

EYE MOVEMENT DESENSITISATION AND REPROCESSING (EMDR) A Must for Treating Eating Disorders!

Healing Trauma and the Effects of Adverse Life
Experiences

Introduction

- My story-how I came to be working with Eating Disorders
- How I came to be doing EMDR

Eating Disorder: Working Definition

- A cluster of thoughts, feelings, and behaviors whereby a person's relationship with food is disordered
- An over-identification with the body, food, and weight
- Starving, bingeing/purging, or overeating is a self-regulating mechanism which creates a perpetual loop

Multi-layered Approach

- Psychotherapy-insight and healing
- Behavioral Change-must address behavior when the time is right
- Nutritional Counseling and support-demystify food and learn to eat intuitively
- Medication Management

Core Elements to an Eating Disorder

- Self-Loathing and Shame-transferred on to the body
- Moralizing Food and weight-"I am good when I am thin and bad when I am heavy"
- Perfectionism designed to avoid my feelings of self-loathing and shame
- Loss of Trust in Self-"I create intolerable rules for myself with food and weight in order to rid myself of my self-hate. Because I can't follow these rules I fail and lose trust in myself"
- Illusion of Control-In my attempt to be in control with these rules, since they are not natural and I cannot follow them I feel out of control. This becomes a theme for my life. The very thing that is supposed to make me feel in control is actually out of control"
- Dissociation-because I cannot self-soothe, make conscious and healthy choices for dealing with stress, and often feel highly anxious or helpless and hopeless; I shut down with either starving or bingeing.

Ultimate Goal for Treatment: Foster Resiliency

- Increase Self-trust
- Reduce Anxiety
- Increase Healthy Forms of Protection
- Reduce Self-sabotage
- Increase Options
- Reduce Reactivity
- Increase Distress Tolerance

What is EMDR?

EMDR – Eye Movement Desensitization and Reprocessing is an evidence-based therapy founded on the idea that negative thoughts, feelings, and behaviors are the result of unprocessed memories. It involves standardized procedures that include focusing on a traumatic image, thought, emotion and associated body sensation, (all at the same time) coupled with the use of Bilateral Stimulation in the form of eye movements, tapping, or audio tones.

Definitions

- Maladaptive-not having the ability to adjust to the conditions of a particular environment. Essentially, we are “adapting” in a way that leads to negative thoughts, feelings, and behaviors whereby we feel stuck.
- Amygdala-where trauma is stored in the limbic system
- Limbic System-part of the brain responsible for emotion and learning, perceives threat, and signals the fight-flight-freeze response.
- Neo-Cortex-the part of the brain that is responsible for language and thought. Also know as the “wise” brain. This part of our brain is essentially offline when we the amygdala is highly activated, such as in panic
- Reprocessing-the processing of unprocessed or “stuck” information that has been encoded and stored in the amygdala; allowing it to move to the neo-cortex whereby it can be seen as “in the past” and no longer as a threat in the present.
- Bi-lateral Stimulation(BLS). The use of bi-lateral movement (side to side) with eye movements, tapping/pulsing, or audio tones.

How Does it Work?

- Mechanisms for action are largely theoretical-at least 6 theories
- What we do know is that the accelerated information processing model (AIP) allows previously unprocessed information that has been stored mal-adaptively to be reprocessed and linked to adaptive memory networks.
- Pagani study-Now through the use of fMRI we can observe the brain in real time. Pagani and his fellows showed during the reprocessing phases of EMDR both the Limbic system and the Neo-cortex were activated at the same time. Typically, the two systems do not “talk to each other” when the amygdala is highly activated.

WHY EMDR THERAPY?

Must Treat Trauma!

- The underlying trauma must be treated or we are simply “sending them out to suffer.”
- EMDR is a whole-person therapy that includes stabilization, self-regulating tools, and the reprocessing of traumatic memories and negative beliefs.
- It is trauma informed-does not re-traumatize

Why Treat Trauma?

A traumatic event is any experience associated with strong negative emotions. They range from Big “T” trauma(severe trauma) to adverse life experiences .

a) These events are encoded and stored differently than “normal” memories

b)The information is encoded and stored in the amygdala(limbic part of the brain) which signals the stress response and triggers fight, flight, or freeze

AND

c)We make meaning of the event that becomes part of our self-concept without our awareness and develop symptoms and maladaptive behaviors(Eating Disorders)

For Instance

- Event: Overly critical, alcoholic father telling his child they are stupid
- Sensory memory: sound of dad's voice, smell of his breath
- Emotional memory: shock, shame
- Body memory(amygdala): tension, panic
- Meaning: "I'm not good enough"
- Result: "When I make mistakes I am flooded with feelings of shame, feel inadequate, and feel panicked"

3 Kinds of Therapy

1. Talk Therapy: Your neo-cortex is relating to mine; otherwise known as “top-down”
2. Medication Management: Alter the bio-chemical chain of events thereby promoting symptom reduction
3. Psycho-Sensory Modalities: Access the part of the brain where trauma is encoded and stored; otherwise known as “bottom-up” EMDR is psycho-sensory

How it works-8 phase protocol

- Phase 1-history taking and identifying strengths, assets, and resources
- Phase 2-stabilization and preparation(resourcing)
- Phase 3 setting up a “target” linking the sensory information(image), negative belief (for example, “I am not good enough”), emotions, and body sensations all together at once
- Phase 4-6 desensitizing the event and allowing the neo-cortex(rational brain) come online and link the event to a positive belief(for example, “I am good enough!”), installing the positive belief, and linking this new information to the body.
- Phase 7-closure of session
- Phase 8-re-evaluation, continuing to reinforce resources, and treatment planning.

Phase 1

- History taking, identifying strengths, assets, and resources, setting goals for treatment

In EMDR therapy we start with the positive: “What do you like about yourself?” and “What kinds of things do you do to help yourself to cope with stress” versus identifying problems at the onset of meeting. It is also client-centered. The client identifies the goals for treatment and chooses where to start with the help of the therapist.

Phase 1

Making connections between life themes, negative beliefs and experiences

- a) Theme = “I can’t control my eating ”
- b) Negative belief = “I am powerless”

Through the use of floating back in time with the belief we identify the first, worst, and most recent example of the belief. For example

- c) First :“my father yelled at me and told me I was stupid when I tried to join in on a family game.”
- d) Worst: “I was attacked by 3 boys on my college campus.”
- e) Most recent: “I ate an entire bag of large-size potato chips and threw up.”

Here we see that instead of the therapist drawing conclusions for the client, the therapist craftily helps the client to make the connections for themselves.

Phase 2: Stabilization through Resourcing

Identification of Internal and External Resources

Building upon the list:

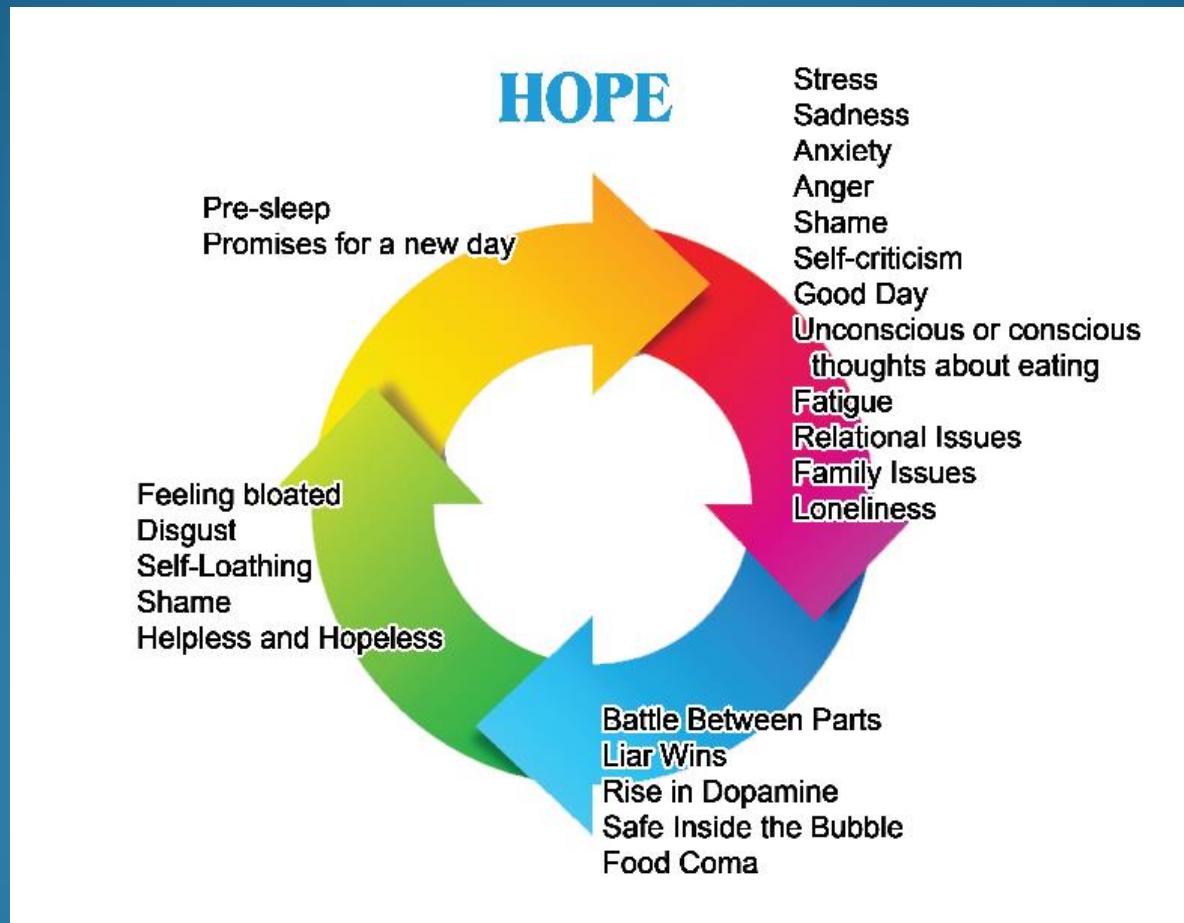
- a) Calm Place
- b) Light Stream
- c) Container
- d) Monkey Tap-demonstration

At the Institute for Creative Mindfulness we offer at least 16 different resources to be taught and practiced. Since everyone is different we must help the client to develop ways to self-regulate which work for them as individuals.

Phase 2: Short-term Therapy

- Phase 2 is the primary focus of treatment until the client demonstrates readiness for working with painful memories. In an in-patient setting or a limited out-patient period of time, the client may not be in treatment long enough to start working on memories. Therefore, Phase 2-continues to be the most viable form of the 8-phase protocol.
- Phase 2 Resourcing is “strengthening the neuro-fiber bridge” between the left and right brain, and the limbic system and the neo-cortex. It is incredibly valuable as a stand-alone treatment, and for patients with Eating Disorders, just being able to self-regulate minimally, is a powerful shift.

Phase 2: Help with binge-eating and can be adapted to help with restricting



How I use resourcing with the cycle

- I encourage clients to take brief “snapshots” of their state of mind, emotions, and body sensations at different times throughout the day
- I invite them to use a resource as soon as they notice stress building and thoughts of food (unrelated to hunger) arising
- I encourage them to stay as present as possible even if they end up bingeing or restricting and take notes, if possible
- If they do hit the green zone I ask them to use a self-compassion exercise to be kinder to themselves
- And in the yellow zone I ask them not to make promises! Every time we make a promise and don't keep it (because we are not equipped to do so) we erode our self-esteem and self-trust.

Phase 2: Mindfulness

- Fruitful treatment requires making the unconscious conscious. With self-observation, one can THINK about what is happening, make new choices, and integrate the new information into the neural network. Mindfulness promotes this level of awareness without judgement and resourcing is mindful.
- Phase 2 resourcing is practice in “noticing.” And in Phase 3 Reprocessing, the therapist asks, “What are you noticing now?” repeatedly. EMDR is a mindful therapy.

Phase 2: The Body

Many clients with Eating Disorders have a difficult time being in their bodies. The mindfulness aspect to Phase 2 is invaluable in aiding a client to develop body awareness and tolerate sensations. Here is how I use it:

- Visualization techniques for creating good feelings in the body
- Developing the art of changing state from, “I am bored” to “I can be in the moment.”
- Tolerating emotional discomfort (and teaching the difference between tolerating discomfort and tolerating abuse)
- Following through to the end- “How will I feel after I starve myself all day?” or “How will I feel when I am done with the binge?”

Phase 2: Working with Food

Distress tolerance is key to working with Eating Disorders. Being able to notice one's thoughts, feelings, and body sensations must take place for a person to be able to step back, put things into perspective, and make positive life-giving choices.

The mindfulness component of resourcing empowers the client to learn to eat intuitively. Dieting and restriction set up feelings of deprivation. Intuitive eating is from “the inside out”.

With a solid mindfulness practice these skills are much easier to execute.

Phase 2: Preparing for Reprocessing

Prior to moving on to phase 3 reprocessing several factors are considered:

- Can the person self-soothe?
- Do they have a support system?
- Given the severity of their disordered behavior (with anorexia in particular) is their brain healthy enough to tolerate distress that may arise?
- Do they have a fear of getting well?
- Do they have a stable living environment?
- Screen for Dissociation: special populations considerations

Negative Beliefs are Core to the Development of an ED

- “My thoughts and feelings don’t matter”
- “I am invisible”
- “I don’t trust myself”
- “I have to be perfect”
- “I am powerless”
- “I am not good enough”

We must treat them by accessing the limbic system-we cannot talk our way out of these beliefs

Phases 3-7 Reprocessing

- When a memory is considered reprocessed it has changed, the negative belief is no longer charged and the positive belief feels completely true. The body is scanned and is free of any lingering negative sensation that had been associated with the target memory. For example...
- “My thoughts and feelings don’t matter” has been replaced with “My thoughts are important to me and to others”
- “I am invisible” has been replaced with “I am seen”
- “I don’t trust myself” has been replaced with “I can trust myself”
- “I have to be perfect” has been replaced with “I am okay with making mistakes”
- “I am powerless” has been replaced with “I have the power to choose”
- “I am not good enough” has been replaced with “I am fine just the way I am”

Phases 3-7 Adaptive Resolution

Once a memory has been reprocessed in phases 3-7 a person is free to have a new response to old information. These are examples of how a person experiences themselves as new and different:

- “I was in a situation yesterday that normally would have triggered me and I felt okay”
- “On my way home from work I am now able to think about whether or not I am hungry and hold off until I can get home and eat something healthy instead of stuffing myself with drive-thru food”
- “In the past I would have had a very difficult time eating bread and now I can eat a piece and I not only do I not beat myself up, I forget about it”
- “Yesterday I said no to a date with a guy who treats me poorly because I was able to tolerate the feeling of being alone”

Phase 3-7 and on to 8

Through careful and comprehensive treatment planning we develop a system to reprocess a series of negative beliefs and past associated memories. Then we move on to current events and even those that may occur in the future. One by one, we unburden the brain and body of the client, leaving them healed and much more able to do the arduous work involved in dealing with an Eating Disorder.

Additional Protocols

- In EMDR therapy there are hundreds of protocols for working with specific situations. In helping clients with Eating Disorders in addition to Phases 1-8, I use:
- DeTur-Desensitization for Triggers and Urges: Since restricting and overeating are essentially a way to distract from, deny, or dissociate from negative thoughts and feelings; with this protocol we have the client identify what they WANT to be feeling instead from a conscious perspective and “anchor” it. We then identify an urge to act out with and desensitize the urge using fast Bi-lateral Stimulation.
- Positive Affect Tolerance: many clients with eating disorders have a low tolerance for positive feelings. This protocol is attachment based and not only helps the client to see that they prevent themselves from having positive feelings but helps the client build on the capacity for allowing them.

Thank You for
Listening!

Resolving Trauma with EMDR – Client’s handout

A traumatic event is any experience which is associated with strong negative emotions. Examples include rape, sexual assault, domestic violence, being in or witnessing a holdup or motor vehicle accident, witnessing an unexpected or violent death, being in a natural disaster or being caught up in conflicts or war.

Other traumatic events are more personal. They include public ridicule, performing badly in front of one’s peers, critical put downs by parents or others, and any form of emotional abuse. Although some people might not call these events “traumatic” because they can be associated with a high level of emotional distress, the brain treats them in exactly the same way.

The emotions and bodily reactions created at the time of the traumatic event are associated with chemicals in the nervous system and these cause the brain to store or encode the traumatic experience in a manner different from an everyday event which doesn’t carry a strong emotional charge.

What is a “Traumatic Memory” and how does it differ from a normal memory?

We can think of the memory of a traumatic event as consisting of three components: the **sensory memory**, the **emotional memory**, and its **meaning**.

The **sensory memory** is stored in the sensory cortex of the brain, where the details of sight, sound, smell, etc. are encoded. There are many different sensory elements which make up a traumatic event, and our recollection of a recent trauma often consists of sensory fragments of the event, rather than a complete and coherent memory. A traumatic memory is vivid and often detailed in some aspects but lacking detail in others. For example, a person in a holdup may recall the detail of the weapon, but not recall what the robber was wearing. Whereas non-traumatic memories generally fade over time, losing their vividness and detail, traumatic memories are recalled vividly and as though they are happening in the present. Non-traumatic memories are recalled with a clear sense of being in the past. Traumatic memories are experienced as flashbacks, disturbing dreams, or a sudden sense of re-living the event.

The **emotional memory** is often called the “body memory”, as activation of this part of the trauma memory reactivates the body sensations associated with the event. The emotional(bodily) component of the event are activated in a different area of the brain known as the amygdala, more commonly referred to as the

“emotional brain”. Recalling the sensory memory generally reactivates the emotional memory, which is why many people try to avoid talking about the event, or avoid possible reminders of the event. A person may experience a general sense of hyper-arousal, in the form of increased irritability, sleep disturbance, concentration difficulties, being easily startled, and being on guard. The person’s mind may try to distance the emotional component of a traumatic memory by a process called “dissociation”, which can be experienced as a sense of emotional numbness.

Some time after the trauma occurs the third component is formed in yet another part of the brain, the prefrontal lobes. This third component of the traumatic memory is the **meaning** that the event has for the person. This meaning is then applied to other situations subsequent to the traumatic event, triggering emotional and behavioral reactions long after the original traumatic event occurred.

In the table below are examples of traumatic events, and their components.

Traumatic Event	Sensory Memory (images, sounds, e.g.)	Emotional/Body Memory	Meaning
A motor vehicle accident	The sight of the other vehicle filling the windscreen a fraction before impact	Fear, tensed muscles, knotted stomach	I’m not safe.
Sexual Assault	Being held down, seeing the wild glare in the attacker’s eyes, the smell of alcohol on his breath	Terror, numbness	I’m helpless, I can’t trust men.
Being criticised in front of colleagues	Seeing everyone staring at me, some people are sniggering	Shame, embarrassment, blushing and sweating	I’m incompetent and useless. People think I’m an idiot.

What happens when a trauma memory resolves?

Memories of trauma will often resolve over time. People talk of “getting over it” but just what does this mean? Complete resolution involves changes in the three aspects of trauma memory described above. As the trauma memory is resolved the sensory memory becomes less detailed, less vivid and more distant.

Recalling or talking of the traumatic event no longer evokes a strong emotional charge. Present events that are related to the original trauma no longer activate a significant emotional charge. For example, if you were in a motor vehicle accident where a truck came through a stop sign, you would know that the memory had resolved when intersections and trucks no longer triggered a significant emotional or physical reaction.

The third aspect of the trauma memory is resolved when you have a useful perspective of the event that feels true. For example, if you were a pharmacy assistant who was held up, you would be able to recall the memory of the hold up, and at the same time think to yourself: "It's over, I did well, I can keep myself and others safe." If these thoughts feel right, if they have the ring of truth, and are not just empty words, then it is assumed that resolution has been achieved.

What about the situation when Resolution does not happen naturally?

Trauma memories may settle and resolve naturally over a few weeks, but for many people they do not. When problems persist from the trauma the condition is known as Post Traumatic Stress Disorder (PTSD). PTSD is a relatively new term, but the condition is not new, and descriptions of this condition can be found in literature going back 2500 years. Some of the symptoms of PTSD include:

- * Recurring or distressing memories that happen while awake or in dreams
- * Sudden flashbacks to the traumatic event
- * Distress triggered by reminders that link back to the traumatic event
- * Avoiding or attempting to avoid thoughts and feelings associated with the trauma
- * Avoiding activities, places, and people which trigger recollections of the trauma
- * Diminished interest in normal activities
- * Being emotionally distant
- * A loss of positive feelings
- * A pessimistic view of the future(atypical for the client)
- * Sleep difficulties
- * Concentration difficulties
- * Increased irritability or anger
- * A sense of being on guard
- * Easily startled

UNRESOLVED	RESOLVED
The memory is detailed, vivid, “in your face”, it seems more recent than it actually is, and it may be relived through dreams or flashbacks.	The memory is less vivid and less detailed. It has lost its sense of immediacy. It has become a part of one’s history. Sleep is not disturbed, and flashbacks do not occur.
The memory continues to have a strong emotional charge when discussed or thought about.	The memory can be recalled or discussed without significant distress.
Current events which have some element in common with the trauma event will reactivate the memory and its distressing emotions. Patterns of avoiding situations or activities may develop as a result.	Current events which have some element in common with the trauma event no longer reactivate the old memory and its distressing emotions. A person no longer avoids normal situations or activities.
The person carries negative or limiting beliefs from the traumatic event into their present life.	The person can recall the traumatic event, but also think and believe more positive and useful thoughts about themselves in the present.

Therapists help people resolve trauma by creating a safe environment in which the experience of the traumatic event can be shared, and its meaning explored. Talking about the trauma can be difficult initially, if the person often has tried to avoid the trauma memory. While avoidance does help in the short term, much research has shown that it can make the avoided memory even more distressing. In the end, avoidance strategies are not helpful, and this has long been recognised. There is an old African proverb that says, “You can outrun the lion that is chasing you. You cannot outrun the lion in your head.” Trauma memories are like lions in your head.

EYE MOVEMENT DESENSITISATION & REPROCESSING

In 1989 a new therapy called Eye Movement Desensitisation and Reprocessing (EMDR) was announced which claimed to rapidly resolve trauma memories, with greater speed and effectiveness than other therapies used at the time. Studies have now demonstrated that EMDR is more effective and efficient in resolving trauma compared with ANY other psychological or psychiatric treatment, including medication.

During EMDR the client is guided to deliberately bring into conscious awareness the sensory memory, thoughts, and the accompanying emotions and bodily

sensations associated with that memory. Clients need to be open to experience the emotions and body sensations that accompany the recall of a distressing memory and associated thoughts.

Then by following the moving fingers of the therapist, (or other dual attention stimulation) this stimulates a distinctive and naturally occurring pattern of electrical activity in the brain, which causes the stored trauma memory to quickly change. The exact mechanisms in the brain which cause the memory to change have not yet been discovered, but the regions of the brain involved with sensory storage, emotional activation and reasoning all become more active, with changed patterns of nerve cell firing.

During the eye movement the therapist does not talk or offer suggestions. The client does not try to change any aspect of the memory, and is asked to just notice the experience, to observe their memory, emotions, bodily sensations and thoughts. At the end of each set of eye movements the client is then asked to report their present experience. It may be that the sensory memory becomes less detailed or less vivid, and clients often report that the memory has become quite distant. Commonly the emotional or bodily sensations reduce in intensity quite quickly. If other associations are observed, they are shared with the therapist. Further sets of eye movement follow.

Once the trauma memory no longer triggers feelings of distress, the client is asked to associate a more useful thought to the now more distant trauma memory, and further sets of eye movements follow. The EMDR process is complete when the new perspective feels true even when the old memory is recalled. This entire process may take as little as ten minutes, or as long as a full session. Where there are several different experiences underlying the client's difficulties, it may take a number of sessions to fully resolve them.

Because EMDR therapists teach and encourage a strong plan for self-care both during the sessions and at home, the clients often benefit from even doing the preparation stages of EMDR. EMDR is not suitable for all clients. The therapist and client will discuss contra-indicating factors to doing EMDR and arrive at a decision that is sound and based on solid clinical judgement and the client's comfort with moving forward with the reprocessing.

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