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EMDR: Promising Treatment for Co-Occurring Eating Disorders and
Childhood Sexual Abuse

Submitted by Victoria L. Cameron
May 2013

MSW Clinical Research Paper

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The purpose of this study was to explore the use of Eye Movement Desensitization and Reprocessing (EMDR) with clients who have an eating disorder co-occurring with a history of childhood sexual abuse. Qualitative interviews were conducted with nine mental health clinicians who work primarily in the outpatient setting using EMDR with their clients. These audio-recorded interviews took place over a period of three weeks and the data were analyzed using grounded theory methodology. The most common themes that emerged were *client-therapist relationship, stabilization of eating disorder, chronology of treatment, grounding, and dissociation*. Given the high co-occurrence of childhood sexual abuse and eating disorders, the serious and pernicious nature of eating disorders, and the growing body of research that points to EMDR as a highly successful method for treating a variety of conditions including trauma, it is important that research into the use of EMDR with this population be continued.

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EMDR: Promising Treatment for Co-Occurring Eating Disorders and Childhood Sexual Abuse

Up to 24 million people in the United States are afflicted with anorexia, bulimia, or eating disorder NOS (EDNOS) (Hudson, Hiripi, Pope, & Kessler, 2007). The age of onset for eating disorders is very young, with approximately 86% reporting onset before age 20, and half of that (43%) before the age of 16. Eating disorders disproportionately affect young women; about 10-15% of people diagnosed with eating disorders are male (Hudson, et al., 2007). Eating disorders are known to have the highest mortality rate of any mental illness, and many people never fully recover (Geller, Williams & Srikameswaran, 2001). The actual mortality rates vary from study to study in large part because tracking the deaths is difficult. Many die of complications related to their eating disorder such as heart failure, organ failure, suicide, and malnutrition; of those who do survive and reach partial or full recovery, many deal with chronic health complications life abnormal vital signs, weakening of enamel, magnesium deficiency, decreased bone density, esophageal and gastric rupture, and irregular heartbeat (Rome & Ammerman, 2003). Infertility and relationship difficulties are other common effects of chronic eating disorders (DeAngelis, 2002).

In addition to the significant impact eating disorders make on the health of those afflicted, there is also an economic cost attached to these illnesses. Though understudied at this time, there have been some attempts to quantify the economic effects of these disorders. One study examined a national database of health insurance claims to conduct a year-long study comparing the costs of eating disorders in comparison to other

psychiatric disorders and found that anorexia in particular costs significantly more to treat than both schizophrenia and obsessive-compulsive disorder (OCD). Bulimia and EDNOS cost significantly less than schizophrenia to treat, and in relation to OCD, bulimia costs significantly more, and EDNOS was comparable (Striegel-Moore, Leslie, Petrill, Garvin, & Rosenbeck, 2000). Given the pernicious nature of eating disorders and the fact that many people undergo treatment multiple times, the cost to individuals, health plans, and the public is large.

A significant percentage of women diagnosed with eating disorders have additional psychiatric co-morbidities (Salbach-Andrae, Lenz, Simmendinger, Klinkowski, Lehmkuhl & Pfeiffer, 2007; Steiger & Israel, 2010). These co-existing conditions range from personality disorders and mood disorders to anxiety and substance abuse (Steiger & Israel, 2010). One comorbid condition that has appeared in a significant amount of research in the past two decades is post-traumatic stress disorder (PTSD) (Fallon & Wonderlich, 1997; Holzer, Uppala, Wonderlich, Crosby & Simonich, 2008). While some research does look specifically at the link between PTSD and eating disorders, most research is not as concerned with whether or not the patient meets the threshold definition of PTSD, rather, a greater emphasis is placed on whether or not the patient reports incidences of trauma in his/her past. There are a few studies that examine trauma without breaking it down by subtype, and others differentiate between different types of trauma (Fuemmeler, Dedert, McClernon & Beckham, 2009). One study also attempted to look at the differences between sexual trauma and abuse that occurred while the patients were children versus incidences of trauma that were perpetrated on the victims when they were adults (Fischer, Stojek, & Hartzell, 2010). By far, most of the

past research has looked at the incidence of sexual trauma in the lives of the patients, and the bulk of that focused on childhood sexual abuse (CSA) (Brewerton, 2007). There are many and varied ways of defining CSA, some stringent and some broader. For the purposes of this examination, a general definition will be used. CSA will be conceived of as “any erotic activity that arouses an adult and excites, shames, or confuses a person under age 16, whether or not the victim protests and whether or not genital contact is involved” and will encompass pornographic photos, exposure to pornography, sexualized teasing, and boundary violations (Berger, 2005, p. 354).

Childhood trauma is a predictor of eating psychopathology and can act as a mediating variable in patients with eating disorders (Palmer & Oppenheimer, 1991). Although some research indicates no significant differences in rates of CSA between eating disorders and other psychiatric disorders (Palmer & Oppenheimer, 1991), other research shows that women who do not have any psychiatric disorder have significantly lower rates of CSA than women with a psychiatric disorder (Brewerton, 2007). In this way, research supports that CSA may be considered a non-specific risk factor that predisposes a victim to psychiatric disorders, but not specifically eating disorders.

Given the breadth of literature that points to a high co-occurrence of eating disorders and CSA, there should be a commensurate amount of inquiry into the question of treatment for co-morbid eating disorders and CSA. Harper, Richter & Gorey (2008) looked at the effects of group work with female survivors of CSA and found poorer outcomes among those who were also diagnosed with an eating disorder. Findings suggested that at discharge and at 6-month follow-ups, women who had eating disorders were statistically more likely to be experiencing depression, and also have lower self-

esteems. Individual treatment outcomes of individuals being treated for eating disorders (broadly defined, to include both threshold and sub-threshold incidences of anorexia nervosa and bulimia nervosa, as well as eating disorders not otherwise specified and the binge-eating disorder subtype) were less positive for those individuals who also had significant incidences of trauma in their histories (Folsom, Krahn, Nairn, Gold, Demitrack, & Silk, 1993; Yackobovitch-Gavan et al., 2009). Another possible outcome is that there is measurable improvement for a short time followed by relapse, and given that one of the most reliable indicators of a positive outcome for eating disorders is early intervention, relapse is a negative thing. An indicator for a less-positive outcome is repeated treatment (Yackobovitch-Gavan, Golan, Valevski, et al., 2008). Finally, there is research that suggests that if the eating disorder behaviors do improve but the trauma has not been adequately dealt with, other impulsive/self-destructive behaviors may arise such as self-injury (Everill & Waller, 1995).

Much of the research that focuses on treatment modalities to be used when working with individuals diagnosed with trauma had population samples drawn from war veterans. Currently most inquiry has been focused on cognitive-behavioral therapy (CBT) and eye movement desensitization and reprocessing (EMDR) (Bisson, Ehlers, Matthews, et al., 2007). Though some research is focused on the effects of the war environment and experiences, most focuses not on the specificities but on the resulting cluster of symptoms that are known as PTSD. In this way, comparisons can be made between groups of war veterans and people who have arrived at the diagnosis on PTSD through other traumatic events. CBT has long been considered the gold standard for treating PTSD and mediating the effects of the trauma on the lives of the victims (Bisson, et al.,

2007). There is also research that points to CBT being useful for treating eating disorders, so the decision to treat the co-morbidity of these two disorders is a natural fit (Protinsky, Sparks, & Flemke, 2001).

More recently developed, EMDR suggests that not only can the effects/signifiers of PTSD be mitigated but that perhaps they can go completely away (Shapiro, 1989). In essence, people who have undergone trauma in their lives that result in threshold or sub-threshold PTSD can experience healing; the PTSD diagnosis is no longer appropriate or valid. EMDR is a promising treatment methodology that is used extensively with PTSD and is beginning to be used with other populations. Given the current lack of understanding of CSA in women suffering from eating disorders, as well as a lack of research on EMDR for simultaneously treating eating disorders and trauma, it is crucial to investigate the experiences of practitioners who provide this treatment to this demographic of women. The purpose of this study is to look more in-depth at the burgeoning use of EMDR with patients who have a history of childhood sexual abuse and are undergoing treatment for an eating disorder.

Literature Review

Trauma Treatment Approaches

EMDR. EMDR was developed by Francine Shapiro to work with trauma and “unlock” the memories in the right side of the brain that are held as a whole memory because of the severe/significant nature of the memory, without being processed as they would be ordinarily (Protinsky, Sparks, & Flemke, 2001). Untreated, these disturbing memories often cause post-traumatic symptoms such as nightmares, flashbacks, and hypervigilance. By using a pattern of rapid eye movements from side to side (or

alternating buzzers or sounds), both sides of the brain are activated in a way that spurs the brain to process information, thereby unlocking the traumatic memories and emotions (Shapiro, 1989). Though it remains controversial, EMDR has been generally accepted as a useful form of treatment for PTSD in adults. A meta-analysis of twelve studies compared EMDR groups to a comparison group that was either wait-listed for treatment or offered another standard psychological intervention (Bisson, et al., 2007). EMDR was found to be superior to the wait-list comparison group when it came to reducing post-traumatic symptoms in all studies except one that only studied Vietnam vets. Another significant finding indicated that EMDR was superior to non-directive, supportive forms of treatment. It has also been shown to be efficacious in treating adolescents with PTSD in a residential setting (Louvelle, 2005).

CBT. CBT is a structured form of psychotherapy that results from a combination of cognitive therapy and behavior modification. The use of CBT with people carrying a diagnosis of PTSD purposes to modify the behaviors and thoughts that developed as a response mechanism to a traumatic event or series of events through a combination of psychoeducation (including an examination of the etiology of symptoms), exposure to triggers, and cognitive restructuring. The exposure can be either imaginary (leading the client to remember elements of the trauma) or “live” exposure, that is, setting up an encounter with real life stimuli (Jackson, Nissenson & Cloitre, 2009). CBT actually encompasses a variety of treatment methodologies including exposure therapy, stress inoculation training, cognitive-processing therapy, cognitive therapy, relaxation training, dialectical behavioral therapy, and acceptance and commitment therapy; there are also treatments that combine two or more of these different types (Cahill, Rothbaum, Resick,

& Folette, 2009).

CBT has been found to be effective for a variety of treatment populations, when compared to no treatment or treatment limited to supportive counseling. Though there is not a significant amount of research that looks specifically at using CBT with childhood sexual abuse survivors, a review of the research shows that there have been positive results found using CBT with sexual assault survivors (Foa, Dancu, Hembree, et al., 1999; Resick, Nishith, Weaver, Astin & Feuer, 2002). It is relevant to state that these studies failed to look at the age when the assault occurred. Other research reports positive results of using CBT with childhood abuse survivors including childhood sexual abuse (Cloitre, Koenen, Cohen & Han, 2002; McDonagh, Friedman, McHugo, Ford, Sengupta, Mueser, et al., 2005). The results of these studies report favorable outcomes for survivors who are treated with CBT.

In one study conducted by Resick et al. (2002), a control group of rape survivors who were on a wait list for treatment was compared with two treatment groups who were given a course of CBT, one with an emphasis on cognitive restructuring, and one with an emphasis on exposure to triggers from the assault. The results found that upon completion of either course of CBT and at subsequent follow-up, 50% of the women no longer met the criteria for PTSD. The control group of wait-listed women, in contrast, did not change significantly, and 98% of the women still met the full diagnostic criteria for PTSD.

Eating Disorder Treatment Approaches

CBT. CBT has mainly been used as a treatment modality to address bulimia nervosa (Wilson, G.T., 2010). It has been largely recognized as the best and most

effective “treatment of choice” for bulimia and has been demonstrated to be an effective method of treatment for over thirty years (Braun, 2009; Mitchell, Agras, and Wonderlich, 2007). The studies have ranged from ones with small sample sizes to ones increasing in number, and greater standardization has occurred over time (Braun, 2009). One advantage CBT has shown is that it has a quick response time for those being treated, with individuals often seeing improvement after only a few sessions (Wilson, G.T. 2010). Moreover, it is a manualized treatment option, providing for wide availability (Braun, 2009), and it has been shown to be more effective than medication alone (Jacobi, Dahme, & Dittman, 2002). CBT has also been shown to be an effective treatment methodology for treating binge eating disorder (which will be included in the DSM-V) in obese patients (Grilo, Mashed, Guerorguieva, Wilson, & White, 2011).

Though CBT has been shown to be an effective approach for treating bulimia and EDNOS, there has been little published on the effectiveness of using CBT to treat anorexia. One study conducted by Pike, Walsh, Vitousek, Wilson & Bauer (2003) looked at weight-restored adults in a post-hospital follow-up study that compared the results of a group that had completed CBT with a control group that received only nutritional counseling. This study found that 77% of the CBT group had better outcomes than the group that had not received the treatment, though a limitation of that study was that nutritional counseling is not a psychotherapy intervention. A second year-long community study was conducted in 2007 to compare CBT with the standard maintenance treatment, with a group of adults with weight-restored anorexia (Carter, McFarlane, Bewell, et al., 2007). The standard maintenance treatment was most commonly individual psychotherapy on an outpatient basis. The results found that 67% of the adults in the CBT

group kept their BMI at a 17.5 or above, compared with 34% of the women in the comparison group. A third study compared CBT with two other forms of treatment, but differed from the first two in that it was conducted with patients who were not weight-restored and were in the acute phase of treatment (McIntosh, Jordan, Carter, et al., 2005). The results showed that CBT was not significantly different than either other method, which may suggest that CBT may only be efficacious with individuals who are past the acute phase of treatment and are already restored to a healthier weight.

Family-Based Therapy (FBT). FBT is a manualized form of treatment for eating disorders (Lock, Le Grange, Agras, Dare, 2001). FBT was developed by the Institute of Psychiatry at the Maudsley Hospital in London and is the best-known methodology for treating adolescents with anorexia (Bean, Louks, Kay, Carlson, & Weltzin, 2010). FBT is divided into three phases, whereby the parents first take control over the daughter's food intake, then gradually, as weight is restored, turn control of the food back to the daughter and restore the daughter back to normal development (Couturier, Isserlin & Lock, 2010).

FBT takes an agnostic stance in regards to the etiology of AN; it is some of the first eating disorder treatment methodology that doesn't cite unhealthy family patterns and chaotic relationships with being a contributing cause to AN (Bean, et al., 2010). FBT, rather, maintains that the way AN developed does not matter, and that the family, rather than being blamed, should be looked to as a necessary source of support and healing for the stricken adolescent (Paulson-Karlsson, Engstrom & Nevonen, 2009).

A number of studies support the use of FBT. A qualitative twins study introduced a pair of 17-year old identical twin adolescent females, one of whom has AN, the other who does not (Loeb, Hirsch, Greif, & Hildebrandt, 2009). This study highlights

important questions of nature versus nurture, as the twins have identical DNA and share a home environment; yet, one child emerged healthy and the other sick. This seems to support the idea of not placing blame on the family unit or parental figures, because the family functioning is at least somewhat intact as indicated by the healthy siblings. A study by Paulson-Karlsson, et al., (2009) does not dispute this entirely, but it does suggest that FBT strengthens the family and restores them to a greater level of functioning, so in that way, while not blaming the family directly, it shapes (and improves) the way that the family interacts; even the siblings without AN are benefited by the “new and improved” family.

After completion of the three stages of FBT, research conducted by Paulson-Karlsson et al., (2009) suggests that at 18- and 36-month follow-ups, 75% of the patients were still in full remission from their eating disorders. This is quantitative data that reaffirms what the qualitative data obtained in the twins study found—with supportive parents united to take control over their daughter's eating disorder, there are very good outcomes to be obtained from using FBT (Loeb et al., 2009). Couturier, Isserling & Lock (2010), in a study of fourteen adolescents, echoed these positive findings but cautioned that the success of the FBT depends very much on therapist training and fidelity to the methodology. Bean et al. (2010), compared FBT to “therapy as usual” at the eating disorders program at Rogers Memorial Hospital and also found that the adolescents with AN who engaged in the family-based therapy improved on all measured outcomes, at the level of or greater than the controlled “therapy as usual” group.

EMDR. EMDR, originally developed to treat post-traumatic stress disorder, has shown itself to be useful in treating other disorders beyond its original scope. Clinical

applications of EMDR have been expanded to include depression, anxiety, attachment issues, early and medically-based trauma, sex offender treatment, and eating disorders, among others (Shapiro, 2009). Though there has been anecdotal evidence and case studies that support the efficacy of EMDR in treating eating disorders, there is a dearth of scientific research that supports its use currently, and it is becoming more widespread as a possible treatment focus for people diagnosed with eating disorders (Shapiro, 2009).

One controlled study looked at using EMDR with this population. Bloomgarden and Calogero (2008) studied a group of women in residential treatment and found that at completion of the program, the group that was offered EMDR in addition to the standard residential treatment fared better than those just receiving the standard residential treatment. At both 3-month and 12-month follow-up, the women were still showing lower negative body image and body dissatisfaction. One limitation of this study was its focus on body image and dissatisfaction, which is only one concern when it comes to the success or failure of treatment for eating disorders. Still, it is a promising study and suggests that more research should be done in this area.

Treatment Approaches Addressing Comorbid PTSD and Eating Disorders

CBT and EMDR are treatment modalities that have been used to treat trauma and eating disorders to various degrees and with a fair amount of success and empirical support. However, there is a dearth of research that examines ways to treat these disorders when they are co-occurring. Given their common comorbidity, it would be advantageous to examine ways that these disorders can be treated together. EMDR is an especially desirable potential modality because of the research that indicates that EMDR can actually eradicate the symptoms of PTSD (Shapiro, 1989). CSA, because it happens

during childhood and causes a disruption in “normal” development, often creates huge gaps that, if they could be mitigated or eradicated through use of EMDR, could have a significant impact on the client’s ability to heal. This potential for healing from the impact of trauma should be explored further. This study will attempt to add to the knowledge base by exploring the use of EMDR with clients who have a history of childhood sexual abuse and are undergoing treatment for an eating disorder.

Conceptual Framework

In order to examine possible linkages between childhood sexual abuse and eating disorders, it is important to look at the impact that traumatic interruptions in childhood can have on normal development. For the purposes of this project, which will specifically look at childhood sexual abuse (CSA), a wide and general definition will be used. Because children are not able to freely consent to sexual activity, any sexual activity whereby a child is used to fulfill the sexual pleasure impulses of another is considered abusive. It is important to note that genital contact is not necessary in order for an act to be considered sexual abuse.

When a child is sexually abused, it is a disruption that can cause chaos in emotional and social development. Children react to traumatizing experiences in relation to where they are in their stage of development; the developmental tasks that are in front of them are often negatively affected (Salmon & Bryant, 2002). Oftentimes traumatized children will have deficiencies in their language development, have poor school performance, fall behind in their social and emotional development, and even have lowered IQ as a result of the trauma (Osofsky, 1999; Veltman & Brown, 2001). There are oftentimes health consequences of childhood sexual abuse, ranging from physical illness

to psychological disorders in adolescence and beyond (Wilson, D.R., 2010). Importantly, not all children who are sexually abused will develop PTSD, because many of them will not meet criteria A in the DSM-IV; that is, they will not have been threatened with violence and/or thought that their life was in danger (APA, 2000). Other research has been done to identify protective factors that can mitigate the lasting effects of the trauma. Some of these qualities that point to quick and thorough recovery include adequate services following the trauma, good health that is not negatively affected by the event, the ability to return to pre-trauma functioning, and a strong support network (Lyons, 1991). Child sexual abuse tends to be shrouded in secrecy, with a large percentage of the victims not immediately reporting the abuse. Hence, they do not receive services, and are not given the support that would suggest a quick and thorough recovery. Attachment is interrupted in many cases, and deep and long-lasting trauma occurs (Lovelleville, 2005). It is important to note that trauma, while affecting individuals differently, is capable of impairing the functioning of anyone; the symptoms that develop are a greater reflection on the traumatic experience than they are a reflection on the pre-trauma personality (Lovelleville, 2005).

Case Vignette

Karen is a 23-year-old college student. She lives alone in an apartment off-campus and is studying sociology. Karen has struggled with eating disorder since she was 14 years old. There have been periods where she has done better and regained an amount of weight that is within a normal range, and she currently is at a healthy weight. Her patterns of eating, however, are severely disturbed. When she first began showing signs of an eating disorder at age 14, her parents put her in counseling. She was diagnosed with

depression and anxiety. Karen has always struggled with feelings of needing to be perfect. At times she found it paralyzing and would miss days of school. When she was 17 years old, her weight dropped and she was diagnosed with anorexia. Instead of going off to college that fall, she began intensive outpatient programming (IOP) to deal with her eating disorder. Work at the IOP helped her regain enough weight that she began college the following fall, having spent one year focusing on treatment. She went away to school 500 miles from her home and lived in a dormitory. Some of her eating disordered thoughts began to re-emerge and she struggled over the next three years. During this time she received general counseling at the student center on campus. She formed a good relationship with this counselor, and eventually disclosed to her that when she was a child she had been sexually molested by her uncle. It began when she was eight years old and continued about once a week until she was 11 years old. She never told anyone.

Disruptions like this affect the way a child develops. There is a good amount of evidence that states trauma impacts the way a brain develops; a child who is traumatized will develop differently than a child who is not victimized. Potential is affected, and developmental tasks are a struggle. In a case like Karen's, sexual abuse that occurred as a child has affected the way that she has moved through normal adolescent development. The anxiety and depression she struggled with from early adolescence likely grew out of the undisclosed (hence untreated) trauma that had been a part of her childhood. It has become in a disruption that has impacted her life. The protective factors that Lyons (1991) talked about were largely absent in Karen's life. She received no timely intervention; the therapy that she received for well over a decade did not address the trauma because it remained undisclosed. Her health suffered as a result of the eating

disorder; her family and friends, unaware of the abuse, were unable to offer her support. While the eating disorder has been addressed, as well as the depression and anxiety she has struggled with, the trauma that she had undergone as a child has never been addressed. With this new information, there is a new direction for therapy to move. Though it will be a hard road, Karen's decision to disclose the abuse means that the trauma can be addressed along with her eating pathology.

Method

Research Design

The purpose of this study was to explore treatment implications and therapeutic interventions used with patients diagnosed with eating disorders who have a history of childhood sexual abuse, specifically focusing on EMDR. The study's research design was qualitative and exploratory in nature. This type of design was chosen in order to allow for a wide range of responses that would provide a more robust and in-depth set of data. Choosing a qualitative design allowed the respondents to respond to a wide range of open-ended questions and not be limited to specific predetermined answers. This project was exploratory, aiming to explore the knowledge base, training, treatment approaches, and other important considerations when working with patients seeking treatment for eating disorders with a history of CSA. The data were obtained through qualitative interviews with clinical professionals who use EMDR in their work with clients diagnosed with eating disorders.

Sample

The sampling technique that was used was a snowball sample. The researcher made contact with clinical professionals through the EMDR International Association

(EMDRRIA) online listing of EMDR trained or certified therapists. EMDRIA is the agency that licenses EMDR therapists. Contact information for additional professionals was obtained through them. The sample size was nine clinicians. These clinical professionals had a wide range of experience, education, and training in working with individuals with eating disorders. It was desired to recruit professionals who have worked in inpatient, day treatment, and outpatient programs, as well as clinicians in private practice, in order to recruit a sample that reflected the breadth of treatment options currently being offered to clients diagnosed with eating disorders.

Protection of Human Subjects

Prior to conducting the interview, the respondents were presented with a consent form approved by the University of St. Thomas Institutional Review Board (IRB) (see appendix). The consent form provided a description of and background information on the study, highlighted the confidential nature of the study, and outlined the process through which the interview would take place. It also stated that there are no risks or benefits to participating in the research and that they could withdraw participation at any time. In order to participate, the respondents agreed to the interview and terms that had been outlined, as well as to the interview being audio-recorded. The participants' confidentiality was maintained by storing the data on a password protected computer until the conclusion of the project, at which point it was destroyed.

Data Collection

After securing respondents willing to participate, interviews lasting approximately thirty minutes were conducted to obtain raw data. The interview consisted of questions prepared prior to the interview and approved by the research committee and Institutional

Review Board (see appendix). The open-ended questions addressed the use of EMDR with patients diagnosed with eating disorders who have a history of childhood sexual abuse, as well as asked about alternative methodologies for dealing with the co-morbidity of trauma-effects and eating disorders. The interview was also an inquiry into the training that the providers have had in preparation to work with this population, and other salient characteristics and implications that the respondents felt were important when working with this population. The interviews were audio-recorded for subsequent transcription, and brief impressions and thoughts were hand-written during the interview. The interviews were transcribed for data analysis purposes.

Instrument

The appendix contains the interview schedule that was used with the clinicians. The questionnaire also tracked pertinent demographics, including education, licensure, and number of years in practice. The interview consisted of approximately ten mostly open-ended questions. The questions covered a variety of topics in addition to EMDR, including which eating disorders they most commonly see co-occurring with CSA, what strategies they find most effective in treating people with co-occurring disorders, common symptoms they see when comparing trauma and eating disorders, and what are the best practices they employ with their clients who have an eating disorder and a history of CSA. Questions were not personal in nature.

Analysis Technique

As a first step in analyzing the data, the interview transcripts were reviewed multiple times in an effort to identify codes and themes. Codes are a record of patterns that appear in the data, and while reviewing the transcript, certain codes are anticipated to

repeat over and over. When a code appeared multiple times in the data, it became a theme of the research. The themes identified in the data will be represented in the findings section with direct quotes from the therapist respondents. Open coding was used to comb the data line by line, looking for similarities and differences (Berg, 2009). An inductive grounded theory method was used to move from the specifics (transcript words or data) to the more general (themes and theory) (Berg, 2009).

Strengths and Limitations

The qualitative nature of this study was a strength of the research, in that it allowed for a wide range of thoughts and opinions from the clinicians. Though the interview schedule was used with all of the respondents, there was allowance made for follow-up questions and room for the clinicians to express themselves freely about their experience working with clients using EMDR.

Limitations of this study included a relatively small sample size of nine clinicians. All of them are employed in the outpatient setting (one does some work in intensive outpatient day treatment-type programming) which certainly is a limitation to the study. Given that this project was conducted for a social work project, it was disappointing to have no MSWs among those interviewed. Finally, it is assumed that there was some degree of self-selection bias, with the people agreeing to be interviewed being enthusiastic about the use of EMDR with this population.

Results

Sample Demographics

Nine semi-structured interviews were conducted between March 8, 2013 and March 25, 2013. All respondents were female. Six of the clinicians interviewed were

Licensed Psychologists (LPs), three with a master's degree and three with a PhD. The remaining three were Licensed Marriage and Family Therapists (LMFTs). All of the clinicians currently work in outpatient settings, primarily in private practice. The clinicians had between 12 and 36 years of experience, with the average length of 23 years. All of the clinicians have done training in EMDR with between 2 and 21 years of EMDR practice. The following themes were most commonly identified by the respondents.

Client-Therapist Relationship

All respondents talked about the need for developing a good rapport with their clients before beginning the EMDR process of addressing the trauma and eating disorder behaviors. Building a good relationship between client and therapist was universally noted as being an important step towards effective treatment of the client issues. Several clinicians noted that they often have people referred to them for EMDR work from other therapists who are not trained in EMDR, and that even in that case it is important to take a thorough history and build the relationship, which takes time.

I want to have some type of history with the client so they have some trust in the process of therapy and with me as their therapist.

You really do need good rapport. And you need to take time for that, however much time that client needs. Whether it's ten minutes or four years.

Build up that trust and then you can address the trauma.

As you can imagine, with some of these clients, it takes a long time to trust anybody. But they really do need to trust you if you want this thing to go well, obviously. They aren't going to sit there and let you muck about with their psyche if they don't trust you.

Stabilization of Eating Disorder

A common theme that emerged was the need to medically stabilize the eating disorder behaviors before beginning the main work of EMDR. If clients are not medically stable, they may need to be hospitalized or sent to a higher level of care. If clients do not have some control in place over their eating disorder, brain function may not be adequate to dive into the past. Respondents stressed the need to take things slowly when necessary, in order to not jeopardize the health and safety of their client.

Well, the basis of EMDR is to create a safe enough setting so that you can help add resources to the psyche so that they are stable enough to look at the trauma. And a lot of people aren't stable enough without acting out in their eating disorder, right? So you first have to stabilize the eating disorder.

For some people, they need a year or two of [therapy] just to stabilize and so that you know they aren't going to put their lives in jeopardy... I think that those are usually the precautions, just that there is some stability and some controls in place.

You have to help get [clients] more stable before you can even begin to stir up some really serious stuff, because a lot of their life has been organized around trying to defend themselves against those memories.

This theme is a basic consideration for all people who work with clients with eating disorders: stabilization first. Given the high morbidity rate of clients with eating disorders and the lifelong health problems that often arise from long struggles with eating disorders, priority has to be placed on making sure that they are healthy enough to engage in this level of treatment. Sometimes getting a client to a higher level of care (hospitalization or inpatient) is the only acceptable option.

Support System

All respondents spoke of the need to assess a client's support system, and build it up, if necessary, as part of stabilization. Many respondents talked about not only assessing family structures of support and network of friends, but also utilizing support

groups like Overeaters Anonymous, dieticians, and other mutual aid supports. Many respondents also mentioned groups like Alcoholics Anonymous and Narcotics Anonymous, because a large number of their clients also struggle with addiction to drugs or alcohol.

They need their support system and places to go [for support], because if they just come here first to address their abuse and their eating disorder is still present, when they hit some pretty heavy stuff, their body and brain will want to go to that.

When they don't have the luxury of dissociating anymore, [stuff] gets overwhelming. So I want to make sure that they have stuff in place, because if you take that away from them without them having a good support system, they are screwed.

I really think that people need to be careful about not rushing into EMDR [with a client] right away. They need to do a lot of building of their supports and resources.

Chronology of Treatment

One question that was asked of the respondents was whether they chronologically address the trauma or eating disorder first when beginning EMDR work. A few respondents replied that it is highly individual and depends on the client and their circumstances and degree to which their lives are being affected by the different variables. Surprisingly, the rest of them were equally divided on where to start.

Trauma First. Some felt that the work needs to begin with the trauma, because it came first and because they feel that the eating disorder largely stems from the abuse. It was also noted that some EMDR training stresses working chronologically from the earliest memories, which would generally place the CSA memories before the eating disorder.

I believe that the trauma and abuse is the first to treat in most cases.

I treat the abuse first. It's the same whether people come in and they have alcohol

issues... we want to be aware of it, but it isn't going to change unless we deal with the trauma.

Eating Disorder First. The remaining respondents felt that the best course of action is to get some improvement on the eating disorder before delving into the trauma work. Several clinicians expressed concern that doing trauma work before more fully addressing the eating disorder could cause a rise in compulsive and risky behavior.

Chronologically, I always address the eating disorder first. [The goal is] to get some stability, because [EMDR is] just going to trigger whatever compulsive behavior is happening. Because they are so linked.

I go after some strategies with the eating disorder piece. With the childhood sexual abuse, we might name it right away, at least, if that comes up... [but] we won't get into it. But at least name it and acknowledge that they shared that.

Though there is disagreement over where to start, it is interesting to note that both views are grounded in the importance of development. Those who treat the eating disorder first believe that the eating disorder continues to interrupt development (and halt all progress) until it is addressed. Those who treat the trauma first seem to be working from the belief that the earlier developmental issues must be treated before addressing the issues that have (at least in part) sprung from that early trauma.

Grounding

All of the respondents talked about resourcing and mindfulness practices that allow a client to “ground” themselves in a calming, peaceful, safe place, where they are able to be fully be present and not be overcome by distressing emotions or feelings. Whether the client is fairly resourced when beginning therapy, or whether it takes a lot of work in the therapy session, all respondents agreed that it is of the utmost importance that clients are able to moderate their mood and stay grounded. Multiple respondents talked

about a window of tolerance where the EMDR can be effective, with the clients being neither understimulated and “flat,” nor overstimulated.

They've got to have certain basic skills. They need to get pretty good at changing, pulling their affect from something negative, because you can get very upset during EMDR and you need to be able to turn it around to something more positive.

[They have to] be able to have it together enough to calm themselves sufficiently, and then go home with it until the next session. And manage okay.

If you bring up a memory or a thought, do they get stuck in it, do they dissociate, do they get overwhelmed, flooded? Or can they bring themselves back? Can they ground themselves and be in the present?

They don't have the capacity in their brain, they don't have the neural network in their system to be able to hold a positive. And so there is no safe place for them to work on the trauma and hold their sense of self.

If you work with a client to help them get to a safe, calm place, [and] they are unable to hold that, that would be a sign that they are too activated to want to be adding more to the mix. [If they can hold it] then that's a sign that even if they go into the worst places of trauma, they'll be able to pull out of it.

It's resourcing with bilateral stimulation. So when you feel stressed, being able to go to their peaceful place, or their safe place, or when was the time you handled it well, you handled it wisely. When was the time you nurtured somebody, or they nurtured you? So that they've got those resources when all they want to do is go eat. What else can you do?

If somebody can't hold a positive, like say we're doing some resourcing, and I'm strengthening the ego with doing some resourcing using slow bilateral with a powerful image of security or safe place or whatever, and they can't hold that, then I'm not going to do trauma processing.

This theme, highlighted by all respondents, endorses the idea that clients need to have a basic ability to do some trauma processing in order for EMDR to be a viable treatment option. Some clients may show up with this ability; some clients may need years of resourcing to get there. The capacity to process their trauma is a necessary skill.

Dissociation

Surprisingly, one of the strongest themes to emerge from the data in a couple of ways was dissociation. Respondents were quick to assert that they were not referring to a full-blown Dissociative Identity Disorder (DID), but rather it would be described more as a compromised ability to be present and aware of their behavior, mood, and activity. It is important to note that when a client with an eating disorder is medically compromised because of malnourishment, they are often cognitively impaired in a way that can appear like dissociation. It is important, through assessment, to determine whether the symptoms are, in fact, dissociation, or simply the effects of medically-based cognitive impairment.

Dissociation in ED/CSA Clients. Many respondents described dissociation in their clients as very common. Some said that they had clients coming in after years of therapy where their dissociation had never been addressed.

Eating disorders that dissociate, it's over half. And sexual abuse victims that dissociate, it's like seventy percent. And how many eating disordered people were sexually abused? So there is a huge overlap. You know, when something traumatic is going on, how do you not dissociate and get up the next day to go to school?

I would say that fifty percent of my people dissociate to a degree of not being aware of things that they are doing.

There is a huge percentage of people who dissociate who were sexual abuse victims, and a huge percentage of [people with] eating disorders who dissociate.

People are looking for the big DID split personalities sort of stuff, and a lot of times miss more subtle stuff. Like, 'yeah, I sort of just start eating, and I don't remember what I ate or when I ate it,' or, 'I just stop eating, and I don't even think about eating.' And a lot of times it's a trauma thing going on there, they are just sort of checking out from the trauma, and so they are checking out from their food.

I think an eating disorder is a form of dissociation. A lot of people, when they are bingeing and vomiting, they are in a trance.

Eating Disorders as Dissociative Symptom of Trauma. Many respondents described the eating disorders that they see in their clients as the response to the trauma

that they have experienced. Rather than being a distinct and separate entity from their sexual abuse, the eating disorders were described as a coping mechanism for dealing with the past, a symptom of the trauma, or a way to distract themselves from their pain.

Eating disorders, in my mind, are just ways that clients cope with the trauma. So if they could distract themselves with comfort eating, or if they could take control of their life when they feel out of control by managing their food—it's all a layer over the trauma, I think.

A lot of times, the eating disorder is the symptom. It's a self-medicating 'I have to control' because of the abuse.

A common symptom of trauma is [the thought] 'I don't want to go back and think about that.' The eating disorder helps [them] not go there.

In my experience, I find that the eating disorder is the distraction from trauma and abuse experiences.

I think that the element of dissociation that occurs with childhood sexual abuse, that the eating disorders is a manifestation of the dissociation.

[Without the eating disorder] they don't have their coping strategy. Although it's a maladaptive coping strategy, it's their coping strategy.

Several clinicians did further note that simply addressing the trauma will not be sufficient; however, because the eating disorder has become a coping mechanism and a habit, it has an addictive quality.

Usually, the human body doesn't do something that doesn't have an advantage, or a reason to do it. A reason. It may not be a good reason, but it's their way of coping, right? And sometimes, over time, it gets to be a habitual thing and it's hard to get out of.

[After addressing the trauma] they'll still have a lot of bad habits to deal with and there are still always issues. And also years of their bodies being out of whack—there may be permanent damage. There is still a lot of stuff to deal with.

Though the eating disorder may be a function of the trauma, after a number of years, or after the behavior has been so thoroughly adopted as a coping mechanism that it has become second nature, it is a difficult pattern to break out of. Even after getting help

for the behavior and the thoughts that trigger the behavior, there are often lingering and lasting physical effects on the body. This can, in turn, cause more stress and pain on the client.

Discussion

The intersection of eating disorders and child sexual trauma is well-established; though most research points to CSA as a non-specific risk factor, the larger and more important point is that CSA, which occurs in every socio-economic bracket, every race, every region, predisposes the victims (who by definition are blameless and innocent of wrongdoing) to a wide variety of mental disorders, including eating disorders. As a graduate student who has worked in the mental health field, I have always had a particular interest in eating disorders partially because they are such a complicated affliction to treat, cure, and mitigate the effects of. Food can be an addiction, but unlike alcohol or drugs, the addict cannot choose abstinence. Further, the intersection of culture has always fascinated me. Supermodels, fashion magazines, and exacting standards for female beauty may not *cause* disorders, but certainly they cannot help. Map onto the top of that the fact that eating disorders have a high rate of mortality and a relatively low rate of recovery, that many get sick young and stay sick for a long time, and the picture emerges that this is an area ripe for research.

Enter into the picture EMDR, originally developed to address trauma, but now found to be effective with a wide variety of conditions. What draws me to EMDR, in part, is the research that states that EMDR does not only work to mitigate the effects of trauma; it can actually get the brain to move past it (Shapiro, 2009). EMDR is becoming more widespread but the research on using it with eating disorder clients is still slim, and

research looking at using it with comorbid eating disorders and PTSD (or co-occurring eating disorders and CSA) is even slimmer. Still, to bring these disparate elements into conversation with each other is possible.

Client-Therapist Relationship

The respondents were unanimous in their endorsement of the client-therapist relationship as being a key consideration when using EMDR as a method of treatment for clients who have an eating disorder and history of CSA. There is no literature that looks at the relationship issue with this population and method, but it is widely supported by a large amount of literature that places the therapeutic relationship as one of the major factors of how effective therapy will end up being in the lives of clients. It is not surprising that the data obtained from these respondents furthered the idea that the relationship between practitioner and client is of the utmost importance. EMDR's eight-step protocol makes provisions for gathering history, and the beginning stages seem to posit relationship building as important for a successful outcome.

Stabilization of Eating Disorder

The importance of stabilizing clients in their eating disorders is well noted in research on eating disorders (DeAngelis, 2002). Given the high mortality rate of anorexia in particular, as well as the organ damage that can occur from any eating disorder, it is important, on an ongoing basis, to make sure that a medical doctor is following the clients, that their weight is stable, their heart strong, that they are eating and not abusing laxatives. So this theme is not unique to the situation of using EMDR, but it is an important consideration. Likewise, the importance of having a robust support system emerged from the data and this is a widely accepted consideration when treating both

eating disorder clients and traumatized clients. When looking at options for treatment that include holistic health elements, individual therapy, group therapy, nutritionists, medical doctors, and psychiatrists, among others, a *both/and* approach is generally preferable to an *either/or* approach.

Chronology of Treatment

After establishing and building a relationship with a client, working to stabilize the eating disorder including putting supports in place, the EMDR work on the trauma or eating disorder begins to be addressed through the bilateral eye movement work. The disagreement among the interviewed respondents over where to begin is actually somewhat supported by the literature about EMDR. Some people and some training endorses starting with the earliest memories and working chronologically, but others propose starting with what is more disruptive or distressing and beginning there, with the belief that you will always get to the root, the target of the distress, if you just float backwards from where you begin. What this is getting at is the negative cognitions; as long as EMDR is being used to root out the negative cognitions that the client has about themselves, their behaviors, their past, and work towards replacing them with positive cognitions, the literature largely states that it does not really matter where you begin and in what order you move in. The negative cognitions (*I'm defective/no good* is common in abuse survivors and eating disordered people) are the same no matter where you start.

Grounding

All nine respondents spoke in great detail about the importance of clients having basic skills that allow them to be grounded in the present while doing EMDR that is oftentimes bringing them to painful moments in their past. This is well reflected in the

literature about EMDR (Protinsky, 2001). Literature suggests that the root of some of the effectiveness of EMDR is related to the bilateral eye movement that helps keep a client “in the room” while their mind drifts elsewhere. It is a tie to what is going on in the present, when the past may feel scary or overwhelming. Shapiro (2009) designed EMDR with the belief that there is an optimal zone to keep a client in, where they are neither flooded with the past nor are they detached, or flat.

Dissociation

Dissociation was an unexpected theme to emerge, and one that was not found in the literature review done in preparation for this project. This is not surprising; several of the clinicians noted that more attention needs to be placed on dissociation and expressed dismay that it is not more routinely screened for when treating eating disorders. If the respondents are correct in their assessment that dissociation is in many ways a link between childhood sexual abuse and the eventual eating disorder, then it is an area to be explored further. The literature did point to a strong link between CSA and eating disorders, and dissociation is a natural result of CSA. Children need to attach. It is a biological imperative, this need for attachment. It is also a biological imperative to flee from danger. Given that most CSA is perpetrated by trusted adults in a child’s life, there are two things going on at the same time. The need to attach pulls, and the need to run away propels. The child is pulled in two directions. The only thing that can really be done, to survive, is mentally and emotionally leave the situation. And it may not show up as full-blown Dissociative Identity Disorder (DID), but there will be symptoms and there will be elements of it.

Implications for Social Work Research and Practice

In terms of research, one important implication is a need for greater examination into eating disorders, and more research into treating the trauma and abuse conjointly with the eating disorder. There is a lot of emphasis in chemical dependency treatment on dual diagnosis (addiction and mental disorder) and a similar approach may need to be developed for the treatment of eating disorders. It is not enough to achieve a healthy weight, though that is important, especially given how much brain function suffers when it is in starvation mode. However, treating the symptom—the eating behaviors—without treating the underlying issues of why this person is not eating—or overeating, or bingeing and purging—leaves clients with a diminished ability to cope with whatever it is in their past or their psyche that has convinced them that their eating disorder is a necessary coping mechanism. Many of the respondents interviewed for this study also strongly stated that, without dealing with the trauma, recovery from eating disorders is unlikely and if they do recover, many will turn to another maladaptive coping mechanism like cutting, burning, drinking, or using drugs. The behavior is a layer over the trauma, but that trauma will bubble up to the surface if it is not addressed. More research into how to best treat the trauma or other underlying psychological issues alongside the eating disorder is needed.

There are several implications for social work practice that come out of this research. One basic implication would be to put more emphasis on holistic care, and incorporating more psycho-education on the impact of nutrition and proper hydration on mood. Another implication would be continued attention to developing strong

relationships between therapist and client. An additional strong implication was the importance of helping our clients build an expanded network of support for their journey to health, whether that be spiritual like a faith family, or a dietician or personal trainer to help with diet and physical issues, a 12-step program, couples or family therapy, or a support group. This resonates deeply with the person-in-environment theoretical framework that really underpins the work we do as social workers. Our clients are interconnected in a web of social connections and forces—what is working for them? What needs to be put in place so that things can work better? It is important for clients to develop good relationships with their therapists and to learn how to participate in the therapeutic process, but we also need to help our clients develop connections to, and skills for interacting with their community.

Another possible implication surrounds the idea of dissociation that emerged. Several of the respondents remarked that they will often get clients who have had years of therapy and no one had ever screened them for the obvious dissociation that they are experiencing. Thus, more screening needs to be developed for dissociation, at intake, and on an ongoing basis, and more training needs to take place about dissociation, and what that looks like, and how it affects these clients with eating disorders. Too often these dissociative aspects seem to be overlooked, and many times social workers are not trained in how to identify it and how to work with it. A final implication to consider would be a movement to develop programs that incorporate EMDR (or some of the underlying principles of EMDR) into the treatment of clients who have eating disorders and a history of childhood sexual abuse.

Clinical social work practice is underpinned by a strong code of ethics and set of

core values that inform the work that is done. We must always strive for improved care that is based on the best research available. When considering a client population comprised of individuals with a history of childhood sexual abuse who currently struggle with an eating disorder, it is clear that it is a vulnerable group of people who have a high rate of relapse and a high rate of morbidity. This is an area where much more research needs to be done, and the information obtained needs to be put to work to find new treatment options that will hopefully work towards better outcomes for these clients.

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Appendix A

Contact Letter (Email)

Hello,

My name is Victoria Cameron and I am finishing my master's in social work program at St. Catherine University/University of St. Thomas, which requires me to complete a clinical research project for graduation.

My project is exploring the use of EMDR with clients who have an eating disorder and a history of childhood sexual abuse. My intention is to interview practitioners who see clients who meet this criteria. You are being contacted because you list with EMDRIA as someone who uses EMDR to treat eating disorders, or your name was passed along by someone on my committee as someone who would be good to talk to about this subject.

I'm sure you know that there aren't a whole lot of practitioners in the area who meet the criteria for the study, and it is my hopes to recruit more than a handful of participants—I'd appreciate your time. The interview won't take long; I would only need about thirty minutes. I'm happy to supply you with a list of questions in advance, if you'd like. I will meet you at your place of business or wherever works for you.

I will follow up with you early next week to see if you are interested in participating. Alternately, if this sounds like something you would be willing to do, or if you have questions, you can reply to this email or call me at 612-XXX-XXXX.

Thank you!
Victoria Cameron

Appendix B**Consent Form
University of St. Thomas****Exploring the Use of EMDR as a Treatment Modality for Co-occurring Eating Disorders and Childhood Sexual Abuse****417719-1**

I am conducting a qualitative study that explores using EMDR with patients with a history of childhood sexual abuse (CSA) who are being treated for an eating disorder (ED). I invite you to participate in this research. You were selected as a possible participant because you are a practicing psychotherapist and member of the EMDR International Association (EMDRIA), or have been referred someone already participating in this study. Please read this form and ask any questions you may have before agreeing to be in this study.

This study is being conducted by Victoria Cameron and supervised by Dr. Lance Peterson, Assistant Professor in the School of Social Work at St. Catherine University and the University of St. Thomas.

Background Information:

The purpose of this study is to explore the ways in which EMDR can be used to successfully treat clients who have a history of CSA and are seeking help for an ED. Exploring the therapist's subjective experience around this topic may provide insight for clinical social workers on more effective and productive ways to treat clients who have both CSA and ED, which research states commonly co-occur.

Procedures:

If you agree to be in this study, I will ask you to do the following: complete a live, audio-taped interview of approximately 30 minutes in length. You will receive, in advance, a list of the questions you will be asked during the interview. You will be able to choose both a time and place for the interview that is convenient for you. In addition, you will be invited to a presentation of this research in May, 2013.

Risks and Benefits of Being in the Study:

The study poses little risk to you. It is not anticipated that the questions will elicit an emotional response in you.

There are no direct benefits, and no compensation offered for participating in this research.

Confidentiality:

The records of this study will be kept confidential. In any sort of report that I publish, I will not include information that will make it possible to identify you in any way. The types of records that I will create include audio-taped interviews, transcripts of interviews and handwritten notes and impressions on these interviews. I will be completing the transcribing myself. All data collected in this study will be kept in a locked filing cabinet in my home office, and on a password protected computer. Only I will have access to these materials. Furthermore, all data collected will be either erased or destroyed by June 1st, 2013.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the researcher, Victoria Cameron, research advisor, Dr. Lance Peterson, your place of employment or St. Catherine University or the University of St. Thomas. If you decide to participate, you are free to withdraw at any time. Any data collected will remain confidential regardless of whether or not you complete this study. You may choose to complete all or part of the interview without consequence to you. Your participation in the study to the extent you are able is highly valued.

Contacts and Questions

My name is Victoria Cameron. You may ask any questions you have now. If you have questions later, you may contact me at 612-XXX-XXXX. You may also contact my chair, Dr. Lance Peterson, at 651-XXX-XXXX. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age.

Signature of Study Participant

Date

Print Name of Study Participant

Date

Signature of Researcher

Date

Appendix C

Interview Schedule

Education and licensure:

What formal training do you have specific to eating disorders/PTSD?

Number of years in practice:

Setting where you practice/have practiced with ED clients (hospital, residential, day treatment, outpatient, etc):

Which eating disorders do you primarily treat that are co-occurring with CSA?

What are some strategies from EMDR that you find apply to both the eating disorder and the trauma a client experiences?

Are there times when you feel EMDR fails to address eating disorder issues? If so, what specific circumstances help you understand when to use a different approach for the eating disorder? Chronologically, what do you treat first, the eating disorder, or the abuse?

What factors might preclude you from using EMDR with a client, or what factors need to be in place in order to consider EMDR the best fit for treatment?

When considering the clients you treat, what do you see, if any, as the common symptoms for eating disorders and trauma?

As you consider the comorbidity of eating disorders and trauma, what do you think are some strategies practitioners should adopt for treatment?