EMDR AND EATING DISORDERS: THE EMDR THERAPY PROTOCOL FOR THE MANAGEMENT OF DYSFUNCTIONAL EATING BEHAVIORS IN ANOREXIA NERVOSA

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LEARNING OBJECTIVES

Read and comprehend attachment dynamics across the life span with focus on complex case (eg. eating disorders)

Identify targets (relational/attachment traumas) on the basis of the patient's attachment dynamics

Understand the origins of dissociative personality structure in early dysfunctional attachment to caregiver, and how they play a fundamental role in the patient's history and in the history of the disorders.

Identify, comprehend and work with patient's ego states in complex case

Deal with complex cases in the light of attachment issues and ego-states work.

Strategies to overcome blocks during the reprocessing of traumatic memories and in other phases

CLINICAL CASE VIDEOS

THE EMDR ANOREXIA NERVOSA PROTOCOL

Maria Zaccagnino

Zaccagnino, M. (2019). The EMDR Anorexia Nervosa Protocol. In M. Luber (Ed.), *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols and Summary Sheets: Treating trauma, anxiety, and mood-related conditions*. New York: Springer.

THE EMDR ANOREXIA NERVOSA PROTOCOL

IN THE PROTOCOL WE LEARN HOW TO

- Collect target starting both from the past and from the present problems
- How to assess attachment history
- How to construct therapeutic plan
- Work with the parts

PHASE 1: ASSESSING PATIENT'S LIFE HISTORY

HISTORY TAKING

History of attachment

- *I'd like to ask you to choose five adjectives or words that reflect your relationship with your mother/father starting from as far back as you can remember in early childhood.*
- *Can you think of a memory or an incident that would illustrate why you choose to describe your relationship as..* (insert adjective chosen by patient)?
- Now I wonder if you could tell me, to which parent did you feel the closest, and why? Why isn't there this feeling with the other parent?
- *When you were upset or worried, and/or in emotional difficulty as a child, what would you do? And how did your parent react? Can you tell me about some specific incident?*
- *When you got hurt physically what would happen? Can you think of any particular incident?*
- *Do you remember the first time you were separated from your parents? How did you react? And how did they react? Can you think of other significant separations?*

PHASE 1: ASSESSING PATIENT'S LIFE HISTORY

HISTORY TAKING

History of attachment

- *Were your parents ever threatening with you in any way - maybe for discipline, or even jokingly? How old were you at the time? Did it happen frequently? Do you feel this experience affects you now as an adult?*
- *In general, how do you think your overall experiences with your parents have affected your adult personality? Are there any aspects to your early experiences that you feel were a set-back in your development?*
- *Why do you think your parents behaved as they did during your childhood?*
- *Were there any other adults with whom you were close, like parents, as a child?*
- *Other than any difficult experiences you've already described, have you had any other experiences which you should regard as potentially traumatic?*
- *We've been focusing a lot on the past in this interview, but I'd like to end up looking quite a ways into the future. We've just talked about what you think you may have learned from your own childhood experiences. I'd like to end by asking you what would you hope your child (or, your imagined child) might have learned from his/her experiences of being parented by you?*

PHASE 1: ASSESSING PATIENT'S LIFE HISTORY

HISTORY TAKING

Episodes of rejection

Did you ever feel rejected as a child? How old were you when you had that feeling and what did you do then? Why do you think your parents behaved like that? Do you think they realized how you felt?

Episodes of neglect

Do you remember any times when your parent/s was/were physically present but absorbed in his/her own thoughts and therefore emotionally unavailable?

Episodes of pressure to achieve

Do you remember experiences where you felt pressured to achieve in school or athletics that resulted in considerable anxiety about failure?

***DISMISSING PATIENTS:** If dismissing clients are generalizing or unable to get to specific memories, ask them to bring in **photographs** or tell some of the **family stories**.

OTHERS HISTORY'S COLLECTION STRATEGIES

HOW TO COLLECT INFORMATIONS WHEN THE PATIENT IS NOT ABLE TO BRING THEM

- If the patient struggles to find memories of the past, ask the patient to retrieve **diaries, photographs, parents' written letters, childhood themes** to use as targets.

- Ask the patient to **hypothesize how things have gone and imagine situations and scenes** that do not contain conscious memories or which they are not actually aware of.

- FLOAT BACK TECHNIQUE

From negative beliefs about the self	*"What are your main negative beliefs about yourself?"*
From the symptoms	*"How do you feel?"* → *«Where do you have felt it before?"*
From disturbing emotions and/or physical sensations	*"Where do you have already experienced it?"*
From the worst future scenario	*«If you imagine the situation which you are afraid of, what's the worst thing that could happen?"*

PHASE 1: ASSESSING PATIENT'S LIFE HISTORY

HISTORY TAKING

Mourning and/or traumatic experiences

- *Did you experience the **loss of a parent or other close loved ones** while you were a young child? Could you tell me about the circumstances?*
- ***How old were you** at the time?*
- ***How did you react** at the time? Was this death sudden or was it expected?*
- *Can you remember **your feelings** at the time? Have they changed since then?*
- *Are there **any other experiences** that you consider might have been traumatic?*

CLINICAL CASE: ALESSANDRA'S MOTHER

Age: 50 years old

She is in treatment to work on transgenerational traumas linked to Alessandra's symptoms

Previous treatment: no

Triggering event: no

T: mother's death during pregnancy CN: I'M UNABLE

t: critical attachment wounds:

- mother's derogation CN: I'M NOT WORTHY

Other's traumas (t): husband's betrayal

CLINICAL CASE: ALESSANDRA

Age: 17 years old
Disorder: Anorexia Nervosa, BMI 13
Previous treatment: no

Triggering event: bullying and grandfather's illness
T: death of grandmother during pregnancy CN: I'M HELPLESSNESS
t: critical attachment wounds:

- mother's depression CN: I'M NOT ENOUGH
- father's aggressive modality CN: I'M IN DANGER

ED'S TARGET IDENTIFICATION AND WORK PLAN

1. TRIGGERING EVENT: addressing the triggering event (if any) which elicited the onset of the disorder is a priority in the therapeutic work with patients affected by eating disorders. It will thus be useful to start with the memories reported by the patient in the history taking phase and proceed with float back to trace back all the episodes connected with the triggering event in the patient's life history. E.g. a separation from a boyfriend can be linked to attachment separation.

2. T TRAUMAS: if the patient suffered major traumas in his or her life, they will have to be processed, in accordance with the EMDR standard protocol. E.g. mourning

3. THE ATTACHMENT TRAUMAS (t) LINKED TO THE DEEPEST MEANING OF EATING DISORDER. E.g. 5 years old: mother forgot child at the swimming pool.

4. ALL OF THE TARGETS DIRECTLY CONNECTED WITH FOOD WILL HAVE TO BE IDENTIFIED WITHIN THE PATIENT'S LIFE AND DISORDER HISTORY. All of the targets explaining why the patient chose food (rather than something else) to manifest her area of vulnerability will have to be especially identified.
E.g. a close friend that lose weight and became very popular.

5. WORK ON SYMPTOM AND MEMORIES CONNECTED TO IT. E.g.
the first time of food-restriction.

DISSOCIATIVE ASPECTS: PARTS WORK

WHEN USING IT: GOALS

- Integration of the self
- Collaboration in different phases of the therapy:

1. Psychoeducation
2. Motivation and secondary advantages of the symptoms
3. History taking
4. Mealtimes
5. Blocks and defenses
6. Emergency management and crisis moments
7. Acute phase in the hospital

Zaccagnino M., Civilotti C., Cussino M., Callerame C., Fernandez I. (2017), "EMDR in Anorexia Nervosa: from a theoretical framework to the treatment guidelines". In Lobera, I.J. (Ed), *Eating Disorders. A Paradigm of the Biopsychosocial Model of Illness*. ISBN 978-953-51-4888-3. In press.

For a more comprehensive illustration of the parts work concept refer to the studies conducted by Solomon, van der Hart, Steele, Fraser, Forgash, Knipe, Gonzalez and Mosquera.

PARTS WORK

WHAT WE DO

- Approach
- Welcoming
- Visualization
- Empathy / tuning
- Reassurance
- Comprehension
- Recognition
- Legitimation
- Validation
- Enhancement

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PARTS WORK: THE CONTROL HISTORY

In the preparation phase it is important for the therapist to explain to the patient the meaning of the parts of self concept, and specify that such parts play a fundamental role in her history and in the history of the eating disorder. In order for a climate of trust to be established between the therapist and the patient, the therapist must co-construct together with the patient shared knowledge about a specific aspect of her personality which plays a crucial role in maintaining the symptoms: the control part. Only after working in a spirit of co-awareness, acceptance and recognition, will it be possible to ask specific questions of this part, to understand its history. One question may be where it comes from, and where the patient has learned to use this specific defense strategy.

- *Is this part visible? How old is she? What happened to her?*
- *Where did she learn to control?*
- *What is the task assigned to this part?*
- *Is she protecting someone?*
- *If the control part were no longer there, what would happen?*
- *Are you able to see the part that she is protecting? Can you describe that part? What is her history?*

CLINICAL CASE: MARIELLA

Age: 16 years old
Disorder: Anorexia Nervosa, BMI 14
Previous treatment: 1 year of CBT without results

Triggering event: Depressive symptoms of the father after some working problems **CN: I'M HELPLESSNESS**
T: grandfather's mourning at 14 years old **CN: I'M HELPLESSNESS**
t: critical attachment wounds:

- derogation from the mother **CN: I'M NOT WORTHY**
- victimistic modality from the father **CN: I'M HELPLESSNESS**

Blocks:

- Self-harm part activated during a crisis moments doesn't permit the processing of traumatic memories.
- The risk: serious injury due to self-harm behavior.

CLINICAL CASE: ALESSANDRA M.

Age: 20 years old
Disorder: Bulimia Nervosa, BMI 21
Previous treatment: no

Triggering event: no
T: grandfather sexual abuse from 3 to 10 years old
CN: IT'S MY FAULT
t: critical attachment wounds:

- mother's neglecting and derogation CN: I'M NOT WORTHY
- father's neglecting and derogation CN: I'M NOT WORTHY

Blocks:
The part that says "**nothing happened**" blocks the access to the emotional contact and reprocessing of sexual abuse traumatic memories.

WORKING WITH PARENTING ISSUES WITH EMDR THERAPY: THE PARENTING PROTOCOL

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Zaccagnino, M. (2019/in press). Working with Parenting Issues with EMDR Therapy: The Parenting Protocol. In M. Luber (Ed.), *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols and Summary Sheets: Treating trauma, anxiety, and mood-related conditions.* New York: Springer.

THE PARENTING EMDR PROTOCOL

The healing obstacles are not only the parts of the patient. An important role in the healing process is covered by the dissociated parts of the parent that may cause strain or breaks in the therapeutic process.

These parts sometimes need to express discomforts and familiar/transgenerational dynamics through the symptom of the patient, so we need to work with these parent's parts that do not allow the symptom resolution, towards an integration.

BLOCKS AND DEFENSES COMING FROM PARENT'S PARTS

Unresolved transgenerational trauma is transmitted through the caregiving system also with non verbal modalities like gestures and gazes. At the moment of the original trauma, the **parent developed a** defense to survive (through strategies like anesthetize, minimize, derogate the trauma).

The transgenerational transmission of an unresolved trauma contains both the traces of the trauma and the defenses structured by the parent in facing the original trauma.

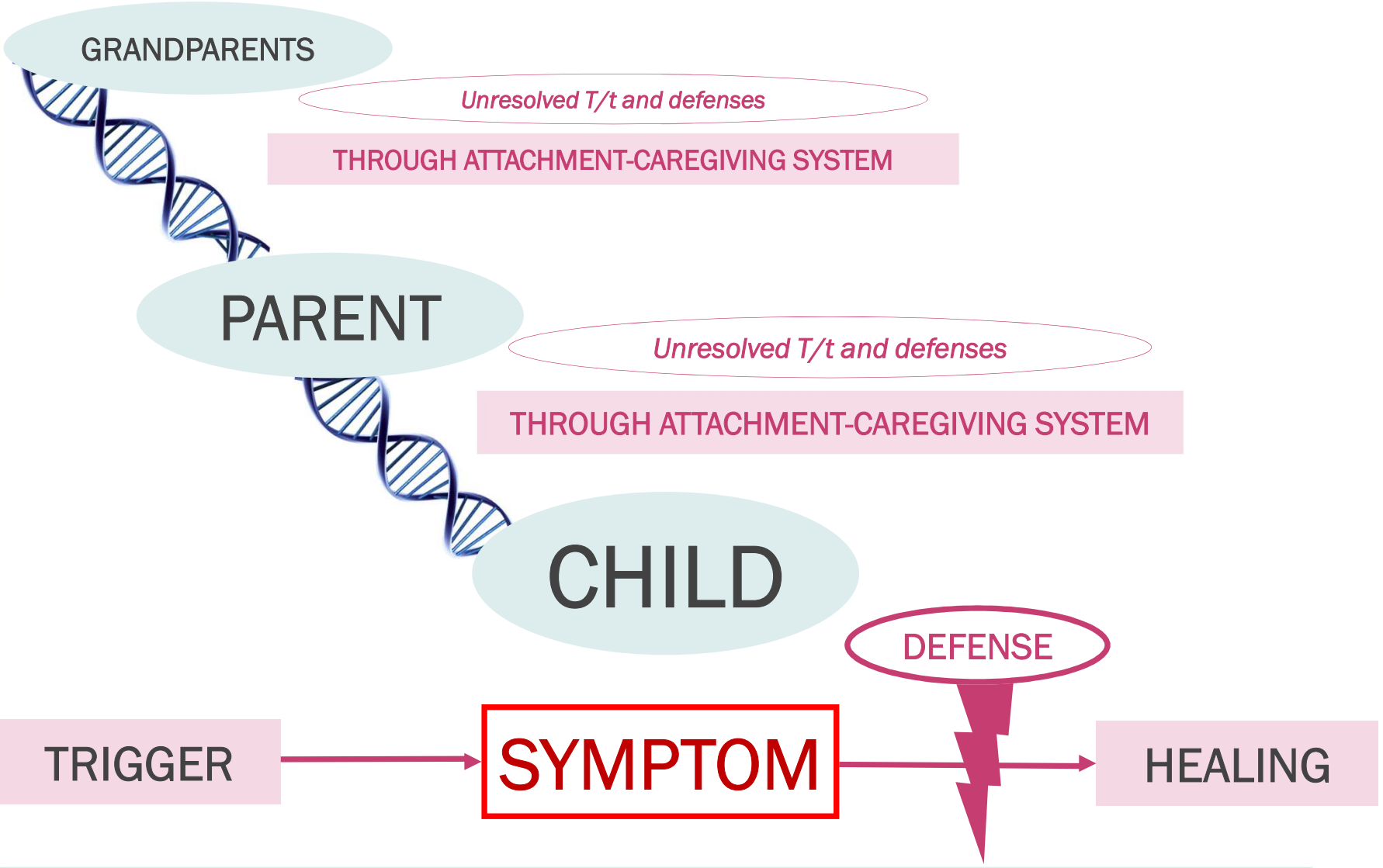
This defense lives in trauma time and protects with the same strategies the child and/or the entire relational family system.

The traces of an unresolved trauma and defenses may be activated by a trigger event in the child's life.

This is why the child could not unlock the symptoms.

Our first goal must be to integrate the parent's defense.

BLOCKS AND DEFENSES COMING FROM PARENT'S PARTS



BLOCKS AND DEFENSES COMING FROM PARENT'S PARTS

The **involved parent's part** could be:

- Parts who, through the daughter/son's symptoms, protect the parent to be in contact with her/his traumatic memories: understand which parent's parts are activated with the aim of protecting the parent from access to her/his traumatic memories (the child's symptom could be maintained with the aim of avoiding direct access to some traumatic targets of the parent)
- Parts who, through the daughter/son's symptoms, express the parent's unexpressed and unlegitimated suffering
- Parts who, through the daughter/son's symptoms, maintain a secondary advantage within current relational dynamics e.g. problematical family dynamics

THE DISSOCIATIVE TABLE WITH THE PARENT'S DEFENSES ON THE CHILD'S SYMPTOMS

We ask to all the parts of the parent to come for a meeting to discuss about child's symptoms.

Focus on the **symptom of the daughter/son,** and ask for the collaboration of the parts of the self.

Knowing all the parts involved (age, sex, physical description and function of each part, feelings and emotions that each part feels to the other parts). The parts that came represents parent's attachment traumas.

Ensure that all the present parts know that there is an adult part, the parent of an X-year-old daughter/son named X.

Focus on the adult part's resources as a parent.

Ask who is the part that needs to say something about child's symptoms.

Ask if there is a part that doesn't agree to collaborate.

QUESTIONS TO ASK

- *Is there any part of you who wants to say something when you see your daughter/son suffering? What does that part would like to say?*
- *Is there any part of you that fears something if the daughter/son's symptoms disappears?*
- *Is there any part of you that feels that she can communicate only through the daughter/son's symptoms?*
- *Is there any part of you that finds it hard to let the daughter/son's symptoms go? Does that part fear anything? Why?*

FOR EACH IDENTIFIED PART

- *Is this part protecting you and your daughter/son somehow? Does she allow (you and your daughter/son) to do something? Does she prevent (you and your child) from acting something?*
- *Is this part visible? How old is she? What happened to her?*

CLINICAL CASE: ALESSANDRA'S MOTHER

Age: 50 years old
She is in treatment to work on transgenerational traumas linked to Alessandra's symptoms
Previous treatment: no

Triggering event: no
T: mother's death during pregnancy CN: I'M UNABLE
t: critical attachment wounds:

- mother's derogation CN: I'M NOT WORTHY

Other's traumas (t): husband's betrayal

Blocks:

Through Alessandra's symptoms her parts want to express her suffering about:

- her attachment traumas
- current problems with husband

THANKS FOR YOUR ATTENTION!

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