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Perspectives

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The 22nd Annual Conference Update & CALL FOR PROPOSALS for 2013 are included in this issue.

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CONTRIBUTORS

A Word from the Editor

Our Winter 2013 issue highlights the complexity clinicians face in providing high quality care to their patients with eating disorders. We've seen a resurgence of interest in the role of relationships in eating disorders over the past couple of years as we struggle to integrate biology, nutritional, neurological and relational models. All five articles in this issue will provide you with some provocative ideas about how you can enhance this integration in your own work.

Doug Bunnell, Ph.D., FAED, CEDS
editor

Acceptance-based Separated Family Treatment for Adolescent Anorexia Nervosa

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Anorexia nervosa (AN) is the deadliest of all psychiatric conditions, yet treatments for AN have lagged behind those for other psychiatric illness. Over the last 30 years, Family-Based Treatment (FBT) developed at the Maudsley Hospital in London by Eisler and colleagues (Eisler, et al., 2000), and later elaborated and manualized by Lock and Le Grange (2013), has received the most empirical support.

This approach has revolutionized the treatment of AN – changing the role of the family from a position of ostracism and exclusion to integration as the central part of the treatment team (Loeb, Lock, Greif, & Le Grange, 2012). As with all treatments, FBT does not work for all families all the time. In a recent randomized clinical trial, 42 percent of adolescents met criteria for full remission at treatment end and 49 percent met criteria for full remission 12 months post treatment (Lock, et al., 2010). Despite the large gains made in the treatment of adolescents with anorexia, more work is needed– particularly in developing tailored strategies designed for those for whom FBT might be less effective.

Over the course of the last decade there has been an increasing focus on the integration of acceptance and mindfulness-based approaches with cognitive behavior therapy in the treatment of psychopathology (Herbert & Forman, 2011), including eating disorders (Berman, Boutelle, & Crow, 2009; Juarascio et al., 2012; Wildes & Marcus, 2010). Although the evidence for the effectiveness of these approaches for AN is only emerging, the data that does exist indicates that acceptance-based approaches can be

potentially powerful treatments for eating disorders. In this article we will describe a novel acceptance-based approach to treating adolescents with anorexia within a family context. Using the broad clinical framework of Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl, & Wilson, 2011) and incorporating documented moderators of treatment outcome, the program incorporates key components of FBT and integrates them with skills to address parents' distressing emotions. The result is an acceptance-based treatment for families of an adolescent with AN known as Acceptance-Based Separated Family Treatment (ASFT) (Merwin, Zucker, & Timko, in press; Timko, Merwin, & Zucker, 2010). ASFT retains the non-parent blaming stance of FBT while also focusing treatment directly on factors believed to maintain the disorder. ASFT is designed to target the function of anorexic symptoms and to increase flexibility and adaptability in adolescents with AN and their parents.

ASFT is grounded in ACT, which has emerged as one of the most scientifically supported of the new acceptance-based models of CBT (Forman, Juarascio, Martin, & Herbert, 2012). From the perspective of ACT, psychopathology – and indeed broader problems of living – are conceptualized as resulting largely from emotional and experiential avoidance (Hayes, Luoma, Bond, Masuda, & Lillis, 2006), that is, rigidly engaging in behaviors aimed at avoiding or dampening distressing or unpleasant thoughts, feelings, or sensations. When avoidance becomes the predominant focus and purpose of behavior, and when failure to achieve such avoidance is feared, then two maladaptive consequences may occur. First, individuals can rigidly engage in behaviors that temporarily work to suppress or avoid distressing internal experience. Second, they lose sight of broader and more meaningful values and goals that could guide their behavior. From this perspective, the behaviors associated with AN can be interpreted as attempts to avoid distressing internal experiences, while the phenomenology of AN can be construed as behavior organized around a narrow and rigid goal: control over weight and shape. In this sense, AN can be considered a disorder of psychological inflexibility.

Avoidance and Anorexia

Individuals with AN are less likely to approach rewards and are highly sensitive to punishment (Harrison, O'Brien, Lopez, & Treasure, 2010), a behavioral pattern consistent with the temperamental trait of harm avoidance. Harm avoidance is high in individuals with AN and is characterized by a preference for routines, avoidance of threatening or risky situations, and generally inhibited or cautious behavior (Klump, et al., 2004). Individuals with high levels of harm avoidance typically worry, have high levels of uncertainty, and struggle socially (Mulder & Joyce, 1997). Individuals with AN also tend to be experientially avoidant, that is they attempt to avoid or control thoughts, feelings, sensations, or other subjective experiences that are perceived as threatening or ambiguous. The combination of behavioral and experiential avoidance not only has the paradoxical effect of increasing subjective distress over time, but also inhibits learning that the avoided event is not dangerous. Avoidance then interferes with reaching personal goals and fully engaging in life.

The impact of avoidance on individuals with AN is magnified by the cognitive and behavioral rigidity often observed in those with other eating disorders. Cognitive rigidity refers to difficulties in switching gears and behavioral rigidity refers to preservative behavior and rigidly following rules. In order to avoid threatening or ambiguous situations or emotional experiences, individuals with AN rely on rules (which are often implicit) to structure their world and to minimize uncertainty. Rules provide a sense of control and certainty and are most easily developed and enforced in an area perceived to be readily controllable, namely diet and exercise. This focus on the body and food serves to focus attention on an area believed to be amenable to control, provides clear rules for behavior, and aids individuals in avoiding aspects of experience perceived to be unpleasant, frightening, or new (Merwin, et al., 2011). In the short-term, the relief experienced by following rules is highly reinforcing; however, in the long-term restriction, results in obvious medical consequences and has negative impacts on interpersonal relationships, quality of life, and the adolescent's ability to experience new things. In this way, the behaviors associated with AN can be viewed as functioning as coping mechanisms for subjective distress. For individuals who struggle with being psychologically flexible, changing behaviors or learning new ways to cope with distress is particularly difficult. Modifying rigid rules and learning to change ineffective but familiar behavior patterns requires both cognitive and behavioral flexibility. Moreover, the process of attempting to learn new methods of coping or changing rules may itself be quite distressing.

Avoidance in Parents

When treating adolescents with AN in a family-based context, it is important to consider how parents may also be avoiding or attempting to control negative thoughts, feelings, or urges. Having a critically ill child is extraordinarily stressful and many parents experience high levels of distress (Zabala, McDonald, & Treasure, 2009). High levels of caregiver burden are associated with more avoidant coping styles that function to reduce distress in the short-term, but in the long run only increase the burden (Scazufca & Kuipers, 1999). Examples of this pattern can clearly be seen in the case of symptom accommodation. Typically discussed in the context of pediatric obsessive-compulsive disorder (OCD), symptom accommodation refers to action taken by the family members to reduce the adolescent's immediate distress, including such things as facilitating rituals and re-assuring the child. In the case of OCD, accommodation can reinforce symptoms and inhibit the learning that would occur during exposure and ritual prevention (Peris, et al., 2008). In this way, familial accommodation of OCD behaviors maintains the dysfunctional pattern and can impede treatment. Accommodation is more likely to happen when parents have high levels of anxiety or depression. Anxious parents may accommodate their child's symptoms because they do not want him or her to be unduly distressed, because they struggle with managing escalating situations, or because of their own difficulties managing anxiety (Caporino, et al., 2012). Symptom accommodation can also occur in the context of AN (Loeb, et al., 2012). For example, in an attempt to reduce the

child's anxiety and prevent high conflict around meal time, parents may attempt to avoid conflict by not challenging food rituals, by reducing portion sizes, and so on. This type of symptom accommodation is functionally a type of avoidant coping in that it results in a short-term decrease in both the child's and the parent's own distress, thereby negatively reinforcing the avoidance behavior.

Acceptance-based Separated Family Treatment

ASFT is a 20 session treatment program delivered over 24 weeks. Sessions are 90 minutes in length, split evenly between the adolescent and his or her parents. In the first 16 sessions , the adolescent and parents are seen separately. The last four are conjoint sessions and occur every-other week. The treatment is divided into four modules, as described below. These modules must be delivered in the prescribed order, but are flexible in length. ASFT combines elements of FBT and a parental skills training program, known as *Off the C.U.F.F.* (OTC; Zucker, 2008), in the context of the ACT framework. The goal of ASFT is to reduce behavioral and psychological avoidance in both parents and adolescents, to increase their awareness and acceptance of distressing thoughts and feelings, and to develop and realize goals associated with larger life values outside the domain of weight and eating.

Module 1: Setting the Stage for Treatment. In this module (typically 1-3 sessions), parents and the adolescent are oriented to treatment. We prepare the family for the hard work that the program will demand, emphasizing the importance of developing the willingness to experience discomfort that will occur while the parents are working to re-nourish the adolescent and the while the adolescent is doing the hard work necessary for recovery. This includes predicting some of the difficult thoughts and feelings that will likely occur for the family during the course of treatment and providing psycho-education about the actual physical discomfort that will occur when re-nourishment begins. During Module 1, the adolescent is provided with a workbook that contains homework sheets and sections for practicing skills. During this time the therapist acknowledges that the adolescent is "more than her disorder," and asks her to begin sharing more about herself.

Parents are given a copy of the OTC workbook, modified for ASFT. OTC emphasizes the power of parents as healthy role models for their child by attending to their own physical and emotional needs. It addresses family meals, perfectionism, emotional awareness, and other features needed either to acutely manage the symptoms of AN or to address long-standing features reported to increase risk for symptom relapse (Zucker, et al., 2011). The OTC workbook provides psychoeducation about eating disorders, information about authoritative parenting, behavioral management principles and approach-based coping, and stresses modeling of healthy coping by the parents. Parents use the workbook throughout treatment to identify difficult thoughts and feelings they may experience when attempting to implement strategies to help their child, either directly or via modeling changes in their own behavior. During the early stage of treatment (usually Module 1 and Module 2), parents are responsible for the renourishment process and, as in FBT, take control over the adolescent's eating. This control is gradually returned to developmentally appropriate levels for the adolescent during Module 3.

Module 2: Functional Assessment of Behavior. In this Module (typically 3-5 sessions), the therapist conducts a functional analysis of the adolescent's symptoms, both currently and historically. During this process, the therapist acknowledges the "gifts" of the eating disorder – how the eating disorder has been helpful in the past and present to help the adolescent cope with unpleasant thoughts, feelings, or sensations. Through this process, the adolescent begins to see the ways in which the eating disorder has interfered in her life and increased her suffering. This functional analysis is then broadened to include any other avoidant (non-eating disordered) behaviors. For parents, the functional analysis focuses on over- or under-responding to the adolescent's eating disorder behavior. The functional analysis with parents is also broadened to include other challenges that may be interfering with their ability to model appropriate and adaptive coping mechanisms. Often the analysis will focus on ways to improve the parent's ability to engage in their own self-care and to increase vitality and engagement in other areas of their lives (e.g., the marital relationship or friendships). Module 2 ends with a comprehensive case conceptualization that drives the rest of treatment. During Module 2, the ground work for the subsequent work on engagement in Module 3 is laid by facilitating the adolescent and parents' identification of their values (e.g., interacting with friends, their child's health) in order to motivate treatment.

Module 3: Open, Centered, Engaged. Module 3 (typically 8-12 sessions) is the heart of the treatment and where one most readily observes the features of ACT. Parents learn to support healthy behaviors, in both themselves and their child, even when feeling guilty, scared, anxious, and emotionally aroused. Adolescents learn to behave in new, more flexible, ways even if they are experiencing difficult thoughts, feelings, or sensations.

"Open" refers to metaphors and experiential exercises used to facilitate acceptance and defusion in the adolescent and her parents. Acceptance refers to an individual's willingness to experience thoughts, feelings, and sensations nonjudgmentally, without attempting to control or otherwise change them. Defusion refers to achieving psychological distance from one's subjective experience. In the case of distressing thoughts, it refers to the ability to notice the thought without believing that it is literally true or untrue. For example, the thought "I am fat" may be taken literally by an adolescent with anorexia such that their concept of self is equated with being fat. This belief then supports the creation and following of rigid rules surrounding eating behavior. In defusion, the adolescent learns to disentangle herself from distressing thoughts (or feelings and sensations); in the process of doing this, the literality of the thoughts is weakened. Thus, increased defusion can increase willingness to experience and accept distressing experiences in the service of behavior change. Parents learn the same skills by stepping back from painful thoughts and feelings, such as guilt or anxiety.

"Centered" refers to present-moment awareness and the "observer self." Present-moment awareness refers to nonjudgmental awareness of both

internal experiences and the outside environment. This essentially means being aware of the present rather than excessively focusing on either the past or the future. Present-moment awareness facilitates recognition of thoughts and feelings that occur within a person and reinforces the notion that these thoughts and feelings do not have to define the person. Such awareness facilitates development of a strong sense of self as a stable perspective from which all events are observed, in contrast to a sense of self defined by specific cognitive content. This observer-self allows an individual to be less invested in having or avoiding certain experiences and facilitates the family's detachment from particular narratives about the development of the eating disorder, how the family "should" be, and so on.

"Engaged" processes are characterized by clear values and goals, and committed action that is in line with those values and goals. Values are important areas of life that provide a sense of vitality and purpose (e.g., being a good parent, being a good friend). Values help to motivate treatment as they provide a guidepost for behavioral choices. As broad life directions, values are not directly obtainable, yet behavior in-line with values is likely to persist over time and result in more life satisfaction (Hayes, Levin, Plumb-Vilardaga, Villatte, & Pistorello, 2011). Clarification of one's values promotes greater willingness to engage in behavior that is in line with values even in the face of unpleasant internal experiences. Thus, committed action is concrete behavioral change in line with values. For parents, promoting their child's health is usually a central motivating value early in treatment. Focusing on the health of their child can help parents make difficult decisions such as keeping the adolescent home from school temporarily even though she enjoys it and is still doing well in school. In ASFT, eating is considered a value-guided action as the body needs enough energy and nourishment to engage in behaviors that are important to the adolescent's functioning. Throughout treatment, the adolescent's values are emphasized as a guiding force for treatment and relapse prevention. The self-care promoted from the beginning of treatment is also construed as a value-guided action. Thus, work with Engaged processes builds on foundations laid early in treatment with both the parents and adolescent.

Interaction of Processes and Psychological Flexibility.

Although we describe Module 3 as having three separate foci, in practice these are highly integrated processes. ACT is an ideographic and dynamic treatment and this is true in the context of ASFT as well. Early in treatment, the family will need to develop skills associated with observing experience, identifying values, and responding to their experience as opposed to responding to their evaluations of their experience. Treatment uses metaphors, experiential exercises, and graduated exposure to distressing experiences to practice increasing contact with avoided events and to decrease the literality of language. As treatment progresses, the interwoven nature of these processes becomes more evident. One process (e.g., values) can be used to leverage change in another (e.g., enhancing acceptance), and vice versa. The end goal is psychological flexibility – or the ability to step back from and observe thoughts, feelings, and sensations, and to let one's values guide behavior choices. Within the context of ASFT, the end goal is to help the adolescent to get back on track developmentally, to help her be more aware of and accepting of her own emotional experience, to be less governed by rules, and to make decisions about her behavior that will continue to move her towards her chosen goals and values. Parents become more skilled at engaging in effective parenting (even while distressed), and are able to model flexibility and healthy coping. Both parents and adolescents learn the function of the eating disorder to plan for relapse prevention.

Module 4: Conjoint Sessions. In the last four sessions, the family comes together to focus on communication and relapse prevention. Often, by this point in treatment, parents are learning to differentiate between "normal" adolescent behavior and eating disorder behavior. Parents continue to model healthy coping and communication during this time. Any difficulties that arise in the two weeks between sessions are discussed and the therapist assists in problem solving around various issues as needed.

CONCLUSION

ASFT is a promising option for families with an adolescent with AN. Preliminary data indicate that a significant portion of adolescents reach partial or full remission by the end of treatment (Timko, Zucker, Herbert, Rodriguez, & Merwin, 2012). Furthermore, caregiver distress is significantly reduced over the course of treatment. Anecdotally, families report a high degree of satisfaction with the treatment. Research on ASFT is currently underway to refine the treatment and to evaluate it further.

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Therapeutic Ruptures: What Relational Theory can Teach us about Repair and Resolution

Dana A Satir, Ph.D.

"It is the repair of relationship ruptures that leads to transmuting internalizations and personality growth." –H. Kohut (1984)

Contemporary relational theory provides a conceptual framework for therapeutic ruptures in the treatment alliance and informs how careful focus on rupture repair may improve treatment retention. The article will focus on clients with anorexia nervosa (AN), a group with particularly low treatment retention rates. After a brief review of treatment research in this population, I will summarize the research on the treatment alliance, both generally and in eating disorders (EDs) specifically. I will focus briefly on some of my research on rupture resolution in the treatment of clients with AN, and illustrate in-depth clinical process with some case material.

Treatment Research in Anorexia Nervosa

The stakes for identifying effective treatments for adults with AN are high, as AN has the highest mortality of any psychiatric illness with estimates of upwards of 15 percent (Herzog et al., 2000). However, currently no treatments have been established as 'efficacious' for the treatment of adults with AN. This is not for lack of effort or creativity. A recent review of fifty-seven psychological treatment studies for AN (twenty-three of which were randomized controlled trials) reported that there was currently no evidence that one specialized treatment was superior to another for treating adults with this illness (Hartmann, Weber, Herpertz, & Zeeck, 2011).

One of the greatest challenges for clinicians and researchers working with clients with AN is the high patient drop-out rate from treatment. It is estimated that on average between one-third and one-half of patients with AN drop-out of treatment trials (Agras et al., 2004). These high patient drop-out rates often preclude adequate analyses of potential treatment effects.[1] Prominent ED researchers have suggested that large randomized controlled trials should not be conducted until the problem of drop-out is adequately addressed (Halmi et al., 2005).

The experience of patient drop-out is also likely to produce feelings of frustration, and potentially inadequacy and incompetence among therapists. These emotional reactions may further interfere with the treatment process and increase therapist burnout. A recent review of multiple studies of clinician reactions to patients with EDs suggests that clinicians commonly experience negative reactions to patients with EDs, particularly when the patient is not improving (Thompson-Brenner, Satir, Franko, & Herzog, 2012).

Explaining Patient Drop-Out

So, what is behind this patient drop-out problem and what can we do to improve it? A comprehensive review indicated that premature drop-out from outpatient treatment was associated with several interrelated factors including maturity fears, harm avoidance, and borderline traits (Fassino, Pierò, Tomba, & Abbate-Daga, 2009). Several clinical researchers (e.g., Halmi et al., 2005; Strober, 2004; Vitousek, Watson, & Wilson, 1998) have suggested that the development of a *collaborative treatment alliance* is the key challenge to working with this patient population. They attribute failures in the formation and maintenance of treatment alliances as the leading reason for high patient drop-out. This is supported in the general psychotherapy treatment literature where higher quality treatment alliances are consistently associated with better outcomes (e.g., Horvath & Luborksy, 1993; Zuroff & Blatt, 2002) and poor treatment alliances are correlated with unilateral terminations (Samstag et al., 1998; Tryon & Kane, 1990, 1993).

Treatment Alliance

The treatment alliance is considered to be an essential aspect of successful psychotherapy and is the most intensely researched subject in psychotherapy (Horvath & Greenberg, 1989; Norcross & Wampold, 2011). According to the definition proposed by Bordin (1979), an alliance develops between a patient who wishes to change and a therapist who helps facilitate that change. This general definition violates the basic assumptions of the clinical experiences of working with clients with AN, who frequently do not want to change. Bordin further defined the alliance as consisting of three components: (1) agreement regarding the *goals* for change; (2) mutual understanding of the *tasks* needed to reach these goals; and (3) establishment of the *bonds* to maintain the work together. Patients with AN and their therapists are likely to have divergent goals (e.g., weight regain) which can cause conflict in the treatment relationship and compromise the alliance if left unresolved.

There are only two published studies of the effect of the alliance in the treatment of adults with AN. One study included a mixed sample of ED outpatients (with a small subsample diagnosed with AN) receiving a course of Cognitive Behavioral Therapy (CBT). Participants overall reported high ratings of the treatment alliance, however the authors did not observe a relationship between the strength of the alliance and early behavioral change in ED symptoms (Waller, Evans, & Stringer,

1 No naturalistic data are available on AN patient drop-out in community samples.

2012). This study only focused on the first six sessions of treatment and did not trace the course of the alliance and its development.

A second study, which is described in greater detail below, focused on the longer term effects of the development of the treatment alliance in a sample of seven women with full and subthreshold AN (Satir et. al, 2011; Satir et al., unpublished manuscript;). This study emphasized the quality of the therapeutic alliance by using a modified version of a treatment focused on repairing alliance ruptures called Brief Relational Therapy (BRT) (Muran, Safran, Samstag, & Winston, 2005; Safran & Muran, 2000). Alliance ratings were overall high across participants and there was a significant direct effect of the treatment alliance on outcome (overall kilocalorie intake). Furthermore, over time the relationship between alliance and kilocalorie intake increased.

Brief Relational Therapy

Brief Relational Therapy (BRT) is a psychodynamically oriented psychotherapy that has its roots in contemporary relational theory. The fundamental premise of relational theory and one way it differs from other schools of psychoanalysis is its emphasis on the concept of a two-person psychology (Greenberg & Mitchell, 1983). The therapist is considered a co-participant in the therapy relationship and can never be an impartial observer. One of the implications of this theory on the therapeutic alliance is that clinician countertransference is directly used as part of the treatment because it invites the therapist to consider his/her own contributions to patient interactions (Muran et al., 2005; Safran & Muran, 2000). BRT has been used to improve the likelihood that patients who are at risk for treatment dropout or poor outcome will complete treatment by repairing strained treatment alliances. Empirical studies of BRT have found preliminary evidence for its relative efficacy in comparison to short-term dynamic psychotherapy (STDP) and CBT in patients with Cluster C personality disorders (Muran et al., 2005) which are highly co-morbid with AN. Importantly, BRT was superior to both treatments in dropout status. (Muran et al., 2005).

One of the key features of BRT is the process of alliance rupture resolution (Safran & Muran, 2005). Ruptures are defined as deteriorations in the relationship between therapists and patients (Safran & Muran, 2000) and there are two types (withdrawal and confrontation), both of which are understood as avoidance processes. Each rupture begins with a specific marker (Rice & Greenberg, 1984), usually a patient statement or action. Withdrawal ruptures are characterized by patient denial or patient acquiescence. A therapist might find him/herself reacting to this rupture by working harder than the patient to give advice or noticing that his/her attention is drifting (Safran & Muran, 2000). Confrontation ruptures are usually more obvious. In these ruptures therapists experience themselves as objects of patients' intense aggression which may inspire therapists' anger and defensiveness (Safran & Muran, 2000).

There is a five stage rupture resolution (Safran & Muran, 2005) process which starts with the therapist attending to his/her countertransference reactions and being aware of the feelings being avoided by the patient (Stage 1: Rupture Marker). Next the therapist disembeds from the enactment and negative interpersonal process by mindfully acknowledging his/her contributions to the interaction (Stage 2: Disembedding). This is often done by being explicit with the patient (e.g., 'I feel in this moment that anything I say will be experienced as invalidating to you.'). The therapist facilitates the exploration of the patient's experiences and creates space for emotions as acceptable and valid in the context of their relationship. In this stage, the patient may begin to express negative feelings but may qualify them or minimize them (Stage 3: Exploration or Qualified Assertion). This is observed by patient's efforts to disavow or avoid his/her underlying feelings (e.g., 'I might be angry if I knew you were not trying to help me.'). It is helpful for the therapist to explore the patient's fears of being more direct with the therapist in these moments (e.g., 'What are you afraid might happen if you tell me you are angry with me?') to help them overcome avoidance (Stage 4: Avoidance). Ultimately, the therapist works to facilitate the patient's self-disclosure of vulnerability or underlying wishes which were avoided when the initial rupture event occurred (Stage 5: Vulnerability).

Brief Relational Therapy and Anorexia Nervosa Study

Our investigation of a modified version of BRT was an effort at identifying the potential relationships between the treatment alliance, kilocalorie intake, and the rupture/repair process. The methodology of this investigation is more fully described in a published case study (Satir et al., 2011). The Working Alliance Inventory (Horvath & Greenberg, 1989), the most frequently used measure of the treatment alliance based on Bordin's definition, was used to assess overall alliance and its three dimensions. To assess the occurrence of ruptures and their resolution, the Post Session Questionnaire developed by Safran and Muran's group to identify ruptures and their resolution was used (Samstag et al., 1998). Kilocalorie intake was measured by participant self-report using daily food monitoring records. These data were later entered into a nutritional software database for analyses (ESHA Research Inc, 2010).

Summary of Main Findings

Alliance ratings were overall high across all seven participants and there was one drop-out due to extraordinary life circumstances (death of a participant's parent) that required temporary geographical relocation. Though it was a small sample, the retention rate was high. Analyses indicated that the global alliance had a significant direct effect on kilocalorie intake. Furthermore, the interaction between global alliance and time (as measured by session number) also showed an independent significant relationship to treatment outcome. This suggests that as time went on, the relationship between the global alliance and kilocalorie intake increased (Satir et al., unpublished manuscript).

When we assessed the relationship between kilocalorie intake and dimensions of the alliance (agreement on goals, tasks, and bond) separately, no significant relationships were found in the bond or goal dimensions. However, analyses of the task subscale suggested a significant direct effect on kilocalorie intake. The interaction between the task alliance and time also showed an independent significant relationship with outcome. In other words, as treatment progressed the participant and therapist agreement on the tasks of therapy became a stronger predictor of symptom change or kilocalorie intake.

No significant results were found when we investigated whether the presence of a rupture in a session affected the global alliance (controlling for time). A brief review of the open-ended responses on the Post-Session Questionnaire suggested that, across BRT sessions, the reported cause of session tension in nearly 30 percent of the cases was some form of emotional distancing/avoidance or fear of disappointing the therapist. When asked to respond to what was most 'helpful' in resolving ruptures during sessions, participants reported that some form of acknowledgment and discussion was the most reparative factor in over 30 percent of these episodes.

Rupture Repair Process

I want to share a session transcript that illustrates the rupture/repair process and how working with countertransference can help patients overcome experiential avoidance. This example comes from session nineteen of a twenty-four session therapy with a patient I called Ms. O (Satir et al., 2011). At this point in treatment the patient had fully weight restored and had sustained a two week period of no binge-eating and purging behaviors until the week prior to this session. There had been numerous prior ruptures in treatment; however, this was the first confrontation rupture that I was aware of as her therapist. Leading up to this session, Ms. O had been more constricted and withdrawn. In the moments before the interaction described below, Ms. O displayed an almost icy silence and made clipped, seemingly irritated responses when answering my questions (Stage 1: Rupture Marker). We had worked hard to accomplish the behavioral goals of weight restoration and abstinence from binge/purge behaviors but it seemed she was projecting her anger at me for 'helping' reduce these symptoms and/or was frustrated she had recently lapsed.

T: I'm gonna ask a question that may feel kind of strange so I feel cautious about raising it (Stage 2: Disembbeding). Does it feel like you deserve to get better?

P: Yeah I do. I don't want to live the rest of my life like this.

T: It's not a way to live…What's going on? It feels like there's more that's not getting said (Stage 3: Exploration).

P: I just feel very stuck.

T: Have you felt this way before?

P: I've had the feeling of being stuck before. But I've never felt this way about my ED. Up to this point I haven't wanted to recover so I always had the option of going back. I don't want to do that now. That doesn't seem like a good option.

T: Are you aware of what you experience when you say it's not an option? (Stage 3: Exploration).

P: I feel a little sad about it. In a way it makes me a little angry – this whole time this is where everyone is trying to get me to but now that I'm here, what the hell am I supposed to do? I'm not restricting, I'm at a normal weight, I haven't been purging and but [stuff] for me still kinda sucks (Stage 4: Avoidance).

T: And beyond that you don't want to go back so you've lost that option. It does suck that you've worked hard, made changes, and there feels like there's been a false promise or hope, like a pot of gold at the end of the rainbow. But now you're there and it's not like you've made a step forward.

P: It doesn't feel like a step forward at all. But I kind of had this perception before. Like everything would be great when I lost the weight and I held the opposite idea that everything would be better when I regained the weight.

T: So these fantasies may have been motivating. I wonder if you feel the anger you described in here. Or if you don't, if you could.

P: Yeah, I feel it here (Stage 5: Vulnerability). In relation to my previous treaters everyone said 'things would be better when you got over my ED.'

T: So maybe it feels like 'thanks for nothing.' That's kind of what it sounds like.

P: It's frustrating because now that I'm healthier I've lost my ability to get people to listen to me in a lot of ways. At least with my ED I had a voice because people were worried about me.

Ms. O goes on to discuss other frustrations outside of the current and past treatment relationships (Stage 5: Vulnerability). As her therapist, I was mindful of her avoidance at saying she was angry at me and re-directed her to what I believed she was feeling towards me but she continued to struggle to express it more directly.

Discussion and Implications

How is this all relevant to day-to-day clinical practice? Our investigation found for the first time in a sample of adults with AN in outpatient treatment, that the global alliance was significantly associated with kilocalorie intake (Satir et al., unpublished manuscript). This emphasizes the importance of actively working on the alliance in the treatment of clients with AN in an effort to promote ED symptom improvement. Furthermore, the Task dimension of the alliance was significantly associated with kilocalorie intake and interacted with time. The Task subscale assesses the degree to which the participant and therapist agree about what work needs to be done, as opposed to the goals (where they will get to) or the bond (how they feel about each other). Though this is a unique finding in the field of AN outpatient treatment, the findings are consonant with those from a recent study of CBT in depression (Webb et al., 2011). This suggests that at the onset of therapy the tasks of treatment should be enumerated clearly and collaborated upon.

Where do we go from here? Hopefully, this article may help you start to notice ruptures and provide a framework for moving through the

stages of resolution. As a community of professionals, we need to be actively teaching clinicians how to effectively explore patients' previously denied or minimized affective experiences and be mindful, as therapists, of the ways that these experiences may be enacted or manifested in the therapy relationship. Consistent with the literature on emotional avoidance and AN (Schmidt & Treasure, 2006; Steinglass et al., 2011), affect intolerance represents a specific area of treatment that may be more effectively explored in an interpersonal context which the alliance presents.

Brief Relational Therapy also offers opportunities to prevent patient drop-out by addressing conflicts and ruptures in the treatment relationship. While some researchers have questioned the potential of therapies that require a certain degree of cognitive functioning given the impairments associated with low-weight (Zakzanis, Campbell, & Polsinelli, 2010), this has not been adequately investigated. While the pressure is high to help stabilize patients who may have numerous secondary complications to weight loss, it does not preclude the development of a collaborative relationship. Our emphasis on behavior change is vital, but it cannot come at the expense of working on resolving ruptures and our patients' experiences of empathic failures.

The study described above is one of the first investigations to carefully examine the working alliance in the outpatient treatment of adults with AN. We need more research on the role of the treatment alliance and its relationship to symptom change over the course of treatment in outpatient therapy and at different levels of care (inpatient/residential treatment). Whether you believe that the alliance is curative in and of itself, it warrants consideration as a necessary ingredient in reducing ED symptoms and in addressing the challenge of premature treatment drop-out.

As treaters we need to not only acknowledge our successes but where we may be failing our patients in our willingness to explore our own countertransference and its impact on the co-created treatment relationship. Anorexia nervosa deserves our humility and respect as a serious mental disease. If we do not account for how we contribute directly and indirectly to our patients' experience of therapy, we are missing an important area of self-reflection and an opportunity to create different experiences for our very ill patients.

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Dietary Energy Density and Diet Variety in the Nutritional Management of Patients with Anorexia Nervosa

Janet Schebendach, Ph.D.

Anorexia Nervosa (AN) is a serious psychiatric illness characterized by a persistent disturbance of eating behavior and determined weight loss (Fairburn & Harrison, 2003). Specialized treatment programs are largely successful in restoration of body weight; however, recidivism is common, and the rate of relapse is estimated to be as high as 50 percent (Pike, 1998). By-and-large, treatment programs and clinicians generally recommend sensible strategies for nutrition management, like adequate energy intake and balanced macronutrient content of the diet. And while there is little doubt that a healthy diet is central to the weight restoration process, the relation between diet and treatment outcome has been minimally investigated in this population.

Characteristics of Diet and Food Choice in Patients with Anorexia Nervosa

While restricted energy intake is characteristic of this disorder, macronutrient content of the diet may vary. Indeed, the early literature often described AN patients as carbohydrate "phobic" (Crisp, 1965; Hurst, Lacey, & Crisp, 1977; Russell, 1967) but recent studies suggest that patients preferentially restrict their intake of dietary fat (Affenito, Dohm, Crawford, Daniels, & Striegel-Moore, 2002; Fernstrom, Weltzin, Neuberger, Srinivasagam, & Kaye, 1994; Hadigan et al., 2000).

Hadigan et al. (2000) and Fernstom et al. (1994) monitored 24-hour food intake in low weight patients. Compared to normal controls, patients consumed far fewer calories and less energy from dietary fat. Similarly, Gwirtsman, Kaye, Curtis, and Lyter (1989) found that when low weight AN patients were permitted to self-select a weight-maintenance diet over a 19-day period, observed energy and fat intakes were significantly lower than that of controls.

In addition to restricted energy and macronutrient intakes, patients appear to eat a rather narrow repertoire of foods (Drewnowski, Pierce, & Halmi, 1988; Hadigan et al., 2000; Stoner, Fedoroff, Andersen, & Rolls, 1996; van der Ster Wallin et al.,1995;Vaz, Alcaina, & Guisado, 1998). Surprisingly few studies have examined food choice in AN. Of these, most have assessed attitudes towards foods, rather than food intake behavior, and have done so in low weight vs. weight-restored patients. Drewnowski and colleagues (1988) evaluated self-reported food preference in low-weight restricting-type AN patients. Reference foods, categorized into food groups, were ranked from the highest to lowest level of preference as follows: fruits and vegetables, starches, proteins and fats, desserts, and snacks. Patients predominantly disliked high-fat, high-calorie foods; preference for carbohydrate-rich foods was only slightly less than that of healthy controls. Using a questionnaire,Vaz et al. (1998) asked low-weight patients to rank, by order of preference, the foods they avoided during periods of food restriction and dieting. Foods ranked from highest to lowest levels of avoidance were fats and oils, sweets and cakes, cereals, milk and eggs, fresh meat, sauces, legumes, starchy roots, sausage-meat, dried fruit, fish, fruit, and alcoholic beverages. Stoner et al. (1996) used visual analogue scales to assess preference and desire for 50 common foods in hospitalized patients. Based on perceived energy content, high-calorie foods were rated as less preferred but more desirable after weight gain; however, preference and desirability of the low-calorie foods did not change during the course of hospitalization.

A varied diet containing adequate calories and fat is generally prescribed during inpatient weight restoration. Although the extent to which a healthy diet is maintained after discharge has been minimally investigated, the high relapse rate suggests that many patients quickly revert to patterns of restricted food intake. In a 10-year follow-up study of previously hospitalized patients, Eckert, Halmi, Marchi, Grove, & Crosby (1995) found abnormal eating behaviors during the month immediately prior to follow-up. These included eating low-calorie foods (71%), eating small meals (80%), and skipping meals (67%). Eckert et al. (1995) concluded that the high rate of relapse within one year of hospital discharge suggested the need for intensive interventions aimed at decreasing abnormal eating and weight control behaviors.

Change in Eating Behavior During Weight Restoration

The majority of AN patients successfully gain weight in a structured and supervised setting (Walsh, 2011); however, two recent studies examined the degree to which actual eating behaviors changed over the course of treatment. To assess changes in unsupervised eating behavior, Sysko, Walsh, Schebendach, & Wilson (2005) presented hospitalized patients and healthy controls with a large sealed opaque container of a novel strawberry yogurt shake; neither quantity nor caloric content were disclosed. Participants were instructed that the shake would replace their lunch meal for the day and they could drink as much shake as they liked. Patients were studied at the beginning and end of treatment; healthy controls were studied at similar time-points. In the first meal, low-weight patients consumed an average of 108 kcal. After weight-restoration, intake increased slightly but not significantly to 185 kcal. In contrast, healthy controls consumed significantly more at both time points, with an average intake of 509 kcal. It is noteworthy that scores on validated psychological measures of eating behaviors and attitudes improved significantly over the course of treatment but actual eating behavior did not.

Mayer, Schebendach, Bodell, Shingleton, & Walsh (2012) replicated and extended these findings using a standardized multi-item meal paradigm. Patients were again asked to consume the lunch meal, freely chosen from a multi-item buffet, at the beginning and end of inpatient treatment. In contrast to the findings of Sysko et al. (2005), average caloric intake increased significantly from the first meal (364 kcal) to the second meal (516 kcal); nevertheless, intake remained significantly reduced relative to that of healthy controls at the same time points (775 kcal and 758 kcal, respectively). Weight-restored patients also consumed substantially less energy at the multi-item meal (516 kcal) when compared to their prescribed lunch meal on the inpatient unit (900 kcal). With respect to dietary fat intake, the average percent of fat calories increased from approximately 20 percent (meal 1) to 25 percent (meal 2) but remained substantially below that of controls (40 percent fat).

Results of these eating behavior studies suggest that weight restoration may not resolve the core eating difficulties in AN. In a study of body composition, Mayer et al. (2005) collected food records that were completed by weight-restored inpatients prior to hospital discharge, and 3-, 6-, 9-, and 12 months after discharge. Upon analysis, it was observed that if the diet were to deteriorate, it did so early on, i.e., at the 3-month time point (unpublished data). This observation led the researchers to question if characteristics of the self-selected diets of weight-restored patients prior to hospital discharge predicted their outcome after discharge.

Schebendach and colleagues (2008) found that two variables particularly captured the characteristic eating behaviors of patients with AN: the dietary energy density score (DEDS; caloric intake divided by the total gram weight of all foods and beverages consumed) and the diet variety score (DVS; the cumulative number of "different/unique" energy-containing foods and beverages consumed, divided by the total number of food record days). Results indicated that the DEDS and DVS, which differed significantly between the outcome groups, were significant predictors of successful vs. failed outcome during the year following hospital discharge.

Dietary Energy Density

Energy density, as opposed to the macronutrient content of foods, is currently thought to be a key factor in the regulation of food intake (Drewnowski, 1998; Drewnowski, Almiron-Roig, Marmonier, & Lluch, 2004). Under ad libitum conditions,

people tend to consume a constant weight of food rather than a constant quantity of energy (Drewnowski, 1998; Yao & Roberts, 2001). Foods with lower energy density (i.e., fewer calories per unit of weight) deliver fewer calories per eating occasion than do energy dense foods.

Water accounts for the bulk of food weight; therefore, it contributes to energy density more than any macronutrient (Drewnowski, 1988; Drewnowski et al., 2004). Consequently, water weight accounts for most of the variance in energy density studies (Drewnowski, 1988; Drewnowski et al., 2004). The high water content of raw vegetables and fruits results in the low energy density of these food groups. In contrast, foods with little or no water content (e.g., dry cereals, dried fruit, crackers) are generally higher in energy density (Drewnowski, 1988; Drewnowski et al., 2004). All beverages are energy diluted because of their high water content; those that are sugar-free and fat-free have an energy density approximately equal to water (Drewnowski, 1988; Drewnowski et al., 2004). The energy density of foods is also strongly associated with their fat content (Drewnowski, 1988; Drewnowski et al., 2004). High fat foods (e.g., cheese, ice cream, cake), particularly those with minimal water content (e.g., potato chips, nuts, cookies), are high in energy density.

The relationship of energy density to energy regulation may, in part, be due to differing effects of energy density on satiety and palatability, which, in turn, have opposite effects on food intake. Energy density and satiety appear to be inversely linked. Foods with higher energy density are considered less satiating than foods with lower energy density, and vice versa. In contrast, foods that are high in energy density tend to be more palatable than foods that are low in energy density, and it has been demonstrated that high palatability is associated with increased food intake in single meal studies, and with increased energy intake at subsequent meals (Yao & Roberts, 2001). As a rule, energy-dense foods are palatable but not satiating, whereas foods with low energy density are more satiating but less palatable (Drewnowski, 1998).

Dietary Energy Density in Weight-Restored Patients with AN

Schebendach et al. (2008) observed that the dietary energy density score (DEDS) predicted treatment outcome in recently weight-restored patients: a higher score predicted success and a lower score predicted failure. Fat, fiber, and fluid content of the diet affect energy density. Not surprisingly, carbohydrate and protein consumption failed to predict the DEDS. Fat intake, however, was a significant positive predictor of the DEDS. While dietary fat avoidance is characteristic of low-weight patients, this study suggests that some recently weight-restored patients quickly revert to the selection of low fat foods. This behavior, in turn, reduces overall dietary energy density, setting the stage for potential relapse.

Non-caloric beverage intake was a significant negative predictor of the DEDS and it explained 54 percent of the variance in the score. Given this finding, should clinicians be concerned about non-caloric beverage consumption in recently weight-restored patients? If so, which beverages? In the initial study, Schebendach et al. (2008) consolidated all non-caloric beverages into one group, but in the follow-up study (Schebendach et al., 2011) intakes of specific types of non-caloric beverages (water, coffee/tea, and diet beverages) were quantified and compared between the treatment outcome groups. Upon analysis, a difference in total non-caloric fluid intake was observed between the groups, with the failure group drinking significantly more (1787 ml/day in total; 772 ml water, 701 ml coffee/tea, 314 ml diet beverages) and the success group drinking significantly less (1139 ml/day in total; 376 ml water, 618 ml coffee/tea, 145 ml diet beverages). The predominant non-caloric beverage consumed by the failure group was water, and their intake was more than double that of the success group.

So, what are the clinical implications of this finding? During the initial phase of weight-restoration treatment, specialized programs often promote the consumption of caloric beverages and limit access to non-caloric beverages. However, as treatment progresses, patients often have increased autonomy and decreased supervision of food choice and food intake. In the short run, it is possible that replacement of caloric beverages with non-caloric beverages may be offset by increased solid food intake, or decreased energy requirements during the weight maintenance phase of treatment. Nevertheless, this finding suggests that, in the long run, increased non-caloric beverage intake will decrease dietary energy density and increase the risk for relapse after discharge from inpatient treatment. Additionally, water appears to be the predominant non-caloric beverage choice among low weight patients, and recently weight-restored patients with a poor treatment outcome. A clinician would most likely notice and monitor the consumption of diet beverages in a recently weight-restored patient. However, water-drinking, which is generally regarded as a healthy behavior, may not raise the same "red flag" or be viewed as an equally high-risk behavior in this population.

Diet Variety

Diet variety occurs when a meal or diet contains foods that differ on at least one sensory quality (e.g., flavor, color, texture, shape). Introducing variety into a meal enhances food intake, with effect sizes ranging from 15 percent enhancement (when only the flavor and texture of the same food are altered) up to 40 percent (when several foods have been offered over successive meal courses) (Hetherington et al., 2006).

Mechanisms that influence the biological drive to maintain a varied diet include sensory-specific satiety, monotony, and habituation. Sensory-specific satiety is defined as the change in pleasantness of an eaten food relative to the pleasantness (i.e., hedonic value) of other uneaten foods during the same eating bout (Hetherington, Foster, Newman, Anderson, & Norton, 2006). As the hedonic value of a food decreases, ingestion of that food generally decreases. The hedonic value of foods with similar sensory properties (i.e., a similar taste or texture) also declines along with the eaten food, but to a lesser extent (Hetherington et al., 2006).

The change in hedonics appears to be related to exposure to the sensory qualities of food rather than the post-ingestive feedback of the food (Sclafani, 1991). A phenomenon related to sensory-specific satiety is monotony. This occurs when there is increased exposure to a food over time, resulting in a decreased hedonic rating and decreased intake of that food (Raynor & Wing, 2006). Lastly, a theoretical model relevant for understanding the role of varied sensory experiences is habituation (Hetherington & Rolls, 1996), a phenomenon in which repeated presentation of a stimulus results in a decreased response to that stimulus.

Research findings in animals and humans demonstrate that increased diet variety, particularly from energy-dense foods, leads to enhanced food intake and increased body weight and/or body fat (Raynor & Epstein, 2001). In contrast, limiting diet variety may have the opposite effect on food intake and body weight. Indeed, a sample of 2227 successful weight loss maintainers from the National Weight Control Registry reported the consumption of a diet with very limited variety in all food groups, but especially in foods with a higher fat density (Raynor, Jeffrey, Phelan, Hill, & Wing 2005).

Dietary Variety in Weight-Restored Patients with AN

Weight-restored patients with a successful treatment outcome consumed more diet variety, and those with a failed treatment outcome consumed less diet variety (Schebendach et al, 2008). But was diet variety "globally" restricted, or limited from select food groups? To answer this question, Schebendach, et al. (2011) manually coded the food choices from 4-day food records into 17 food groups. Two calculations were derived: the total number of food items selected, and the total number of unique/different food items selected. Upon analysis, the success and failure groups selected almost an identical number of total food choices over the 4-day period (73 vs. 74, respectively); however, the failed outcome group selected significantly fewer unique/different food items compared to the success group (43 vs. 51, respectively). Indeed, the failed outcome group selected a different food only 58 percent of the time, whereas the success group selected a different food 71 percent of the time. So, what food groups were most affected? The failed outcome group selected significantly less variety from five groups: starchy carbohydrates, added sugars, added fats, miscellaneous foods (e.g., pasta sauce, marinades), and caloric beverages. Not surprisingly, patients with a poor outcome selected less variety from highly palatable food groups, like added fats, added sugars, and added sauces/marinades. Surprisingly, less variety was also selected from the starchy carbohydrate group, a low fat food group that included potato, rice, pasta, corn, and legumes. Given the breadth of this food group, restriction in choice is likely to impact on adequacy of caloric intake over time.

CONCLUSION

Recent studies have shown that among a group of recently weight-restored women with AN, the selection of a diet characterized by low energy density and limited variety is associated with poor outcome (Schebendach et al., 2008; Schebendach et al., 2012). It is well established that patients with AN generally require high energy intakes to restore and maintain a healthy body weight (APA, 2006). To meet this high caloric requirement, patients will have to eat either smaller amounts of energy-dense foods or larger amounts of energy-dilute foods. Although the latter is possible within a structured, supervised setting, it may be more difficult to maintain this behavior after hospital discharge.

Treatment programs vary with respect to the amount of input that patients initially have over food choices; nevertheless, most provide for the transition to a self-selected diet at some point in the weight restoration process. It has been demonstrated that increased diet variety predicts better treatment outcome. This suggests that treatment programs must reinforce the need for a varied diet and monitor this behavior accordingly.

Weight loss is associated with risk for relapse in patients with AN. A large body of research in normal-weight, overweight, and obese individuals provides compelling evidence that the consumption of a diet characterized by low energy density and low diet variety results in decreased food intake, decreased energy intake, and weight loss. From a theoretical perspective, it makes sense that low energy density and low diet variety will impact similarly on patients with AN.

There are few evidence-based guidelines for the nutritional management of weight-restored patients with AN. Although patients with AN typically find the consumption of energy-dense foods to be emotionally challenging, study findings suggest that the intake of energy-dense foods and a greater variety of foods may be crucial to relapse prevention; therefore, the consumption of a varied diet that includes energy-dense foods must be continually reinforced and practiced throughout the course of inpatient and outpatient treatment.

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Self Psychological Understanding of the Etiology and the Therapy of Eating Disorders

Eytan Bachar, Ph.D.

INTRODUCTION

The following is a review of self psychological application to the treatment of eating disorders (ED). Being a psychodynamically oriented therapy, the treatment is directed not solely at the symptom but intended also to achieve underlying broader inner structural change.

The studies that we will review below show that one year of individual self psychological psychotherapy of ED achieved significantly better results both in alleviating overt symptomatology, as well as improving inner psychological structure (the cohesion of the self), in comparison to a specific kind of cognitive therapy (cognitive orientation treatment) and to a nutritional counseling only treatment.

In another study we showed that a central trait or a central stance of the ED patient or potential ED patient, "selflessness," was found in a community-based prospective longitudinal study of two and four years, to predict the development of ED. This later study, stressed the need to address this trait of the ED patient, in order to achieve a more comprehensive change. We will try to show that self-psychology with its specific therapeutic stance of the therapist and the unique conceptualization of interpersonal relationships (self-selfobject relationships), is particularly well suited to address this central trait.

We believe that treatment which can bring both symptom remission and address a basic personality morbid trait, and which enables the patient to express and share his/her inner world with another human being is worth undertaking. Such an experience is enriching and can be generalized to widen and deepen future interpersonal relationships. At the outset, it is important to also stress that, alongside the psychodynamic approach (in this paper, the self psychological one), we believe that treatment should include nutritional counseling which will follow the patient's eating behavior and will help the patient acquire healthy eating habits.

At the heart of the self psychological understanding of eating disorders, lies the observation that the adolescent who is liable to develop an ED, is characterized by self denial and self sacrifice for the needs of others.

Theoreticians and clinicians that wrote before the emergence of self psychology, also made that observation (mainly Minuchin, Rosman, & Baker, 1978 and Selvini-Palazzoli, 1978), but limited it to the family realm. Both Minuchin and Selvini-Palazzoli describe the adolescent's tendency to sacrifice her[1] own needs for the sake of the family needs. Selvini-Palazzoli showed retrospectively, in anecdotal case reports (what we will empirically show prospectively on a community based sample), that children who are liable to develop ED, feel guilt whenever they require something for themselves (Selvini-Palazzoli, 1978).

A Review of Self Psychology Theory

Self psychology, through the explanatory power of the interesting concept of selfobject and self-selfobject relationships, links these same observations to the patient's entire range of interpersonal relationships and to her basic view of the world. Through this conceptualization, self psychology gives us specific therapeutic tools to deal with this basic interpersonal dynamic.

The patient's tendency to relinquish her own interests and ignore her own needs in order to serve the interests and well-being of others, is apparent in many utterances of patients, or recovered patients: *"All of my life I lived for other people", writes one ex-patient, "not out of choice, but because I didn't know any other way. It wasn't until years later that I found out that I didn't actually have a self. I became what other people liked, thought, said and did: without respect for myself, going day by day trying to please other people so that I could be good enough."* (Claude-Pierre, 1997; p. 256). Another recovering patient quoted by Bachner-Melman (2012; p. 95) said: *"I was a pleaser from a very young age to my father, mother and other family members and friends, and this took away my freedom to make choices that were right for me….The happiness of others was primary in my life… I did everything… I volunteered for every job, every week."*

We gathered similar statements using the Selflessness Questionnaire (Bachar, Latzer, Canetti, Gur, Berry, & Bonne, 2002). These examples are representative of the responses:

"I am willing to sacrifice a lot for the benefit of others."

"I usually give in to the will of others."

"If the family budget is limited I will give up my part."

"If someone is unhappy I will immediately turn to comfort them."

"My own enjoyment is the last thing that is important to me."

Extreme manifestations of selflessness are also evident in interview responses

1 Since more than 90 percent of ED patients are female and therefore in this article I will generally refer to them as such when gender is mentioned.

from patients who were hospitalized for their eating disorder:

"Every breath of mine is at the expense of others."

"Every pound of mine is a burden upon earth."

All these statements express a wish and a readiness to ignore one's own needs and serve the needs of others. These wishes and beliefs ensue from the patient's (or future patient's) feeling that she does not deserve to have others serve as a selfobject for her, i.e. she does not believe that other people can give up, even temporarily, their own needs in order to serve hers.

When individual A refers to another individual B and needs and expects B to fulfill for A an internal need that A cannot fulfill for him/herself, we can, in the language of self psychology, say that A refers to B as a selfobject. A on that occasion expects B to behave as if B were not an independent center of initiative. In other words, the term "selfobject" refers to that dimension of our experience of another person that relates to that person's function of shoring up our self.

The internal needs of the self that we have been referring to are the needs for self-esteem, regulation of emotions, calming, soothing, and a feeling of continuity over time and space. The healthy self, can, to a great extent, internally regulate self-esteem and can calm and soothe itself. A healthy self maintains a sense of consistency, cohesiveness and clarity of patterns of experiences and behaviors even if faced with considerable stress. In the course of such healthy functioning of the self, others may serve as selfobjects, but in a mature and limited manner.

Self psychology stresses that even healthy and mature individuals do require that their internal self needs be met, at least partially, by selfobjects. However, their reliance upon such selfobjects is flexible and mature. They can endure and even outgrow failures of such selfobjects. The weak self, on the other hand, is dependent, sometimes desperately and totally or archaically, on selfobjects to do what the weak self cannot do.

Extending Self Psychology to the Treatment of Eating Disorders

Though referring to other human beings with the expectation that they will behave as selfobjects for us is universal and natural (though in different degrees of neediness), the anorexic patient, as we said, does not believe she deserves that others do that for her. Goodsitt (1997) identifies in the anorexic patient an extreme manifestation of the inability to refer to human beings in order to fulfill selfobject needs - she wishes to behave as if she were a selfless human being. In order to insure her selflessness, she sticks to the position of fulfilling selfobject needs for others, primarily her parents. Clinging to this position of her being a selfobject to others serves as a barrier that keeps other people from being a selfobject for her. Her selflessness is expressed, by her ignoring even her basic needs, such as nutrition and occupying space in the world.

The typical observations of many parents of anorexics are, *"She was our best child. She was obedient and never thought of herself and always was conscientious and aware of the needs of other family members."* These observations ensue from the basic position of the anorexic as a selfless human being who devotes herself to the fulfillment of other's selfobject needs.

Because she cannot rely on human beings to fulfill her selfobject needs, she refers to the food as a selfobject. The anorexic patient derives her satisfaction for selfobject needs through food, mainly through mirroring selfobject experiences. Her need for grandiosity is met not by admiration or approval from her fellow human beings, but rather from her own notion that she possesses supernatural powers which enable her to avoid food. Everyone who meets anorexic patients becomes acquainted with their feeling of great triumph that comes with every pound they lose. The elimination or the denial of the need for food, fulfills mirroring selfobject needs.

The bulimic patient derives satisfaction of her selfobject needs through food, mainly through idealizing selfobject experiences (Barth, 1991; Sands 1991). Food is experienced by her as an omnipotent power; it supplies soothing, calmness, and comfort and regulates painful emotions such as anger, depression or shame and guilt (Barth, 1991; Sands 1991; Kohut 1977, 1987). Since food and the ceremonies around it are experienced as the main source for fulfilling selfobject needs, it is defended by her with much the same intensity that other people will adhere to a human selfobject.

When an anorexic patient (or potential patient) does promote her own interests, according to this theory, she is liable to feel self-guilt. As a result, she often finds herself living life in its narrowest parameters, relinquishing her own interests, compromising her development, giving up her well being and denying even her most basic needs, including nourishment (Goodsitt, 1997).

In 2010, we (Bachar, Gur, Canetti, Berry, & Stein, 2010) found empirical support to the theoretical conceptualization of self psychology, which points to the etiological role of the selflessness position and being selfobject for others, in eating disorders. The selflessness scale, to which we referred above, predicted the development of ED in a prospective longitudinal study, over a two and four year follow-up. We followed seventh grade females in a large community based sample, during four years and the selflessness scale predicted the development of ED in these people with a sensitivity of 82 percent, that is, in 82 percent of the cases the scale predicted correctly that they would develop ED from the baseline to a two and four year follow-up.. While a high score on the selflessness scale predicted the development of ED, a normal or lower score on the selflessness scale (i.e when the adolescent did not tend to ignore her own needs and serve the needs of others), served as a protective factor from developing ED, even in an at risk population (Bachar el. al 2010).

Self psychology (Geist, 1989; Sands, 1991) assumes that eating disorders originate, like other disturbances of the self, from chronic disturbances in empathy emanating from the caretakers of the growing child. The uniqueness of eating disorders is that at some crucial

point in her development, the eating disordered child, whose crucial selfobject needs were not being met empathically, invents a new restorative system in which disordered eating patterns (as we showed above) are used instead of human beings in order to meet selfobject needs. The child relies on this system because previous attempts to gain selfobject-sustaining responses from caregivers were disappointing and frustrating.

Again we found empirical support to the difficulties of mothers of anorexic daughters, to fulfill the expected role of behaving as a selfobject for their daughters (Bachar, Kanyas, Latzer, Canetti, Bonne, & Lerer, 2008). We, of course, expect parents to demonstrate the ability to be selfobjects for their offspring and not visa versa. In this study we found that the selflessness levels of mothers of anorexic daughters were significantly lower than the levels found in control mothers of normal adolescents. We also found a very high correlation between anorexic daughter selflessness scores and mother's signs of depression, hinting to the possibility that when the anorexic patient identifies signs of emotional distress in her mother, she increases her tendency to behave as a selfobject for her. No such correlation was found in the control group between normal adolescent girls and their mothers (Bachar et al., 2008).

We have mentioned the well-known observation Selvini-Palazzoli made long ago that children who are liable to develop EDs feel guilt whenever they require something for themselves (Selvini-Palazzoli, 1978). Our prospective study (Bachar et al., 2010) showed that children who are high in selflessness tended to develop EDs within two and four years. Moreover, we quoted parents' observations with regard to the daughter who became ill: *"She was our best child. She was obedient and never thought of herself and always was conscientious and aware of the needs of other family members."* It might well be that children who are afraid "to occupy space in the world" and who did not feel they have the right to exist and to require that their needs be met, may not challenge their parents' selfobject skills enough, and not provide opportunities for them to practice those skills sufficiently. The end result may be a reduced capacity to serve as effective self objects for their daughters (Bachar, 1998).

The Therapy

In therapy, the therapist works to reverse the pathological circle of belief that others should not serve as a selfobject. The goal is to challenge the patient's use of food as the source of her selfobject needs, either via consumption of food in bulimia or via deriving self-esteem from avoiding food in anorexia. The therapist looks for opportunities to revive the patient's hope, expectation and belief that other people are able and willing to behave as selfobjects for her, that she deserves to enjoy the "services" of a human selfobject and that she deserves to be a self and not just a selfobject for others. Technically, the therapist must be more relationally active than in a classical psychoanalytic model. The optimal therapeutic stance is one that is "experience near" (near to the patient's subjective experience), rather than an "experience distant." I will exemplify this stance through the following vignette.

M., a 23-year-old anorexic woman, came to the session stating that the progress in her condition and in her life had begun when she started to make notations about her thoughts, her therapy and, especially, about her dreams. "Therefore," she went on to claim, "I have to give credit for my improvement to my notes and not to the therapist." The female therapist interpreted that the patient was competitive and somewhat belligerent. The supervisor thought that this was an unfortunate example of a failure to empathically understand the patient from within, from an experience near stance from her subjective experience. The therapist, assuming an outside observer's perspective, had interpreted completely "from without" from an experience-distant perspective. The content of the interpretation might have been correct, but what the patient needed, according to self psychology, especially during the long beginning stage of therapy, was to feel her therapist's efforts to empathically understand her "from within." M's newly developing capacity to search for her own existence and presence should be approved of and acknowledged. She needed to feel successful, competent and skillful by contributing to her own improvement.

The proper order for intervention in such a case, according to self psychology, would be to first make a patient feel that the therapist feels and acknowledges what the patient feels, discovering one's competence and capacity to understand herself and contribute to her development. One possible comment from the therapist could have been: *"How good does it feel to be competent and successful in the way you treated yourself?"* In such an intervention, the therapist behaves as a selfobject because she ignores her own perspective (being an active agent in the patient's cure), and views the situation only from the patient's point of view. The interpretation concerning competitiveness, stemming more from an object relations perspective rather than self psychological perspective, of self-selfobject relations, should be postponed until the final stages of therapy or perhaps not be presented at all, depending on whether other material on such a level is accumulating. [2]

Self psychologically informed therapists, more often than traditional psychodynamic therapists, slip from free-floating attention to the patient into special attention on vicarious introspection (introspection "from within" from the patient's perspective) into the patient's sense of self. Special attention is given to the patient's experience of the therapist's impact on the patient's sense of self. According to Wolf (1988), the patient in therapy with a self psychologically oriented therapist feels that the therapist maintains an attuned stance rather than an adversarial one. The patient experiences the therapist's neutrality as

2 This vignette is was one of several similar examples drawn from a paper describing the therapeutic process of self psychology in eating disorders (Bachar, 1998). The other 14 examples provide detailed accounts exemplifying the mental processes in the patient and the therapist's stance vis-à-vis the patient.

benign, that is, the therapist is effectively on the side of the patient's self without necessarily joining the patient in all of his/her judgments. The therapist, according to Kohut (1984) sees him/herself as being simultaneously merged with, and separated from, the patient.

The activity of the therapist that enables the mutative process of the restoration of the self involves the awareness of the therapist of failures in being empathic to the patient's needs. Provided the therapist succeeds in establishing an empathic milieu, these failures will not be harmful. The therapist's ability to analyze them in the transference is what brings about the transmuting internalization: the taking over by the patient of functions of the self that the therapist fulfilled for the patient.

Treating ED patients involves many cases in which the therapists find themselves unable to empathize with the patient's perspective. How for example, can the therapist empathize with the great triumph the anorexic patient expresses upon losing more and more weight? A therapist on our staff conveyed his distress to the patient upon his inability to empathize with her perspective by using the following metaphor: *"You are like the pilot who suffers from vertigo, who plummets towards the sea convinced that he is rising towards the sky. All his senses tell the pilot that he is correct and one can easily understand him, but I am in the control tower, warning the pilot that he is falling."* Using this metaphor, the therapist expressed the danger and the fatal consequences that can occur, when one's subjectivity cannot be addressed or acknowledged by others. Pointing at the tragedy of the inability to be empathic entails, of course, a great amount of empathy, or at least mention of the wish to be emphatic and the tragic circumstances that ensue when that cannot happen.

We found empirical support for the efficacy of the self psychological approach compared with 2 other interventions. We (Bachar, Latzer, Kreitler, & Berry, 1999) compared a self psychological approach to a specific kind of cognitive therapy – cognitive orientation treatment (Kreitler, Bachar, Canetti, Berry, & Bonne, 2003), and a control/nutritional counseling only treatment, without psychological therapy. These interventions were administered over a one year period. Patients in the two psychological treatments also received nutritional counseling. After initial evaluation, patients were randomly assigned to one of the three interventions, self-psychological treatment achieved significantly better results than the other two interventions, both in removing the ED symptomatology and in an intrapsychicvariable of the cohesion of the self.

CONCLUSIONS

Self Psychology addresses the selflessness trait or selflessness stance of the ED patient which, according to clinical observations from several theoretical viewpoints that we mentioned above and according to the longitudinal prospective study, is at the root of the disorder. The unique therapeutic stance of the therapist who stays, more than the classical psychodynamic/psychoanalytic therapist in an experience near selfobject position, is specially suited to renew the patient's hope in human beings as potentially able to serve as a selfobject for her. The potential in this relationship can renew her belief in her right to exist, help to develop both her individuality and an independent center of initiative. This stand in contrast to her previously morbid style of living life in its narrowest parameters, ignoring her interests and relinquishing her development.

These gains are no less important than the remission of the symptoms, which were also found to improve in self psychology treatment significantly more that in the other two interventions, as the empirical study we mentioned above showed in both domains: in the inner gains and remission of the symptoms, self psychology treatment achieved better results than the other two interventions.

I can refer therapists who are interested in acquiring more knowledge in supplementary studies of self psychology, to the international association for self psychology whose website is: ***http://www.iapsp.org***. Their base and the great majority of members are Americans. Those who are interested can inquire there about further studies, courses, or individual psychotherapy in self psychology at large.

In my opinion, the best of Kohut's books for getting acquainted with the theory and clinical practice of self psychology is: Kohut, H. (1987). The Kohut Seminars. *On self-psychology and psychotherapy with adolescents and young adults.* New York and London: Norton.

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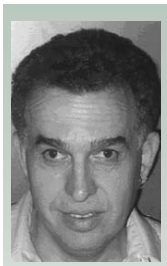

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The Digital Reality: What Clinicians Need to Know about Eating Disorders and Social Media

Marci E. Anderson MS, EDRD, LDN and J. Amber Barke, LICSW, RYT

INTRODUCTION

Over the past 15 years, social media has become more tightly woven into the fabric of our daily lives. According to Media Bistro (2012):

- 250 million tweets and 800 million Facebook status updates are now made every single day
- Facebook users spent just under 8 hours a month on Facebook
- Social networking is the most time consuming activity for an Internet user. A normal Internet user spends around 22 percent of her time on social networking sites, 21 percent on searches, 20 percent on reading content, 19 percent on emails and communication, 13 percent on multimedia sites and 5 percent on online shopping

We know that throughout history–the dominant political climate and cultural ideals have always shaped the public's perception of the ideal female body type. However, today's culture is unique in that the media (including television, Internet, movies, print, and social media) is a far more powerful presence than ever before (Derenne & Beresin, 2006). Social media is not only more prevalent, but it is also more complicated. This complexity affects each of us as eating disorder clinicians. It is no longer realistic to make black or white recommendations. "Avoidance" of certain types of media is unrealistic. *"Do not view pro-Ana or pro-Mia websites"* is too simplistic given the current media environment. Today, the World Wide Web is filled with resources that may either derail or support the recovery process. Just as our clients must develop a more nuanced view of food in order to recover, we must develop a more nuanced view of how to welcome the social media dialogue into our offices.

As we refine our lens, we discover that the Internet presents complicated layers of therapeutic issues. In fact, learning about our clients' social media habits accesses an untapped reservoir of information. As we will highlight, the way a client interacts with social media

is a microcosm for how she interacts with the world.

In this article we will define social media, Facebook, twitter, and blogging. We will discuss the biology of connection and its intersection with the world of social media, explain how to assess and create clinical interventions through the use of case studies, provide suggestions for further research, and review current resources.

Definitions

It is not necessary to have personal involvement with social media in order to discuss it with your clients. However, a basic working knowledge of definitions and ideas is useful. The list below is not exhaustive but covers the most common forms of social media.

Social Media is defined as web-based and mobile technologies used to turn communication into interactive dialogue ("Social Media", 2012). Essentially, this is a general term that encompasses any digital technology that facilitates interaction. Just think of this as any form of communication that happens digitally.

Facebook is a popular free social networking website that allows registered users to create profiles, upload photos and video, send messages and keep in touch with friends, family and colleagues (Rouse & Dean, 2009). Most users post "status updates" about their daily activities and their lives. This may be as mundane as *"enjoying the beautiful weather"* to something potentially provocative as *"just finished two hours on the elliptical and feeling good."* It's worthwhile to note that a recent study in Israel showed that the more teenage girls use Facebook, the higher their risk is of developing negative body image and eating disorders such as anorexia and bulimia (Siegel-Itzkovich, 2011). Another study discusses how Facebook interactions are playing a significant developmental role as adolescents form their identities, ask for support from their online friends, and promote causes or beliefs that are important to them (Larsen, 2007).

Twitter is one of the newest social marketing tools. The Twitter format allows users to write and share statements, comments, conversations, links, even pictures, while limiting them to 140 characters or less (Nations, n.d.). Think of Twitter as a micro-blog and one of the fastest ways to stay current on news and trends. The digital world of Twitter is rich with pro-recovery tweets written by eating disorder treatment facilities, clinicians, and patients themselves. However, there is no shortage of tweets that glorify thinness and eating disorder behavior. Twitter users choose whom they follow which allows them to self-select what information they will be receiving.

Blogs are websites that contain an online personal journal with reflections, comments, and often hyperlinks provided by the writer ("Blog", n.d.). Blogs typically contain a more substantial amount of information than Facebook posts or tweets. Blogging creates an open forum for bloggers to share their opinion on a multitude of topics. There are a surprising number of pro-recovery, non-weight focused, positive body image blogs. We have provided a small sampling of resources at the end of this article.

It is critical to note that all forms of social media are largely unregulated. Developing media literacy skills for both the clinician and the client is critical. We recommend exploring the resources on The Center for Media Literacy's website (2011).

Current Research

The majority of the current research which investigates the effect of media primarily focuses on fashion magazines and body image (Pinhas et al., 1999; Field et al., 1999; Thomsen, McCoy, & Williams, 2001; Turner et al., 1997). Results of these studies show increased pre-occupation with the thin ideal, increased risk for dieting, negative feelings about body image, and increased depression and feelings of anger. A content analysis of pro-eating disorder websites appeared in the *American Journal of Public Health*. Among the statistics reviewed, the article states that 80 percent are interactive, inviting dialogue and posting pictures, 85 percent provided "thinspiration," while 83 percent also offered overt suggestions on how to engage in eating disorder behaviors. A meta-analysis for pro-eating disorder websites shows that pro-ED viewers compared with controls showed higher levels of dieting and exercise; higher levels of drive for thinness, body dissatisfaction and perfectionism; a reduced likelihood of binging/purging; increased negative affect (two studies); and a positive correlation between viewing pro-ED websites, disease duration and hospitalizations (one study). Viewing pro-ED websites positively correlated with disease duration and hospitalizations (Talbot, 2010).

Only a couple of studies have begun to look at Facebook and eating disorders. In a recent study from the Center for Eating Disorders at Sheppard Pratt in Maryland, researchers surveyed 600 Facebook users, ages 16 to 40. More than half said that Facebook makes them more self-conscious about their bodies and weight (Meredith, 2012).

Why the appeal? Connection

Understanding the nature of our clients' relationship with social media is not only interesting, it is integral to understanding the way they interact with the world. Our clients use social media to interface, communicate, express, and – most importantly – to connect. Research in biology and neuroscience confirms that we are hardwired for connection, and our relationships shape our biology as well as our experiences. Our routine activities, day-to-day encounters, and otherwise mundane experiences shape the brain and prime us for emotional experiences, some pleasant and some unpleasant (Goleman, 2006). As we know from the basic tenants of cognitive-behavioral theories, our emotions affect our thoughts and our behaviors (Fairburn, 2008). An understanding of *how* we connect and *why* we connect is paramount in any therapeutic relationship.

Brené Brown (2010), a researcher and author who examines shame, vulnerability, and connection defines connection as *"the energy that exists between people when they feel seen, heard, and valued; when they can give and receive without judgment; and when they derive sustenance and strength from the relationship"* (p.19). With all of the negative attention that the media has received surrounding its effects on our clients, we can easily

overlook social media as a potential *facilitator* for connection. This is where we can use our clinical discernment. Technology and social media can produce what we are calling a *"false sense of connection."* Brown warns us of the dangers of confusing communicating with connecting. Just because we are plugged in-does not necessarily mean that we feel seen, heard, and valued. I have had clients who report that tweeting with a friend, or reading a colleague's Facebook posts provide them with a sense of comfort: *"I don't feel as alone."* While there is an exchange of information here, there is little support actually being received. By contrast, as we will discuss in the case studies section, when a client is able to allow herself to be mindful, open, and active in their pursuit of supportive social media, it can be a powerful therapeutic tool.

While our clients cannot avoid the potentially damaging effects of some media, we can help them become critically aware of how their own social media use affects their own thoughts, behaviors, and emotions. If we can understand the way people use the platforms of blogging, Facebook, and Twitter, we can more accurately assess the potential pros of these fascinating relationships.

Assessment and Interventions

• When assessing a client to understand the impact of social media in his or her life, here are some questions to consider:

-What is your client's current relationship with social media?

-Which types of social media does he/she use?

-What is the amount of time spent using social media?

-How does your client feel before, during, and after using social media?

-Has the client noticed that social media usage impacts their behavior?

- Do they use social media as a way to avoid eating? To avoid binging?

-Is time spent on social media a trigger for ED symptoms?

-Does the client's personality traits- (i.e. axis II characteristics such as difficult maintaining appropriate boundaries) impact appropriate usage of social media?

-Are there similarities between the ways that clients engage in actual relationships compared to how they engage in relationships with others online?

Once your assessment is complete, you can use the information to construct appropriate interventions. Interventions might include:

- Decreasing or increasing time spent on social media
- Providing resources for viewing pro-recovery social media
- Engage in regular in-session discussions about social media

Webber and Mascari (2008) suggest the following:

- Explore congruence between the social media profile and actual perception of self
- Discuss recent social interactions online
- Discuss the role of connection online vs. offline with acquaintances or friends
- Explore how personal information is shared and it's reflection of their personality and identity
- Discuss safety and high risk behaviors online
- Examine how clients respond to online and offline conflict. Is it effective? Is it harmful? Is it different?

Case Studies

Wendy, a 26-year-old Caucasian female is a graduate student and lives with her fiancé. She presented to outpatient treatment with a primary diagnosis of EDNOS, and a history of anorexia-nervosa- restricting type. With a long history of restrictive eating and low weight, Wendy's initial treatment plan involved weight restoration and stabilization of normative eating. After one year, Wendy had achieved these goals but she continued to struggle with significant body image disturbance, low self-esteem, and generalized anxiety. This, in fact, is a common plateau in the recovery process. Wendy regularly engaged in media consumption, including reading women's magazines and fashion blogs. She continually reported body comparisons to women in the magazines, and in everyday life, including at school, out in public, and in social circles. Wendy felt totally isolated in her struggle of body acceptance. She often commented that every woman she knew hated her body and was on a diet. Wendy, as well as the rest of her treatment team, felt stuck. Although she had restored her weight, her body image concerns were interfering with full recovery.

Her treatment team added positive body image blogging to Wendy's treatment plan. She was asked to read from a provided list of resources for five minutes per day. The purpose of this intervention was to challenge Wendy's core belief that "all women hate their bodies" and to connect her with other women working towards body acceptance. After one week, Wendy reported reading the positive body image blogs for one hour per day. She described feeling connected to and supported by a community of women in recovery. This was a transformative and pivotal moment in her recovery.

Over the next year, Wendy continued to discuss the use of positive body image blogging with her team. On her own, she gradually decreased the amount of time spent on social media. Wendy exemplified a strong ability to set boundaries, self-regulate, and modify her social media consumption based on her needs.

Paula is a 32 year-old single, Caucasian, female with a 10-year history of severe restrictive eating and periods of over exercise. She has had multiple inpatient and residential admissions. In addition to her eating disorder, Paula struggles with insecure attachment, difficulties maintaining appropriate boundaries, and is frequently unable to follow the treatment recommendations of her team. Paula lives alone and spends three hours per day using social media. She reports purposefully engaging in social media usage that results in comparisons, feelings of shame, and self-hatred. She frequently reports feeling triggered after usage, yet is either unwilling or unable to stop. She also states that viewing pro-recovery social media material is unhelpful to her. Paula's team developed multiple interventions to mitigate her self-destructive behavior. These included blocking certain blogs and websites, decreasing time spent on

social media, and on-going dialog around her impulses to self-harm. She continues to show an inability to follow through with the team's interventions, and thus there has been an ongoing therapeutic discussion of the parallel of her self-destructive social media usage and her other self-destructive behaviors like restricting and purging.

It is difficult to predict how clients will utilize social media. But careful questioning and ongoing assessment can be critical to identifying barriers to recovery.

CONCLUSIONS

It is clear that there is a need for further study in the areas of eating disorders, body image, and social media (Hogan & Strasburger, 2008). One suggestion for future research is to specifically examine the relationship between social media usage and a felt sense of connection (feeling seen, heard, and valued). The National Eating Disorders Collaboration cites several individual protective factors against disordered eating, including media literacy, good social skills with success at performing multiple social roles, and good problem-solving and coping skills ("Protective Factors", 2012). Future research would benefit from investigating how an individual's usage of social media may reflect or predict resiliency against disordered eating and/or body image disturbance.

With technology and social media developing at an exponential rate, there is much that we, as clinicians, do not yet know or understand, and it can be intimidating to discuss topics that we know very little about. However, if we can allow ourselves to be vulnerable with the unknown, we can continue to invite the topic of social media into the conversation with our clients. With an openness to learn, and a willingness to explore the burgeoning complexities of the digital world, we can continue to model authentic and genuine connection.

RESOURCES

Pro-Recovery Virtual Communities

MentorConnect:
www.mentorconnect-ed.org

Something Fishy: *www.something-fishy.org*

Voice-in-Recovery:
www.voiceinrecovery.com

Facebook Group:
Eating Disorder Awareness

Positive Body Image Blogs

Adios Barbie: *www.adiosbarbie.com*

Body & Brood: *www.bodyandbrood.com*

Guiltless: *www.iamguiltless.blogspot.com*

Medicinal Marzipan:
www.medicinalmarzipan.com

Nourishing the Soul:
www.nourishing-the-soul.com

Rosie Molinary: *rosiemolinary.com/blog*

The Body Image Project:
www.bodyimageproject.com

Operation Beautiful:
www.operationbeautiful.com

Voice-in-Recovery:
www.voiceinrecovery.com

Weightless on Psych Central:
blogs.psychcentral.com/weightless

Media Literacy Websites

www.newmoon.com
www.beautyredefined.net
www.revolutionofrealwomen.com

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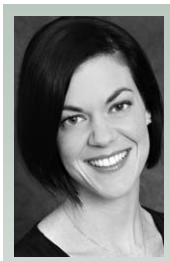

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The Twenty-Second Annual Conference Update

Thank you to all the attendees, speakers and staff who participated in the 22nd Annual Renfrew Center Foundation Conference, ***Feminist Perspectives and Beyond: Exploring Controversy, Building Collaboration.*** In spite of the lingering effects of Hurricane Sandy, virtually everyone attended and the Conference atmosphere was charged with energy and excitement. Your overall feedback ranked Conference 2012 among the best!

This year's program provided a platform to discuss issues of great importance to those practicing in the field of eating disorders. The Keynote Speakers were not only superb, but kept us riveted with the depth and breadth of their presentations. On Friday, a panel led by **Dr. Amy Baker Dennis** examined different perspectives on the use of externalization techniques. **Drs. Ivan Eisler and Kelly Bemis Vitousek** presented their ideas in a clear, engaging way, providing clinical insight into the potential advantages and disadvantages for patients, families and therapists. Our Saturday Keynote speaker, **Dr. Deb Burgard**, explored the issue of obesity, offering data on the insidious nature of weight stigma and its implications for clinical work. Sunday closed with a unique, dynamic presentation by **Dr. Kathryn Zerbe** who utilized art and story-telling to express the difficulties that controversy can bring when it gets personal. The range of topics in the breakout sessions offered something for everyone. In addition to networking receptions and poster presentations, we continued our tradition of the Friday night dance party where a great time was had by all.

Planning is currently underway for the 23rd Annual Conference, ***Feminist Perspectives and Beyond: Integrated Approaches to the Complexity of Eating Disorders,*** to be held from November 8-10, 2013. A CALL FOR PROPOSALS may be found on PAGE 26.

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 2012 such a great success. We look forward to seeing you next year!

Judi Goldstein

Judi Goldstein, MSS, LSW
Conference Chair

"This was the best professional conference I've attended in my career. I walked away with a ton of new information and ideas. Well done!"

"Thank you for the unique blend of workshops, keynotes and networking opportunities that helped me to recharge and be ready for work on Monday."

"Great experience overall. Very well organized and run. Speakers were fantastic. Topics were relevant and useful and food was great too. Loved the dance party… fun!"

Call for Proposals

The 23rd Annual Renfrew Center Foundation Conference

Feminist Relational Perspectives and Beyond: Integrated Approaches to the Complexity of Eating Disorders

November 8-10, 2013
Philadelphia Airport Marriott

How and why an eating disorder develops, and is maintained, is informed by an ever expanding body of knowledge highlighting the inherent complexities of every clinical situation. At the same time, clinical experience and empirical research have identified multiple treatment options, and there is growing recognition that different patients may require different therapeutic approaches at different times. The challenge now facing professionals is how to best utilize available information to most effectively connect complex treatment needs with complex treatment approaches.

The 23rd Annual Renfrew Center Foundation Conference invites presentations on topics that relate to the integration of different therapeutic practices during the treatment of eating disorders. Presentations that focus on the use of evidence based guidelines in combination with an emphasis on clinical wisdom and the importance of the therapeutic relationship, are particularly encouraged.

Accepted Proposals will address topics such as the following:

- Factors that affect patient complexity, such as symptom severity, chronicity, motivation, cognitive impairment, trauma, co-morbidity, and body image issues
- Neurobiology, biochemistry and the etiology and treatment of eating disorders
- Patient and therapist variables that influence the development and maintenance of the therapeutic relationship
- The selection and timing of different therapeutic approaches during the course of treatment
- When and how to terminate treatment, refer to a higher level of care, or recommend a different treatment approach
- Using experiential therapies during the course of treatment
- The relationship between the findings of empirical research and clinical practice
- The specific needs of underserved populations and how to address these needs
- The impact of interpersonal, social and cultural issues.
- When and how to alter treatment plans and treatment goals

Conference Format:

- Keynotes
- Two-Hour and Three-Hour Presentations
- Full-Day Trainings
- Networking Receptions
- Poster Presentations*

***Poster Presentations** which document new research findings on eating disorders and approaches to treatment may include research studies (exploratory studies, single subject or group case studies, or randomized controlled studies), reviews of current research and/or discussions of theoretical issues in the field. The Poster Session will take place on Saturday, Nov. 9th and will feature the work of both senior and junior investigators. Graduate students are encouraged to submit proposals. Questions regarding the poster format should be addressed to Dr. Douglas Bunnell at *dbunnell@renfrewcenter.com*.

DEADLINE FOR SUBMISSION: MARCH 15, 2013

Please submit (A) Cover Letter, (B) Abstract, (C) Biographical Sketch, and (D) Presentation Experience, as indicated below:

Only ONE proposal per person

A. Cover Letter: Attach a cover letter that includes the following:

1. **TITLE** of proposal presentation
2. **TYPE** of proposed presentation: Full day workshop, Three-hour workshop, Two-hour workshop, Poster
3. **PRESENTER(S):** Maximum of **two** presenters
   i. Lead presenter: name, address, degree, phone number, fax number, and email address
   ii. Additional presenter: same information as lead presenter.
4. **FORMAT:** primarily didactic, interactive or experiential
5. **CONTENT:** primarily theoretical, clinical/case examples or research/experimental
6. **SUGGESTED AUDIENCE LEVEL** for the presentation: (Beginner, Intermediate, Advanced, or All Levels.) **Beginner** - Presentations that all participants will be able to fully comprehend and/or appreciate. Presentations will discuss concepts that are considered basic skills/knowledge for those working in the field of eating disorders. **Intermediate** - Presentations are appropriate for participants with an advanced graduate degree in behavioral/nutritional health since they may address concepts that require additional knowledge, workplace/internship experience or a special skill. **Advanced** - Presentations require the knowledge level of professionals with advanced degrees in behavioral/nutritional health and with both general and specialized work experience in the particular area/topic to be discussed.

The Conference Committee encourages *Advanced* workshop proposals that are *Interactive*.

B. Abstract: Attach a description of the presentation that includes the following:

1. An extended abstract that describes major ideas, themes and aims of the presentation (**150** words maximum)
2. A brief summary abstract for inclusion in the Conference brochure (**50** words)
3. **Three** behaviorally measurable learning objectives that are achieved by the presentation

C. Biographical Sketch: Attach a description of your professional experience in the following order: current title and affiliation; relevant publications; relevant organizations; private practice location and area of expertise (**100** words maximum).

D. Presentation Experience: Provide a list of professional presentations you have done within the past **two** years.

PRESENTATION GUIDELINES:

1. Whenever possible, integrate relevant clinical examples and case material.
2. Plan to be interactive with attendees; time must be allotted for questions and answers at the end of the presentation.
3. Do not plan to read your lecture or PowerPoint presentation.
4. Presentations **must** relate to the Conference theme and **meet** stated learning objectives.
5. Handouts are important learning tools and **must** be provided to attendees.

SUBMIT a proposal by electronic mail, on two pages only, and within the body of the email. The SUBJECT line should read: 2013 Conference followed by the LAST name of the LEAD presenter. Attachments will *NOT* be accepted or opened.

SEND THE PROPOSAL TO THE FOLLOWING MEMBERS OF THE CONFERENCE COMMITTEE:

jgoldstein@renfrewcenter.com
aressler@renfrewcenter.com
dbunnell@renfrewcenter.com
jrrabinor@gmail.com
wmndavis@comcast.net
bmcgilley@psychology.kscoxmail.com

CONFERENCE COMMITTEE DECISIONS WILL BE MADE BY MAY 6, 2013.

AUDIO CD & MP3 ORDER FORM

THE 22ND ANNUAL RENFREW CENTER FOUNDATION EATING DISORDERS CONFERENCE FOR PROFESSIONALS

November 9-11, 2012 in Philadelphia, Pennsylvania

KEYNOTE PRESENTATIONS

- ❑ FR Within or Without: The Use of Externalizing Techniques in the Treatment of Eating Disorders with Amy Baker Dennis, PhD, FAED; Ivan Eisler, PhD, CPsychol, AcSS; Kelly Bemis Vitousek, PhD (Friday)
- ❑ SA Promoter, Profiteer or Peacemaker: What Role Will We Play in the War on Obesity with Deb Burgard, PhD, FAED (Saturday)
- ❑ SU Embracing Controversy: What Contemporary Neuroscience, Evidence-Based Research and Psychodynamic Practice Teach Us About Getting Along with Kathryn Zerbe, MD (Sunday)

WORKSHOPS

Friday, November 9, 2012

- ❑ FR 1 "On Becoming:" Implications for Clinical Resistance and Client Recovery - Gayle Brooks, PhD; Marjorie Feinson, PhD; Heather Maio, PsyD
- ❑ FR 2 Eating Disorders as Fate or Destiny: Moving Beyond the Nature Versus Nurture Debate - Anita Johnson, PhD
- ❑ FR 3 Ethical Considerations with Eating Disorder Clients: Resolving Dilemmas with Chronic, Noncompliant & Difficult Clients - Ruth Lipshutz, LCSW, ACSW
- ❑ FR 4 Cognitive Remediation Therapy Versus Mentalization -Based Treatment for Eating Disorders - Chelsea MacCaughelty, LCSW, CGP; Rebecca Wagner, PhD
- ❑ FR 5 The Barbara M. Greenspan Memorial Lecture: Body Discomfort as the "New Normal" for Women: From Girdles to Spanx or How We Have Not Come a Long Way, Baby… - Margo Maine, PhD, FAED
- ❑ FR 6 Interoceptive and Mindful Body Awareness Training for Eating Disorder Treatment - Cynthia Price, PhD
- ❑ FR 7 Exercise and Eating Disorder Recovery: If, When and How - Dotsie Bausch & Beth Hartman McGilley, PhD, FAED
- ❑ FR 8 Families Around the Table: Helping Families to Tackle Their Child's Eating Disorder - Ivan Eisler, PhD, CPsychol, AcSS
- ❑ FR 9 "ED in the Head" - The Neurobiology of Eating Disorders with Clinical Applications for Clients and Families - Laura Hill, PhD
- ❑ FR 10 Bullying Among Teens and Young Adults: Building Resilience - Jane Shure, PhD, LCSW; Sarah Barrett, LCSW
- ❑ FR 11 Males as Patients, Males as Professionals: How Do Men Fit into the Field of Eating Disorders? - Mark Warren, MD, MPH, FAED; Douglas Bunnell, PhD, FAED, CEDS
- ❑ FR 12 What Professionals Need to Know: Understanding the Affordable Care Act, Mental Health Parity & Insurance Appeals - Kitty Westin, MA, LP; Lisa Kantor, JD

Saturday, November 10, 2012

- ❑ SA 1 The Treatment of Eating Disorders and Trauma with Emotional Freedom Techniques
  - Dawson Church, PhD **FULL DAY WORKSHOP
- ❑ SA 2 Understanding the Complexities of Anorexia Nervosa and Implications for Therapeutic Management
  - Michael Strober, PhD, FAED; Craig Johnson, PhD, FAED **FULL DAY WORKSHOP
- ❑ SA 3 Eating Disorders in Children and Adolescents: Perspectives from a Pediatrician and a Parent
  - Harriet Brown, MFA; Rebecka Peebles, MD
- ❑ SA 4 Deepening the Conversation: Integrating Interpersonal Neurobiology and Relational Cultural Theory in Eating Disorder Treatment
  – Lynn Redenbach, RPN, MA, RCC
- ❑ SA 5 Obesity and BED: Exploring Philosophical and Scientific Perspectives
  - Jonathan Robison, PhD, MS
- ❑ SA 6 Away from the Clinic and Off the Script: Making Better use of Behavioral Experiments in Outpatient Therapy
  - Kelly Bemis Vitousek, PhD
- ❑ SA 7 What Do Women Really Eat: An Experiential Discussion
  - Judith Brisman, PhD; Sondra Kronberg, MS, RD, CDN
- ❑ SA 8 The Attunement Model of Self: How the Interactions Between Self and My World Can Lead to Eating Symptoms
  – Catherine Cook-Cottone PhD; Tracy Tylka, PhD
- ❑ SA 9 Personality in Eating Disorders: Conceptual Understanding and Treatment Applications
  - Lisa Lilenfeld, PhD
- ❑ SA 10 Eating Disorders and Alcohol Abuse: Similarities, Differences and Best Practices
  - Anita Sinicrope, MSW; Lisa Maccarelli, PhD

Sunday, November 11, 2012

- ❑ SU 1 The New Alphabet Soup: ACT, CBT-E, DBT, FBT and MI-Based Nutrition Techniques
  - Marcia Herrin, EdD, MPH, RD, LD
- ❑ SU 3 Size Matters: Recognizing and Addressing Weight Stigma in the Treatment of Binge Eating Disorder
  - Amy Pershing, LMSW, ACSW; Chevese Turner, BA
- ❑ SU 4 Utilizing Attachment Theory in Understanding and Treating Eating Disorders
  - Judy Scheel, PhD, LCSW
- ❑ SU 5 The Intricate Web of Digital Boundaries: How Clinicians Can Use Social Media in the Treatment of Eating Disorders
  - Ashley Solomen, PsyD
- ❑ SU 6 "Almost Anorexia": Will DSM-5 Changes Go Far Enough to Validate Patients' Diverse Experiences and Enhance Clinical Practice?
  - Jennifer J. Thomas, PhD; Jenni Schaeffer, BS

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FIRST IN EATING DISORDERS

2013 Spring Webinar Series for Professionals

The Renfrew Center Foundation is proud to offer online training seminars for healthcare professionals. Our clinical experts have developed cutting-edge presentations, which explore the many issues surrounding the treatment of eating disorders. They will provide a variety of perspectives, tools and tactics to more effectively treat this complex illness.

February 27	**Maternal Mirrors: Mothers and Daughters in Search of a Healthy Body Image** Presented by: Laurie Cooper, PsyD
March 27	**The Struggle for Fulfillment: Eating Disorders and Substance Abuse** Presented by: Nadine Lewandowski, MSEd, NCC, LPC
April 24	**Opportunities for Intervention: Medical Indicators and Complications in Eating Disorders** Presented by: Susan Ice, MD
May 29	**Eating Disorders and the Angst of Adolescence** Presented by: Joanna Bronfman, LCSW, PsyD
June 26	**Eating Disorders and the Far-Reaching Effects of Trauma** Presented by: Rebecca Berman, LCSW-C, MLSP

All webinars are FREE and run from noon to 1 PM EST.

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