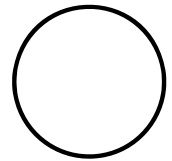


# Schema Therapy for Eating Disorders

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# Focus of talk

- Rationale
- Description of the treatment model
- Schema Therapy for Eating Disorder Group Protocol



# Eating Disorders in Australia

- Estimated to affect approximately 9% of the total population (males and females of all ages) (Weltzin et al, 2005)
- Current population of 22,823,615, more than two million people are experiencing a form of eating disorder.
- 15% of Australian women experiencing an eating disorder requiring clinical intervention during their lifetime (Wade et al., 2006).
- Eating disorders have an overall mortality rate of up to 20%.



# Eating Disorders are Difficult to Treat

- Complex interaction between distorted eating behaviours, psychological distress and physiological disturbance.
- Comorbidity with other mental health and physical illness, increase severity and chronicity (Blinder, Cumella, & Sanathara, 2006).
- Societal factors, such as cultural standards, personal relationships, and community attitudes, play an important role in the prevention or heightened risk for the development of eating disorders
- The interplay between these factors result in an egosyntonic illness



# Limited treatment efficacy of maintenance models

- CBT for BN –Less than 50% achieve clinical recovery at follow-up (Fairburn et al 1995, Fairburn & Harrison, 2003)
- CBT-E –transdiagnostic model (Fairburn, 2009; Byrne et al, 2011) – Reduction in ED symptoms: 56% of completers in full remission
- Approximately 50% of patients with EDs highly symptomatic at 60 week follow-up.
- Attrition rates: 50% (AN); 35% (BN); 37.3% OSFED
- CBT-AN – Efficacy with AN particularly limited with no clear indication of improvement (Bulik, 2007)
- Need to consider treatment models that can address more complex needs of those who do not respond to standard treatments (Jones, Leung, & Harris, 2007).



# Comorbidity with Personality Disorders

- 69% of people suffering with an eating disorder meet diagnosis for at least 1 personality disorder
- 93% have a concurrent AXIS 1 - affective disorder, anxiety or substance misuse (Blinder, Cumella, & Santhara, 2006).



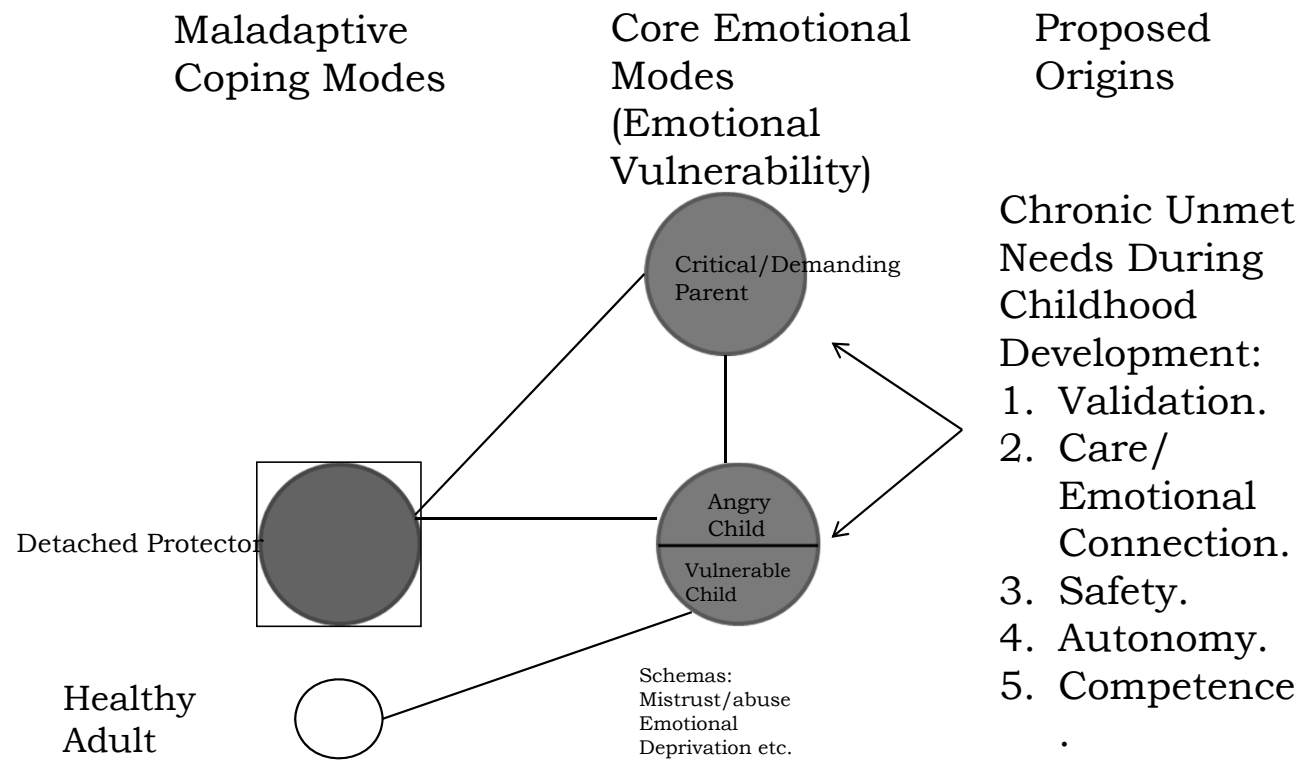
# Eating Disorder and Personality Disorders

- Borderline PD most prevalent with Bulimia Nervosa and Anorexia Nervosa Binge Eating/ Purging Type
- Obsessive Compulsive and Avoidant PD most common in Anorexia Nervosa Restricting type and Binge Eating Disorder
- OSFED have more severe and widespread personality pathology

(Sansone, Levitt and Sansone, 2004; Cassin and von Ranson 2005; Levitt and Sansone 2006)

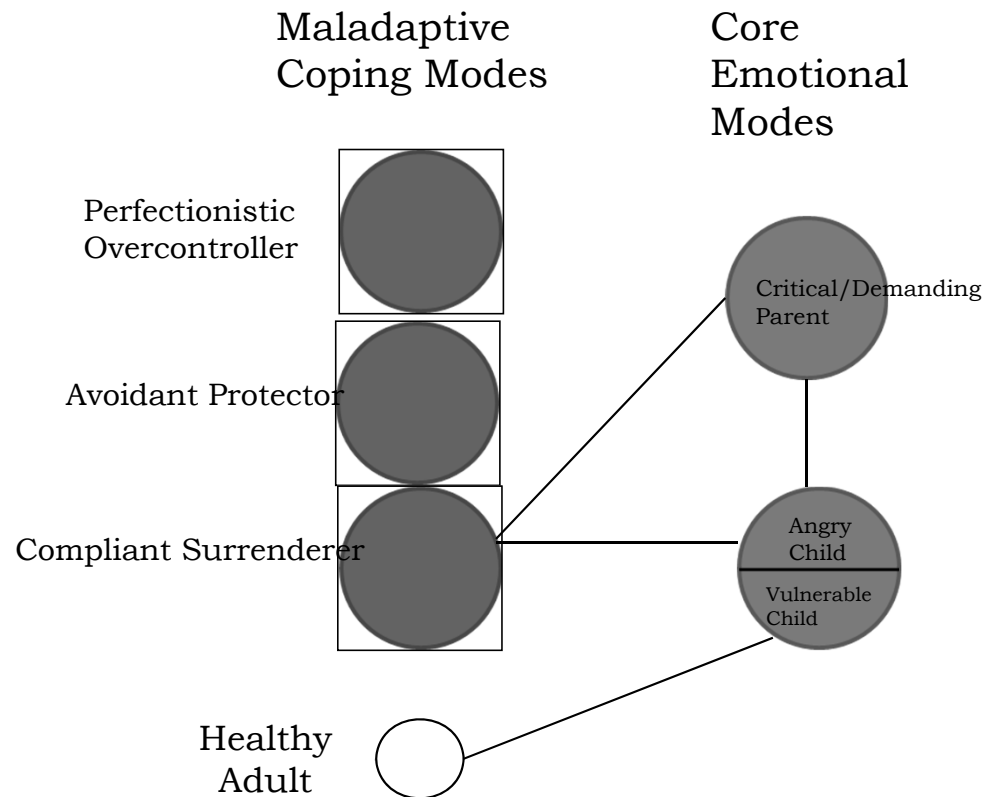


# Basic BPD Mode Model





# Extended Mode Model (Arntz, 2012) Cluster C

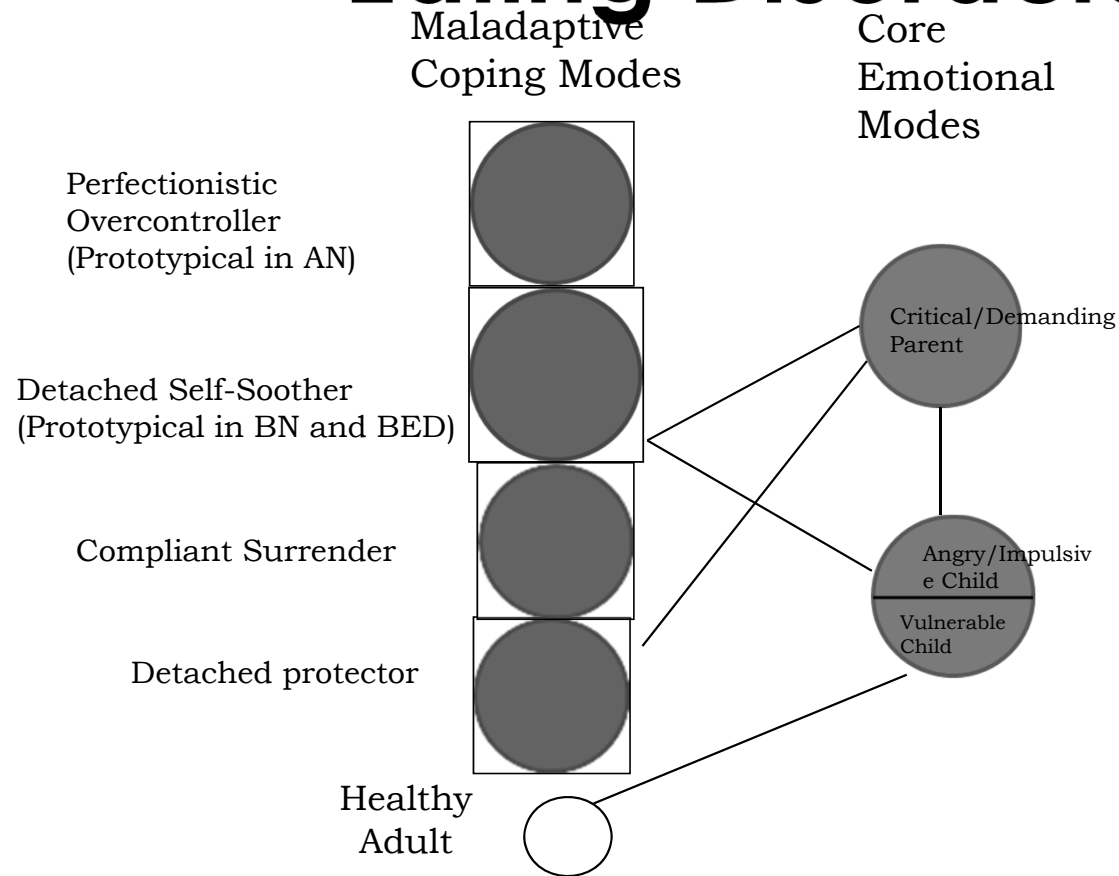


# Schema Modes in Eating Disorders

- In clinical practice, eating disorder behaviours may have a range of different functions linked to schema modes.
- These may also be linked to comorbid personality disorders or traits.  
E.g.
  - OCPD pattern of overcompensatory coping
  - BPD pattern of detached/avoidant coping, impulsivity, self-destructive behaviours.
  - AvPD pattern of detached/avoidant coping



# Extended Mode Model Eating Disorders



Simpson;  
Talbert et al,  
2015



# The group program

- Developed by Susan Simpson
- Combining interpersonal, experiential, cognitive and behavioural element
- 25 weekly session, 90 mins each
- 2 follow up sessions at 6 months and 1 year
- Access 4 individual sessions over the duration of the program



# Focus of the group

- Group format promotes a secure space to communicate about eating disorders
- Identify coping modes and understand the function, disempower parents modes and build healthy adult
- Participants support each other in learning how to get their emotional and physical needs met (connect with VC and AC)
- Experiential group exercises that facilitate change



# Structure of the group

- Pre- group assessment
- Phase 1
  - Education and exploration of modes
  - Case conceptualisation
  - Bonding within the group
- Mid way review
- Phase 2
  - Using empathic confrontation and reality testing to challenge and change schema
  - Follow up
- Follow up



# Therapists

- 2 therapists are essential in the group
- The therapist work together to keep the focus on the entire group
- The group facilitators take the “parental” role and model interpersonal communication and gentle confrontation



# Balancing goal, content, and process.

- The manual provided session outlines with detailed information
- Each session was content heavy
- Therapist own Demanding Parent Mode
- This makes it difficult to remain mindful in session
- Flexibility in the therapist is important as a central feature of ST is that the therapist intervention matches the mode the consumer is in





# The Underlying Function of Eating Disorder Behaviour

- ST focused on developing a formulation that addressed the function of eating disorder behaviour
- In the group we did not focus on links between eating behaviour, thought and feeling in the here and now
- By keeping the focused on unmet emotional needs we can address eating disorder behaviour without focusing on eating disorder behaviour



# Corrective Emotional Learning Experience

- Egosyntonic nature of schema can be addressed within the group relationship
- In the group there were times when participants with the same schema mirrored beliefs e.g. defectiveness schema in which 2 people voices a belief that “that other participants deserve compassion”
- These opportunities added to the corrective experience as it allowed for defusion from the schema and reality testing



# Emotion Focused Work

- Program included imagery, chair work and imagery rescripting activities modified to incorporate the group
- Aim is to connect with participants vulnerable child mode
- Imagery related activities were the most difficult to implement in the group setting
- Client would detach during the course of the activity
- Remain emotion focused in order to promote connection with vulnerable child mode.



# Group vs Individual Therapy

- Features of the group augment ST techniques by allowing participants to experience validation/support and a safe place to experiment with emotional expression and new behaviours with peers
- In group the experiential techniques are modified to involve the group
- Group program allowed for 4 opportunities for individual sessions.
- Is there an optimal combination of group and individual session?



# Transdiagnostic Nature of the Mode Model

- Comorbidity between eating disorder and personality disorders
- Observed detached, avoidant and overcompensation coping modes in participants
- These modes are also present in personality disorders
- To maximise effectiveness and minimise relapse there is need to address both eating disorder and personality pathology
- The mode model allows us to address a range of comorbidities by working to address schema level beliefs

