizontal axis and engage in attunement as the client may start opening up on an emotional level. As described above, bypassing maladaptive coping and increasing schema attunement is a fluid, unfolding process. The therapist balance matrix may be a useful tool for schema therapists to keep aware of these two important therapist tasks.

Behavioural pattern-breaking techniques

While we have focused practically thus far on within session management strategies to 'bypass' the over-analysing behaviour, within ST it is also important to reverse maladaptive patterns of behaviour in real life so as to disrupt schema maintenance. Several behavioural skills and techniques taken from the broader CBT literature appear to be promising here, including, but not limited to, behavioural activation (Jacobson, Martell, & Dimidjian, 2001), mindfulness skills (Linehan, 1993; , Strosahl, & Wilson, 2011), and process focused CBT approaches (Watkins, 2016). Techniques such as these are promising for breaking the pattern of RNT, helping people connect with a healthier style of self-processing more reminiscent of a *HA* (Roediger et al., 2018). Timing the introduction of behavioural pattern-breaking techniques takes some careful consideration. Ordinarily in ST, these techniques should be implemented more at the back end of treatment, once considerable healing has taken place via the cognitive, emotive, and limited reparenting. However, some clients may benefit from some early focus on very small, graded attempts to pattern-break, particularly for those whose avoidant coping is very strong, and emotional engagement very low. For those with strong over-analyser coping, we have similarly noticed that an earlier focus on pattern-breaking is warranted, as they can assist in overcoming some of the problems of over-analysing behaviour earlier in treatment, increasing emotional engagement.

Conclusion

RNT processes have been conceptualised as a transdiagnostic maintenance factor common to the experience of EDs. Further, these negative processing styles represent a significant threat to ST, which relies heavily on corrective emotional experiences for treatment effects. Treating RNT as representing 'over-analysing' coping mode activity represents a promising approach to formulating and managing these difficult clinical phenomena within a ST approach.

References

Arntz, A., Bernstein, D., & Jacob, G. (2012). *Schema Therapy in Practice: An Introductory Guide to the Schema Mode Approach*. John Wiley & Sons.

Borkovec, T. D., Alcaine, O., & Behar, E. (2004). Avoidance theory of worry and generalized anxiety disorder. *Generalized Anxiety Disorder: Advances in Research and Practice, 2004*. New York: Guilford.

Borkovec, T. D., & Ruscio, A. M. (2001). Psychotherapy for generalised anxiety disorder. *Journal of Clinical Psychiatry*, 62, 37–42.

Cochrane, C. E., Brewerton, T. D., Wilson, D. B., & Hodges, E. L. (1993). Alexithymia in the eating disorders. *International Journal of Eating Disorders*, 14(2), 219–222.

Ehring, T., & Watkins, E. R. (2008). Repetitive negative thinking as a transdiagnostic process. *International Journal of Cognitive Therapy*, 1(3), 192–205.

Erskine, R. G. (1998). Attunement and involvement: Therapeutic responses to relational needs. *International Journal of Psychotherapy*, 3(3), 235.

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*, 99(1), 20–35.

Fairburn, C. (2008). *Cognitive Behavior Therapy and Eating Disorders*. New York: Guilford.

Farrell, J. M., & Shaw, I. A. (2017). *Experiencing Schema Therapy from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists*. New York: Guilford.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2011). *Acceptance and Commitment Therapy: The Process and Practice of Mindful Change*. New York: Guilford.

Jacobson, N. S., Martell, C. R., & Dimidjian, S. (2001). Behavioral activation treatment for depression: Returning to contextual roots. *Clinical Psychology: Science and Practice*, 8(3), 255–270.

Jacob, G. A., & Arntz, A. (2012). Emotion-focused techniques in schema therapy and the role of exposure techniques. In P. Neudeck & H. Wittchen (Eds.). *Exposure Therapy* (pp.167–181). New York: Springer.

Linehan, M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: Guilford.

Moulds, M. L., Kandris, E., Starr, S., & Wong, A.C. (2007). The relationship between rumination, avoidance and depression in a non-clinical sample. *Behaviour Research Therapy*, 45(2), 251–261. doi:10.1016/j.brat.2006.03.003

McEvoy, P. M., Moulds, M., & Mahony, A. E. J. (2013). Are worry, rumination, and post event processing one and the same? Development of the repetitive thinking questionnaire. *Journal of Anxiety Disorders*, 24, 509–519. doi:10.1016/j.janxdis.2010.03.008

Nolen-Hoeksema, S., & Watkins, E. R. (2011). A heuristic for developing transdiagnostic models of psychopathology: Explaining multifinality and divergent trajectories. *Perspectives on Psychological Science, 6*, 589–609. doi:10.1177/1745691611419672

Nolen-Hoeksema, S., Wisco, B. E., & Lyubomirsky, S. (2008). Rethinking rumination. *Perspectives on Psychological Science*, 3(5), 400–424.

Papageorgiou, C., & Wells, A. (Eds.). (2004). *Depressive Rumination: Nature, Theory and Treatment*. John Wiley & Sons.

Rawal, A., Park, R. J., & Williams, J. M. G. (2010). Rumination, experiential avoidance, and dysfunctional thinking in eating disorders. *Behaviour Research and Therapy*, 48(9), 851–859.

Roediger, E., Stevens, B., & Brockman, R. (2018). *Contextual Schema Therapy: An Integrative Approach to Personality Disorders, Emotional Dysregulation, and Interpersonal Functioning*. New Harbinger.

Sassaroli, S., Bertelli, S., Decoppi, M., Crosina, M., Milos, G., & Ruggiero, G. M. (2005). Worry and eating disorders: A psychopathological association. *Eating Behaviors*, 6(4), 301–307.

Shearer, S. L., & Tucker, D. M. (1981). Differential cognitive contributions of the cerebral hemispheres in the modulation of emotional arousal. *Cognitive Therapy and Research*, 5(1), 85–93.

Smith, K. E., Mason, T. B., & Lavender, J. M. (2018). Rumination and eating disorder psychopathology: A meta-analysis. *Clinical Psychology Review*. doi:10.1016/j.cpr.2018.03.004

Spinhoven, P., Penelo, E., de Rooij, M., Penninx, B. W., & Ormel, J. (2014). Reciprocal effects of stable and temporary components of neuroticism and affective disorders: Results of a longitudinal cohort study. *Psychological Medicine*, 44, 337–348. doi:10.1017/S0033291713000822

Startup, H., Lavender, A., Oldershaw, A., Stott, R., Tchanturia, K., Treasure, J., & Schmidt, U. (2013). Worry and rumination in anorexia nervosa. *Behavioural and Cognitive Psychotherapy*, 41(3), 301–316.

Stavropoulos, A., Haire, M., Brockman, R., & Meade, T. (in preparation). *Examining a Schema Mode Model of Pathological Worry, Rumination, and Repetitive Negative Thinking*.

Waller, G., Ohanian, V., Meyer, C., & Osman, S. (2000). Cognitive content among bulimic women: The role of core beliefs. *International Journal of Eating Disorders*, 28(2), 235–241.

Waller, G. (2003). Schema-level cognitions in patients with binge eating disorder: A case control study. *International Journal of Eating Disorders*, 33(4), 458–464.

Watkins, E. R. (2008). Constructive and unconstructive repetitive thought. *Psychological Bulletin*, 134(2), 163–206. doi:10.1037/0033–2909.134.2.163

Watkins, E. R. (2016). *Rumination-Focused Cognitive-Behavioral Therapy for Depression*. New York: Guilford.

Watkins, E., & Moulds, M. (2005). Distinct modes of ruminative self-focus: impact of abstract versus concrete rumination on problem solving in depression. *Emotion*, 5(3), 319–328. doi:10.1037/1528–3542.5.3.319

Watkins, E., & Teasdale, J. D. (2004). Adaptive and maladaptive self-focus in depression. *Journal of Affective Disorders*, 82(1), 1–8. doi:10.1016/j.jad.2003.10.006

Young, J. R., Klosko, M. E., & Weishaar, M. E. (2003). *Schema Therapy: A Practitioner's Guide*. New York: Guilford.

Chapter 7

Experiential mode work with eating disorders

Susan Simpson

Abstract

The schema therapy (ST) model aims to bring about transformational change through working in four main areas: cognitive, behavioural, experiential and interpersonal. Experiential techniques 'fire up' the cognitive work, transcending intellectual change and penetrating early maladaptive schemas (EMS) that are held at a deeply embodied level. The experiential techniques employed in ST are potent mechanisms for reducing entrenched shame and cultivating self-compassion in eating disorders (EDs). It is only by establishing significant shifts in deeply held EMS, that behavioural changes can be established without risk of relapse. A range of experiential techniques are described in this chapter, which can be adapted, depending on the primary coping modes being manifested.

One of the main objectives in ST is to help participants to recognise and distinguish their different 'sides' or modes, with the aim of differentiating and gradually integrating them into a coherent sense of self. Many clients with EDs are 'fused' within a particular coping mode (e.g. *Detached Protector* (*DetPr*), *Overcontroller* (*OC*)) that they identify as 'self'. Whilst acknowledging the functional value of coping mechanisms as a means of dealing with developmental disruptions, the therapist's primary task is to bypass these in order to access underlying painful feelings and emotional needs. The *Vulnerable Child* (*VCh*) side is often hidden behind guarded and resistive coping modes, which we must find ways of bypassing. It is only once we have reached the *VCh* that we can introduce therapeutic healing work.

The behavioural eating responses associated with coping modes are largely resistant to change unless the underlying EMS are also addressed. We do this in ST firstly by helping clients to recognise and gradually accept the existence of the *VCh* – the side of themselves that has suffered as a result of unmet needs during childhood. EDs partly operate through mechanisms that result in a 'shut-down' of physiological [and emotional] needs. Although a significant component of behavioural work takes place once the underlying EMS have been at least partially healed, there is usually a need to explicitly work on reducing behaviours (e.g. restriction or bingeing that poses a severe risk to the client) through empathic