PROTOCOL FOR EMDR THERAPY IN THE TREATMENT OF EATING DISORDERS

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INTRODUCTION

Eating disorders (ED)—anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED)—are persistent and complex disorders and, therefore, a challenge for therapists with any theoretical orientation. Regularly, eating disorders develop into chronic disorders supplemented by medical complications, psychosocial problems, (ED) and comorbid psychopathology. International guidelines advise treatment by an interdisciplinary team of specialists with a common view, offering a broad-spectrum approach (Multidisciplinary Guidelines for Eating Disorders, 2006; National Institute for Health and Clinical Excellence, 2004, 2017).

A prominent place is reserved for cognitive behavioral therapy (CBT). However, empirical data of treatment outcome studies show mixed results with significant relapse rates for all eating disorders (American Psychiatric Association, 2013; Steinglass et al., 2011). BN and BED patients show relatively positive results after treatment with CBT (Agras & Apple, 1997; Dingemans, Bruna, & van Furth, 2001; Wilson & Fairburn, 2007). Nonetheless, for AN no treatment of choice is available yet, based on empirical grounds, and for other eating disorders current treatments are inadequate for relapse prevention (Steinglass et al., 2011). This implies that treatment of patients with an eating disorder—especially AN—is expensive because generally patients are "in treatment" for many years. Existing treatments are insufficient, and new effective and efficient treatment approaches are needed.

Patients with different eating disorders not only have distinct features but also share common ones. Besides, patients can switch over time from one disorder to another. For this reason, Fairburn, Cooper, and Shafran (2003) introduced the "transdiagnostic perspective": a theoretical cognitive behavioral model applicable to different eating disorders explaining how the disorder is maintained by mechanisms that perpetuate vicious circles. This transdiagnostic model (Fairburn et al., 2003) assumes that eating disorders share *core psychopathology* (i.e., overvaluation of eating, weight, and shape and their control) and several *additional factors* that are present in different degrees in affected individuals and can interact with both these core symptoms and with each other (i.e., clinical perfectionism, low self-esteem, trouble with intense mood states, and interpersonal problems).

This model is applicable to AN, BN, and BED and has been translated into therapeutic programs that have been tested empirically (Dalle Grave, Calugi, Doll, & Fairbirn, 2013; Fairburn et al., 2009, 2013). Binge eating and purging stop completely in 30% to 50% of the patients, another group shows some improvement, and the rest drop out of treatment or do not respond (Wilson & Fairburn, 2007).

Based on Fairburn's transdiagnostic model, a treatment program has been developed for adolescent patients with AN, BN, and atypical eating disorders, consisting of 11 potential modules, each focusing on different aspects of eating disorders that are treated with cognitive behavioral interventions (Beer & Tobias, 2011). Clinical experience has demonstrated that EMDR therapy can be implemented efficiently in several of these modules and that a combination of CBT interventions and EMDR enhances the effectiveness of both. Moreover, therapists who do not work with CBT interventions can work with these modules and apply EMDR, when there is an indication for EMDR. This is the case

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whenever intrusive images are motivating the psychopathology. EMDR therapy can play a significant role in the following modules:

- Suffering from distressing memories
- Eating disorder–related fears
- Eating disorder–related urge-driven behaviors
- Low self-esteem
- Clinical perfectionism
- Negative body image

In this chapter, an EMDR eating disorders (EMDR-ED) protocol, as integrated in the eight phases of the Standard EMDR Protocols, will be described. It is geared to treat the unique issues that arise when using EMDR therapy to treat either the potential focuses of concern or parts of the disorder translated into modules.

In line with the guidelines, EMDR therapy is considered a valuable supplement, but not sufficient as a standalone therapy for the treatment of an eating disorder. Neither is the case with CBT or family therapy because eating disorders demand a broad-spectrum treatment. The aim of this chapter is to clarify when and how EMDR therapy can be a part of the broad-spectrum treatment of patients with an eating disorder.

Because the EMDR-ED protocol involves six modules, covering relevant mechanisms mentioned by Fairburn et al. (2003), and six potential procedures for target selection, both the potential modules and procedures will be explained. Five of these procedures for target selection to be described have been developed in the Netherlands.

The application of the EMDR-ED protocol, as described here, has not yet been validated empirically. An earlier version, focusing on binges, self-esteem, and body image, has been used in the Netherlands since its publication (Beer & Hornsveld, 2012), but no data are available related to its effectiveness.

Members of the Special Interest Group for EMDR and Eating Disorders of the Dutch EMDR Association have been exchanging clinical experiences with this "protocol-in-progress" since 2010.

In 2014, a pilot study was published that tested the efficacy of the standard EMDR protocol on change in the body image while distressing memories of adverse experiences were reprocessed by the participants. After 5.4 sessions on average, a positive change was found in the body image of all 13 women included (Pepers & Swart, 2014). Whether this change had an impact on their eating disorder or on treatment progress is not clear. This was not measured.

Roedelof (2016) started a study exploring whether empirical validation can be established for the efficacy of this EMDR-ED protocol on the change of distorted negative body image.

FEATURES IN EATING DISORDERS

The most prominent psychological features of distinct eating disorders according to the *ICD-10* (www.eatingdisorders.org.au) are listed. Pica, rumination, and avoidant/restrictive food intake disorders are left out.

Anorexia Nervosa (AN)

- Body weight is maintained at least 15% below that expected (either lost or never achieved), or Quetelet body mass index is 17.5 or less. Prepubertal patients may show failure in making the expected weight gain during the period of growth.
- Weight loss is self-induced by avoidance of food intake and possibly one or more compensatory behaviors: self-induced purging (vomiting, using laxatives and/or diuretics), excessive exercise, and/or use of appetite suppressants.
- Distorted body image; a dread of fatness persists as an intrusive, overvalued idea, and the patient imposes a low weight threshold on him/herself.
- In prepubertal patients, the pubertal development may be delayed or arrested.

Bulimia Nervosa (BN)

- Persistent preoccupation with eating, irresistible craving for food, and episodes of overeating where large amounts of food are consumed in short periods of time (binges).

- Attempts to counteract the "fattening" effects of food by one or more compensatory behaviors: self-induced purging (vomiting, using laxatives and/or diuretics), excessive exercise, and/or use of appetite suppressants.
- A morbid dread of (disgust for) fatness, leading to setting a sharply defined threshold for him/herself, well below a normal, healthy weight.

Binge Eating Disorder (BED)

- Recurrent episodes of binge eating, characterized by frequently eating excessive amounts of food, often when not hungry.
- Binges represent a distraction that allows a person to avoid thinking about the real root of the problems.
- Feelings of guilt, disgust, and depression often follow a bingeing episode.
- Binge eating disorder is not the same as overeating, as it is recurrent and more serious.
- The binges are not associated with recurrent inappropriate compensatory behavior (self-induced purging: vomiting, using laxatives and/or diuretics).

MEASURES

Different validated instruments are available in different countries/languages. The following instruments are recommended:

- *Eating Disorder Inventory—3* (EDI-3; Garner, 2004). The EDI assesses psychological domains that have conceptual relevance in understanding and treating eating disorders.
- *Eating Disorder Examination* (EDE; Fairburn & Cooper, 1993). The EDE is a semistructured interview directed at general ED symptomatology, not specifically at distorted body perception.
- *Eating Disorder Examination Questionnaire* (EDEQ; Fairburn & Beglin, 1994). The EDEQ is a self-report questionnaire derived from the EDE, which contains its three main subscales (restraint, weight concern, and shape concern).
- *Body Shape Questionnaire* (BSQ; Cooper, Taylor, Cooper, & Fairburn, 1987). The BSQ is a self-report questionnaire that measures body dissatisfaction, the fear of becoming fat, self-devaluation due to physical appearance, the desire to lose weight, and avoidance of situations where physical appearance might draw others' attention.

PREVALENCE AND PROGNOSIS

The prevalence of eating disorders is relatively high among adolescents, taking the third position in the top five of psychiatric disorders (Vandereycken & Noorderbos, 2008). Eating disorders have been identified as one of the most common and serious forms of adolescent disorders in developed societies (Slade, 1995). However, in the general population this is different: Prevalence of AN is about 0.3% and BN 1%. AN is manifested mainly among women. The peak of onset for AN is between 14 and 18 years of age and for BN it is between 16 and 20 years. Over the past years, the onset of AN at even younger ages has been rising. If the onset is during puberty/adolescence after the menarche, the prognosis is better than with an earlier start before the menarche or an onset later in life. In about 50% of AN patients there is complete recovery, 30% show progress, and 20% remain chronically ill (van Elburg & Danner, 2015).

BED though is not primarily a female disorder; the prevalence is comparable to BN, around 1%, and the rate of prevalence is equal for men and women (Hoek & Van Hoeken, 2003).

Eating disorders have the highest mortality rate of all psychiatric disorders. As many as 15% of AN patients die of the consequences (complications) of the disorder, two-thirds by starvation, and one-third by suicide (van Elburg & Danner, 2015).

EATING DISORDERS AND TRAUMA

Specific risk factors for either onset or maintenance of eating disorders have not been identified yet. Adverse or traumatic experiences—like having been bullied or excluded or having been sexually assaulted—often precede the onset of the disorder, but they are not specific factors. They happen more

often than in healthy controls, but not in the same degree in comparison to other psychiatric patients (Multidisciplinary Guidelines for Eating Disorders, 2006). It has been observed that sexual trauma plays a role in 20% to 40% of all adult patients with an eating disorder (Vandereycken & Noorderbos, 2008). Fairburn et al. (2003) discuss the vital importance of negative self-esteem as a risk factor, but the potential significant role of traumatic or adverse experiences in this respect is not mentioned.

Group therapy is "core business" in most specialized institutions for eating disorders, focused on the change of eating patterns and the general themes, as described by Fairburn and colleagues. In most cases, there is neither room nor expertise for individual treatment of trauma. Eating disorders and trauma are considered two separate issues. In clinical practice and in published case studies, nevertheless, adverse or traumatic experiences are reported to be "present" in many patients with an eating disorder.

A full-blown PTSD is diagnosed rarely because, often, the patient develops the eating disorder more as a kind of self-medication or coping against trauma symptoms. Minor "t" traumas, like being assaulted or neglected, result regularly in the presence of negative self-esteem, negative beliefs about body appearance, and dieting issues in this population (Ferreira, Pinto-Gouveia, & Duarte, 2013; Pepers & Swart, 2014).

A negative body image is a persistent and invalidating aspect of an eating disorder, difficult to treat, and a significant predictor of relapse, if it has not disappeared by the end of treatment (Stice & Shaw, 2002). Anorexia nervosa patients have an internal model of their body size that is bigger than reality (Keizer et al., 2015), which can manifest as a delusional symptom. This internal model can result from adverse (traumatic) experiences. In patients where this is the case EMDR therapy could have a significant effect on this delusional symptom.

EATING DISORDERS AND EMDR THERAPY

The rationale for the implementation of EMDR therapy in the treatment of an eating disorder is that several symptoms, such as fear of weight gain (or other fears), negative body image, and low self-esteem, seem to be motivated and maintained by *intrusive and distressing negative images of either past or anticipated future experiences.* Other symptoms—like binges and compensatory behaviors (vomiting, using laxatives, or hyperactivity)—seem to be motivated by a compelling urge to perform these behaviors, where this urge is activated by *intrusive positive images of anticipated effects of these specific behaviors*. These anticipated effects are positive because either a required state is achieved or a feared state is avoided. Some examples of these required states are the following: an emotional state (relief, consolation) or a physical sensation (liberation of satiation or bloating). Distressing for the patient is the fact that he/she knows that the behavior leads to negative consequences ultimately, but he/she is short of alternative responses.

Whenever any (eating disorder) behavior serves to cope with problems that result from *intrusive and distressing images*, EMDR therapy is to be considered an option.

In addition to this rationale, there is a collateral attraction to use EMDR therapy because it is a pleasant therapy approach for patients with an eating disorder for several reasons:

- *Experiential orientation*: In EMDR therapy, cognitive, physical, and emotional changes happen instantly and simultaneously. Changes are not the result of explicit self-control and motivation-based efforts, but they simply arise and the patient needs to only notice them.
- *Respect*: EMDR therapy relies on the AIP model (F. Shapiro, 2001) and the self-healing power of the individual. Whatever the patient experiences during the process is regarded as valuable. This is often a relief for these patients, who have been confronted with irritation, frustration, and incomprehension by people in their environment and by themselves during many years of futile attempts at improving self-control.

EMDR PROTOCOL FOR EATING DISORDERS SCRIPT NOTES

The Standard EMDR Protocol has eight phases, and the EMDR protocol for eating disorders (EMDR-ED) protocol covers these phases. The EMDR-ED protocol indicates how six potential modules can fit into the structure of the eight phases of the standard protocol.

Part of the history-taking phase (the target selection) is repeated several times for the identification of targets to be reprocessed within a module. Reevaluation is expanded by the selection of the next module with which to continue intervention. Figure 1.1 shows an overview of the similarities and differences.

Standard EMDR Protocol	Protocol for Eating Disorders: EMDR-ED Protocol
1. History-taking and case conceptualization 2. Preparation 3. Assessment 4. Desensitization 5. Installation 6. Body scan 7. Closure 8. Reevaluation	1. History-taking and case conceptualization: *- Identify relevant modules for EMDR* *- Select relevant targets within the module with appropriate procedures for target selection* 2. Preparation: *- Introduce EMDR; explain when it is possible and useful.* *- Assist in regulation of eating pattern* *- If useful: RDI* *- Choose first module when ready to start EMDR* 3-8. Assessment—reevaluation: *Reprocess/neutralize every relevant target within one module successively until module is treated sufficiently.* 8+ *Reevaluation+*: *- When module is treated sufficiently, select relevant next module* *Then repeat:* *Selection of targets (=1)* *Assessment–reevaluation (3 to 8) on every single relevant target.* *Continue until all modules are treated sufficiently.*

Figure 1.1 Standard EMDR Protocol and EMDR-ED protocol.
RDI, resource development and installation.

All phases will be described in detail after clarification of the following: therapist criteria, potential procedures for target selection, and the content of the six modules.

EMDR Therapist Criteria

For efficient implementation of EMDR therapy with the EMDR-ED protocol discussed here, we recommend some prerequisites for therapists:

- *Experience in treatment of patients with eating disorders*
  Practitioners should be experienced in working with this difficult population to be able to recognize and cope with the characteristic dynamics in the therapeutic process and in the relationship between therapist and patient.
- *Understanding motivating through case conceptualization*
  For optimizing full cooperation, therapists should be able to develop an accurate case conceptualization and explain clearly their analysis and treatment plan, including the rationale for using EMDR. This is discussed with the patient, depending on the age of the patient (younger than 16 years) and the circumstances the patient is currently living in, as well as the patient's parents/family. Keeping the patient motivated to continue treatment is a fragile variable in this population and merits careful attention.
- *Understanding procedures for target selection*
  In this EMDR-ED protocol five additional procedures for target selection are included besides the regular one (F. Shapiro, 2001). These additional procedures have been developed by Dutch trainers, some of which are published in this series (de Jongh, 2016; Horst & de Jongh, 2016; Logie & de Jongh, 2016; van der Vleugel, van den Berg, de Bont, Staring, & de Jongh, 2016) and others elsewhere (de Jongh, ten Broeke, & Meijer, 2010; Logie & de Jongh, 2014; Markus & Hornsveld, 2015, 2017).

  Because these procedures have been published before in the English language under the name "First and Second" in the "Two Methods Questioning Approach" (de Jongh et al., 2010) and "Third" (Logie & de Jongh, 2016; van der Vleugel et al., 2016), it would be consequent to call the next ones the "Fourth," the "Fifth," and the "Sixth." However, because these names are neither meaningful nor instructive, the procedures are renamed and will be indicated in this chapter by more meaningful names. The procedures will be described briefly, including situations where they are applicable. For further information, reading of relevant publications of the developers of these procedures mentioned previously is recommended. Understanding them and being able to apply them properly is essential for working with this EMDR-ED protocol.

Procedures for Target Selection

In search of ways to optimize the efficiency of EMDR therapy with different kinds of psychopathology, distinctive procedures for target selection have been developed. These procedures mark different paths the therapist can follow in looking for the most relevant targets. Therefore, these procedures are referred to as paths. The exact questions to be asked during these structured procedures are scripted in the scripted protocol that follows. In this section, the procedures/paths will be clarified roughly so the therapist can understand in general when and how to use them. They will be described more specifically later, in the script part. Figure 1.2 shows an overview of the potential paths.

All of these paths can be relevant for the selection of targets when working with patients with EDs.

I. Intrusion Path

This path is relevant in case of intrusive and distressing memories of specific events, when a direct connection between memories and symptoms is obvious. Relevant targets are identified by asking the patient which memory or which image of the memory is the most disturbing (F. Shapiro, 2001).

Targets are ranked by subjective units of disturbance (SUD)'s level.

Key questions: Which memory is bothering you the most?

What is the worst image of that memory?

II. Timeline Path

This path, called "the First Method" in earlier publications (de Jongh et al., 2010), is used for conceptualizing EMDR therapy in the treatment of symptoms or *symptom clusters*, which have developed over time gradually after several events. The path starts with the selection of the specific target symptom that the patient wants to get rid of primarily, because of the disturbance the symptom is causing. Subsequently, events are sought after that the selected symptom started and aggravated later. These events are positioned on a timeline and then the patient indicates which of these events contributed strongest to onset and aggravation of the symptom (in this population this is frequently "fear of being excluded or rejected").

Targets (memories of the selected events) are reprocessed chronologically to eliminate the symptom (de Jongh et al., 2010; Logie & de Jongh, 2014).

Key questions: After what experience did . . . (the symptom) start?

After what experiences did it increase?

When all relevant memories have been reprocessed, the therapist checks if there are any related anticipatory fears (flash-forwards) to be reprocessed. The next step is preparing the patient for the future with a future template or a mental video check. With a mental video check, the patient is asked, with eyes closed, in his or her imagination, to go through a future (formerly anxiety-provoking) situation from beginning to end, and check whether there are aspects ("cues") that provoke any tension and, therefore, might prevent the person from confronting the formerly frightening situation. The patient is asked to open his/her eyes when discomfort or tension is sensed and to concentrate on the anxiety-provoking or disturbing cue. Then one set of eye movements is performed and the patient continues this movie until he/she experiences his/her next tension. Another set follows. This procedure is continued until the end.

I. Intrusion path	From intrusive and distressing memories to targets
II. Timeline path	From symptoms that developed gradually over time to targets
III. Dysfunctional belief path	From symptoms that are driven by core beliefs to targets
IV. Flash-forward path	From symptoms that are driven by negative future-oriented fantasies to targets
V. Dysfunctional positive targets path	From urge-driven symptoms to urge-evoking targets: Positive memories (1) Present trigger situations (2) Positive future-oriented fantasies (3)
VI. Emotion path	From (problematic) emotions to targets

Figure 1.2 Overview of procedures (paths) for target selection.

III. Dysfunctional Belief Path

This path, called "The Second Method" in an earlier publication (de Jongh et al., 2010), is devised for the identification of memories of events that underlie dysfunctional core beliefs or associated assumptions that elicit dysfunctional behavioral patterns and/or persistent psychopathology. Core beliefs are not just thoughts connected to specific situations but enduring beliefs that are generalized, absolute, and deeply rooted and, therefore, rigid and hard to modify. In these situations, there is a great stock of potentially relevant events in the past, mostly starting early in life, which have resulted in the formation of negative dysfunctional beliefs about the self and others (Beck, 1995). These *core beliefs* will elicit, through *intermediate beliefs* (precepts resulting from the core beliefs), behavioral and emotional reactions that cause negative emotional and/or interactional experiences. These experiences in turn are stored in the memory as "confirmation" of the cognitive bias and increase its credibility. Core beliefs are regarded here as the primary symptom or "the driving force," leading to secondary symptoms: behavioral, emotional, and interactional problems. For the modification of core beliefs, we need another search strategy to find constituting memories because an abundance of events could be placed on a timeline, whereas it is unclear on what criteria to select relevant ones from these. For these cases the "Google-search strategy" (de Jongh et al., 2010; E. Shapiro & Laub, 2009, 2014) is proposed because here a selection seems relevant of events that "prove" for the patient—in the strongest way—the credibility of the belief. The aim is to "discredit" the "evidence" for the belief. In computer terminology, therefore, the selected core belief or assumption is the *keyword* and all potential relevant past events are in the World Wide Web. As with Google search, the therapist and the patient search for the most relevant "hits." Memories of the events appearing at the top of the list seem to be the most crucial ones, and these "proofs" are "discredited" one after another by reprocessing these memories with EMDR (de Jongh et al., 2010; ten Broeke, de Jongh, & Oppenheim, 2012). Sometimes a patient provides evidence that doesn't concern a single experience, but a bunch of experiences, repeated over and over during a certain period. This is referred to as an "archive." Then, the next step is selection of one experience per archive to symbolize the experience. The criterion for selection of a memory as target is how much it is experienced in the present as a "piece of evidence" for the validity of core belief.

Targets are ranked by degree of sustaining credibility to the belief instead of SUD's level or chronology.

Key questions: Which past experiences still prove for you, at this moment, that you are _____ (state the dysfunctional belief)?

How do you know that you are ____ (state the dysfunctional belief)?

IV. Flash-Forward Path

The flash-forward path—called the Third Method in "EMDR for Traumatized Patients With Psychosis" (van der Vleugel et al., 2016)—is devised for the treatment of irrational fears, provoked by intrusive fantasies of catastrophic events that might happen to the patient in the future. With the fear-related behaviors, the patient intends to prevent from happening what he or she sees in imagination. The target image is the worst image of this nightmare or scenario, the so-called flash-forward. Common flash-forwards in this population include the following: being rejected, despised, or ridiculed because of their appearance. Although the patient's focus is on the future, the fears are experienced in the present, triggered by negative, irrational thoughts and images associated with a catastrophic content. The flash-forward path addresses patients' irrational fears and anticipatory anxiety responses that persist after the memories of past events have been fully processed. However, if no relevant past events can be identified, then the flash-forward should be processed straight away. The flash-forward path has proven to be an effective application of EMDR to deal with the second prong ("present") of the three-pronged approach, if the first one ("past") is either dealt with or does not seem relevant. This path is based on experimental findings, showing that vividness and emotional intensity of recurrent intrusive images can be reduced by taxing working memory using eye movements—not only of past events but also of potential future catastrophes (Engelhard, van Uijen, & van den Hout, 2010; Logie & de Jongh, 2014).

Targets are ranked by SUD's level.

Key question: What is the worst scenario of what might happen to you in the future in your imagination?

What would be the worst thing about that?

What is the worst image in your head about that?

V. Dysfunctional Positive Targets Path

This path is used for the treatment of specific eating disorder–related behaviors, like dieting, binge eating, or vomiting. These behaviors are urge-driven and can be motivated by either *positive memories of past experiences* or *images of present situations* (present triggers) activating the urge to perform the dysfunctional behavior or *positive future-oriented fantasies* (also present triggers) of what might happen to the patient in the future resulting from this behavior.

The aim of the behavior is to achieve a positive affect or sensation. The targets are intrusive and compelling images of these anticipated effects: dysfunctional positive flash-forwards. The use of EMDR therapy on dysfunctional positive targets (Hornsveld & Markus, 2014; Markus & Hornsveld, 2015) is based on research that has shown repeatedly that eye movements make negative images less negative, but dysfunctional positive ones less positive (Engelhard et al., 2010). Neutralization can move in two directions. Similarly, Knipe (2010) observed this phenomenon and developed a procedure for reprocessing "dysfunctional positive affect." Popky (2009) used this phenomenon in the treatment of addiction disorders to desensitize memory representations of triggers that elicit an urge to take the substance to which the patient is addicted.

Three kinds of dysfunctional positive targets can be distinguished:

V1. MEMORIES OF POSITIVE EXPERIENCES

Activation of the memory evokes an urge to relive the desired state and, thus, to perform the specific behavior to achieve this state. The target must be identified that evokes the strongest *level of urge* to perform the behavior (LOU) and/or the strongest *level of positive affect* (LOPA).

Targets are ranked by LOU or LOPA, whichever evokes the strongest urge.

For the negative cognition, words must be identified that intensify the urge maximally (e.g., "I always want to feel like this") and the positive cognition is the standard "I am strong" or "I can deal with the image, resisting the urge" or "I can resist the image."

Key questions: What is your most positive memory of having performed _____ (state the specific behavior: dieting/binge eating/excessive exercising/vomiting/using laxatives)?

Which positive memory now evokes the urge to _____ (state the specific behavior) the strongest?

V2. IMAGES OF PRESENT TRIGGERS (POSITIVE OR NEGATIVE)

A variety of situations can activate the urge to perform these specific ED behaviors. The choice for desensitization of these triggers is based on the work of Popky (2005, 2009, 2010), Hase (2009), and Markus and Hornsveld (2015), who use their procedures in patients with different kinds of addictions. Daily recurring trigger situations can evoke the urge to perform the ED behavior. In these situations, the patient expects a reward from the ED behavior of positive emotions/sensations or relief by escape from negative ones. The outcome of the ED behavior is positive either way.

The target is an image of the situation that evokes the strongest level of urge to perform the behavior (LOU).

Targets are ranked by LOU.

For negative cognition, words are identified that intensify the urge the most or are the most disturbing. The positive cognition is the standard "I am strong" or "I can deal with this image, resisting the urge" or "I can resist the image."

In the assessment phase the therapist asks for both LOU and SUD.

Key question: Which situations are difficult for you because they evoke the urge to perform _____ (state the specific ED behavior)?

V3. POSITIVE FLASH-FORWARDS

Patients often have clear fantasies of what might happen to them if they succeed in achieving their goal with this specific behavior. These future-oriented fantasies are present triggers.

The target is identified that gives the strongest level of urge to perform the behavior (LOU) and/or the strongest level of positive affect (LOPA).

Targets are ranked by LOU or LOPA, whichever is the strongest.

Instead of a negative cognition those words are identified that strengthen the urge the most or are the most disturbing. The positive cognition is the standard "I am strong" or "I can deal with this image, resisting the urge" or "I can resist the image."

I. Intrusion path	Images of intrusive and distressing memories - Ranked by SUD's level
II. Timeline path	Memories of crucial experiences for development of symptom - Ranked chronologically
III. Dysfunctional belief path	Intrusive memories sustaining credibility to dysfunctional core/intermediate belief - Ranked by degree of sustaining credibility
IV. Flash-forward path	Images of anticipated frightening future experiences (catastrophes) - Ranked by SUD's level.
V. Dysfunctional positive targets path	Images evoking a compelling urge to perform unhealthy behavior 1. Memories of positive affect of the specific behavior (symptom) - Ranked by LOU, LOPA (whichever is the strongest). • Instead of NC: words that evoke maximally the urge or the positive affect • Standard PC: "I can resist the image" or "I am strong" Not mentioned in assessment, but installed after LOU or LOPA is reduced significantly • Back to target/process measures: LOU/LOPA instead of SUD 2. Images of present trigger situations - Ranked by LOU to perform the specific behavior • Instead of NC: words that evoke maximally the urge • Standard PC: "I can resist the image" or "I am strong" Not mentioned in assessment, but installed after LOU is reduced significantly and SUD = 0 • Back to target/process measures: LOU besides SUD 3. Positive images of required future experiences (fantasies) - Ranked by LOU or LOPA (whichever is the strongest) • Instead of NC: words that evoke maximally the urge or the positive affect • Standard PC: "I can resist the image" or "I am strong." Not mentioned in assessment, but installed after LOU or LOPA is reduced significantly • Back to target/process measures: LOU/LOPA instead of SUD
VI. Emotion path	Memories that evoke the problematic emotion - Ranked by SUD's level

Figure 1.3 Characteristics of paths for target selection: Type of targets, (-) sequence of targets, (o) deviations from standard protocol.
LOPA, level of positive affect; LOU, level of urge; NC, negative cognition; PC, positive cognition; SUD, subjective units of disturbance.

Figure 1.3 provides an overview of characteristics of paths for target selection.

Key questions: What is the most desired outcome of performing _____ (state the specific ED behavior)? Or What are you most looking forward to when you _____ (state ED behavior)?

VI. Emotion Path

The emotion path is appropriate for the treatment of symptoms that result from problematic emotions. The procedure, though it seems similar to the floatback technique (Shapiro, 2001), is different. In the floatback technique, the therapist asks the patient to look for memories of the first time he/she remembers feeling this way, whereas in this procedure the patients look for memories that evoke the emotion the most. Common problematic emotions in this population are disgust, anger, guilt, shame, and sadness.

Key question: As you bring up your _____ (state the problematic emotion), which memory evokes this emotion the strongest?

This section offers an overview of the potential modules for EMDR therapy with their indication criteria, relevant targets, associated procedures for target selection, and goals.

All in all there are six modules and six paths for target selection.

Module 1: Distressing Memories

This module is relevant when intrusive memories of specific experiences are causing distress or are obstructing progress in the treatment of the eating disorder. The distress does not induce additional symptoms necessarily. There is a direct link between memories and distress. The targets are the most intrusive and disturbing memories, and the therapist finds the targets with the intrusion path.

Goal: Distressing memories are neutralized so much that they no longer obstruct progress in the treatment of the eating disorder and no longer cause suffering.

Module 2: Eating Disorder–Related Fears

This module is applied when irrational fears—related to eating, weight, or appearance—start and exacerbate later on after specific experiences. In these cases, there is no suffering from memories of experiences, but from symptoms (fears), which resulted from or were aggravated after these negative experiences. The targets are memories of relevant experiences, and two procedures for target selection can be considered here:

1. If specific experiences can be identified as a clear "starting point" or as the "cause" of exacerbation of already existing symptoms, targets are identified with the timeline path.
   Goal: Memories maintaining the fears are neutralized, so the fears will disappear or diminish so much that they no longer obstruct progress in the treatment of the eating disorder.
2. If there are irrational fears for anticipated future negative experiences (e.g., "If I will continue treatment, I will end up like an elephant and everybody will ridicule me"), and relevant past experiences either have been reprocessed or cannot be identified, then the therapist asks for the worst scenario in the patient's head about the specific anticipated future experience and its potential consequence. The target is the worst image of this scenario. For target selection, the "Flash-Forward Path" is to be used.
   Goal: Future-oriented fantasies maintaining the fears are neutralized, so that fears disappear or diminish so much that they no longer obstruct progress in the treatment of the eating disorder.

Module 3: Urge-Driven ED Behaviors

Behavioral eating disorder (ED) symptoms like having binges, dieting, or performing compensatory behaviors (moving excessively/purging) are urge-driven behaviors. They are performed either to avoid or to escape from negative outcomes (emotional states or sensations) or to achieve positive outcomes (required emotional states), whereas the patient realizes that these behaviors have unhealthy consequences in the long run. The patient seems incapable of resisting the urge or impulse; the resulting behavior looks like voluntary behavior, but it is not.

The targets that reflect a "dysfunctional" positive outcome of this behavior should be neutralized.

Three kinds of dysfunctional positive targets can be relevant: memories of past experiences, images of daily recurrent situations that trigger the urge, and fantasies about future experiences.

1. *Memories of positive experiences*: Examples are positive feelings of autonomy after having exercised excessively, comfort after a binge episode, relief after having vomited, and pride after dieting. Memories of experiences of this "dysfunctional" positive affect are positive targets to be reprocessed.
2. *Present trigger situations*: Daily recurring present situations can activate the urge to perform the ED behavior. This does not concern specific events stored in the episodic memory, but global images or memories evoking the urge in daily life (Hornsveld & Markus, 2014); for example, the sensation of a full stomach, or seeing an empty plate after eating. Neutralization of memory representations of these situations should promote the patient's ability to resist the urge that is evoked.
3. *Positive flash-forwards*: If the patient has intrusive fantasies, evoking required anticipated positive affect, the target can be the image of the fantasy that evokes the positive affect the strongest. Examples are "After having vomited, I will feel free"; "After a binge, I will feel relaxed"; "If I keep on moving my body/take these laxatives, my weight will remain below 40 kg"; "If I can keep my weight below 40 kg, I am fully in control of myself, which will make me feel happy."

However, if the urge seems to be activated primarily by a predominant negative emotion like anger, disgust, or shame, then it can be helpful to look for those memories that evoke this problematic emotion the strongest. Then the emotion path might be helpful for finding relevant memories.

Goal: The relevant memories, trigger situation, and/or fantasies no longer elicit the urge to perform the dysfunctional behaviors, or the patient is better able to resist the urge that is evoked, and/or the dysfunctional behaviors disappear or diminish so much that they no longer obstruct progress in the treatment of the eating disorder.

Module 4: Low Self-Esteem

Predominant hypothesis in many case conceptualizations is that the eating disorder is maintained by negative dysfunctional belief(s) about the self, a so-called low or damaged self-esteem (Fairburn et al., 2003). Negative dysfunctional beliefs about the person usually have resulted from a multitude of negative experiences, starting early in life. It is obvious that the negative self-image is still "activated" and sustained in a clinically sub-threshold way. Therefore, it is important to identify those targets that will "deactivate" the dysfunctional beliefs. In other words, the dysfunctional belief should no longer feel as valid, when those targets (memories) will have been reprocessed. The selected targets are supposed to contribute substantially to loss of credibility of the belief. The dysfunctional beliefs path is appropriate here for target selection.

Goal: Reduction of credibility of the core belief to such a degree that behaviors and moods resulting from this core belief stop or are diminished so much that they no longer obstruct progress in the treatment of the eating disorder. Reduction of the credibility of the core belief is achieved by neutralizing relevant memories.

Module 5: Clinical Perfectionism

Clinical perfectionism (setting unhealthy and unrelenting standards for oneself) is closely associated with low self-esteem and can be regarded as an avoidance strategy for being confronted with feelings of weakness, failure, and worthlessness. People with clinical perfectionism consider making an error as a proof for being imperfect, not good enough, or even a bad person. Clinical perfectionism can be a focus for EMDR therapy when dysfunctional core beliefs and intermediate beliefs can be identified that motivate the behavior, for example, "I must do everything that helps me look perfect"; "If I do not look perfect, everybody will reject me"; "If I do not look perfect, this means I am a weakling." Intermediate beliefs are precepts, expectations, and assumptions—derived from core beliefs—that govern and guide our behavior (Beck, 1995). The targets are memories of negative experiences that still "prove" that the person is, for example, "worthless." The recommended path for target selection is the dysfunctional belief path, for the same reasons as described in Module 4. If the patient has clear fantasies of what might happen to him/her in the future when he/she would appear to be imperfect, according to his/her intermediate belief(s), then the flash-forward path or the dysfunctional positive targets path can be relevant to find relevant targets for reprocessing: negative or positive flash-forwards.

Goal: Reduction of the credibility of the core belief and associated intermediate beliefs (if x, then y) by neutralizing relevant memories or fantasies so much that behaviors and moods resulting from this core (intermediate) belief stop or at least diminish so much that they no longer obstruct progress in the treatment of the eating disorder.

Module 6: Negative Body Image

Characteristic for eating disorder patients is the overrating of their body shape as a determining element for their self-image and specific for AN patients is the rigid, distorted perceptions of their body shape, that is, body shape being not congruent with reality. This phenomenon of AN patients, called "(delusional) body image disturbance" by some, has features of both an obsession and a delusion (Steinglass, Eisen, Attia, Mayer, & Walsh, 2007). A body image that is negative—distorted or even delusional—ultimately may have developed gradually after several experiences. In that case, relevant memories must be identified, clarifying how the body image got damaged. Often, specific experiences can be traced that are relevant for the start and exacerbation of the body image. However, if this is not the case, then experiences can be looked for that "prove" the validity of the dysfunctional core belief such as "My body is fat/ugly/despicable, therefore I am worthless." If relevant memories for the development of the negative body image cannot be found with the timeline path or the dysfunctional belief path, then the emotion path can be an option to look for relevant memories. The negative body image

MODULES	TARGETS	PROCEDURES	GOALS
1. Distressing memories	Distressing memories of past experiences	Intrusion path (I)	Reduction of (di)stress, caused by intrusive images of past experiences; elimination of any psychopathology, caused by this distress
2. Fears	Memories of experiences relevant for development of symptom, if traceable Fantasies about anticipated negative future experiences, if relevant past experiences are not traceable or have been reprocessed	Timeline path (II) Flash-forward path (IV)	Reduction of fear by reprocessing relevant images of past experiences Reduction of fear by reprocessing relevant images of anticipated future experiences
3. Urge-driven ED behaviors: binges, fasting, and compensatory behavior (purging or hyperactivity)	Memories of positive affect/effect caused by the ED behavior Present trigger situations: images of situations that elicit the urge to perform the behavior Images of anticipated positive future experiences (fantasies) Images of memories evoking the emotion, which activate the urge to perform the behavior	Dysfunctional positive target path (V.1) Dysfunctional positive target path (V.2) Dysfunctional positive target path (V.3) Emotion path (VI)	Stop the dysfunctional behaviors by neutralization of relevant images of past, present, or future (feared or required) experiences that activate the urge to perform the behavior
4. Low self-esteem	Memories of experiences that "prove" the current validity of the negative core belief	Dysfunctional belief path (III)	Stop the behavioral and/or mood problems resulting from dysfunctional core beliefs. Weaken the dysfunctional core beliefs
5. Clinical perfectionism controlled by dysfunctional (intermediate) beliefs	Memories of experiences that "prove" the actual validity of the dysfunctional belief(s) Fantasies of anticipated negative consequences of not realizing the set standards Fantasies of anticipated positive consequences of realizing the set standards	Dysfunctional belief path (III) Flash-forward path (IV) Dysfunctional positive target path (V.3)	Stop setting irrational standards for oneself, resulting from dysfunctional core/intermediate beliefs Stop setting irrational standards for oneself, resulting from negative images of anticipated feared experiences Stop setting irrational standards for oneself, resulting from positive images of anticipated desired experiences
6. Negative body image	Memories of experiences relevant for the development of negative body image Memories of experiences that "prove" the current validity of the dysfunctional core belief about the body Memories of experiences that evoke the negative emotion accompanying the negative body image	Timeline path (II) Dysfunctional belief path (III) Emotion path (VI)	Improve the body image and restore damage to the body image caused by maladaptively stored memories

Figure 1.4 Overview of modules: Type of targets, procedures for target selection, and goals.
ED, eating disorder

is accompanied usually by strong emotions like disgust, anger, and sadness. With this procedure, the memories are looked for that evoke the specific emotion the strongest, triggering the delusional body image as it is stored in the long-term memory.

When no more relevant memories are left to be neutralized, then the focus can move to present triggers. The next group of targets to focus on can be distressful images of current or anticipated future body shape, activating their delusional negative body image as it is stored in the long-term memory.

Procedures for target selection in this module in the preferred order (minding the three-pronged approach) are as follows:

- *Timeline* path: To be used when past experiences can be identified that contributed to the development of a negative body image.
- *Dysfunctional belief* path: To be used when the learning history is diffuse and past experiences can be identified that prove the validity of dysfunctional beliefs about their body shape.
- *Emotion path*: To be used when relevant past experiences for the development of the negative body image cannot be identified and problematic negative emotions accompanying the negative body image are predominant.

Goal: Change of the distorted, or even delusional, body image, by neutralizing relevant memories so much that the body image no longer obstructs progress in the treatment of the eating disorder.

See Figure 1.4 for a summarizing overview of potential modules for EMDR based on the transdiagnostic features with their associated targets and procedures for target selection and goals as mentioned by Fairburn et al. (2003).

INTEGRATION OF THE EATING DISORDERS PROTOCOL WITH THE EIGHT PHASES OF THE STANDARD PROTOCOL

Phase 1: History-taking and case conceptualization

In this phase the therapist collects sufficient relevant information in order to be able to formulate hypotheses regarding factors eliciting and maintaining the symptoms. Both personal and interpersonal factors are explored. Wherever possible, the therapist uses validated questionnaires.

The therapist formulates in consultation with the patient a hypothesis concerning the supposed function of the eating disorder: What is achieved or avoided by having and keeping the disorder? Potential functions for an eating disorder are as follows:

- Avoidance of maturation
- Escape from taking responsibilities
- Punishment of oneself
- Supply oneself with an identity, becoming “someone special”
- Get the feeling of having control
- Avoidance of negative memories
- Disconnection from negative feelings
- Adaptation to the family as a way of life

In the case of comorbidity, the therapist formulates hypotheses concerning the relationship between the eating disorder and additional psychopathology.

See Figure 1.5 for relevant issues to explore on behalf of the case conceptualization.

Based on the case conceptualization (gathered information, analyses, and hypotheses) an overall treatment plan is composed, making explicit which interventions are supposed to be relevant—including EMDR therapy—for the treatment of which symptoms. Also, the potential modules for EMDR are mentioned. The case conceptualization is explained and discussed with the patient and the parents (if the patient is younger than 18 years of age or still living in his/her parental home).

Phase 2: Preparation

Priority in this phase is to ascertain if the patients’ illness has brought them into mortal danger. Survival is the highest priority. Quality of life becomes an issue for therapy only when there is no (more) mortal danger. In this phase, patients start with normalizing their eating patterns and restoration of a

CLINICAL SYMPTOMS AND SUSTAINING FACTORS	DESCRIPTION
Symptoms related to eating, appearance, weight: behavioral, cognitive, emotional, physical, interactional	
Distressing memories or future-oriented fantasies related to eating, appearance, weight, interfering with daily life	
Present triggers for these memories or fantasies	
(Lack of) skills • Social skills • Affect regulation	
(In)adequate functioning in: • Family • School/work • Peers	
Aspiration level	
Mood problems	
Comorbidity	
• Developmental history: Adverse-traumatic experiences • Psychological diagnostics: (neuro)psychological vulnerabilities	
Supposed function of ED	
Diagnosis *ICD-10*	
Hypotheses	

Figure 1.5 Worksheet for case conceptualization.
ED, eating disorder; ICD-10, *International Statistical Classification of Diseases and Related Health Problems*

healthy body weight, assisted by therapeutic interventions (not per se EMDR), including behavioral interventions, consultation with a dietician, and physical checkups by a pediatrician or internist. If outpatient care is not effective enough, day clinical or more extensive clinical treatment is considered.

In general, EMDR therapy becomes possible and useful when patients can keep their attention focused, feel emotions or sensations, tolerate high SUDs, and concentrate on cognitions. These are requirements for reprocessing.

Generally, these requirements are met when the body mass index (BMI) is greater than 17 or standard deviation (SD) is greater than –1x (for children and adolescence).[1] There are exceptions, of course, but in the case of patients who are severely underweight, attempts to reprocess traumatic material can be a very disappointing endeavor for both therapists and patients. It is essential to support them in regulating their eating patterns for the restoration of a healthy body weight, if useful. If necessary, monitoring this process can be continued during the next phases. Either the EMDR therapist or a colleague within the interdisciplinary team can do this.

If there is an indication that there is insufficient internal support for the patient during the process of identification and selection/reprocessing of memories, the protocol for resource development and installation (RDI; Korn & Leeds, 2002) can be applied here. This protocol is not described in this chapter.

If the patient has agreed to the treatment plan (Phase 1), EMDR therapy is introduced as soon as the eating pattern is regulated enough for EMDR to be viable and useful. The order of modules to be applied can be determined more accurately in this phase. Potential modules for EMDR have been explained in Phase 1.

[1]*Body mass index* or *Quetelet index* is a value derived from the weight and height of an individual. It is calculated by dividing the body mass (weight in kilograms) through the square of the body height (length in meters). *Standard deviation* (*SD*) is used in children and adolescents because BMI must be corrected for age. Degree of underweight is expressed by comparison of length and weight with the growth curve of the patient. With 0.5 to 1 SD, there is 10% to 20% weight loss, meaning severe underweight.

Phases 3 to 8: Assessment—Reevaluation

When a specific target memory to be processed is identified with the appropriate path for target selection in Phase 1, the therapist continues with Phases 3 to 8 (assessment, desensitization, installation, body scan, closure, reevaluation) and repeats these for all relevant targets, until all the targets within one specific module have been reprocessed one by one (SUD = 0, VoC = 7). Then, a check takes place to ascertain whether the stated goal for that module has been reached and whether additional interventions are needed.

Phases 3 to 8 follow the standard EMDR protocol, except for a few exceptions. Therefore, description of all phases will not be repeated for all modules. Deviations from the standard procedure will be mentioned and described.

Reevaluation +

When the goal of a module is reached and relevant memories are neutralized, the next module is selected to continue. Subsequently, relevant targets must be identified again and selected with appropriate paths for target selection (Phase 1).

During treatment it may be necessary to adjust the previously determined order of modules, depending on the progress of the patient. Based on theoretical grounds and clinical experience, the order of modules, as described here, is recommended; however, this is not yet validated empirically. The case conceptualization of the individual patient is guiding in this respect.

EMDR PROTOCOL FOR EATING DISORDERS SCRIPT

Phase 1: History-Taking and Case Conceptualization

Presenting Problem

Say, *"What is the problem that is bringing you into therapy?"*

_____

_____

Say, *"Which are the behaviors related to this that are bothering you the most?"*

_____

_____

Say, *"What thoughts or beliefs do you have connected with your problem?"*

_____

_____

Say, *"What firm beliefs do you have about yourself and/or others that you regard as guiding you in life?"*

_____

_____

Say, *"What are the emotions that you are having connected with your problem?"*

_____

_____

Say, *"What are the physical symptoms that you are having connected with your problem?"*

Say, *"What are the relational problems that you are having connected with your problem?"*

Say, *"Do you have disturbing memories of events that happened to you in the past or intrusive fantasies about events that might happen to you in the future?"*

Say, *"Do you know in what situations these disturbing memories or intrusive fantasies happen to appear?"*

Etiology

Say, *"Do you have any ideas about circumstances or factors that may have caused your problems?"*

Maintenance

Say, *"Do you have any ideas about what might keep your problems going?"*

Say, *"Are you satisfied with your relations with peers? Any problems there?"*

Say, "Do you have problems with your emotions, either to be aware of them or to express them?"

Say, *"How are you getting along with your family members? Any problems there?"*

Say, *"How are you dealing with school/work? Any problems there?"*

Say, *"Do you have an explanation for the problems you are having (*if there are any*) with other people?"*

Say, *"Could you be demanding too much of yourself by setting high standards for yourself?"*

Say, *"How is your mood predominantly?"*

Comorbidity

Say, *"Do you have any other emotional or behavioral problems or diagnoses besides your problems with eating?"*

Developmental History

Say, *"During intake, your developmental history has been explored. Did you experience adverse, or maybe even traumatic, experiences in your past that you have not mentioned then and that might be relevant?"*

Say, *"You took some psychological tests. If details were found that I consider relevant for our work here, we will incorporate these in our treatment plan. Do you have any questions about this?"*

Measures

Say, *"To understand your problems as fully as possible, I would like you to fill in these paper-and-pencil tests, if you have not done this already. The results of these measures combined with what we discussed so far will give us enough information for a good analysis and understanding of your situation. We will devise a treatment plan based on this information and I will explain that to you. Are you willing to cooperate?"*

Scores

Say, *"Thank you for filling in these tests. We read what you filled in and our conclusions are* _____ (state the conclusions). *What do you think about this? Please comment on what you heard."*

Function

Say, *"Did your behaviors related to eating, like dieting or having binges, start because you chose for them to start or did they just seem to happen to you?"*

Say, *"What, in your opinion, has having an eating disorder added to your life since it started?"*

Say, *"By having your eating disorder, what do you think you have achieved?"*

Say, *"By having your eating disorder, what do you think you were able to avoid?"*

Say, *"Have you ever thought about what you should learn* (to do) *to be able to give up your eating disorder?"*

Say, *"It seems that the meaning of the eating disorder for you is* ____ (state your understanding of the meaning of the ED for the patient). *What do you think about that?"*

_____

_____

Case Conceptualization

Say, *"I have figured out through our work that you have* _____ (state the diagnosis). *I know this because you are troubled by the following symptoms* _____ (state the patient's behaviors, emotions, cognitions, physical symptoms, and relational problems). *Does this make sense to you?"*

_____

_____

Say, *"We have also discussed what circumstances or factors may have caused your problems and what keeps your problems going. It may seem as if your behavior started not because you chose it, but as if it just happened to you. So, I will help you address the distressing behaviors and emotions that are troubling you. I have discussed the factors that may explain why you arrived where you are now. It is my job to proceed from here. Do you want to add anything to this?"*

_____

_____

Say, *"We also discussed what function the eating disorder seems to have for you. By maintaining the disorder, you achieve* _____ *and/or you avoid* _____ (state what is achieved and/or avoided). *So, in order to be able to give up the eating disorder, you will have to learn to* _____ (state the goal/s of treatment). *And therefore you will work on* _____ (state issues for interventions) *by* _____ (state type of interventions). *Part of your treatment will incorporate EMDR therapy that can be used for several purposes. To give you an idea of how this works, I will show you the themes we can work on with EMDR therapy."*

Introduction to Modules

Say, *"Here is a list of possible issues for our EMDR work. We call them 'modules'*:

Module 1. Distressing memories of negative experiences.

Module 2. Fears related to the eating disorder.

Module 3. Eating disorder (ED) behaviors that you feel compelled to do, like binges, fasting, or compensatory behaviors, like excessive moving or purging: vomiting and using laxatives, or diuretics.

Module 4. Low self-esteem resulting in dysfunctional behavior patterns and/or negative moods.

Module 5. Clinical perfectionism.

Module 6. Negative body image.

These issues appear to occur frequently with patients who have an eating disorder. It seems that for you _____ (state modules) *could be useful. In a while, when we will start with EMDR, we will decide what modules we will use specifically and in what order. So, this is your treatment plan* _____ (show concept treatment plan). _____ (I/the team) *consider(s) these interventions essential to give you good treatment."*

Discuss the treatment plan. Show Figure 1.4 and explain which modules will be chosen.

Say, *"Do you agree with this plan? Please let me know if you have any doubts or questions, so we can discuss them!"*

Phase 2: Preparation

Introduction to EMDR

Say, *"Your problems seem partly related to memories of experiences from your past or images in your head about potential future experiences that might happen to you. These memories or images get activated in the present in certain situations and they are causing you problems. For dealing with these problems, I will introduce EMDR therapy to you. The treatment plan has been discussed with you before. To begin with, your eating pattern must improve so much that we can start working on these other related issues with EMDR therapy. When we start with EMDR therapy we will run through your treatment plan once more and then we will concentrate on our goals with EMDR. For now, it is important that you realize that we can release you from the problems these images and memories are giving you. Is that clear for you?"*

Say, *"Although we are not starting with EMDR right away, I will explain to you what EMDR is now, so you know what you can expect."*

Give the regular introduction to EMDR.

Say, *"When a person gets traumatized, the memory of the experience seems to get locked in the nervous system with frozen pictures, sounds, thoughts, and feelings. With EMDR we facilitate the unlocking of the nervous system to allow the brain to process the experience. It is important to note that it is your own brain that will be doing the healing and that you are the one in control."*

Regulation of Eating Pattern

Say, *"Our first goal is to help you restore* a *more regular eating pattern and a healthy weight, so that you will not be in mortal danger any longer. We can start working on other issues only when you are out of the 'danger zone.' We will start working with EMDR therapy, when you will be able to keep your concentration focused and when you can feel emotions and physical sensations again. Do you understand this? And, do you agree to this?"*

Resource Installation

Introduce other planned interventions; these do not have to be guided by an EMDR practitioner necessarily. If resource work seems relevant for the patient, the therapist can work with the protocol for resource installation here.

Selection of First Module

Say, *"We have discussed before which modules could be relevant for you potentially, when we discussed the treatment plan. Let us look now to see if that idea is still correct or if there are better choices in the meantime. Based on our view of your problems my guess is that we should start with* _____ (state the module). *Do you agree, or would you suggest another module to start with?"*

_____

_____

Say, *"Okay, then we agree that we can start with* _____ (state the module for EMDR therapy processing). *When we have finished this one, we can continue with other modules for EMDR processing, based on what you need. We will start working on a new module after we are satisfied with our results achieved with this one. We will know that we accomplished our goal when the issue of the module seems no longer to interfere with making progress in recovering from your eating disorder. That will be our criterion. Okay, so now we have a plan, a reason, and a purpose for EMDR within your treatment plan."*

Directions for therapist:

1. Choose one of the modules listed in Figure 1.6.
2. Identify the most appropriate path for target selection.
3. Follow the designated path script (see Note 1).
4. Work with any target until completion.
5. After having completed all relevant targets within one module, choose the next module until all necessary modules are completed.

Note 1: The scripts for each path are listed in the following order for easy access and use:

- I. Intrusion path
- II. Timeline path
- III. Dysfunctional belief path
- IV. Flash-forward path
- V. Dysfunctional positive targets paths 1, 2, 3
- VI. Emotion path

Note 2: In all the paths, skip asking for the positive cognition during assessment if the negative cognition is, "I am powerless/I cannot deal with the image," because the positive cognition can only be, "I can deal with the image." However, install the standard positive cognition, "I can deal with the image," after SUD has become 0.

Phase 3 to 8: Assessment—Reevaluation

On the next pages, the full scripts are described for all paths for target selection/modules, including Phases 1 and 3 to 8.

MODULES	POTENTIAL PATHS
1. Distressing memories	• Intrusion path (I)
2. Fears	• Timeline path (II) • Flash-forward path (IV)
3. Urge-driven ED behaviors	• Dysfunctional positive targets path (V) • Emotion path (VI)
4. Negative self-image	• Dysfunctional belief path (III)
5. Clinical perfectionism	• Dysfunctional belief path (III) • Flash-forward path (IV) • Dysfunctional positive targets path (V)
6. Negative body image	• Timeline path (II) • Dysfunctional belief path (III) • Emotion path (VI)

Figure 1.6 Modules with potential paths.[a]
[a]Preliminary suggestions based on theoretical/pragmatic grounds and clinical experience. Empirical validation may prove other paths to be more efficient/effective.

I. INTRUSION PATH SCRIPT

Modules: Applicable in Module 1 (distressing memories) and Module 6 (negative body image).

Reference: F. Shapiro (2001).

Core: "Classical" procedure for target selection. The most disturbing memories are ranked by SUD's level and then reprocessed until related symptoms are gone.

Use the Standard EMDR Protocol on each relevant memory/target until the patient is no longer suffering from the memories.

Say, *"We discovered that you are bothered by distressing memories of past negative experiences. We will work on these until they no longer bother you. What are the experiences whose memories trouble you the most?"*

List of Distressing Memories of Past Negative Experiences

_____

_____

Say, *"What memory is bothering you the most? Tell me how this experience is stored in your head as a picture."*

_____

_____

Phase 3: Assessment

Image

Say, *"What image of this picture is the most distressing to look at?"*

_____

_____

Negative Cognition (NC)

Say, *"What words go best with the picture that express why the picture is still distressing to you now?"* Or *"What words go with the picture that express what you believe about yourself now?"*

_____

_____

Positive Cognition (PC)

Note: Skip asking for the positive cognition during assessment if the negative cognition is, "I am powerless/I cannot deal with the image," because the positive cognition can only be, "I can deal with the image." However, install the standard positive cognition, "I can deal with the image," after SUD has become 0.

Say, *"When you bring up that picture or* _____ (state the issue)*, what would you rather like to believe about yourself now?"*

_____

_____

Validity of Cognition (VOC)

Say, *"When you think of the incident* (or picture) *how true do those words* _____ (clinician repeats the positive cognition) *feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

This question is skipped if the NC is, "I cannot deal with the image," and no PC is asked.

Emotions

Say, *"When you bring up the picture or* _____ (state the issue) *and those words* _____ (clinician states the negative cognition)*, what emotion do you feel now?"*

_____

_____

Subjective Units of Disturbance (SUD)

Say, *"On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Location of Body Sensation

Say, *"Where do you feel it* (the disturbance) *in your body?"*

_____

_____

Phase 4: Desensitization

To begin, say the following:

Say, *"Now, remember, it is your own brain that is doing the healing and you are the one in control. Please focus mentally on the target and follow my fingers* (or any other bilateral stimulation [BLS] you are using). *Just let whatever happens, happen. After a set, just tell me what comes up, and don't discard anything as unimportant. Any new information that comes to mind is connected in some way. Anything that comes up is good and valuable. If you want to stop, just raise your hand."*

Then say, *"Bring up the picture and the words* _____ (clinician repeats the negative cognition [NC]) *and notice where you feel the distress in your body. Now follow my fingers with your eyes* (or other BLS)*."*

Continue until SUD = 0.

Phase 5: Installation of PC

Say, *"How does* _____ (repeat the PC, or introduce here *"I can deal with the image,"* if the NC was, "I cannot deal with the image") *sound?"*

Say, *"Do the words* _____ (repeat the PC) *still fit or is there another positive statement that feels better?"*

If the patient accepts the original positive cognition (PC), the clinician should ask for a VOC rating to see if it has improved.

Say, *"As you think of the incident, how do the words feel, from 1 being completely false to 7 being completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Say, *"Think of the event and hold it together with the words* _____ (repeat the PC)*."*

Do a set of bilateral stimulation (BLS).

Say, *"And now as you think of the incident, how do the words feel, from 1 being completely false to 7 being completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Say, *"Think of the event and hold it together with the words* _____ (repeat the PC)*."*

_____

_____

Repeat until VOC = 7.

Phase 6: Body Scan

Say, *"Close your eyes and keep in mind the original memory and the positive cognition. Then bring your attention to the different parts of your body, starting with your head and working downward. Any place you find any tension, tightness, or unusual sensation coming up?"*

_____

_____

Phase 7: Closure

Say, *"Things may come up or they may not. If they do, great. Write it down and it can be a target for next time. You can use a log to write down triggers, images, thoughts, cognitions, emotions, and sensations; you can rate them on our 0-to-10 scale where 0 is no disturbance or neutral and 10 is the worst disturbance. Please write down the positive experiences, too."*

"If you get any new memories, dreams, or situations that disturb you, just take a good snapshot. It isn't necessary to give a lot of detail. Just put down enough to remind you so we can target it next time. The same thing goes for any positive dreams or situations. If negative feelings do come up, try not to make them significant. Remember, it's still just the old stuff. Just write it down for next time. Then use the tape or the safe-place exercise to let as much of the disturbance go as possible. Even if nothing comes up, make sure to use the tape every day and give me a call if you need to."

_____

_____

Phase 8: Reevaluation

It is important to pay attention to the following questions when the patient returns after doing EMDR work.

Say, *"When you think of whatever is left of the problem that we worked on last time, how disturbing is it now on a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Say, *"Have you noticed any other material associated with the original memory since the last session?"*

Say, *"Have all the necessary targets been reprocessed so that you can feel at peace with the past, empowered in the present, and able to make choices for the future?"*

Say, *"Has the work that we have done with EMDR helped you be more adaptive in your day-to-day life?"*

Say, *"Okay, then we can move on and start with the next module."*

II. TIMELINE PATH

Modules: Applicable in Module 2 (fears) and Module 6 (negative body image).

References: de Jongh (2012); de Jongh, ten Broeke, and Meijer (2010); Hofmann and Luber (2009); Logie and de Jongh (2014).

Core: For treatment of symptoms that have developed over time gradually after several events. Relevant memories are reprocessed chronologically.

The scripted questions are concentrated on fears here. If used for other symptoms, then replace "fear" by whatever is the alternative symptom.

Rationale

Say, *"For better understanding of your fear we must figure out which memories are crucial. You were not born with this fear, right? So, it started after one specific event or a series of events and then subsequently got worse after another series of events. Due to these events, you have learned to fear and avoid certain objects and situations* (e.g., having a meal with others).

Memories of these past events are still active. This means that your memories of these events can be triggered and reactivated, consciously or unconsciously, every time you are exposed to a situation that reminds you of these former 'distressing' events, like being criticized about your figure by a relative, or being excluded by a friend.

With EMDR, I will help you resolve/integrate these memories so they become neutral and will no longer disturb you and keep you from participation in these situations. Your fear will disappear and you can re-experience a sense of safety and confidence and do things you couldn't do before. To find the crucial memories for the development of this fear, I'll ask you, as if in a time machine, to search your mind through time to determine which events on your timeline started, or aggravated, your fear. Is this clear to you?"

Say, *"We discovered that distressing memories of past negative experiences have gradually made you afraid of* _____ (state the specific fear). *In this module, we will work on these memories until your fear has gone."*

Timeline

Say, *"When, after which event, did this* _____ (fear) *start?"*

Say, *"Are you sure that you did not suffer from this* _____ (fear) *before this event already?"*

Say, *"What other events came later that increased your* _____ (fear)*?"*

Options Only for Fears

Say, *"What in this situation specifically frightens you?"*

Say, *"When, after which event, did this specific fear start?"*

Say, *"What other events came later that increased your fear?"*

Say, *"What do you expect that might happen to you when you are exposed to the object/situation you fear?"*

Say, *"When and what event started this fear?"*

Say, *"When and what event aggravated this fear?"*

Say, *"Now, we have collected the events that seem related to your fear. Let's put them on a timeline."*

Use pencil and paper to create the timeline with your patient.

Progression of the Symptom in Time

Say, *"Let us now look at how your specific fear was affected by these events over time. Please indicate which of the events had the biggest impact on the increase of your fear. Not all of them will have contributed in the same degree. Which of them contributed the most? You can indicate this in different ways, like drawing a line that shows how your fear developed over time, marking with an angle upward how strong the fear increased after specific events. Another way to indicate this is highlighting those events that gave a strong increase in fear. Please choose a way and indicate it, so we see which events seem to be the most crucial ones."*

Sequence of the Targets

A reason for deviation from chronology might be if a specific, more recent event seems to have contributed more than an earlier one on the timeline and is now still strongly distressing (i.e., high SUD). In case of doubt, the therapist can ask the following question, to identify relevant memories:

Say, *"Which of these memories raises your fear most, right now?"*

Determine which memory to start with, based on the patient's answer.

Phase 3: Assessment

Say, *"Okay, so we start with the memory of* ___ (state the selected memory). *What is the worst image of that memory?"*

Negative Cognition (NC)

Say, *"What words best go with the image that express your negative belief about yourself, or the image now?"*

Positive Cognition (PC)

Note: Skip asking for the positive cognition during assessment if the negative cognition is, "I am powerless/I cannot deal with the image," because the positive cognition can only be, "I can deal with

the image." It is not useful to ask for the PC during assessment. However, install the standard positive cognition, "I can deal with the image," after SUD has become 0.

Say, *"When you bring up that picture or* _____ (state the issue)*, what would you like to believe about yourself now?"*

_____

_____

Validity of Cognition (VOC)

Say, *"When you think of the incident* (or picture) *how true do those words* _____ (clinician repeats the positive cognition) *feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Emotions

Say, *"When you bring up the picture or* _____ (state the issue) *and those words* _____ (clinician states the negative cognition)*, what emotion do you feel now?"*

_____

_____

Subjective Units of Disturbance (SUD)

Say, *"On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Location of Body Sensation

Say, *"Where do you feel it* (the disturbance) *in your body?"*

_____

_____

Continue with the rest of the Standard EMDR Protocol.

Phase 4: Desensitization

To begin, say the following:

Say, *"Now, remember, it is your own brain that is doing the healing and you are the one in control. I will ask you to mentally focus on the target and to follow my fingers* (or any other bilateral stimulation [BLS] you are using). *Just let whatever happens, happen, and we will talk at the end of the set. Just tell me what comes up, and don't discard anything as unimportant. Any new information that comes to mind is connected in some way. If you want to stop, just raise your hand."*

_____

Then say, *"Bring up the picture and the words* _____ (clinician repeats the negative cognition [NC]) *and notice where you feel it in your body. Now follow my fingers with your eyes* (or other BLS)*."*

Phase 5: Installation

Say, *"How does* _____ (repeat the PC) *sound?"*

Say, *"Do the words* _____ (repeat the PC) *still fit or is there another positive statement that feels better?"*

If the patient accepts the original positive cognition (PC), the clinician should ask for a VOC rating to see if it has improved.

Say, *"As you think of the incident, how do the words feel, from 1 being completely false to 7 being completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Say, *"Think of the event and hold it together with the words* _____ (repeat the PC)*."*

Do a long set of bilateral stimulation (BLS) to see if there is more processing to be done.

Phase 6: Body Scan

Say, *"Close your eyes and keep in mind the original memory and the positive cognition. Then bring your attention to the different parts of your body, starting with your head and working downward. Any place you find any tension, tightness, or unusual sensation, tell me."*

Phase 7: Closure

Say, *"Things may come up or they may not. If they do, great. Write it down, and it can be a target for next time. You can use a log to write down triggers, images, thoughts, cognitions, emotions, and sensations; you can rate them on our 0-to-10 scale where 0 is no disturbance or neutral and 10 is the worst disturbance. Please write down the positive experiences, too."*

"If you get any new memories, dreams, or situations that disturb you, just take a good snapshot. It isn't necessary to give a lot of detail. Just put down enough to remind you so we can target it next time. The same thing goes for any positive dreams or situations. If negative feelings do come up, try not to make them significant. Remember, it's still just the old stuff. Just write it down for next time. Then use the tape or the safe-place exercise to let as much of the disturbance go as possible. Even if nothing comes up, make sure to use the tape every day and give me a call if you need to."

Phase 8: Reevaluation

It is important to pay attention to the following questions when the patient returns after doing EMDR work.

Say, *"When you think of whatever is left of the problem that we worked on last time, how disturbing is it now on a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Say, *"Have you noticed any other material associated with the original memory since the last session?"*

Say, *"Have all the necessary targets been reprocessed so that you can feel at peace with the past, empowered in the present, and able to make choices for the future?"*

Say, *"Has the work that we have done with EMDR helped you be more adaptive in your day-to-day life?"*

Other Targets: Flash-Forward

After having neutralized all relevant memories that currently fuel the fear, check as part of the timeline path whether the patient has an explicit imagination about a future event, a so-called flash-forward.

Say, *"We have to figure out now what you fear will happen when you are confronted with* _____ (object or situation that is avoided). *Basically, what catastrophe do you expect to happen, that prevents you from doing what you want or need to do? What's the 'worst nightmare' that's in your head? And what is the worst image of it?"*

The standard NC is, "I cannot deal with the image."

And the standard PC is, "I can deal with the image."

Continue with the assessment and desensitization phases until SUD = 0. Do installation until VOC = 7.

Preparation for the Future

Prepare the patient for the future with either the mental video check or future template. The mental video check seems to be an effective alternative for the future template. Application of both, however, may be redundant. However, because this is not yet validated empirically, consider using both, if an extra boost seems useful for this patient.

Mental Video Check

> Say, *"And now I'd like you to imagine yourself stepping into the scene of a future confrontation with the object or the situation. Close your eyes and play a movie of this happening, from the beginning until the end. Imagine yourself coping with any challenges that come your way. Notice what you are seeing, thinking, feeling, and experiencing in your body. And tell me about that. While playing this movie, let me know if you hit any blocks of tension. If you do, just open your eyes, concentrate on what you see or otherwise experience, and I will do one set of eye movements. Then continue playing the mental video until you feel any tension again. Open your eyes, concentrate on what you experience, and I will do another set. Resume the movie, and run the movie until the end."*

If the patient is at the end of his or her mental video, he or she is asked to play the movie once more, from the beginning until the end; eye movements are introduced if the patient encounters any new tension.

> Say, *"Okay, play the movie one more time from beginning to end and open your eyes when you experience tension. Concentrate on what you see or experience otherwise. When you open your eyes, this is a sign for me to perform another set of eye movements."*

_____

_____

Repeat this procedure until the movie can be played without any tension or significant disturbance during the movie.

Future Template

> Say, *"What is the image of the situation that you want to be capable of dealing with again, now that you have come so far?"*

_____

_____

> Say, *"To what extent do you feel capable of dealing with this situation, on a scale of 1 to 7?"*

_____

_____

Continue installing the PC until the VOC does not increase any further.

Homework Assignment

Say, *"Let us make an agreement now about your homework for the coming week to profit from the wonderful work you have done. I suggest that you* _____ (give assignments with behavioral experiments, building up confrontation with the phobic objects or situations)*."*

III. DYSFUNCTIONAL BELIEF PATH

Modules: Applicable in Module 4 (low self-esteem) and Module 5 (clinical perfectionism).
References: de Jongh, ten Broeke, and Meijer (2010); de Jongh, ten Broeke, and Hornsveld (2014); ten Broeke, de Jongh, Oppenheim (2012).
Core: When dysfunctional beliefs have resulted in persistent symptom clusters, memories of events are reprocessed that are "pieces of evidence" for the patient currently for the validity of these dysfunctional beliefs. The aim is to discredit these core beliefs.

Rationale

Say, *"We discovered that some of your problems, like* _____ (state specific symptoms), *are related to one or more several deeply rooted beliefs you have about yourself, like* _____ (state core belief: I am ____)*."*

If the core beliefs are not clear yet, say the following:

Say, *"Some of your problems, like* _____ (state specific symptoms), *seem related to one or more deeply rooted beliefs about yourself. First, we are going to find out what specific beliefs you have about yourself that causes these problems. We are looking for beliefs that have resulted from big or minor experiences, mostly with other people, which you may have had early in your life, like being bullied, violated, neglected, or sexually abused. Also, other kinds of experiences may have played a role, like having failed in school or sports, having done or left things that you regret deeply.*

Because a lot of experiences in your past and current life confirmed and strengthened this belief continuously and still do, this belief became firm like a conviction. Beliefs like these become like the glasses through which you look at the world.

One of the characteristics for these kinds of beliefs is that you know that they are not true, but they feel true. Do you recognize this?"

_____

_____

Goal of EMDR Therapy

Say, *"With EMDR we are going to change these deeply rooted beliefs that are causing you problems. We do this by working with your memories of early experiences that 'prove' to you still today that your belief is true. To this end, we will first look for memories of your most key experiences upholding this belief about yourself. When we have found these, we will make this belief lose its credibility by reprocessing your memories of these experiences. Does this make sense?"*

_____

_____

Identification of Core Belief

Say, *"Negative beliefs about oneself can result in various psychological symptoms, like depressive moods and persistent behavioral patterns, or* _____ (state the

symptoms of the patient). *What negative belief about yourself is related to these problems? What is the conviction you have about yourself that drives you to do or feel like this?"*

_____

_____

Say, *"When you think of this belief, how true does it feel now on a scale of 0 to 100, where 0 is not true at all and 100 means that the belief is completely true?"*

0 10 20 30 40 50 60 70 80 90 100

(not true) (completely true)

Identification of "Pieces of Evidence"

Say, *"At this moment, which past experiences still prove to you that you are* ____ (state core belief)*?"*

_____

_____

Or ask alternative questions:

Say, *"What have you experienced in your life that makes you believe* _____ (state core belief) *so constantly and persistently?"*

_____

_____

Say, *"What made you start believing that you are* _____ (state core belief*)?"*

_____

_____

Say, *"What or who 'taught' you that you are* _____ (state core belief)*?"*

_____

_____

Say, *"Which early experience/s 'prove' to you still that you are* _____ (state core belief)*?"*

_____

_____

Say, *"Think of a more recent situation that makes it clear to you that you are* _____ (state core belief)*."*

_____

_____

Say, *"Convince me that you are* _____ (state core belief)*?"*

_____

_____

Say, *"Let's give a brief title to each memory or situation that you just mentioned."*

_____

_____

Say, *"Please write down now between three and five of the 'strongest proofs for the belief' that feel like 'pieces of evidence' for this belief. Use a maximum of 10 lines to describe each memory."*

_____

_____

If a patient mentions a number of experiences instead of a single experience, you can propose an *archive*:

Say, *"It seems that this evidence concerns not just a single experience, but a bunch of experiences that fit together, like in an archive. Which one is the most relevant memory of this archive, proving most convincingly that your belief is true? We are going to target that one with EMDR. If needed, we can target more than one memory within this archive. Just let me know, if you think several ones of this archive must be selected. We will start with one. And, when this one is 'ready', we will see how we continue from there."*

Ranking of the Memories as "Pieces of Evidence"

Say, *"We selected* _____ (state a number between three and five) *'pieces of evidence'. Now we must decide which memory to start with. Tell me, which experience proves to you most strongly that* _____ (mention core belief) *is true?"*

_____

_____

Continue from here with the Standard EMDR Protocol until the end of Phase 4: SUD = 0.

Start with the strongest "piece of evidence" and go on with the next one until all memories ("pieces of evidence") have been reprocessed.

Postpone installation of the PC (if in the domain of self-esteem) until all pieces of evidence have been neutralized, so that the positive cognition can become VOC = 7.

The first targets (pieces of evidence) usually take quite some time before they get neutralized, SUD = 0.

Say, *"We will keep on working on each of the memories, pieces of evidence, that we have selected, successively, until you can think of them without believing any longer that you are a* _____ (state core belief).

_____

_____

Phase 4: Desensitization

Desensitize all relevant memories ("pieces of evidence") from the archive for one belief.

Phase 5: Installation

Say, *"Now we are going to finish all targets we have been working with so far. I will mention per target* (memory/image that we worked on) *the positive words that you have chosen before, and I am going to ask you to think of the image together with these words. We will finish them one by one."*

"As you think of the first image ___ (state the title of the event)*, how do the words* ___ (state PC) *feel, from 1 being completely false to 7 being completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Say, *"Think of the image and hold it together with the words* _____ (repeat the PC)*."*

_____

_____

Repeat this for all images until PC for all images has become VOC = 7.

Continue until Phase 8.

The Standard EMDR Protocol is repeated for all "pieces of evidence."
For each piece of evidence, select the image that the patient experiences/sees as the strongest proof (until there is no convincing evidence left).

COMPLEMENTARY INTERVENTIONS

Future Template

Say, *"What could be a good alternative to believe about yourself?"*

_____

_____

Say, *"Slowly but surely you will start to believe in your new positive belief about yourself or at least you will lose your firm conviction that your negative belief is true. Imagine that you no longer believe in your* (negative) *core belief* _____ (state belief) *but instead you're starting to believe your new, positive assumption more and more strongly. What would your life look like? Take a moment for this and make it as specific and detailed as possible."*

_____

_____

Say, *"What would you do that you are now* not *doing* (e.g., "I would dare to speak up, if I would want to")*?"*

_____

_____

Say, *"What current behavior would you stop* (e.g., "I would stop apologizing all the time")*?"*

_____

_____

Say, *"Start practicing this new behavior and for now, just pretend, or as some say, 'Fake it, 'til you make it.' Once you practice, you'll get better and better at it, or 'Fake it, till you are it!'"*

IV. FLASH-FORWARD PATH

Modules: Applicable in Module 2 (fears) and Module 5 (clinical perfectionism).
References: Logie and de Jongh (2014, 2016).
Core: For symptoms of anticipatory anxiety caused by images of distressing and intrusive fantasies of a potential feared future experience (catastrophe). The most distressing image is reprocessed.

Rationale

Say, *"Fears or worries can be aroused in people by images in their head of past experiences and also by images of future experiences. People can have fantasies of what might happen to them in the future, and these fantasies can guide their present behavior and emotions. These fantasies can be positive and negative. Both can cause problems. Now we are going to work on your negative images of possible future events. Our aim is to help you realize that this image is only an image in your head, and that also your body is going to realize that, so that you will be able to tolerate looking at these images and they will no longer disturb you."*

Identify the Catastrophic Event

Say, *"We need to figure out what kind of image is in your head making you scared about a future confrontation with what you fear. What is the worst thing you could imagine happening? Basically, we look for your ultimate doom scenario."*

_____

_____

If necessary, ask additional questions:

Say, *"What do you imagine might go wrong if you* _____ (state the concern, like, 'Eat everything that is on your plate', 'Will have gained weight according to your schedule', or 'Stop vomiting after eating', etc.)*?"*

_____

_____

Say, *"If you had a terrible nightmare about* _____ (state the concern), *what would the most disturbing picture look like?"*

_____

_____

Follow the Event to Its Ultimate Conclusion

Say, *"Why would this be so terrible for you?"*

_____

_____

Say, *"What would be the worst thing about that?"*

_____

_____

Repeat as necessary until the patient cannot identify anything worse.

Phase 3: Assessment

Make a Detailed Picture of Flash-Forward

Image

Say, *"What would the worst image of this nightmare* _____ (the flash-forward identified previously) *look like exactly?"*

_____

_____

Or say, *"What do you see?"*

_____

_____

If more than one picture:

Say, *"If you were forced to choose, what would be most disturbing for you now: the picture of* _____ (state the most disturbing) *or the picture that represents* _____ (state the picture)*?"*

_____

_____

Negative Cognition (NC)

Say, *"The words coming with that picture must be 'I cannot deal with the image,' right?"*

_____

_____

Positive Cognition (PC)

Assessment of positive cognition is skipped because it has no added value to ask for it. There is only one option: "I can deal with the image." It will be installed, however, when SUD = 0.

From here continue with the Standard EMDR Protocol until SUD = 0.

Emotions

Say, *"When you bring up* _____ (state the flash-forward) *and those words* _____ (clinician states the negative cognition)*, what emotion do you feel now?"*

_____

_____

Subjective Units of Disturbance (SUD)

Say, *"On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Location of Body Sensation

Say, *"Where do you feel it* (the disturbance) *in your body?"*

_____

_____

Phase 4: Desensitization

Apply the Standard EMDR Protocol in the usual way. During the reprocessing, the therapist should ask the patient to do the following:

Say, *"Go with that."*

Or say, *"Notice that,"* for subsequent sets of BLS.

To begin, say the following:

Say, *"Now, remember, it is your own brain that is doing the healing and you are the one in control. I will ask you to mentally focus on the target and to follow my fingers* (or any other bilateral stimulation [BLS] you are using). *Just let whatever happens, happen, and we will talk at the end of the set. Just tell me what comes up, and don't discard anything as unimportant. Any new information that comes to mind is connected in some way. If you want to stop, just raise your hand."*

_____

Then say, *"Bring up the picture and the words* _____ (clinician repeats the negative cognition [NC]) *and notice where you feel it in your body. Now follow my fingers with your eyes* (or other BLS)*."*

_____

Even though the target is a future catastrophe, the patient may spontaneously bring up the original trauma even though it had previously, apparently, been fully processed. If this occurs, the therapist should continue to allow the patient to go with the past event because the flash-forward may have elicited other channels connected to the trauma that had not previously been processed.

As appropriate, the therapist should use cognitive interweaves if these become necessary.

Note: EMDR focused on flash-forwards usually goes smoothly and therapists rarely need to use cognitive interweaves.

Phase 5: Installation

Install the PC.

Say, *"As you think of the* _____ (state the flash-forward), *how true do the words, 'I can deal with the picture,' feel from 1 being completely false to 7 being completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Say, *"Think of the* _____ (state the flash-forward) *and hold it together with the words* _____ (repeat the PC). *Go with that."*

Continue this procedure until the VOC is 7. Then continue with body scan.

Prepare for the Future

As in the timeline path, the mental video check can be used as an alternative for the future template.

Mental Video Check

Say, *"This time, I'd like you to imagine yourself stepping into the scene of a future confrontation with the object or a situation that we just worked on. Close your eyes and play a movie of this happening, from the beginning until the end. Imagine yourself coping with any challenges that come your way. Notice what you are seeing, thinking, feeling, and experiencing in your body and tell me about that. While playing this movie, let me know if you hit any blocks. If you do, just open your eyes and let me know. If you don't hit any blocks, let me know when you have viewed the whole movie."*

If the patient encounters a block and opens his/her eyes, it is a sign for the therapist to instruct the patient further and do one more set of bilateral stimulation. Then let the patient continue going through the scene. Repeat this until the movie can be played without any blocks or significant disturbances.

Future Template

Say, *"What is the image of the situation that you want to be capable of dealing with again, now that you have come so far?"*

Say, *"To what extent do you feel capable of dealing with this situation, on a scale of 1 to 7?"*

Continue installing the PC until the VOC does not increase any further.

Homework Assignment

Say, *"Let us make an agreement now about your homework for the coming week to profit from the wonderful work you have done. I suggest that you* _____ (give assignments with behavioral experiments, building up confrontation with the phobic objects or situations)*."*

Phase 7: Closure

Say, *"Things may come up or they may not. If they do, great. Write it down and it can be a target for next time. You can use a log to write down triggers, images, thoughts, cognitions, emotions, and sensations; you can rate them on our 0-to-10 scale where 0 is no*

disturbance or neutral and 10 is the worst disturbance. Please write down the positive experiences, too.

If you get any new fantasies, memories, dreams, or situations that disturb you, just take a good snapshot. It isn't necessary to give a lot of detail. Just put down enough to remind you so we can target it next time. The same thing goes for any positive dreams or situations. If negative feelings do come up, try not to make them significant. Remember, it's still just the old stuff. Just write it down for next time."

Phase 8: Reevaluation

After the application of the flash-forward procedure, there may still be a need for additional targeting and other strategies necessary to ensure that the treatment goals are met. An evaluation of what still remains to be done should be made at the beginning of the next session. The patient is asked about his/her current symptoms and about his/her progress. It is advisable to always evaluate in terms of a patient's SUD level on the already processed material.

Say, *"As you think back on the target that we were working on last time* (mention the flash-forward the patient had), *on a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

If the disturbance level has increased above 0, these reverberations need to be targeted or otherwise addressed. The therapist should assess the necessity of teaching the patient additional self-control techniques or other relevant exercises that could further enhance his/her ability to confront the former anxiety-provoking situation in real life.

Say, *"So what other resources do you think might be helpful in assisting you to deal with this situation?"*

_____

_____

V. DYSFUNCTIONAL POSITIVE TARGET PATH

Modules: Applicable in Module 3 (urge-driven ED behaviors) and Module 5 (clinical perfectionism).
References: Hornsveld and Markus (2014) and Markus and Hornsveld (2015).
Core: For reduction of specific urge-driven ED behaviors: having binges (uncontrolled eating), fasting, or compensatory behaviors (excessive motor activity or purging, vomiting, taking laxatives or diuretics); also for behaviors related to clinical perfectionism. Aim is neutralization of images (of past, present, or future situations) that activate the urge to perform these behaviors. There are three potential steps.

V.1. Positive Memories

Rationale

Say, *"Now we are going to work on behaviors that you keep on doing, though you know that they are not good for you. We will focus specifically on* _____ (state the symptom such as binges, fasting, vomiting, using laxatives, diuretics, excessive moving; optionally also: setting extremely high standards for yourself). *These behaviors are so persistent, because the urge to perform them is triggered by images of either positive past experiences* (like seeing yourself feeling content with yourself) *or images of possible future experiences* (like seeing yourself being admired by others). *Our aim is to*

make sure that these images will no longer elicit your _____ (state the symptom). *Therefore, we will look for the images that elicit in you the strongest urge to perform them and then we will neutralize these memories/fantasies. Okay?"*

_____

Say, *"We discussed that your* _____ (state particular behavior) *is difficult to stop because of the positive consequences of it. The positive consequences that we discussed are* _____ (state the positive consequences). *We will work in three steps; first, we will focus on past memories, then on the present triggers for your* _____ (state particular behavior), *and finally on your expectations of the future."*

Positive Memories of the Past

Say, *"What is your most positive memory related to having performed your* _____ (state specific behavior)*?"*

_____

_____

Say, *"What positive memory has contributed the most to your* _____ (state specific behavior)*?"*

_____

_____

Say, *"What positive memory evokes the strongest urge to perform this* _____ (symptom) *right here and now?"*

_____

_____

Phase 3: Assessment

Say, *"So we can conclude that probably your most positive memory evoking the urge currently to perform* ___ (state behavior) *is* _____ (have patient choose the strongest memory of those just mentioned)*."*

_____

_____

Say, *"Which image of this picture evokes the urge the strongest?"*

_____

_____

Say, *"What words about yourself go with this image that evoke the strongest urge in you to* _____ (state the symptom)*? So this time we are not looking for words that cause the distress of the image, but words that maximize the effect of the image on your urge."*

_____

_____

Say, *"When you look at the image, and you say to yourself* _____ (state the positive words)*, what emotion do you feel right now?"*

The SUD is not measured. Instead, measure the level of urge (LOU) and the level of positive affect (LOPA) that the image is evoking.

Say, *"When you look at the image, and you say to yourself* ___ (the chosen words)*, how strong is the urge to* _____ (mention the symptom) *that you are experiencing right now, on a scale from 0 to 10, where 0 is no urge or neutral and 10 is the highest urge you can imagine?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Level of Urge _____/10

Say, *"When you look at the image and say to yourself* ___ (the chosen words)*, how positive or attractive is it right now on a scale from 0 to 10, where 0 is neutral and 10 is the most positive or attractive you can imagine?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Level of Positive Affect ___/10

Say, *"So the strongest of these two is* ___ (mention either LOU or LOPA)*. Where in your body do you feel this urge/positive affect the strongest?"*

From here continue with desensitization with the Standard EMDR Protocol.

Phase 4: Desensitization

Back to target deviates from the regular procedure: either LOPA or LOU is monitored instead of SUD.

Say, *"Bring up the image that we started with, as it is now. How much* ___ (LOU or LOPA) *goes with it now?"*

Say, *"What in the image is causing this?"*

Say, *"Focus on that and go on."*

_____

_____

Continue desensitization until there is a significant decrease of LOPA or LOU—not necessarily until 0, but a significant decrease.

Then continue with installation.

Phase 5: Installation

Say, *"Bring up the image that we started with, as it is now, and say to yourself, 'I can deal with the picture'* (meaning *'I can resist the image'), or 'I am strong.' Which of these do you prefer?"*

Say, *"On a scale from 1 to 7, how true do the words feel from 1 being completely false to 7 being completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Continue until VOC = 7 and the last part of the Standard EMDR Protocol.

After having reprocessed relevant memories, the focus can move to present trigger situations that evoke the urge.

V.2. Present Trigger Situations

Images of Present Trigger Situations

Say, *"As I told you at the start of this module, the first step for reducing your ___* (state the symptom) *was to work with relevant memories, so that they would no longer evoke the urge to perform this behavior. Now we are ready for the next step, that is, to work with current situations. We know that a lot of situations can trigger an urge to perform your _____* (state symptom). *Our next goal is that you will get more control over yourself in these situations and not be seduced any longer to perform this behavior. Does this make sense to you? Are you ready for it?"*

_____

_____

Say, *"What situations are difficult for you, because they evoke the urge to do this? I will give you some suggestions and let me know please if they fit for you."*

- *When you are depressed, nervous, lonely, bored, sad, or angry?* ☐ Yes ☐ No
- *When you are relaxed and happy?* ☐ Yes ☐ No
- *When you are alone?* ☐ Yes ☐ No
- *When you are dissatisfied with your body?* ☐ Yes ☐ No
- *When you are dissatisfied with yourself?* ☐ Yes ☐ No
- *Other situations* _____

Say, *"Let us make a list of the five most difficult situations for you."*

Trigger Situation 1: _____

Trigger Situation 2: _____

Trigger Situation 3: _____

Trigger Situation 4: _____

Trigger Situation 5: _____

Phase 3: Assessment

Say, *"With respect to the first trigger situation* _____ (state Trigger Situation 1), *which image gives you the strongest urge to perform* _____ (state symptom). *Look at the picture of this situation and pause it at the image where you feel the strongest urge."*

Image: _____

Then identify the NC by asking for the words that go with the picture, strengthening maximally the urge to perform the behavior.

Say, *"What words do you say to yourself that maximize the urge to perform* _____ (state symptom)*? For example: 'I need this'; 'This food is my best friend'; and/or 'I have earned it.'"*

Or say, *"Vomiting gives me the relief that I need," or "Performing excellently shows the world that I count."*

_____

_____

Say, *"When you look at the image of the trigger situation and say those words* _____ (state the words), *what emotion do you feel now?"*

_____

_____

Say, *"When you look at the image of the trigger situation and say those words* _____ (state the words), *what is the intensity of your urge to perform the behavior on a scale of 0 to 10, where 0 is no urge or neutral and 10 is strongest urge you can imagine. How strong is your urge right now?"*

0 1 2 3 4 5 6 7 8 9 10

(lowest urge) (highest urge)

LOU _____

Say, *"When you look at the image and you say to yourself the words* ___ (state the words), *how much disturbance do you feel right now on a scale from 0 to 10, where 0 is no disturbance or neutral and 10 is the most distress you can imagine."*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

SUD: _____

Say, *"Where do you feel this in your body?"*

_____

_____

Say, *"Go with that."*

From here continue with the Standard EMDR Protocol from Phase 4 until Phase 8.

Process the image of this first trigger situation until the LOU no longer decreases. Repeat the procedure for all relevant trigger situations.

Phase 4: Desensitization

Note: Back to target is again deviating from the regular procedure: Both LOU and SUD are monitored.

Say, *"Bring up the image that we started with, as it is now. How much* ___ (state the measure of LOU/SUD you are using) *is it now?"*

____/10

Say, *"What in the image is causing this urge/disturbance?"*

_____

_____

Say, *"Focus on that and go on."*

_____

_____

Continue desensitization until there is a significant decrease of LOU/SUD—not necessarily until 0, but a significant decrease.

Phase 5: Installation

Say, *"Bring up the image that we started with, as it is now, and say to yourself, 'I can deal with the picture'* (meaning *'I can resist the image'), or 'I am strong.' Which of these do you prefer?"*

_____

_____

Say, *"On a scale from 1 (completely false) to 7 (completely true), how true do the words feel?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Continue until VOC = 7.

Preparation for the Future

Use the mental video check as an alternative to the future template.

Mental Video Check

Say, *"Now close your eyes and imagine yourself going through this trigger situation that we have been working on. Imagine yourself going there and see how you manage from beginning until the end. Check if there are any cues or aspects in this situation that are still difficult for you to deal with because they evoke so much disturbance or urge that they could keep you from dealing with this situation adequately. Open your eyes when you experience any disturbance or urge. Notice what you are seeing, thinking, feeling, and experiencing in your body and tell me about it. While going through this scene, let me know if you hit any blocks. If you do, just open your eyes. Then we will do another set of* _____ (state BLS). *If you do not hit any blocks, let me know when you have gone through the whole scene of the situation."*

If the patient encounters a block and opens his/her eyes, this is a sign for the therapist to do one more set ____ (state BLS). Then let the patient continue going through the scene. Repeat this until the movie can be played without any blocks or significant disturbances.

Then prepare homework assignments and behavior experiments for the coming week.

After having reprocessed relevant memories and images of present trigger situations, activating the urge, the focus can move to dysfunctional images of desired future experiences (fantasies), positive flash-forwards.

V.3. Positive Flash-Forwards

Positive Images of Future Situation

Say, *"What is the most desired outcome you see in your head of performing* ____ (the specific behavior)*?*

Say, *"Please make an image of that, representing the most desirable outcome that you have in your head and tell me what you see."*

Give an example if your patient does not understand the question.

Say, *"For example, some people say that they vomit because they expect to feel free afterwards, so an image of yourself feeling free after vomiting could be what we are looking for. Other people may say that they expect to feel relaxed after eating a lot of food, or that they expect to feel in control when they are below a certain weight level. What is the outcome that you desire of the behavior we are now focusing on?"*

Phase 3: Assessment

Say, *"What is the image that you have in your head?"*

Note: The NC is not asked, but instead words that go with the picture and strengthen the urge and the positive affect.

Say, *"What words about yourself go with this image that evoke the strongest urge in you to* _____ (state the symptom)*? So, we are not looking for words that cause distress of the image, but words that maximize the effect that the image has on your urge."*

Say, *"When you look at the image, and you say to yourself* _____ *what emotion do you feel right now?"*

Instead of SUD, ask for level of positive affect (LOPA) and level of urge (LOU) that the image is evoking.

Say, *"When you look at the image, and you say to yourself* ___ (the chosen words), *how strong is the urge to* _____ (mention the symptom) *that you are experiencing right now, on a scale from 0 to 10, where 0 is no urge or neutral and 10 is the highest urge you can imagine, how much urge do you experience right now?"*

0 1 2 3 4 5 6 7 8 9 10

(no urge) (highest urge)

Level of Urge _____

Say, *"When you look at the image and say to yourself* ___ (the chosen words), *how positive or attractive is it right now on a scale from 0 to 10, where 0 is neutral and 10 is the most positive or attractive you can imagine?"*

0 1 2 3 4 5 6 7 8 9 10

(not attractive) (highest attraction)

Level of Positive Affect ___

Say, *"So the strongest of these two is* ___ (mention either LOU or LOPA). *Where in your body do you feel this urge/positive affect the strongest?"*

From here continue with the desensitization phase in the regular way.

Phase 4: Desensitization

Note: Back to target is deviating from the regular procedure: Either LOPA or LOU is monitored instead of SUD. The strongest sensation of the two is chosen in the assessment phase and that one is monitored.

Say, *"Bring up the image that we started with, as it is now. How much* ___ (LOU or LOPA) *goes with it now?"*

___/10

"What in the image is causing this?"

Say, *"Focus on that and go on."*

Continue desensitization until there is a significant decrease of LOPA or LOU—not necessarily until 0, but a significant decrease. Then continue with installation.

Phase 5: Installation

Say, *"Bring up the image that we started with again as it is now and say to yourself: 'I can deal with the picture'* (meaning *'I can resist the image'*), *or 'I am strong.' Which of these do you prefer?"*

Say, *"On a scale from 1* (*completely false*) *to 7* (*completely true*), *how true do the words feel?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Continue until VOC = *7* and then proceed to the last phases of the Standard EMDR Protocol.

VI. EMOTION PATH

Modules: Applicable in Module 3 (urge-driven ED behaviors) and Module 6 (negative body image).
Reference: de Jongh and ten Broeke (2012).
Core: For predominant emotions, behaviors in Module 3 can be motivated by either anticipated positive emotions/sensations or by currently experienced negative emotions. The emotion path is appropriate when negative emotions are problematic intrinsically or if they are the driving force for symptomatic behavior.

Rationale

Say, *"Now we are going to work on behaviors that you keep on doing, though you know that they are not good for you. We will focus specifically on* _____ (state the symptom such as binges, fasting, vomiting, using laxatives, diuretics, excessive moving; optionally also: setting extremely high standards for yourself). *These behaviors are so persistent because the urge to perform them is triggered by a powerful negative emotion. What emotion could that be do you think?"*

_____

_____

If the patient cannot tell, say the following:

Say, *"My impression is that you feel a lot of* ____ (state emotions, like anger, shame, guilt, disgust) *that motivates you to perform this behavior. Does that make sense, and do you recognize this?"*

_____

_____

Or say, *"Maybe you are troubled by the predominant presence of* _____ (state emotions, like anger, shame, guilt, disgust)*."*

_____

_____

Say, *"What we are going to do now is look for memories that instantly evoke the strongest* ___ (state the identified emotion) *in you. By reprocessing the most important memory or memories that evoke this* ___ (state emotion*) in you, you will regain more control over this emotion and eventually, ultimately, also over this behavior. Okay?"*

_____

_____

Say, *"Which memory evokes the strongest feeling of* ___ (state emotion) *now?"*

Say, *"What is the image of that memory the makes you the most* ___ (state emotion)*?"*

From here continue with the Standard EMDR Protocol.

After having completed this target, continue with the next target: the memory that is acutely evoking the most emotion by then. Continue until the patient has more control over this problematic emotion and potentially resulting behavioral symptoms.

REEVALUATION+

Each module uses the reevaluation + script as follows.

To check if the module has been worked on sufficiently, the next questions are asked:

Say, *"Do you think that all relevant memories/images concerning this issue/module that kept your problems going are neutral now? Are any of these images still disturbing you?"*

Say, *"Shall I tell you which module I think is appropriate to continue with and why? Or, do you want to tell your suggestion first? We will discuss this, so we come to an agreement for our next step. I am encouraged by your progress. What do you think?"*

SUMMARY

Existing treatments for eating disorders are not sufficiently effective and efficient. This chapter describes how and for what symptoms EMDR therapy can be implemented in a multidisciplinary broad-spectrum treatment of patients with an eating disorder. An experimental protocol is introduced, consisting of six potential modules and six procedures of target selection. The protocol is based on the transdiagnostic theoretical model of Fairburn et al. (2003) and has shown positive results in clinical practice. Empirical validation is needed, and empirical results may necessitate adaptations in this protocol.

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