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RESILIENCE

The Intersection of Eating Disorders and EMDR

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Resilience is more than a buzzword circulating throughout the therapy community and among the general population. Resilience is a competency that can be learned and developed through treating trauma and in the context of

eating disorder (ED) recovery. Resiliency highlights strengths and capabilities in place of diagnoses or deficits. There are various iterations of resilience, and for this article, we will use Bonanno's articulation (2005). Resilience is "a stable trajectory of healthy functioning after a highly adverse event" (Southwick et al., 2014, p. 2). There is a qualitative link between resilience and its role in the lived experience of those who have experienced adverse events leading to the development of an ED. The qualitative link between EMDR, ED, and resilience will be examined through a content analysis perspective, noting the similarities in both themes and concepts within the proceeding domains and definitions.

DOMAINS OF RESILIENCE

The domains of resilience have been situated throughout literature. According to various sources, the domains of resilience include affect and emotional regulation, cognitive flexibility, prosocial and adaptive behavior, and social support (Bonanno, 2005; Herman, 1998; Ivtzan et al., 2016; Shapiro, 2018, Ozbay et al., 2007; Southwick et al., 2016). All domains are specific to the competency of resilience and are no strangers to the psychological community as evidenced by various trauma treatment models offering their interpretation of components exemplifying the importance of integration. Resilience is not a final product, rather it is part of the process in the pursuit of recovery, including from trauma and ED. Qualitatively, EMDR and ED are ways individuals may lean to help heal trauma, one being more efficacious than the other. Defining the domains of resilience helps us to understand more.

Affect and emotional regulation involves the regulation of negative emotional expressions while embracing positive emotions and outlook after experiencing a traumatic event. Research suggests that embracing more positive emotions may temper both psychological trauma and social withdrawal. In EMDR, trainers teach clinicians to help clients identify a positive cognition to help them with reprocessing. In ED, individuals may struggle to identify emotions in their bodies, given the disconnect with the illness, and may also struggle with regulating distressing emotions. Emotional regulation is directly associated with a person's values and beliefs. By experiencing emotional regulation, literature has noted the impact on overall psychological well-being.

Cognitive flexibility is how individuals can create fluidity in their cognitions instead of a more rigid mindset. This entails a person's ability to use behavioral and psychological techniques to lessen and respond to negative external and internal stimuli. In ED and through experiencing trauma, the client's ability to think more broadly and flexibly may be hampered, which is where EMDR can create an opportunity to broaden perspectives. EMDR is a modality that works on expanding cognitions through embracing the malleability of the brain's neural networks and shifting narrow perspectives.

Prosocial and adaptive behavior is for the benefit of others, to move away from self, contributing to society's overall well-being. In this domain, the importance is on people's capability to mold and adjust behavior to meet the demands of a given stressor, which assists in the recovery process. In trauma and with ED, isolation can occur, separating one from the world, which limits people's ability to interact with the creation around them. While working toward recovery from both ED and trauma, clinicians can encourage clients to modify behaviors toward gratitude, compassion, kindness, and generosity, which all further enhance prosocial and adaptive behavior.

Social support involves a complex construct of a system of people accessible to provide healthy interpersonal relationships and contribute to one's material and psychological well-being. Social support is in the same vein of creating expansion, like previously discussed domains of resilience. With the treatment of both trauma and ED, social support involves building a strong recovery-oriented team, including both professional and personal supports. Social support can be assessed by understanding where the client is in terms of stages of change and their openness to receiving help. Literature shows that ED can wreak havoc on social supports in the process of recovery and is not limited to the individual suffering.

EATING DISORDERS

EDs are serious mental illnesses and typically require specialized treatment. The number of individuals affected by eating disorders during their lifespan is 28.8 million according to the National Eating Disorder Association (NEDA; 2022). ED benefits from being treated by a multidisciplinary treatment team (therapist, physician, psychiatrist, registered dietitian) given the layering of various

physician, psychiatrist, registered dietitian) given the layering of various components within the disorder. ED can impact a person biologically, socially, psychologically, and spiritually. By engaging in "treatment, about sixty percent (60%) of people with eating disorders recover. Without treatment, up to 20 percent of people with serious eating disorders die. With treatment, that number falls to two to three percent (2-3 percent)" (Center for Discovery, n.d.; ED Referral, n.d.).

EDs are complex cases that have historically been treated separately from the co-occurrence of experienced trauma. Brewerton (2015) asserts the connection by stating, "it is clear that stress, trauma, and adverse life experiences are important risk factors for the development and maintenance of EDs" (p. 455). EMDR for trauma processing can help a client with co-occurring ED to expedite the recovery process. To engage in the process of EMDR, clinicians can confirm medical stability and assess cognitive functioning with screening for dissociation before entering the reprocessing phase. Clinicians may take more time in the initial phases of EMDR to ensure stability and orientation to place, person, and time, similar to working with populations who experience various dissociation. As key researchers in the ED field, Brewerton et al. say, "given that there are no clear treatment guidelines for comorbid ED and PTSD," emphasizing the need for more comprehensive treatment (2014, p. 394). For some people, EDs can also take the form of coping mechanisms for distressing memories, situations, and feelings, which create more complications. These complications derail or prolong long-term relief, resolve, and recovery. Domains of resilience are also clearly evidenced in ED recovery.

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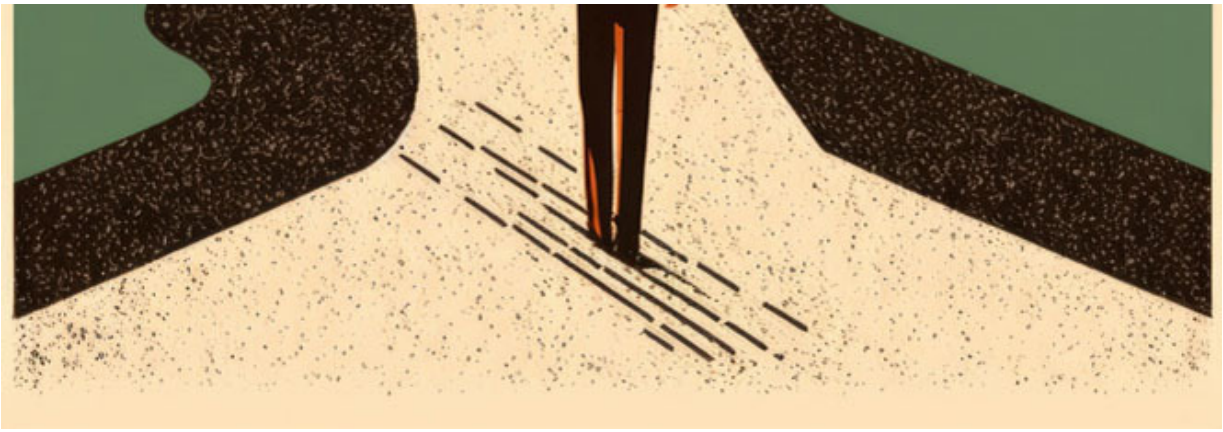
DOMAINS OF RESILIENCE WITHIN ED RECOVERY

Grogan et al. (2021) postulate a dynamic process of resilience, suggesting "by building up one's resilience (rather than focusing on symptom reduction), adults with EDs arrive at a point whereby they no longer depend on their ED to function or survive" (p. 12). This study focused on resilience with an emphasis on context instead of solely holding the individual responsible for developing resilience. The process of resilience transitions from adversity to positive adaptation. To demonstrate this, Grogan et al. (2021) highlight the lack of differentiation

demonstrate this, Grogan et al. (2021) highlight the lack of differentiation between a person and ED in the beginning phase to gaining more perspective with separation and concluding with "resilient me" separated from the illness in recovery (p. 9). Other literature surveyed appeared hesitant to address the capability of being resilient until an individual is considered "recovered" or "in recovery," which is counter to a strengths-based approach that emphasizes empowering the individual in the treatment process. Three distinct areas of ED recovery for an individual are physical, behavioral, and psychological (NEDA, 2022).

ED recovery entails all the domains of resilience, including affect and emotional regulation, cognitive flexibility, prosocial and adaptive behavior, and social support. Recovery builds up the skill of affect and emotional regulation by teaching individuals awareness of their emotions and reconnecting their heads (cognitive) with their bodies (somatic). The reconnection creates opportunities for awareness of affect and emotion to regulate when feeling dysregulated in times of distress. Recovery is all about cognitive flexibility in that it helps people stretch their perception of themselves, others, and the world in which they interact. It also provides opportunities to expand how they think about food, bodies, and movement. Examining prosocial and adaptive behavior, through recovery, the individual is shifting to more adaptive ways to care for themselves and can engage again in relationships honoring recovery in place of illness.



> **There are significant similiarities between resilience and EMDR.**

Eating disorders are isolating and strive to disconnect the person from themselves and others. This connects well with the last domain of resilience being social support. Recovery is generated in the context of social support with a trained therapist, a supportive community, and the ability to receive resources from others. Next, we will explore EMDR with the domains of resilience.

EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

Knowing that Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 2018) is a model that was initially created to aid in the recovery from trauma, we can begin to investigate how EMDR is connected to resilience. When trauma happens, there is typically a shift in perspective about the world (internally and externally), begging to explore the post-traumatic growth a person experiences following trauma(s). These shifts can include perceptions of safety, questioning the possibility of goodness, and disruptions in systems of meaningfulness (turning them into meaning-loss) with self, others, or the world around them. When these interruptions happen, we can see the impact that can influence the development of an ED. ED can develop for various reasons, including biological, psychological, social, and environmental factors. Trauma can impact each of these factors uniquely. Trauma approaches have historically focused on transitioning through the phases of remembering what occurred in the context of

safety, processing by retelling the traumatic story, and concluding with growth through reconnection. Herman (1998) discussed destruction in various systems while recovery works toward the restoration of relationships while empowering the survivor. To begin, readers can notice the domains of resilience within the evidence-based trauma treatment of EMDR. There are significant similarities between resilience and EMDR.

DOMAINS OF RESILIENCE WITHIN EMDR

Exploring the domain of affect and emotional regulation, EMDR clinicians can promote resilience through phase two, preparation. In this phase, we are helping clients to prepare for their engagement in EMDR. Preparation typically involves psychoeducation about the process, building trust with rapport in the context of the therapeutic relationship, and collaboratively developing coping skills should there be elevated emotional distress. Clinicians can use imagery alongside various grounding exercises, helping the client with resource development, which are in turn supportive of resilience efforts. Those exercises can include calm (safe or joyful) place and container, two exercises traditionally included in basic training. From an explanatory perspective, resilience practices are how each of these exercises helps the client identify and then regulate their emotions.

With the resilience domain of cognitive flexibility, we know that the AIP Model (comprised of cognitive and somatic experiences), which is the basis of EMDR, supports the processing of memories stored in the brain (Shapiro, 2018). As clients participate in EMDR, like other trauma models, there is a widening of the "window of tolerance" to move toward recovery with the competency of resilience. This is done through engaging in dual attention while balancing sensory elements with memories. The client is actively involved in the process of cognitive flexibility throughout the process of EMDR. Cognitive flexibility is more pronounced in phases two through five (preparation, assessment, desensitization, and installation). The most distinct phase is desensitization as clients expand their cognitions and progress into great perspectives from initial cognitions.

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Prosocial and adaptive behavior is a byproduct of reprocessing. More specifically, clients engage in this domain of resilience within the seventh and eighth phases (closure and reevaluation) of EMDR. This is also a great place to use future templates reinforcing some of the resilience characteristics, which are strengths-based with future endeavors or interactions and working toward an overall more improved self-concept to relate with others in the world around them.

Lastly, the domain of social support is symbolically shown from a strong therapeutic alliance demonstrated in all phases of the EMDR process if the match is favorable between client and clinician. This is shown in the trust, rapport, self

is favorable between client and clinician. This is shown in the trust, rapport, self-report about progression made, and documented clinical outcomes. The domain of social support shows the collective efforts in building the competency of resilience. Social support helps clients notice they are not alone in their journey, demonstrating openness to receiving support and restoration of faith in others and reappraising the good found in the world around them.

Through the already established eight-phase protocol (history taking, client preparation, assessment, desensitization, installation, body scan, closure, and reevaluation), we can see the various opportunities for helping clients foster resiliency in their trauma recovery. There is a symbiotic relationship between the mechanisms of change through the model of EMDR and the concept of resilience. The three-prong approach to trauma recovery provides a map of where clients were, where they are, and finally, where they are going regarding post-traumatic growth with the elements of resilience.

IMPLEMENT THE DOMAINS OF RESILIENCE

The call to action for EMDR clinicians is to begin recognizing the domains of resilience. By identifying the various domains in cases, the intentionality expands with the implementation of resilience domains threaded throughout treatment planning geared toward helping clients experience post-traumatic growth through adversity. Use of the recognized domains of resilience can better inform the treatment of trauma and foster eating disorder recovery simultaneously. As an EMDR clinician, I help clients discover a new narrative about identity, others, and the world around them in ways that empower them, bringing back voice and choice with recognizable corresponding elements found within the domains of resilience. Celebrate resilience in the process of recovery, in place of confining it to a concluding result.

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References

Bonanno, G. A. (2005). Clarifying and extending the construct of adult resilience. *American Psychologist,* 60(3), 265–267.

Brewerton, T. & Brady, K. (2014). The Role of Stress, Trauma, and PTSD in the Etiology and Treatment of Eating Disorders, Addictions, and Substance Use Disorders. In Brewerton, T. & Dennis, A.B (Ed.), *Eating Disorders, Addictions, and Substance Use Disorders* (pp. 379-404). https://doi.org/110.1007/978-3-642-45378-6_17.

Brewerton, T. (2015). Stress, Trauma, and Adversity as Risk Factors in the Development of Eating Disorders. In Levine, M.P, Smolak, P. (Ed.), *The Wiley Handbook of Eating Disorders, First Edition* (pp. 445-460). John Wiley & Sons, Ltd.

Center for Discovery (n.d.). *Expectations after treatment: Statistics on eating disorders*. www.centerfordiscovery.com/blog/statistics-on-eating-disorders

ED Referral (n.d.). *Eating disorder statistics.* www.edreferral.com/statistics

EMDR Institute Inc. (n.d.). *History of EMDR*. www.emdr.com/history-of-emdr

Grogan, K., O'Daly, H., Bramham, J., Scriven, M., Maher, C. & Fitzgerald, A. (2021). A qualitative study on the multilevel process of resilience development for adults recovering from eating disorders. *Journal of Eating Disorders, 9*, 66. https://doi.org/10.1186/s40337-021-00422-8

Herman, J.L. (1998), Recovery from psychological trauma. Psychiatry and Clinical Neurosciences, 52: S98-S103. https://doi.org/10.1046/j.1440-1819.1998.0520s5S145.x

Ivtzan, I., Young, T., Martman, J. et al. (2016). Integrating mindfulness into positive psychology: a randomised controlled trial of an online positive mindfulness program. Mindfulness 7, 1396–1407 https://doi.org/10.1007/s12671-016-0581-1

Ozbay, F., Johnson D.C., Dimoulas, E., Morgan C.A., Charney, D. & Southwick, S. (2007) Social support and resilience to stress: from neurobiology to clinical practice. Psychiatry 4(5):35-40.

National Eating Disorders Association (2012). *Trauma and Eating Disorders*.

www.nationaleatingdisorders.org/sites/default/files/ResourceHandouts/TraumaandEatingDisorders.pdf

National Eating Disorders Association (2022). *Recovery and Relapse*. www.nationaleatingdisorders.org/learn/general-information/recovery

National Eating Disorders Association (2022). *What Are Eating Disorders*? www.nationaleatingdisorders.org/what-are-eating-disorders

Shapiro, F. (2018). Eye movement desensitization and reprocessing (EMDR) therapy: Basic principles, protocols, and procedures (3rd ed.). Guilford Press.

Southwick, S. M., Bonanno, G. A., Masten, A. S., Panter-Brick, C. & Yehuda, R. (2014). Resilience definitions, theory, and challenges: interdisciplinary perspectives, *European Journal of Psychotraumatology, 5*(1). https://doi.org/10.3402/ejpt.v5.25338

Southwick, S., Sippel, L., Krystal, J., Charney, D., Mayes, L. & Pietrzak, R. (2016). Why are some individuals more resilient than others: the role of social support. *World Psychiatry, 15*. 77-79. https://doi.org/110.1002/wps.20282.