The Renfrew Center Foundation
FOR EATING DISORDERS

Perspectives

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The 29th Annual Conference Recap

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Contributors

A Word from the Editor

One of the main reasons clients come to therapy is about change: to decrease or change problematic behaviors (e.g. addictions, disordered eating), to improve difficult relationships, to receive guidance on altering painful work or life situations. And yet, despite talented therapists, strong therapeutic relationships and a variety of creative therapeutic techniques, clients often are unable to make the desired changes; they remain stuck in old behaviors, relationships, situations.

What may be hindering clients from making changes? What is it that makes even desired change so elusive? What is keeping clients stuck?

One possibility is that change involves loss. Changing one's behavior around food, leaving an abusive marriage, becoming more assertive with a supervisor or parent – all of these are positive changes and yet, all involve a degree of loss. It is entirely possible that the impending loss may feel too devastating, may involve too much of a risk and ultimately, contribute to clients feeling unable to make the desired change – in a word, stuck!

To consider the complexity of this topic more fully, we are devoting this issue of *Perspectives* to exploring the hidden losses that accompany change, especially change that is positive and beneficial. Specifically, we invited five experienced clinicians to share their ideas about how **'change and loss travel together' (Lori Gottlieb, 2019).** To describe their experiences with clients who desire change, but may not be expecting the loss that occurs alongside, we provided framing questions that make the theme more tangible:

- *How does impending loss affect the changes your clients are trying to make?*
- *Have there been special or unusual emotional reactions that caused your client to reconsider (or discontinue) making the desired change?*
- *What effect, if any, has the loss had on the therapeutic process or your relationship with your client?*

We begin with an extremely moving essay about a trans client who encountered multiple losses during his transition from female to male. As **Henah Gupta** so eloquently explains: "Acceptance of a transgender person was just not going to happen for his parents. Jo needed to come to terms with the limits of their interpretation of religion that judged anyone who challenged heterosexuality… Helping Jo see the reality of who his parents are, and working on accepting them EVEN if their views conflicted with his was a repeated discussion in sessions." She poignantly adds: "Finding compassion for those we do not understand can help reduce our own emotional suffering."

Next, **Judith Matz** provides us with a vivid description of how her work with Wendy focuses on helping her to lose the blame and shame that comes from believing her body is the problem, that

her inability to lose weight through dieting is her fault. "As Wendy collected attuned eating experiences – honoring hunger and fullness signals – her bingeing decreased significantly. The loss of her dieting mindset meant she could enjoy her eating experiences without emotional and physical discomfort. However, I often find that making peace with food is the less challenging part of the journey. Letting go of body shame is fraught with challenges from the internalized weight stigma our clients carry and the very real weight stigma that exists in the world."

The dynamics of a father-daughter relationship around food and body image are clearly captured in a dialogue by **David Hall** who describes his client, Steve, as being upset with his daughter. "She needs to lose some weight, I know how it is out there. I don't want my daughter being left out because she is the fat kid." David explains his approach so that Steve can retain his sense of being a competent father: Steve's "internal self-talk would be 'This is just common sense, what does Dr. Hall know that I don't already know? He's probably one of those social worker types.'" This leads David to acknowledge that "if I enter into a power struggle with him (I know more about this than you do!), I will lose. He will completely discount my input and might even remove himself from treatment."

As a feminist therapist well known for her expertise in the field of eating disorders, **Beth McGilley** articulates a powerful and essential element of her clinical intervention: "I routinely ask my clients what they expect to be the enemies of their therapeutic convictions – the internal or external resistances, obstacles, requisite losses or even potential gains they don't feel ready for or worthy of achieving. These so-called 'down-sides' to growth need to be identified, addressed and "worth it" if the change is to be risked or sustained. Common examples in ED therapy include preparing clients for changes in their weight and shape, the emergence of powerful emotional states, dramatic shifts or conflicts in important relationships as they become more centered in their own experience. The latter, disrupted relationships through the process of recovery, is not uncommon and requires therapeutic neutrality and diligence."

Three compelling portraits by **Rachel Bachner-Melman**, a seasoned clinician from Jerusalem, Israel, illuminate experiences of therapeutic dilemmas associated with change and loss. Hanna, a 60 year old woman, has avoided treatment for anorexia for 40 years until hospitalized for a recent fall. "She wanted a recipe for magical salvation, but mine included food, effort and change… Challenges to Hanna's eating disorder symptoms were met with "limited success, since they were dearer to her than anything else. Hanna expressed regret at having 'trapped herself' into therapy by falling, and I felt helpless at failing to find helpful tools or create the degree of safety necessary for symptom abatement."

Nina, a collage age student who was physically, sexually and emotionally abused by a gang of 'friends' when she was 14 years old, used self-starvation, regular bingeing and purging, self-harm, and symptoms of PTSD to help her to survive. She also used "vomiting and cutting to remain sane and bring relief when plagued by flashbacks of past horrors. This and food restriction calmed her, distracted her, and allowed her to feel she could control her flashbacks and her unwanted body to some extent. It was so much easier to think and talk about food, weight, and calories than to confront the demons of her past. How could I as a therapist possibly persuade her to give up her support system?"

In summary, each of our contributors has provided wonderful and unique descriptions of how they navigate the complexities of change and loss with their clients. As Rachel reminds us: "It is imperative for me to understand that change is a bitter-sweet pill, because it requires the sacrifice of… [rewarding symptoms] for amorphous and uncertain gain. My clients' engagement in a process of loss and change is unlikely without a strong therapeutic alliance, trust and a sense of safety, although these things in no way guarantee such a process."

Warmest wishes,

Marjorie

Change & Loss: Must It Hurt?

Henah Gupta, Ph.D., CEDS

Jo has been in therapy ever since he can remember. Moving from a biological SHE to a transforming HE is what Jo identifies as his biggest emotional and physical undertaking. Working with someone transitioning from being a female to becoming a male is new to me. I looked at his history to piece together this case. As a child, Jo was always in and out of therapy for reasons of sadness, anger and 'moodiness.' School was academically easy and Jo excelled with top grades. The social part of school was painful and fraught with difficulties connecting to people. Jo struggled to make any kind of lasting friendships; his peers seemed immature and goofy to him. No one took life on as intensely and seriously as Jo did. No one understood. Teachers on the other hand loved Jo. He was reliable, studious, articulate and participated well.

Middle school years were tough emotionally and his high school years were even worse. Here, as a female, the focus on weight and trying to make a 'better-looking' body began. Jo also started an endless search for psychiatric help that would 'fix things.' Nothing seemed to stick - no psychiatrist, no therapist, no friendship and no relationship. No weight loss, diet or exercise plan worked. Jo's anxiety, depression, eating disorder and emotional fragility grew and grew. There were many points of rejection which fueled self-doubt and low self-esteem. Then Jo discovered marijuana. The substance use was reinforced every time by a reduction in anxious and ruminative thinking. The relief was welcome.

In therapy, we spent time identifying the types of thinking Jo engaged in that were problematic and allowed for self-destructive behavior to occur. It took repeatedly catching of thoughts, labeling them and then choosing to follow a different action to get the momentum of change going. We identified the negative consequences that followed Jo's past behavior and how he wanted a different life going forward. Jo's ability to connect the dots between his thinking, emotions and behavior improved with repeated practice in sessions.

"Fighting the old may not help…what about building the new?" I found myself saying one day in session. Jo would reflect on the repeated battles with his parents, about how he viewed them as narrow-minded orthodox people that were rigid and dogmatic. Acceptance of a transgender person was just not going to happen for his parents. Jo needed to come to terms with the limits of their interpretation of religion that judged anyone who challenged heterosexuality. And what would become of his relationships with his younger siblings. The parents, at times, showed much anger and requested Jo to not 'act out' and to be 'normal' in front of them. What did this mean? Wearing skirts and not pants? , Sitting with women not men? "But what if that's not who I am?" Jo would ask.

We tried to find who and what Jo identified with and as Jo did not want to offend or hurt his family; yet, that is exactly what was happening. Helping Jo see the reality of who his parents are, and working on accepting them EVEN if their views conflicted with his was a repeated discussion in sessions. Finding compassion for those we do not understand can help reduce our own emotional suffering. Holding a more non-judgemental stance and finding their kernel of truth helped reduce Jo's emotional pain. Not everyone will understand and accept what is in front of them. We each have a choice in how we handle that. I dug deep for compassion towards Jo's parents and practiced lots of validation of Jo in every single session. Jo needed a safe space free from feeling rejected and I could provide that.

While sitting in a session recently with this young-adult transgender individual, I found the concept of loss clearly illustrated. It is a painful reality to sit with, and I felt the sadness for him. Jo is facing the reality of having a life that his parents and siblings will not know and may not fully accept. What a tragic

choice this is for Jo; being true to who he knows he is with the weight of possibly losing his family. His family cannot look at him the same way. The change in his voice is obvious. The facial hair is different. Using a binder to change his chest presentation and dressing in loose male clothing is awkward. No more jewelry or make-up. Hair is cut short. How about their ability to digest all of this? How do they face who they NOW see – this complete foreigner has emerged out of the daughter they once knew. I started to see how this is a loss for them too. Their vision for Jo's future shifted to something they could not fathom. The change, and loss, is fraught with emotional pain from both sides.

The disappointment, confusion and judgement drips off their faces when they try to spend time together. Jo can feel the tension and discomfort sitting close to his parents. This is the first summer Jo has come back from college and it is the first time his parents have seen him since he began taking testosterone. Jo needed to come home in order to work full-time so he could save up money for the top surgery. This is not something his parents would fund. Being home feels unwelcome and prickly. Maybe this will be the last summer he does this. Maybe in the future he will see his family less and less. Their phone calls will only hold superficial niceties. Talking about this in session was full of mourning – the loss of his parents and their ability to be parents to him as they were before.

Working with Jo has shown me what courage can look like. When clients acknowledge the pain inherent in change and what they must give up in order to make progress for themselves – we open a new door. Sometimes people choose to walk through it and develop that new person, and sometimes letting go becomes more than they can tolerate.

Change your thinking and you can change your behavior. That does not mean others will come along with that change. This is loss for all involved. If you cannot change something then work on acceptance. Sounds good, right? How tough that can be! For Jo, maybe it is about the process of acceptance of his parent's limits and who they need to be. As the clinician working with Jo, my ability to digest it all and join Jo in the process of experiencing that pain really counts. After all, if I could not take this on, how could I guide Jo? So I chose to listen and support Jo through his process of understanding what his reality was and is, and how the future may shape up for him. In session, I would ask questions to help him think about himself in ways that could lead to a new future. My patience and willingness to sit with his confusion helped. Going at his pace of discovering himself was important too.

Jo reminded me that I can always hold hope for change. What I may see as unsurmountable is irrelevant, and clearly sometimes plain wrong! Limits are only decided by the client. There were times that Jo felt helpless. I validated how Jo felt over and over again and then presented the possibility of doing something different and positive for himself regardless of how he felt.

The experience of loss that he went through positively deepened the therapeutic connection. I was the consistent and accepting adult in his life. Being able to see the loss for what it is required strength. This only arrived after establishing therapeutic rapport and starting to develop trust in someone new. There were relapses with self-destructive behavior that occurred along the way, which is consistent with understanding that recovery is not a straight road. We sometimes take turns and twists with our clients as we attempt to find their new path.

Maybe change can be like the life cycle of a lotus flower. A prominent figure in Buddhist culture, the lotus holds symbolic weight. The lotus has a life unlike any other. With its roots based in mud, it submerges every night into murky river water. Undeterred by its dirty environment, it miraculously re-blooms with color the next morning with no residue on its petals. How about that!

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Letting Go Of Body Shame in a Weight-Focused World

Judith Matz, LCSW

We usually think about loss as something painful, but when I read the questions posed for this issue my immediate association to change and loss was the word "relief!" I've spent my career helping people let go of dieting, end bingeing and feel at home in their bodies. As they make these changes, they are typically relieved to lose the blame and shame that comes from believing their body is the problem and that their inability to lose weight through dieting is their fault.

When I first met Wendy, she tearfully explained that since she was four years old, she's been told she's "too fat." Her story is that while her mom was in the hospital giving birth to her younger sibling, she stayed with her grandmother and "blew up like a balloon." She was put on Weight Watchers as a pre-teen while at the same time food was love. She was told repeatedly to finish everything on her plate. Over the next 40 years Wendy never questioned her own body hatred, until one day she heard me interviewed on a podcast talking about diet culture, and she decided that maybe there was a different way to feel about her body.

As I listened to Wendy's story, I expressed empathy around her desperation to lose weight and for how hard she's tried to "follow the rules." As we went over the details of her diet-binge history, I gently added information about the high failure rate of diets. I explained the physiology behind weight regain that typically increases set point over time, helping her to understand why her own struggle to keep off the pounds wasn't her fault. Most importantly, I offered hope about how she could make peace with food and learn to accept, appreciate and respect her body. Wendy left our first session exclaiming, "No one has ever spoken to me before with such compassion about this topic. I feel a weight lifted." We both took a deep breath, and I felt her relief.

As Wendy collected attuned eating experiences – honoring hunger and fullness signals – her bingeing decreased significantly. The loss of her dieting mindset meant she could enjoy her eating experiences without emotional and physical discomfort. However, I often find that making peace with food is the less challenging part of the journey. Letting go of body shame is fraught with challenges from the internalized weight stigma our clients carry and the very real weight stigma that exists in the world.

But Wendy surprised me. During one of our sessions I felt a smile cross my face when Wendy referred to her "weight issues" as a kid and then quickly corrected herself; she reframed it as her family's issues about weight. The following week she brought in a picture of herself as a child and pronounced that looking back she remembers feeling "just fine" in her body. She had also perused family photos and realized that she resembled her ancestors built with sturdy bodies.

When Wendy attended her first plus size yoga class, she again felt tearful as she experienced an environment of body acceptance. With a supportive husband, a sibling who had also recently came across Intuitive Eating, and the discovery of anti-diet, Health At Every Size® resources, Wendy continues working at rejecting cultural messages about body size. Even as she mourns the loss of time, money and energy wasted in pursuit of weight loss, Wendy has also lost much of the shame while gaining acceptance, compassion and connection.

I wish all of my clients could heal their body shame at this pace. I use many strategies to help people feel comfortable in – and take care of – their bodies: cultivating self-compassion and focusing on behaviors that support their physical and emotional well being regardless of whether weight is lost. Seeking out communities and social media that reject fat shaming and weight stigma also help my clients move toward body acceptance. But most express that even when they feel better in their bodies at home or in my office, they have to walk back out into a fat phobic and fat shaming world.

This is the aspect of my clinical practice that leaves me feeling broken hearted at times because the impact of weight stigma is so pervasive in session after session. Victoria came to see me about her ongoing depression, binge eating and unsuccessful attempts

at dieting. Her mother was also depressed, and Victoria explored how she turned to food growing up because there was no safe place to get the soothing she needed in times of distress. In our early sessions, I helped Victoria work toward ending her deprivation driven eating, and as she gave herself permission to eat all types of foods without judgment, her bingeing decreased. But Victoria felt triggered about her body size at work when her colleagues frequently commented that they couldn't eat those items because they were dieting. They went on to discuss what's "good" and "bad" as well as their latest weight loss attempts. Victoria found a place to eat by herself so she wouldn't have to hear these comments, but her strategy also meant a loss of connection with her co-workers. While these kinds of conversations are normative in our culture, does it surprise you to learn that Victoria works in an eating disorders treatment program and her colleagues are eating disorder specialists?

Unfortunately, Victoria's encounter with fat phobia among mental health professionals is not unusual. Early on in my work with clients I witnessed the devastating impact of weight stigma on my clients who struggled with eating and weight concerns: the client who felt the relief of accepting her current size, but felt the loss of connection with her family as conversations continued to focus on the latest diets, and they chided her for "giving up." The client who experienced the actual loss of income because of policies at his workplace that gave employees a discount on insurance if they maintained a lower BMI. I realized that no matter what kind of healing took place in treatment, I also had a responsibility to work toward changing diet culture. My view of my role as a therapist has moved beyond my counseling practice to include ally and advocate. I've found that I have the most reach through my writing and through the trainings I give across the country.

During trainings, clinicians participate in an experiential exercise to assess attitudes and implicit weight bias. Their typical responses include: "I would never make fat shaming comments, but I think them," or "I don't judge other people but I feel upset about my own body size." Another common reaction is "Wow! I didn't realize I had these biases about weight." I encourage mental health professionals to stay compassionate toward themselves as they reflect on their attitudes toward "thin" and "fat." After all, we've all marinated in diet culture. At the same time, I believe that each of us has an obligation to address our biases so that we no longer contribute, even inadvertently, to the fat shaming our clients may feel as the result of our own attitudes.

I gave my first workshop on attitudes on body size at the Renfrew conference in 2003 where, along with Ellen Frankel and Sally Strosahl, we explored how body size of both the therapist and client impacts interactions. We ended the workshop by asking the participants: What did you think of each of us, of our size, and each other's size, as you walked in the room today? Did your impressions of us change during the course of the workshop? If so, how and why? As I speak around the country with a Health At Every Size lens, I've slightly changed that question. I talk about thin privilege – the unearned advantages that come from having a thinner body in our culture. Then, as a thinner presenter, I ask the following: Would you have heard the information I've presented today any differently if I were a higher weight presenter? I'm met with looks of surprise and heads shaking "yes."

As the saying goes, if you're not part of the solution, you're part of the problem. What does it mean for us to change as a profession to a weight inclusive model where we focus on behaviors that support health and wellbeing rather than using weight as a proxy for diagnosis and successful recovery? What does it look like to become an ally to Higher weight clients, including those with marginalized identities, and to advocate for their respectful treatment and care? What kind of loss would these changes lead to for you?

I ask these questions with the hope that they will foster more conversations about our profession and the role we can play in combatting weight stigma so that all of us – all shapes, sizes, colors, gender identities - can exist peacefully in our bodies in this diverse world.

Judith Matz, LCSW is co-author of *Beyond a Shadow of a Diet: The Comprehensive Guide to Treating Binge Eating Disorder, Compulsive Eating, and Emotional Overeating* and *The Diet Survivors Handbook: 60 Lessons in Eating, Acceptance and Self-Care*, and author of *Amanda's Big Dream*. Judith is a popular speaker at national conferences and offers trainings on the topics of Binge Eating Disorder, emotional overeating, chronic dieting and weight stigma throughout the US. She has a private practice in Skokie, IL. and is co-author of the upcoming The Body Positivity card deck (PESI Publishing, Spring 2020).

THE RENFREW CENTER for Eating Disorders

CELEBRATING 35 YEARS

The Renfrew Center has been the pioneer in the treatment of eating disorders since 1985. As the nation's first residential eating disorder facility, now with 19 locations throughout the country, Renfrew has helped more than 85,000 adolescent girls and women with eating disorders and other behavioral health issues move towards recovery, and has trained more than 40,000 professionals.

Atlanta, GA
Baltimore, MD
Bethesda, MD
Boston, MA
Charlotte, NC
Chicago, IL
Coconut Creek, FL
Los Angeles, CA
Mount Laurel, NJ
Nashville, TN
New York, NY
Old Greenwich, CT
Orlando, FL
Paramus, NJ
Philadelphia, PA
- *Center City*
- *Spring Lane*

Pittsburgh, PA
Radnor, PA
West Palm Beach, FL

Over the next few months, we will be hosting **35th Anniversary celebrations** at our facilities across the country. Dates and registration will be available on our website (www.renfrewcenter.com) soon—we hope you will join us in celebrating this great milestone!

Involving Parents in the Recovery Process

David Hall, Ph.D.

This is a story about a father-daughter relationship. For a devoted, involved father, the transition from "my baby girl" to "my teenage daughter" to "my young adult daughter," is a transition that requires change – and loss. The child to woman path is a major identity change; it's called growing up and kids expect it! For a father, however, there are confusing losses along the way.

Emily is a fifteen year old girl, a tenth grade student in a large suburban public high school. Emily's father, Steve, is a mechanical engineer. During six therapy sessions, I learned from Emily that other students have called Emily "a little chubby," saying, "You are so cute, just lose some weight." Emily also worries about her grades; she wants all A's.

Dad has been an involved father although now that she has entered the puberty years, he feels some distance from his daughter. Steve is upset with Emily because, as he tells me not in Emily's presence, "She needs to lose some weight, I know how it is out there. I don't want my daughter being left out because she is the fat kid." Steve is a fitness aware man. He goes to the gym on a regular schedule, and has a personal trainer. Presently, he overtly and covertly tries to control Emily's food intake.

In session, Emily disclosed that she is very concerned about her weight and that "my Dad is always on me. If we eat out and I get some dessert he says, 'Well, you really needed that, huh!' He took all the potato chips out of our cupboard and even threw a new bag in the garbage saying 'Nobody around here needs these!'"

As I prepared to meet dad I thought: Dad is an engineer and will need a well understood and authentic reason to adjust his behavior. Since Steve has a narcissistic flavor, I will have to re-direct his energy so he will not lose his own definition of competent father. If he thinks I am working against him, he will withdraw Emily from treatment. After listening to Emily, I believe his present theory is 'Listen to my instructions; I'm correct; just do what I say and things will be better.'

Probably, Steve approaches Emily this way, and most important for me to understand, he will listen to me with this same self-theory in place. His internal self-talk would be "This is just common sense, what does Dr. Hall know that I don't already know? He's probably one of those social worker types…" I must be very careful not to behave with him the very way he behaves with Emily! If I enter into a power struggle with him (I know more about this than you do!), I will lose. He will completely discount my input and might even remove himself from treatment.

I began my work with Steve by supporting his intentions. This validates his theory of what Emily needs to change and once he sees that I agree with him, we can open a discussion on strategy for input with his daughter. The clinical goal here is to have him accurately observe his own behavior, then help him gain insight regarding what he must change. My first task with Steve is to neutralize his present action plan for implementing his definition of competent father. The "must be right" male is a fragile patient!

D: "Well Steve, as I listen to Emily, I think I'm realizing your frustration. You are explaining to Emily what would be good for her, but she just doesn't seem to take it in."

S: "Yeah. Emily just doesn't get it!"

D: "So we both are seeing the same thing. In fact, I'm really glad you put it that way. Emily just doesn't get it! Can I completely change the topic for a few minutes? With your permission, I want to tell a couple of what I will call 'Silly Stories.'"

S: "Hey, maybe I could use a silly story this time of day!"

D: "Okay - I'm going to start with a sex therapy joke.

S: "Hey, a real guy thing! Go for it!"

(Yes! I'm getting connected with Steve)

D: "Why at the moment of conception is there only one egg, but many, many sperm?

(Necessary joke pause here)

D: "Because our creator knew men would never ask for directions!"

I respond with my best stage laugh - he also does the same.

D: "You see Steve, we both 'get it.' Tell this joke to a seven year old child and a seven year old just won't get it! Remember, you said 'Emily just doesn't get it!' You and I get the sex joke because we have a database gained from our cultural history about men and directions and who knows what else. Bottom line; when material comes into our adult heads, we have the right bits and pieces of data already there, the punchline of the joke sort of synchronizes these data fragments and we 'get it.'

S: "So what you are saying is that Emily doesn't have enough of a database so she can't 'get' what I'm telling her?"

D: "Yes, Steve, 'you get it,' and that sir, is what we call insight!" (My enthusiastic feedback to Steve is a very important part of my treatment strategy with him. Remember, this is a man who prides himself on being correct. If he is to internalize my instructions, my best relationship status with him is that we are colleagues in the matter of helping Emily.)

D: "We will never get Emily to change her eating patterns and we won't be able to get her to adopt a gym workout program either. We only do behaviors that make internal sense to us! It's that simple, but it's also that complicated!"

S: "Got it! So, Emily has to think differently before she will behave differently."

D: "Exactly. I've only spent about six hours with Emily, so you know her far better than me! That's why I need your help. I think I understand what's going on and have some ideas we can talk about to make things better for her."

(Remember, I have to be sure he does not lose his expert role)

D: "You know, I see a lot of teens and Emily is a great kid! That's not just luck; that's a big reflection on you and your wife - excellent supportive parents!"

(I must be sure he recognizes that I know he has been a competent dad)

D: "Emily is perfectionistic in her own way, she wants to do things right and be one of the top kids in her world. So, she is internally motivated, no pushing necessary! Your daughter needs you to be a good consultant, and less a direct supervisor. What I think will be useful is to show her that you really understand her world, and that you trust her ability to manage it. Ask her to explain her thinking. Demonstrate to her that you understand she is in charge of her life."

D: "You and I will show Emily we understand this is all 'hard work for her' and ask her 'How can we help?' I will start by saying expect discomfort; when changing a self-soothing behavior there is always discomfort. I will help her define the discomfort of not snacking - no chips or Milky Way bars - as signals of success! You know it as "no pain, no gain," right?

D: "At the same time we will introduce her to some new activity that might be able to become self-soothing to her."

S: "Yeah, like a good gym workout!"

(Notice how Steve sticks to his theory)

D: "Yes, but it has to authentically work for her. Now here is a little twist, I want to address some changes in your role and what you are going to lose."

S: "Well now I'm a little confused - but I'm listening."

D: "You are a good, strong leader, Steve. You told me you were head of your department with twelve engineers working for you – that's not just good luck, that's field tested and proven leadership ability. Of course, you bring that home! Now, given Emily's age and circumstances, it would be useful to become the staff consultant, and not the work force leader. This will be a big change for you Steve. Moving from leader to consultant will feel uncomfortable. Your brain will say 'I'm doing something wrong here.' But you are a guy who wants to be right. Now you think you are doing something wrong. See the problem?"

S: "Not really. Explain some more."

D: "Have you ever driven a car in England? You know, the "wrong" side of the road thing."

S: "Yeah and the first few hours, I was always fading to the right side of the road. Then a car would be coming toward me and I had to jerk over to the left real quick. It felt weird!"

D: "Similar to driving, you have learned your leadership style of interaction and you practice it with everyone. If you change that style, you will feel like you are losing who you are. It just won't feel right. You will fade back into the leader, just like you faded back into the right lane driving in England."

S: "O.K. I get it. So, what do I do?"

D: "A few things. First, explain to your daughter you both have exactly the same problem which requires changing something in your behaviors. And change always feels like you are losing something. Second, you can explain to her about driving in England, that learned things seem automatic, but they are not. We can regain conscience control, but the change just feels funny in the beginning. Before you talk with her, do a mental rehearsal; practice in your mind how you will talk with your daughter as

a consultant. Learn your lines before you go on stage with her. Stepping out of the leader role will probably seem like you're giving in. Remind yourself, I must lose my leadership style in order to gain my consultant style. Adopt a new "mantra," I have to feel like I'm losing in order to actually win."

Steve learned to replace his scolding behavior with "What's your plan Emily, how can I help?" This dramatic change in his approach to Emily made the two of them "partners" once again in pursuing Emily's goals. Steve stimulated her interest in tennis which became one of her selected self-nurturing activities. Under the care of her physician and a registered dietician, her physical health was restored and I continued to work with Emily using cognitive therapy - eating disorder focus.

David Hall, Ph.D. received his degrees at the University of Michigan in Ann Arbor, MI. He began his professional career as a high school physics teacher and became a counselor while developing a peer counseling program for adolescents in 1970. As a therapist in private practice since 1974 he has specialized in family and adolescent issues including substance abuse, sexuality and eating disorders. He is a retired Adjunct Professor, School of Medicine, Michigan State University.

Same-Same: The Blessings and Burdens of Therapeutic Change

Beth Hartman McGilley, Ph.D., FAED, CEDS-S

Heaven and hell, same-same as best selling author Elizabeth Gilbert learned from her ageless Balinese healer, Ketut, in her infamous journey across Italy, India and Indonesia, eating, praying and learning to love in her "search for everything," her self most critically (Gilbert, 2006). Hardly similar to engaging in traditional self-searching endeavors, sitting across from a licensed professional, formally schooled in the process of change and how to facilitate it in hourly increments, sans spaghetti and sangria, the scrubbing of temple floors, and starry-eyed sunsets over an archipelago. Regardless of the backdrop or the healer, the transformative process is inherently heavenly and hellish, up and down, change and loss same-same as Ketut so wisely informs us. This article will briefly expand upon a few of the blessings and burdens of therapeutic change–what is lost as healing is gained, and how therapists can best partner their clients in the process.

Amy is a client I've seen for less than a year in a group setting. She's had clinical training herself and has been in therapy off and on since childhood, addressing issues related to an eating disorder, depression and trauma. When asked to describe her experience of issues of change and the loss that may accompany it, she indicated she was "well acquainted with it" having been on both sides of the therapeutic couch:

> "I think therapy, in general, is all about loss in many ways. Perhaps shedding is a more appropriate term. You shed what you once learned, now maladaptive, to grow a new skin, one that fits. But it is excruciatingly painful, and if you are giving up your numbing agents, be it an eating disorder, substance abuse, inappropriate anger, etc., you are going to be pretty damn raw while your new skin heals on. If you have a therapist who doesn't help you to understand what is happening, and help hold you steady in that process, you will return to what you knew helped ease that pain. I think that's why relapse rates are so high. I think that's why there needs to be better understanding and patience. Some therapists have it. Some don't. Those who don't, need to leave the field." (Amy, personal communication)

How we, as therapists, receive and respond to our clients as they cross the therapeutic threshold—these skin-shedding, pride-swallowing risks of transformation—can make or break their therapeutic potential. When I return a client's first contact call, I purposefully acknowledge the sacred leap already taken by reaching out. My informed consent directly addresses the inevitable challenges attendant to change, including potential losses. As a feminist oriented therapist, I am emphatic about the essential nature and quality of the therapeutic relationship. So much so that I insist their first job is to fire me by the third session if they aren't sure they can relax in my presence. The ensuing dance of deliverance from all that's held their "ousia," their most essential self from emerging, is replete with gains and losses that must be recognized, relished, grieved and often repeated. It is the stuff of effective clinical practice, "the heart of the matter" as expertly recounted in the book by the same name (Maine, Davis & Shure, 2008).

What else is in it, that special sauce which Amy boldly suggests that therapists must have in order to effectively companion clients as they shed their former maladaptive means of being and coping in the world? Are the therapeutic skills required to foster growth any different than those necessary for preparing clients for the voids left in its wake? Also same-same, in my experience, as both clinician and client. Loss is change! In this regard, it's a false dichotomy of sorts, though variously viewed as welcomed or unwanted.

I routinely ask my clients what they expect to be the enemies of their therapeutic convictions—the internal or external resistances, obstacles, requisite losses or even potential gains they don't feel ready for or worthy of achieving. These so-called 'down-sides' to growth need to be identified, addressed and "worth it" if the change is to be risked or sustained. Common examples in ED therapy include preparing clients for changes in their weight and shape if requiring nutritional rehabilitation, the emergence of powerful emotional states previously numbed by symptoms, dramatic shifts or conflicts in important relationships as they become more clear minded, self-aware, and centered in their own experience. The latter, disrupted relationships through the process of recovery, is not uncommon and requires therapeutic neutrality and diligence.

I distinctly recall my first prima ballerina client who was an only child and had danced to her parents' delight since childhood. It was naturally assumed that her anorexia developed as a result of performance and appearance pressures. However, once I was able to decode the voice of her eating disorder, we learned that she had lost her passion for dance. Anorexia was her path out of the profession, and a way to assuage the grief and disappointment she was experiencing as well as that anticipated from her family. This illustrates how clients may, in fact, desire the "losses" that come with change, but then are faced with resistance from loved ones, adding another layer of loss to their healing process.

The shift from denial to reality is the quintessential milestone in the recovery process, at once ennobling and demoralizing, challenging our very identity and knocking the wind out of our eating disorder selves' false pride. Living with an eating disorder has it's own obvious losses, but many find shelter inside its emotion deafening storm. Accepting that one has a problem is a profound and necessary loss of innocence, born of our ego's drive to see ourselves as perfectly sufficient, or worse, "fine."

For Margot, another group client who's spent half her life in treatment for alcoholism and bulimia nervosa, getting real was

> "a grieving for your sense of self and having to swallow your pride completely, thinking that you know yourself; admitting that you haven't been honest with others and therefore your relationship to them has never been as true as you wanted it to be when you couldn't let yourself be fully known."

Margot is symptom free for the first time in her adult life. Therapy now revolves around learning how to show up in true measure in her family, friendships, work, marriage and treatment, and letting go of the outcome. Her candor, humor and humility have been invaluable assets in this process, allowing me unusual access to those same qualities in myself to reflect and nurture her. I chide her about writing the end of the story before she's opened the book—in other words, learning to live in the moment and into the answers with every right to be wrong. We laughed together recently when, despite her years as a sous chef, she immediately cut herself with a knife on a group therapeutic retreat in which we cooked, and ate together. Seeing me frenzied on her behalf and reversing roles as the comfort provider humorously allowed her to experience the pride busting impact of mutual empathy. For Margot, the losses currently associated with healing have been enlivening despite requiring Band-Aids!

Our job as change agents, is to name and normalize client's ambivalence, 'resistance' and relapses, breathing life and hope into their laborious process of healing and "getting real." Share relevant stories that demonstrate strength in vulnerability, fertility in mistakes, and which emphasize that to need, feel, and relax, if not rejoice in, our imperfectly sufficient selves are fundamental necessities to growth. I share my own story about the dangerous power of distorted perceptions in which I almost abandoned a bike race I was winning but was convinced—despite ample evidence to the contrary—that I was losing. I've developed many mantras (McGilley, 2005) to both offer comfort and speak truth to the power of their denial during various phases of treatment.

"No one ever gets well being comfortable" was coined for a client who lamented that she felt worse in recovery than she did while actively symptomatic. This is a good example of the "losses" attendant to change—getting well and feeling well are not necessarily tandem processes. Clients must learn that experiencing and embracing all feeling states is the objective, as well as learning how to effectively manage and share them.

Lastly, we have a tremendous opportunity and obligation to do right and be real with our clients as they navigate the vicissitudes of the recovery process. Without burdening them with our own wounds, clients need to know we've also got callouses on the knees of our hearts, similar self-doubts, fears and resistances to change. They need to know they are not alone in the hurts that come with healing. Self-disclosures, carefully considered and relevant, such as acknowledging your personal recovery, can enhance client's experience of mutual empathy and regard. We must graciously own our gifts and repair our mistakes, allow tears and triumphs to be mutually seen and shared, admit our

limitations and seek other's help when necessary. In this way, we are emanating our "ousia" through our therapeutic stance and interventions and inviting their own to emerge. Healing happens in genuine connection—change and loss inextricably tethered. It can be brutal. It can be blessed. Embracing both is essential. Same-same!

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Beth Hartman McGilley, Ph.D., FAED, CEDS-S is a psychologist in private practice, specializing in the treatment of eating disorders, athletes, trauma, and grief. Her practice is informed by feminist, HAES, and social justice perspectives. A Fellow of the AED, and a Certified Eating Disorders Specialist/Supervisor, she has practiced psychotherapy for over 35 years, in addition to writing, lecturing, and supervising. She is the co-editor of the book: *Treatment of Eating Disorders: Bridging the Research/Practice Gap*.

Recovery: Gaining by Losing

Rachel Bachner-Melman, Ph.D.

I feel privileged, in a field with frustratingly low recovery rates, to have accompanied many admirable individuals along their paths of change, growth and healing from an eating disorder (ED). Each path of change is unique, unpredictable, tortuous yet rewarding and life-affirming, and, I embrace with my whole soul that recovery from an ED is possible and leads to infinite gain.

Yet, recovery from an ED also leads to infinite loss, which explains why some people never seek treatment, drop out, or resist change in therapy. The destructive, seductive, life-threatening symptoms of anorexia nervosa, earned by dogged determination, persistence and single-mindedness, are ineffably rewarding. They create purpose, structure, clarity and a sense of pride and achievement. The symptoms of bulimia nervosa and binge eating disorder can numb pain, soothe and distract from painful events, feelings and connections. It is imperative for me to understand that change is a bitter-sweet pill, because it requires the sacrifice of these things for amorphous and uncertain gain. My clients' engagement in a process of loss and change is unlikely without a strong therapeutic alliance, trust and a sense of safety, although these things in no way guarantee such a process.

I met 60-year-old Hannah in the psychiatric ward where I worked after she accepted the recommendation of the consultant psychiatrist in the orthopedic ward to treat her severe and enduring anorexia nervosa. She was skeletal, had severe osteoporosis, abused alcohol, and persistently avoided treatment for over 40 years. Now, after a serious fall, she could no longer deny the gravity of her physical condition, and enthusiastically announced that she wanted to be healed. Genuinely wishing for help, she imagined her family's delight at seeing her healthy, and I fleetingly fused with the fantasy of cure.

Frustration set in when I felt that Hannah's expectations were somewhat magical, as if she had appointed me as her healer. She wanted a recipe for magical salvation, but mine included food, effort and change. Walls of resistance to my "recipe for loss," to remain sturdy during our 13 years of therapy, revealed themselves along her tortuous treatment path. I strove to embrace ambivalence while encouraging change and struggled to maintain my alliance both with her and with the ward staff whom she constantly criticized. My genuine affection for Hannah and support for her struggles contributed to my immunity from this criticism, enhancing my capacity for empathy. Anorexia had been Hannah's almost life-long pursuit, way of life and identity and she felt enraged that her decades of investment in thinness were being sabotaged. "I'm losing myself," she declared in desperation.

Despite Hannah's openness, she was not allowing me to really touch her in any significant way; I felt she did not really want to change and was ambivalent about closeness. Feeling discounted and somewhat impotent vis-à-vis Hannah's anorexia was no picnic. Yet, we continued to meet in an outpatient setting because therapy was essential and we had built a bond that I saw as significant to both of us. Hannah was candid, often leaned on me as a caring other, and appreciated supportive, experience-near comments (e.g. "being alcohol-free seems to be giving you a new lease on life"). However, she impatiently dismissed interpretations and investigations of conflict, such her relationship with her ex-partner, as "psychobabble." I therefore avoided them, so as not to "disturb the peace," until she was secure enough within herself and in her relationship with me to tolerate a shift to a less admiring and more interpretative therapeutic stance.

As I became more challenging, Hanna complained I was opening a "Pandora's box" that she had been trying to keep sealed. The illusion of harmony was destroyed, and I became prone less to idealization and more to devaluation. I also challenged her eating disorder symptoms, with limited success, since they were dearer to her than anything else. Hanna expressed regret at having 'trapped herself' into therapy by falling, and I felt impotent at failing to find helpful tools or create the degree of safety necessary for symptom abatement.

We agreed on "red lines" (e.g. minimum weight, suicide plans) for the continuation of treatment. I took a firm stance on critical issues and compromised on others so as to preserve her sense of autonomy. We focused on what Hannah did want to change, like how she could develop pastimes, and connect to her children and grandchildren. Over the years, she improved many aspects of her life and grew somewhat more comfortable sharing her inner world with me. She also made progress overcoming the need to present herself as self-sufficient. Growing support from various people eventually allowed us to discontinue therapy.

Nina developed an ED at age of 14 after several years of physical, sexual and emotional abuse by a gang of "friends." She was referred to me as a college student presenting with self-starvation, regular bingeing and purging, self-harm, and symptoms of PTSD. These symptoms were literally helping her to survive. She used vomiting and cutting to remain sane and bring relief when plagued by flashbacks of past horrors. This and food restriction calmed her, distracted her, and allowed her to feel she could control her flashbacks and her unwanted body to some extent. It was so much easier to think and talk about food, weight, and calories than to confront the demons of her past. How could I as a therapist possibly persuade her to give up her support system?

Despite some initial progress with her dietitian and psychiatrist, she knew deep down that my stance was correct – that to really move into recovery, she needed to talk about and connect to the abuse she had experienced. "There is a volcano inside me," she said, wanting it to disappear but fearing she would "lose control" if it erupted. She worked hard to contain the fires raging inside her. During our meetings she was composed and collected, dissociated from negative memories; my efforts to encourage her connect to her feelings failed. Between meetings she was flooded by flash-backs and negative emotions that she often shared via desperate and sometimes accusatory messages that I could sometimes transform into helpful exchanges. She battled, and still battles, to overcome voices forbidding her to come to therapy.

My role has been to constantly and tirelessly remind myself that I'm being helpful I also need to remind Nina that she wants and needs to talk and can benefit from skills that will allow her to do that without exploding or dissociating. Guided imagery, breathing, mindfulness and other DBT skills have been useful, but the one most helpful tool in her therapy is the one she herself requested: hypnosis. Nina's unusual hypnotic talent provides her with a "safe place" where she can relax and connect to her inner wisdom and healthy intuitions that we then apply in therapy and in her life.

For example, "a bridge to the future" allowed her to experience her future self as recovered under hypnosis and recall what she felt – including an unfamiliar desire to be kind to herself and a connection to her emotions, both positive and negative. This gave her hope and helped her understand that tolerating negative feelings may, in fact, have advantages.

Our extended investment in building trust and a sense of safety has begun to bear fruit. Nina has begun to speak the unspeakable and sculpt her suffering in words. She is daring to sacrifice the safety net of her denial and avoidance, and summoning the courage to extinguish the flames of destruction. By changing, she is losing the ability to protect herself from her past abuse by focusing on food, eating and weight. Rather, she is beginning to learn to connect to herself, her feelings and her past instead of running away from them.

Change is a leap of faith for Nina since she has no guarantee that she will be able to protect herself in ways that are better or safer than her symptoms. She cannot yet fully feel or taste the freedom and richness that await her as she gives up the rules that bind her. The emerging trust between us and her nascent ability to calm herself when the going gets tough, I believe, are preconditions for the sacrifice of her symptoms and positive change.

18-year-old Simon, too, took a leap of faith, and says today in retrospect that it paid off big time. His parents brought him to see me at the age of 14 with symptoms of anorexia nervosa, that had persisted, despite therapy, for two years. I pointed out the long-term damage that was accumulating to his physical and social development and explained the urgency of reestablishing adequate nutrition.

Simon stood to lose a great deal from the changes I told him he needed to make. In his mind, gaining weight meant undoing two years of his persistent efforts to achieve a thin and athletic body. "You don't understand," he cried; "you're going to turn me back into a 'fatso!'" Even thoughts about what he stood to gain – his lost friends, the ability to concentrate and return to school and a return to riding his beloved horses, for example – left him unconvinced. Change felt like a raw deal to him because not eating meant certain thinness whereas gaining felt like a gamble.

For Simon, it was my insistence that either a family approach or inpatient treatment was necessary that triggered motivational change. When I explained that others – his parents or hospital staff – were going to make sure he ate every meal, he stood up in defiance and declared "I'm going to do this myself." And unlike

many others with anorexia who declare this, Simon proved true to his word. His parents supported him every inch of the way, but it was he who took the plunge, began taking bites of faith and fought tooth and nail against his eating disorder.

Simon feared me slightly, but respected and trusted me and knew I believed in him. He brought me his dilemmas, which were predominantly cognitive. He could see that his behaviors were illogical and felt perplexed that they had such a hold on him. For example, he asked: "Why do I feel so fat when everybody tells me I'm too thin?" I explained that body distortion is a symptom of an eating disorder and would improve with time. We listed arguments he could use against the "fat voice" (e.g. "everybody tells me I'm too thin, they can't all be wrong," "You are feeding me lies"), but complained next meeting they were "not working." "It's not enough to read them out softly," I told him. So he learned them by heart and recited them loudly and confidently, shouting them out when needed.

Gradually, Simon literally ate himself back to school, to cafeteria lunches with his friends, to horse-riding, soccer and Life. It took a while, but I knew he had turned the corner when he said: "You know, I think I made a mistake by believing that kid who called me a fatso. I shouldn't have given him so much power over me."

Simon terminated therapy after a year and a half. A few months ago, I was surprised by a request from him to meet. When I saw him standing at my doorstep, tears filled my eyes. Little Simon was now a strapping young man, towering above me. He asked me to write a letter for the Israeli army stating he was fit to serve in a combat unit despite his eating disorder history. He updated me about his high school graduation, his horses, his hopes for the army and his girlfriend. "Anorexia was a stupid idea," he said, "and giving it up was the best thing I ever did."

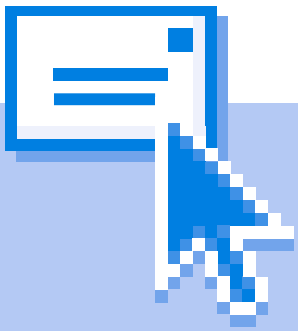
The process of change and loss is difficult to navigate with people with eating disorders, particularly for egosyntonic symptoms that feel so rewarding. I believe I need to understand what relinquishing symptoms means to and demands from my clients, to invest in building as genuine a bond as possible, and give each client the tools, and sense of safety (s)he needs in order to begin replacing symptoms with healthier behaviors. In the end, my clients' choices and efforts determine their progress. I can, however, increase the chances that they will gradually be able to shed their eating disorder with grace, like a well-worn garment, and slowly discover a secret place of recovery more rewarding than any other; a grove that can grow, bite by bite and bud by bud, over the grave of an eating disorder.

(Names have been changed to protect the privacy of the people described)

Rachel Bachner-Melman, Ph.D., is a clinical psychologist with expertise in eating disorders. She is a Senior Lecturer at the Ruppin Academic Center and the Hebrew University of Jerusalem, President of the Israel Association for Eating Disorders, Director for Outreach of the Academy for Eating Disorders, and Director of "Koli, the Jerusalem Center for Recovery from Eating Disorders."

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

The Renfrew Center Foundation FOR EATING DISORDERS



Emails to the Editor

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

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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 eating disorders education, prevention, research, advocacy, and treatment; however, we cannot do this without your support.

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The 29 Twenty-Ninth Annual Conference

The 2019 Conference Committee thanks all of the speakers, attendees and Renfrew staff who contributed to yet another successful event. It was a joy to see colleagues and friends gather from across the country to further not only their education, but also strengthen their connections during the many networking opportunities, including the Friday evening dance party! We're grateful for the positive comments and feedback that continues to come in, and we hope the weekend's excitement left you inspired and impassioned.

This year's theme, *Feminist Relations Perspectives and Beyond: Discerning Truth*, explored a topic of great importance in our culture: seeking and determining truth. In today's climate of "fake news," unsubstantiated claims and slanted rhetoric, it is especially critical for us as clinicians to cut through the noise, challenge personal biases, and foster genuine, meaningful connections.

This year's incredible and accomplished speakers reminded us of our powerful role at the intersection of eating disorders treatment and compassionate, research-backed care. With a packed audience and a standing ovation following each Keynote presentation, we are confident this was our best conference yet!

On the opening day, the audience was riveted by journalist **Laura Ling**'s story of resilience in the face of her captivity in North Korea. Laura's search for the truth, despite the risks, made evident the vital importance of standing firm for what is right and finding hope in the most dire of circumstances.

Saturday morning, **Kelly L. Klump, Ph.D.,** moderated a panel with **Carolyn Black Becker, Ph.D., ABPP** and **NiCole Therese Buchanan, Ph.D.,** discussing the biases and potential blind spots in eating disorder science and research. They discussed new research challenging long-held assumptions in our field, and why acknowledging the lack of neutrality in science is essential.

William J. Doherty, Ph.D., presented a lively, interactive keynote Saturday afternoon focused on the polarizing world we live in, and how therapists can help clients process the stressful disruption of today's civic life.

Jennifer L. Gaudiani, MD, CEDS, FAED closed out the Conference on Sunday with a presentation about rejecting antiquated conceptualizations of mind, body and weight. The audience learned that with a diverse and inclusive perspective, clinicians can provide the optimal care their patients need – and deserve.

The committee is already hard at work for the Foundation's 30th Annual Conference, *2020 Perspectives on Feminism, Eating Disorders and Beyond*, to be held from November 13-15, 2020. We look forward to celebrating this very special event with all of you!

This update includes photos from the 2019 Conference, as well as a form to order audio recordings if you were unable to attend or missed some of the workshops.

A sincere thanks to you all, once again, for making the 2019 Conference a resounding success. We hope to see you next year!

Judi Goldstein

Judi Goldstein, MSS, LSW
Conference Chair

"Outstanding material, exceptionally valuable research."

"I'm so grateful to have attended this Conference. The keynote presentations were among the most inspiring I've ever heard."

"So great to have dynamic, interactive speakers."

"Wonderful professional voices to help guide my practice and advocacy."

"Thank you for presenting diverse and inclusive material. Excellent information provided."

2020 PERSPECTIVES

on Feminism, Eating Disorders and Beyond

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To commemorate three decades of growth, outstanding scholarship and interpersonal connection, Conference 2020 has invited experts and luminaries in the field of eating disorders and women's mental health to create an exceptional program. Through thoughtful reflection, research and clinical practice, we will explore treatment, cultural influences, trauma, genetics, and trends in neuroscience. In keeping with our Feminist-Relational roots, numerous events are planned to foster rejuvenation as well as networking with professionals from around the globe.

For more information, please visit www.renfrewcenter.com or contact Kelly Krausz at 1-877-367-3383 or kkrausz@renfrewcenter.com.

The Renfrew Center Foundation FOR EATING DISORDERS

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KEYNOTE PRESENTATIONS

❑ KEY 2 **Discerning Truth: Tackling Biases and Blind Spots in Eating Disorder Science and Research**
Kelly L. Klump, PhD (moderator); Carolyn Black Becker, PhD, ABPP & NiCole Therese Buchanan, PhD

❑ KEY 3 **Polarization in Civic and Intimate Life: How Therapists Can Help**
William J. Doherty, PhD

❑ KEY 4 **Doing Better: Rejecting Antiquated Conceptualizations of Mind-Body-Weight**
Jennifer L. Gaudiani, MD, CEDS, FAED

WORKSHOPS

Friday, November 8, 2019

❑ FR 1 **Making Relationship Visible: Harnessing the Power of Relationship in an Evidence-Based World**
Amy Banks, MD & Melanie Smith, MS, LMHC, CEDS

❑ FR 2 **Multicultural Perspectives: The Impact of Colorism, Microaggressions and Trauma**
Paula Edwards-Gayfield, MA, LPCS, LPC, NCC, CEDS; Carolyn Coker Ross, MD, MPH, CEDS & Caryl James Bateman, PhD

❑ FR 3 **Atypical Anorexia in Higher Weight Clients: Stigma, Intersectionality and Advocacy**
Kara Anne Emery, PsyD, CEDS & Jessica Wilson, MS, RD

❑ FR 4 **Clinical Applications of the Developmental Theory of Embodiment**
Niva Piran, PhD, CPsych, FAED & Douglas W. Bunnell, PhD, FAED, CEDS

❑ FR 5 **Systemic Strategies for Helping Parents of Emerging Adults with Eating Disorders**
Frani Pollack, PhD, MSW, MS & Fran Gerstein, MSW, LCSW, BCD

❑ FR 6 *The Barbara M. Greenspan Memorial Lecture* **Genes Trump Prevention... Fake News!**
Tamara Pryor, PhD, MSW, FAED; Brogan Rossi, MS, RYT & Michael P. Levine, PhD, FAED

❑ FR 8 **DBT and Radically Open DBT for Eating Disorder Dietitians**
Stefanie Boone, MS, RD, CEDRD

❑ FR 9 **Interoception and the Autism-Eating Disorder Connection: A Guide from Inside**
Kim Clairy, OTR/L & Kelly Mahler, MS, OTR/L

❑ FR 10 **Discerning the Underlying Genetic and Neurobiological Truths of Eating Disorders Treatment**
Laura Hill, PhD, FAED

❑ FR 11 **All About Survival: Eating Disorders Through a Developmental Trauma Lens**
Kathleen Love, LMFT, LPC, SEP

❑ FR 12 **Ending Eating Disorders Starts with Boldly Inhabiting Our Own Bodies**
Elizabeth Scott, LCSW, CEDS-S & Connie Sobczak, BA

Saturday, November 9, 2019

❑ SA 1 **Permission to Pause: Supporting College Students in Pursuing a Higher Level of Care**
Lori Ciotti, LICSW, CEDS & Carrie Landa, MA, PhD

❑ SA 2 **Taking Your Practice to the Next Level: Expanding Your Skill Set and Outcomes**
Melissa Gerson, LCSW; Lucene Wisniewski, PhD, FAED & Ashley Simon, MA

❑ SA 3 **The Interesting Relationship Between ADHD, Eating Disorders and Body Image**
Roberto Olivardia, PhD

❑ SA 4 **Relational Perspectives: Strategies, Interventions and the Healing Therapeutic Stance**
Judith Ruskay Rabinor, PhD & Judith Brisman, PhD, CEDS

❑ SA 5 **Bridging the Body-Mind Gap: Bringing the Body Back into Body Image**
Adrienne Ressler, LMSW, CEDS, F.iaedp & Susan Kleinman, MA, BC-DMT, NCC, CEDS

WORKSHOPS

- ❑ SA 6 **Healing Toxic Effects of Trauma: Shifting Patterns of Self-Sabotage to Self-Support**
  Jane Shure, PhD, LCSW & Beth Weinstock, PhD
- ❑ SA 7 **Befriending Your Body: Building Embodiment, Self-Compassion and Mindfulness**
  Ann Saffi Biasetti, PhD, LCSW, CIAYT
- ❑ SA 8 **The Missing Link...Binge Eating Disorder and Insulin Resistance**
  Carolyn Hodges Chaffee, MS, RDN, CEDRD & Amy Enright, RD
- ❑ SA 9 **Treating Eating Disorders at Midlife and Beyond: Forging Relational Hope**
  Margo Maine, PhD, FAED, CEDS; Karen Samuels, PhD & Mary Tantillo, PhD, RN, PMHCNS-BC, FAED
- ❑ SA 10 **Kickstart Psychological Flexibility: Promoting Acceptance and Change Using the ACT Matrix**
  Jacob Martinez, MA, LPC
- ❑ SA 11 **That's Fake News! Or is it? Media Literacy in the Cyber-Age**
  Alexandra Raymond, RD, LD, CEDRD; Millie Plotkin, MLS & Carrie Arnold, MPH
- ❑ SA 12 **Fibbing and Falsification: Uncovering Truths and Moral Health**
  Sandra Wartski, PsyD, CEDS

Sunday, November 10, 2019

- ❑ SU 1 **100 Shades of Gray: Ethics in the Treatment of Eating Disorders**
  Kelly Broadwater, MA, LPA, LPC, CEDS-S & Kendra Wilson, LCSW, CEDS, DBTC
- ❑ SU 2 **Nutrition for Therapists: Disseminating the Truth and Dispelling Myths**
  Flavia Herzog Liebel, MA, RD, LDN
- ❑ SU 3 **Body Image: What Research and Clients Say and How to Respond**
  Martha Peaslee Levine, MD & Beth Clark-Byers, LCSW
- ❑ SU 4 **Building LGBTQIA+ Affirming Environments by Challenging Personal and Organizational Bias**
  Rebecca Newman, MSW, LCSW & Em Gormley, MSW, LCSW
- ❑ SU 5 **Girl, Wash Your Facebook Feed**
  Rebecca Scritchfield, MA, RDN, EP-C & Melissa Toler, PharmD
- ❑ SU 6 **Memoir, Psychotherapy, Truth: Using Guided Memoir to Revision 'False' Narratives**
  Natasha Weston, MS, LPC & Deborah Gussman, PhD

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