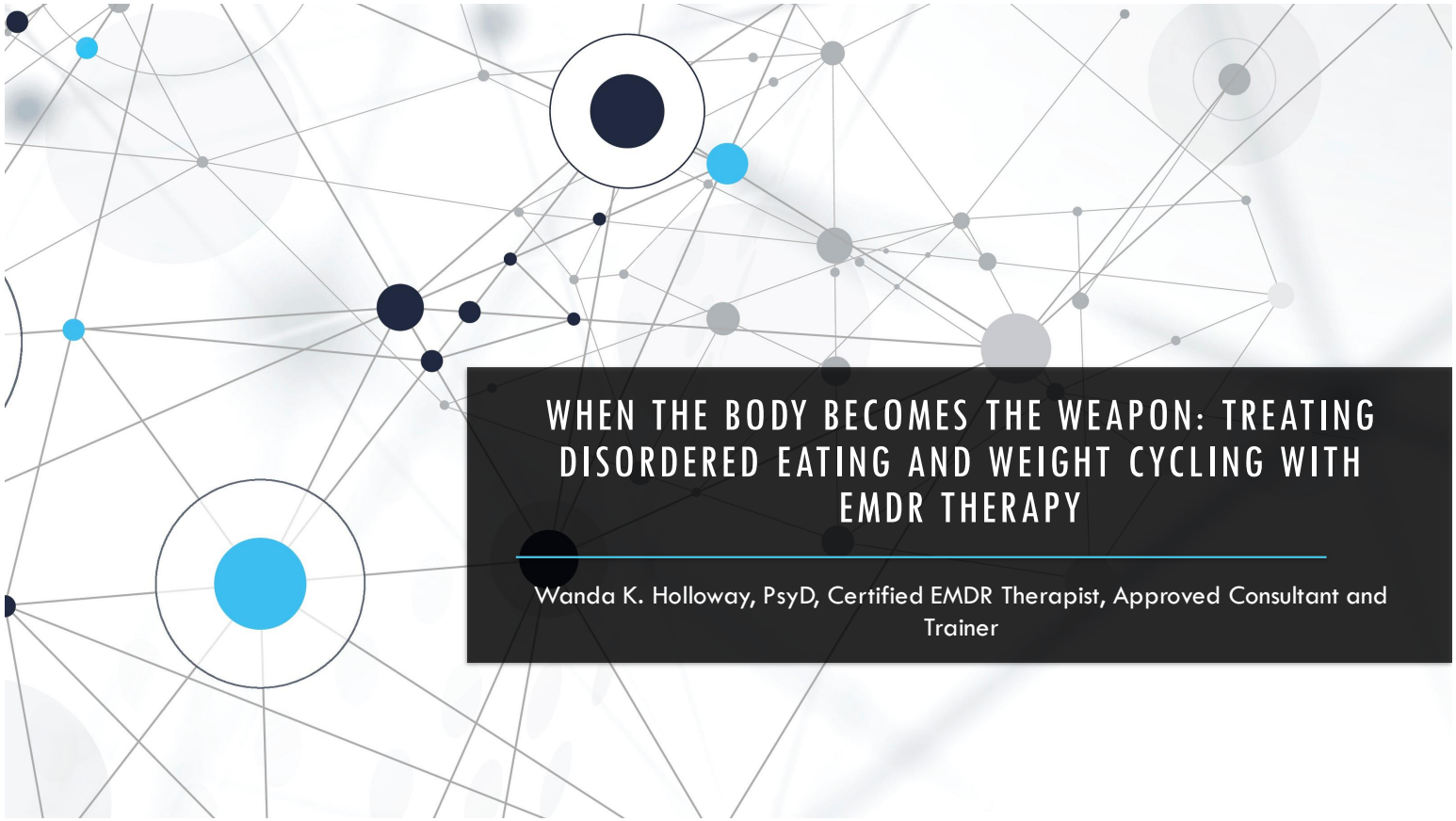


WHEN THE BODY BECOMES THE WEAPON: TREATING DISORDERED EATING AND WEIGHT CYCLING WITH EMDR THERAPY

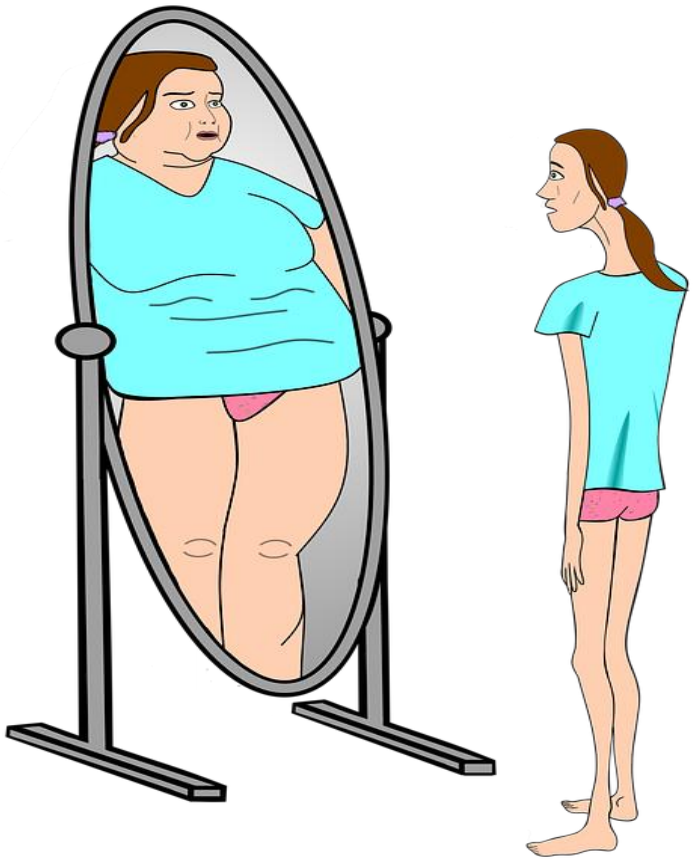
Wanda K. Holloway, PsyD, Certified EMDR Therapist, Approved Consultant and Trainer

PRESENTATION OUTLINE – DAY 1

- Identification and symptoms of disordered eating
  - Anorexia Nervosa
  - Bulimia Nervosa
  - Binge Eating Disorder
- Brain chemistry that is utilized in managing pain/loss of control
- Address how the brain uses the body as a defense against pain
- Use of "The Answer" to identify protective behaviors to stay safe and connected
- Development of negative perceptions and beliefs to manage pain
- Use of EMDR therapy to process memories related to food, body, and loss of control

ANOREXIA NERVOSA

- Restriction of food intake leading to weight loss or failure to gain weight resulting in a "significantly low body weight" of what would be expected for someone's age, sex and height.
- Fear of becoming fat or gaining weight
- Have a distorted view of themselves and their condition. Examples include a perception of being fat when actually underweight or believing you will gain weight from one meal.
- Includes subtypes: Restricting Type and Binge-Eating/Purging Type (American Psychiatric Association, 2013).

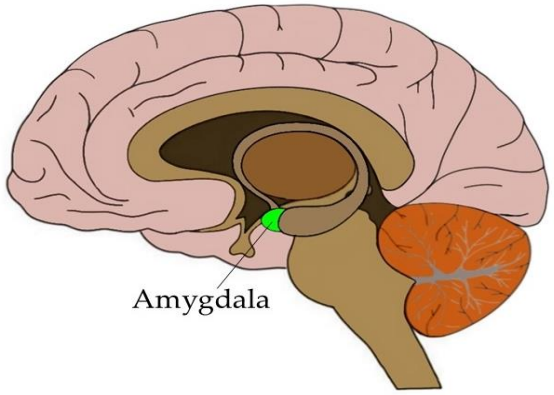


BULIMIA NERVOSA

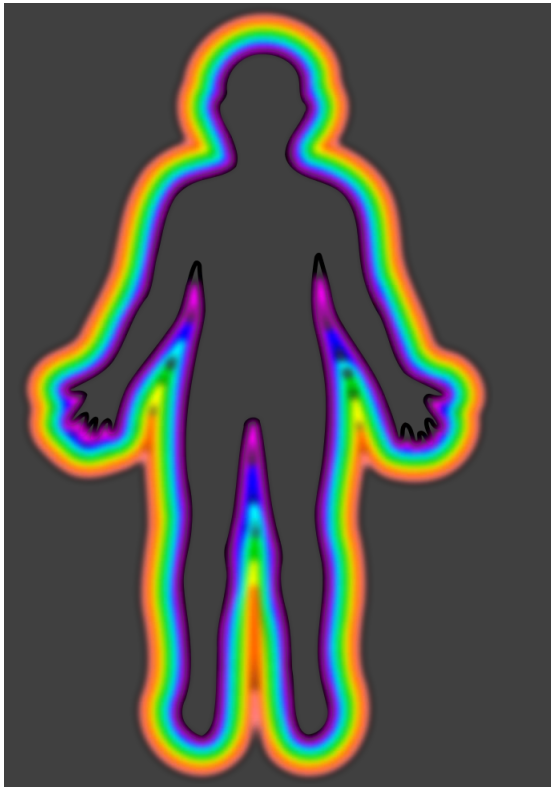
- Recurrent episodes of binge-eating – An episode of binge-eating is characterized by both of the following:
  - Eating in a discrete period of time (e.g., within a two-hour period), an amount of food that is definitely larger than what most people would eat during a similar period of time and under similar circumstances.
  - A Lack of control over eating during the episode (e.g., feeling that you cannot stop eating, or control what or how much you are eating.
- Recurrent inappropriate compensatory behavior to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications , fasting or excessive exercise.
- The binge eating and inappropriate compensatory behaviors, both occur, on average, at least once a week for 3 months.
- Self-evaluation is unduly influenced by body shape and weight.
- Bingeing or purging does not occur exclusively during episodes of behavior that would be common in those with anorexia nervosa. (American Psychiatric Association, 2013).

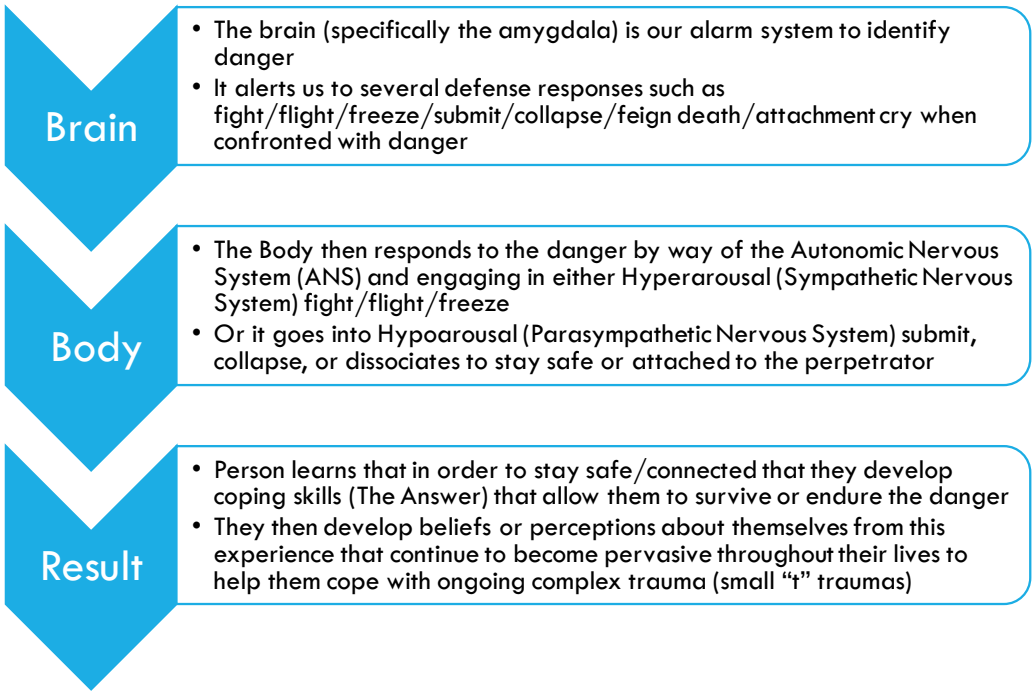
BINGE EATING DISORDER

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
  - Eating, in a discrete period of time (for example, within a two-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances.
  - A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- The binge eating episodes are associated with three (or more) of the following:
  - Eating much more rapidly than normal
  - Eating until feeling uncomfortably full
  - Eating large amounts of food when not feeling physically hungry
  - Eating alone because of feeling embarrassed by how much one is eating.
  - Feeling disgusted with oneself, depressed, or very guilty afterwards.
- Marked distress regarding binge eating is present.
- The binge eating occurs, on average, at least once a week for three months.
- The binge eating is not associated with recurrent use of inappropriate compensatory behavior (e.g., for example, purging) and does not occur exclusively during the course of anorexia nervosa, bulimia nervosa, or avoidant/restrictive food intake disorder. (American Psychiatric Association, 2013).

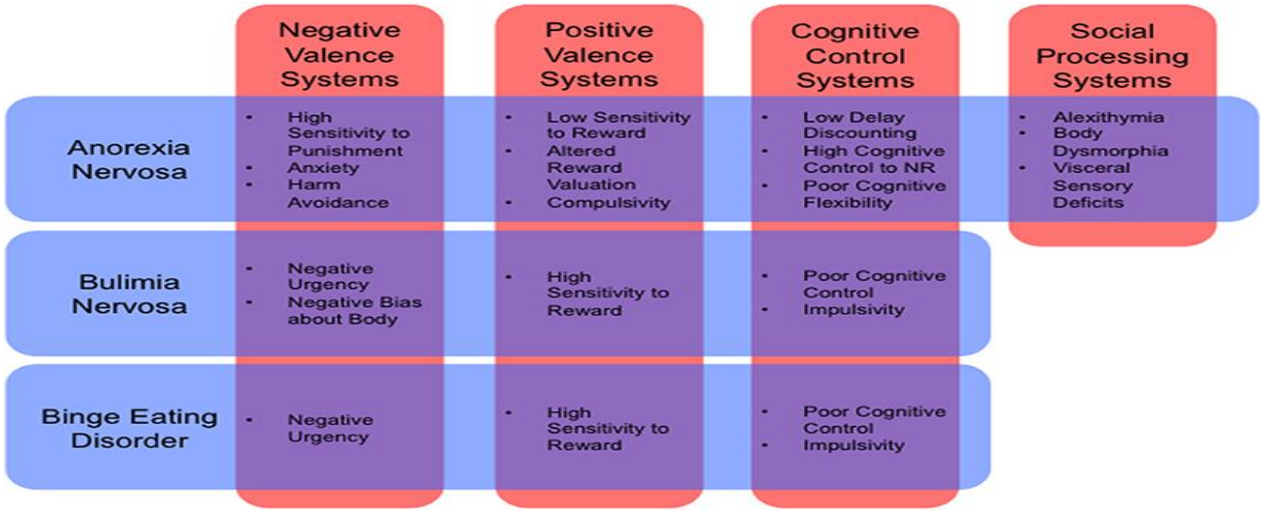


UNDERSTANDING THE CONNECTION BETWEEN THE BRAIN AND BODY

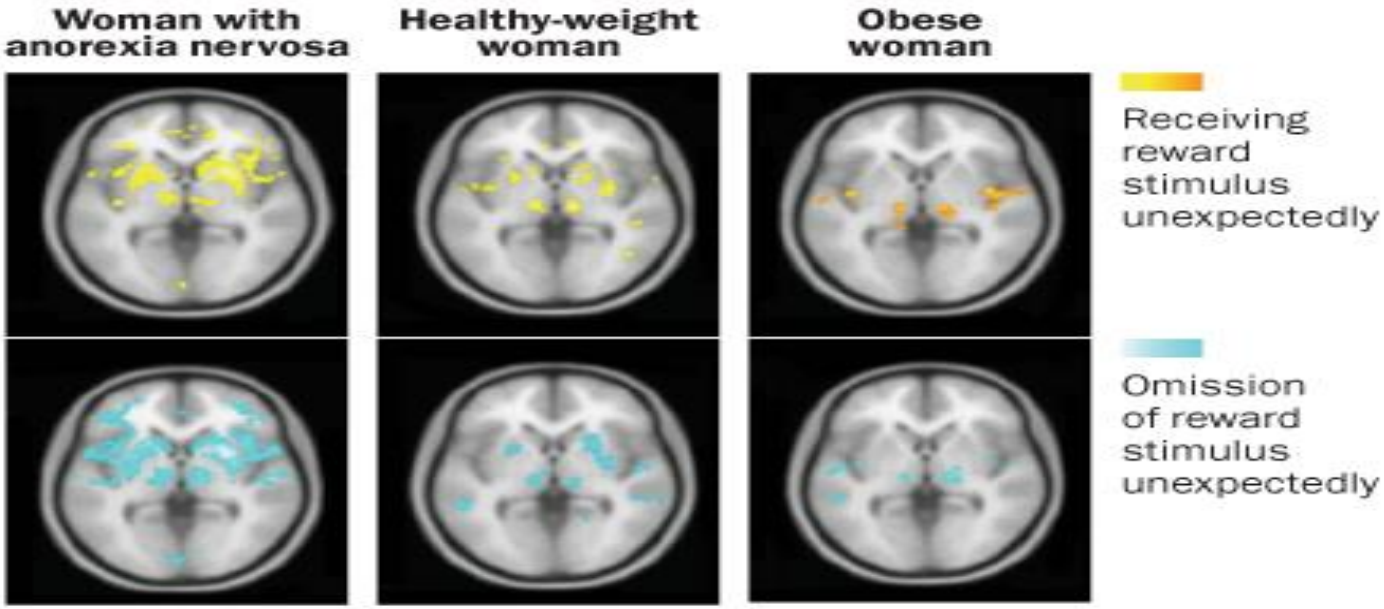



Brain
• The brain (specifically the amygdala) is our alarm system to identify danger
• It alerts us to several defense responses such as fight/flight/freeze/submit/collapse/feign death/attachment cry when confronted with danger
Body
• The Body then responds to the danger by way of the Autonomic Nervous System (ANS) and engaging in either Hyperarousal (Sympathetic Nervous System) fight/flight/freeze
• Or it goes into Hypoarousal (Parasympathetic Nervous System) submit, collapse, or dissociates to stay safe or attached to the perpetrator
Result
• Person learns that in order to stay safe/connected that they develop coping skills (The Answer) that allow them to survive or endure the danger
• They then develop beliefs or perceptions about themselves from this experience that continue to become pervasive throughout their lives to help them cope with ongoing complex trauma (small "t" traumas)

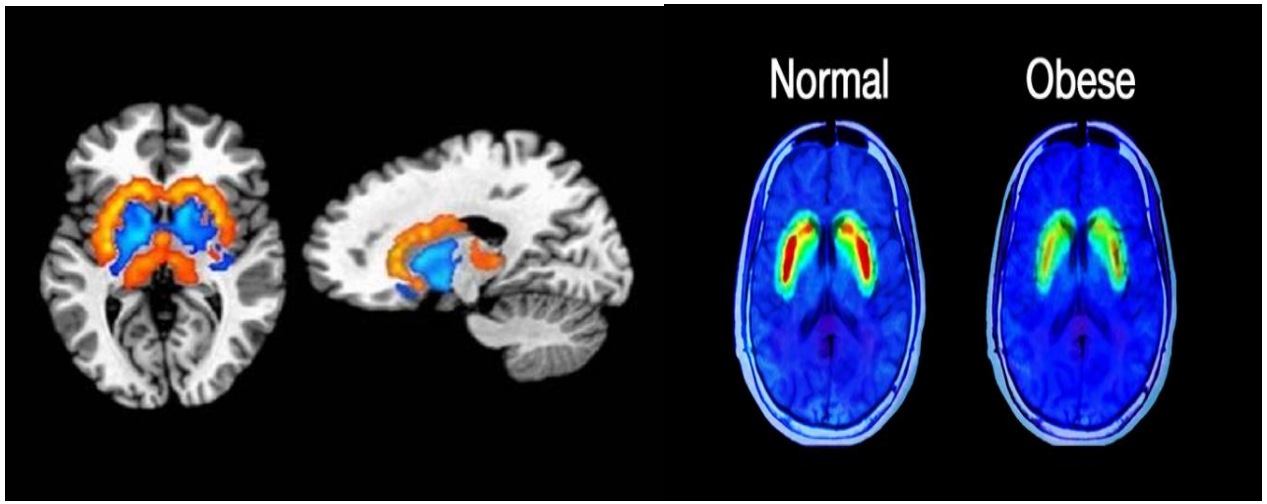
SYSTEMS INVOLVED IN DISORDERED EATING AND WEIGHT CYCLING



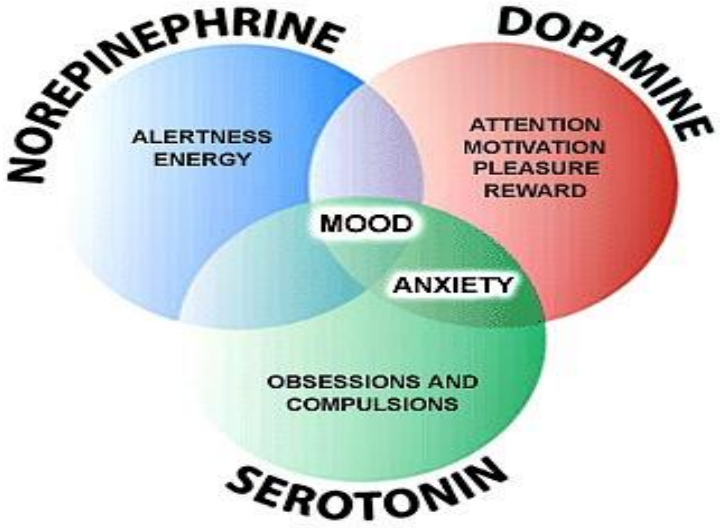
BRAIN IMAGING FOR HEALTHY VS. ED/OBESITY



BRAIN IMAGING INDICATING NORMAL VS. OBESE



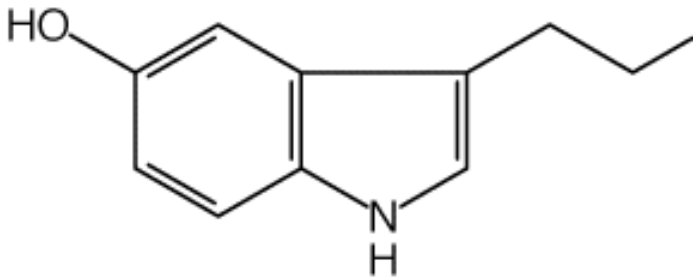
BRAIN CHEMISTRY IDENTIFIED IN MANAGING PAIN AND LOSS OF CONTROL



HOW DOES OUR BRAIN USE FOOD TO PROTECT US?

Serotonin

5-HT; 5-hydroxytryptamine

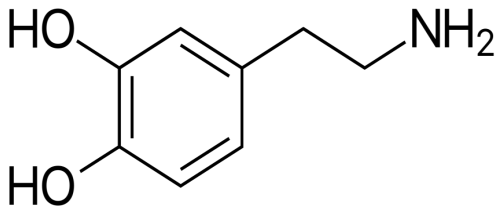


CHEMICALS INVOLVED IN DISORDERED EATING AND WEIGHT CYCLING - SEROTONIN

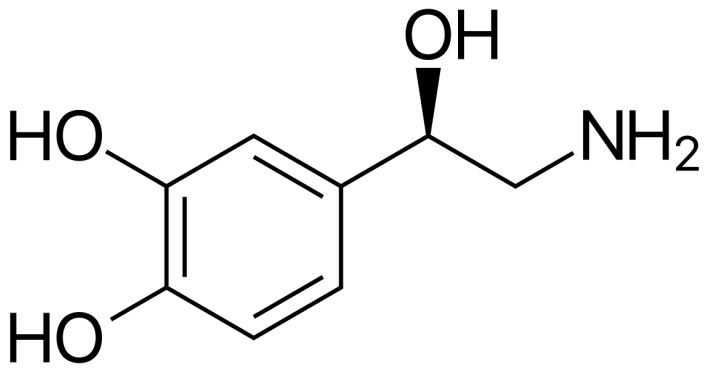
Serotonin (5htp; hydroxytryptophan) – works in the brain and Central Nervous System (CNS) by increasing the production of serotonin. It is implicated in several disorders including depression, anxiety, panic attacks, irritable bowel, PMS/hormonal dysfunction, fibromyalgia, insomnia and sleep-cycle disturbance, GI distress, carbohydrate cravings and obesity. Obsessions and compulsions are also part of this.

CHEMICALS INVOLVED IN DISORDERED EATING AND WEIGHT CYCLING - DOPAMINE

Dopamine (DA) – low levels can effect body movement and control and certain conditions can be permanent (Parkinson's and Alzheimer's disease) and can include muscle tremors and rigidity. The principal symptom of dopamine deficiency is depression, apathy, loss of satisfaction (anhedonia), chronic boredom, chronic fatigue, low energy level and motivation, lack of enthusiasm, poor concentration and attention, and inertia - with no desire to move the body, which may lead to anxiety. Food intake (especially sugars and fat) increases dopamine levels in the brain acting as a pleasurable reward which can trigger binge episodes and an inability to stop excessive eating habits or behaviors often triggered by stress.

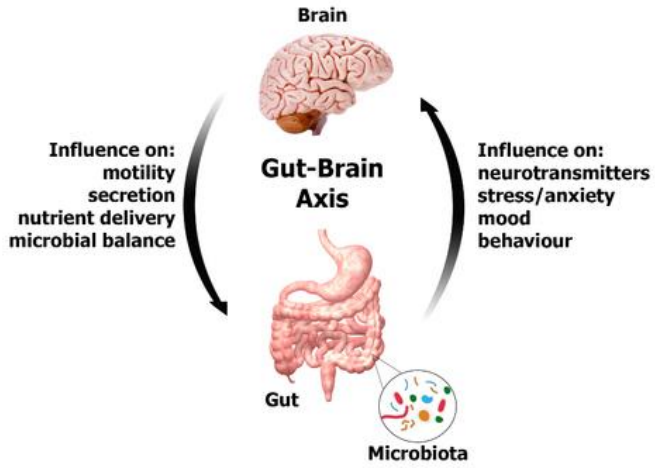


CHEMICALS RELATED TO DISORDERED EATING AND WEIGHT CYCLING- NOREPINEPHRINE



Norepinephrine (NE) – low levels can result in anxiety, depression, changes in blood pressure, changes in heart rate, low blood sugar (hypoglycemia), low blood pressure (hypotension), migraine headaches, problems sleeping, and may lead to ADHD.

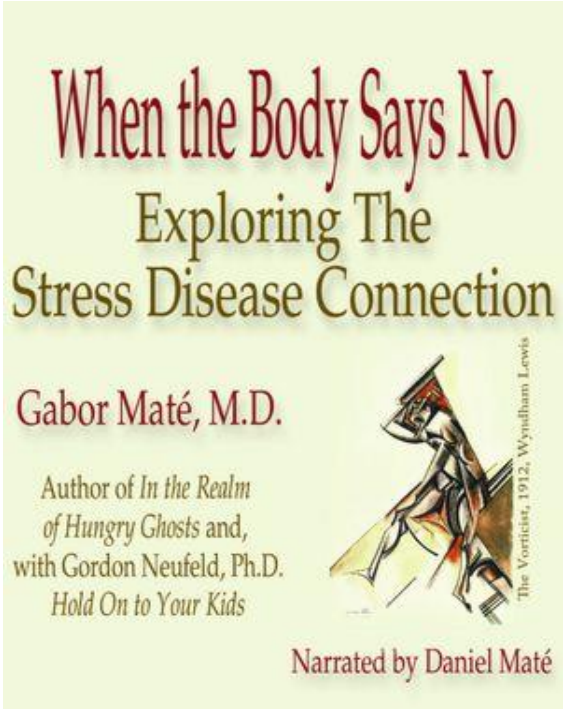
GUT-BRAIN AXIS AND HOW IT IS IMPACTED BY TRAUMA



- The gut is triggered by the brain due to stress and then releases cortisol which activates the safety responses in our system in the same manner as the fight/flight, freeze, submit or collapse responses.
- It also causes loss of appetite, initially, until safety can be assured and then can engage the hunger response or calming response once the danger is abated.
- Most disordered eating behaviors have an underlying "control" aspect and the individual then choose to have control over food or feeding when lacking that in other areas.

UNDERSTANDING THE STRESS-DISEASE CONNECTION

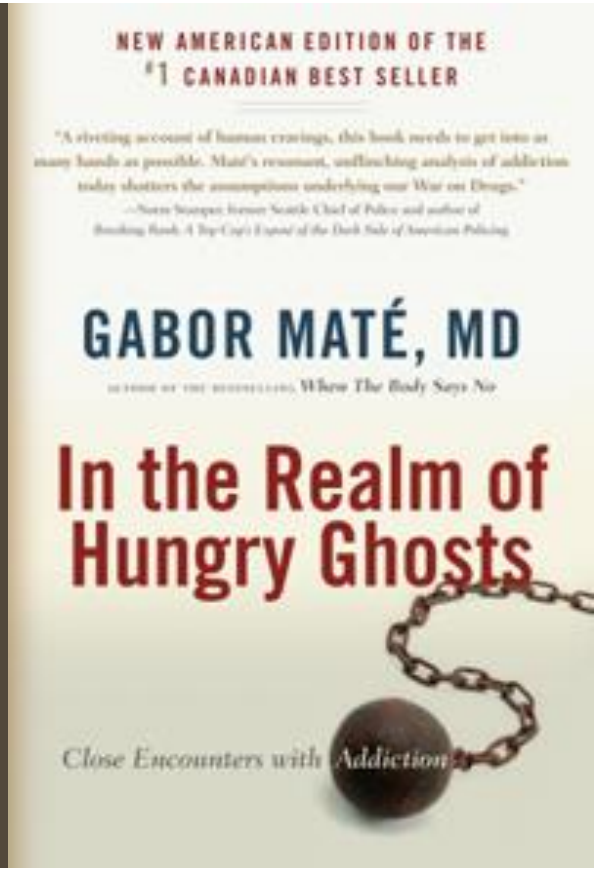
Gabor Mate' in his book When the Body Say No – Exploring the Stress-Disease Connection stated, "Eating patterns are directly connected with emotional issues arising both from childhood and from current stresses. The patterns of how we eat or don't eat, and how much we eat, are strongly related to the levels of stress we experience and to the coping responses we have developed in face of life's vicissitudes. In turn, dietary habits intimately affect the functioning of the hormones that influence the female reproductive tract. Anorexics, for example, will often stop menstruating."



OVEREATING AND DEFICIENT SELF-REGULATION

Gabor Mate' in his book In the Realm of Hungry Ghosts: Close Encounters with Addiction, stated, "The evidence is compelling in the case of overeating, where we most clearly see that a natural and essential activity can become the target of faulty incentive-reward circuits, aided and abetted by deficient self-regulation. PET imaging studies in addictive eaters have, predictably, implicated the brain dopamine system. …addictive eaters have diminished dopamine receptors; in one study the more obese the patients were, the fewer dopamine receptors they had."

He also goes on to state, "Junk foods and sugars are also chemically addictive because of their effect on the brain's intrinsic 'narcotics,' the endorphins. Sugar, for example, provides a quick fix of endorphins and also temporarily raises levels of the mood chemical serotonin." (Mate' 226).



THE BODY BECOMES THE WEAPON TO PROTECT THE SELF FROM ABANDONMENT OR TO STAY SAFE

- When understanding the Somatic and Attachment approach to Complex Trauma there is an interpersonal component that involves attachment and the body responds by doing what is necessary to maintain that attachment even if it is dangerous or maladaptive.

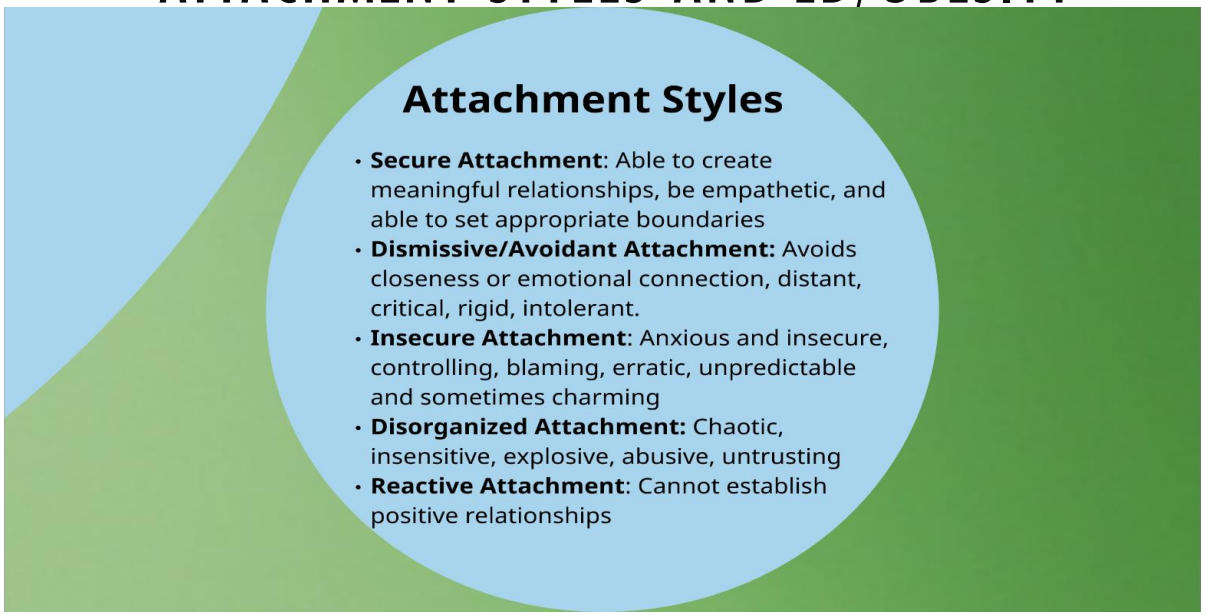
- There is also a cognizance to do what is necessary to keep the self (body and mind) safe by the develop of dissociation, which allows the individual to be present in body, but not in mind.

BODY DISTORTION OCCURS DUE TO NEGATIVE BELIEFS AND PERCEPTIONS AND THE LACK OF ATTACHMENT AND SAFETY

How did your perception of your body develop?

WHAT DID OTHERS SAY ABOUT YOUR BODY?

ATTACHMENT STYLES AND ED/OBESITY



ATTACHMENT STYLE DIFFERENTIATION WITH DISORDERED EATING AND WEIGHT CYCLING

Anorexia

- Ambivalent Attachment Style
- Defend against Affect
- Avoidance of Novelty
- Perfectionism, Obsessiveness, self-doubt and worry, compliance and perseverance in the face of non-reward
- Serotonergic mechanisms involvement

Bulimia

- Disorganized Attachment Style
- Emotionally dysregulated and engage in thrill-seeking behaviors
- 2 models for bulimic behavior: a) starvation model: which leads to binge eating and loss of control, and b) blocking model – eating is an escape from awareness (or dissociation) and is stress related

PROTOCOLS/TECHNIQUES FOR USE WITH DISORDERED EATING - ROBIN SHAPIRO, EMDR SOLUTIONS II

Anorexia

- Pendulation Protocol (page 138)
- 2 Hand Technique (page 142)
- Brain Lock (page 144)
- Grounding (page 141)
- Mindfulness (page 137)
- Affect Management (Page 139)

Bulimia

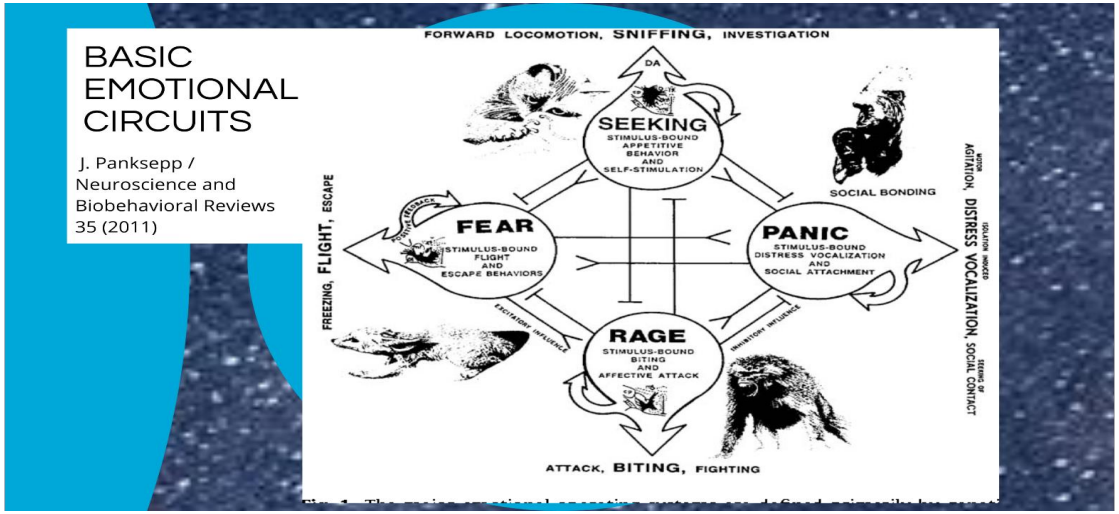
- Back of Head Scale (page 138)
- Sensorimotor Sequencing (page 212)
- Fractionated Abreaction (page 213)
- Stopping at Satiation (page 213)
- Integrating Ego States (page 214)
- Somatic Integration into Healthy Functioning (page 214)

STAYING SAFE AND STAYING ATTACHED

- When identifying natural human responses, Panksepp compared them to "animal responses," or our bodies natural and protective responses that are activated at a deep subcortical level without conscious awareness. He identified 7 emotional patterns (both positive and negative) that are activated with interpersonal relationships or attachments (Panksepp 35).
- There is excitatory and inhibitory responses that are stimulus-bound and attached to reward-seeking that causes the organism to react when confronted with various situations that are very instinctive.
- This behavior is learned during the early years of attachment and is often very intrinsic and tied to fears or intense "states" which is often referred to as "state dependent behavior, associations or responses." These occur as "learned behaviors" that are often very spontaneous but are repeated because they were effective at the time. When similar occurrences happen in the future the brain "searches" for what was effective in the past and responds accordingly.

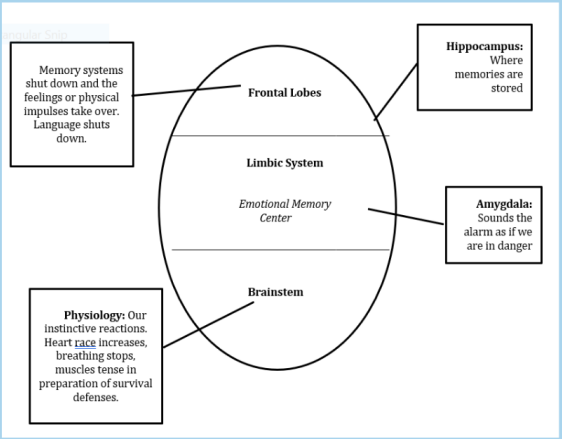
PANKSEPP 7 EMOTIONAL PATTERNS

PANKSEPP: RESEARCH ON HARD-WIRED SUBCORTICAL HUMAN STRUCTURES

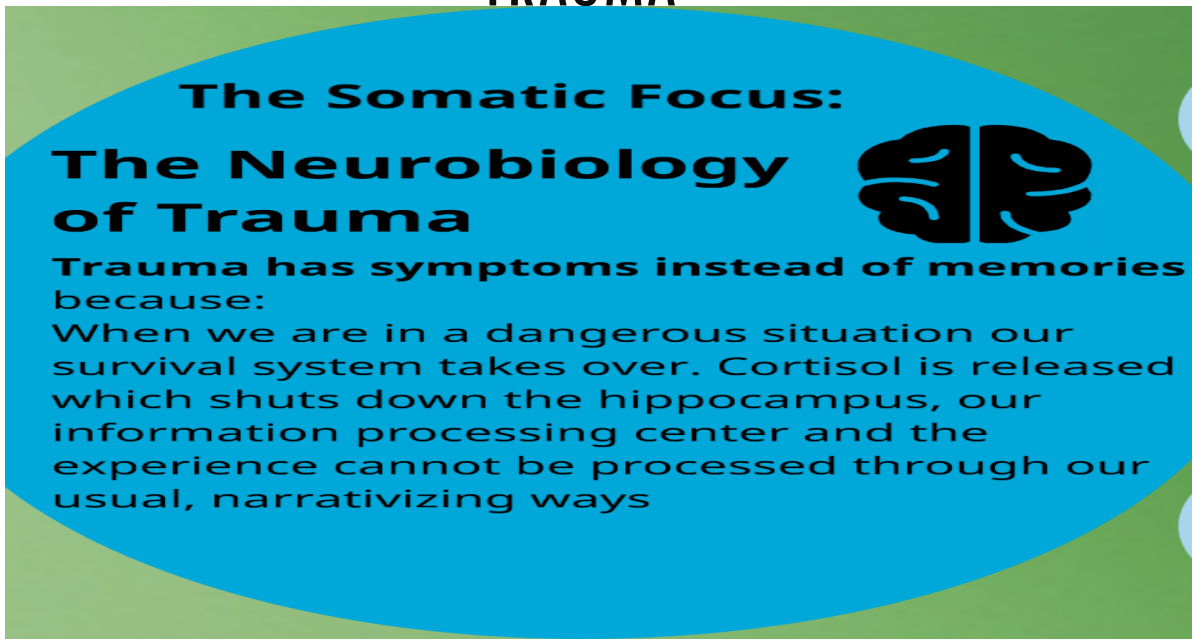


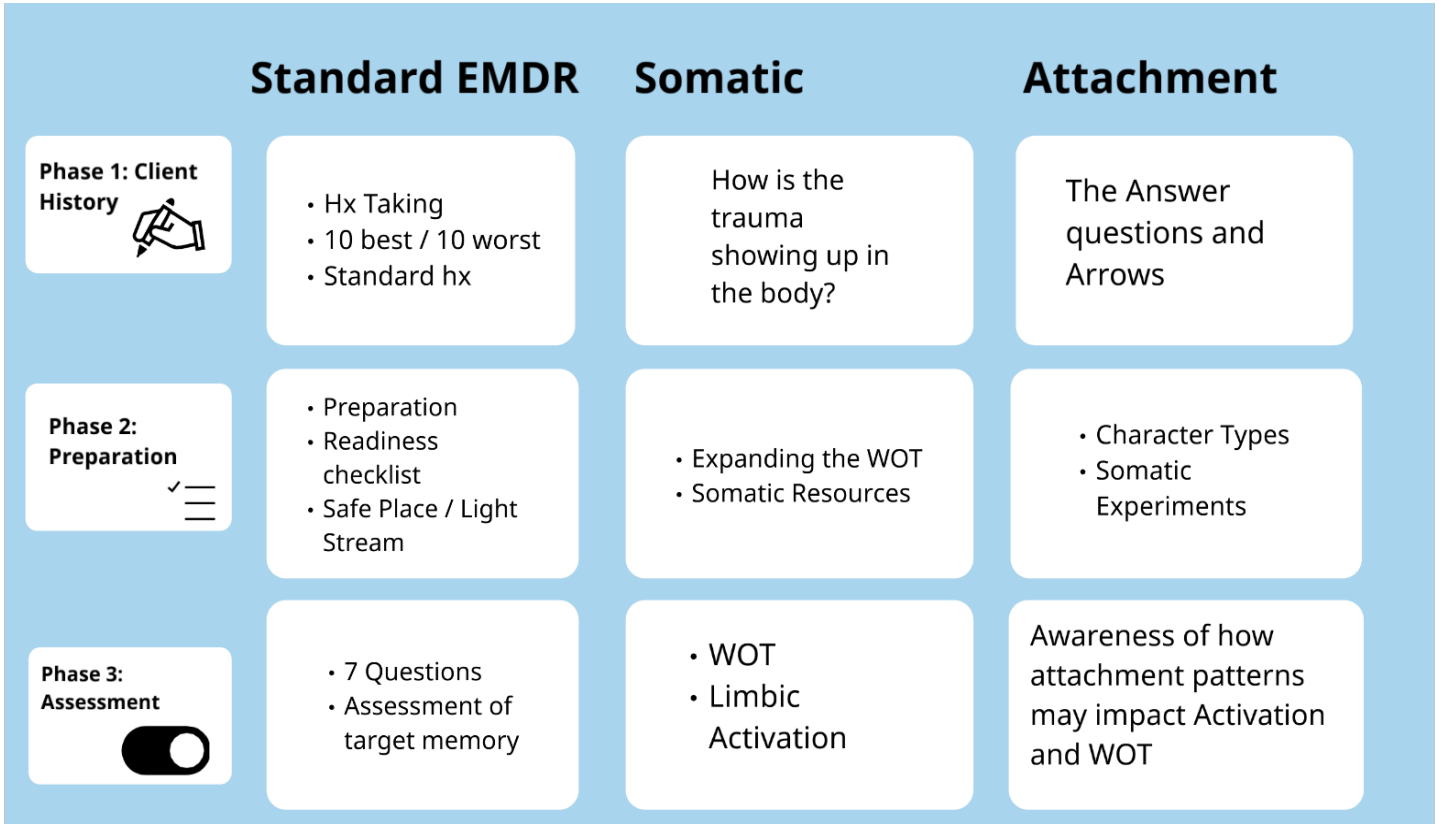
The Triune Brain (Paul D. MacLean)

A. Reptilian – Brain stem (bodily functions)
B. Paleomammalian – Limbic System (emotions)
C. Neomammalian – Frontal Lobes (thinking)



HOW THE SOMATIC FOCUS IS INVOLVED IN TRAUMA

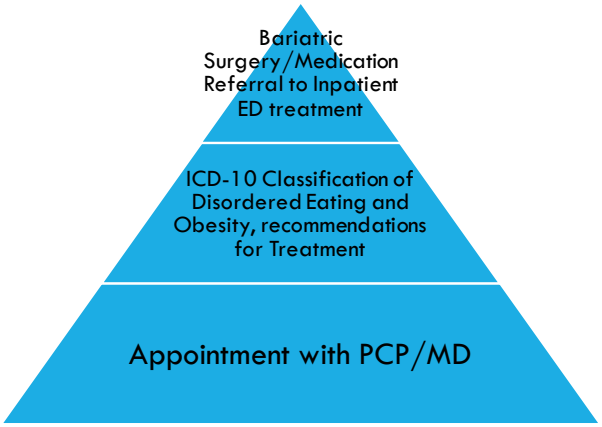



Standard EMDR
Somatic
Attachment
Phase 1: Client History
• Hx Taking
• 10 best / 10 worst
• Standard hx
How is the trauma showing up in the body?
The Answer questions and Arrows
Phase 2: Preparation
• Preparation
• Readiness checklist
• Safe Place / Light Stream
• Expanding the WOT
• Somatic Resources
• Character Types
• Somatic Experiments
Phase 3: Assessment
• 7 Questions
• Assessment of target memory
• WOT
• Limbic Activation
Awareness of how attachment patterns may impact Activation and WOT

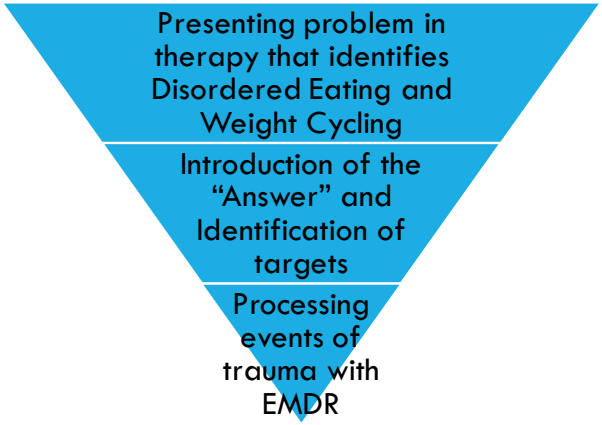
	Standard EMDR	Somatic	Attachment
Phase 4-6: Reprocessing 	Staying Out of the Way Cognitive Interweaves	Somatic Processing Somatic Cognitive Interweaves	Recognizing The Answer as it surfaces in reprocessing The 5 Cs
Phase 7: Closure 	Complete or Incomplete Standard Stabilization, e.g., Safe Place	Recognizing arousal within the WOT Somatic Resources	Capitalizing on existing containment and stabilization resources, i.e., The Answer
Phase 8: Reevaluation 	Current symptoms, reactivity to triggers, response to last Target	Somatic Symptoms Effectiveness of Somatic Resources	Degree of activation of client's Answer in response to triggers and symptoms

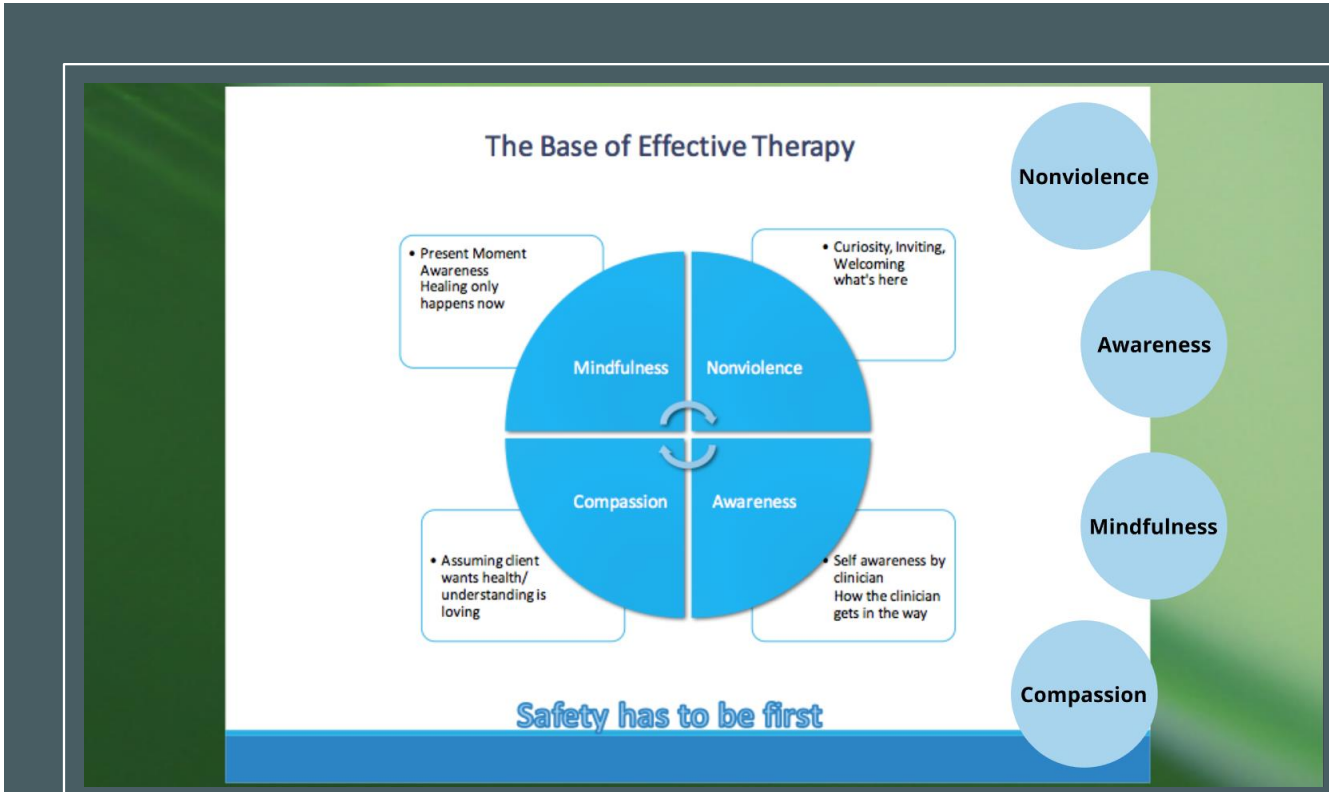
COMPARISON OF MEDICAL APPROACH TO TRAUMA-INFORMED APPROACH

Medical treatment of Eating Disorders/Obesity



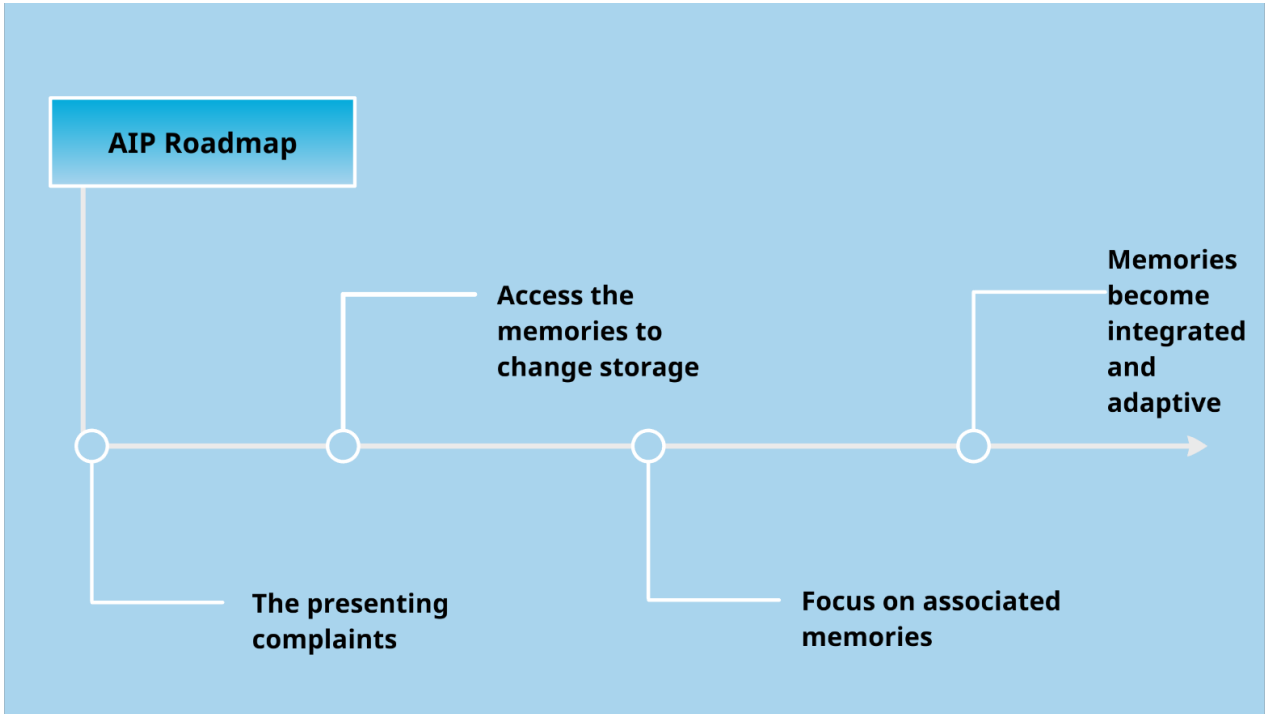
Trauma-Informed Approach with EMDR and Identification of Targets



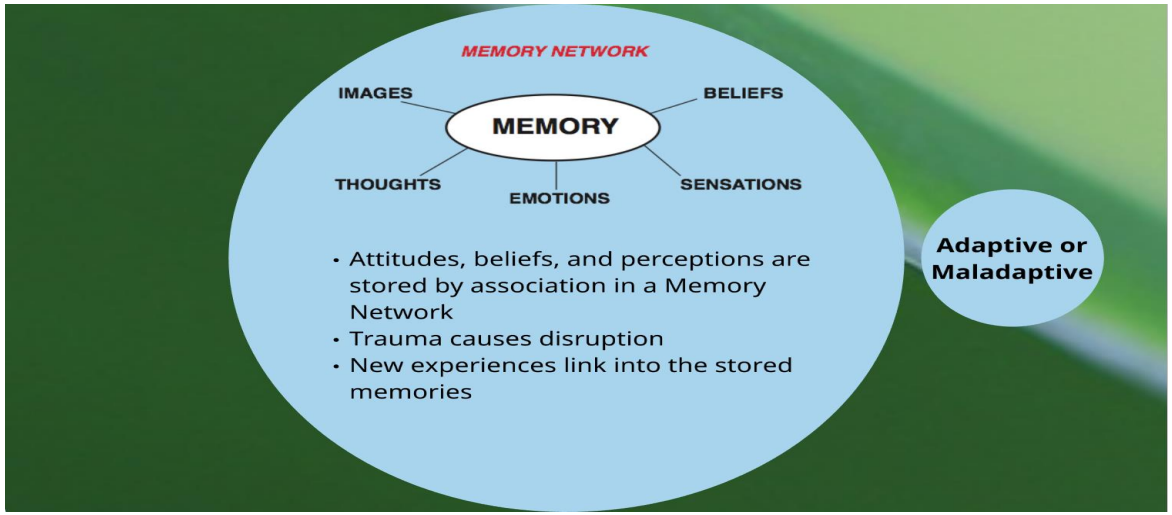

The Base of Effective Therapy
• Present Moment Awareness Healing only happens now
• Curiosity, Inviting, Welcoming what's here
Mindfulness
Nonviolence
Compassion
Awareness
• Assuming client wants health/ understanding is loving
• Self awareness by clinician How the clinician gets in the way
Safety has to be first
Nonviolence
Awareness
Mindfulness
Compassion

LOOKING THROUGH THE LENS OF THE AIP

- Much of psychopathology is a result of maladaptive encoding of, and/or incomplete processing of, traumatic or disturbing events
- The unprocessed experiences become stored in the emotional part of the brain without a time and date stamp
- When something happens in the present to activate the stored experiences, they feel as if it is happening right now, creating what appears to be an "over-reaction" to the present

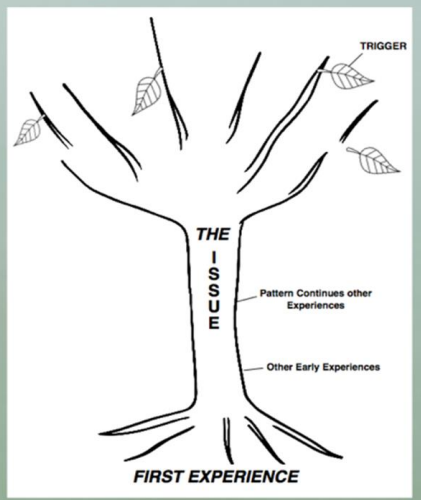

AIP Roadmap
Access the memories to change storage
Memories become integrated and adaptive
The presenting complaints
Focus on associated memories

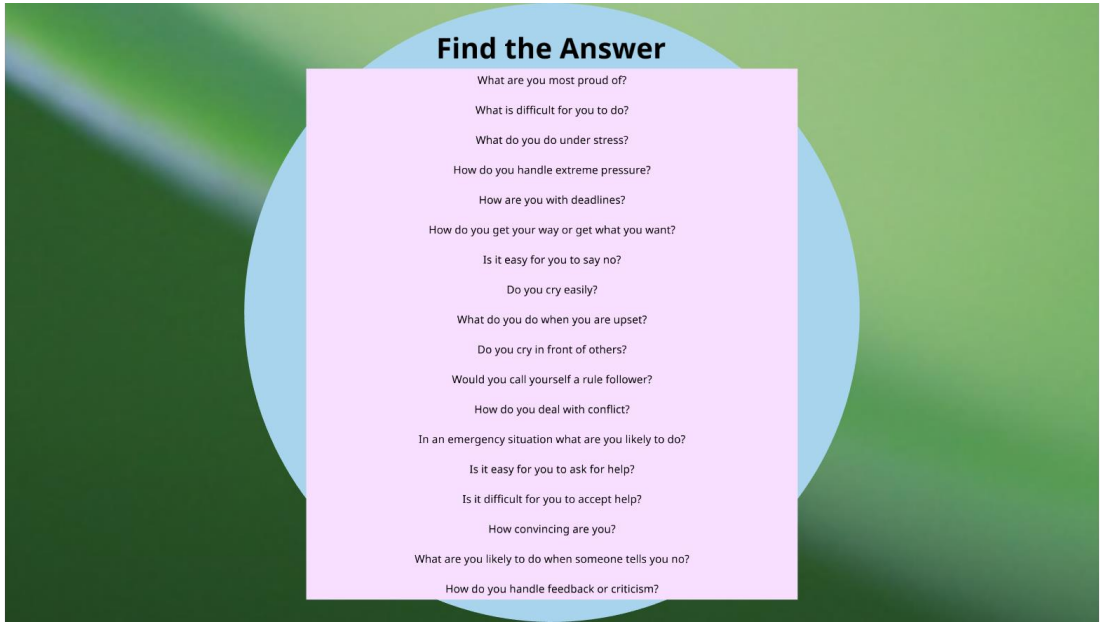
UNDERSTANDING THE MEMORY NETWORK



FINDING THE TARGETS/ROOTS OF DYSFUNCTION

We trim the leaves to get to the first experience (the Touchstone Memory) and find out the root cause of our client's Presenting Issue




Find the Answer
What are you most proud of?
What is difficult for you to do?
What do you do under stress?
How do you handle extreme pressure?
How are you with deadlines?
How do you get your way or get what you want?
Is it easy for you to say no?
Do you cry easily?
What do you do when you are upset?
Do you cry in front of others?
Would you call yourself a rule follower?
How do you deal with conflict?
In an emergency situation what are you likely to do?
Is it easy for you to ask for help?
Is it difficult for you to accept help?
How convincing are you?
What are you likely to do when someone tells you no?
How do you handle feedback or criticism?

USE OF "THE ANSWER" WHEN WORKING WITH DISORDERED EATING AND WEIGHT CYCLING

Identify beliefs about body, weight, feeding and eating characteristics in the home and what that consisted of for the individual

Evaluate the use of food as a "coping mechanism" or the denial of food as a means of punishment or if this was something that the parent/caretaker used for discipline

Inquire about perception of body and weight related to what other's would have expressed about their body and words used to identify their body, i.e., "nicknames" used in reference to the body or size.

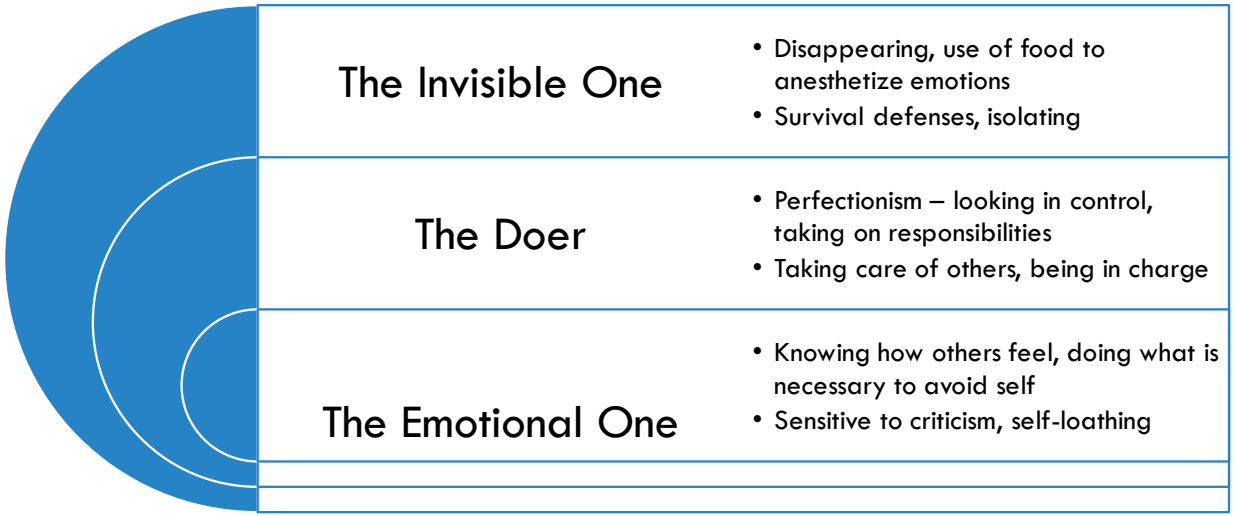
Ask them to recall how eating is experienced in social settings, at work, and in intimate relationships and how is eating different in private and public settings

Ask them to describe their body now in terms of beliefs or perceptions they hold currently about themselves and where that belief first begin (others or self)

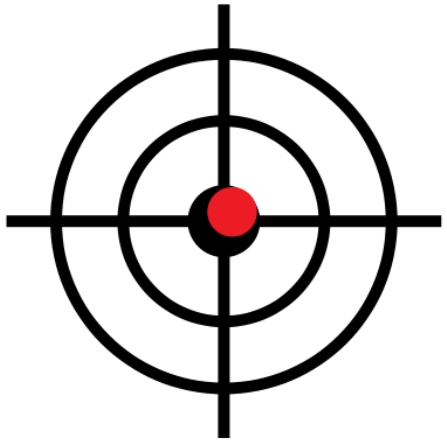
Character Types

Character Type	Possible Neg. Belief	Over-Developed	Under-Developed	Needed to hear
The Invisible One	I'm in danger. I'm going to die.	Disappearing. Survival Defenses, Sensitivity	Safety, grounding, staying present, feeling	"You are welcome here." "You are safe now."
The Emotional One	I'm in danger. It's not safe to feel safe.	Merging into other person. Knowing how others feel. Sensitivity.	Boundaries, ability to self-soothe.	"It is okay to feel safe when you are safe."
The Nice/ Non-threatening One	I'm helpless. I'm powerless.	Getting pity. Being a victim.	Personal power. Self-soothing.	"I'm here for you." "You can get your needs met."
The Independent One	I'm alone.	Competency. Ability to take control.	Asking for help. Trusting others to help.	"You can get support." "It's okay to ask for help."
The Rock	I don't matter. My needs don't matter.	Being dependable. Tolerating negative. Enduring suffering.	Knowing what they want. Asking for what they want. Action.	"What you want matters."
The Chameleon	I'm not enough.	Adaptation to environment. Ability to manipulate and adapt.	Being honest. Knowing who they are. Being straight forward.	"It's okay to just be you." "You matter."
The Hero	I'm not safe. I'm powerless.	Setting firm boundaries. Withstanding pain.	Being vulnerable. Connecting with authentic emotions.	"It is safe to connect."
The Doer	I need to be perfect. I'm not enough.	Energy, working hard, taking action.	Play. Connection. Self care.	"You don't have to work so hard." "It's okay to play."
The Life of the Party	I don't matter.	Energy. Fun. Action.	Rest. Being grounded and authentic.	"You matter." "You don't have to work to be noticed."

CHARACTER TYPES IMPLICATED IN DISORDERED EATING AND WEIGHT CYCLING



FINDING THE TARGETS WITH FOOD AND BODY IMAGE ISSUES



- Start out with the "Presenting Issue" of what brought them into therapy
- Pinpoint what is harder for them to do? Have them recall times in their lives that they may have tried to do "what is harder to do" (regarding eating, dieting, restricting, and bingeing) and it did not go very well, and how that shows up in social situations, their work setting, and intimate relationships
- Have them identify a "Present Trigger" in each of these settings
- Take a SUD score of 0-10 of how disturbing this was when they tried to do their identified behavior and it did not go well
- Identify the Negative Cognition they have of themselves regarding their body and weight, size, etc.
- Ask and when was an earlier time this happened, and continue until they cannot find any additional targets, taking us to the "touchstone" with their food/body issue

PTI RESOURCES TO USE WITH BODY ISSUES

The Somatic Resources are most beneficial to use with Disordered Eating and Weight Cycling, these include:

- Body Squeeze
- Progressive Muscle Relaxation (PMR)
- Grounding
- Alignment Exercise
- Scarf Connection/Boundary Exercise
- Orienting to Body – Name each part of body and what it does
- Scarf Crossing Boundary Exercise

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