

The 26th Annual
Conference Update
is included
in this issue.

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CONTRIBUTORS

AMY BANKS, M.D.

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SUSAN OSHER, MSC,
RD, CEDRD

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JOE KELLY, NCLC

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SUSAN KLEINMAN, MA,
BC-DMT, NCC, CEDS

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SUZANNE B. DALY, LCSW, DSW

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JUDITH RUSKAY RABINOR, PH.D.

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EDITOR:

MARJORIE FEINSON, PH.D.

ASSOCIATE EDITORS:

ADRIENNE RESSLER,
LMSW, CEDS, FIAEDP

S. ROY ERLICHMAN,
PH.D., CEDS, CAP, FIAEDP

ALECIA CONNLAIN

JENNA MCCORMICK

A Word from the Editor

As we are all well aware, therapeutic work involves helping clients make changes - in attitudes, beliefs and ultimately (eating) behaviors. And yet, processes of making change are neither easy nor comfortable in part because of the risks they involve. To explore this topic from a relatively unexplored perspective, we decided to shift the focus from risk-taking by clients to risk-taking by therapists. To this end, we invited several professionals to expose some of their own risk-taking experiences within a therapeutic context. Several framing questions, indicative of the types of issues we hoped the contributors would address, included:

1. Risk-taking is an element of your response to the patient, the issues presented – and the way treatment is proceeding (among numerous other factors). How does risk-taking fit into the way you conceptualize the process of treatment?
2. Have there been specific clinical situations or circumstances that motivated you to take a risk – or to avoid taking a risk?
3. Can you describe your process of deciding to take a risk? Is it spur of the moment or planned in advance?
4. Can you describe a risk that turned out well – and what does ‘well’ mean?
5. Can you share a risk that did not turn out well – and what happened when the risk went awry?
6. How did either experience (a risk gone awry or one that went well) affect the client-patient relationship?



I am delighted that our essayists responded enthusiastically and courageously, while sharing a broad variety of perspectives. The issue begins with a compelling description by **Amy Banks**, a psychiatrist from Massachusetts, who writes that in order to help her client, Mel, she (Amy) had to risk looking at a traumatic event in her own family and “...more importantly, to feel the terror and grief that lived underneath my need to ‘fix’ people.” **Susan Osher**, a Canadian nutritionist, provides a vivid account of her reaction to her client, Paul, when he appeared at her door one weekend with six macarons from her favorite French patisserie in Paris. **Joe Kelly**, a California coach who works with males whose loved ones suffer with eating disorders, describes feeling “fear and risk when sharing my knowledge and experience within the eating disorders treatment, prevention, and advocacy community... Without a graduate degree, I often feel like I’m jumping off a cliff...”

Susan Kleinman, dance movement therapist at The Renfrew Center of Florida, provides a striking account of the circumstances which motivated her to risk developing nonverbal interactions with a group of angry patients by letting go of the “... hold I had

on the leadership and empower[ing] some of the patients to collaborate with me more actively.” **Suzanne Daly**, an eating disorders and body image therapist, graphically describes the risk of bringing her body into the therapy room when her client, Leah, says: “I’m not sure that you know what it’s like to have issues with food since you’re so thin.” The issue concludes with a poignant and powerful essay from **Judith Rabinor**, a renowned professional from New York City, who squirms as she considers taking a risk in response to her client, Alyssa’s, trigger for her bulimia: “I knew why I’d been so sensitive to her trauma: because our own pain is a window to others’ suffering. I’d had a painful experience being scapegoated when I’d been her age. I wondered if it would be helpful to her to hear that I had identified with her suffering.”

We hope you find these essays enlightening, if not provocative, and that they encourage you to consider how the therapeutic process might be strengthened if clients view us as role models in taking risks!

MARJORIE FEINSON, PH.D.

EDITOR

Becoming a Vulnerable Therapist

AMY BANKS, M.D.

As therapists, we ask our clients to take risks continually. We encourage them to speak truths not yet revealed, to trust when their hearts and minds tell them it is unwise, to show up for appointments despite our vacations and illnesses. But what about the therapist? There is little discussion about the wisdom or the technique of taking risks within the therapy hour, yet so many of my colleagues and supervisees stretch themselves within their practices on a regular basis. Back in the earliest days of psychoanalysis, Freud and his colleagues maintained a distance from their clients, not simply because they felt safer, but also because they believed their expressionless, objective faces allowed their patients to project their deepest demons onto the “blank screen.” And while most

psychotherapies no longer support this blank screen approach, I believe there is still a bias against the type of risk-taking that could enliven and embolden therapy. In fact, I believe clinician risk-taking is absolutely necessary in building a healthy connection for growth.

I am a risk taker naturally; I believe it fits my dopamine driven personality. I suspect I spend a little too much time thinking about my next adventure (cage diving with great white sharks in Australia is high on the list) and not enough time enjoying the present moment. However, the risks that can

be helpful in therapy are not the type that most people think about in life.

It is not about climbing mountains or running marathons; it is often about exposing your soft underbelly to another human being with your fingers crossed and your heart racing and trusting that stepping out of the role of expert and into the role of human being may be just the thing needed to take the healing work to the next level. The kind of risk taking I usually thrive on requires me to pretend I am invulnerable, the kind I believe can help my clients is where I sit in my own insecurity and worry and

believe that my being more vulnerably human will help another person.

Mel has been in treatment with me for five years, the last year of which has been filled with vulnerability and risk on my end. Mel was raised by a sadistic father and an exceedingly self-absorbed mother and learned early in life that who she was mattered not at all in her house. In this environment, a very powerful relational template was formed, one that told her she was essentially invisible, that her feelings did not matter and that her parents had absolute impunity for any of the rather

horrific things they did to her. Naturally, as she grew into adulthood, this template was the basis for all relationships. In her bones, she believed that the only way she could get any love was by hiding her most wounded self deep behind a wall. Her reality was that no one would want to see this vulnerability or neediness; her value was in what she could do or give to others. In this relational state, she was profoundly stuck, despairing and hopeless, often suicidal, even as she built a family and a career that was the envy of those around her.

Our relationship was tormenting to Mel for the longest time and in fact, sometimes still is. And for much of the beginning of the work, I contributed that to my being too careful. Her terror and grief shook me to my core and when she would show me what was behind the wall, I often took two steps back and tried to “understand it” cognitively from a more objective point of view. I retreated to a place where I was not in danger of falling into the abyss with her. Each time this would happen, she would feel my distance, experience my attempts at understanding her from afar as my looking at her like a rat in a lab. When she first began to share this experience, I tried to understand that, again stepping back and using my cognitive skills and all of the information I knew about neuroscience to help her understand what was going on and how she could see it differently. It took me a long time to know, really know that this was not what she needed.

Truth is, I didn't quite know exactly what would help Mel and it was then that we stumbled upon one of my strategies of disconnecting from my vulnerability and from the relationship – an overzealous desire to “fix” things, to cauterize the hemorrhaging, to relieve

the pain. This is what I had been taught in medical school – it is unacceptable to watch someone bleed out in front of you, it is your job and your responsibility to stop it in anyway possible. But underneath this superficial understanding of my desire to “fix” things was a much more painful reality – a history of trying to “fix” my own mother, who had been crippled by a traumatic event in our family, long before I had the skills to help. In order to help my client, I had to risk looking at this and more importantly, to feel the terror and grief that lived underneath my need to “fix” people.

As this became clearer, our work changed and deepened. I couldn't instantly stay in this place of vulnerability when my client was in her deepest pain, but I began to observe my desire to leave the scene when the most intense pain came. I started to simply breathe and stay in it for another minute or two or five. And I lived. Not only did I survive, but the relationship grew. Mel began to take other small risks and before I knew it, I was taking bigger risks. I was tearing up when I heard her sadness. I was demonstratively sharing the many ways that she mattered to me. We exchanged regular texts to stay in touch and to build on the new growing relational template, with many of mine saying that I loved her and that this work was deeply meaningful to me. We began to recognize that these robust efforts were necessary to lift her thoughts and

feelings out of the old relational ruts that defined her childhood and much of her adult life and place them squarely on a new pathway of respect and healing.

The very nature of risk taking has inherent risks, which, by definition, means traveling outside of our comfort zone. When a person (or even a therapist) becomes uncomfortable, her sympathetic nervous system fires warning signals that often lead to a fight or flight response – creating reactivity rather than responsiveness which is rarely helpful in the therapeutic setting. Fortunately, however, clients are also blessed with therapists who have a frontal cortex, which sends inhibitory signals to the sympathetic alarm system assuring us that the risk may not be as inherently dangerous as it first seems. This balance between the cognitive and the affective is where the money lies in relational risk taking. Too much affect and my own alarm system can fire loudly sending me metaphorically fleeing from the room. Too much cognitive and I might neglect to show up for those deeply resonant, empathic moments that are the essence of healing.

For any therapist attempting to take more risks in a therapeutic relationship, a trusted supervisor or supervision group is a must. It is in those trusted relationships and communities where I am most able to increase the cognitive and affective resonance skills that help me guide the therapy relationship into places of healthy and mutual relational risk. For it is those moments of risk where healing lives.



Amy Banks, M.D. is the Director of Advanced Training at the Jean Baker Miller Training Institute, the author with Leigh Ann Hirschman of *“Wired to Connect: The Surprising Link Between Brain Science and, Strong Healthy Relationships,”* a Clinical Advisory Board member for The Renfrew Center. She has a private practice in Lexington, MA.

“When sharing your food is worth a thousand words....”

SUSAN OSHER, MSC, RD, CEDRD

On a recent Saturday afternoon, I answered a knock at my front door to find a finely dressed, 50 year-old man holding a pale green box with gold rope and italicized matching writing. It was my client, Paul. I was surprised and taken aback. He apologized for the intrusion on the weekend, but explained that he had been in Paris for 23 hours and bought me six macarons from Laduree. I was extremely touched, but felt a little awkward. He is a highly appropriate person who is extremely aware of procedures and boundaries. As he handed me the gift, he apologized again and expressed his gratitude for our work together.

Paul knew of my fondness for Laduree, a French patisserie, due to my self-disclosure a couple of weeks before. In the course of my work with eating disorders clients, I have found self-disclosure to be an important component of a successful treatment approach. While many therapists shun self-disclosure and avoid any reference to their own experience during counselling sessions, I have come to recognize that it is occasionally necessary. Taking risks of sharing a feeling or reflection from one's own life can help nudge clients to take the risks needed for their own therapeutic benefit in overcoming an eating disorder.

During a period of recovery, Paul had arrived cheerfully at a session with a bag of fresh croissants from a local patisserie for his new partner and him to enjoy after dinner that night. He was excited to connect and indulge in delicious food without guilt. His eating disorder was silent. A couple of weeks later, amidst acrimonious divorce proceedings, Paul was unsure of the new relationship and had cancelled his European vacation. His recovery was in jeopardy, as was his relationship with his partner. His work, ex-wife and difficult family dynamics were drawing him back into the eating disorder abyss.

As we were planning the following week's goals, I reminded him of his love of French pastries. As it happened, my husband had just returned from France with macarons for me from the famous Parisian bakery Laduree. I shared with Paul how much I was enjoying the delicious pastries with their exquisite flavours and delicate texture. This intimate and personal detail from my recent experience enabled me to connect with Paul and shift him out of the self-destructive mindset that had taken hold of him. Invoking a shared appreciation for sweet confections was the first step in enabling Paul to remember that eating could be enjoyable and allow himself to indulge in the foods he loved. Paul left our session resolved to treat himself to a pastry that week.

During the session, I took a risk and revealed a lot about my food preferences including the connection I had with the food as a gift from my partner. Self-disclosure was potentially boundary crossing. Was I sharing too much personal information? I decided that the benefit of my risk taking was hopefully to normalize Paul's experience of eating, reminding him of what he was rejecting along with the pastry. The risk became a launching pad for a discussion about how he was starting his downward spiral,

head-first, into his eating disorder by feeling that he did not deserve a good life, to be fed and nurtured. My sharing reminded him of the happiness and stability he had recently experienced and highlighted what he truly valued and wanted for his future – food as a connector to others rather than a weapon against himself.

The decision to risk self-disclosure should be undertaken with full confidence that appropriate professional boundaries will be maintained. With Paul, I knew that revealing an intimate detail about my husband's gift and a shared food preference would not be misconstrued as an invitation of friendship. I had no doubt that he understood clearly and respected my role as his nutrition therapist. There had been no indications during our counselling sessions of boundaries being crossed or challenged in any way.

Another important reason for self-disclosure in the context of eating disorders treatment is to provide a functional example for the client of 'normal eating.' I consider myself a healthy eater, deeply grateful for all that the human body can do and resolved to feed mine accordingly. I am aware of my hunger and fullness cues. I sometimes overeat and occasionally skip an eating time because life gets in

the way. By sharing my experiences, clients' self-perceived mistakes are normalized. I also shop, cook and eat with clients. While these actions are powerful tools in nutrition therapy, they further challenge professional boundaries as they are inherently more social. The purpose and structure of these activities need to be clearly defined and discussed with clients prior to the sessions to ensure that the session meets the clients' needs on their terms.

There have been occasions that dropping traditional, professional boundaries challenged the client-dietitian relationship. At times a nutrition therapy session has felt more social than professional, whether it was taking a client grocery shopping, eating together in a restaurant or the small talk during meal support. So, too, in some cases, when clients send persistent questions about meals, urges or symptoms, the time and place of client-dietitian connection is blurred by the immediacy of email and texts. It feels too intimate. I have had to process my feelings and re-establish boundaries by having less spontaneous contact and ensuring that we have more traditional nutrition therapy sessions than experiential eating. There also are times

that I have felt that blurring boundaries might be misinterpreted as an invitation of friendship and the risk outweighed the potential benefits. I don't dare to share myself in these situations.

According to our Jurisprudence Handbook, there are key questions to assess whether a boundary is being crossed: Is this in my client's best interest? Whose needs are being served? Could this action affect my services to the client? Could I tell a colleague about this? Could I tell my spouse about this? Am I treating the client differently? Is this client becoming special to me?

For most of those questions, the answers are resounding affirmatives. I have no secrets to hide and I am confident that my actions are in the best interests of my clients. But sharing myself definitely creates a connection that needs to be guarded carefully. While I'm not a risk-taker in my personal life, I am definitely open,

warm and sharing with people I trust. That spills over very naturally into my work. However, professionally, I listen carefully to my clients and assess whether boundary crossing could be misconstrued or abused in any way. While the choice to share is somewhat intuitive, I do progressive mini-assessments by sharing a little at a time in order to test whether it is a helpful therapeutic tool.

While Paul's surprise visit left me feeling uncomfortable and self-doubting, when we met in session a couple of weeks later, I was reassured that my risk-taking and his gesture of gratitude did not affect our therapeutic relationship. There was just less of his eating disorder present as he shared – without shame – all he had eaten on his trip. We went back to 'business as usual' – reflecting on his eating struggles and planning for the upcoming week, as his weight had dropped and he was able to identify areas to work on.



Susan Osher, MSc, RD, CEDRD received her Master's Degree in Nutrition with a focus on psychiatry at the University of Toronto. She enhanced her nutrition therapy skills at the Hospital for Sick Children and Toronto General Hospital Eating Disorders' Programs. Susan founded her private practice 18 years ago providing counseling, education, training and consulting to treatment centers.

Risks of Working with a Client's Male Loved One(s)

JOE KELLY, NCLC

Entering the "eating disorders field" nearly 20 years ago was intimidating at first. I wasn't a therapist, dietitian, parent whose child suffered from the illness, or another obvious recruit to the cause. Thus, I didn't see an obvious place for a feminist father and journalist experienced in reporting, listening, reflecting, writing, and speaking on father-daughter relationships – and who simply saw eating disorders as a logical outcome of how our culture treats girls and women.

Fortunately, a handful of kind and knowledgeable women and men welcomed me and introduced numerous others of their ilk. They encouraged me

to continue exploring the ways that men who love someone with an eating disorder are impacted by the illnesses. This exploration eventually led to

providing psychoeducation for family members – and even some groups of female clients – at ED treatment programs.

For the last six-plus years, I've formally coached male loved ones (MLOs, for short) on how to respond to their partner, child, relative, and/or friend's eating disorder and be an effective treatment and recovery ally. I've also trained treatment professionals on how to mobilize and employ their clients' often-reluctant MLOs.

Nevertheless, I still feel fear and risk when sharing my knowledge and experience within the eating disorders treatment, prevention, and advocacy community. The treatment field – rightly! – places great value on graduate and practice training. Without a graduate degree, I often feel like I'm jumping off a cliff when responding to professionals' queries, and/or explaining the value of utilizing the traditionally untapped natural resource of male loved ones. When I co-present with treatment colleagues (psychologists, physicians, and researchers) at prestigious conferences, our sessions attract small turnouts and we are mostly preaching to the choir. Of course, this response (or lack thereof) is not the least bit malevolent; rather, it's evidence of unintentional blind spots about the potential contributions of MLOs. So, I risk feelings of rejection when encountering questions from professionals in the field, like: "what are you doing here?" Yet, I also understand that attitudes of resistance and defensiveness arise in a specialized field (not just ED). I simultaneously recognize how such attitudes keep the field from gaining diverse perspectives, including non-academic sources of knowledge and experience. Not surprisingly, I am sometimes wearied by the effort and risk required to engage with the resistance.

At the micro level, I work individually and in small groups as a certified life coach with men (and some women)

affected by their loved one's eating disorder(s) and/or their loved one's death from eating disorders. Obviously, therapy and coaching have parallels and divergences. Similar to therapists, I work with people in distress. However, as a coach, I rely heavily on curricular materials, playing out scenarios, and stories. Therefore, my experience and perception of what is risky (e.g., self-disclosure) may be fundamentally different from a therapist's.

When I began coaching Geoffrey¹, he vehemently resisted my efforts to shift the focus from his wife's symptoms to how profoundly her eating disorder impacted his life. Like many loved ones, he attempted to reason with the illness. Geoffrey felt trapped in an endless cycle of reaction to the symptoms (including things he didn't recognize as symptoms). His perspective narrowed so completely that he lost sight of virtually everything in his life not related to the eating disorder. As a result, Geoffrey seldom thought or said things other than: "Why won't she listen to me? What the hell is happening in her treatment? No one on the inside tells me anything or asks me anything. Nothing I say makes any difference."

I persisted with my approach, including stories from other MLOs, and sharing some aspects of my own experiences with addiction and 35+ years in recovery. Geoffrey shouted and cursed a couple of times in our early conversations and it was risky to keep proceeding for fear that he would break off our work together and remain stuck in a cycle of self-defeating fear and anger. I felt vulnerable in the presence of so much rage – and pain. Fear of personal rejection was fleeting – my stronger emotions were sadness for him and concern for the price he paid for continuing along his current path. Yet, I also felt confident, appreciating

the source of his distress. I responded by following an important practice I teach my clients: recognizing differences between the eating disordered self and the authentic self. That meant recognizing that the rage radiating from Geoffrey came from feeling that his life was "hijacked" by his wife's eating disorder—rather than thinking, feeling, and acting from his authentic self. I found comfort in remembering that I have the freedom to respond differently to his authentic self than I do to his "hijacked" self, just as Geoffrey eventually learned how to respond differently to his wife's authentic self and her "eating-disorder" self.

Despite his waves of rage and reluctance, I kept persisting and he kept his appointments. Before long, he was willing to experiment with some of the practices I teach. He developed some effective self-care and began practicing loving detachment from his wife's illness.

I consistently find that men like Geoffrey are eager to learn about new strategies for thinking, speaking, and behaving in their life alongside an eating disorder. They long to do something that will be effective for their ill loved one, for themselves, and for the rest of the family. This longing comes from an admirable, deep, and often lifelong desire to protect and provide for the ones they love.

Men's "tell me what to do" approach is often interpreted as "let me fix it," which can be frustrating to a treatment provider. Like most other people, these men want the disorder to end, but they quickly realize (if they don't already understand) that any "fix" is not in their control. What is in their control? Learning loving detachment, practicing self-care, creating fellowship, and the like. That's the process we engage in as coach and client.

Fortunately, most men with whom I've worked have been willing – usually eager – to risk sharing their concerns, distress, and perspectives. In my experience (and that of other male and female colleagues willing to work consistently with MLOs), by the time a male family member gets to us, he is terrified by long-term feelings of helplessness, fear and impotence regarding his loved one's eating disorder. This distress is so deep that he is willing to risk vulnerability and dramatic changes in how he responds to the baffling and powerful impact of eating disorders, regardless of his background. When we

providers risk challenging our own pre-suppositions about men in families, and then use strategies to explicitly and personally invite MLOs into the treatment process^{2, 3}, these men respond quickly.

I invite all ED professionals to take that risk and experience the ways that positive MLO involvement can benefit everyone's well-being.

¹ Names are changed for this article.

² Walters, J. (1997). Talking with fathers: The inter-relation of significant loss, clinical presentation in children and engagement of fathers in therapy. *Clinical Child Psychology and Psychiatry*, 2, 415-430.

³ Carr, A. (1998). The inclusion of fathers in family therapy: A research based perspective. *Contemporary Family Therapy*, 20, 371-383



Joe Kelly, NCLC served on the Eating Disorders Coalition board, and was Fathering Educator at The Emily Program. A journalist since 1985, he co-founded *New Moon Girls* magazine. Joe's 13 books include *Dads & Daughters*[®], *The Pressure to Be Perfect* (with Margo Maine) and *Yoga and Eating Disorders* (with Carolyn Costin).

Learning to Trust My True Self: A Work in Progress

SUSAN KLEINMAN, MA, BC-DMT, NCC, CEDS

As a dance/movement therapist, I use the cues and signals from within my own body when responding to patients. Achieving and sustaining this level of authenticity is always complex as it requires balancing the knowledge from my inner senses with my clinical knowledge. As I continue to practice this art, my confidence grows so that I am able to take more risks in working with patients while never knowing what will unfold.

I walked into the community room, as usual, to facilitate a special part of a group called 'after meal.' 'After meal' was designed to be one of the only times when patients could complain about food; their anxiety would permeate the entire room. I would come in for the last 15 minutes and provide them with what was called "Susan's soothing session," essentially, a relaxation experience.

This particular day, 'after meal' was being facilitated by a practicum student and the patients were 'eating her up alive.' I was greatly relieved that I wasn't in her position. As I quietly walked into the room, I immediately noticed the tension. While I empathized with the student's dilemma, I realized that she was really stuck. Recalling the many times I had been in her shoes, I was grateful that

I wasn't there now – at least not yet.

The student and I exchanged a glance; she quickly (and I think gratefully) left. I felt as if I had walked into the lions' den. Would they accept or reject what I had to offer? A few patients were expressing their anger, but there were others who were visibly scared. I was concerned about not being able to handle the situation as well as setting up a potential for further acting out. I tried to center myself while assessing the situation and deciding how to proceed. I noticed there were a few patients with whom I had previously established a relationship. I saw this as hopeful as I would probably need their support. I also knew that there was no time to ponder the situation; I had to trust myself and take charge immediately.

I sensed that the patients would be unable and unwilling to accept what I had to offer unless I first addressed the unease so evident in the room. So I commented on what I saw: "Wow! It looks like there is a lot of discomfort here in the room." I don't know if I even used the word anger. I probably didn't, but I did say: "I'd like to do some things that I think will help. Is that ok?" I got enough of a 'yes' in order to proceed:

"I'm going to need a volunteer, but first I will show you what we're going to do. Does anyone have a pillow that I can borrow?" When somebody tossed me a pillow, I explained: "I am going to take a deep breath in and a deep breath out, lift the pillow above my head and then bring it down to the floor and just let go of it – whoosh – just like that

and then take another deep breath in and out.” When I did that, one of the patients who had worked with me before, wanted to try it and so we worked together, letting go of the pillow, pausing and breathing.

Continuing to interact with her in this way, others also wanted to try and eventually, many of the patients expressed their feelings through their movements. It became visibly apparent that, as more trust ensued, the agitation in the room began to subside.

I decided to risk developing the nonverbal interactions further by using the expressive cues that had been unfolding. I thought that now I might be able to let go of the hold I had on the leadership and empower some of the patients to collaborate with me more actively. I identified a patient I saw as a key leader and asked her to push up against my hands. Even though I’m only 5 feet tall, she felt comfortable enough to do it. As she pushed against my hands, I encouraged her to push harder. “I promise you it won’t hurt me.” As she pushed harder, others became more engaged, commenting, “look how strong she is. I want to try that too!” More patients volunteered to try to ‘release’ their pent-up feelings in what had become an even safer space.

Only then, did I invite them, as a group, to lay down and get centered with their pillows and blankets. With soft soothing music in the background, I helped them relax and move into in a calmness that would never have been possible when I entered the room fifteen minutes earlier. Afterwards, some of the women thanked me for helping them express their feelings by being empathic and non-judgmental. They felt safe enough to express what they were feeling and understood that, in time, they might need to transform these feelings by exploring what fears were lurking underneath.

In reflecting on this experience, I believe that the practicum student was not succeeding because she was trying to engage the patient group with a rigid agenda that did not respond to or address their needs. The patients could not become fully engaged as they were fully preoccupied with their own unrest. Likewise, the student could not be fully centered because the resistance she faced

blocked her own ability to be fully present. The risk for me in this situation was to be able to shift from one presentation style to another without knowing the outcome.

I have taken many risks through the years that did not end so well. For example, I was having a lot of trouble engaging a very difficult group of adolescents when one boy challenged me to participate in a trust fall. Although not enamored of the idea, they promised me that it would work. With a great deal of trepidation and against my better instincts, I decided to take a risk. I chose to go first in order to demonstrate that the activity was a safe way to begin establishing trust. As I fell back and landed on the floor, they laughed. I later learned that they signaled one another to let me fall. One invaluable lesson I learned from this experience was to not take a risk when it seems too risky, but rather to take a risk by trusting my instincts.



Susan Kleinman, MA, BC-DMT, NCC, CEDS is creative arts therapies supervisor and dance/movement therapist for The Renfrew Center. She is a trustee of the Marian Chace Foundation and a past president of the American Dance Therapy Association. Her work is featured in the documentary entitled *Expressing Disorder: Journey to Recovery*.

The Risks of Inviting My Body into the Therapy Room

SUZANNE B. DALY, LCSW, DSW

Leah, a woman in her early 30’s, contacted me for help managing her relationship with food. She had an extensive history of yo-yo dieting yet wanted to be clear, “I don’t have an eating disorder.” Leah was afraid of coming across like her other female friends who she said, “just complain.” She was terrified of seeming needy. Now, the mother of a young child, Leah was finding it increasingly difficult to manage her “insatiable” appetite. And she was confused, having learned early on that she, and by extension food and her body, were the problem, not the humiliation and neglect she experienced from her parents. Leah’s childhood home echoed the surrounds of a misogynistic

culture – her needs and hungers were illegitimate. By not having needs of her own, Leah was able to protect herself from preemptive disappointment.

Although Leah was overweight by the culture's unrealistic standards of beauty, in her mind, she was "massive." And in comparison to me, she felt even more massive. I am aware that my body can provoke feelings for patients, as it did for Leah. Women suffering from eating disorders often overvalue appearance and the physical body in interpreting the world. During our first session, Leah commented: "I'm not sure that you know what it's like to have issues with food since you're so thin." Mindful of my own thin privilege and the potential envy that my body might incite, I usually weigh the risk of more explicitly inviting my body into the room with waiting for a client to comment (either directly or indirectly) on my body. Since Leah remarked about my body, I quickly had to assess how much she really needed to know about me, and how much she needed just to feel safe. I decided it was important to share my understanding that women don't often talk about their bodies in an open and vulnerable way, and that I hoped this space would be different. I explained that her questions were welcomed, even if they were about my body, and that before answering, I wanted to explore what her questions meant in order to understand her better. Leah looked at me wide eyed, seemingly in disbelief that this kind of a conversation existed.

The next week Leah asked me to share a little bit more about how I came to this work. Given my sense that she tended to avoid sitting in her vulnerability, I felt the need to risk staying with the body, perhaps to show that I was not afraid of being in my

body in the presence of hers, and not afraid of being envied. "You know," I said, "one of the things you noticed about me was being in a thin body and I'm wondering if you believe there's a relationship between noticing my body and how I came to this work. What are your thoughts and feelings about my being in this body?" Leah let me know that she imagined that I must have had struggles of my own, but that she had always longed to be thin. She then stated, "I just don't understand, like, how do all of your organs fit in there?" She seemed truly perplexed by my anatomy. I wondered aloud what it was she might really be asking. Leah couldn't yet articulate the meaning of her question. I suggested that perhaps she had more questions about how our being in different bodies might impact her treatment. For example, could I be in a culturally privileged body and hold her body in acceptance? Could she trust me in my body? Do I know how to feed myself and will I be able to help her learn to feed herself? Or, could I possibly understand her since her body was so different from my own? She sat there silently.

In another session, Leah wondered "You seem so small in your chair, but how much bigger can I be if I fit on just one of these couch cushions?" She was confused about where her body ended and mine began. I told Leah that I was getting the sense that she was really trying to assess who I am, and who she is in relation to me and my body. What emerged from these body-centered questions was a conversation about how confused she has been her entire life about who she is in relation to others, especially her family of origin. Her parents could not provide any mirroring for Leah; in essence she and her bodily needs did not exist. I knew deep down,

however, that there was so much more to this dynamic. The hostility she felt towards both her body and mine was palpable.

As our work progressed, Leah risked showing more emotions, which she'd often follow with, "I'm just a fat sobbing mess on your couch." She was full of self-hatred and rage, and didn't understand why. Leah learned to dismiss her enmity by comparing herself to those who she believed had it worse. She was furious and ashamed that her problem was binge eating, and she wondered why she couldn't be anorexic so that at least she could have a problem that seemed legitimate and she would not be fat. Leah insisted that thin people had it better. I realized I was beginning to take this personally, despite the pain in her expression. Her rage felt contaminating. "Do you imagine that thin people don't struggle too?" I asked. Leah became visibly angry as she squirmed in her seat. She replied sharply, "Yes, but you don't have to be fat!"

Taking the risk of bringing my body into the room is not always a conscious decision, as illustrated above. In that interaction, I became exactly who Leah feared that I would be in our first session – someone who could not understand her because of our difference in body size. I attempted to repair the rupture, recognizing that we were in an enactment, by telling Leah that I had reacted defensively, and that I noticed I had upset her. I encouraged her to tell me how she was feeling, but she denied any anger towards me and instead took the blame stating, "Geez, I can even offend my therapist." I let her know that I had dismissed her exactly the way her family had. We spent a lot of time talking about the dismissive stance and how much hurt and rage she has

been saddled with as a result. I revisited her comment about my organs fitting in my body. I asked if she worried that I would not have enough room inside of me for her, and all of her big fat feelings. She became tearful and said that no one had ever cared for her like this.

Given Leah's mystification with the body, I felt that I needed to risk allowing my body to be a safe place for exploration in order for her to access her deeper feelings. Sometimes this meant acknowledging my thin privilege directly, and inviting Leah to share her feelings about my body. At other times, when Leah's rage towards thin bodies was too intense, I opted not to bring my

body into the discussion because I feared that I would only be welcoming an attack and potentially causing a rupture. In those moments, it seemed safer for both of us to understand her feelings via external transferences. I strongly believe that when I can observe my own bias and privilege with regard to my body, I am better equipped to determine when to appropriately risk inviting

explicit conversations about the body into the room. The critical piece for me is being able to survive my client's direct and indirect expressions of hostility, while still holding her in acceptance. In taking thoughtful risks with Leah, and being prepared for the inevitability of the risks that went awry, we cleared some space inside of her for a corrective emotional experience.



Suzanne Daly, LCSW, DSW is a Licensed Clinical Social Worker in Philadelphia who specializes in the treatment of problems relating to food, eating, and the body. She practices from a contemporary psychodynamic orientation, and pays special attention to the ways in which the social context influences psychological development.

Self-disclosure in Psychotherapy: A Powerful Healing Tool

JUDITH RUSKAY RABINOR, PH.D.

Several years ago I received an unusual referral. It was late May when Alyssa, who had completed her sophomore year of college, called and requested a few sessions before leaving for a June summer school session in California. "I'd like just a few sessions, a checkup," was how she introduced herself in our first session. She had recovered from a long battle with bulimia, but was still prone to "fat attacks" where she worried about her weight and became phobic about certain foods. And so we began our work.

By the fourth session, Alyssa was elated, amazed with our progress. She had been in previous therapy but had never understood what had triggered her bulimia. "You really zeroed in on the scapegoat incident in junior high school" she said. "How could you have known how that would have been so awful for me?" she asked.

As she spoke, I squirmed. I knew why I'd been so sensitive to her trauma: because our own pain is a window to others' suffering. I'd had a painful experience being scapegoated when I'd been her age. I wondered if it would be helpful to her to hear that I had identified with her suffering.

Sitting in my chair I was faced with a decision all therapists grapple with at some (or many) points in their careers: should I self-disclose something personal? Certainly, I had the option of remaining silent—that's normative therapist behavior, isn't it? That's the safe way, and you can't really be faulted for just listening. It's what I generally advise supervisees: when in doubt, remain silent—there's always another chance to bring up something you are uncertain about disclosing.

But as I sat in the silence, the pros and cons of self-disclosing my personal experience flew through my mind.

On the one hand, after years of practice, I know that self-disclosure can be a uniquely empathic validation, one that builds trust, crucial for a good psychotherapy relationship. A "me too!" self-disclosure can communicate normalcy, can reduce shame. On the other hand, self-disclosure is not always wise. For some patients, knowing "personal" information about their therapist is off-putting. It may feel like a narcissistic injury and/or an annoying interruption when a therapist "tells a story" from her own life. It can feel like an assault or an attack, a repetition of a "take-over" parent or another family member.

Therapists need to continually monitor the question: What is best for this patient at this moment? And yet, when sitting in a session, one does not have the luxury of leisurely mulling over the nuances of each response; it is precisely because therapy sessions are not scripted that, for the most part, we must rely on balancing our professional stance with our intuition

★ ★ ★

Sitting with Alyssa, something inside tugged at me, urging me to take a risk. “Share your experience,” whispered a voice from within.

“I want to share something that happened to me, something that helped me understand you,” I said. Her eyes widened and my story unfolded.

“In the last year of junior high school, I was scapegoated too. I was singled out by the ringleader of a vicious group of girls in my class. They made my life hell,” I told Alyssa. “Every day I dreaded going to school, feared being teased and bullied. It was really awful.”

I paused, trying to assess the impact of my words on her. She was sitting on the edge of her chair. “Green light,” whispered that voice within. I continued.

“You’d have thought that now, decades later, I would have forgotten all that – but not so.”

“Just last year,” I continued, “I was sitting in the balcony of a huge Broadway theater, waiting for the play to begin. Just before the curtain rose, I looked down – and to my surprise, I spied my old junior high school tormenter. Suddenly she looked up, spotted me, gazed at me intensely and waved. My stomach dropped and I began sweating. Momentarily, the house lights went down, but I was unable to concentrate on the play: it was as if a

40-year-old wound had burst open. Instead of watching the play, my mind was filled with memories of that horrible year. I felt sick and devastated, exactly as I’d felt in junior high. I was overwhelmed with so many different feelings – I felt nervous, powerless, bitter, and vengeful – all at the same time.”

“I couldn’t believe that those old emotions were still raw,” I told Alyssa. “But they were. And that’s why I’m telling you this story. Because painful experiences stay with us, live on in our bodies. And I guess that’s how I understood your pain. Your story made me think about your eating disorder: bulimia may have been one way you coped with your pain – and distracted yourself from it.”

The following session, within minutes of arriving, Alyssa began crying. Before I had a chance to ask her about the impact of my self-disclosure, she burst out, “Dr. R, I’ve lied to you... or at least, I haven’t been 100% truthful.”

She paused to catch her breath. “There’s something I didn’t tell you. I still vomit. I’m still bulimic. I told everyone I recovered, but that’s not really true – and no one knows. And now I’m leaving for California next week, and I’m scared. What should I do?”

“Thank you for trusting me,” I told her and she again burst into tears. “We’re going to work this out together.” We set up a phone session for the following week and the next chapter of Alyssa’s therapy began.

Years later, when I was writing a book, I contacted Alyssa requesting permission to tell her story. In response to the draft of the chapter about our work together (disguising her identity, of course), she wrote the following letter, which she has given me permission to include here:

*Dear Dr. R,
Thank you for sending me the chapter. Of course I recognize myself. Reading this made me think about all I’ve learned in my Psychology class this semester. I know that many professionals frown upon a therapist revealing parts of his/her life to a patient. However, I think that by allowing the patient into your life, you set up a much more comfortable situation for the patient. Speaking from personal experience, the first psychologist that I went to, before I saw you, made me very uncomfortable. Looking back now, it is very clear to me as to why I dreaded going into her office once a week. I always felt like she was judging me, looking at me as just a patient with a problem rather than as a real person. There is much more to my life than just the eating disorder, but none of that concerned her. She was also very secretive about herself. I didn’t know anything about her, and so I was uncomfortable revealing so much to someone who I didn’t know anything about. Most things in life are give and take, and I think was uncomfortable in giving away so much private information about myself, and not really receiving anything in return... I didn’t want her life story, I just wanted for her to maybe relate something that I was saying to an experience of her own... I wanted to be treated like a real person with real emotions, but instead I felt like this object she was trying to analyze and fix...”*

Alyssa’s letter is a testament to one of my core beliefs: self-disclosure can promote self-disclosure. It is clear that my self-disclosure helped Alyssa. However, it would be reckless to ignore the word “can” in the earlier sentence. Self-disclosures are risky as they can and do backfire. This possibility is minimized, however, when I follow the Golden Rule of self-disclosure: Every self-disclosure should be carefully monitored and processed.

It is essential that I pay attention to my patients' bodily as well as verbal responses. Interventions such as:

1. What was it like for you to have me share that with you?
2. How is it to know this about me?
3. You haven't said much since I let you know this about me.
4. You haven't said much, but I notice you are tapping your foot, looking out the window, watching the clock since I told you about...

Questions such as these provide powerful opportunities for me to assess the impact of a self-disclosure and to

apologize when a self-disclosure has been inadvertently harmful, further deepening the therapeutic relationship.



Judith Ruskey Rabinor, Ph.D., is author of *A Starving Madness: Tales of Hunger, Hope and Healing in Psychotherapy (2002)* and *Befriending your Ex: Making Life Better for You, Your Kids and Yes, Your Ex (2012)* is in private practice in New York City where she sees individuals, families and groups, conducts clinical consultations groups for mental health professionals, writing groups and retreats.

Portions of this article appeared in an article, *Self-Disclosure as a Turning Point in Psychotherapy*. In A. Bloomgarden and J. Mennuti (Eds.). *Psychotherapy Revealed*. New York: Routledge Press, 2009.

Your Donation Makes a Difference

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

Your Donation Makes A Difference...

- To many women who cannot afford adequate treatment.
- To thousands of professionals who take part in our annual Conference, national seminars and trainings.
- To the multitude of people who learn about the signs and symptoms of eating disorders, while learning healthy ways to view their bodies and food.
- To the field of eating disorders through researching best practices to help people recover and sustain recovery.

An important source of our funding comes from professionals like you. Please consider a contribution that makes a difference!

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The Renfrew Center Foundation will offer professional seminars and webinars through the spring. Please visit www.renfrewcenter.com for information on these events.



The Renfrew Center of Orlando NOW OPEN!

The Renfrew Center is pleased to announce the opening of our Orlando, FL site. This is Renfrew's 17th location and second in Florida. Programming consists of a comprehensive range of services:

- Day Treatment
- Intensive Outpatient
- Group Therapy
- Nutrition Therapy



The Renfrew Center of Orlando is located at:
3452 Lake Lynda Drive, Building 100
Suite 120, Orlando, FL 32817.

For more information on the site or its services, please call 1-800-RENFREW.

The Renfrew Center of Pittsburgh

Opening Summer 2017

The Renfrew Center will open its 18th facility nationally in Pittsburgh, PA. Programming consists of a comprehensive range of services including:

- Day Treatment
- Intensive Outpatient
- Group Therapy
- Nutrition Therapy

For more information on the site and its services, please call 1-800-RENFREW.



THE 26th TWENTY-SIXTH ANNUAL CONFERENCE UPDATE



On behalf of the 2016 Conference Committee, I would like to extend my sincere thanks to each of you who made this year's Conference so successful and memorable – speakers, attendees and Renfrew staff. We hope that you all left feeling a strong sense of community and enlightened to issues most salient in our field – widening the scope of those who are affected and those for whom we provide a safe place to feel valued, accepted and deserving of care.

This year we explored lifespan transitions, as well as diversity and intersecting forms of oppression on the development and treatment of eating disorders. Our program opened on Friday with an inspirational presentation by **Anne-Marie Slaughter** who spoke eloquently of her own experience trying to manage work life and the care of her family. This Keynote, entitled *Evolution of a Feminist: From Competition to Care*, challenged gender roles for both men and women who each have to balance the role of caregiver while trying to succeed in the work environment. Saturday morning's speaker, **Dr. Diane Fosha**, creator of Accelerated Experiential-Dynamic Psychotherapy, showed videotapes of her therapeutic interventions aimed at helping a patient deal with his emotions. Watching her actual work was compelling and demonstrated the skills she used around mirroring and creating mutual empathy. On Saturday afternoon, **Gayle Brooks, PhD** and **Rachel Levine, MD** shared the stage and offered personal reflections on race and gender identity, helping to increase our knowledge of the context in which these issues affect eating disorders. Each spoke in authentic and meaningful ways. **Rachel Simmons**, our final Keynote presenter, delivered powerful messages about the challenges facing adolescent girls and how to help them build resilience. Rachel's blend of authenticity, intellect and humor were described as a "great trifecta". In addition to the Keynotes, many of the workshops explored issues related to social justice, and the LGBTQ community as well as developmental and transitional stages which increase the risk for eating disorders.

Recognizing that our patient population has become increasingly more complex and diverse, next year's Conference entitled *Feminist Relational Perspectives and Beyond: Integrating Science, Creativity and Clinical Wisdom* will be held from Nov. 10-12. A major focus will be on Evidence-Based Practice. We will also continue to address feminist/relational perspectives, diversity and skill development. More information can be found on page 16, as well as an order form for recordings of this year's workshops.

Again, thank you to all who have enthusiastically participated in our annual Conference year after year, and the new professionals who we had the pleasure of meeting this past November. Each of you has enriched our community and together, we have made a significant impact in the eating disorders field.

Best wishes for a wonderful 2017 and we hope to see you at our next Conference!

JUDI GOLDSTEIN, MSS, LSW
CONFERENCE CHAIR



“I will be coming year after year. This conference was warm, inviting, caring and of course, educational and inspiring.”

“As always, the Conference was exciting and energizing – just like my professional home.”



“Renfrew consistently offers exemplary speakers; cutting edge topics and practical take home strategies.”

The 27th Annual Renfrew Center Foundation Conference

*Feminist Relational Perspectives and Beyond:
Integrating Science, Creativity and Clinical Wisdom*

NOVEMBER 10-12, 2017
PHILADELPHIA AIRPORT MARRIOTT

Being a highly effective eating disorder therapist is a process, not a destination. As our patient population has become increasingly more complex and diverse, research has provided us with a growing body of evidence-based practices (EBPs). As a result, clinicians now face the daunting task of mastering new, cutting edge treatment approaches and integrating them into our well established and uniquely nuanced practices. In order to provide the quality of care our patients require and deserve, we must evolve along with the field.

Conference 2017 will examine the challenge of learning new skills at different points in the professional “lifespan.” These can include the incorporation of innovative therapeutic approaches and evidence-based practices, the integration of clinical intuition, creativity and wisdom, as well as the critical role of supervision.

Accepted proposals should fall into one of four program tracks: Evidence-Based Practices (EBPs), Skill Development, Diversity, and Feminist-Relational and will address topics such as:

- Translating research into clinical practice
- The art of psychotherapy and counseling
- Increasing competency and integrating new knowledge
- Body oriented/Somatic practices
- Transdiagnostic treatments
- Supervision and consultation
- Intersectionality
- Research and practice with underserved populations
- Effects of oppression and privilege on ED identification, clinical practices and recovery
- The role of attachment and connection
- Relational cultural theory skill development

CONFERENCE FORMAT:

- Keynotes
- Two-Hour and Three-Hour Presentations
- 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. 11th 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 Kavita Patel at kpatel@renfrewcenter.com.

Call for Proposals

DEADLINE FOR SUBMISSION: MARCH 10, 2017

Please submit (A) Cover Letter, (B) Abstract, (C) Biographical Sketch (D) Resume/CV and (E) 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: 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 – 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 – 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 – Requires the knowledge 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 Program 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
4. Description of **handout(s)** to be provided. A handout may be a bibliography, power point presentation, outline of presentation summary, additional resources, a case study, etc. A handout is **mandatory**.

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. Resume/CV

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

PRESENTATION GUIDELINES:

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

SUBMIT a proposal by electronic mail, on two pages only, and within the body of the email. The SUBJECT line should read: 2017 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
aresler@renfrewcenter.com
gbrooks@renfrewcenter.com

bmcgilley@psychology.kscoxmail.com
mdm@mws.org
mark.warren@emilyprogram.com

CONFERENCE COMMITTEE DECISIONS WILL BE MADE BY MAY 8, 2017.

AUDIO RECORDINGS ORDER FORM

THE 26th ANNUAL RENFREW CENTER FOUNDATION CONFERENCE FOR PROFESSIONALS

November 11-13, 2016 in Philadelphia, Pennsylvania

Please check your selections

KEYNOTE PRESENTATIONS

- KEY 3 Shining the Light on Marginalized Populations: A Discussion on Race and Gender
- Gayle E. Brooks, Ph.D. & Rachel Levine, M.D.

WORKSHOPS

Friday, November 11, 2016

- FR 1 Utilizing Sensitivity in the Treatment of LGBTQ Individuals with Eating Disorders
- Brandi E. Baumkirchner, PsyD
- FR 3 Beginning with Ourselves: Conversations About Race and Ethnicity in the Treatment of Eating Disorders
- Sarah Chipps, PsyD & Marissa Sappho, LCSW, BCD, CEDS
- FR 4 Healing Hungry Hearts: Psycho-Spiritual Factors of Emotional Eating
- Linda Ciotola, MEd, CHES, TEP, CETIII
- FR 5 Breaking the Links of Experiential Avoidance and Psychological Rigidity: Using ACT and Radically Open DBT to Address Treatment-Resistance Maintenance Factors
- Danielle Doucette, PsyD & Chelsea Bath, LPC
- FR 6 The Barbara M. Greenspan Memorial Lecture - Preventing Eating Disorders: Looking Backward, Moving Forward; Looking Inward, Moving Outward
- Dianne Neumark-Sztainer, PhD, MPH, RD
- FR 7 Finding Self Again: The Dismantling of Eating Disorder and Trauma Identity
- Michael E. Berrett, Ph.D.
- FR 8 Eating Disorders: What's Feminism Got to Do With It?
- Andrea LaMarre, MSc & Carmen Cool, BM, MA, LPC
- FR 9 Where is the Hope When You're Ashamed to Exist?
- Nikki Rollo, Ph.D., LMFT & Norman H. Kim, Ph.D.
- FR 10 Attachment-Based Family Therapy for Adolescents: Applications for Eating Disorders
- Jody M. Russon, Ph.D.
- FR 11 Recovery, Wellness and the Brain
- Craig Strickland, Ph.D. & Winden S. Rowe, MS
- FR 12 Binge Eating Disorder: Current Paradigms in Treatment and the Advancement of a More Inclusive Eating Disorders Community
- Chevese Turner, BA & Robyn Goldberg, RDN, CEDRD

Saturday, November 12, 2016

- ❑ SA 1 A Developmental Perspective on Binge Eating Disorder
-Victoria Butterworth, Ph.D.
- ❑ SA 3 Biopsychosocial Transitions Across the Lifespan: Critical Risk Factors for Eating Disorders
- Margo Maine, Ph.D., FAED, CEDS & Theodore Weltzin, M.D., FAED, CEDS, FAPA
- ❑ SA 4 Matters of Life and Death: Eating Disorders and Suicide
- Nicole Siegfried, Ph.D., CEDS
- ❑ SA 5 It Takes a Village: Providing Treatment, Coaching and Mentoring to African-American Women with Eating Disorders at Predominantly White Colleges
- Charlynn Small, Ph.D., CEDS & Mazella B. Fuller, Ph.D., MSW, LCSW
- ❑ SA 6 Emotion Exposures: Leaning-in to Food Avoidance
- Heather Thompson-Brenner, Ph.D., FAED & Dee Ross Franklin, MA
- ❑ SA 7 “I’m Not a Little Adult”:The Art of Matching Clinical Approach to Cognitive Development in Adolescents
- Sara Gould, Ph.D.
- ❑ SA 8 Type 1 Diabetes and Eating Disorders:A Complex Dual Diagnosis
- Susan Ice, M.D. & Trish Lieberman, MS, RD, LDN
- ❑ SA 9 Exposure with Response Prevention:Treatment Implications Across the Lifespan to Target Body Dissatisfaction in the Later Phases of Recovery from an Eating Disorder
- Brad Mac Neil, Ph.D.
- ❑ SA 10 Menstruation to Menopause: Hormones Throughout the Lifespan and Their Intersection with Eating Disorders
- Maria Sorbara Mora, MS, RD, CDN, CEDRD, RYT
- ❑ SA 11 Eating Disorders:Who Dies?
- Mark Warren, M.D., MPH, FAED & Mary Tantillo, Ph.D., PMHCNS-BC, FAED
- ❑ SA 12 Exploring Identity through Recovery: The Power of ourVoices
- Cynthia Whitehead-Laboo, Ph.D., Nettie Reeves, CPT, CHC & Ryan Sallans, MA

Sunday, November 13, 2016

- ❑ SU 1 Moving Off the Couch: Utilizing Experiential Techniques in Family Therapy
- Rebecca Berman, LCSW-C, CEDS, MLSP & Lisa Luse, LCSW-C
- ❑ SU 2 A Thin Line Between Childhood Obesity and Eating Disorders
- Carolyn Hodges Chaffee, MS, RDN, CEDRD & Annika Kahm, MS
- ❑ SU 3 The Influence of Ovarian Hormones on Genetic Risk for Eating Disorders Across the Lifespan: Research Data and Clinical Care
- Kelly Klump, Ph.D.
- ❑ SU 4 Multicultural and LGBTQ Populations:The Influence of“Isms” on the Development of Eating Disorders
- Marcella Raimondo, Ph.D., MPH

The 26th Annual Renfrew Center Foundation Conference Philadelphia, Pennsylvania

- Share the information with colleagues & clients who could not attend.
- Listen to the sessions you did not attend.
- Review the sessions you did attend.

FULL SET – CONFERENCE SPECIALS

2030-99 ____ 2016 Renfrew Center Foundation Conference Special--Full Set of Audio files for only \$99**

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Individual Workshop Sessions	_____	\$10.00		\$ _____
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2015 Renfrew Conference Full Set of Audio Recordings	_____		\$49.00	\$ _____

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Emails to the Editor

*Join the discussion by emailing your thoughts
on this issue to perspectives@renfrewcenter.com*

The opinions published in *Perspectives* do not necessarily reflect those of The Renfrew Center. Each author is entitled to his or her own opinion, and the purpose of *Perspectives* is to give him/her a forum in which to voice it.

LOCATIONS

RESIDENTIAL:

Philadelphia, Pennsylvania
475 Spring Lane
Philadelphia, PA 19128

Coconut Creek, Florida
7700 Renfrew Lane
Coconut Creek, FL 33073

OTHER LOCATIONS:

Atlanta, Georgia
50 Glenlake Parkway
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Nashville, Tennessee
1624 Westgate Circle
Suite 100
Brentwood, TN 37027

New York, New York
38 East 32nd Street
10th Floor
New York, NY 10016

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Old Greenwich, CT 06870

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