Reflections on 30 Years of Renfrew

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This issue of Perspectives marks The Renfrew Center’s 30th Anniversary as the country’s first residential eating disorder treatment facility devoted exclusively to adolescent girls and women. When I first considered launching a treatment center for women with eating disorders, I never dreamed where that path would take me.

As a practicing attorney, I knew almost nothing about the field—in fact there was no field at that time—eating disorders were a well-kept secret and no specialized treatment facilities existed. It was the death of talented singer/musician Karen Carpenter in 1983 that provided a “wake-up call” about the severity of eating disorders and the grave medical and psychological consequences. Profoundly affected by a number of individuals within my own circle of friends and colleagues whose suffering had come out into the open, I vowed to provide a safe therapeutic haven, a community for girls and women, unlike any other. Toward that end I established The Renfrew Center in 1985, on a 27 acre farm, complete with a Manor House and horse stables, in a setting imbued with the restorative and healing power of nature. A superb clinical and administrative team was assembled and fundamental decisions were made: treatment would be relational, clinical teams would be egalitarian, patients and families would be regarded with respect.

In 1990, a second residential facility was established on 10 acres in Coconut Creek, Florida. Since then, Renfrew has developed a network of out-patient services and, with the latest opening in Los Angeles in early 2015, there are now 16 Renfrew sites across the country.

As part of our commitment to excellence in everything we do, all of our sites evolve literally from the ground up – each site is established as a Renfrew site, a part of the Renfrew system. Each one offers the same treatment protocols and philosophy and
continues to evolve under the creative and forward-focused thinking of our clinical leaders. As explained by Dr. Gayle Brooks, Renfrew’s Vice President and Chief Clinical Officer, “A core principle of the relational model that guides treatment at The Renfrew Center is the belief that healing occurs most effectively through collaborative, empowering relationships. Within this type of relational, therapeutic environment, how an evidence-based treatment intervention is implemented is as important as the intervention itself. The unique relational quality of mutuality in the therapeutic environment is essential to healing our patients’ profound disconnection from self and others—which often serves to maintain the eating disorder. Therefore, we will continue to invest effort to both fostering a collaborative, empowering relational environment and, just as important, incorporating cutting edge, evidence-based treatment for effective treatment and recovery.”

During the past few years, a systematic, empirically-supported approach known as The Renfrew Unified Treatment Model, has been developed to integrate new, evidence-based treatment procedures into Renfrew’s strong relational model. Renfrew staff are trained in this evolving treatment model through the expansion of our Training Department. Ongoing efforts are in place to evaluate this integrated model and study its impact on patient satisfaction and outcome.

As Renfrew has grown over the years, it has remained a multi-generational, family-run organization that is dedicated to maintaining the highest quality of services and patient care. This journey, spanning three decades, has been incredible. I am extremely grateful to all of those individuals, clinical, corporate, support and administrative, who have been a part of our Renfrew staff over the years. There are no words of appreciation that can possibly convey how invaluable your contributions and expertise have been to make Renfrew what it is today. I want to extend my sincerest thanks to all of our colleagues who have supported us and, especially to the 65,000 courageous patients we have had the privilege to treat.

This year also marks another important milestone, the 25th anniversary of The Renfrew Center Foundation, dedicated to advocacy, education, prevention, and research. To celebrate both anniversaries, we have selected some of our favorite essays from the past, designed to capture a look back at some of the issues that have informed us and engaged our interest over the years. Many have withstood the test of time; others remind us how far we have come as a field. We hope you enjoy reading them too, whether for the first time or as a trip back to the future.
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Celebrating 25 Years of The Renfrew Center Foundation Conference

Judi Goldstein, MSS, LSW

I’ve had many memorable moments shaping and organizing The Renfrew Conference during the past 25 years – moments of great joy as well as others filled with panic! I will never forget hearing Gloria’s Steinem’s recognizable voice for the first time and thinking “what in the world am I doing talking on the phone to this woman who has literally changed the world?” Nor can I ever forget the panic of trying to find a last minute “stand-in” for a keynote speaker who cancelled only days before the start of the Conference. And then there was the first time I gave my opening remarks and started to well up with tears because I was so overwhelmed by the magnitude of being on this Conference stage! (I made sure that never happened again).

In November 1991, The Renfrew Center Foundation convened its first National Conference in Philadelphia. There were 150 in attendance. Because we wanted to focus on issues related to the culture, we selected Dr. Susan Wooley, a strong and prominent female voice in the field, to be the keynote. Many of the attendees at this first conference were new to eating disorders. Although some worked in treatment programs, the majority were clinicians in private practice. Everyone felt challenged by their patients’ complicated medical, psychological and social issues. Conference attendees were seeking not only knowledge and skills, but also a place where they could openly share ideas and find support as they struggled with this highly specialized, intensive and demanding clinical work. Among the dilemmas was how to most effectively address life-threatening symptoms and how to respond to the growing realization that the culture was playing a large part in the increased incidence of eating disorders. Informed by the work of Carol Gilligan and The Stone Center, discussion centered on the possibility that women might have therapeutic needs that differed from those of men and that eating disorders, in particular, might require a different type of treatment.

At the time of this first conference, The Renfrew Center had been providing specialized eating disorder treatment for adolescent girls and women in a residential setting for five years. In contrast to most psychotherapy, which was based on a male model of development, and most treatment approaches, which utilized a medical model for the delivery of care, Renfrew was experimenting with a variety of group therapies as well as exploring the concept of the healing power of community. These relational approaches, which incorporated the work of Gilligan and The Stone Center, became the foundation for both our clinical treatment and educational programs.

Throughout its 25 year history, the Conference has featured thought leaders, clinical experts, researchers, and scientists who have informed our understanding of eating disorders. In order to provide clinicians with the training they need, each Conference program is designed to showcase emerging theories, cutting edge treatment and evidenced based practices. Over time, we have experimented with the Conference format, attempting to offer longer training sessions, shorter workshop presentations as well as ample time for networking which allows our attendees to develop connections to one another and to the Conference community in general.

Since that first Conference, Renfrew has continued a unique tradition of inviting keynote speakers to address cultural issues which put young girls and women at risk for developing eating disorders. We have been honored to welcome Gloria Steinem, Jane Fonda, Carol Gilligan, Naomi Wolf, Arianna Huffington, Jennifer Weiner and many others who have challenged society’s messages and inspired attendees to help their patients develop greater self-esteem and speak their truth.

From the beginning, the spirit and focus of the Conference has purposefully encompassed and reflected the values of collaboration, connection and mutually respectful relationships. Over time, the meetings have fostered a strong sense of companionship and camaraderie among the many women and men.
superb program offerings and emphasis on a supportive and engaging learning environment, there is no doubt that The Renfrew Center Foundation Conference will continue to have a significant influence on the field in years to come, highlighting current trends and research, emerging therapies and women’s issues. As Conference Chair for almost 25 years, I have had the honor and privilege of bringing this rich resource to our field.

Our focus remains on improving the lives of women suffering with these disorders. Many of the speakers over the past 25 years have been pioneers in rethinking and reshaping clinical theory and practice. They have shared their work, often taking risks, as they disclosed stories revealing the intersection of their professional work and personal growth. Over and over we have received feedback about how these stories inspired clinicians to develop new skills, insights and a deeper appreciation of their patients’ lives and needs. The speakers’ expertise and dedication to the field have been invaluable. Many have become mentors and role models for the next generation of clinicians. With its consistent history of

Judi Goldstein, MSS, LSW is Vice President of The Renfrew Center Foundation and Chairperson of The Renfrew Conference. After receiving her Master’s Degree in Social Service from Bryn Mawr College, she joined The Renfrew Center when it opened in May, 1985. Over the past 30 years, Ms. Goldstein has held a number of clinical and administrative positions, including Director of Admissions and Vice President of Professional Relations, Education and Marketing. Since 1994, she has been responsible for the development of The Renfrew Center Foundation Conference. Ms. Goldstein is a Founding Member of The National Eating Disorders Association.

A Garden of Opportunities: Personal Writing for Therapists


Update by Barbara Greenspan’s husband, Peter Greenspan, and best friend, Lisa De Lima: Barbie was a dedicated writer. She wrote copious therapy notes, many articles and religiously wrote in her diary. As her career evolved, she became increasingly aware of the value of writing as a therapeutic tool.

I in the musical version of The Secret Garden, Mary sings a song whose lines live in my heart. She says, “I need a place where I can go, Where I can whisper what I know, …I need a place to spend the day/where no one says to go or stay, Where I can take my pen and draw the girl I mean to be.” Writing has become my secret garden. It is a private place I go to find solace. In the process I have learned that many other things appear and can grow in this garden. I have also discovered that the line between self-care and self-healing is so fine as to be invisible. So, what I grow in this garden is both; a gardener would call it a hybrid.

I was a silenced girl who grew into a woman adept at silencing myself. After having banished so many words and ideas, abandoning so much of myself, judging whatever was inside me so harshly, it was profoundly liberating and eventually, deeply healing to find a place where I could begin to stop doing that. I found that it is an act of generosity to listen to myself, give myself the time and space to express my thoughts, grant myself legitimacy, and respect myself enough to be interested in what I have to say. It was in this way that
writing became and has remained the heart of self-care for me, and it explains my interest in sharing this tool with other therapists and clients.

Come and enter what I imagine is a familiar scene. You have just finished an incredibly challenging, upsetting therapy session. Your mouth is dry, you can feel tension rippling through your body, you wonder if a headache is coming. You feel slightly off-balance. You would really like to describe what happened as a way of getting some relief and a little distance. You still have other appointments and a group to lead and want to re-center yourself. You know the likelihood of a friend being available right now is small. But, you have a few minutes and an alternative. You could reach for paper and pen or sit down at your computer.

There is a place where you can go to set forth your experience and reactions, things I often refer to as “afterthoughts.” Writing about what happens in therapy, our reactions and the things that disturb us personally and puzzle us professionally, can offer comfort, and often, a measure of clarity. It is a means of unburdening ourselves, clearing our minds and our hearts for the next client, or for the rest of the day. It is a way to save the intensity and confusion of the moment for further reflection and to take care of ourselves in the midst of the demanding work of engaging with others who are suffering.

I don’t remember when I first heard the term “self-care.” I am not sure what it might consist of or why it might be important for me as a therapist. I was one of those women under the illusion that for “good enough” women and “real” therapists the reservoir of caring was inexhaustible. It would be replenished without deliberate effort or thought. A lot has changed between then and now. I have come to believe that the capacity for self-care is essential to well-being and emotional health. I think that self-care skills are critical to a client’s recovery and development; that understanding enabled me to appreciate that they have a legitimate place in a therapist’s life as well.

I think self-care involves attitudes and behaviors. The attitude component is about learning gentleness in relation to oneself. It involves softening harsh judgments and muting self-criticism. It means learning to take oneself seriously and be responsible without condemning oneself in the process. The behavioral dimension is about finding activities that nurture us, things that are soothing, and allow us to switch gears and be rejuvenated. It is the search for rituals we can engage in for renewal, pursuits that will revive our spirits and replenish the inner reserves from which we do our work.

I am not a silent therapist. I talk and I laugh, but on most days I listen more than I speak. By the end of a day or week, I am likely to have all sorts of reactions and thoughts inside that I have not articulated. Writing is a way to make a place for them, to discover more of what has been going on within as I sit with my clients. Writing informs me; it lets me know that from moment to moment there is so much more going on than I am conscious of or can express. It is a way to pause and enter a stillness within where I can reflect upon the complexity of this process known as psychotherapy. In writing, I often make connections that surprise me and enrich the work I am doing with someone.

Personal writing is a practice that offers emotional and cognitive benefits. It offers a safe channel for the expression of intense, often inchoate feelings. It can become a canvas on which to name and face our reactions. In writing, we can release toxic emotions we have witnessed or experienced. Writing can provide access to an increased range of thoughts, feelings and perspective. We begin with what is in our awareness but often find unexpected things hovering just on the edge of our mind. Sometimes writing enables us to connect with something that was far beneath the surface. At those times we may experience an element of awe that our hand can guide us to things we didn’t know we perceived.

Writing about a particular issue may help us find a new way to approach it and provide a form of self-supervision. Focusing on a particular client and what we experience in our relationship can reveal new aspects of the transference and counter-transference. It offers a means of exploring our feelings and associations. It gives us a safe place to encounter the many facets of our inner life—a chance to see our light, face our dark side and thereby embrace our wholeness.

After all of this buildup about the benefits of writing, you may be wondering how to begin. First of all, you need to know that there is no right or wrong way to do this. There is, however, an attitude that is helpful to cultivate, one of
permission and acceptance. The idea is to let yourself wander, let yourself experiment with the process and be patient, especially if you’ve always considered writing to be intimidating, or if you thought it was the special province of a talented few. You do not need to perform. You are not writing for publication or for an audience.

Most people I know who use writing in the service of self-care struggle with maintaining a permissive and accepting stance toward themselves. The territory of writing is very big; any subject is valid. You don’t have to write about your clients or your work, although you may sometimes find that helpful. You can begin by naming what is on your mind, or by naming a topic that you don’t associate with your professional life. Following are some starting points, places from which I hope you are able to begin your own writing.

Begin with a sentence stem, for example, “I am aware of…”. Try to write steadily, returning to the stem as often as necessary. Try writing continuously for ten minutes. This is a deceptively simple way to increase awareness and promote centering. It is also likely to take you to an unexpected place. A few other sentence stems to try: “I remember…,” “I would like…,” “If only…” In time you may find your own.

Making lists serves several functions in a personal writing practice. You can make a list about almost anything: foods you love and where you like to eat them, your favorite clothes, people you have imitated, things you love, wishes that have come true, people you cried with, things you worry about, etc. Sometimes you’ll know immediately that you’ve identified the place where you want to begin that day. Other times, you may need to look over your list and see what intrigues you, or what you would like to avoid. Sometimes, you just need to choose one and see what happens. Keeping your lists gives you possibilities for other writing excursions.

Personal writing can be a container for whatever you want to express. It is remarkably accommodating. You can write about memories, moods, dreams, longings, aspirations, fears, repetitive thoughts and complaints. It can also be a resource for us in our work lives. We can address the unmentionable, such as a case we never talked about and never want to, our moments of doubt, anxiety or shame. We can describe moments of courage, risk or confidence in our work, those times when we tried something radical or felt we really knew what we were doing. Writing can increase our self-possession, our sense of ownership or our experiences, our lives, our selves. It is truly a port available in any storm, in all weather. If dreams are the royal road to the unconscious, writing is a great means of transportation. In your travels, you are likely to experience moments of tranquility and transformation. Over time, writing has brought me many gifts. I wish the same for you.

Barbara Greenspan, Ed.D. was a psychologist in private practice in Newton, MA. She taught in the Massachusetts School of Professional Psychology Continuing Education Program and conducted workshops on therapeutic writings for clients and therapists. She passed away in December, 2000. To honor her memory, The Barbara Greenspan Memorial Lecture is given every year at The Renfrew Center Foundation Conference.

Spirituality, Self-Care and the Therapist

Rev. Steven W. Emmett, Ph.D. – Reprinted from the Winter 1999 issue

Update from the Author: My view of the article today, 16 years after its conception, is that its message may be more relevant than ever before. Everything in society currently seems to be moving towards greater worship of technology and a corresponding dehumanization of all that is truly enduring and sacred in existence. What is most personal in life is most spiritual and thus most universal. I am convinced that there is no better place to engage and rediscover the most soul nurturing aspects of life than in psychotherapy.
My suspicion is that this paucity of literature is indicative of a deeper, more pernicious unawareness afflicting not only people in the mental health field, but the general society as well. Historically, Americans have not been particularly comfortable with expending much energy on interior odysseys. From the lure of manifest destiny to the exploration of outer space, we seem to be imbued with a restless, outer-directed spirit. Be it our vacuous worship of celebrity, rampant consumerism or pervasive inability to sit still and contemplate anything beyond sound-bite length—all outward signs point to a cultural ethos that is firmly rooted in superficial exteriority. The increasing technologization of humanity merely adds to this societal soullessness. While an analysis of what has engendered this malaise is beyond the purview of this article, suffice it to say that the dualism of mind and body promulgated by Descartes, led to centuries of belief that the mind held sway above all else; the spirit’s impact on the human psyche was marginalized. The Industrial Revolution served merely to reinforce this Weltanschauung, with the apotheosis of all things mechanized. And finally, with the introduction of Marxist thought and the immense influence of Freud’s secular psychoanalytic theory (which posited that spirituality was simply a manifestation of regressive, infantile wishes) the soul was pushed to the periphery.

Thankfully, as we approach the new millennium, this sterile approach is gradually being displaced by a more holistic worldview. A transition from such reductionistic thinking, which proclaims that experience creates belief, has been “...supplemented with the wisdom that belief creates experience. This is no superficial, unverifiable ‘mind-over-matter’ cliché but... a vigorous, authentic spirituality represents the sine qua non of a mature, self-actualized existence” (Emmett, 1997, p.95).

Merton (1961) views spirituality as “…the highest expression of [human] life…” (p.1). Commonly cited descriptions include “passionate wonder,” “intense gratitude,” “spontaneous awe at the sacredness of life and being,” the sense of a “transcendent” and “transforming” divine presence, and the “awakening” to the “holy” in everyday life, the “intuitive experiencing” of an infinite power that anchors us and speaks to the very depths of our being. Our spirituality triggers the questions (and supplies the answers) percolating in the very core of our existence: “What do I most deeply value and cherish?” “What gives my life ultimate meaning and direction?” “From what source do I derive enduring hope?” “To whom or to what could I ever surrender myself in complete trust?” Ultimately, the deepest personal elements of our existence are the most universal and thus the most authentic aspects of our lives.

The great English poet W.H. Auden enters the heart of this mystical topography when he notes, “What is real about us all is that each of us is waiting.” And Spanish theologian Miguel de Unamuno captures the fervent yearning underlying the spiritual quest when he writes, “To believe in God is to long for his existence. It is to make this longing the wellspring of our every thought and action.” As Thomas Moore (1992) observes in his brilliant guide for would-be cultivators of the sacred in everyday life, “… it is when we are most human that we have greatest access to soul” (p.9). For it is when we are most vulnerable, when we are in the terrifying clutches of what Kierkegaard terms the “fear and trembling” engendered by existential dread, that we relinquish our false selves, break down, and allow for the possible breakthrough of our true selves. The Biblical description of this soul-stirring process is succinct: one must lose oneself to find oneself. It is at this point that faith carries us forward when there is no longer any reason to carry on. “It enables us to exist during the in-between times: between meanings, amid dangers of radical discontinuity... [it] is a primal force we cannot do without” (Fowler and Keen, 1978, p.1).

But what if one has “lost faith,” is left to wander, disoriented by the insidious spiritual amnesia cloaking the cultural landscape, bereft of an inner moral compass? What if one has lost all hope, as was the case

An Internet search yields 5,792 references to “spirituality.” When combined with “therapist” it drops dramatically to 19 citations. And when self-care is added, not one entry is produced. What should one make of this? That psychotherapists’ spiritual orientations are not worthy of consideration? That their self-care is of little importance?
with Dr. Dante, a prominent middle-aged psychiatrist. Possessed of a prodigious intellect, she felt “dead emotionally, spiritually” and knew the “dreary statistics” vis-à-vis her decades-long struggle with an intractable eating disorder. Dr. Dante was a quintessential wounded healer: parentified in her teens, the family nurturer, she was hyper-responsible, yet felt incompetent professionally and personally. Conditional love and inadequate mirroring had left her saddled with little self-esteem. She gave away too much without knowing how to receive. She worked incessantly and was virtually friendless. While she professed to a vague belief in God, the connection was tenuous at best. Everything about the doctor seemed tightly controlled—from her bearing and dress to her monotone speech. She was living a life of idolatry, paying homage to “small ‘g’ gods.” Salvation was sought in work and money; theories of psychology and her slender body were worshipped to no avail. Inevitably, she was plagued by a nagging sense of “never being, never having” enough. Hidden behind a role of pseudo-omniscience and invulnerability, idealized but unknown and isolated, she committed silent acts of spiritual suicide daily. Dr. Dante was ravaged by a loss of soul issuing in a ravenous spiritual hunger. In excluding the transrational realm from her field of contemplation, in presuming to understand and control powers completely unfathomable and beyond her control, she had fallen, unconsciously, into a state of self-delusion, adrift from a centering ground of “Being,” desperately “out of tune” with her deepest heart’s desires. Her painful state of “sin” could only be assuaged by learning that “taking an interest in the soul is a way of loving it… the ultimate cure comes from love and not from logic” (Moore, 1992, p.14).

Nourishment of the spirit can spring from numerous sources. Genuine caring for the soul requires that we be ever mindful of the seductive secular influences serving to attenuate our spirituality. Hubris (and the myriad manifestations of its companions—anger, ignorance and mistrust) impede the flow of the sacred in our everyday lives. Particularly at risk are helping professionals who are endlessly meeting others’ needs, often to the detriment of their own. Moreover, some “… may be lured … by the position of authority, by the dependence of others, by the image of benevolence, by the promise of adulation… others use the role to manipulate their world in a convenient, simplistic manner, ultimately failing to take responsibility and using authority precisely to avoid it” (Maeder, 1989, p.37). And while a “recipe” for feeding the soul is, inevitably, exceedingly personal, I believe the following: time, play, study and connection are essential ingredients in any hearty sacred stew.

As we traverse this hyphen between two eternities, nothing quite concentrates the mind as contemplation of the breathtaking brevity of time’s passage. We risk relinquishing all that has ultimate value as we submit to the demands of a fast-paced society, which looks upon time as a commodity to be “spent” wisely and efficiently. In our capitalist culture, where time is money, we think in terms of “making time” as if it were some sort of unlimited currency. Time is our most precious asset. In “giving ourselves time” we bestow a valuable gift. Most of us lead lives that are increasingly busy. But can we say that they are truly full? How often do we feel guilty if we’re not “doing something” with our time? And that is just the point. We have forgotten how to simply be. In granting ourselves this gift of time, we create room for the spirit to enter our hectic lives.

Play, likewise, is a soothing balm for the soul. The Biblical injunction to “become as children” offers a spirit-freeing path where wonder is re-ignited, one is fully in the present moment, and fun for fun’s sake permeates our being. We permit ourselves the luxury of shedding our work-dominated, goal-directed mentality to enter a time and place of recreation, for re-creation of the innocence and joy of childhood. The “treadmillitis” of the adult world, particularly the stresses and burdens of those in the demanding mental health field, can be dramatically transcended as we let go of our grown-up personas and invite the liberating spontaneity of a playful spirit into our existence.

I once had the privilege during my graduate days to speak with Nobel Prize winner Elie Wiesel, whose courageous exploration of the meaning of suffering and evil has exerted a profound influence the world over. At the time, I was struggling with my own spiritual identity and so, after briefly explaining my dilemma, I sought the wise professor’s counsel. He thought for a moment, and then gravely replied: “You must study!” If we wish to deepen our own spiritual awareness, we must acquaint
ourselves with the ancient tradition of spiritual quest that is revealed in the writings, art and music of those who have wrestled with life’s ultimate questions down through the ages. To paraphrase Kant, mind without heart is empty; heart without mind is blind.

And finally, in fashioning a “good enough spirituality,” we must connect—with others, ourselves, nature and ultimate reality, so as to counteract what German theologian Martin Heidegger has termed the random “thrown-ness” of our existence. It is only through prayer, meditation, celebration of community and development of an intimate bond with and respect for the interdependent web of being that we can ward off paralyzing loneliness and succeed in our most challenging human undertaking: the courage to be. A healing connectedness imbues us with faith in the world and ourselves; sharing memories, hurts, fears, dreams and reflections results in empathy and caring, which humanizes and unites us all.

Gifting ourselves with the time to play, study and connect heightens our awareness of what is of utmost value in our lives. We develop an existential orientation, depicted in Eastern religions as “mindfulness.” We ensure that we live as human beings, not human doings. We discover that in opening our minds, hearts and souls and letting go, we are better able to receive the bounties of the spirit.

**REFERENCES**


**Rev. Steven W. Emmett, Ph.D.** is a Unitarian-Universalist minister and psychologist in private practice. He is the Executive Director of the Anorexia and Bulimia Association of Rhode Island, and a member of the editorial board of *Eating Disorders: The Journal of Treatment and Prevention.*

**Caring for the Caregiver: Healing Ourselves**

**JUDITH RUSKAY RABINOR, Ph.D. – REPRINTED FROM THE WINTER 1999 ISSUE**

**Update from the Author:** Although so much has changed in the world of evidence based therapy, the principles of this article seem relevant, timely and right on! Learning to breathe in and out, to let go of what we don’t need and embrace the present moment remains at the heart of healing. Much is unknowable in life and in therapy, yet learning to honor the wisdom of the body remains at the core of growth, renewal and healing.

Every person alive has demons—inner anguish, old pain, new pain—demons that gnaw at the soul in the dark of the night. People seek therapy when this darkness becomes too deep, too bleak, too much to bear. Patients come to therapy hoping to escape their darkness. What I have learned is that the first step of the healing journey, my patients’ and my own, involves going into the dark tunnels of pain that run within each of us. Being a therapist offers me, as well as my patients, the ongoing possibility of entering into the darkest places of my soul, for when we touch another’s pain, ours too is touched.

Women with eating disorders come to therapy with deep psychic pain contained in their bodies, expressed in the words, “I feel fat.” It is with their bodies that they speak of the unbearable anguish from which they have cut themselves off. Too often we are unable to help them connect to their deep body pain, for as therapists, we are limited to our primary tool: language. Most of therapy has to do with talking, yet...
for patients with eating disorders, words often offer only a limited access to the dark, inner world of pain contained, hidden and expressed in the language of the body: bingeing, purging, starving and compulsive exercising.

Many of us entered this field with the conscious goal of healing others and a less conscious goal of self-healing. We became healers seeking the opportunity to rekindle the flame, our patients’ and our own. But so often the limitations of the “talking cure” have left both our patients and us discouraged and burned out. “Knowing” why one has an eating disorder, or any kind of problem, does not necessarily lead to healing. Insight does not always lead to symptom alleviation or deep healing, our patients’ or our own. Our training as therapists has focused on verbal language. Yet the “language” of our patients is often non-verbal and body-based.

In the past decade we have learned a great deal about what heals. We have become educated about the different functions of the left and right brain. The left brain, the seat of reason, is language and logic-based. It is analytic and cerebral; it is scientific. It is the language of explaining and interpreting. It is most often the language of psychotherapy.

Our patients are not good at left brain communication. They communicate differently, in the messages embedded in the metaphors and rituals of anorexia and bulimia. Our patients are right brain experts: storing, processing and expressing ideas non-verbally. Information and knowledge are cryptically communicated through unconscious processes, such as body language, music, eye contact, tone of voice, metaphor, story and imagery. The right brain is the language of healing.

A major aspect of the therapeutic journey involves helping patients connect with disowned thoughts and dissociated feelings. But like our patients, many of us have lost touch with the sensations, information and power of our own bodies. We often block and are blocked from our own bodily energy, estranged from our own authentic feelings and thus, distanced from our deepest selves. We rely on theories rather than the information contained in our images, sensations and our bodies to guide us. Getting in touch with our deepest selves, making contact with our own essence opens our patients, and us as well, to deeper levels of self-awareness.

Integrating deep breathing and guided imagery, as in the following three examples, offers us a pathway to a deeper self-awareness:

**Example 1:** Take three deep breaths, settle down and create a quiet moment for yourself. Breathe deeply, in and out, and allow yourself to imagine something you “should do.” Get a sense of how you feel about something you have been putting off. It may involve a person, an event, an obligation, a chore... Take a moment and allow an image to emerge as you make contact with something you “should” do. How are you feeling? How do you know what it is you are feeling?

Often in therapy we ask people how they are “feeling” and yet, since they are disconnected from their bodies, our questions fall flat. When we slow down and breathe, we go inside, to where our deepest work gets done. Imagery offers a new way of tapping into how our feelings “live” in our bodies. Feeling scared, anxious, shy, terrified, enraged, powerless -- these are all body-based experiences. Getting in touch with my own body frees me to help my patients make contact with theirs. Getting in touch with my body deepens my connection to myself.

**Example 2:** Take three deep breaths, settle down and stay with your breathing. Now, cross your hands over each other. Keeping your hands crossed, one on top of another, hold your heart with your hands. Breathe deeply as you hold your hands, crossed one on top of the other, over your heart, your energy center. Give yourself permission to be fully present as you breathe deeply, as you feel your heart, your energy center. Holding your heart with your hands will help you find and know your own loving center. Your heart will experience this quite literally as support... Now, ask your heart how it feels about you making time to slow down and pay attention to it. Watch for a physical response. You may notice a response like a softening or a relaxing. Feel your physical body reaction as you “hear” the answer.

Many people are reluctant to acknowledge their soft, tender places. This exercise helps integrate and honor one’s desire for and capacity to love.

The last exercise facilitates the capacity to sit with pain:

**Example 3:** Again, cross your hands over each other and hold your heart with your hands. Breathe deeply into your heart, your energy center. Now, give your attention to a dark place in your life. Breathe into a difficult situation or a troublesome relationship that you are dealing with now in your life. How does it feel as
you allow yourself to be present with your darkness? With your difficulties and troubles?

These exercises deepen one’s awareness and connection to the way our deepest feelings of love and pain “live” in our bodies. In guiding my patients through these exercises, I, too, connect anew with myself. All of us have incredible powers of imagination. A bottomless well of images, memories, visions, nightmares, illusions and delusions are stored in the rich reservoir of the mindbody, reminding us of journeys we have taken, voyages we dream of embarking upon, of hopes and fears, blocks and yearnings. Our internal images can wound and destroy us. They can also guide, support, teach and heal us.

Many therapeutic practices focus on retrieving painful memories yet neglect teaching people how to access and build up their own healing resources. In my work, I have found that tapping into, developing and integrating the life-affirming images that reside deep within each of us is a powerful and often untapped healing force. Freeing that force within exhilarates me as well as my patients. Making contact with this spark does not minimize deep trauma or pain, but instead reminds me of the infinite possibilities for growth and repair that dwell within. Often I take my patients through an exercise based on the concept that deep within, we each have an endless bowl of light. I ask them to breathe deeply, as they listen to this story:

At birth, every person alive is given a perfect bowl of light. This bowl holds a deep well of creativity, energy and your life force. The bowl of light keeps us centered through life’s inevitable clouds and storms. If you tend your light, it will flourish, as will you. You will be able to do all kinds of incredible things—swim with dolphins, fly with geese, run with wolves and deer. But as life goes on, unbearable things can happen to your bowl of light, for we all face the darkness, inner and outer darkness that dims our inner light. When this happens, a stone drops into the bowl of light. When a stone drops into your bowl of light, some of the light goes out, for the stone suffocates light. Doubt, fear, old learnings are stones. Each time you become cruel, envious, jealous, greedy, another stone is dropped into your bowl. Trauma—more stones. Light and a stone cannot occupy the same space. When too many stones fill up your bowl, the light will go out and you will become a stone.

As healers, we seek to help our patients rid themselves of stone so that they can reclaim their light. To do so, we must sit on the banks of the river of sorrow as they unravel their stories, explore and examine how their lights became dim. As we peruse their bowls of light and their stones, our own stones and stories are unearthed, and often, our own lights dim. What I have learned is that in welcoming the melancholy into my life, I am enriched, for when we welcome what is, we grow. I am reminded of the words of Rumi, a 16th century sufi mystic, who wrote:

Listen/Make a way for yourself inside yourself/Stop looking in the other way./You already have the precious mixture that will make you well./Use it.

What I learn every day in my office is that in helping others “make more room inside” for themselves, I too have the same transformative opportunity. When I am carefully attuned to my own intuition and allow myself to be guided by the wisdom of my body, I expand my boundaries and am often drawn into new, unknown places. And being in a new unfamiliar place, in admitting there is so much that is unknowable in life and in therapy, I become open to learning something new about my patients, myself and the elusive process of growth, renewal and healing.

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Perspectives on Body Image

ADRIENNE RESSLER, LMSW, CEDS – REPRIN TED FROM THE SUMMER 2010 ISSUE

Update from the Author: Since I wrote this article in 2010, one of the biggest changes I have seen in the eating disorder field has been the acknowledgement of the importance of body image as a core element in treatment. When I first became intrigued by the concept of body image in the early 1980’s, I felt a bit like a “lone wolf” in my pursuit of a holistic approach focused on the integration of mind and body. Today, the concept of bodymind is widely accepted and methods are plentiful. Still, however, my concern is that some of these methods do not adequately address body image complexity nor the underlying emotional issues and experiences stored and imprinted in the body. My hope for the future is that there will be greater emphasis on bringing the body itself, and all it holds, into body image treatment.

"Without corrective change in the body image, improvement is apt to be only a temporary remission."
–Hilde Bruch (1962).

Body image is perhaps the least understood and most complex of the core issues associated with eating disorder treatment. Body image issues have been linked primarily to the pressures that arise from attempts to conform to an unrealistic cultural standard of beauty and the subsequent relentless drive for thinness that follows. However, this is only one aspect of the far-reaching parameters that contribute to body image. Development of body image is an integral part of the life cycle, shifting and adapting as we age and engage in life experiences.

The complex nature of body image is manifested in disturbances of perception, an inability to recognize signals and sensations from the body, delusional-like distortions of size and weight, and identity issues that involve differentiating “who” I am from “how” I look. Instead of gaining a sense of identity from the feelings, wants and needs of their bodies, many clients turn away from these inner sensations and respond to external representations to define who and what they are. “The feeling of identity arises from a feeling of contact with the body.” (Lowen, 1967)

The characteristics of a healthy body image indicate how far removed our clients are from achieving satisfaction and a sense of wholeness vis-à-vis their relationship with their body. A healthy body image is flexible and influenced by inner sensations, intrapsychic events and external events which can change from moment to moment; core body schema (source of our drives and bodily needs) remains constant. In contrast, for individuals with body control issues, images are rigid and unchanging. Another important aspect of healthy body image includes a mental image of the body that is realistic and coincides with what the body actually looks like as perceived by others. The body is experienced fully with a sense of aliveness and energy as opposed to being shut down or “frozen” (Rice, Hardenberg, & Hornyak, 1989).

Body image begins before birth, involving matching the expectations on the part of the family as to the sex and looks of the infant with the reality of what they actually receive on the “birth” day. The closer the match, the greater the likelihood of positive attachment and bonding (Fisher, Fisher, & Stark, 1990). Stimulation of the body, particularly through the skin (Montague, 1971), touch, positive eye contact (mutual gaze transaction), mirroring, and affirming language, all set the stage for critical elements in body image development. These include boundaries, trust, the capacity for connection and a sense of wholeness in the body, without gaps and distortions. It is essential that the clinician get a sense of how the client has registered and stored these “felt” sensations and memories in her body/mind: pleasurable, painful, deprived, intrusive, or otherwise. Repetition of messages and experiences over time become internalized and influence not only self-perception and self-talk but the very body itself. In the catch-phrase, “neurons that fire together wire together,” Robertson, (2009) explains that it is the “wiring” of neurons that links memories together, along with
the facts or details related to a given memory. Each time one thinks about an event, that memory is strengthened. This is why obsessions and rituals can be so powerful (Robertson, 2009).

Joan, a BED client, constantly referred to herself as “short, fat, and ugly,” three words that over the years had lost their shock value for her. Joan’s body itself, as if literally listening to the punishing mantra, had taken on a hunched, squat pose and her facial scowl served as a boundary to keep others at a distance, thus confirming her belief that she was “unacceptable.”

Repeated negative self-talk becomes so familiar that it feels “true” and, thus, is taken on by the client as her identity. Words like “gross,” “disgusting,” “fat,” “stupid,” and “worthless” are not just feelings for the client; they become who she is.

An excellent example of the eating disorder’s effect on physiology and body image is presented in “Singing and Eating Disorders” written by recovered singer/songwriter/author, Jenni Schaefer and her vocal instructor, Judy Rodman. No one with an ED can approach her full vocal potential, according to Rodman, because breathing (power), tone (path through open throat) and communication (performance) are all compromised.

What I noticed the first time I met Jenni was her strange numbness. She couldn’t move out the “guarded stance”: slumped shoulders, head hung forward, eyebrows frozen, jaw clenched, spine and hips frozen, arms limp and legs locked. She was like a stick figure. Her voice was thin, colorless. She complained that her throat hurt when she sang. Her range was limited, and she had several “breaks” in her voice. I tried to help her loosen up, but I could barely get her to lift her arms from her sides to allow ribcage expansion. She inhaled from the upper chest in short gasps. (Rodman, 2007).

Through the trust and friendship (attachment) that Rodman and Jenni developed, and Rodman’s ability to help Jenni build flexibility into her body/mind, Jenni’s voice became strong, controlled, confident and beautiful. In addition she now is able to express the full range of emotions that make her songs so endearing.

Concluding his keynote address on trauma (Renfrew Center Conference, 1997), Dr. Bessel van der Kolk acknowledged the contributions of clinicians who work with the stored memories and emotions that are buried deep within the body’s structure and as reflected in its energy, posture, musculature, boundaries, flexibility, rigidity, sense of aliveness, balance, and breathing. Similarly, clinicians in the field of art therapy, dance movement therapy, gestalt, psychodrama, and other experiential modalities often are able to capture the essence of the client through a healing process involving the integration body, mind, and soul to anchor change. Today, the field of psychoneurology has research that substantiates why these modalities are so effective (see Lapides review, 2010).

Body focused strategies are designed to help the client reconnect to her body in order to identify, access, and express stored emotions and experiences. Suggestions for assisting the client include stabilizing breathing, encouraging touch/self-soothing, speaking of and experiencing the body as a whole rather than separate parts. Listening for “emotion” words and locating them in the body is also part of the process as is identifying body boundaries, and grounding and centering through martial arts, yoga, and pilates. It is important to gently push the patient into “taking action” by moving the body to counter the emotional helplessness and physical paralysis of surrender.

Also essential to recovery is reframing negative body image with a word that captures the essence of how the individual would like to feel living in her body. By frequently repeating and reinforcing the new identity word and saying “No, that’s not me” when the negative word is used, a gradual shift can occur that allows the new identity word to become imprinted in the body/mind. (Ressler 2009, 2010) Returning to the body provides clients with a feeling of support and strength, a feeling of connection to the earth.

The body must be reclaimed in order for individuals to heal. “Evoking awareness of impulses originating within the patient is essential if treatment is to succeed.” (Bruch, 1962, p. 194) For many of our clients, their memories and emotions have been relegated to a place far from their consciousness, but continue to influence their thinking, behavior, and very identity. It is not necessary for there to be language to evoke a memory or tell a story. The body’s felt sense is accurate and true. In many cases there are no words with which an individual can describe trauma, often referred to as “speechless terror” because the nervous system shuts down language in extreme threat conditions (Ogden, 2010). While words are important, they are insufficient. As new paradigms in psychotherapy...
highlight the importance of the right, non-verbal hemisphere of the brain, the “emotional” brain, clinicians will need to avail themselves of body-centered modalities such as Emotional–Kinesthetic Psychotherapy, Rubenfeld Synergy, Hakomi, Bodydynamics, in addition to methods from the past: Bioenergetic Analysis, Alexander Technique, Gestalt, Psychodrama and Dance/movement therapy. As clinicians we must learn to listen to the music and rhythm of our clients’ stories and bodies. These stories, shared verbally and viscerally, enable us to dance the dance of client/healer, resonating together to create growth and change.

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Toward a Common Ground: Bridging the Gap between Research and Practice in the Field of Eating Disorders

JUDITH BANKER, MA, LLP, FAED AND KELLY KLUMP, PH.D., FAED

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Update from the Authors: The issue of how to bridge the research-practice gap in the field of eating disorders is as keenly relevant today as it was when we wrote this article—our first joint publication on the subject—back in 2007. Since that time, we have witnessed the implementation of many of the recommendations set forth in the article. The Academy for Eating Disorders and its Research-Practice Committee has been instrumental in addressing this gap, but the complex task of fostering on-going and meaningful research-practice integration remains a challenge for our field.
Clinicians who treat people with eating disorders express frustration over pressure from researchers to provide empirically supported treatments (ESTs). Researchers scratch their heads over the seeming resistance of clinicians to stay current on the latest findings in research. Clinicians feel their expertise is dismissed by researchers; researchers feel their expertise is met with indifference from clinicians.

We are witnessing, in the field of eating disorders, the classic research-practice gap, a long-standing phenomenon spanning fields as varied as medicine, engineering, education, public health, and even geography and library science. Indeed, a quick Google search of “research-practice gap” yielded 16,000 hits, highlighting the universality of the gap in fields with both an applied and basic science component.

As colleagues, the two of us have had many conversations about this issue since we first met over six years ago through our involvement in the Academy for Eating Disorders (AED). An international professional organization comprised of research scientists and practitioners, the AED has seen the research-practice gap played out within its own membership—clinicians at times reporting that they feel marginalized and unsupported, and researchers expressing frustration over the underutilization of empirical data. Researchers work to disseminate the latest findings, yet most clinicians do not use them as their first line of treatment.

Professionally, we (the authors) are poster children for the opposing sides in this research–practice deadlock. Kelly is the AED President Elect and is a tenured faculty member at a major research university. She does not treat patients. Judith is the AED Treasurer, a clinician, and the Founding Director of an outpatient treatment center. She has only recently begun to dabble in the world of conducting formal research. We decided to build on our differences for this article and investigate the causes for, and possible solutions to, the research-practice gap in our field. Instead of conducting the usual review of the empirical literature, we chose to conduct our own analysis by conducting an informal survey of our colleagues in the AED. This survey is humbly unscientific—however, it provided us with information on why the gap persists despite long-standing empirical literature on the topic.

Our “research” questions were straightforward:

1. There appears to be a researcher–clinician gap in our field. What do you think is the main cause of this gap?
2. What is one step we can take to close the gap?

We e-mailed these questions to 32 AED colleagues from North America, Europe, Australia, and the UK, half of whom do both research and clinical work. Of the half remaining, one quarter were strictly clinical practitioners and one quarter were strictly researchers. The response to our survey was overwhelming. We received all of the responses within one week. More importantly, the responses were uniformly thoughtful and united in their concern about this issue and about the importance to our field of finding effective ways to bridge the gap.

Although we purposefully kept our research questions general, not surprisingly, the majority of responses focused on the gap between treatment research and standard clinical practice. We reviewed these responses for common themes, but also for important differences that likely underscore the persistent gap. These commonalities and specific points of departure are delineated below, but we feel that we must make a “process” comment before proceeding. With few exceptions, the tone of the responses differed between researchers and clinicians. Clinicians clearly felt “under attack,” as their responses included references to “a faith-based jihad against clinicians” and the view that they are perceived as “unscientific charlatans.” By contrast, the tone of responses from researchers was not of feeling attacked, but instead reflected a feeling of resignation and a bit of hopelessness that the gap could be closed.

What should we make of these differences in tone? We think they reflect the perceived power differential between clinicians and researchers and the tendency for researchers to be more commonly at the podium espousing the need for clinicians to change (rather than the reverse). Clinicians understandably feel attacked by this, while researchers feel

“It were not best that we should all think alike; it is difference of opinion that makes horse-races.”

–Mark Twain
hopeless, as the researchers’ data fail to translate into new clinical practices. All of this points to a need to change our dialogue—change how it takes place, where it takes place, and the nature of the interchange. These feelings about the gap and the history between “camps” run deep and affect how we think and talk about the differences in our field.

Question #1: What Accounts for the Gap?

Commonalities
At least one structural obstacle to achieving optimal clinician-researcher collaboration was cited with startling uniformity: a lack of time and resources. This was the most frequent response for researchers and a common response for clinicians. Researchers noted that providing clinical care is not valued or rewarded at their academic institutions where publishing and grant funding are the standards by which they are evaluated. Likewise, researchers and clinicians acknowledged that clinicians neither have the time nor the resources to stay abreast of research in their practice, where demands from managed care and/or other clinical pressures take precedence. The lack of funding for studies involving clinician-researcher collaborations, as well as limited funding for translating research findings into practice, were also noted. Finally, clinicians pointed out several resource-based obstacles, including the lack of funding for long-term supervision for training in ESTs, and time and financial constraints that tend to lower motivation to apply research to practice.

In addition to a lack of resources, both clinicians and researchers perceived the differential “evidence” standards for good practice as a key to understanding of the persisting gap. Respondents noted that researchers value data from randomized controlled trials (R.C.T.s), whereas clinicians value clinical data from professional experience and observation. These differences in the definition of “evidence” are viewed as contributing to the devaluation and dismissal of the other side rather than encouraging understanding about the underlying reasons for the different perspectives.

A final commonality focused on training. Researchers and clinicians both felt that they had received inadequate training to engage in integrated clinical-research activities. Respondents felt that researchers were not trained in how to disseminate research findings effectively and translate them into practice. Likewise, respondents felt that clinicians were not adequately trained in how to interpret and apply empirical data to their work. Deficits in each of these areas were thought to contribute to a resistance to change and a dualistic either/or mentality that continues to inhibit the integration of clinical and empirical data.

Differences
Aside from these commonalities, there were also some striking differences in clinician and researcher responses. While researchers overwhelmingly viewed a lack of resources and the differences in “evidence” as the primary obstacles to clinical-research collaboration, clinicians cited many more issues that needed to be addressed. This difference in the number and type of factors viewed as causative underscores our earlier comments about the differential experience of the gap in these two groups.

A number of clinicians reported feeling that the gap was due to a perception that most research findings are irrelevant for the realities of clinical practice. Respondents reported that exhortations from researchers to practice evidence-based treatment in the face of limited effectiveness for all eating disorder patients (e.g., for those with anorexia nervosa and/or extensive comorbidities) lead to significant frustration and a sense of disconnect from the usefulness of empirical data. Clinicians reported that it is often necessary to blend a variety of treatment modalities in order to adapt to the shifting symptom picture and multiple disorders they encounter in their patients. They also felt that few empirical guidelines exist for adapting ESTs to “real life” treatment and for changing course when ESTs are ineffective. Importantly, one researcher agreed with these responses, saying that researchers must do a better job of demonstrating generalizability of research findings to standard clinic populations. Likewise, two additional researchers felt that most eating disorders research lacks clinical relevance, as it focuses on issues that have little-to-no bearing on day-to-day practice.

Question #2: What Can We Do to Close the Gap?

Fortunately, the responses to this question were almost wholly uniform! First and foremost, our respondents believed that promoting institutional and organizational support for clinician-researcher interaction and collaboration is key to bridging the research-practice
Many suggestions centered on creating forums for open and honest discussions between clinicians and researchers. The most commonly cited venue for such discussions was professional meetings, such as the AED annual conference. Both researchers and clinicians alike called for a stronger fusion of clinical and research data at these conferences, where ideally, presenters of empirical data would discuss clinical applications and presenters of clinical data would incorporate knowledge from empirical research. Moreover, there was a desire for smaller, informal group discussions where professionals could discuss the “evidence” they value, the reasons for their opinions, and the ways in which the different forms of evidence inform, rather than contradict, each other. This coming together of the “minds” (aptly described by one clinician as a “researcher-clinician rapprochement”) on the same playing field would serve to mitigate any perceived power differential or implied value placed on one type of evidence over another.

In addition to broadening the appeal of conferences, respondents felt that it would be useful to have regular clinical commentaries on empirical data in professional journals (e.g., the AED’s official journal—the International Journal of Eating Disorders) and professional newsletters (e.g., The Renfrew Perspective; the AED Forum). Finally, respondents called for a need to lobby for funding for clinician-researcher collaborations and for translating research into patient care. Many felt that changes at the level of academic institutions or managed care would only occur if there were funding opportunities available for exploring clinical-research collaborations.

Respondents also felt that improvements in training could close the gap. Suggestions in this area included:

1) encouraging the inclusion of evidence-based interventions in clinician training to impart an appreciation for—rather than suspicion of—research;
2) changing training expectations by creating and encouraging “clinician investigator” job profiles rather than “clinician” OR “investigator” profiles;
3) providing refresher research design and statistics courses at conferences;
4) teaching scientists to think like clinicians and vice versa.

Finally, clinicians made several suggestions for ways to increase the clinical relevance of research including testing treatments in RCTs and in “real life” treatment settings. Clinicians also stressed the importance of studying what clinicians do in their treatments rather than simply expecting clinicians to do what researchers study.

CONCLUSIONS

It is clear that the research–practice gap is a universal phenomenon that exists within virtually all professions that have an applied and basic science component. Given this universality, it is likely that the basis of the gap lies somewhere in human nature and somewhere in the character of organizational systems, both quite daunting variables with which to tamper. Nonetheless, the resounding enthusiasm of our colleagues for developing ways to address the research–practice gap is heartening, and we very much agree with the steps suggested above. However, before our field is able to enact the larger structural changes needed to ensure funding and institutional support, we must first focus on establishing on-going opportunities for clinician-researcher dialogues. Despite our quite different professional experiences, we, the authors, developed mutual trust and respect for each other through our AED opportunities to work closely and talk together about our

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perspectives. Dialogue, shared experience, and support bridged any gap that may have initially existed between us. Programs and organizations like The Renfrew Center and the AED can help close the research-practice gap by using these same tools—dialogue, collaboration, mutual support, and respect—to bring researchers and clinicians together. In joining the richness of clinical observation with the world of formal scientific investigation, the quality of our research and treatments will improve and our community of professionals will be all the better for it.

Clinical Intuition and Scientific Evidence: What is Their Role in Treating Eating Disorders?
JAMES D. HERBERT, Ph.D., AMY M. NEEREN, Ph.D. AND MICHAEL LOWE, Ph.D.
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Update from the Authors: This commentary on our 2007 article reflects both how little and how much has changed since its publication. The historical gulf between relying on clinical intuition versus scientific evidence to guide psychotherapy is as wide and multifaceted as ever. Yet, most practicing clinicians would probably agree that clinical decision-making and behavior change approaches should be based more on research evidence and most clinical researchers would probably agree that relying only on empirical findings doesn’t provide a complete guide to optimally effective therapy.

The practice of psychotherapy is not for the faint of heart. In addition to myriad bureaucratic, legal, and ethical issues, there is the ongoing challenge of determining the best treatment plan for each individual patient. Even when working in a setting that serves those suffering from a particular spectrum of psychopathology such as eating disorders, each patient presents a unique challenge. The specific symptoms, interpersonal dynamics, co-morbid conditions and a host of other issues vary widely across individual cases. Working within the constraints imposed by third-party payers and institutional regulations, therapists must somehow choose from among a dizzying array of treatment options those that are most likely to be helpful for each individual patient.

This raises the question of how such clinical decisions are made. That is, how do practicing clinicians decide what is most likely to work for their patients? When posed this question, most psychotherapists reply that they rely primarily on an intuitive sense of what is most likely to be helpful, based on their clinical experience with similar patients. This seems like a reasonable strategy. Over the course of years of experience, one gradually accumulates knowledge of what tends to work and what does not. Astute clinicians come to observe patterns across patients. In addition, knowledge imparted by recognized authorities through books and workshops can also be helpful. Not surprisingly, most clinicians describe their theoretical orientation as eclectic. Based largely on their clinical experience, they use whatever they feel will work best with each patient.

A movement that has gradually been gaining steam among many therapists emphasizes a different criterion for making decisions about how best to intervene with clients. Advocates of an approach called “evidence-based practice” suggest that scientific studies provide a more reliable and effective means of determining what treatments are most likely to work, and are critical of over-reliance on clinical intuition and experience. Practicing psychotherapists retort that although research has its place, it is naïve to believe that it can guide clinical practice in any significant way. First, the methods of research studies, especially randomized clinical trials, render them too far removed from actual practice to be of much value. In such trials, relatively “pure” groups of homogenous patients are selected for study, and are offered standardized treatments based on structured manuals. Everyone knows that therapy in the real world is far messier. Besides, research reports tend to be published in scientific journals using obscure jargon and sophisticated statistical analyses that are not readily accessible to busy clinicians. Moreover, conclusions drawn from scientific research change over time, illustrating that they
themselves are unreliable. Given this state of affairs, reliance on one’s own personal experience as the primary guide for clinical decision making seems immanently reasonable.

**The Problem**

There is a serious problem, however. Despite their apparently obvious appeal, there is a great deal of evidence that intuition and personal experience are not optimal guides to effective clinical decision making. The experiential approach described above assumes that the clinicians are able to mentally tabulate and store in memory the approaches that did and did not work with different clients and then use this knowledge base to determine what approach is most likely to work with each new client. This information processing may take place largely outside of awareness, resulting in an intuitive sense of what works and what does not. Yet the process is assumed to be reasonably objective, as if the clinician’s mind makes a kind of recording of psychotherapy sessions, and then acts like a sophisticated computer to correlate interventions with outcomes.

In spite of the popularity of computer analogies to describe human information processing, human cognition does not work like a computer. Rather, it is subject to a range of non-conscious biases and distortions that often lead to erroneous conclusions, even while giving the subjective sense of accuracy and certainty (Tversky & Kahneman, 2004). Human cognition relies heavily on heuristics, or information processing shortcuts. Computers, in contrast, solve problems by means of algorithms, or complicated formulae. Heuristics tend to be more efficient—that is, they permit us to quickly draw conclusions from complex patterns (which most likely explains why they evolved in the first place)—but are also more prone to error.

Consider the case of Benjamin Rush, as described by Stanovich (2007). Rush was a leading physician in colonial Philadelphia and a signer of the US Declaration of Independence. In 1793, there was an outbreak of yellow fever in Philadelphia. Following the accepted conventional wisdom of the time for treating conditions associated with a high fever, Rush believed that bloodletting was an effective treatment for this condition.

Of course we now know that bloodletting is completely ineffective for yellow fever, and in fact almost certainly contributed to the demise of many of his patients. Nevertheless, as the epidemic began to wane, Rush was more convinced than ever of the effectiveness of bloodletting, based on his clinical experience with his patients. How could this intelligent and observant physician fail to recognize the futility of his treatment? The answer lies in a phenomenon known as the confirmation bias. Confirmation bias occurs when one selectively processes information that is consistent with an existing belief (Nickerson, 1998). Rush already believed in the healing power of bloodletting. He therefore attributed the recovery of any patients who got well to his treatment. Those who died were dismissed as too ill to be helped by any treatment.

Unfortunately, confirmation bias is not simply historical artifact of a prescientific era. Rather, there is a great deal of evidence that the bias is alive and well in modern clinical decision making. For example, in a recent study, we provided clinicians with case vignettes and asked that they make a diagnosis (Parmely & Herbert, 2006). A week later, they were provided with the same vignette and the diagnosis they had made, along with new information about the case. They were asked to consider the new information, and either confirm their original diagnosis or change their diagnosis based on the new information. In one condition, the new information was consistent with what they were originally given. In another condition, the information was inconsistent, and should have resulted in a new diagnosis. In fact, 33 percent of the clinicians in the latter condition kept their original diagnosis, even though it was clearly no longer appropriate given the new facts of the case. Even more disturbing is what happened when some of the clinicians were explicitly reminded of confirmation bias, and told that they should carefully consider the new information and change their diagnosis if indicated. In fact, this warning had no impact; clinicians continued to stick with their original diagnoses at roughly the same rate as before, even in the face of contradictory information. The most obvious explanation is that the clinicians were filtering the new information through the lens of their preexisting beliefs about the case, highlighting any consistent facts while dismissing inconsistent ones.

Some scholars have suggested that educational level may be positively correlated with the tendency to stick to one’s beliefs even in the face of disconfirming data (Shermer, 2002).
That is, highly educated individuals appear to be especially prone to confirmation bias in certain situations, perhaps because they are better able to defend their beliefs through sophisticated verbal reasoning, even when these beliefs are challenged by the facts.

Confirmation bias is only one of many common problems in human reasoning that psychologists have identified. Humans also have difficulty estimating probabilities, especially of relatively infrequent events. For example, Wolpert (2006) describes the following problem. Suppose a disease occurs at the rate of one in 1000 in the population. Now suppose a new diagnostic test accurately detects the disease 80 percent of the time in those who have it. Suppose further that the false positive rate of the test is ten percent; that is, ten percent of those who obtain a positive reading on the test will in fact not have the disease. Now, here is the question: what is the likelihood, given a positive test result, that one actually has the disease? Most people, even highly educated physicians, estimate somewhere around 75 percent. In fact, the correct answer is approximately seven percent. This dramatic error occurs because most people tend to focus on the 80 percent positive hit rate, and fail to consider that, whereas only one in 1000 people will get the disease, the test will falsely identify 100 out of 1000 (or 10 percent) as having the disease.

It is easy to see how cognitive biases can inadvertently impact the clinical decision making of psychotherapists. Like Benjamin Rush, clinicians may find that they automatically tend to remember their treatment successes and forget those clients who did not fare as well. They may attribute those successes to the most salient features of treatment. Consider a patient who improves following Eye Movement Desensitization and Reprocessing, a technique in which the patient recalls traumatic memories while tracking a therapist’s finger back-and-forth across her field of vision (Shapiro, 1995). The improvement is likely to be attributed to the most unique and salient treatment component—the eye movements—rather than the less vivid aspects of treatment (e.g., habituation of the emotional response to the memory due to repeated imaginal exposure). In fact, controlled studies reveal that the eye movements have nothing whatsoever to do with any benefits produced by the technique (Devilly, 2002; Herbert et al., 2000). Yet many clinicians continue to maintain the importance of eye movements, based on their personal experience. Similarly, clinicians may overestimate the importance of salient diagnostic signs, failing to appreciate the base rates at which they occur in the general population. For example, many women diagnosed with Borderline Personality Disorder report a history of childhood sexual abuse, leading some clinicians to conclude that such abuse causes the condition (e.g., Lieb, Zanarini, Schmahl, Linehan and Bohus, 2004; Wilkins and Warner, 2000). Such conclusions, however, generally fail to consider base rate information about childhood sexual abuse in the larger population; that is, the large number of children who were abused, but who do not develop Borderline Personality Disorder.

Clinical experience, as noted above, was not associated with confirmation bias. In fact, age was actually found to be correlated with a greater tendency toward the bias, such that older therapists were more likely to stick to their diagnoses even when the data no longer fit. Furthermore, if clinical experience yielded more accurate clinical judgments, we would expect experienced clinicians to come to increased consensus. Yet, as any psychotherapist who attends case conferences can attest, experienced clinicians often disagree vehemently with one another. In fact, studies of the inter-assessor reliability of clinical case formulations reveal very low agreement among independent assessors (Garb, 1998).

It is important to note that empirical studies are not just used to study particular approaches to eating disorders treatment (e.g., cognitive-behavior therapy), but to study and improve the process of psychotherapy itself. For example, such research has supported therapists’ assumption that the therapeutic relationship is one of the most powerful sources of change. For example, such research has shown that factors such as positive regard, competence/experience, activity/guidance, self-disclosure and cooperation/goal-orientation (Bennun & Schindler, 1988) can improve treatment outcome. Research has suggested that these specific therapist effects account for improvements in psychotherapy that are separate from the effects of particular treatments. For example, Ilardi and Craighead (1994) examined several studies of cognitive-behavioral therapy (CBT) for depression. These authors found that patients had a rapid response early on in treatment, before the specific components of CBT were introduced.
A Way Forward

So, given the aforementioned problems with clinical decision-making that is based on personal experience and intuition, how do we ensure that our diagnoses and assessment formulations are accurate and valid, and that our treatment decisions are most likely to yield beneficial results? If clinical experience is not the answer, then what is?

The solution lies in learning how we can best combine what we know from the science of clinical decision-making with the therapist’s unique knowledge of each client. At its most essential, science is fundamentally a way of knowing—what philosophers refer to as an “epistemology.” A popular misconception is that science is basically a collection of facts, like those found in a high school biology text. In fact, science is more properly understood as an approach to inquiry, consisting of certain philosophical assumptions and methodological tools, designed to yield reliable and valid knowledge about the natural world. In the case of psychotherapy, science provides a lens through which we can see beyond the distorting effects of our cognitive biases that otherwise obscure our view of clinical phenomena. In this way, science has the potential to illuminate our work in a way that intuition and clinical experience alone never can.

This is not to suggest that science is a perfect approach to knowledge, yielding flawless guides to clinical practice. Quite the contrary; science yields imperfect, tentative, provisional conclusions that are continuously evolving as new research is conducted. However, a scientific approach is an important advance over raw clinical experience because it addresses the limitations imposed by human cognition. Science allows us to come closest to evaluating our treatments as they really are, rather than as we want them to be.

There are three additional points that need to be acknowledged. First, neither scientists nor anyone else are immune from the distorting effects of cognitive heuristics like confirmation bias. Scientists are human and sometimes cling tightly to cherished theories despite disconfirming data. However, the process of science should not be confused with the behavior of individual scientists. Science is characterized by features such as peer review and replication that serve a self-correcting function, so that sooner or later errors are brought to light and corrected. Second, scientifically-minded psychotherapists share some of the blame for the failure of many clinicians to recognize the limitations of clinical experience and the benefits of a data-based approach to clinical decision making. Due to the peculiarities of the academic culture, they tend to publish their findings in highly technical formats in obscure journals that are not readily accessible to busy practicing professionals. Although this is beginning to change as a growing body of more accessible scientifically-grounded material is becoming available, the scientific community needs to do much more along these lines. Finally, clinicians need not feel threatened by recognizing the limitations of their own clinical intuition and by adopting an orientation toward a research-based perspective. Clinical research can yield practice guidelines, but the clinician must always adapt these general principles to the specific features and unique circumstances of each case. This adaptation is the “artistic” heart of psychotherapy.

REFERENCES


My Field of Dreams

MARGO MAINE, Ph.D. – REPRINTED FROM THE FALL 2000 ISSUE

Update from the Author: Inspired by the 1989 baseball film about persistence and vision making the impossible possible, my essay challenged the eating disorder field to counteract the many sociocultural risk factors by creating a culture of body peace. Over the years, activists and organization like NEDA, IAEDP, AED, BEDA and the EDC have accomplished so much: building treatment resources, information networks, support systems, prevention programs and advocating for public policy as well as improved access to care. Simultaneously, a globalized consumer culture continues to place relentless demands on women to meet cultural standards of beauty and perfection, and effectively contributing to eating disorders spreading across gender, age, race, ethnicity, social class, and place. Just as the battle for civil rights is ongoing, so is our battle for body peace.

Over the next decade, we must transform the field of eating disorders into a field of dreams. The time has come for rose-colored glasses and for optimism, creativity, and a commitment to making the world a safer place for women’s bodies.

We, professionals, patients, families, loved ones, and the general public, must become advocates and activists, fighting the cultural and economic forces that promote the body hatred and Body Wars that lead to disordered eating. For, if we build a better world, women’s bodies, minds and spirits will thrive.
In this field of dreams, the prevention of eating disorders at all levels—primary, secondary and tertiary—will finally be accepted, supported and funded by all stakeholders. The argument in the past decade, that we do not know enough about the causes of eating disorders to fund research in prevention, will be over. We do know the causes: they are multifactorial and very complex. The increasing prevalence of eating disorders in the past two decades, however, can only be attributed to a culture, social structure and economy that breeds body dissatisfaction and despair, and equates a woman’s power and self-worth with appearance. Once we create my field of dreams, women’s bodies will no longer be public property—objectified, criticized, shamed, squeezed into abnormal shapes and clothes, harassed, touched without permission, and raped. Women will begin to own their bodies and feel proud to take up space. Men will be allies, promoting the cause, joining forces. The prevention of eating disorders will no longer be denigrated as “women’s work.”

Also, in this field of dreams, prevention programs of all sorts will be happening at all times. Primary prevention—identifying, addressing and changing the root causes of eating disorders – will be universal, not limited to activities like Eating Disorders Awareness Week. Effective prevention programs will take place in every community, in every school system, reaching all families, and will be tailored to the developmental and cultural needs of each group. Secondary prevention—identifying those with a problem as early as possible and directing them to appropriate interventions—will be easy, not the struggle most eating-disordered patients currently experience. And, successful tertiary prevention—treating people effectively once they have the illness and avoiding deterioration—will be the standard. The health care system will manage to care, not manage to neglect as it has in the past decade.

How will this field of dreams emerge? First, we have to want women’s minds, bodies and spirits to thrive. Second, we have to believe we can make a difference. And, third, we must fight to make this happen with every ounce of energy and every minute of time we have. When we think of the destruction of women’s potential our culture promulgates, we need to be angry, agitated, aggravated. These feelings, appropriately channeled through consciousness-raising, education, legislation and policy-making, can and will transform this culture.

In the process of social change, individuals do make a difference. Think of Rosa Parks. One day in 1955 in Montgomery, Alabama, she decided not to give up her seat on a bus to a white passenger. She was arrested and punished, put in jail. Her one act mobilized the community and over the next decade, the Civil Rights movement was born. Race relations will never be the same thanks to this one brave act.

To build my field of dreams and create a culture that promotes body peace, not Body Wars for women, each of us must find the courage, conviction and commitment that Rosa Parks showed us. Each of us must ask: How can I help to turn the field of eating disorders into a field of dreams? How can I do for women’s relationships with their bodies what Rosa Parks did for race relations? This is the decade to answer these questions, to act individually and to rally together to make our world a safer place for women’s bodies.

Margo Maine, Ph.D. is a Founder and Adviser of the National Eating Disorders Association and Founding Fellow of the Academy for Eating Disorders. She is the author of numerous books including Treatment of Eating Disorders: Bridging the Research-Practice Gap; Effective Clinical Practice in the Treatment of Eating Disorders; The Body Myth; Father Hunger; and Body Wars, and a senior editor of Eating Disorders: The Journal of Treatment and Prevention. Recipient of the 2015 NEDA Lifetime Achievement Award, she serves on the Renfrew Clinical Advisory Board, and the Renfrew Foundation Conference Committee and practices in Connecticut.
The Renfrew Center is celebrating its 30th Anniversary as the country’s first residential eating disorder treatment facility.

As the first and largest eating disorder treatment network in the country, Renfrew has treated more than 65,000 women struggling with anorexia nervosa, bulimia nervosa, binge eating disorder, and other related mental illnesses.

We provide a comprehensive range of services including residential, day treatment, intensive outpatient and group therapy, with facilities in California, Connecticut, Florida, Georgia, Illinois, Maryland, Massachusetts, New Jersey, New York, North Carolina, Pennsylvania, Tennessee, and Texas.

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As a professional and educator working with individuals affected by eating disorders, you are undoubtedly aware of the devastation these illnesses cause to families and communities. The Renfrew Center Foundation continues to fulfill our mission of advancing the education, prevention, research and treatment of eating disorders; however, we cannot do this without your support.

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**A Co-Occurring Dilemma: Eating Disorders and Addiction**  
Presented by: Jenifer Harcourt, LPC

**October 14**  
**Countertransference and the Eating Disorder Client: Making it Work**  
Presented by: Heather Russo, MFT

**December 9**  
**Comida y Cultura: Cultural Differences When Working With Hispanic Eating Disorder Patients and Their Families**  
Presented by: Yaneth Beltran, BS and Carolina Gaviria, LMHC, NCC  
* At Noon in English; 8 PM EST in Spanish

All webinars are FREE and run from noon to 1 PM EST.  
To register, please visit [www.renfrewcenter.com](http://www.renfrewcenter.com).
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