Lawson, R. & Waller, G. (2006). Schema-focused cognitive behaviour therapy with the eating disorders: A brief overview. *New Zealand Clinical Psychologist, 16(3),* 8-12.

Schema-focused cognitive behaviour therapy with the eating disorders: A brief overview

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Introduction

Cognitive behavioural therapy (CBT) is a well-established treatment for the eating disorders. Trials of CBT based on maintenance models of the disorders show good outcomes for bulimia nervosa and binge eating disorder (Agras et al., 2000; Fairburn et al., 1995; Fairburn & Harrison, 2003). In dealing with other eating disorders, CBT for anorexia nervosa has been shown to be no more effective than other therapies, and little evidence at all exists for how to treat the atypical eating disorders (Fairburn & Harrison, 2003; Waller & Kennerley, 2003). A second set of maintenance models has been developed in order to address these shortcomings (e.g., Fairburn, Cooper & Shafran, 2003), and work is underway to evaluate the treatment that is derived from those models.

In dealing with managing those eating disorders that are resistant to current treatments, it has been suggested that models need to take into account more past experiences as causal factors. Cooper (1997) and Waller & Kennerley (2003) have concluded that the schema level of representations (based on cognitive, emotional, behavioural and somatic elements) is the most likely to aid in the development of broader CBT models of the eating disorders. They reason that a complex model of functioning is necessary to work with psychological phenomena such as perfectionism, multiple impulsive behaviours, compulsive pathology and personality pathology (e.g., Fichter, Quadfleig & Reif, 1994; Sansone & Fine, 1992; Waller, 1997). Schema focused treatments may be useful in that they target factors that may underpin these phenomena. Schema focused treatments are proposed to be useful in augmenting existing treatments for the eating disorders rather than replacing them.

Schema research

There is a modest literature examining schemas in the eating disorders. Studies to date have looked at:

- the psychometric properties of some schema measures (Waller, Meyer & Ohanian, 2001; Waller, Ohanian, Meyer & Osman, 2000; Cooper et al., 1997; Luck et al., 2005);
- background experiences leading to the development of unhealthy schemas (Hartt & Waller, 2001; Emanuelli et al., 2004; Sheffield et al., 2005)
- schema content and process relevant to the eating disorders (e.g., Cooper et al, 1997; Leung et al., 1999, Shah & Waller, 2000)
- schema-focused treatment (Leung et al., 2000; Kennerley, 1997; Ohanian, 2002; Cooper, 2003).

The majority of the studies examine cognitive content and process, with fewest studies in the area of treatment. However, drawing any firm conclusions from the literature is made difficult by the use of differing definitions of the term "schemas". Some authors have seen "schemas" as consisting of only cognitive content (e.g., Cooper 1997), while others describe both cognitive content and process drawing upon the Young's (1999) conceptualisation of schemas. Young (1999) describes "early maladaptive schemas" as pervasive themes in thinking about oneself and one's relationships, which begin in childhood and are elaborated on as we grow, but which have become dysfunctional in the present environment. Such schemas include negative core beliefs (content) and schema processes.

It is important to note that the literature described here is limited to female adults, is made up of cross-sectional or correlational studies, and involves those who mostly meet full diagnostic

criteria for an eating disorder rather than those that make up the EDNOS group. There is much more research to be carried out to establish the generalisability of these findings.

Psychometric properties. Studies of the psychometric properties of schema measures in the eating disorders have established good psychometric properties for the full and short versions of the Young Schema Questionnaire (YSQ) (Waller, Meyer & Ohanian, 2001; Waller, Ohanian, Meyer & Osman, 2000). Good psychometric properties have also been established for measures of schema processes (Young-Rygh Avoidance Inventory – YRAI; Young Compensatory Inventory – YCI; Luck et al., 2005), although the subscales that emerge from factor analysis of these scales are not as Young proposed. Cooper et al. (1997) have developed a measure of eating disorder cognitions, including core beliefs, but this does not take schema processes into account.

Relationship to eating pathology. Negative core beliefs have been found to be useful in the appraisal of cognitive patterns in anorexia nervosa and bulimia (Cooper & Hunt, 1998; Cooper & Turner, 2000; Leung, Waller & Thomas, 1999; Waller, Ohanian, Meyer & Osman, 2000). Core beliefs found to be central to bulimic disorders include defectiveness/shame, insufficient self-control and failure to achieve (Waller et al., 2000). However, schema content does not differ between groups with different eating disorder diagnoses (Waller, Kennerley & Ohanian, in press), although there are more pathological core beliefs among those eating-disordered patients with a multi-impulsive presentation (Lawson, Waller, Corstorphine, Ganis & Luck, under consideration). In contrast, schema processes differ across bulimic and restrictive pathologies (Luck et al., 2005).

Background experiences relevant to schemas in the eating disorders. There is evidence that trauma (Hartt & Waller, 2001) and unhealthy family functioning (Emanuelli et al., 2004; Sheffield et al., 2005) are associated with unhealthy core beliefs and schema processes.

Treatment studies. Several case reports (Kennerley, 1997; Ohanian, 2002) describe treatment using a schema-focused approach. These case reports show positive outcomes of SFCBT for eating disorders. Leung et al. (2000) have shown that core beliefs have an impact on the outcome of conventional CBT for the eating disorders.

Models of schemas in the eating disorders

Drawing upon the existing literature, Waller (2004) has developed a preliminary SFCBT model of the eating disorders. This model aims to explain the range of phenomena in the eating disorders, and to account for both the similarity of cognitive content and the discrepancies in cognitive processing across different types of eating disorders. Waller suggests that different schema processes are central to the development of restrictive and bulimic psychopathologies. This model proposes two new constructs to encapsulate the differences that occur in managing affect, and suggests that those constructs distinguish bulimic from restrictive pathology. The constructs are primary and secondary avoidance of affect. Primary avoidance of affect is linked to the process of schema compensation for a maladaptive schema (e.g., engaging in perfectionist behaviours to mask the belief that one is a failure). Following such behavioural and cognitive compensation (e.g., manifestations such as restriction and compulsive behaviours), the maladaptive schema does not get triggered. Thus, painful affect is avoided entirely. Secondary avoidance of affect is linked to the process of schema avoidance. When a maladaptive schema is triggered, the resulting negative affect is dealt with by cognitive and behavioural 'blocking' mechanisms (e.g., binge-eating, alcohol use, self-harm). Evidence to date (Luck et al., 2005) supports this model. Thus, bulimia is marked by secondary avoidance of affect (schema avoidance), while restrictive pathology is linked to primary avoidance of affect (schema compensation).

Summary

Schema focused cognitive behaviour therapy (SFCBT) is a treatment that may prove a useful adjunct to existing treatments for the eating disorders. A moderate literature exists in support of the relationship between pathological schemas and the eating disorders. There is evidence for

the psychometric utility of the measures designed to evaluate this construct among patients with eating disorders, and there is early evidence to support the efficacy of this treatment approach. Development of schema-focused models of the eating disorders has begun, although these still await full testing.

SFCBT should be used with caution (James, 2001) when working with the eating disorders. As has been indicated earlier, one of the key gaps in the literature is the lack of systematic research into the effectiveness of SFCBT in treating eating disorders. At present, there is one randomised controlled trial under way, with patients with bulimia nervosa and binge eating disorder (McIntosh et al., in progress). It will be vital to establish treatment matching criteria - which patients will require this treatment over and above standard CBT. To date, we have little evidence of what criteria would be useful in such treatment matching.

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