A Publication from the CHEMOTION sm **INSTITUTE**
Counseling, Research, and Education for Ingestive Disorders

TREATMENT OF BULIMIA AND BINGE EATING DISORDER USING THE CHEMOTION/EMDR PROTOCOL†

by
JOHN OMAHA, M.A.‡

† Paper presented at EMDRIA Conference, "EMDR...Forward from the Future" Toronto, Ontario, Canada, September 10, 2000

‡ Correspondence concerning this article should be addressed to:
John Omaha, MA P.O. Box 528 Chico, CA 95927-0528 (530) 899-7719

Email: jomaha@sunset.net

Abbreviations: AMST, Affect Management Skills Training; AN, Anorexia Nervosa; BN, Bulimia Nervosa; BED, Binge Eating Disorder; EMDR, Eye Movement Desensitization and Reprocessing; EMs, Eye Movements; NC, Negative Cognition; PC, Positive Cognition; SUD, Subjective Units of Disturbance; TA, Traumaphor Associations; TFP, Traumaphor Focused Processing; VOC, Validity of Cognition

P.O. BOX 528 CHICO, CA 95927-0528 530/899-7719
email: jomaha@sunset.net

Introduction

The ingestive disorders are characterized by their expression of aspects of the personality through an abused substance, which in the case of the eating disorders is food. The personality system is conditioned by both deficit experience and by trauma. Deficit experiences can defect the attachment and include failures of physical connection, affective attunement, and secure emotional holding. Other deficits include failure to transmit skills to manage affects, deficiencies in modeling, and narcissistic failures. Trauma is understood in terms of Shapiro's adaptation of the Information Processing Model as an event or events that exceed the mind's innate ability to process the event to adaptive resolution[1]. These events run the gamut from verbal abuse, shaming, intimidation, neglect, deprivation, and abandonment to physical and sexual abuse. The ultimate effect of deficit and traumatic experiences on development is conditioned in part by genetic factors that are not well understood. These factors are grouped as resilience, the innate psychological self-healing mechanism, that is, the ability of the self to process disturbing events to an adaptive resolution. Resilience is believed to be a distributed function across the population.

Chemotion

Chemotion is a psychodynamic model that traces present day pathology to causal events in infancy, childhood, and latency[2]. The attachment process sets the basic relational scripts, the attachment styles, in place by the stage of symbiosis at six months. Failures of attachment adversely impact all subsequent developmental stages. Deficit and/or traumatic experiences occurring during development can (1) prevent completion of separation-individuation and attainment of object constancy; (2) cause splits in the undifferentiated self- and object representation; (3) trigger formation of a False Self Identity. Unresolved, disturbing affects and sensations resulting from deficit and/or traumatic experiences are assembled with the undifferentiated self- and object-representation or with split off parts. Unresolved, disturbing affects and sensations along with accompanying images may also be sequestered into split off parts of the self, forming nascent ego states.

Adolescence is accompanied by prominent neural alterations in brain regions such as the prefrontal cortex[3]. A pruning of synapses occurs in neocortical and prefrontal cortical regions with as much as a 50% reduction in synapse density. Receptors for several neurotransmitter systems are overproduced and pruned during adolescence as the organism prepares for socialization and reproduction. Psychologically, the self reorganizes during adolescence. Chemotion hypothesizes that the emerging adult self constellates around the introjects, undifferentiated self- and object-representations or splits thereof, False Self Identity, and split off parts of the self formed during previous developmental stages. At this time, Chemotion hypothesizes, unmetabolized disturbing affects that have persisted in a state-specific form along with

associated images and sensations become the nucleus around which a symptom-expressing ego state coalesces. Through a trial and error process, the symptom-expressing ego state will find a substance that facilitates its expression. For the emerging addict, the facilitating substance will be a drug, which may include one or several among alcohol, nicotine, and illicit drugs. For the emerging eating disordered personality, the facilitating substance is food. The symptom-expressing ego state will vicariously (1) reenact the archaic deficit and/or traumatic experiences, and (2) reexperience the unresolved affects assembled with those experiences through the relationship to the abused substance. For the eating disordered person the relationship may include bingeing, purging, or restricting, which may be done individually or in all combinations. Obsession with the abused substance reflects the fact that significant aspects of the self are being expressed through that substance. Compulsive symptom expression occurs because the symptom-expressing ego states are assembled around powerful, disturbing, unresolved affects. These principles are illustrated in Figure One and Figure Two.

Chemotion, the Chemotion/EMDR Protocol, and Treatment of Bulimia and BED

Chemotion and treatment based on it are syncretic, uniting information from attachment theory, object relations, dissociation, traumatology, EMDR, and ego state theory. The goals of treatment are: (1) to remediate the deficit experiences; (2) to reprocess trauma(s), desensitize unmetabolized affects being expressed through symptoms, and integrate symptom-expressing ego states (if they exist) that may hold such traumas and affects; (3) to complete separation and individuation of the self-representation from primary (mother) and secondary (father) object-representations; (4) to restructure the personality around a healthy core, the authentic self. Treatment components are presented in Figure Three.

Treatment begins with a thorough history that stresses: (1) attachment history, including whether client was nursed; (2) childhood relations to principal care givers; (3) present relations to principals including spouse/partner, children, parents, in-laws; (4) careful attention to past and present disturbing affects; (5) triggers for symptom expression; (6) relations to the abused substance.

Affect Management Skills Training (AMST), which is derived from work by Leeds[4], Leeds and Korn[5], and Linehan[6], teaches a skill set to recognize, cope with, and decrease disturbing affects. The basic skills are: (1) affect recognition and association with a sensation; (2) sensation as signal; (3) grounding cord to stay grounded and present while experiencing a disturbing affect—this skill avoids "fast processing" thereby intervening acting out; (4) witnessing self (hypnotic duality); (5) garbage chute, a resource to decrease disturbing affects. Adequate AMST preparation is essential to subsequent processing. If the client

begins to dissociate or shut down as disturbing affects arise, the clinician can remind client of her skills and facilitate her use of them. In ego state negotiations, the client can inform a symptom-expressing ego state that he now has the skills to tolerate the disturbing affect that the ego state was formerly expressing through the symptoms. EMDR is used to facilitate effective, efficient acquisition of these skills.

EMDR is also employed to remediate attachment failures. When the client accesses an affect that was apparently unacceptable to the client's primary care giver during infancy, the therapist can tap on client's shoulders (where ethically appropriate and therapeutically indicated) to provide the physical connection while at the same time verbalizing statements of affective attunement and secure emotional holding. This application draws from work of Wesselmann[7].

A central component of the Chemotion/EMDR treatment protocol is elicitation of traumaphor associations[2, 8] (TAs). The traumaphor is the substance of abuse, so called because its use suggests similarities with the original trauma. Gestalt communication technique is employed diagnostically to uncover the images, behaviors, cognitions, affects, and sensations being reenacted and reexperienced through the eating disorder. The protocol can be found in Figure Four. The TAs
uncover an intrapsychic dialogue between ego states. TAs provide a road map of affects, cognitions, and sensations being reenacted through the disorder, informing the clinician of what must be desensitized and structuring his interventions and cognitive interweaves.

Treatment moves immediately to traumaphor focused processing (TFP), an adaptation of the EMDR standard protocol[1,2] in which the target is the food placed in an empty chair. A negative cognition (NC), positive cognition (PC), validity of cognition (VOC), affect, sensation, and subjective units of disturbance (SUD) are elicited and processing, facilitated by eye movements (EMs) or tactile stimulation begins. Chemotion employs several interventions including abreaction[9], cognitive interweaves[1], and ego state work[9] in the course of processing. Ego state work begins with identification of ego states. Ego states observed in eating disordered individuals include: symptom-expressing ego states, false self, authentic self, damaged or wounded child, defiant self/defiant child, parents, ego states that protect by dissociation. Ego states are recognized by their actions and effects on the system. When an ego state makes itself known, the clinician elicits its appearance through techniques like the "conference room"; affiliates with it; honors its contribution to the system; negotiates for the authentic self to take responsibility for the affects, sensations, cognitions and behaviors the ego state has been expressing; and negotiates a role reassignment for the ego state, which is often to function as a sentinel to warn the authentic self when it is experiencing the affects the ego state has previously been responsible for. The goals of ego state work are to move responsibility for affects from the symptom-expressing ego state to the authentic self; completion

of the separation-individuation process; trauma processing; and installing positive affects. Another important piece in treatment where a false self is present is to transfer responsibility for the physical body from the false self to the authentic self. Processing is complete when the SUD has moved to a zero or one. The PC is then installed in the image of the traumaphor, a process that is complete when the VOC has moved to seven.

Relapse prevention employs EMs to strengthen associations between recovery skills and situations in which the client has previously acted out her eating disorder. The client is asked to identify the triggers, images, cognitions, emotions, and sensations experienced in five situations where acting out or thinking of acting out previously occurred. She next verbalizes the recovery skills appropriate to each situation. Using EMs the clinician establishes one or more dimensions of the relapse scenario as signals for the client to employ the identified skill. The process is complete when the VOC for a PC ("I can use my skills to intervene a relapse.") has gone to a seven.

The intensive intervention phase of treatment for eating disorders can be successfully concluded with an Optimal Future Self Visualization[10], a visualization facilitated by EMs or trance in which the client meets the self she is becoming. This visualization provides a direction for the system and assists the client in connecting with her deepest aspirations.

Post-treatment counseling is an absolutely essential component in treatment of eating disorders. The Chemotion protocol is a brief, intensive intervention of a pernicious disorder; it forcefully intervenes an established, dysfunctional behavior. Bulimia and BED have been successfully treated with the Chemotion protocol in an intensive format of five sessions of three hours each on successive days. Without post-treatment counseling or after care, the danger of relapse is great. In post-treatment counseling the client can consolidate gains made in the intensive phase of therapy; she can explore application of recovery skills to current life situations; and she can continue to utilize the object relations and ego state perspectives.

Treatment of Bulimia Nervosa

Participant 99A is a 30 year old woman who has binged and purged on a regular basis since age 21. At the inception of treatment she was bingeing seven times per week and purging 6.25 times per week. Figure Five presents her TAs to the traumaphor food. Figure Six and Figure Seven present a road map of her EMDR facilitated TFP. Note that the TAs elicited the affects "anger" and "disgust" toward the traumaphor, while in the adapted standard protocol she identifies "sadness" as the affect experienced. The TAs apparently reveal unresolved archaic affects, while TFP elicits a current, if on-going affect.

Figure Eight presents 99A's TAs to the traumaphor vomit. While food is the abused substance in BN, AN, and BED, the purge phase distinguishes BN

from both AN and BED. Chemotion principles suggest that vomit must be facilitating a reenactment and reexperiencing in BN. The TAs for vomit reveal that 99A experiences affects of relief, desperation, hopelessness, embarrassment, and disgust when she looks at the vomit in the empty chair. She also experiences the affect/sensation "hurt". Figure Nine summarizes the TFP for vomit. In Figure Ten, 99A's personality structure before and after treatment is presented. In summary, 99A apparently expressed archaic anger through her binge phase; bingeing also expressed an undifferentiated self- and maternal object-representation. 99A was incompletely individuated from her mother's "fat, gross body." Furthermore, bingeing reenacted a trauma-coded scene from the age of four of her mother compulsively eating candy. 99A's purge phase appears to express emotional and physical hurt that she had witnessed occurring in her family as a child. Also, the purge reenacted a trauma-coded scene from about age six when she witnessed her father torment her older brother about homework to the point where the brother vomited. "Little Person" is an ego state that came into being during this traumatic incident with the function of dissociating hurt out of awareness.

99A was treated in two sequences of brief intensive therapy, the first consisting of five sessions of three hours, the second three sessions of three hours. Although she did not participate in post-treatment counseling, in the 24 weeks following the second sessions, 99A reduced her harm from bingeing by 41% and her harm from purging by 47.4%. Her symptoms steadily improved over these 24 weeks, and when the most recent five weeks are compared to pretreatment, she reduced both binge harm and purge harm by 71%.

00B is a 45 year old woman with a history of over 20 years of bulimic symptomatology. In the period prior to treatment, 00B was bingeing and purging an average of five days per week. 00B had been in therapy for her eating disorder for four years with no change in symptomatology. She was treated intensively for 15 hours over five days employing the Chemotion/EMDR protocol as described (data not presented). 00B has participated in post-treatment counseling at one therapy session per week. 00B has reduced her binge frequency and her purge frequency by 100% for the 30 days post-treatment.

Treatment of Binge Eating Disorder

00C is a 41 year old woman who binges 3-4 times per week. She alternates bingeing and dieting. On days when she binges, she experiences 2-3 episodes per day of bingeing. At 13 years, she began to eat when she got upset. At age 23 when she married, she began to diet to please her husband, and she began to eat in secret at this time. 00C has been in therapy for her eating disorder for six years with no
change in symptomatology. 00C is the oldest of three siblings. She was forced by the circumstances of her mother's absence from the home to become a

caretaker for her siblings and for her father after he lost his job. She describes her father as mean, nasty, or withdrawn. 00C did not get along with her mother. She pictures her family home as filled with tension. Her current affects are mostly fear and panic.

Figure 11 presents the preparation work that was necessary to accomplish prior to eliciting TAs. The degree of 00C's fusion of self representation with paternal representation is demonstrated by the difficulty she experienced placing an image of him in a visualized container. She cried, stating, "I feel like if I move him from where he wants to be then he'll be made at me and I'll be mean to him." A resource constellating the required quality, total indifference, was developed and installed, and 00C could then move her father's image into containment. Additionally, a Protector ego state was identified by its action of shutting down 00C's access to affects, cognitions, and sensations. In trance, this ego state was transformed into a powerful ally. Yet another ego state, Little Girl, was uncovered, this one identified as "holding sadness and fearing loss and abandonment." Little Girl is also a Wounded Child ego state. Attending to the needs of this ego state permitted treatment to continue.

Figure 12 presents 00C's TAs for the traumaphor, food. The most significant associations belong to the food, which thinks "I want you to have me" and believes 00C "can be tricked." The food feels powerful and possessive. 00C thinks that "Food gets what it wants." She states that her relationship to food as revealed in the TAs reminds her of her relationship to men and to her father.

00C's TFP targeting food is presented in Figure 13. A key element in her processing was recognizing the unlovableness assembled with the Little Girl ego state. A second key element was the physical sensations of nausea and tingling in her arms and legs. AMST was employed to enable 00C to tolerate an intense panic and phobic reaction as she experienced the sensations. 00C was able to verbalize for herself that her father molested her. Ego state work and cognitive interweaves facilitated by bilateral tactile stimulation resolved the Little Girl's inappropriate taking responsibility for her own molest and restored lovableness to her. Figure 14 illustrates 00C's personality structure before and after treatment. 00C has achieved a harm reduction of 100% over the 30 days post-treatment.

Conclusions

These cases and the outcome data demonstrate the promise for successful, efficient, and effective treatment of bulimia and BED employing EMDR in the context of the Chemotion/EMDR protocol. The data show the potential of a syncretic approach to theory and treatment of these eating disorders and in particular demonstrate the utility of Gestalt and ego state interventions, facilitated by bilateral stimulation, for completing the separation-individuation of self and object representations and for transferring affects from symptom-expressing ego states to the authentic self. Our results indicate the centrality of

the abused substance in decoding the neural networks involved in eating disorders. The cases also demonstrate the importance of the TAs for identifying unresolved, archaic affects.

Acknowledgement

Gina E. Rayfield, Ph.D. was the referring and collaborating therapist in treatment of 00B and 00C.

References

1 Shapiro, F. (1995) *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures*. New York: The Guilford Press.

2 Omaha, J. (1998, July 11) "Chemotion and EMDR: An EMDR Treatment Protocol based upon a Psychodynamic Model for Chemical Dependency" Paper presented at the 1998 EMDR International Association Conference "EMDR~Treatment and Transformation" Baltimore, MD.

3 Spear, L.P. (2000). "The Adolescent Brain and Age-related Behavioral Manifestations." *Neuroscience and Biobehavioral Reviews* 24, 417-463.

4 Leeds, A.M. (1995, June 24). "EMDR Case Formulation Symposium." Paper presented at the 1995 EMDR International Association Conference: "Research and Clinical Applications," Santa Monica, CA

5 Leeds, A.M. & Korn, D.L. (1998, October 16-17) "Clinical Applications of EMDR in the Treatment of Adult Survivors of Childhood Abuse and Neglect." The Menninger Clinic, Topeka, KS.

6 Linehan, M.M. (1993) *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: The Guilford Press.

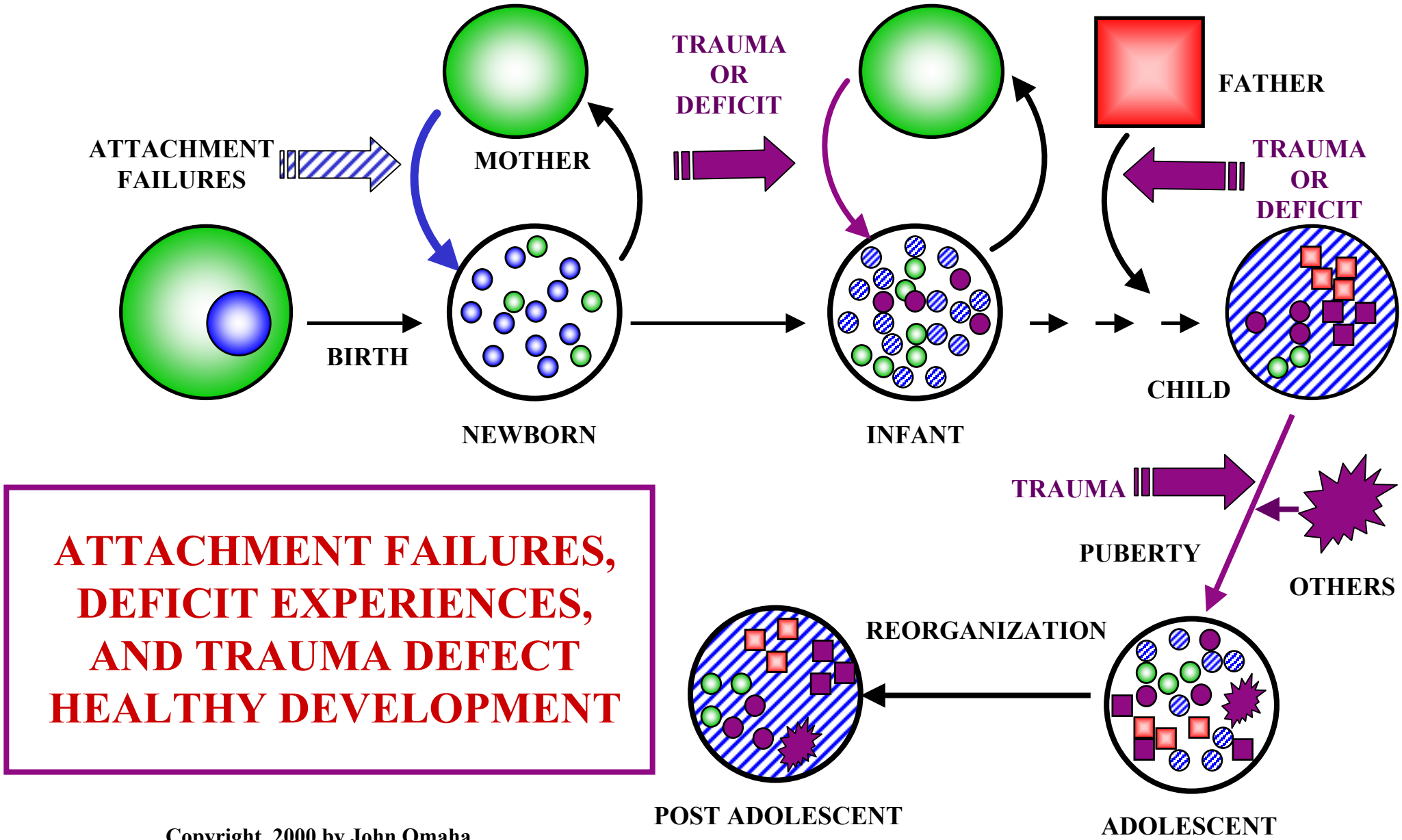
7 Wesselmann, D. (2000, March 5) "Interventions for Treating Core Attachment Issues and Related Problems." Workshop presented by Montclair Seminars, Iselin, NJ.

8 Omaha, J (2000) *The Psychodynamic Basis of Chemical Dependency*. Ph.D. Dissertation. In preparation.

9 Watkins, J.G. & Watkins, H.H. (1997) *Ego States: Theory and Therapy*. New York: Norton.

10 Napier, N. *Recreating Your Self: Building Self-Esteem Through Imaging and Self-Hypnosis*. New York: Norton, 1990.

Figure 1



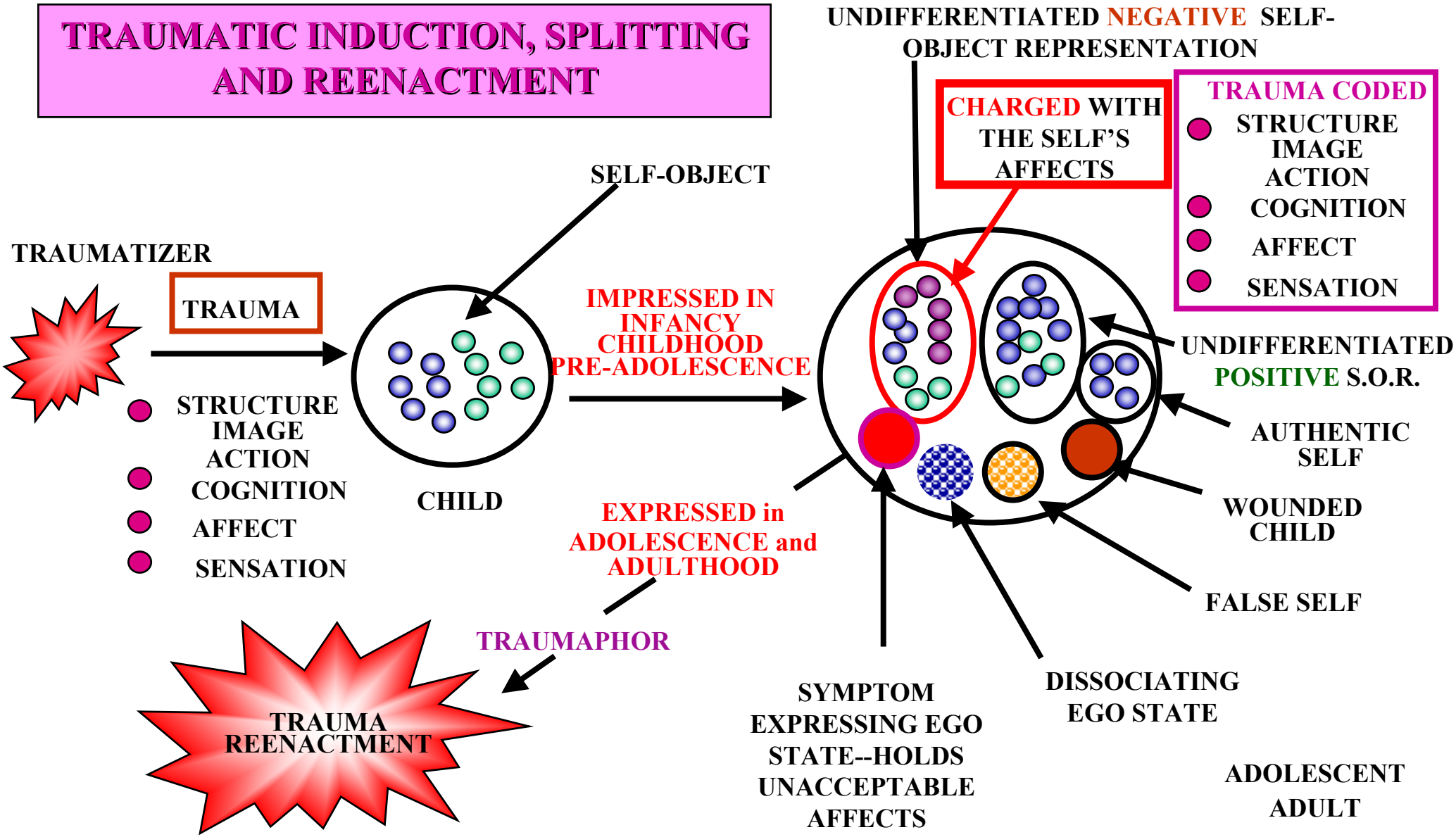


Figure 2.

SUBJECT 99A

TRAUMAPHOR ASSOCIATIONS

Figure 5.

TRAUMAPHOR: FOOD

IMAGE ICE CREAM, DIFFERENT VARIETIES AND BRANDS, 200 POUNDS, A BIG PILE, ROLLING OFF THE CHAIR.

BEHAVIOR Object — EXPANDING

Object → 99A — INVITING, CALLING TO 99A, SUGGESTING, PROMISING SATISFACTION, GIVING PERMISION TO TAKE IT. READS 99A'S THOUGHTS. TELLS 99A HOW SHE FEELS. SAYS, "YOU NEED ME."

99A → Object — WANTS TO SAY, "YOU'RE LYING."

COGNITION

Object → 99A — YOU CAN'T LIVE WITHOUT ME. YOU'LL ALWAYS COME BACK. I HAVE POWER TO CONTROL YOU. "I'LL DO ANYTHING TO GET YOU TO TAKE ME. "

99A → Object — IT IS RELENTLESS. IT CARES ONLY ABOUT ITS OWN NEEDS. I NEVER GET ANYTHING I NEED FROM YOU. YOU BEAT ME UP HORRIBLY. YOU SHOULD TAKE CARE OF YOUR OWN NEEDS AND LEAVE ME ALONE.

99A — THIS IS A TRAP. AND YET I WANT TO BELIEVE IT EVERY TIME. I JUST GET HURT ALL THE TIME. I WOULD LIKE TO BE NURTURED AND TAKEN CARE OF AND BE MADE TO FEEL GOOD.

AFFECT

Object — PATRONIZING, SMUGNESS, DESPERATION, DRIVEN, COMPULSIVE,

Object → 99A — DESPERATE DESIRE, INDIFFERENCE TOWARD 99A

99A → Object — ANGER. DISGUST

99A — I FEEL LIKE CRAP. SADNESS. DESPERATE. WANT. POWERLESS.

GENDER OF TRAUMAPHOR FEMALE **ASSOCIATED RELATIONSHIP** MOTHER AND SELF

SUBJECT 99A

TRAUMAPHOR FOCUSED PROCESSING

Figure 6.

TRAUMAPHOR: ICE CREAM, DIFFERENT VARIETIES AND BRANDS, 200 POUNDS, A BIG PILE

NC: I CAN'T TAKE CARE OF MYSELF. **PC: I AM CAPABLE OF TAKING CARE OF MYSELF. VOC = 4**

EMOTION: SADNESS **BODY: EYES** **SUD = 8**

	INTERVENTION	ISSUE	OBJECTIVE
	TRAUMA-CODED SCENE: MOTHER COMPULSIVELY EATING CANDIES. 99A FEELS FURY		
1.			ABREACTION
2.	HAVE 99A ENTER SCENE		
3.	VERBALIZE FORBIDDEN COGNITION		
4.		FUSION WITH OBJECT	
5.	EMPLOY IMAGE OF PERSONAL POWER		
6.			ACHIEVE COGNITIVE MEANING
7.	VERBALIZE EFFECT (DEFICIT EXPERIENCE)		
8.	VERBALIZE OBJECT'S RESPONSIBILITY		
9.			IDENTIFY ASSEMBLED AFFECT
10.			ABREACT ASSEMBLED AFFECT
11.		DISSOCIATION	

SUBJECT 99A

TRAUMAPHOR FOCUSED PROCESSING--SLIDE TWO

Figure 7.

	INTERVENTION	ISSUE	OBJECTIVE
12.	AMST TO GROUND, STAY PRESENT		
13.		FEAR	
14.	AMST TO DECREASE AFFECT		
15.			DEEPEN COGNITIVE MEANING
16.			IDENTIFY ASSEMBLED AFFECT
17.	VERBALIZE ASSEMBLED AFFECT		
18.			SEPARATION /IND INDIVIDUATION
19.	VERBALIZE SEPARATION		
20.			DEEPEN COGNITIVE MEANING
21.	VERBALIZE OBJECT'S RESPONSIBILITY		
22.	VERBALIZE OBJECT'S RESPONSIBILITY		
23.			AMBIVALENT PERCEPTION OF OBJECT

SUD = 0 INSTALL PC "I CAN TAKE CARE OF MYSELF" NC = 7

SUBJECT 99A

TRAUMAPHOR ASSOCIATIONS

Figure 8.

TRAUMAPHOR: VOMIT

IMAGE VOMIT IN EMPTY CHAIR; BATHROOM SCENE WITH MIRROR, TOILET, VOMIT

BEHAVIOR

Object	SPLATERING. LYING THERE.
99A	AVOIDING LOOKING IN THE MIRROR

COGNITION

Object → 99A	"YOU IDIOT!" "WHY DO YOU KEEP COMING BACK HERE?" "THIS IS YOU." "I AM YOUR FEELINGS."
99A → Object	THIS IS YUCKY. THIS IS GROSS. IT DOESN'T GET MORE GROSS THAN THIS. IT'S HOT. IT'S HEAVY. IT'S EXPLOSIVE. IT HURTS. IT BURNS. IT SMELLS. IT'S MESSY. IT'S SICKENING ME.
99A	THE RELIEF I FEEL IS NOT ENOUGH. THE PURPOSE IS NOT TO FEEL ANYTHING. I AM A SICK PERSON.

AFFECT

Object	EVERYTHING
99A	SADNESS. RELIEF. DESPERATION. HOPELESS. EMBARRASSMENT. DISGUST

SENSATION

99A	STOMACH (SADNESS; HURT--"BECAUSE I'VE EATEN SO MUCH") EYES (EMBARRASSMENT, DISGUST) CHEST (DESPERATION--HARDER TO BREATHE)

SUBJECT 99A **TRAUMAPHOR FOCUSED PROCESSING** **Figure 9.**

TRAUMAPHOR: VOMIT

NC: I AM DISGUSTING. I AM SICK. **PC: I AM OKAY.** **VOC = 1**

EMOTION: SADNESS **BODY: EYES AND THROAT** **SUD = 8**

	INTERVENTION	OBJECTIVE
	AFFECTIVELY CHARGED SCENE: ENTERING BATHROOM TO VOMIT.	
1.		ABREACTION
2.	SENSORIVERBALIZATION	
3.	FLOATBACK TECHNIQUE	
4.	SENSORIVERBALIZATION	
5.	VERBALIZE COGNITION	
6.		ACHIEVE COGNITIVE MEANING
7.	COGNITIVE INTERWEAVES	
8.	ABREACT SERIES OF TRAUMATIC EVENTS	
	TRAUMA-CODED SCENE: FATHER MAKING 99A'S BROTHER VOMIT	
9.		ABREACT ASSEMBLED AFFECT, ACHIEVE COGNITIVE MEANING

PERSONALITY STRUCTURE: 99A

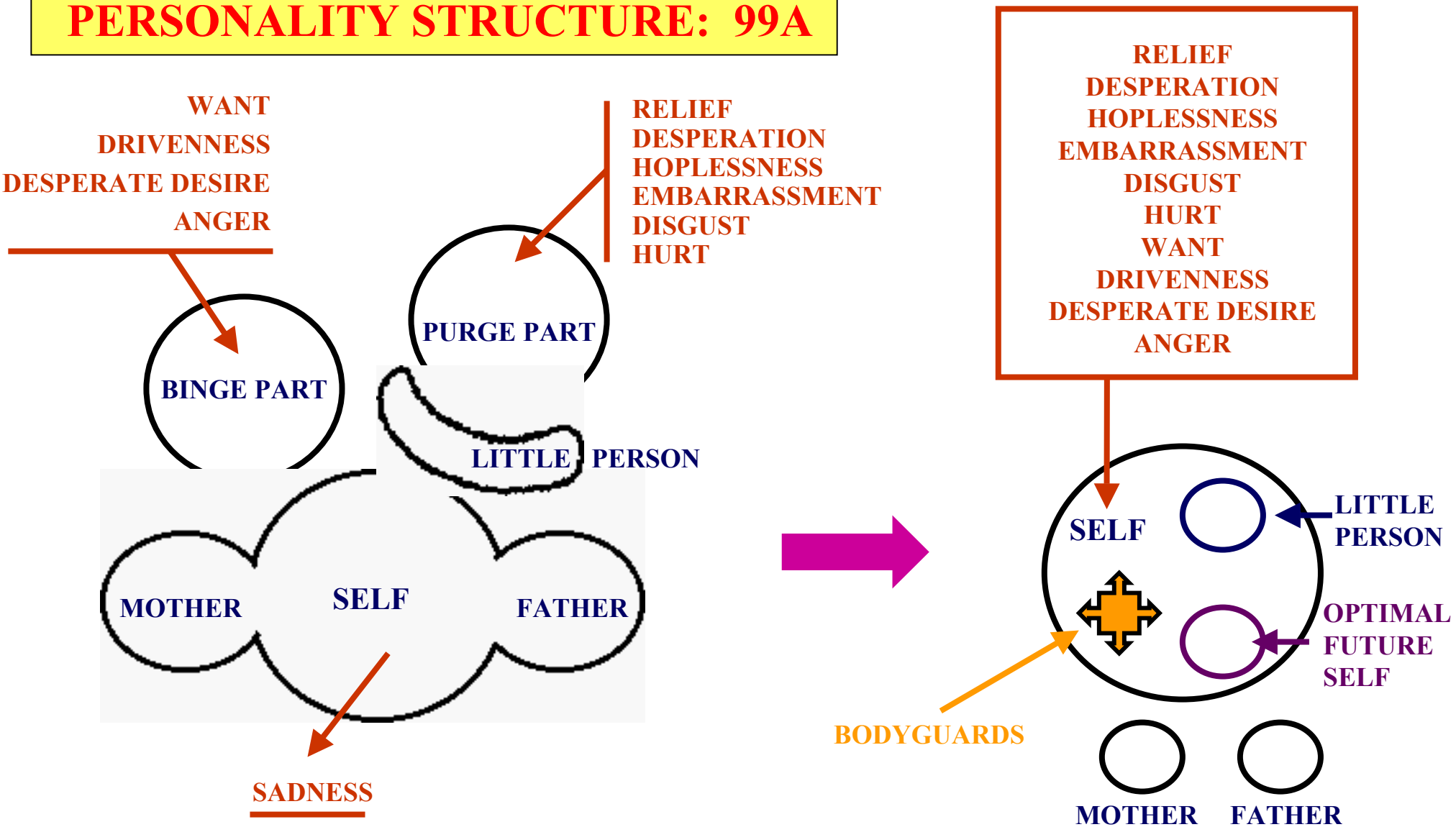


Figure 10.

SYMPTOM REDUCTION FOLLOWING TREATMENT: 99A

	AVERAGE BINGE/WEEK	PERCENT BINGE REDUCTION	AVERAGE PURGE/WEEK	PERCENT PURGE REDUCTION
PRETREATMENT (8 WEEKS)	7.00	——	6.25	——
POSTTREATMENT #1 (17 WEEKS)	5.29	24.4	3.41	45.4
POSTTREATMENT #2 (24 WEEKS)	4.125	41.0	3.29	47.4
OVERALL (41 WEEKS)	4.61	34.1	3.34	46.6

Figure 10A.

SUBJECT 00C

INTERVENTIONS PRIOR TO PROCESSING

Figure 11.

	INTERVENTION	INDICATION	OBJECTIVE
1.		DIFFICULTY WITH SAFE PLACE/FATHER	
2.			INSTALL CONTAINER FOR FATHER
3.		FEAR OF BEING MEAN TO FATHER	
4.	INSTALL RESOURCE FOR DESIRED QUALITY: INDIFFERENCE.		
5.	INSTALL CONTAINER FOR FATHER		
6.	AMST: FEAR AND PANIC		
7.		SHUTTING DOWN AFFECTS, COGNITIONS, SENSATION.	
8.			IDENTIFY PROTECTOR EGO STATE
9.	TRANCE: CONFERENCE ROOM		
10.		SHUTTING DOWN DURING TRAUMAPHOR ASSOCIATIONS	
11.			IDENTIFY EGO STATE HOLDING FEAR OF ABANDONMENT
12.	TRANCE: MEET LITTLE GIRL/CARETAKER		
13.			ADULT 00C TO TAKE RESPONSIBILITY FOR CHILD, HOLD PARENTS RESPONSIBLE
14.	EGO STATE WORK AND GESTALT COMMUNICATION		
15.		CODEPENDENT ATTITUDES, BEHAVIORS	
16.			PROCESS CARETAKING ISSUES
17.	EGO STATE WORK AND GESTALT COMMUNICATION		

SUBJECT 00C

TRAUMAPHOR ASSOCIATIONS

Figure 12.

TRAUMAPHOR: FOOD

IMAGE VANILLA ICE CREAM; PRETZELS; MILK; PASTA ALFREDO; BREAD/BUTTER. 50 POUNDS.

BEHAVIOR

Object	GETTING MELTY, WARM, MUSHY.
Object → 00C	SAYING, "I FEEL GOOD."

COGNITION

Object	"00C CAN BE TRICKED."
Object → 00C	"I WANT YOU TO HAVE ME."
00C	"FOOD GETS WHAT IT WANTS."
00C → Object	"I WANT IT, BUT I DON'T WANT IT."

AFFECT

Object	POWERFUL
Object → 00C	POSSESSION, OWNERSHIP
00C	SHUT DOWN ("I DON'T WANT TO FEEL ANYTHING.")
00C → Object	IT'S DISAPPOINTING.

GENDER OF TRAUMAPHOR MALE & FEMALE **ASSOCIATED RELATIONSHIP** OTHER MEN, FATHER

SUBJECT 00C

TRAUMAPHOR FOCUSED PROCESSING

Figure 13.

TRAUMAPHOR: 50 POUNDS OF BINGE FOOD

NC: I AM A GLUTTON FOR PUNISHMENT **PC: I AM MASTERFUL.** **VOC = 4.5**

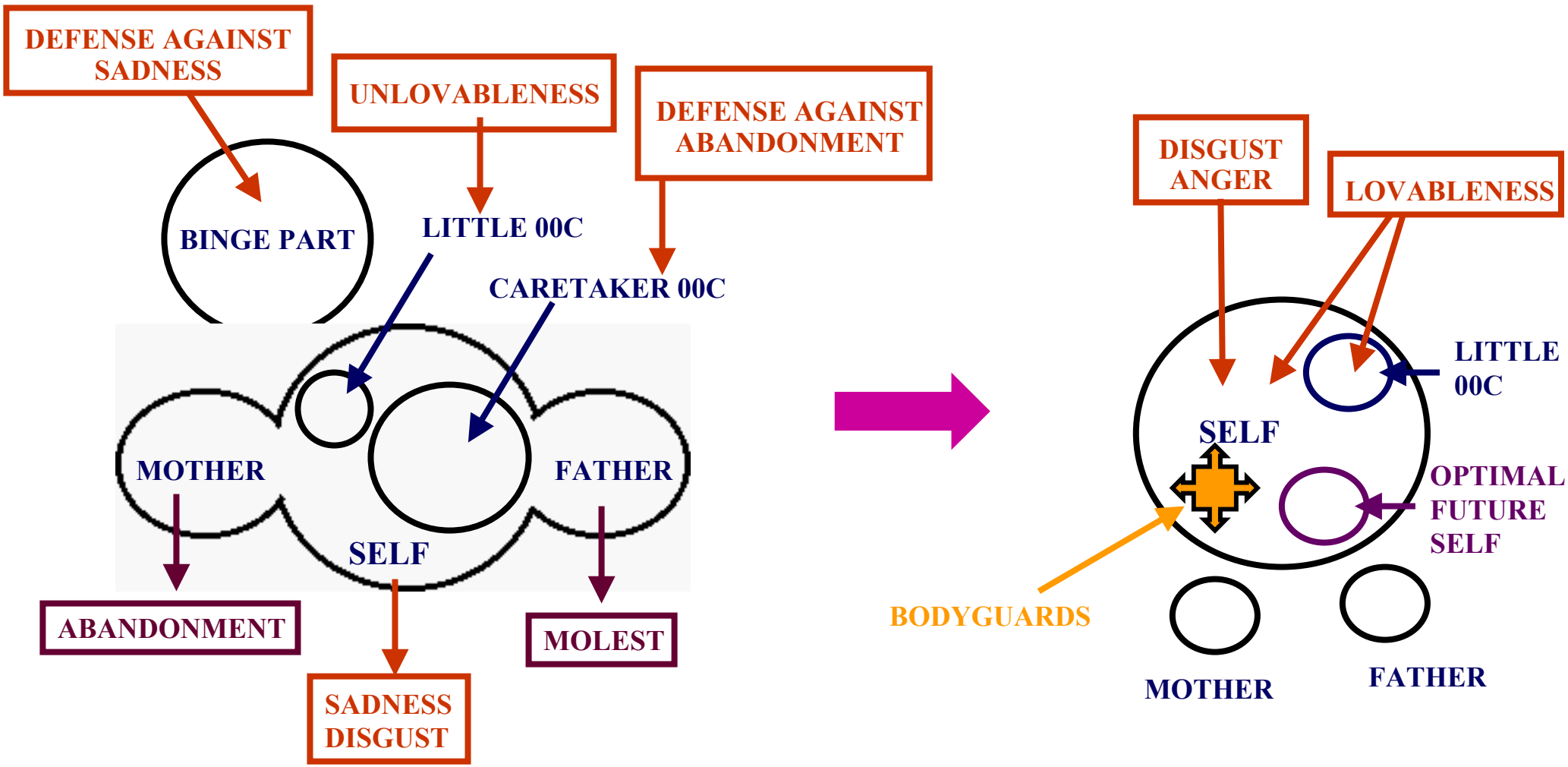
EMOTION: DISGUST **BODY: PIT OF STOMACH** **SUD = 5**

	INTERVENTION	INDICATION	OBJECTIVE
1.		COGNITIONS RE SADNESS AND LOVABLENESS	
2.			IDENTIFY WHAT MADE LITTLE 00C UNLOVABLE
3.	EGO STATE INTERVENTION		
4.	COGNITIVE INTERWEAVE		
5.	FLOATBACK TECHNIQUE		
6.		SENSATIONS & BODY MEMORIES	
7.	FLOATBACK TECHNIQUE		
		TRAUMA-CODED SCENE: FATHER'S SEXUAL ABUSE	
8.			ABREACT TRAUMATIC EVENTS ACHIEVE COGNITIVE MEANING
9.	COGNITIVE INTERWEAVES		
10.			REDEEM UNLOVABLE SELF

SUD = 0 **INSTALL PC "I AM MASTERFUL"** **VOC = 6.5**

PERSONALITY STRUCTURE: 00C

Figure 13A.



TREATMENT OUTCOMES AND SYMPTOM REDUCTION

SUBJECT 00B

	AVERAGE BINGE/PURGE PER WEEK	PERCENT BINGE/PURGE REDUCTION
PRETREATMENT	5	——
30 DAYS POSTTREATMENT	0	100

Figure 13B.

SUBJECT 00C

	AVERAGE BINGE PER WEEK	PERCENT BINGE REDUCTION
PRETREATMENT	3-4	——
30 DAYS POSTTREATMENT	0	100

Figure 3.

TREATMENT OVERVIEW

- BRIEF INTENSIVE THERAPY FOR BULIMIA AND BED.
- HISTORY
- TENTATIVE INTRAPSYCHIC MODEL
- WHAT IS THE PROBLEM?
- COMMITMENT TO ABSTINENCE
- EGO STATE CONFERENCE
- AFFECT MANAGEMENT SKILLS TRAINING
  - TARGET AFFECT
  - AFFECT RECOGNITION
  - GROUNDING CORD
  - WITNESSING SELF
  - GARBAGE CHUTE
- ATTACHMENT INTERVENTIONS
  - PHYSICAL CONNECTION, ATTUNEMENT, SECURE HOLDING
- TRAUMAPHOR ASSOCIATIONS
- TRAUMAPHOR FOCUSED PROCESSING
- EGO STATE INTERVENTIONS
  - IDENTIFICATION
  - ELICITATION AND AFFILIATION
  - HONORING
  - NEGOTIATION
  - ROLE REASSIGNMENT
  - GOALS
- RESPONSIBILITY FOR PHYSICAL BODY
- REPLAPSE PREVENTION
- OPTIMAL FUTURE SELF VISUALIZATION
- POST-TREATMENT COUNSELING

Figure Four
CHEMOTION/EMDR PROTOCOL

I. Traumaphor Associations

Direct the client to visualize the traumaphor, the favored binge food or the vomit, in an empty chair, which is placed facing the client. The clinician next facilitates the following exploration, which is illustrated for food.

A. Image:

"As you visualize the food in the chair, describe what you are seeing."

B. Behaviors:

1. "As you visualize the food in the chair, what is it doing?"
2. "What is it saying?"

C. Cognitions:

1. "As you visualize the food in the chair, and it is doing (state behavior) and saying (state what it is saying), what is it thinking?"
2. "What is it thinking about you?"
3. "As you visualize the food in the chair, what are you thinking?"
4. "What are you thinking about the food?"

D. Affects:

1. "As you visualize the food in the chair, and it is doing (state behavior) and saying (state what it is saying) and thinking (state cognition), what is it feeling?"
2. "What is it feeling toward you?"
3. "As you visualize the food in the chair, and it is doing (state behavior) and saying (state what it is saying) and thinking (state cognition), what are you feeling?"
4. "What are you feeling toward the food?"

E. Sensations:

"As you become aware that you are feeling (name affect) and feeling (name affect) toward the food, tell me what sensations in your body accompany those emotions?"

F. Gender:

"As you visualize the food in the chair, tell me what is its gender?"

G. Associated Relationship:

"What we are discovering in this exercise is your relationship with food. In this relationship, it is doing (state behavior) and saying (state what it is saying) and thinking (state cognition), and feeling (repeat what it is feeling) these things, and you are doing (state behavior), saying (state client's verbalizations), and thinking (state client's cognitions), and feeling (state client's affects) these things. Tell me, going back from now all the way into the past, what earlier relationships does your relationship to food remind you of?"

II. Traumaphor Focused Processing

With the same traumaphor target (food or vomit), elicit an NC, PC, VOC, Affect, Sensation, and SUD, and proceed with processing as in the standard protocol.