A Word from the Editor

Several years ago, Perspectives published an intriguing article on how clinicians help clients tap into their inner wisdom—described as “knowledge beyond words, beyond logic, steeped in a wisdom our ego-conscious minds can barely comprehend” (M. Bilich, PhD, Summer, 2008). In the current Perspectives, we re-visit the issue and shift the focus to professional reflections on the role of intuition in therapy. Accordingly, we invited six contributors to share their thoughts concerning how (or if) intuition functions in their work. Framing questions, reflecting the scope of commentaries we hoped would emerge, included:

- What is your understanding of intuition?
- What does it mean to ‘listen to your gut/heart’ and is this the same as intuition?
- Does intuition have a place in your clinical practice. If so, how do you integrate it into your work?
- How do you distinguish an intuitive response from ‘something else?’
- Have you had any formal education about intuitive processes in therapy?

Not surprisingly, our contributors have provided a plethora of rich therapeutic ideas and experiences. We begin with an intriguing physician’s perspective from Fleur Sack, who describes how Mr. Carrot, her malnourished client, taught her about the value of listening. Next is a beautiful meditative piece by Jacqueline Szablewski, a psychotherapist, who describes how her intuitive process made a meaningful connection between her client, Marianna, and an old fishing rod. “With channels cleared for access, the intuitive sense becomes divine.” Leigh Cohn, publisher of Gurze Books, takes a risk as a non-clinician and explores how ‘divine inspiration’ emerged during conversations with callers to an impromptu hotline who were desperately looking for help.

Dietician Jessica Setnick explains that intuition is not part of the traditional dietician curriculum. Yet, it is an invaluable resource in her nutrition counseling toolkit and enabled a breakthrough with an especially resistant client. Psychotherapist Laura Weisberg provides illuminating details of her therapeutic process with Sarah as she eloquently illustrates how “clinical intuition is reflected in the music and dance within the therapeutic relationship, one of the most powerful agents of therapeutic change.” Finally, we have invaluable insights from psychologist Robert Fox who shares his dilemma, one that undoubtedly will resonate with many practitioners, namely, how to distinguish between intuition and attunement.

I am extremely appreciative to our authors for all the time and effort spent preparing such meaningful essays on an issue essential to recovery, yet largely absent from the professional literature. Hopefully, these commentaries will prod us all to seek a stronger relationship with an enduring source of wisdom that resides within.

Warmest wishes,

Marjorie Feinson, PhD

editor
entered medical school 47 years ago and only recently realized I have never been taught about, read about, thought much about or even, until recently, spoken to any of my colleagues about intuition. My training and all of my continuing education has been based upon using analytical thinking. However, I use intuition many times in my clinical work as a family physician and I know that many of my colleagues unknowingly do so as well.

Often physicians “know” almost immediately what a patient’s problem is and, perhaps more importantly, whom to be concerned about and whom to reassure. This usually happens without conscious thought, which is how I define intuition. However, I recognize that intuition is not magic, but rather a combination of experience, knowledge and keen observation. We are at our intuitive and clinical best when we “listen” intently to the verbal and non-verbal cues our patients give us. These cues may defy clinical symptoms and, perhaps, a patient’s verbal presentation of his or her state of health. Still, I may simply “know” that what I have heard or seen may differ from what is.

Mr. Carrot was a 43-year-old male referred by an eating disorder specialist who was frustrated about being unable to help his client. I introduced myself to this a very thin and ill-appearing individual whose first words to me were: “I was born hungry.”

In the blink of an eye and for reasons that seem inexplicable to me, I knew what to do. I pulled up a chair and listened to his story. He explained he was a twin and that, in utero, his brother received more food than he did due to an unequal distribution of blood through the placenta. As a result, his twin was born healthy, while he was undernourished and underweight. He believed that his brother was always the favored child and told me that he was called “Mr. Carrot,” because carrots were all he was able to eat without becoming ill. Due to malnutrition, he suffered from many health problems including neuropathies and severe osteoporosis.

My gut feeling was that I should not treat him with drugs, as my medical training would have me do, but that the best “medication” I could offer him was my time and attention. For several months he came for weekly office visits. All I did was listen, fascinated by his stories. He gained weight and introduced new foods slowly—we never discussed how or why. But he did teach me many valuable lessons which were not in my medical textbooks.

Mr. Carrot explained that since we do not know when we may encounter the Buddha, everyone should be treated as if he were the Buddha. I have taken that teaching very seriously as I interact with all my patients (even a patient who was a convicted pedophile). He also pointed out what he perceived to be a problem with doctors who constantly look for and comment on what is wrong with their patients. Rarely do doctors comment on what is right. Upon hearing that, I began pointing out to Mr. Carrot what was healthy about his body and refrained from commenting on any negative findings. I think this helped him begin to picture himself as healthy and may have been one of the reasons he was able to start eating.

Mr. Smith, a 40-year-old patient with an eating disorder, was referred to me because, while on his honeymoon, he became unable to urinate. This necessitated the placement of a catheter for what was diagnosed as a urinary obstruction. As he entered my office, I witnessed his new bride helping him as she held his catheter bag. I instantaneously thought: “wrong diagnosis, wrong wife.” Reflecting back on what triggered this thought, I remember noting a flash of hostility on his face as his wife helped him. I also recall thinking that this fairly healthy looking male should be able to carry his own catheter bag. All this occurred within a split second of time.

As I observed the interaction between him and his seemingly caring wife, I intuitively understood that this marriage would not succeed. It took several weeks before he could urinate and the catheter could be removed. No reason for his urinary obstruction was ever found. I believe that his illness may have been symbolic of his own intuitive
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 related mental illnesses.

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Throughout the year, Renfrew will be hosting 30th Anniversary celebrations at some of our sites!

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understanding that he had made a mistake by choosing this woman. After several painful years in therapy, the marriage ended.

In medical school we are taught to think analytically. All possibilities are considered; many tests are often ordered and, sometimes, the patient is referred to other specialists. For example, Mr. Carrot could have been referred to a neurologist for the management of his neuropathies. Or, he could have had a bone density test to assess his osteoporosis. Neither would have been helpful to him. Instead, I chose to listen because I believe that listening is often times as therapeutic as many of our most powerful medications.

It is important for physicians to keep in mind that our patients often intuitively know the diagnosis and treatment needed. The question is ‘if’ and ‘how’ we listen. A young patient of mine came in to see me for a cough. Nothing in her history or examination pointed to anything more serious than a common cold. She asked me to order a chest X-ray, which I initially refused because my medical judgment dictated that it was unnecessary. However, I reluctantly ordered it only because she told me that she knew something was terribly wrong. My intuitive sense told me that I should listen to her. She turned out to have tuberculosis.

Good medical judgment relies on analytical thinking which could conceivably be replaced by a computer. Good intuition relies on the observation of more subtle findings. Intuition should be an integral part of medical school training but, sadly, is not taught or even acknowledged as important. Intuitive thinking may be the first and most important impression. However, it should not be the last impression. The best physicians are those who are well educated and trained, follow their clinical hunches and listen intently to verbal and non-verbal cues of the patient.

Fleur Sack, MD is a board certified family physician, providing medical care to patients with eating disorders for 25 years. She was born in South Africa where she graduated from medical school. After immigrating to America, she completed a residency in Family Practice at the University of Miami. She has served as President and Chairman of the Board of the Florida Academy of Family Physicians. In 2001 she was the recipient of the prestigious Florida Family Physician of the Year. Presently she is in private practice in Miami.

Listening In-to-It: Intuition in the Psychotherapy Process

Jacqueline Szablewski, MTS, MAC, LAC

Grandma takes another deeper breath as she returns her coffee cup to its saucer. She reaches for the green babushka. In a move expertly choreographed over years of time, she covers her head. As gently as her kiss on my cheek, she ties the knot below her chin. Leveraging her weight with the help of her cane she raises herself from the red kitchen chair. To me she announces, “Okay, Jackson – time to go.”

We travel in comfortable silence to the family church. We park where we have always parked for as long as I can remember in the six years I have had thus far. We walk together up the five front steps to the vestibule. I let go of her left arm to which hand she moves her cane. She dips the fingers of her right into the holy water and blesses herself before she enters, as do I. Another deep breath and in we walk to the third pew on the left. Genuflect to enter it and then kneel.

The first few minutes are about acclimating the senses: incense and melting wax, gladiolas, Jean Nate, breakfast toast; pages restle; a purse clasp snaps; greetings in soft voices. A baby cries. I feel my stomach rumble and then the old pipe organ warming to its first notes. Open stained glass window ushers in the morning chill. Reverently mimicking my Grandmother, I take another purposeful breath and close my eyes. Now the listening … inside… the images that rise.

Decades later, in another city in another state, my Grandmother gone from this world too long a while, I settle my tea cup in the sink, take the deep breath that assists me in slinging my bag over my left shoulder, grab my lunch sack and the handles of a worn soft sided brief case with my right hand, assert to the dog that it’s time for me to go and I head out the door… for work…

Nearing a quarter century as a master’s level mental health clinician with 15 years in private practice, I
reflect often on this early template of attuning, attending, listening in, out, in between, and relating with authenticity, reverence and humbleness. This template has been added to, of course, through all the life experiences that came after. Sometimes directly and sometimes despite its neglect, it has been impacted by schooling, training, supervision, certifications, workshops, colleagues and therapy. Most especially though, in the professional realm, it has grown through the sharing of therapeutic relationships.

There are places that are sacred beyond those designated for formal worship or religiosity. I believe they exist within each of us: the “still small voice”; the truth that has no reason to shout; the intuitive voice particular to the vessel it resides in that brings us to itself.

In many clients I have been privileged to see over the years, there has been an initial distancing from their intuitive voices. Often symptoms and the underlying mechanisms of the eating disorder, substance use disorder or both, while initially likely serving to protect, add layers and miles and time complicating or blocking its access. A central theme of recovery then, becomes recovering this aspect of the self, even if meeting it consciously for the first time. Deciphering, discerning, untangling that which has masqueraded as, or grown over into, the sacred space of the intuitive becomes essential to the process. For our intuitive sense, unbraided from our addictive tendencies, is crystalline. It behooves us to listen, see, learn its voice and, at the least, get curious about it.

In the words of one client:
“It’s like clearing a recording of static, background noise, and overlays to...”

really hear the message... I mean a year ago I heard from a friend that my ex was dating someone new. We had broken up three months earlier and that is what got me into therapy... She told me this news while we were eating lunch—she was supposed to be my support person for lunch one day a week. Immediately, I put down my fork. I heard my insides say, ‘I am not taking another bite... ever. I’m too fat already and it’s time to be done with all this recovery crap.’ I had a flash of seeing myself on a run and at the liquor store stocking up for the evening activity... I was convinced that’s what my gut was telling me to do and that it was exactly the right thing... Now I get that that was some of my overlay, my static automatic reaction. For the real stuff, the real message, I gotta hang in there, listen deeper, see me again...

Another client likens her process to, “clearing a path through the overgrown forest to come upon the ancient city of HOME and the treasure inside... binging-purging-drinking-drugging, it only keeps me in the forest longer... and I get tired and out of resources.”

Within the deep listening attuned presence of the therapeutic relationship, the various modalities, techniques and approaches we might use ourselves and choose to employ with the people we see, each have something useful, even vital, to offer in clearing channels for intuitiveness. Meditation; mindsight practices as described by Dan Siegel* and others in the realm of interpersonal neurobiology (IPNB); the integrative aspects of various somatic modalities, EMDR, and others; mindful awareness, radical acceptance, values identification, affect regulation, distress tolerance, thought watching, interpersonal skills also included in ACT, DBT, CBT are among the resources available for clearing our static and honing our antennae. Within the milieu of the therapeutic relationship, they all are helpful in assisting clinician and client to relate better—deepening and potentiating compassionate connection within self, with other and amidst the space in between. It is as if we, in our relational connectivity, are synapses in a divine consciousness.

With channels cleared for access, the intuitive sense becomes divine. It encompasses while distinguishing itself from clinical wisdom. It speaks in images and impressions. It bades me in—to the sacred space of the in-between, into the void wherein we find the vulnerability that begets creativity. In the case of my client, Marianna, I found an old hand-held fishing net.

Marianna, a 32-year-old courageous woman, had been attending therapy for about two years to facilitate her recovery from an eating disorder, substance abuse and underlying trauma. She had thus far been able to increase her food intake, decrease her exercise, significantly reduce her purging, and discontinue misuse of prescription drugs. She was medically stable and within her weight restored range. She had had a successful course of EMDR earlier on including resource installation. Marianna worked from home and continued to exhibit great difficulty in developing friendships and interests outside of her home, despite both of these being initial motivators for treatment and recovery.

Our most recent session had been particularly intense with affect and heavily imbued with water imagery. Marianna had been panicked that she might return to old behaviors as she talked about feeling like her “head was just above water...” and how lately she

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Intuitive Counseling: Confessions of an Amateur

Leigh Cohn, MAT, CEDS

“I’m not a therapist,” is something I’ve told each of the 10,000 or so people I’ve consulted with about eating disorders over the past 35 years (yes, there really have been at least that many). If I were being entirely forthcoming—like I am now—I also would have told them that I’d had no training nor had even taken a psychology class. Yet, our conversations, which usually lasted about an hour, always seemed to be deep and insightful for them.

In the early 1980s, when my wife, Lindsey Hall, and I wrote the first publication about bulimia and founded Gürze Books, we had the only toll-free phone number in this fledgling field, ostensibly to sell books. However, for some, it turned into an impromptu hotline. Although the callers’ circumstances were unique, typically they were stuck, distressed, and didn’t expect to receive any kind of personal guidance when they dialed. They didn’t know me, and I generally introduced myself as a “writer” or “publisher” who specialized in eating disorders and offered to answer any questions they might have. I sounded knowledgeable and welcoming and so they often poured their hearts out.

Because I had no formal education in psychology, I learned intuitive counseling by doing what came naturally. At some deep place inside, I’ve always liked the experience of listening, observing, and responding. I’m also pretty good at asking questions. I seem to instinctively convey an aura of availability, which is probably why people have been confiding in me from an early age, when my best friend’s mother routinely told me her personal problems. Later, I took on that role with friends, who unburdened themselves to me, an older sister who ratted on about everything, and my mom, who constantly complained about my complex and volatile dad. I guess you could say I was home-schooled in emotions.

In the years that followed, I became a student of intuition. A couple of potentially fatal escapades in my college years were the best teachers, because I unconsciously listened to a faint inner voice that saved me in both instances. In one of those instances, after two days of playing all day and night in Las Vegas, I found myself foolishly driving back to Los Angeles around 3:00 a.m. In those days, not all cars had seat belts, and I usually didn’t wear one, nor was I that night. I stopped at a gas station, splashed some water on my face, and did a few jumping jacks. Then, as I got back in the car, a quick vision flashed into my mind and I saw myself fastening my seat belt—so I did. The rest of the story is probably obvious. I fell asleep, rolled the car, and ended up suspended face down, with the upside-down car above me and my cheek in the desert sand. After that incident, I gravitated toward metaphysics, probably trying to understand why I’d survived.

In 1977, when Lindsey and I fell in love at first sight, we began living together within three weeks and everything seemed perfect. A short time later, however, she revealed that she’d secretly binged and vomited several times daily for nine years—behaviors that miraculously disappeared when I moved in, but were threatening to resume. We collaborated on her recovery, as described in Bulimia: A Guide to Recovery, and as no one had previously described that process, it became our mission in life to spread the word. As it happened, the whole world was waking up to eating disorders at the same time, and that synchronicity thrust us into an unexpected place—at the center of an emerging field. That’s when the calls really started: women with anorexia and bulimia, parents, husbands, boyfriends, teachers, therapists. Everyone had questions, and people began opening up to us.

Usually we limited callers to once or twice, suggesting they come up with alternatives for support, such as a professional therapist or trusted adult. However, there were a few special callers like a First Nations woman from Canada, with whom we’ve stayed in contact for more than 20 years. She got our number from an Eating Disorders Resource Catalogue, which she picked up while in a locked ward for anorexia nervosa and other psychiatric disorders. We spoke frequently for years and I often interrupted her suicidal thoughts and behaviors with soothing.
compassion and at other times with blunt truths. It all depended on what I intuitively understood she needed at that moment. Though she still has many challenges, she now lives on her own, is healthier about her eating and weight, and hasn’t had suicidal tendencies for years. She’s repeatedly said that we saved her life, and maybe the universe brought us together for that purpose.

We also stay in touch with Nicoletta from Italy, who read our book in the mid-90s and showed up at our doorstep in California. She’d had bulimia for 17 years, had been in therapy without success, and felt drawn to us. She stayed in our home for three weeks, and we guided her with many of the same techniques that Lindsey used in her recovery.

My approach has been to just make it up as I go along, trusting that I will do the right thing. Without being bound by professional standards, I feel that I can say whatever I want. I open my heart, ask questions, and pick up on small details that may signal larger issues. I use my perceptions as a conduit to their consciousness and reflect back with observations that may seem startling, but are actually a clearer articulation of their own thoughts. Eating disordered “clients” are burdened by such a multitude of voices (parents, teachers, peers, ED) that they can’t hear themselves think. When I pick up on their deepest feelings, I am tuning in to their experiences and responding accordingly. Frequently, they say things like, “I’ve been in therapy for years and I never realized that,” or “No one has ever made me understand that.” So, I must be on to something.

While epiphanies can be dramatic, of longer lasting value are my practical recommendations. These are based on what I perceive as being the best approach for their particular needs. I probably express more opinions and give more advice than typical therapists, but I recognize that our time together is extremely short. Of course, I might give the same advice to most people (professional therapy, journal writing, etc.), but I also seem to have ideas that come out of the blue.

Where does this kind of divine inspiration come from? I can’t say for sure, but I know it’s not coming from an intellectual place in my brain. In these conversations, I feel connected to a greater consciousness that I won’t even attempt to define, though I have complete trust in its being right and true for me. When I am relating on this level, I listen and speak mindfully and without preconceived notions or an investment in the outcome. I try to recognize the God force within these people who are seeking help, and I approach our brief encounters as if we have been brought together in that moment through a cosmic connection.

In closing, I must admit that writing this article was not an easy task. I’ve had a fairly high profile in the eating disorders field; writing, editing, publishing, speaking and doing advocacy. I’ve never publicly discussed my pro bono “counseling” work and I’ve always been reluctant to share it with the professional community. I admire therapists and I definitely recommend licensed treatment over talking to an amateur! However, at this time of transition—Lindsey is fully retired, I have one foot out the door—I feel that such disclosure is appropriate. I don’t think anyone should provide therapy without getting proper training and I do not characterize my conversations as therapy. However, I honestly believe I’ve helped thousands of people I’ve never met and always done so out of love.

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And most of all, intuition clashes with the foundational principle of RD education: supporting documentation. Yet, intuition provides information that cannot be obtained by any other method. This may be especially true when a client with an eating disorder does not present completely accurate information due to denial or minimization of the disease and there may be no one to corroborate or correct the misinformation.

My intuitive sense often signals me when something is missing, when a client is leaving out important information such as a purging episode or ambivalence about recovery. At these times, I might mention this possibility: “I’m sensing there is more to this situation, but that you’re not sure you want to tell me about it. Is that correct?” Sometimes the ‘missing’ information is ‘unspeakable,’ something uncomfortable or even traumatic to the client, and not within the scope of the RD to address. A colleague shared with me that she sensed that something was amiss in a client’s relationship with her brother. Although she did not discuss it with the patient, she reported this feeling to the client’s therapist. Later, she learned that the client had been abused by her brother and that an investigation based on additional information gathered by the physician had been initiated.

Another colleague, who works in a residential setting, described a client who refused to come out of her closet for her scheduled nutrition counseling session. Although the RD could have cancelled the meeting, she decided not to and held the session sitting on the floor outside the closet. Although the client did not verbalize her feelings, my colleague intuitively understood that her client was not demonstrating uncooperative or defiant behavior, but rather the need to feel safely contained while discussing issues that increased her vulnerability.

Considering that intuition can be extremely helpful but also puzzling, it would be nice for new RDs to learn the benefits of intuition as well as how to investigate it and integrate it into nutrition counseling, rather than minimizing it or disregarding it. For example, they should learn to consider intuition together with more objective evidence, rather than relying exclusively on either one or the other. And when they are unsure, they should think about corroborating intuitive thoughts and feelings with other members of the treatment team before acting.

An important goal of nutrition counseling is to teach clients to honor their internal cues, consistent with intuitive eating, a practice highly regarded in the field. This process of blending nutrition knowledge with body wisdom and intuition is often a great challenge for clients with eating disorders.

In the initial phases of recovery, it is common for clients attempting intuitive eating to confuse incorrect beliefs about food and eating with intuition. The presence of dysfunctional and especially life-threatening eating behaviors indicates that a client’s relationship with his/her intuitive eating process has been severely disrupted and must be repaired before it can be relied upon as an effective means for good nutritional decisions. This is evident when a client reports “never” feeling hungry or “always” feeling hungry. In order to rebuild the connection with internal cues, clients eat according to a recommended schedule and simultaneously observe their internal senses. This may mean eating ‘by the clock’ even if they don’t feel hungry or not eating even when sensing hunger. Goals are individual and reflect each client’s needs and history of dysfunctional behaviors. This process of observation allows clients to gather information about their internal body cues without continuing dysfunctional behaviors which they may have mistaken for ‘intuition.’

Observing internal cues may also take the form of scanning the body and mind for signs of hunger and satiety at certain times of day or around
mealtime; assigning numerical or descriptive ratings to these sensations and documenting them in writing; journaling or speaking with a support person about these sensations; meditating in order to reinforce the connection with body and mind; and other creative practices that different RDs suggest.

With practice, internal signals about hunger or fullness become stronger and clients are better able to identify them accurately. Step by step, structured eating can be reduced and reliance on internal signals increased. For example, a client who doesn’t feel hungry on stressful exam days could practice eating intuitively on non-exam days. Ultimately, the hope is that clients will become more cognizant of internal signals to guide their eating choices.

This process is unique for each client and requires a great deal of patience since it can take years or decades to heal the damage and reunite the body and mind in a trusting relationship.

Through trial and error, I’ve learned to trust and respect my intuition. I’ve also become more skilled at distinguishing it from anxiety, fatigue or other internal sensations. While there are times when I doubt my intuition, in general, my clinical judgment is enhanced when it is informed by my intuitive understanding. For example, my intuition often signals me that a patient might be more forthcoming if we take a walk instead of sitting uncomfortably in silence. Or, I recognize that patients may be agreeing with me, yet, I intuitively understand that they have mentally checked out of the conversation.

During one particularly memorable session, a client told me that she had fallen asleep while driving. While expressing my concern about this life-threatening situation, both for her and her children, I felt tears starting to well up behind my eyes. Typically, I would have tried to stop the tears before they became visible. However, this time my intuition told me that it was important for the client to understand that my tears were directly related to her refusal to seek treatment and its potential consequences. So I let the tears flow. After many weeks of refusing a higher level of care, this patient finally admitted herself to inpatient treatment. While I don’t recommend crying as a therapeutic intervention, in this instance, I followed my intuition even though it conflicted with my belief about professional behavior. And yet, after I intuitively allowed my tears to flow, something appeared to shift within the client that had not occurred previously.

At times when I am not entirely sure of what to do, I try to quiet myself in order to listen for that sometimes nagging, sometimes surprising, sometimes counterintuitive voice of intuition. When I am unsure if what I’m sensing is intuition or fear, I may consult with someone I trust, because my intuition often emerges more clearly within the context of a conversation. Ultimately, I believe that when I connect with my intuition and allow myself to utilize it constructively, I also become more attuned to and understanding of my patients who are doing the same—a strong reminder that there is no we and they, only us, all finding our way.
The first definition of intuition that pops up in Google describes it as “the ability to understand something immediately, without the need for conscious reasoning… a thing that one knows or considers likely from instinctive feeling…” As a psychotherapist, however, the understanding of intuition that resonates most with me is that of Shore (2012): “Much of the therapist’s knowledge that accumulates with clinical experience is implicit, operates at rapid unconscious levels beneath levels of awareness, and is expressed as clinical intuition. This implicit relational knowledge is nonverbally communicated in right brain-to-right brain affective transactions that lie beneath the words within the therapeutic alliance.”

Sarah was a 20+ year old woman who presented for consultation after being discharged from intensive care. She had nearly died as result of severe electrolyte disturbances associated with low weight and severe laxative and diuretic abuse. Even before I met with her, it seemed the only rational recommendation was for specialized inpatient treatment. Anything else appeared folly. However, Sarah was terrified of this and refused to go.

When I actually met with Sarah, I was strangely moved by her argument that, with the support of her mother, she would be able to manage outpatient care. To this day, I cannot tell you exactly why—just a gut sense that there was something about her that called for a different approach. We set some parameters for a trial of outpatient treatment, I took a deep breath, and we began.

Our clinical intuition is reflected in the music and dance within the therapeutic relationship, one of the most powerful agents of therapeutic change. Instinctively, we use our voices (prosody and pacing), our eye gaze, the synchrony between our posture and movements and those of our patients, to move the therapy forward. The timing and the choice of our interventions also are often guided by intuition. It is “what fills the gaps between theory and practice” (Marks-Tarlow, 2012).

The primary tool that I used during the early phase of Sarah’s therapy was somatic empathy, by which I mean my intuitive attempts to be attuned to both what appeared to be going on in Sarah’s body, and what was going on in mine. I found myself closely attending to her breathing, posture, muscular tension and tone of voice. Through my own non-verbal presence (eye gaze, breathing, posture, tone of voice), I tried to use myself as an instrument to connect with her, and to help her regulate her internal states. Primarily, I felt the work at that stage was in what was happening non-verbally, in the creation of a relationship, a safe space where she could disclose her “true” experience so to speak, vs. feeling she had to defensively protect herself and avoid the shame she felt about her symptoms.

We as therapists can learn to better harness our intuitive processes by making space in the consultation room and in our lives to slow down, becoming aware of our own internal states, and taking time to identify their sources. We are the instruments of our trade—and it only makes sense to tune our instruments. Whether through formal training in mindfulness meditation or Focusing (Gendlin, 1982), through body based approaches like Feldenkrais or yoga, or through our own psychotherapies, we can become better at discerning what is coming up for us as we sit with our patients, and whether it has its origins in us, our client, or the intersubjective space between us. We then are less likely to be pulled by our own reactivity and more open and responsive to what our patients need in the moment.

There can be dangers in relying upon intuition, however. All therapists have histories that influence what we 
experience as intuition, for better and for worse. For example, a recent experience with the death of a severely ill patient may have contributed to my initial strong gut sense that there was no way Sarah should be treated as an outpatient. In this case, it fortunately was counterbalanced by other experiences of working with patients who benefited from more flexible approaches. One of the best ways to prevent misuse of our clinical intuition is to explicitly check things out with our clients, recognizing that they are the experts on their own experience. Taking the time to reflect on where we might be coming from in our own responses, discussing our patients with colleagues and supervisors, and doing our own work, are also key.

The therapy room was an important place for Sarah to practice identifying and expressing her thoughts and feelings. I encouraged her to let me know when I was wrong or when something I said didn’t feel right to her. I knew we had moved in the right direction when she began to challenge me directly. However, the first time she actually did this, I felt an impulse to challenge her right back, to explain that she was totally off track in what she was saying. Fortunately, I took the stance of exploration, instead trying to understand what she was feeling and what was in her mind before offering any reaction of mine. When I introduced additional information that I was concerned she wasn’t considering, I asked her how she felt. “Safe” she said.

It felt different to be able to have a discussion, to neither have to acquiesce to my view, nor to rebel and rigidly adhere to her own view, but, rather, to try to understand what was going on for each one of us.

The clients we work with struggle with their own sensing systems that inform intuition. Many are quite sensitive to both internal and external sensory experiences, but find it difficult not to be overwhelmed by them. As a result, they often distrust and attempt to avoid or control somatic sensations, including those associated with emotions. Restriction, binging, purging, and excessive exercise may provide a type of solution, but they sacrifice access to accurate awareness of the visceral experiences that inform intuition.

As our work together progressed, Sarah described how confused and overwhelmed she often felt by the sensations she experienced in her body. Whether physiological states, such as hunger or fullness, or emotions such as sadness, fear, or anger, the only way she knew how to manage the “craziness” she felt inside was to starve or purge it out. However, she was then left without the guidance of her natural sensing system to provide information about what she felt, wanted, and needed. An important part of our work became making space to experience her internal sensations, to identify what they were signifying, and to learn how to use them as an internal compass to guide her behavior.

As therapists, we need to create a safe place where our clients can begin to connect to and explore their own internal experiences. We utilize our intuitive capacities to sense when to support and when to challenge, when to lean in and when to allow space, when to increase the level of activation in the room and when to help soothe and calm things down. After the fact, we often create a rationale for our decisions, but in the moment, it seems like we are relying upon something else…

Over the course of our work together, Sarah’s ability to connect with herself, and to feel safe connecting with others expanded. At the same time, her eating disorder symptoms subsided, and she began feeling more integrated and whole. While her treatment incorporated many different types of interventions, they appeared guided by what I can only describe as a trained gut or educated intuition, harnessing both my sensing systems and implicit learning experiences, as well as all my explicit education and training.

REFERENCES


Laura J. Weisberg, Ph.D. is an Assistant Clinical Professor in the Department of Psychiatry and Behavioral Sciences at Duke University Medical Center. She is also a Clinical Psychologist affiliated with the Duke Center for Eating Disorders, specializing in EDs since 1982. Currently, she is learning Accelerated Experiential Dynamic Psychotherapy and Somatic Experiencing, which she hopes will add to her effectiveness in treating people with eating disorders.
Intuition? A Dilemma

Robert H. Fox, Ph.D., CEDS, Fiaedp

When first asked to write this article on intuition, I was intrigued and thought: I’m intuitive.” Then, I asked myself, “Okay, but what does that really mean?” One author (Emery, 2001) defines intuition as “…a clear understanding that comes not from our logical mind… but from a deeper part of our being. It’s the secret of heeding premonitions, acting on bolts from the blue, and paying attention to your quiet inner voice…”

Google defines it as, “The ability to understand something immediately, without the need for conscious reasoning.” An article in Psychology Today (8/2011) adds to the above, stating “Intuition is a process… bridging the gap between the conscious and nonconscious parts of our mind, and also between instinct and reason.” Welling (2005) states, “…intuition should be viewed as a cognitive function based on pattern recognition processes.”

I believe intuition is not a ‘higher power’ (although that phrase can be broadly defined), but more likely an amalgam of unconscious observations, feelings, and experiences that emerge into consciousness when presented with a proper or timely stimulus. Intuition has the feel to me of a gestalt, where multiple elements are present, not entirely related, which crystallize into a clear understanding (gestalt) over time. A recent opinion piece in the New York Times (DeWall, 10/27/14) describes “magical thinking” as having an instinctual, adaptive function, coming from a primitive, protective part of our minds. Intuition seems to serve such a function, and in this regard, is not a ‘higher power’ but an evolutionary one.

I most certainly see myself as an intuitive therapist. And yet, while I feel and rely upon this intuitive sense, I cannot define it precisely. The concept raises many questions for me. How is it expressed within my psychotherapeutic work? Is it the same as ‘attunement,’ ‘empathy,’ ‘countertransference,’ ‘creativity’? Herein lies my dilemma. In formulating this article, I struggled to distinguish between therapeutic intuition and attunement, empathy, etc. and other concepts noted above. However, I recognize that an intuitive therapist has these qualities. In addition, I think that intuition evolves over time and reflects the merging of both personal and professional experiences. I’ve repeatedly observed that ‘seasoned’ therapists can experience a level of confidence within themselves that allows a greater trust in their intuitive skills. Feeling free to be more themselves, these therapists enjoy a therapeutic style that becomes increasingly distinctive. For me, this is reflected in the freedom to use humor, offer a hunch, listen to my own voice of caution or, perhaps, to judiciously self disclose.

I think my intuitive sense is most apparent when I first meet someone, either personally or professionally, a first impression. The clearest example I recall dates back many years, when, as a staff psychologist at a state psychiatric hospital, I was part of the selection team to employ a new psychologist. One applicant was a young woman with very good credentials who presented herself appropriately. My intuition signaled ‘danger’ at some level, but my apprehensive negative vote was the only dissent; she was hired. Within six months, she caused significant problems for the psychology department and the hospital, resulting in her dismissal shortly thereafter. To this day, I don’t know what signaled caution, but I trusted it; and that intuitive signal was correct. This intuitive first impression also presents itself within my practice. I will frequently get a sense of how well the therapeutic relationship is going to evolve from the first session. Is this intuition or experience? I’m not sure. While trusting my intuitive sense, I do not take it as a given. My professional experience and training will kick in and I will evaluate the circumstances, looking at my own countertransference and working to build the relationship. I do think some of the metaphors I use with patients are intuitive and cause me to wonder or laugh, asking myself from where they came from. Indeed, I’m a firm believer in the art of psychotherapy much more than the science, even in today’s environment of evidence-based treatment. This is an important distinction for me, for I believe how we...
connect and help our clients grow, recover and heal is vital in our work. Studies showing the therapeutic relationship as the most growth-inducing aspect of therapy are validating for me and guide my treatment.

While I have difficulty defining it, I am sure intuition plays a significant role in effective treatment. As I continue my practice, I am hopeful, even expectant, that time will clarify further the dilemma I admittedly acknowledge in understanding the role intuition holds in my work.

REFERENCES


Robert H. Fox, Ph.D., CEDS, F.iaedp has been a New York State Licensed Psychologist for more than 35 years. He is a Certified Eating Disorders Specialist, Approved Supervisor, and Fellow of the International Association of Eating Disorders Professionals (iaedp). Of special note is Dr. Fox’s treatment of trauma and Post-traumatic Stress Disorder (PTSD), including the use of EMDR. Dr. Fox is a recognized expert in the field of eating disorders and has served as Past President and Board member of the National Eating Disorders Association of Long Island.

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The Twenty-Fourth Annual Conference Update

The 2014 Conference Committee extends a “thank you” to all the speakers, attendees and staff who attended this year. Participants came from all over the U.S. as well as Australia, Israel and South Africa, each finding common ground and sharing a commitment for the work we do each day.

Feminist Relational Perspectives and Beyond: The “Practice” of Practice was one of our most exciting and successful conferences. The theme provided a platform for speakers to share stories of the personal and professional challenges they encounter. The program offered an excellent mix of experiential, interactive, and didactic workshops as well as numerous opportunities for the therapists to reflect on their own experiences, making difficult clinical decisions as well as failures and disappointments. Throughout the weekend, there was an overall feeling of community and connection among the attendees.

Dr. Debora Spar, President of Barnard College, opened the Conference with an engaging presentation, entitled Wonder Women: Sex, Power and the Quest for Perfection. Dr. Spar highlighted the often unattainable demands placed upon young women in our culture for perfection in so many areas of their lives—their families, professional work and how they look, among others. In an entertaining manner which riveted our attention, Dr. Louis Cozolino’s keynote address Saturday morning offered a deep understanding of the underlying biological processes at play during the course of treatment. Saturday afternoon featured a panel discussion, Clinical Dilemmas and Decision Points, moderated by Dr. Judith Rabinor, with panelists Drs. Michael Strober, Laura Hill and Sarah Ravin. The panel provided an excellent learning opportunity to hear divergent opinions on how to provide diagnosis and treatment. Sunday’s plenary was a compelling and provocative presentation on Recovery. The speakers—Carmen Cool, MA, LPC; Suzanne Dooley-Hash, MD; Jillian Lampert, PhD, RD, each from different disciplines, shared personal stories of their own recovery and responded to questions posed by the moderator, Beth McGilley, PhD, who encouraged interaction with audience members. This important topic will continue to be addressed at future Conferences.

During the weekend, professionals enjoyed the camaraderie of meeting and reconnecting with colleagues and attending special networking breakfasts and evening events. We greatly appreciate those of you who participated with such enthusiasm!

Next year, The Renfrew Center Foundation will celebrate its 25th Annual Conference for Professionals. We are greatly looking forward to this milestone event. A preview of what we have planned can be found on page 18.

This update includes photos from the conference as well as a form to order CDs if you were unable to attend or missed some workshops. Many thanks again for making Conference 2014 such a great success and we hope to see you again next November.
“It was a gift to attend! The speakers were so well-versed and knowledgeable.”

“Thank you Renfrew—20 years of conferencing with you and ‘you’re still the one’.”

“It was such an amazing conference—inspiring and challenging. It made me grateful instead of stressed to leave my practice and family for this opportunity.”
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Feminist Perspectives and Beyond: Honoring the Past, Embracing the Future: 25 years later

Philadelphia Airport Marriott
Nov. 13-15, 2015

KEYNOTE SPEAKERS:
Gloria Steinem
Kathryn Zerbe, MD
Bessel van der Kolk, MD

After 25 years of bringing together experts and luminaries who have advanced our field, Conference 2015 will provide opportunities for reflection and foresight – exploring the wisdom of the past and innovative perspectives of the future. Join us as we embrace the challenges ahead with an open spirit!

TOPICS TO BE FEATURED:

- Somatic therapy
- Neuroscience
- Current trends in research and prevention
- Social media
- Overlooked and underserved populations
- History and current status of family therapy and couples work
- The influence of feminism on treatment
- Helping seasoned clinicians move out of their comfort zone
- Emerging therapies

A Call for Proposals and Posters will resume in 2016.

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THE 24th ANNUAL RENFREW CENTER FOUNDATION
EATING DISORDERS CONFERENCE FOR PROFESSIONALS
November 14-16, 2014 in Philadelphia, Pennsylvania

KEYNOTE PRESENTATIONS

- KEY 1 Wonder Women: Sex, Power and the Quest for Perfection
  - Debora Spar, PhD
- KEY 2 Why Therapy Works
  - Louis Cozolino, PhD
- KEY 3 Clinical Dilemmas and Decision Points
  - Judith Ruskay Rabinor, PhD, Laura Hill, PhD, FAED, Sarah Ravin, PhD & Michael Strober, PhD
- KEY 4 Therapists and Recovery: Looking In, Working With, Coming Out
  - Beth Hartman McGilley, PhD, FAED, CEDS, Carmen Cool, MA, LPC, Suzanne Dooley-Hash, MD, Jillian Lampert, PhD, MPH, RD, LD, FAED & Mark Warren, MD, MPH, FAED

WORKSHOPS

Friday, November 14, 2014

- FR 1 Using the C.A.R.E. Program with ED Clients
  - Amy Banks, MD
- FR 2 SoulWork: The Neurobiology and Psychology of Spiritual Practice
  - Rod Birney, MD & Suzanna Yahya Nadler, Med, LPC
- FR 3 An Eating Disorder in the Family: The Application of Systems Theory to Family Work
  - Fran Gerstein, LCSW, BCD & Frani Pollack, LSW, PhD
- FR 4 Self-Contact, Self-Acceptance and the Felt Experience: A Body-Centered Intervention
  - Beth L. Haessig, PsyD & Kate Holt, RN
- FR 5 Working with the Emotional World of the Eating Disordered, Self-Injuring, Trauma Client: The Darker Side
  - John L. Levitt, PhD
- FR 7 Modern Matrix of Mixed Messages: Beyond the Fear of Fat Grams
  - Karen Beerbower, MS, RD, LD, CEDRD
- FR 8 Everyone’s Talking Values: Using Acceptance and Commitment Therapy to Overcome the Values of “ED”
  - Danielle Doucette, PhD
- FR 9 The Therapeutic Meal: What Makes it Therapeutic?
  - Theresa Fassihi, PhD, CEDS
- FR 10 Somatic Countertransference: Bringing the Therapist’s Body into the Room
  - Andrea Gitter, MA, LCAT, BC-DMT
- FR 11 Integrating Behavioral and Emotional Interventions in the Healing Process
  - Susan Ice, MD & Heather Thompson-Brenner, PhD
- FR 12 A Tale of Two Paradigms: Implications of the Biopsychiatric and Sociocultural Perspectives for Treatment, Prevention, Advocacy and Theoretical Resolution
  - Michael P. Levine, PhD, FAED
Saturday, November 15, 2014

- SA 1 Self-Care: The Art of Taking Good Care of Yourself While Giving of Yourself in the Service of Suffering Souls
  - Michael E. Berrett, PhD
- SA 2 Embodied Mindfulness
  - Ann Saffi Biasetti, LCSW-R
- SA 3 The Trauma Triangle of Eating Disorders: Healing in Action
  - Linda Ciotola, Med, CET III, TEP
- SA 4 Why All Psychotherapists Are Neuroscientists
  - Louis Cozolino, PhD
- SA 5 Bodies Come in All Sizes: The Assessment and Treatment of Body Image Disturbances
  - Nicole Hawkins, PhD
- SA 6 He Says…She Says: Managing Relationship, Nutrition and Fitness Issues
  - Page Love, RDN, CSSD, CSCS & Melissa Sparks, MAMFT, NCC
- SA 7 “Non-Diet”itians…Integrating Eating Disorders Wisdom in All That We Do
  - Anna M. Lutz, MPH, RD, LDN, CEDRD & Katherine Zavodni, MPH, RD, LDN
- SA 8 Frustrations, Failures, Ruptures and Repairs
  - Margo Maine, PhD, FAED, CEDS & Michael Strober, PhD
- SA 9 Challenges and Rewards of Working with Mid-Life and Longer-Term Eating Disorders
  - Johanna McShane, PhD, CEDS
- SA 10 Using Interactive Expressive Arts Therapy Techniques for Treating Binge Eating Disorder
  - Deah Schwartz, EdD, MS, MA, CTRS
- SA 11 Walking the Talk: Relational Practices to Strengthen Effective Interdisciplinary Treatment Team Functioning
  - Mary Tantillo, PhD, PMHCNC-BC, FAED* Karen Samuels, PhD
- SA 12 The Therapeutic Relationship in a Wired World
  - Kristine Vazzano, PhD & Bethany Helfman, PsyD

Sunday, November 16, 2014

- SU 1 Multicultural Perspectives—Why Should I Care?
  - Gayle Brooks, PhD, Hue-Sun Ahn, PhD & Rosie Molinary, MFA
- SU 2 Feasting and Fasting in the Jewish Community
  - Marjorie Feinson, PhD, Sarah Bateman, LCSW & Alissa Baum, PsyD
- SU 3 Complexities of Culture: Discerning What is Helpful and What is Harmful from the Perspective of Interpersonal Neurobiology
  - Kim Grynick, LPC
- SU 4 Embracing the Body: Movement Strategies for Treating Binge Eating Disorder Using Health at Every Size Tenets
  - Keli Laverty, LPC, R-DMT & Jennifer Finger, MSW, LCSW
- SU 5 CBT and Psychodynamic Treatment: Can We Put Down Our Swords?
  - Roger K. McFillin, PsyD, ABPP & Judith Brisman, PhD
The 24th Annual Renfrew Center Foundation Conference
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Presented by: Connie Quinn, DSW, LCSW-R

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The Invisible Women: Eating Disorders and Midlife
Presented by: Genevieve Roanhouse, MSW, LGSW & Carolyn Karoll, LCSW-C

April
Treating Complex Cases: A Collaboration Between Outpatient Clinicians and Higher
Presented by: Pam Brodie, Ph.D., LPC

May
The Power of Creativity in the Treatment of Eating Disorders: A Conversation
Presented by: Susan Kleinman, MA, BC-DMT, NCC, CEDS & Rebecca Berman, LCSW-C, MLSP

June
The Slippery Slope of Eating Disorders
Presented by: Lori Ciotti, LICSW

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