A Word from the Editor

When we decided to devote this issue of Perspectives to the theme of challenges to therapeutic boundaries, a book I’d read many years ago by Carter Heyward entitled When Boundaries Betray Us, (1993) immediately came to mind. Although I’m not sure what was transpiring in my life that motivated me to read this book, I vividly remember the powerful impression it made. As Carter Heyward, an Episcopal priest and professor, explained:

“Many contemporary psychological observers would say that Elizabeth [pseudonym for her therapist] and I had a ‘boundary’ problem. We most certainly did, but not in the sense that most therapists would mean. My experience of what happened between us – the account recorded in this book – does not support the prevailing assumption among psychotherapists that they must maintain their ‘professional boundaries’ in order not to harm those who seek their help.

“Much to the contrary, I experienced Elizabeth’s participation in my healing to be strongest and clearest in those moments when she engaged me most fully as a sister, most authentically as herself, rather than as tightly constricted by a sense of professional correctness. As a theologian, I would say that the power for healing in the therapy, a sacred power, was most effective whenever Elizabeth and I were experiencing it most fully as ours, not simply as hers or mine.” (1993: pp. 2-3)

Heyward’s relational and feminist perspective, more fully revealed in a book review with selected excerpts later in this issue, contrasts sharply with three invited essays, two from mental health clinicians and one from a registered dietitian. By way of background, our invitational letter to potential contributors described our expectation that this issue of Perspectives would provide the eating disorders community with a rich and in-depth exploration of therapeutic boundaries. In this regard, our focus was designed to differ substantially from traditional academic approaches by encouraging contributions that reflected on clinical experiences rather than ‘ethics 101.’

We urged each writer to provide a personal and probing commentary, one that reflected his or her expertise and wisdom – a commentary that we acknowledged might require some courage on the writers’ part.

Indeed, the three essays in this issue do not disappoint. They required a great deal of courage as each author provides clinical experiences to illustrate concepts presented more abstractly. Dr. Stefan Pasternack begins his essay by describing a recently widowed client who, at the end of a session, burst into tears and then stumbled. “Reflexively, I reached out to hold her so she would not fall to the floor. As she regained her balance, she suddenly wrapped her arms around me in a tight embrace and wept on my shoulder. I was deeply touched by the depth of her emotions, but also briefly discombobulated.” Dr. Pasternack explains how he responded to the client and the rationale for his professional boundaries that ‘preclude any physical contact other than an occasional handshake.’
A recently widowed, attractive 45 year old woman sought help to work through grief about the death of her husband in a tragic car accident. She had not been able to weep, although she missed him terribly and felt sad and empty. She felt her emotions were frozen. She wanted to cry. As we both stood up at the end of a session in which she was finally able to feel her loss, she burst into tears and then stumbled. Reflexively, I reached out to hold her so she would not fall to the floor. As she regained her balance, she suddenly wrapped her arms around me in a tight embrace and wept on my shoulder. I was deeply touched by the depth of her emotions, but also briefly discombobulated. After a few moments, I slowly backed away to regain my own composure. While feeling anxious about triggering more anguish, I felt it important to explore this with her, to help her make sense of what had happened. I invited her to sit down for a few moments so she could compose herself, going into ‘over time’ beyond the usual session limits. I then shared with her my gut sense that the ending of the session triggered a deeper grief about the ‘forced ending’ of her marriage due to the tragic death of her husband. She said: “I never had a chance to say good-bye to him; he was just gone.”

For several weeks, we discussed her tragic loss and her longing to be hugged, which intensified because I resembled her husband. Rather than feeling rejected when I advised her to talk about wanting hugs instead of hugging me, she delved more deeply into her sense of physical loss, of missing his hugs and the pleasures of their love life. I was able to convey to her that she could ‘hold me in her mind,’ that is, mentalize me (as I could her) so that through intersubjective and empathic

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**Boundaries: Ally of the Therapist**

**Stefan A Pasternack, M.D. DLFAPA**

Christie Caggiani is a registered dietitian who recalls that the concept of boundaries was foreign to her, having learned nothing about them during her professional education. In contrast, the development of her boundaries “did not occur overnight, but rather took years of experience and much trial and error.” As she transitioned into motherhood, she had a boundary-setting epiphany when she realized that she didn’t have the energy to over-give to her clients. This forced her to quickly re-order priorities, including letting go of longstanding clients who she felt needed higher levels of care, but who preferred to continue ‘business as usual.’

Becoming sexually attracted to ‘Laura, a 20 year old, soft-spoken, articulate, and stunningly attractive’ patient is the focus of our third essay. Dr. S. Roy Erlichman, provides an illuminating picture of himself as a young therapist who lacked the “experience to understand and address my visceral reactions to what was about to unfold.” He vividly captures the challenges presented to therapists who need to “be able to manage and metabolize the feelings induced by patients. These feelings may be dark, intense, painful, enduring and seductive.”

Finally, a brief book review with selected excerpts from Carter Heyward’s *When Boundaries Betray Us: Beyond Illusions of What is Ethical in Therapy and Life* (Harper Collins, 1993) is presented. Admittedly, the review does not begin to capture the depth and richness of her therapeutic experience and resulting insights. Rather, it provides readers with a glimpse into the perspective of a lesbian feminist theologian of liberation whose journey reveals the damage, harm and violence that can result “…by the drawing of boundaries too tightly as by a failure to draw them at all” (p. 137).
engagement, there was no need for a physical hug. When we are so engaged with patients, there is no need for physical contact. However, if we are not so engaged, a physical hug is a poor substitute. This experience reinforced for me the importance of sensitively discussing the reasons for a meaning of boundaries with each patient as this helped her and others understand their importance. I did not allow hugs in subsequent sessions; rather, I gently helped her to talk about her longings instead of acting out her feelings by hugging me.

In future sessions, I also stuck to the 50 min time limit. By announcing that the session was almost over, I gave her time to compose herself before leaving on time. I believe that these consistent, predictable boundaries gave her a sense of safety so she could delve more deeply into her inner word of sorrow, knowing I could handle it and help her handle it better too.

Forty five years of clinical practice, teaching and supervising young therapists have highlighted for me the fact that the safe and effective conduct of treatment operates best within a ‘therapeutic frame’ of agreed upon guidelines. Our patients rely upon us to provide a safe and facilitating environment in which to explore their feelings, traumatic experiences, dreams, fantasies memories and such dark side emotions as hate, gluttony, greed, lust and envy. While some practitioners still carp about the stereotype of the rigid analyst who never engages the patient, most mental health practitioners recognize the need for sensitive interactions, but also consistent and reliable boundaries, which may be extended from time-to-time in an empathic and flexible manner. The overarching principle is that everything we do should foster the work of therapy and emotional growth. To accomplish this, the therapist must establish a ‘therapeutic space’ in which both can jointly understand what is happening and to put thoughts and feelings into words, not actions. My patients need to understand that there will be no physical contact other than an occasional handshake. Hugs and kisses are not part of a professional therapeutic relationship and, in fact, may interfere with the process of emotional self-regulation.

At the start, I establish that therapy will occur only within a professional setting, be it office, hospital or clinic. I explain that therapy takes place for a set time, according to an agreed upon schedule and that a regular schedule fosters self-discovery. My patients are expected to pay a reasonable fee, whether through insurance or privately. The only demands which I can legitimately make on my patients are that they come to therapy regularly, take therapy seriously and pay their bills. I do not expect or seek friendship, sex, love, or business deals and I carefully consider whether or not to see any of their friends or relatives as future referrals. I have learned that when a patient refers a friend or relative, they may have some ambivalence about doing so and/or may feel threatened. Psychotherapy is unlike medication management and has profound conscious and unconscious meanings to patients. Why risk undermining the good work we have done by working with someone they have referred soon after treatment ends?

My actions with the grief stricken woman can be defined as a ‘boundary crossing’ as contrasted with ‘boundary violations.’ Boundary crossings are infrequent breaks in the usual frame of therapy that are attenuated, carefully discussed in therapy, and ultimately are not harmful to the patient. On the other hand, boundary violations are exploitative breaks in the frame. They are usually repetitive, often extreme (such as sexual exploitation or trading on insider information), are not discussed in therapy, and usually result in harm to the patient or treatment.

Adhering to a clear set of practice boundaries provides an ‘early warning’ system about potential adverse counter transferences to patients in therapy. For example, a colleague sought my advice when he noticed that he often allowed an attractive younger woman to go 10-15 minutes over time, gave her a reduced fee when she could have paid more and eagerly anticipated her appointments. Struck by awareness of his departures from his usual practice boundaries, he then could confront his counter transference attachment to the patient. He had the insight that treating the patient as ‘someone special’ made him feel ‘special’ too. He then was able to recognize, that in the aftermath of a bitter divorce, he had lost the sense of being special to or feeling special about someone else. He was trying to regain a part of himself lost in the divorce. His insight led him to arrange for regular supervision and to have individual psychotherapy so he could master his counter transference and cope better with the temporary, but acute disruption of his personal life. He later told me that his patient seemed relieved when he set better limits. This reflects the wisdom that by setting healthy boundaries we let others know what we expect in both personal and professional relationships, as well as what we don’t want. What we allow, what we limit, what we reinforce, conveys to our patient how treatment and other
relationships should be structured and reinforces what we talk about with, and interpret to, the patient. When we set reasonable limits, it helps patients do the same in their own lives. The therapy relationship can be a learning laboratory, especially for those who have suffered through abusive relationships and were taught to feel guilty about setting limits.

A recent surge in interest about ‘hug therapy’ (as if it is a form of treatment) may lead some patients to think that hugs are part of treatment. They are not and, in fact, are often the first misstep towards serious violations. I am not being cold and heartless when I decline hugs. I have been trained and encouraged to ask patients to explore their feelings about hugs and why they are needing one. It is never wise for a therapist to initiate hugs and certainly not kisses. One can never know what a hug may mean, especially to someone who has been sexually abused. Also, therapists can never be sure of the goodness of their ‘hugging’ intentions and may be seeking to gratify their own unmet unconscious, sexual or romantic needs. Studies about therapists who become sexually involved with patients show that regular embraces are often the beginning of ever increasing violations and a slide down a slippery slope to more touching, fondling and sexual acting out (e.g. Celenza, A. and Gabbard, G; 2003; Foehl, J., 2005; Gutheil, T. and Brodsky, A., 2008).

In my experience, most therapists who get sexually involved with patients are not psychopathic sexual predators who exploit one patient after another. They often are troubled men or women, perhaps in a mid-life or aging crisis, who deceive themselves about what they are doing. They fall victim to the illusion of a ‘love cure.’ Crossing boundaries should set off alarms.

Another frequent boundary crossing that can become a boundary violation concerns confidentiality. It frequently happens that one therapist treating one member of a couple may refer the other member to a colleague. But the fact of referral does not imply that the patient wants his/her respective therapist to share information with the colleague. One has to avoid slipping into secret conversations and should check with the patients before sharing any information about them. In one case, after a patient confided to his therapist that he had had an affair, his therapist inadvertently blurted it out to the other therapist who then had to cope with a secret piece of information. Unfortunately, the wife’s therapist tipped her hand by asking too many questions about the couples’ sex life in a way that led the wife to infer her husband was having an affair.

A bitter divorce resulted as well as a complaint by the husband to the State Ethics Committee about his therapist’s violation of confidentiality.

Finally, the termination of therapy does not terminate the need for boundaries. One is advised to keep in mind the maxim ‘once a patient always a patient.’ It is important to end relationships in a proper therapeutic manner. It is not advisable to seek friendship with a former patient. The power of the transference and counter transference, while reduced, is often indissoluble and should be contained by post termination boundaries. If you date a former patient, who is it that you are to that person – a representative of their long lost father, their once adored boyfriend, because you can’t really be you once you treat a patient in any type of intensive therapy. Transference casts a long shadow.

Boundaries are the therapist’s ally. When adhered to in a clear, consistent, but sensitive and flexible manner, treatment boundaries provide a safe, predictable, reliable space in which therapy and emotional growth can take place.

REFERENCES


Navigating Boundary Challenges in Nutrition Therapy

Christie Caggiani, RDN, LDN, CEDRD

“Boundaries.” The concept immediately takes me back to the early days of my work in the field of eating disorders, when I would treat clients in therapists’ offices, at a coffee shop, in a church office, or in a client’s home. Feeling pulled in different directions, working around everyone else’s schedules, and attempting to function professionally in a setting that wasn’t congruent, was exhausting, at the very least. While some of this could be attributed to launching my career, I discovered something extremely important about boundaries and their contribution to the effectiveness and sanity of my professional work.

As a registered dietitian, I recall learning nothing about boundaries in my education. Very little, if any, discussion highlighted the value of working within a healthy framework: how do we help people, have compassion and relate to them within clear and balanced parameters, without over-giving ourselves. In fact, my first real exposure to the foreign concept of boundaries came when I was trying to navigate working with a client who also attended the same church as I did. Fortunately, a therapist colleague recommended that I read the aptly titled book by the same name.* There began my unfolding journey of defining how boundaries can support me both personally and professionally.

Boundary issues can surface in a variety of ways. If much of society has a fascination with food and a curiosity about ‘what the nutritionist eats,’ our clients are even more curious about our eating patterns. Depending on such factors such as stage of treatment, the trust a client has developed, the presence of a personality disorder and/or transference issues, disclosing my own food, movement or body stories could have significant consequences. If, for example, I were to share with a client who is in the early stages of recovery that I eat waffles with peanut butter for breakfast without knowing that her abusive mother did the same, negative transference could easily result, with waffles and peanut butter now perceived as a power struggle with me, her “mom.”

When the frequent question, “What do you eat for breakfast?” is asked, I must consider:
- Will my answer really help the client’s recovery process?
- Who is asking the question? The client or her ED?
- If I answer the question, am I helping treatment to progress?
- Am I being made responsible for my client’s decision(s)?

By simply responding to her question with a question, “How might that information be helpful to you?” I can explore what her inquiry is really about. My breakfast wouldn’t truly solve her anxiety. In fact, it might give her something else on which to focus.

That being said, there have been times when, after recovery is solidly underway, I may choose to answer that question, but only after exploring the intent.

As a nutrition therapist working in the field of eating disorders, I hope that each of us has seriously and honestly explored our own food issues, nuances and beliefs, so that we can honor and practice what we preach, including the flexibility to not be perfect. When we have a balanced relationship with our food and body, we can best answer questions presented by our clients and not feel compelled to prove ourselves.

The development of boundaries did not occur overnight, but rather took years of experience and much trial and error. I have vivid memories of responding to my pager (yes, pager) late in the evening, trying to help a particular teen regroup after purging. This particular teen would reach out after using symptoms, a time where my ability to support her was minimal. She had already used her maladaptive behaviors, and I hadn’t clarified guidelines on out of session contact, so she reached out and I jumped in. As I see it now, I was doing (or so I thought) whatever was necessary to prove to my clients (and myself) that I could be the absolutely best nutritionist. I was doing the work: she could purge, then call me, verbally purge some more, and attempt to hand her emotions over to me. And I also remember feeling particularly over-extended, over-committed and probably somewhat ineffective at that time in my life, not surprisingly.

However, as I transitioned into motherhood, I had a boundary-setting epiphany. Not only did I realize that I didn’t have the energy to over-give to
my clients, I also quickly re-ordered my priorities. I found that I couldn’t benefit anyone – my family, my clients or myself – if I wasn’t true to what was important. In fact, my professional boundaries require me to have clear personal priorities first. I now choose to work with colleagues who support my need for family dinners, regular body movement and overall self-care. Additionally, I am willing to let go of clients who need more than I can give, set limits on my client load (most of the time!), and more carefully assess how many projects I can tackle. I am currently setting and holding my boundary with a longstanding client – she wants to continue business as usual, existing at a sub threshold weight and not changing her behaviors. However, I am acutely aware that she needs a higher level of care and ongoing significant work to address her borderline personality. As a result, I have clearly stated my unwillingness to work with her at an outpatient level. Since she has worked with me for years, I believe our therapeutic relationship may have reached its potential and she may likely benefit from a transition to a different nutritionist after her residential treatment.

As my personal values have become clearer, it became easier to direct my clients away from urgent late night phone calls and toward the use of more clinically appropriate skills. Now they are encouraged to write about challenging situations or questions and discuss them in our next session. Should a phone call be appropriate, they can reach me through my office, leaving a message that they understand I will return when I have a moment during office hours. In some cases, I might provide my work email address and explain that their concerns will be addressed in person, where they can practice using their voice effectively. I also explain that boundaries help establish mutual respect: we will deal with the issues when we can both be present, something that cannot be done effectively via text message!

Since I am acutely aware that this work ‘takes a village’, clear and consistent boundaries and communication are critical within the therapeutic team. This becomes even more challenging in outpatient settings, where practitioners may not even work within the same town. I have found it important to connect with team members at the onset of treatment, establishing who will do the weighing (likely me) and how (blindly), how frequently we will communicate, how we can support each other’s roles without infringing, and how we will interact with the family. In one particular situation, my client, BC, was being weighed by multiple team members: her therapist and her physician allowed her to see her weight, yet I weighed her blindly. Not only did the blurred lines of whose-role-is-it-anyway confuse the client, it also sent mixed messages about how weight discussion was best handled. Only after I brought the concern to the team and we aligned and defined our roles, did this client begin to trust that recovery really isn’t about the weight. Clarifying each person’s role helps all of us experience how a healthy system functions, models communication, avoids splitting and assists patients in developing trust.

In addition, regular supervision can help us explore and evaluate our boundaries, which naturally evolve as our needs, skills and clientele change. As dietitians, we aren’t trained in the concept of supervision, yet it’s next to impossible to do this work without it. Over the years, I have had individual supervision from specialized eating disorder dietitians. Currently, I have weekly supervision with therapists in my practice, maintain a strong network of other nutrition therapists with whom I can collaborate, and obtain outside supervision with my team on a monthly basis.

In scenarios when a client has a strong rapport with me and may be struggling with some form of resistance in psychotherapy, it can be natural for her to turn to me for emotional support. Gently validating her emotions while standing firm that I will not function in the role of therapist can be very helpful and curtail splitting. This also rings true for the individual who believes she only needs a nutritionist for some help with food issues. Though it is completely understandable that it may take a few sessions to move a client toward therapy, it is fully within my bounds to state that I support a team approach. Not honoring this quickly leads to a wall of hopelessness for both of us, usually resulting in frustration and possibly the end of nutrition therapy. In the case of my client, AJ, who presented with anorexia nervosa after initiating a vegan lifestyle, she has struggled to see that this was more than ‘taking the veganism too far.’ She is beginning to understand that, though she restored weight fairly quickly, the underlying issues of grief and anxiety have fueled her disorder, and her fear of the discomfort has interfered with her attending regular psychotherapy. She would rather just ‘fix the food’ and move on. However, by holding my boundary and insisting that she consistently work on the emotional piece in therapy, I can continue to support her recovery from the nutrition therapy perspective.

I believe the boundaries also help us to ‘feed’ our clients just enough in their healing process. How many times have I been in an intake session, feeling excited that I know just what my new client needed, then finding myself asking, listening, and talking – to the point of information overload. This
longer-than scheduled session evolved into truly a situation of “overfeeding.” Not only does this boundary breach of time frustrate my next client and me, this over-feeding of my new client could overwhelm her. By initially laying out the session’s expectations, what we will be discussing, what she might expect to leave with and the length of the session, I am laying the foundation for a supportive framework.

While some boundaries may need to be established later in treatment, starting the therapeutic relationship with clear parameters can avoid many headaches later. The first session is a key place to explain appointment policies, the differences between nutrition therapy and psychotherapy, and my policy for out of session contact.

Typically, I also will share how I protect my client’s confidentiality, whether with family members or if we see each other unexpectedly in public. Should I not outline this boundary, my client might feel shunned, disregarded and personally attacked, if I were to not acknowledge her. In one social event, I felt as though I was completely protecting my client by not greeting her. However, her interpretation was that I was embarrassed to be in public with her. During the next therapy and nutrition therapy sessions she needed to work through her feelings of rejection. Had I clearly spoken my boundaries in advance, she would have been better able to navigate that situation.

Laura was about 20 years old, soft-spoken, articulate, and stunningly attractive. My seemingly instant visceral reactions caught me off-guard. I recall pausing to reorganize my feelings. I listened carefully as she explained her reasons for seeking therapy and her determination to fulfill goals and dreams that well exceeded, in fact seemed to defy, the limits and demands her family had hard-etched for her. Laura was at war with their convoluted views of life and personal values. She was an excellent student. She spoke well and courageously, gifted in so many ways, the seemingly ideal analysand and for a budding young psychoanalytic therapist. What I lacked, but did not know then, was the experience to understand and address my unanticipated reactions to what was about to unfold. What are the rules that shape the course of treatment when the material — or the patient — induces sexual feelings in the therapist... whether male or female?

We agreed to meet weekly. Laura arrived for her sessions on time, expressed her thoughts and feelings openly and began to describe and explore the fabric of her life. Trained analytically, I learned early on that, through the phenomena of the transference relationship, the patient’s life will be revealed. It is the therapist’s work to study the elements of these revelations and the questions and resistances presented which constitute ‘the material’ of the work. By addressing thoughtfully the transference issues that arise over the course of treatment, patient and therapist ‘live through and work through’...
unsettled and burdensome life issues. For years I have called this process ‘canvas painting.’ That is, the patient’s words and feelings are, so to speak, the paint, and the therapy hour is the canvas. The patient is the artist, the crafts person who designs and shapes the finished product. As with real painting, the artist can rework the design, change or subtract color, even scrap the canvas and start afresh if he or she wishes. My task as therapist is to aid ‘the artist’ in seeing with clearer eyes what he or she has painted. Is this the picture she truly wishes, or should the canvas be reworked – and, if so, with what design?

As I began to work further with this young and attractive patient, I found myself thinking beyond the treatment room. What would it be like to know her better? Would she, could she, find me a better and kinder person than the other men she had known and dated? I would certainly be ‘better’ than her brutal father, and she clearly had values that appealed to me. Not to overlook that she was attractive, intelligent and very personable. Her sense of humor was delightful. The intensity of these feelings scratched hard at my moral fiber. I began to find it harder to sleep at night. And concentration in our sessions grew increasingly difficult. I said nothing about this to anyone. I was embarrassed. My reactions to Laura had become an obstruction in her progress and an impediment to her acceptance of help. Laura had become painful, not helpful. I was frightened. My responsibility was to help Laura heal, not be harmed...again.

Addressing the intricacies of transference and countertransference is beyond the scope of this paper; however, for the purposes of this essay, in simple terms, transference represents the thoughts, feelings, dreams, memories, projections that a patient brings to the treatment relationship. These may be imposed, unrealistically and tenaciously, upon the relationship and the therapist – as if the therapist truly is the loving grandparent or hated parent. As therapists, we have our own reactions, which we label countertransference. For me, these represent the sum total of our conscious and unconscious reactions to the patient and powerfully color what we think, feel, say and sometimes do. It is ‘the doing;’ however, that may become the source of a significant boundary problem – when the relationship becomes sexually charged and drives one or both parties to ‘do’ – which is to act inappropriately.

This is often referred to as the erotic or eroticized countertransference. Misunderstanding, improperly interpreting or abusing the healing opportunities that the erotic countertransference provides can be toxic to the patient with an eating disorder, whose life frequently reflects hideous sexual wounds or worse, that until now may have rested quietly in the deepest recesses of her memory. How the therapist addresses the patient’s thoughts and feelings and perhaps, for the first time, even legitimizes them can be remarkably healing... or remarkably destructive. In my experience, treatment of persons with eating disorders often requires many years to achieve a state of health (however defined); and during that lengthy process, it is vital for the patient to be able to address freely and ‘know’ her sexual self: Talking about it, though, may foster strong resistance. The therapist, too, needs to face his or her sexual self and be able to manage and metabolize the feelings induced by the patient. These feelings may be dark, intense, painful, enduring and seductive.

What did I ‘do’ in relationship to my patient? I did nothing. Although I thought about rescuing Laura from her pained world and enjoying a richly fantasized intimate life with me, I knew this could not be right. After about three months, I called a trusted supervisor and asked for help. What resulted from this were three critical revelations. First, it was undesirable and unhealthy for me to continue working with this patient. My struggles with my subjective reactions had overwhelmed my ability to be clear-minded and exercise sound therapeutic judgment. The objective fact was that this woman was truly gifted, but I had no need for her as a permanent part of my life, even though I thought I did. Nor did Laura have need for me in her life except as her therapist. Second, the work revealed many of my own unsettled and unconscious wishes and needs to demonstrate achievement. ‘Winning’ her would have been a public statement of some sort about me. But this revelation confirmed to me how unethical it would be to continue our work simply to make that point. Simultaneously, it created the question of how to terminate therapy without inflicting powerful wounds on an already wounded soul. Without knowing what words to say, I needed to be truthful, for to be mechanical would have caused more pain and rejection that she would surely have felt. Third, I realized how inexperienced I was as a professional. I was educated, it is true, but I needed more training, more supervision, and greater self-awareness to manage a case as complex as this.

Fortunately, the treatment relationship was still young. Time could help both of us to heal. When I finally felt clear,
I told Laura that I had been giving great thought to our relationship and believed that she would prosper more fully by working with a more seasoned therapist who could better help her explore her history, hopes and dreams. I explained the obvious, that I was young and new to the field and that my youth and newness must not interfere with my determination that she should get the best possible treatment in order to fulfill the objectives she had set for herself. She told me how sad she felt and that, in fact, she had very caring feelings for me. She also expressed gratitude that I had acknowledged and accepted responsibility for the change in our relationship – that it was not her doing – and that the course of treatment would be responsive to her needs and objectives as opposed to what someone else wanted or demanded of her.

This was a ‘eureka moment’ for Laura; it was the re-awakening of what her life struggles had been. Someone else wanted her to do or be what she did not truly need or wish for herself because she was seen as beautiful and talented, a trophy of sorts. Now, however, in my innocence, inexperience and visceral wandering, we were able, by accident it seems, to begin to resolve that issue for her. The sexualized character of the relationship created the possibilities for clarity, relief, self-determination and growth.

Treatment ended after a few more sessions. At Laura’s request, I referred her to several competent people. She chose a skilled and compassionate woman to work with and, to my knowledge, prospered from treatment. My feelings were explored over many months with my supervisor.

One might wonder about my decision to share with her only my inexperience and not my sexualized feelings as the reason for terminating therapy. In my opinion, that involves needless self-disclosure that would not have helped either of us. It would not have fostered treatment progress. Moreover, it might have led to her feeling that somehow she had caused not only this rupture in therapy but also the feelings of guilt and culpability that I myself had experienced.

That is the core of what projection identification is about—someone else, usually trusted, does something wrong or experiences intolerable feelings, and projects (‘gives’) them onto the child. The child is told critically that she is responsible for these intolerable states (the suffering of others) and grows to believe that the projection is true! Start this process early in life, repeat the message often, and it is soon encrypted in neurological concrete. No, my responsibility was to use my feelings to understand the patient, myself, the objectives of therapy and not directly or indirectly project them onto this woman. The overarching task, to do no harm, was mine in its entirety.

In retrospect, it would have been a simple act for me to terminate treatment and become more intimately involved. That path was clear. However, therapists who are open to feelings generated by our work ought not extinguish sexualized moments. They inform our work and help guide the course of treatment. Finding a patient attractive or sexually intriguing is not a boundary violation, unless the feelings are acted upon, which may include curtailing legitimate, healthful therapeutic process. Acting-in and acting-out are both high risk.

In my experience, erotic countertransference is seldom discussed, other than when it is violated. The sexual response is fundamental, evolutionary and responsible for ‘the origin of species.’ But how often is it discussed as an element of training and supervision? Is it used conceptually to help the therapist understand the life and needs of the patient, or is it, as often presented, the feeling that must lead to treatment termination?

How do we understand and manage these feelings? We are entrusted with a patient’s health and wellbeing. To terminate therapy may be appropriate when erotic feelings disturb the course of our work and disrupt our ability to ethically and morally fulfill the therapeutic path we have established with our patients. Yet, we do not ordinarily terminate treatment with a patient we dislike or a patient who enrages us. Why should sexual feelings necessarily lead to treatment termination as opposed to their being a pathway to understanding, growth and hopefulness?

Boundaries may be clear or confusing. Consulting with others can be of enormous help. But there is no substitute for examining our own internal codes to be sure we are clearer than the people who entrust us, and gift us, with their lives and invite us to paint new canvases with them.

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BOOK REVIEW

by Marjorie Feinson, Ph.D.


In the Introduction to her poignant and courageous account of an “agonizing and ultimately liberating passage through a therapy relationship,” Carter Heyward explains her purpose in writing the book:

“… to sharpen awareness among healers and those seeking healing and liberation that an immutable ‘power-over’ dynamic that does not move us toward a more shared connection serves to diminish and mute the human spirit – even in well-intended, carefully structured professional situations such as psychotherapy” (pp. 1-2).

Diminishing and muting the human spirit is central to her traumatic experience of therapy with Elizabeth Farro (pseudonym) as she challenges “as unethical any so-called ethic that rules out the cultivation of genuinely mutual relation anywhere in our lives” (p. 10). She acknowledges that “conscientious healing professionals today are trying to be genuinely ethical – nonabusive – in our work.” However, she also acknowledges that is important that, “… those of us who work as healers – therapists, doctors, nurses, priests, pastors, rabbis, educators, midwives – understand how badly abusive we can be by withholding intimacy and authentic emotional connection from those who seek our help” (p.10).

Clearly, for Carter Heyward, a feminist lesbian theologian, “abuse is not simply a matter of touching people wrongly;” it is refusing “to touch people rightly” by holding tightly to prescribed role definitions (p. 10). In other words, she believes that the healing dynamic in therapy must be ‘mutually empowering,’ that it touches and changes the therapist as much as the client. “I believe strongly that we are genuinely healed, strengthened and liberated only insofar as our relational energy is calling us both, or all, to life, to be who we are at our best together.” She emphasizes that, “unless the healer is being transformed by the therapy process and the teacher being changed with her students, these relationships are not trustworthy resources for authentic spiritual growth or emotional well-being” (p. 11).

In her response to Carter Heyward’s story (included in part 3 of the book), feminist psychotherapist Miriam Greenspan acknowledges that the author’s powerful and disturbing words… “jolt the reader out of the lull of conventional consciousness about the rectitude of professional expertise and good intentions. They speak to a hidden wrongness in the psychotherapeutic relationship as it is normally defined and practiced. They assert that it is not deviation from a professional ethic of care, but adherence to this ethic, that is inherently, albeit unwittingly, hurtful” (p. 194).

In describing the harm that is done to both patient and professional by the norm of professionalism, Greenspan highlights the systemic source: “… all professionals are trained in a system and an ethic that emphasizes distance, neutrality, and boundaries’ at the expense of person-to-person connection and interrelatedness… What I mean by person-to-person connection is building an authentic bond between the two persons in the therapy relationship and never losing sight of the fact that therapy is a relationship between persons – no matter how tempting it may be for the therapist to treat herself as an objective authority and to reduce the patient to the status of a diagnosis or a bundle of symptoms… “But this person-to-person connection is precisely what professional training in psychotherapy tries to kill. In the patriarchal ethic of professionalism, neutrality is considered to be the essence of the professional posture – and neutrality is defined as the intentional withholding of the personhood of the therapist. The resulting distance is considered to be the sine qua non of good therapeutic work. Connection is seen as inherently tainted and untrustworthy. The danger zone is thought to reside in any manner of person-to-person touching – physical, emotional, or spiritual – that might take place in the relationship.” (pp. 196–7).

In a recently published book, Four Ways to Click (2015)*, psychiatrist Amy Banks, an expert in the neurobiology of human relationships, underscores the necessity of a mutually empowering relationship between therapist and client: “Whereas a separation-individuation therapist would see it as her job to help her patients stand on their own, I forged real relationships with my clients. I shared my own worries and feelings and expanded my emotional repertoire. Within the relationship, the patient grew – and so did I.” (pp. 13-14).

Both Carter Heyward, Amy Banks and others have made invaluable contributions to expanding our understanding of the impact of professional boundaries on therapeutic relationships. Hopefully, this brief review encourages you to explore their work and this topic more fully.

*Amy Banks, M.D with Leigh Ann Hirschman. Four Ways to Click: Rewire Your Brain for Stronger, More Rewarding Relationships (Jeremy Tarcher/ Penguin), 2015. Dr. Banks also serves on Renfrew’s Clinical Advisory Board.
WE’RE BRINGING OUR EXPERTISE TO YOU…

The Nation’s Leader in Eating Disorders Training presents the 2016 Spring Seminar Series for Professionals.

April 1st - Baltimore, MD
**Complex Treatment for the Complex Eating Disorder**
Client: Integrating ACT and Experiential Strategies
Presented by: Adrienne Ressler, LMSW, CEDS, F.iaedp & Gayle Brooks, Ph.D.

April 8th - Newport Beach, CA
Presented by: Adrienne Ressler, LMSW, CEDS, F.iaedp

April 22nd - Louisville, KY
**Getting To the Heart of Eating Disorders: Using Mindfulness to Promote Emotional Awareness**
Presented by: Jancey Wickstrom, AM, LCSW

June 1st - Hartford, CT
**Eating Disorders: Integrating Brain, Body and the Therapeutic Relationship**
Presented by: Adrienne Ressler, LMSW, CEDS, F.iaedp & Margo Maine, Ph.D.

June 3rd - Albany, NY
**Integrating Brain and Body: Mindfulness, Metaphor and Experiential Methods**
Presented by: Adrienne Ressler, LMSW, CEDS, F.iaedp & Jancey Wickstrom, AM, LCSW

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### 2016 Spring Webinar Series for Professionals

The Renfrew Center Foundation is proud to offer free 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.

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<th>Date</th>
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<tr>
<td>February 10</td>
<td><strong>So Hungry For Connection: The New Therapy Relationship for Today’s Dysregulated Teens and Young Adults</strong></td>
<td>Ron Taffel, Ph.D.</td>
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<td>March 9</td>
<td><strong>Demystifying the Medical Complications of Eating Disorders – What Every Non-Medical Practitioner Should Know</strong></td>
<td>David Hahn, MD</td>
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<td>April 13</td>
<td><strong>When Allergies and Eating Disorders Collide: Using A Case Study Approach to Explore Special Diets</strong></td>
<td>Trish Lieberman, MS, RD, LDN &amp; Lauren Rooney, RD</td>
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<td>May 11</td>
<td><strong>Suicide Assessment: Clinical Implications in an Outpatient Setting</strong></td>
<td>Rebecca Berman, LCSW-C, CEDS, MLSP</td>
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<tr>
<td>June 8</td>
<td><strong>But It’s Just a Glass Of Wine! - A Closer Look at the Intersection of Alcohol Use and Eating Disorders</strong></td>
<td>Sandi Morse, LCSW</td>
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All webinars are FREE and run from noon to 1 PM EST.
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As a professional and educator working with individuals affected by eating disorders, you are undoubtedly aware of the devastation these illnesses cause to families and communities. The Renfrew Center Foundation continues to fulfill our mission of advancing the education, prevention, research and treatment of eating disorders; however, we cannot do this without your support.

**Your Donation Makes A Difference…**

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- 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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Featured Speakers:

- Marjorie C. Feinson, Ph.D.
  Professional Development Specialist for The Renfrew Center Foundation

- Sarah Bateman, LCSW
  Jewish Community Liaison for The Renfrew Center

Wednesday, May 18th

DoubleTree by Hilton • 9599 Skokie Boulevard • Skokie, IL 60077 • 8:45 AM - 1:15 PM

For more information visit our website or contact Debbie Lucker at 1-877-367-3383

We will also be hosting a seminar in Philadelphia, PA on May 25, 2016. More details to come.

The Renfrew Center is celebrating its 30th Anniversary as the country’s first residential eating treatment facility.

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

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

This spring, we will be hosting 30th Anniversary celebrations in the following cities:

- Baltimore, MD
- Charlotte, NC
- Dallas, TX

We hope you will join us in celebrating this great milestone!

For more information, and to RSVP, please call 1-800-RENFREW or visit our website at www.renfrewcenter.com
On behalf of the 2015 Conference Committee, I would like to thank all of the speakers, attendees and Renfrew staff who made our 25th Anniversary such a special event. This year we welcomed the greatest number of professionals in the history of the Conference. “Honoring the Past, Embracing the Future – 25 Years Later” featured leaders in the field of eating disorders who shared their expertise, reflections and visions with us.

Our opening Keynote speakers, Gloria Steinem and Kathryn Zerbe, MD, delivered a presentation which was both passionate and unique, on the convergence between feminism and contemporary psychoanalysis. One attendee summed it up beautifully – “my heart and mind were full. Listening to these two iconic women has helped me remember why I do what I do and why I believe in feminism”. Dr. Bessel van der Kolk’s presentation on Saturday offered the audience a deeper understanding of the parts of the brain affected by hyper and hypo arousal during trauma and the effectiveness of utilizing specific treatment interventions in therapy. Saturday afternoon’s panel focused on Males and Eating Disorders and featured Leigh Cohn, MAT, CEDS; Michael Levine, Ph.D. and Catherine Baker-Pitts, Ph.D., LCSW. The debate contrasted different responses to questions regarding whether and how feminist principles should be applied to males and others who identify as non-female. Thought-provoking arguments on both sides were delivered with a great deal of humor, keeping the audience engaged. “Is It the Fat or the Fear”, Sunday’s closing presentation by David Barlow, Ph.D. and Heather Thompson-Brenner, Ph.D., addressed the research and theory of utilizing a unified protocol for treating emotional disorders, including eating disorders. Offering many clinical examples helped illustrate how to put theory into practice using this approach.

Conference 2015 opened with a retrospective video commemorating the past 25 years and closed with a birthday cake to mark the occasion. Throughout the weekend, everyone enjoyed the camaraderie of colleagues and friends at networking breakfasts and evening events. Many thanks to all who participated so enthusiastically!

Planning is now well underway for the 26th Annual Renfrew Conference, Feminist Perspectives and Beyond: Eating Disorders Across the Lifespan and In Diverse Populations which will be held in Philadelphia from Nov. 11-13, 2016. A Call For Proposals is found on Page 16. This update includes photos from the Conference as well as a form to order CDs if you were unable to attend or missed specific workshops.

Many thanks, once again, for making the Conference a great success. We hope to see you next year!

Judi Goldstein, MSS, LSW
Conference Chair
“Excellent job! Superior learning and networking opportunities.”

“It’s more than a conference; it is a retreat for the soul. Thank you!”

“I loved everything – the place, people, workshops, presenters, parking ease, packed schedule, food and the vibe of being taken care of! Bravo to all!”
Call for Proposals

*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. 12th 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 Debbie Lucker at dlucker@renfrewcenter.com.

DEADLINE FOR SUBMISSION: MARCH 11, 2016

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.)

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.

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 or power point presentation.

SUBMIT a proposal by electronic mail, on two pages only, and within the body of the email. The SUBJECT line should read: 2016 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  bmcgilley@psychology.kscoxmail.com
aressler@renfrewcenter.com  mdm@musg.org
gbrooks@renfrewcenter.com  mark.warren@emilyprogram.com

CONFERENCE COMMITTEE DECISIONS WILL BE MADE BY MAY 9, 2016.

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The 26th Annual Renfrew Center Foundation Conference

Feminist Relational Perspectives and Beyond: Eating Disorders across the Lifespan and in Diverse Populations

November 11-13, 2016

Philadelphia Airport Marriott

The manifestations of eating disorders can appear at any point throughout the lifespan. When they occur during developmental transitions, one’s vulnerability is often increased. Age, size, ethnicity, race, genetics, ability, class, gender, religion, sexual orientation or identity, singly or in any combination, also may contribute to the risk of developing the illness.

Conference 2016 will examine these features as well as the influence of maladaptive attachment, the impact of trauma and the marginalization of self – all of which may keep clients stuck and unable to identify or access potential pathways towards healing and recovery. We will further explore, through a feminist relational lens, the way in which intersecting forms of oppression may affect the development and treatment of eating disorders.

**Accepted Proposals will address topics such as the following:**

- Etiological and maintaining factors
- Developmental stages and transitions, including research
- Treatment implications for different age populations
- Influence of marginalization, sustained trauma, family dynamics
- Intersection of obesity management and eating disorders treatment
- Medical and co-morbid conditions
- Bullying
- Gender diversity/gender fluidity
- Transgender
- Social justice
- Weight stigma and prevention
- Self of the Therapist

**Conference Format:**

- Keynotes
- Two-Hour and Three-Hour Presentations
- Networking Receptions
- Poster Presentations*

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AUDIO CD & MP3 ORDER FORM

THE 25th ANNUAL RENFREW CENTER FOUNDATION EATING DISORDERS CONFERENCE FOR PROFESSIONALS

KEYNOTE PRESENTATIONS

- KEY 1 Conversations About Feminism
  - Gloria Steinem & Kathryn Zerbe, MD
- KEY 2 The Body Keeps the Score: Taming the Fear-Driven Brain
  - Bessel van der Kolk, MD
- KEY 3 Are Males Really Marginalized? A Debate About Gender and Eating Disorders
  - Panel of Speakers
- KEY 4 Is It the Fat or the Fear?
  - David H. Barlow, Ph.D. & Heather Thompson-Brenner, Ph.D.

WORKSHOPS

Friday, November 13, 2015

- FR 1 Relational Cultural Theory: Seeing the Forest Through the Trees
  - Amy Banks, MD
- FR 2 The Barbara M. Greenspan Memorial Lecture: How We Can Invite Transcendence into our Clinical Work with Clients and into Our Personal Lives
  - Michael E. Berrett, Ph.D.
- FR 3 It’s Not the Soul Food – it’s the Stress: Treatment of BED among African American Women
  - Gayle E. Brooks, Ph.D., Paula Edwards-Gayfield, MA, LPCS, CEDS, NCC & Nettie Reeves, CPT, CHC
- FR 4 Hope for the Future: Challenging the Harmful Assumptions of Thin Privilege & Weight Stigma
  - Kathy Kater, LICSW & Carmen Cool, MA, LPC
- FR 5 Nutrition and Eating Disorders: Past, Present and Future
  - Sondra Kronberg, MS, RD, CDN, CEDRD & Page Love, MS, RD, LD, CSSD
- FR 6 The Gift of Yoga: Experiencing, Expressing and Enjoying the Body from Inside Out
  - Dianne Neumark-Sztainer, Ph.D., MPH, RD & Elisa Mott, EdS, NCC, RYT
- FR 7 Medical Issues Relevant to Women with Eating Disorders: Time to Reconnect Body & Soul
  - Jennifer L. Gaudiani, MD, CEDS
- FR 8 Eating Disorders in Adult Women: Relational Cultural Reframing of the Biopsychosocial, Developmental & Clinical Considerations
  - Margo D. Maine, Ph.D., FAED, CEDS; Karen L. Samuels, Ph.D. & Mary Tantillo, Ph.D., PMHCNS-BC, FAED
- FR 9 Treating Binge Eating Disorder: Understanding the Problem, Implementing Treatment, Finding Solutions
  - Judith Matz, LCSW
- FR 10 Journal Writing: Restoring the Pathway to Resilience, Recovery and Growth
  - Judith Ruskay Rabinor, Ph.D.
- FR 11 Inner Demonology: Engaging with Imagery from Eating Disorder Symptomatology & Post-traumatic Stress
  - Sondra Rosenberg, ATR-BC
- FR 12 Feminist Psychodynamic Therapy in Practice: Stories for the 21st Century
  - Kathryn Zerbe, MD
Saturday, November 14, 2015

- SA 1 From Weight Fears to Body Respect: Unraveling the Path
  - Linda Bacon, Ph.D.

- SA 2 Gender Sensitive Psychotherapy of Men with Eating Disorders
  - Douglas W. Bunnell, Ph.D., FAED, CEDS; Jerel P. Calzo, Ph.D.; Alison Darcy, Ph.D. and Steven Wiley Emmett, Ph.D.

- SA 3 Therapists and Recovery: Why & How Clinicians should use Experiential Knowledge in Therapy
  - Sander de Vos, MSc; Carmen Netten, BSc & Helena Zorge, BSc

- SA 4 Current Issues in the Treatment of Eating Disorders and their Influence on Nutrition Therapists
  - Molly Kellogg, RD, LCSW & Jessica Setnick, MS, RD, LD, CEDRD

- SA 6 The Body Keeps the Score: When Talk Isn’t Enough
  - Bessel van der Kolk, MD

- SA 7 Understanding and Treating Body Image Disturbance & Eating Disorders
  - Ann Kearney-Cooke, Ph.D.

- SA 8 Prevention, Clinical and Genetics Research in Eating Disorders: Using Lessons from the Past to Navigate the Yellow Brick Road to Our Future
  - Kelly Klump, Ph.D., S. Bryn Austin, ScD & Michael R. Lowe, Ph.D.

- SA 9 Awareness, Attunement & Adaptability: The Triple A’s for Clinical Rupture & Repair
  - Beth Hartman McGilley, Ph.D., FAED, CEDS & Jacqueline Szablewski, MTS, MAC, LAC

- SA 10 The Body in Psychotherapy: Somatic Methods Every Practitioner Can Use
  - Adrienne Ressler, MA, LMSW, CEDS, Fiaedp & Ann Biasetti, Ph.D.

- SA 11 Families, Feelings and Food: Yesterday, Today and Tomorrow?
  - Anita Sinicrope Maier, MSW & Craig Johnson, Ph.D., FAED, CEDS

- SA 12 The Neurobiology & Psychopharmacology of PTSD/Traumatic Exposure
  - Craig Strickland, Ph.D.

Sunday, November 15, 2015

- SU 1 When Surviving is Not Enough: The Role of the Family in the Treatment of Eating Disorders
  - Judith Brisman, Ph.D.

- SU 2 Quantum Physics, Spirituality and Eating Disorders
  - Carolyn Costin, MA, MEd, MFT & Anita Johnston, Ph.D.

- SU 3 Comparing and Contrasting the 3rd Generation of Therapies for the Treatment of Eating Disorders
  - Adrienne Juarascio, Ph.D.

- SU 4 The Art of Attunement, Walking the Walk of Empathic Connection
  - Susan Kleinman, MA, BC-DMT, NCC, CEDS

- SU 5 Working with Shame in the Treatment of Eating Disorders
  - Jane Shure, Ph.D., LCSW & Beth Weinstock, Ph.D.
The 25th Annual Renfrew Center Foundation Conference
Philadelphia, Pennsylvania

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