The Utilization of EMDR in the Treatment of Eating Disorders
Webinar 2

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1

This Seminar Aims to:

- Outline the multifaceted dimensions of history-taking and assessment
- Show how to arrive at a case conceptualisation using the Adaptive Information Processing Model (AIP)
- Identify the most relevant targets for desensitisation
- Give guidance on developing an effective and organised treatment plan – targeting both ED symptoms and traumatic experiences
- Provide an overview of the full range of EMDR interventions used in comprehensive treatment of Eating Disorders

2

Taking the History - Considerations:

- **Usual precautions apply *** As for all clients, depends on client characteristics, nature and intensity of current disturbance, degree of dissociation, and complexity of history
- Does the client have enough emotional stability/capacity to engage in detailed assessment?
- May need to to frontload emotion regulation skills prior to taking any history at all
- May need to take history in a stages and over time

3

Which Method to Use for History Taking & Case Conceptualisation

- **Top 10 Worst Memories**

- **From Presenting Symptoms to Targets**

etiological unprocessed events can be time lined

"when was the first time you remember feeling this way?"

- Float-back technique may be used *(affect bridge, somatic bridge, bridging*) **usual cautions apply***

4

- **From Dysfunctional Core Beliefs to Targets**

(for clients with complex trauma histories – repeated and cumulative trauma and neglect within specific relationships)

"which past experiences still prove for you that you are …(belief)?"

"How do you know that you are …..(belief)?"

5

- History taking for ED clients needs to be thorough & comprehensive

- **Usual Assessments** we would do for any client coming for EMDR, including:

*Adverse events/trauma
*Attachment history
*Screening for dissociation (DES)
* Red flags

- Plus, some specific assessments of the Eating Disorder (ED) and related issues

6

Resources/Positive Memories

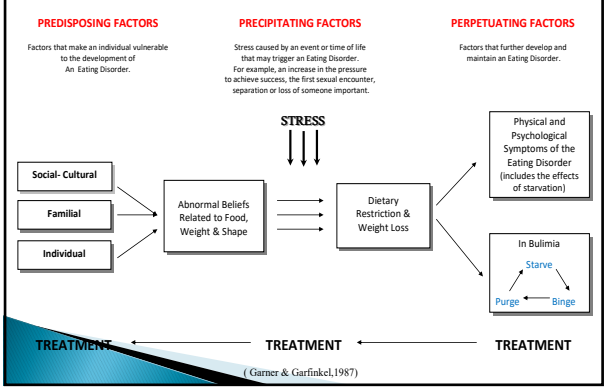
- **As usual practice ***
- Start with assessing strengths and positive resources and memories
- Does the client have adequate positive (adaptive) information & memories?

7

- If not – need to deliberately develop these prior to desensitization
- *"For each adverse experience, list at least one person, experience or situation that helped you cope with it"*
- *"which positive experiences would like to experience again when you are free of the eating disorder?"*

8

Predisposing, Precipitating and Perpetuating Factors in the Development of Eating Disorders



(Garner & Garfinkel,1987)

9

Getting Started

- Goal of first few sessions is engagement
- Why is the client presenting for help now?
- Who is worried about them? Who is pushing them to seek help? How do they feel about this?
- Have ED issues increased stress between self and others? How? (avoidance of sexual intimacy, avoidance of food related activities, controlling what others eat, reassurance-seeking, mood instability etc)

10

- Have ED issues improved relationships with others? (sick role, care eliciting …getting much needed attention and care)
- What are others doing that is helping or hindering client in moving towards recovery? (colluding, minimizing, ignoring, panicking, demanding, forcing, oversurveillance, getting ill themselves)
- Who else in the system needs help to help them more effectively? (link in with carer-support, psycho-education, discuss expectations of treatment outcomes and length of treatment needed) www.beateatingdisorders.org.uk

11

- Start gathering information on **Present Functioning**
- How are eating problems adversely affecting present functioning? health, emotions, cognitive capacities
- Impact on functioning at school/college/work
- Impact on home-life and important relationships?
- **Previous treatment** – helpful/unhelpful…how?
- **What goals does the client have** - what do they want more of/less of?

12

- Negotiate for some **joint sessions with significant others** (if appropriate)
- Communication with others needed? – **transparency** agreed
- **Risk assessment & non-negotiables agreed** before proceeding to more detailed assessment

13

First Intervention: Psychoeducation

- Effects of starvation on behavior
- Self-perpetuating nature of ED behaviors
- Binge-purge-starve cycle
- Ineffectiveness of vomiting and laxative abuse for weight control

14

- Need to restore regular eating patterns
- Medical effects of ED's

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15

Moving On

More Detailed Assessments

16

AIP Informed Assessment of ED & Related Issues

17

Onset and Course of ED Development

(Precipitating Factors)

- Look for **Precipitating Event** triggering first onset of ED
- Deep exploration of life-events surrounding onset of ED
- "What was going on in your life, or the life of people important to you when your ED first started?"
- Explore systemic, family, social and interactional factors

18

- Trace **ALL** the episodes connected with the triggering event and identify targets
- Client may not be able to give a clear precipitating event (complex –PTSD) Floatback(affect scan, somatic scan) can be helpful - Usual Cautions Apply *

19

Development of Negative Body Image

(Precipitating Factors)

- Can Develop a Time Line using photographs of the client (if client is agreeable)
- Photographs can be helpful in giving an objective perspective on body size, weight and shape concerns
- *"When did you first start to believe that your body wasn't ok?"*
- *What kind of experiences have you had that have led you to believe you had to do something to change your body?"*

20

- Look specifically for SHAMING experiences to self or others
- *" bring up an image in your mind's eye of how you **think others see you**" & " bring up an image of how your body **feels to you** -* draw these or use images off the internet
- Discuss **"**Feeling Fat**"** as a displacement defence for negative feeling states that client has no other language for
- Can use standardized measures

21

Identify Specific E/D Symptoms over the Course of Time

- *Episodes of starving, bingeing, purging*
- Cluster targets (first, worst, most recent)
- *Elicit post binge/purge ED N.C's "I am...." statements*

22

Current ED Behaviours

(Maintaining & Perpetuating Factors)

- Obtain a detailed account of client's Current ED behaviors (can use Food diaries, standardized questionnaires)
- Map ED Timeline onto Adverse Experiences Timeline - illuminates how current symptoms and underlying emotional distress are linked (clients usually have poor reflective function & insight)

23

Maladaptive Positive Feeling States

(Maintaining & Perpetuating Factors)

- Identify **Maladaptive Positive Feeling States** linked to Past ED behaviours
- *" How did you learn to associate such good feelings about yourself with deprivation and weight loss?"*
- Positive reactions of others when client first lost weight - applause, admiration, envy ...(may be currently ongoing)

24

Knowledge Deficits
(Maintaining Factors)

- Assess for misinformation and myths about dieting and body weight regulation - can be driving ED behaviors to varying degrees
- Correctional psychoeducation required to facilitate educational interweaves for stuck EMDR reprocessing) (ED Awareness Questionnaire – Schmidt, et al (1995))

25

ED -Secondary Trauma
(Fear as a Maintaining & Perpetuating Factor)

- Identify **Secondary Trauma** arising from E/D behavior and aggressive attacks on the body
- *Enforced hospitalisation*
- *Compulsory NG tube feeding*
- *Strict behavioural refeeding programmes*
- *Fear of sudden death due to electrolyte imbalance*

26

- *Seizures*
- *Medical emergencies*
- *Overdoses*
- *Trying to cut off parts of body*
- *Beating parts of body etc*

27

Present Triggers for ED Behaviors

(Maintaining & Perpetuating Factors)

- **Examples** (not exhaustive)

Being alone in the house
Others losing weight and diet talk
Positive comments "you look good"
Having an argument
Sitting at the table with food on plate
Feeling full
'Feeling fat'
Coming home after a stressful day at work

28

Times of day
Tight clothes
Seeing refection of self in mirror
Not being able to see or feel bones (body checking behaviours)
Numbers on the scales
Flashbacks
Difficult feeling states
A cloudy rainy day
Sunny day
Summer months

29

Urges & Maladaptive Positive Affect

(Maintaining & Perpetuating Factors)

Urges:
"Which triggers most make you want to ….(ed behavior)?"

Examples:
'hearing others saying how much weight they've lost'
'clothes feeling tight'
'seeing the numbers go up on the scales'
'seeing the numbers go down on the scales'
'seeing cake adverts'
'driving past a petrol station on my way home from work'

- Rate the level of urge 0-10

30

- **Maladaptive Positive Affect**

"when you perform that behavior, what are you most looking forward to seeing or experiencing?"

'seeing my stomach looking flat'
'feeling clean'
're-setting'
'feeling empty'
'feeling calm'
'my mind being still'

- **Rituals**

What the client does when preparing to engage in ED behavior

31

Use of Addiction Protocols

(Renee Beer, 2018)

Addiction Protocols used to neutralize:

1. Current Urges to perform ED behaviors

2. Maladaptive positive affect on Past Experiences

3. Maladaptive positive affect on Current Triggers

32

Future Oriented Fears About Making ED Behavior Change

(Maintaining & Perpetuating Factors)

- **Future Oriented Fears of Giving up ED Behaviours**

"If you stopped….(ed behavior) what is the worst thing that you imagine will happen?

'will get fat, and gross'
'I'll just keep getting fatter and fatter'

- Core fear is of being rejected, humiliated, ridiculed because of size and appearance

33

- **Future Oriented Fears of Carrying on with ED Behaviours**

"what is your worst fear if you don't manage to make change in your …(ed behavior)?"

'having another seizure'
'being sectioned and being forced to eat'
'never being able to have children'
'never being normal'
'losing my job'
'having no life'
'killing myself'

34

Use of Flashforward Procedure

(Renee Beer, 2018)

- Flashforward procedure used to neutralize future oriented fears/fantasies relating to:
- 1. Past ED related trauma reoccurring
- 2. Future oriented fears about giving up ED behaviours
- 3. Future oriented fears about not giving up ED behaviours

35

Individual History

(Predisposing Factors)

- General Unprocessed Adverse/Traumatic Experiences (Big T & Small t) (as usual)
- **Perfectionism** as a coping strategy for crippling sense of ineffectiveness – will need to be targeted in treatment
- Attachment disruptions/wounds of invisibility

36

Attachment History
(Predisposing Factors)

- Full Attachment History (as usual) -genograms are helpful
- Identify significant losses/disruptions & positive relationships as resources
- In-depth info on problem areas or distress connected with any relationships (Repairing lost relationships or/and building new social networks is usually necessary)

37

- Interpersonal inventory (detailed analysis of relationships, frequency of contact, closeness, intimacy, mutuality, reliability, trust)
- Birth, bonding and feeding disruptions

38

Family Influences - Food & Body Image
(Predisposing & Perpetuating Factors)

- Parental eating habits and approach to food – dieters?
- Does anyone in the family have an eating issues?
- Mother's relationship with her own body
- Father's relationship with his body
- Explore comparing & competing behaviours
- Internalized weight prejudice in family members

39

- Weight commentaries/criticism
- Explicit or implicit messages about gender roles, femininity, desirable body etc
- Puberty – reactions, comments "puppy fat"
- Meaning parents attribute to food
- What were mealtimes like?
- Overemphasis on health & fitness
- Expectations to achieve

40

Social-Cultural Influences

(Predisposing & Perpetuating Factors)

- Culture of thinness – "fat-phobic society"
- Myths of transformation
- Advertising
- Narrow eurocentric beauty ideals
- Social media

41

- Peer influences *"who do you admire? Is there anyone you compare yourself with?"*
- Growth in cosmetic surgery & body modification procedures
- Rise of Pro-ana & Pro-mia as a 'lifestyle choices' - Thinspirations & Reverse Triggers

42

Target Identification & Developing a Comprehensive Work Plan

- Which target/target cluster to start with first?
- Past? Present? Future?
- Clinical decision dependent on client variables, length of treatment contract, client capacity, current level of ED behaviors and associated risk

43

Developing the Treatment Plan: Potential Target Areas

- **General Adverse Events/Trauma** (Big T & little t) (including attachment related deficits and trauma)
- In complex trauma clients: events/experiences related to **Core Dysfunctional Beliefs**
- Event/s surrounding **Onset of ED**
- **Secondary Trauma** arising from ED behavior and body loathing

44

- **Family Influences** on ED & Body Image
- **Negative Body Image** - shaming and other relevant experiences
- Targets relating to **Perfectionism**
- **Maladaptive Positive Affect** from past experiences driving current ED behaviors (memory of positive past feelings)
- Present Triggers driving **Urges** to perform ED behaviours

45

- **Maladaptive Positive Affect** driving current ED behaviours (positive feeling state being sought in the present)
- Future Oriented Fears of **Negative Consequences of Changing** ED behaviors (e.g., getting fat leading to rejection and humiliation)
- Future Oriented Fears of **Consequences of Not Changing** ED behaviours (e.g.,past ED traumatic experiences reoccurring and anticipated losses)

46

Relevant Protocols:

- **Standard Protocol** (with adaptations of needed)
- **Addiction Protocols**
- **Flashforward Procedure**

47

Guidance for Target Sequencing - AIP Principles

1. Target event/s surrounding onset of ED
2. Big 'T' trauma's (including secondary trauma from ED & attachment wounds)
3. Urges & maladaptive positive affect (includes body image targets)
4. Flashforward on future oriented fears of changing behaviour/not changing behavior

48

HOME-TASK:

Think of a client you are working with. Consider the target areas I have presented and work out a treatment/target sequencing plan

49

FINAL QUESTIONS?

Thank You for Your Time and Contributions!

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50

51

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53