The Renfrew Center Foundation
FOR EATING DISORDERS

Perspectives

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See page 7 for details

Contributors

A Word from the Editor

Marjorie Feinson, Ph.D.
EDITOR

We are extremely pleased with the fresh new look of *Perspectives*. While the format is new, what remains the same is The Renfrew Center Foundation's continuing commitment to addressing those significant matters that we, as professionals in the field of eating disorders, are dealing with on a daily basis.

Consistent with that commitment, this issue is devoted to exploring an overlooked, and often taboo, topic - **treatment failure**. In contrast to those articles that focus on failures from the client's perspective, we have chosen to highlight how clinicians define, understand and respond to their own failures and feelings about failure in the treatment process. At the time we selected this theme, we were unaware that several mental health professions had begun a transatlantic conversation on failure, as it is "increasingly in the ether" (Wolpert, The Psychologist, 2017). They astutely observed how little space there is within the therapeutic community for a discussion of failure. "I have been mulling on why this is such a taboo subject," writes Dr. Tony Rousmaniere.

> "I wonder if this is in part because: (a) we are emotionally invested in success (therapists join the profession to help people); (b) political battles between treatment models discourage acknowledgement of failure by leaders in the field; (c) the lack of agreed criteria on what constitutes success allows us to continue to duck the issue; (d) therapists are worried about removing hope from already very distressed people; (e) we can't cope with the narcissistic wound of not being able to help people."

This cutting edge issue of *Perspectives* provides space for six courageous professionals to respond to the challenge of exploring the complex and very personal topic of treatment failure. To assist in the development of ideas, we designed a series of framing questions including:

- *What does treatment failure mean to you?*
- *What experiences have influenced your view of failure?*
- *Have there been treatment failures that were difficult for you to 'let go' of?*
- *In the aftermath of a failure, how do you respond? Do you discuss it with your client?*
- *Are there merits to a 'failed case'?*
- *Under what circumstances might you embrace a failure?*

We begin with a compelling essay by **Holly A. Finlay, MA, LPCC, CEDS**, about the role of failure in her career: "A wise professional taught me an important lesson about failure: 'Our culture perpetuates a myth that there is only one right way to do something, and if we make the wrong choice,

we have failed. But in truth, there are many ways to do the same thing, and every choice we make is an opportunity to learn.' "

The taboo-ness of the topic is wonderfully captured by **Carolyn Coker Ross, M.D., MPH** who writes: "In my 30 years in medicine, I can only remember one colleague who admitted to me that he had made a mistake while working in the emergency department. I learned so much from that conversation and it helped me deal with the mistakes I made – both large and small."

A moving essay by **Lewis Jones, Psy.D.** will certainly resonate with many as he describes his frame of mind as a young psychologist just starting out. "I couldn't help but have a slightly worrisome reaction to being asked to write about treatment failure for *Perspectives*. Obviously, the only reason I was asked was because the editors believed I have a reputation for failure, right? Trying to leave behind the pangs of insecurity, I began asking myself for rhetorical reassurances. We all fail occasionally, don't we? Shouldn't our mistakes leave us better for having had the experience?"

Two striking case studies provided by **Karen Trevithick, Psy.D., CEDS**, vividly illustrate a significant aspect of her learning process: "I have learned (and continue to learn) through supervision and consultation, that appreciating and facilitating clients' resolution of their resistance – to therapy in particular and, thus, life in general – contributes significantly to treatment success. However, when I ignore, discount or push-through clients' self-protective measures against perceived (or actual) dangers without providing and supporting adequate resources, I have failed them."

In 'The Slippery Slope of Failure,' **Andrew Seubert, LMHC, NCC,** reveals that his "most difficult 'failures' have been the times when I didn't know enough about trauma or dissociation, but was too unaware of what I didn't know or too embarrassed to own it. Eventually, I realized that I felt more alive when telling the truth and being transparent with my client, than when I was holding onto the identity of the-therapist-who-knows."

Finally, we include a poignant meditation about failure from an award-winning American songwriter, **Billy Mann** in conjunction with his friend and colleague, **Brian Harper**. They begin with a story familiar to many football fans about Nick Foles, the quarterback who led the Philadelphia Eagles to their first Super Bowl victory. "… Foles put on one of the best Super Bowl performances in history, despite the fact that he was practically an invisible backup quarterback only a few months ago. But in a recent interview, Foles highlighted another factor that led to his recent success: the ability to embrace failure."

Our decision to open up a space for exploring this taboo topic has generated a diverse collection of essays – essays that reveal not only the complexities but also the growth opportunities that failure may present.

Failure: The Gateway to Success

Holly A. Finlay, MA, LPCC, CEDS

A wise professional taught me an important lesson about failure: "Our culture perpetuates a myth that there is only one right way to do something, and if we make the wrong choice, we have failed. But in truth, there are many ways to do the same thing, and every choice we make is an opportunity to learn."

This case study exemplifies my own learning and growth resulting from choices I made as a young therapist.

Karen came to see me in 2011 to resolve an inability to physically nurture her two young boys. Initially, she discussed a long-standing eating disorder and, over time, revealed a history of sexual abuse. Karen had been violently sexually molested as a child by her mother. Her next-door neighbor also sexually molested her and she was gang-raped as a young teenager. In addition to the sexual abuse, Karen's mother would not allow her to eat any food at home, except for dinner in the evening. She was considered "chubby" as a child and her entire family bullied her for being overweight. She learned to steal food from the kitchen, so she could eat on the weekend in secret. When she was caught, her mother would lock her in her room. Karen recalls spending endless hours in her room "waiting for someone to come for me and show me they care." Consequently, Karen suffered with issues of abandonment, neglect and broken attachment.

Over the course of the next several years, as we got deeper into the trauma, she became increasingly depressed and suicidal. I began checking in with her daily, which was difficult for her. Any type of special attention felt 'wrong' because the hurtful experiences of her childhood taught her that being seen led to pain. I soon realized that these contacts with her outside of our sessions were resulting in dysregulation and she was unable to calm herself down and get out of a non-functioning state of being. Karen had previously tried to kill herself and had a long history of impulsive reckless behavior and self-harm. She agreed not to attempt suicide during the time we worked together, but her past behavior had me worried about her safety.

As fate would have it, while she was under my care, I took a vacation and couldn't check in with her. I didn't know that my vacation destination did not have cell phone service, but I had arranged for her to see a colleague while I was gone. Karen agreed to this arrangement. However, when I returned, she was enraged that I was unavailable and felt that I had "dumped her."

I defended myself explaining that, "I could not have known about the poor telephone service." Additionally, during my vacation I realized the weightiness of carrying the responsibility for her safety. The frequent contacts outside of session were mostly for my own mollification and only exacerbated her symptoms. After all, she had clearly survived the separation. I decided to stop checking in with her and told her that "we would not be doing that anymore." From that point on, our work would be confined to in-person office visits. Karen stormed out of the session telling me she was "done." I telephoned her and invited her to come back to therapy and discuss the situation.

At the next session, she raged at me, yelling, "You didn't even ask me how I felt about it. You just took it away from me and I wasn't the one who suggested the check-ins in the first place!" I apologized, reminded her of my inability to call because of the lack of cell-service, and tried to get her to understand that, in my professional opinion, the calls were detrimental to her wellbeing. The contacts served to dysregulate her and cause her to become more depressed.

Karen agreed to continue treatment. However, over the next three years she struggled with a lack of trust and feelings of safety with me. Her behaviors reflected an insecure attachment – she would bring up the situation, rage, quit treatment, and come back, sometimes only after a few months. Each time I would listen to her rage, apologize for the event, and explain my belief that the check-ins were not helping her, but making her emotional state worse.

After the last iteration of this reoccurring pattern of conflict with my patient, I looked closely at myself and my actions. I realized I was afraid for her because of her history of self-harm and I was angry at her for unloading on me so vehemently when I returned from that much-needed vacation. It dawned on me that we were both stuck in a pattern resulting from our individual histories.

My own childhood need to be appreciated and yet, to also get "space" from a dominant force in my life, were being played out in the relationship with this patient. The check-ins with her carried expectations that she "feel better" and therefore be appreciated. When this didn't occur, I acted out my own counter-transference of resentment and impulsively discontinued the check-ins. I was withholding my attention and blaming her, a behavior not unlike the negative actions she experienced as a child from her mother and family.

It wasn't until I identified my part of the relational rupture that I was finally able to understand what she had experienced. I had offered her something she hadn't received as a child – time and attention – when she was experiencing powerful emotions. Checking on her by telephone outside of our office sessions resulted in a confusion of feelings. They gave her hope that she would finally be heard and metaphorically let out of her bedroom – causing her to feel more vulnerable. After all, if her own family couldn't be trusted **not** to hurt her by taking what was most important to her – innocence, trust, safety, value of self, and her own body – how could I be trusted?

My not being there for her on the phone mirrored what she had experienced as a child: abandonment, loss, punishment, and a lack of control. I made the choice to both give something to her and take something from her without ever consulting her about her thoughts and feelings. I was unsafe and couldn't be trusted, as were those harmful perpetrators during her childhood.

This accurately describes mis-attunement or insecure attachment. In attachment theory, when a care-giver is mis-attuned to an infant's hunger cries, the infant experiences a lack of emotional regulation. This sets the stage for the type of attachment relationship that the child may have with self and others. If the attachment is insecure, the child may have feelings of being unworthy and therefore not deserving of loving care, have difficulty tolerating separations and regulating affect.

When I was truly able to understand my part in the rupture of our relationship and express that understanding to her with authenticity, we became emotionally attuned. She finally felt heard and emotionally understood (the real corrective experience), and the issue was resolved.

Karen's case study is an example of a philosophy that I tell my clients. Every choice we make is an opportunity to learn. We don't learn from the experiences we breeze through; we learn from the bumps, bruises, and mistakes we make in life. Learning from our mistakes so that we may provide excellent patient care is true success.

Holly A. Finlay, MA, LPCC, CEDS is Clinical Director and Co-Founder of the Eating Disorders Treatment Center in Albuquerque, New Mexico. She has been practicing in the eating disorder field for over 25 years and is the current President of the International Association of Eating Disorders Professionals.

Failures in My Career as a Physician

Carolyn Coker Ross, M.D., MPH

When I look back on the beginnings of my career, I'm amazed at how young I was and how little I knew about failure. I didn't learn about it in medical school. There was no talk about even the possibility of failure during my internship or residency program or afterwards in locker rooms at hospitals or at medical staff dinners. And yet, being human, failure was an ever-present threat.

In my 30 years in medicine, I can only remember one colleague who admitted to me that he had made a mistake while working in the emergency department. I learned so much from that conversation and it helped me deal with the mistakes I made – both large and small. My fear of making mistakes led me to be cautious and also to trust my intuition when I felt there was something wrong - even when it was unseen. But the life and death nature of medicine never sat easily on my shoulders. I always wrestled with it.

I find it interesting that failure in medicine doesn't always involve fault. You can feel like you've failed with a patient, regardless of whether or not it was your fault. When I was a pediatric intern, a 4-year-old child was brought in to the emergency room. On the way, the child had stopped breathing. It was difficult to get a history from the mother and because of this and the child's age, we did the full court press to try and save the child who, it turned out, had epiglottitis – a condition where the tissue protecting the windpipe becomes inflamed and can block the flow of air into the lungs. Despite our best efforts, the child could not be resuscitated. I felt so responsible. I had children of my own who were near the same age and I couldn't imagine losing one of them so young. I also remember that none of my attending physicians ever talked to me about it, nor did they ask me how I felt.

I began my career in Pediatrics, Emergency Medicine and Women's Medicine where a patient dying unexpectedly or tragically made me look for any culpability on my part. In my current work as an addiction medicine and eating disorder specialist, failure has both informed my career and changed my definition of failure. I've heard some people explain the death of an addict or the suicide of an anorexic by saying "it's just part of the disease." In other words, it is not unexpected. I've never been able to accept this statement or to accept that I shouldn't work as hard as I can to help my patients. What's changed for me is that I've had to accept that sometimes patients are not able or willing to do what it takes to get well. Some patients are so tired, in so much pain, that they may not be able to exert themselves to heal. I don't see this as failure anymore. I see this is part of the process of healing and I always leave the door open for them to return to treatment and try again. I had to realize that I'm not the one in control of that process.

For example, I treated a 30-year-old woman with severe anorexia who left treatment in the middle of her family week and was angry at every member of the team. She was very ill and I worried that I would not see her again. However, six months later, she called and asked to see me in my private practice. We worked together for several years, during which time she gained enough weight to be in the "triple digits," went back to school, got a psychology degree and reunited with her family. I always told her that one day she would get married to a wonderful man and would be able to use her experience to help a lot of people. Several years after I stopped seeing her, I got an invitation to her wedding. I attended, only to find a healthy, happy woman who had become a children's therapist. What I learned was never to give up hope.

I began working with people with mental health issues after another perceived tragic failure – the suicide of my son, Noah, after a ten-year battle with depression. At the time, as a mother and a doctor, I could not conceive of any greater failure – I had failed to save my own child. Despite my best efforts and some missteps, he had been unable to get relief from the persistent darkness of his depression, the constant suicidality he struggled with and the psychosis that his long-term battle with depression resulted in. While I grieved as any mother would, I also felt mired in a sense that I could have done more; after all, I was not only the person who loved him the most, I was a doctor!

Living with this pain pushed me to enter the mental health arena with a conscious desire to help other parents not have to go through what I had gone through. I remember clearly, when I began working as the head of the eating disorder treatment program, sitting with parents terrified of losing their child to addiction, eating disorders and co-occurring depression or anxiety. I could tell them I knew exactly what they were feeling and really mean it. When I would hear their stories I could observe, in retrospect, the terror I had lived with for so long before Noah died. Sometimes I had to fight back tears when I saw a reflection of myself in a mother whose fear had taken over her life to the point that she could not sleep or eat or function.

Each time I heard another story, I also felt my pain lessen. Was there counter-transference – at times. But mostly, my mission became to cheat death, to fail as little as humanly possible. This informed and transformed my work while, at the same time, healing my personal grief. I could not bring Noah back. But I could help others see that their situation was not hopeless, even though it may have felt like it was.

So what failures have I experienced in this work? At times, I have found myself lacking at times, unable to be compassionate, while also maintaining strong boundaries. I've learned how to recognize when I get triggered by patients' anger at me or their desire to blame someone for their own faults and I'm the target of that blame. With the help of my own therapy work and supportive discussions with the teams I've worked with, I've been able to observe the anger as part of the process of recovery – the epic struggle that people experience within themselves that is sometimes displaced onto treatment providers, family members and others.

Some of my failures have involved missteps in trusting people who should not be trusted – both patients and colleagues or employers, missteps that have put me in compromising situations both personally and professionally. As an example, I took jobs in facilities that promoted themselves as having "patient focused care" only to find that they were "heads in beds" focused. As well, I've crossed boundaries with patients – once renting an apartment to a therapist who was my patient. This ended badly after he experienced a manic episode and trashed the apartment.

I have learned from my failures that I'm at my best when I build a community of support that includes physicians, therapists, dieticians and others who share the desire to excel at their work and who support me and who I can support. I'm patently incapable of being cavalier about the dangers of addictions and eating disorders as an explanation for our failures. I still find myself driven to keep looking for a better way in whatever setting I find myself in.

Doing my best involves "paying attention" which means not letting what some might consider "the little things" slip. It means not becoming complacent. Recently, for example, I was sitting in on a staff meeting about a patient with an eating disorder and there was some discussion about her recurrent problems in relationships. The clinical director said as an aside: "Well, we should focus on her eating disorder. That's enough to worry about now." In fact, her relationship issues were intricately intertwined with her eating disorder. As most eating disorder therapists know, too many times too count, in my experience a relationship breakup can derail eating disorder treatment and addiction recovery in women (although men can also be adversely affected).

Doing my best also means doing my own work on a regular basis. Many people I've worked with don't see this as important, but it has been very helpful to me. Doing my own therapy work keeps me recognizing what I bring to any interaction with patients. It has helped me deal with grief and loss – both personal and professional. I know how much EMDR can help because I've experienced its benefits. I also know how to help people heal – because I've gone through the healing process more than once myself.

Failure also has helped me to have compassion for myself as well as for colleagues and patients. But where we ignore the pain, where we don't look deeper for what is troubling our clients, is where the road to failure lies.

I also am sure that when I've failed – whether in ways small or large – I have taken that failure to heart and learned from it so that I can help the next person and the next after that. While I can never put my biggest "failure" behind me, I have softened my self-judgment and turned the pain into a passion to teach and help others. I think my son would be most proud of that.

Carolyn Coker Ross, M.D., MPH is an author, speaker and expert in the use of Integrative Medicine for the treatment of eating disorders, obesity and addictions. She is the author of three books, the most recent of which is *The Food Addiction Recovery Workbook*. Dr. Ross is the CEO of The Anchor Program™, an online coaching program for obesity and binge eating disorder.

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Shame and Survival

After becoming the focus of a history-changing federal investigation into her private life, Monica Lewinsky found herself, at 24, one of the first targets of a "culture of humiliation" – a now-familiar cycle of personal, political and media harassment, particularly online. In this compelling Keynote Presentation, Ms. Lewinsky shares how she developed the strength and resilience to deal with shame, move beyond trauma and reclaim her personal narrative. In so doing, she explores how the rise of the internet and the explosion of social media over the past several decades has had a profound effect on our current cultural climate. Finally, she speaks at length about the power of women's voices, given the #MeToo Movement and its impact on her.

Psychotherapy Research for the People: Can Feminism and Science Co-Exist?
Heather Thompson-Brenner, PhD (Moderator); Amy Banks, MD & Stephen Wonderlich, PhD

Good and Mad: The Power of Anger
Rebecca Traister

Hope for the Future:
Reinventing the Way We Work with Millennials
Ron Taffel, PhD

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Embracing Failure

Lewis Jones, Psy.D.

I couldn't help but have a slight reaction to being asked to write about treatment failure for *Perspectives*. Obviously, the only reason I was asked was because the editors believed I have a reputation for failure, right? Trying to leave behind the pangs of insecurity, I began asking for rhetorical reassurances. We all fail occasionally, don't we? Shouldn't our mistakes leave us better for having had the experience?

However, it is the murkier depths of failure that we are here to discuss. Just the concept of "treatment failure" feels scary and morose. No therapist really wants to think about it. As a psychologist, I have one job – to help my client feel better. If I don't achieve that, have I failed? Is that treatment failure? I'm not so sure.

During graduate school, just as were preparing to see our first clients, a supervisor gave me some off the cuff advice that still echoes in my head today: "You're not going to make them worse". It may seem somewhat facetious, but it relieved me of the fear that I would immediately fail at my new profession. While I might not make them better, it was pretty unlikely I would make them worse. This sentiment, more than anything, set the tone for my concept of failure in therapy – you only fail if you make them worse.

In my career, I have learned how important it is to stick to your competencies. When we stray from what we do best, we open ourselves up for some forceful and humbling course corrections. With regularity, though, therapists take on clients outside their areas of expertise. While this may occur for a number of reasons, it often boils down to money, obligation or hubris. Money – when private practitioners push the boundaries of ethics to keep themselves afloat financially. Obligation – when the requirements of employment force a therapist's hand. Hubris – a brash sense of confidence that leads clinicians to step outside their scope. Of course, I am not immune to such experiences. My own deviations have been due to both obligation and hubris.

As a young post-doc, I made the singular error of taking on a client I shouldn't have. However, this particular situation, I relegate to obligation rather than to hubris. At the time, I was working in an outpatient clinic for a large healthcare provider. I was receiving excellent training but was overworked to say the least. I met with a young woman in her early thirties, who had experienced severe, unfathomable trauma several years prior and was only now relenting to pressure from her family to see a therapist. Her insurance coverage was accepted by our facility and she wound up being added to my schedule. Meeting her, I couldn't help but picture the image of a scared puppy under the table in a thunder storm. She literally jumped and shuddered any time she heard someone walking down the hallway. The level of trauma she had experienced combined with my lack of experience and the scant amount of time left in my post-doc training, told me I was not the right fit for this client. I went to see my supervisor after that first session and, despite my trepidation, was told firmly that my CBT training was sufficient to treat a client with PTSD. There was no alternative; I would continue to see the client. It's this moment where I begin to lose my willingness to own the idea of "treatment failure" and point directly at obligation as the culprit.

As a new therapist, I was placed in a situation that, at best, was a huge challenge and, at worst, unethical. So I did my best. Right away, the client began to have frequent and, intense dissociative episodes during our sessions. Despite becoming completely stone-faced and unresponsive, she would return from numerous episodes in an absolute panic; on more than one occasion, she would run out of the room. I felt nothing I could do would help her, let alone reduce the dissociations. However, somehow this client and I were able to develop a very strong relationship that helped her achieve some significant, therapeutic milestones over the course of several years working together (she followed me into private practice). You might say my commitment to helping her, despite the failures that were occurring left and right, gave her the sense of safety she needed to continue our treatment together. For me, it's really an example of how failure can deepen the connection between client and therapist, fostering the very thing I feared I didn't have – the ability to help another person.

Later in my career, having embarked on the journey of private practice, I took on my first eating disorder client. By this time, I had the training and supervision under my belt, just not the

experience. As such, hubris got the better of me. This client, recommended by a colleague, was a professional working in the building where I was practicing. I felt confident I could help her reduce her binge eating cycles. But that same confidence blinded me to connecting to her as an individual. I set the foundation for treatment, gave her excellent book recommendations and talked the talk of an eating disorder professional. What I didn't do was to slow down enough to see how scared she was to feel her feelings regarding her body. She was smart and tough with a hardened shell around her. Any attempts to get past that shell were met with resistance and insinuations of the treatment not working. She was showing simple defenses to my cerebral version of treatment. In the desperation to unfurl my wings as an eating disorder therapist, I left her feeling unseen as an emotional and real person. It also left me blind to the relationship that was under-developed. She left treatment after only a few weeks.

While this larger degree of failure still stings to think about, it forced me to learn that no level of expertise or amount of knowledge compares to the value of connecting to a client on a human level. Had I attempted to address the growing disconnect between us, I might have broken through that shell and helped her see value in feeling and expressing what it was like to be in her body.

My experiences in failure showed me how important training, supervision and humility really are in this profession. Knowing myself, both my therapeutic strengths and weaknesses, would have been a tremendous advantage. A better understanding of my competencies in those early stages would have allowed me to avoid such memorable and shaping failures. I recognize that it may be unfair to relegate my experiences to poor training or supervision. However, I do feel that less and less, supervision is being utilized to outline our weaknesses and examine our failures. I truly believe that failure, in its varying degrees, can be a powerful force for change. Exploring, accepting and processing these experiences make us better people, if not better therapists. Learning to be a flawed therapist as well as a flawed person can only serve to make us more resilient in what is often a humbling career. Embracing our failures can lead to deeper connections with our clients, allowing us to be genuinely human in the presence of other humans.

Lewis Jones, Psy.D.
is a Licensed Clinical Psychologist with both Masters and Doctorate degrees from Nova Southeastern University. He is the site director of The Renfrew Center's new West Palm Beach location and maintains a private practice in Palm Beach Gardens, Florida. Dr. Jones has worked in the country's top healthcare companies as well as in university counseling centers, community mental health, inpatient psychiatric units and outpatient clinics. His primary specialties include Anxiety Disorders, Obsessive-Compulsive Disorder and Eating Disorders. Dr. Jones has presented nationally and locally on these topics and is currently on the Board of the iaedp South Florida Chapter.

Please Join Us at our Professional Open Houses

Date: Tuesday, October 9, 2018

Time: 5:30 pm - 7:00 pm

Location: The Renfrew Center of Southern New Jersey
15000 Midlantic Drive, Suite 101
Mount Laurel, NJ 08054

Date: Tuesday, September 25, 2018

Time: 4:00 pm - 7:00 pm

Location: The Renfrew Center of Massachusetts
870R Commonwealth Avenue
Boston, MA 02215

We invite you to meet Renfrew's Founder and President, Sam Menaged; our new Site Directors; and other clinical staff. You will have the opportunity to tour the sites, network with colleagues, and learn about our programs and services. Drinks and hors d'oeuvres will be served.

Personal Reflection of Treatment When Therapeutic Resistances Emerge

Karen Trevithick, Psy.D., CEDS

"When we undertake to restore a patient to health, to relieve him of his illness, he meets us with a violent and tenacious resistance, which persists throughout the whole length of treatment" (Rosenthal, 1987).

I have learned (and continue to learn) through supervision and consultation, that appreciating and facilitating clients' resolution of their resistance – to therapy in particular and, thus, life in general – contributes significantly to treatment success. However, when I ignore, discount, or push through clients' self-protective measures against perceived (or actual) dangers without providing and supporting adequate resources, I have failed them. This is particularly salient when maintaining the delicate balance of the therapeutic relationship: appropriately conceptualizing each client's attachment needs and working through individual resistances. The following are two examples of treatment failure within the context of the therapeutic relationship.

My first significant failure occurred when I was a young therapy practicum extern. My client, Betty, was a mid-30-year-old single, African American female with a significant trauma history, presenting with major depressive disorder and, dissociative symptoms. Betty's mother accompanied her to the clinic and per Betty's request, remained in the room for the first few sessions. A short time following the transition of Betty's independence from her mom in the therapy setting, Betty expressed intense worthless thoughts accompanied by a despondent and tearful effect. In that moment of my heightened anxiety, I experienced Betty as almost child-like and perceived in her a desire to be comforted (or was that my wish?). I therefore immediately responded that I believed her to be a worthy individual, including in my comments, "just because you exist." Upon the session's conclusion, I made an assumption that she was in a positive space.

I returned to the clinic the following week and was informed that Betty had attempted to overdose on over-the-counter medication. In supervision, I learned that Betty was not ready to hear these positive affirmations from me—for this level of attachment I was proposing, anticipating, demanding. As an enthusiastic therapist-in-training, I was focused on "fixing and doing." During this (still) early phase of our therapy, however, I failed to appreciate her fear of emotional intrusion or to recognize my role in it. I learned the importance of not imposing my beliefs onto clients until they will allow me to do so and that trust and mutuality is earned (and requested), not legislated. I neglected to provide Betty the necessary resources to help her work through her resistance to emotional intrusion and, ultimately, to the resistance of intimacy itself.

Fortunately, Betty was willing to resume therapy with me. I apologized for failing her, which initiated a reparative process. As with many of our clients, Betty had not previously experienced that someone she was in a caring relationship with would take ownership of – or apologize for – painful actions. I also created appropriate space to explore and manage emotions as they arose, while learning to recognize and tolerate my countertransference through supervision.

My second example is Carl, a young, single, Caucasian male who presented with anorexia, binge-purge type and severe, recurrent major depressive disorder. He was a highly intelligent, insightful and articulate young man who arrived for most of his sessions on time, if not early. He typically presented as polite and cooperative, yet despondent – tearful, hopeless, helpless, and worthless. Carl's eating disordered behaviors fluctuated in intensity throughout the course of therapy. As with many clients, he expressed feeling undeserving of food, a common theme in treatment. His overall self-care also reflected this belief system and his ADL's tended to suffer: avoiding bathing for several days, refusing rest when fatigued, and not cleaning his living area, especially following a binge/purge episode.

Carl was the eldest in a sib-ship of two. He was raised by his biological parents who had since divorced. His mother was a recovering alcoholic, continuously relocating, and with whom he had infrequent contact. His brother and father lived locally, though he reported having a conflictual relationship with his brother. Carl recalled having "anger problems" as a young child and was consequently placed in a locked closet by his parents for behavioral containment [He also disclosed a history of sexual

molestation by his coach during early adolescence. He reported the incidents to the authorities and his coach was subsequently arrested].

Throughout the course of our therapy, Carl repeatedly expressed his belief that his life had no meaning, purpose, or value. At times, he appeared to struggle with the existential crisis of how to understand or grasp how anyone finds the purpose in life. On occasion, he would work on connecting in relationships and in pleasurable activities. Unfortunately, Carl returned to discussing how pervasive and unrelenting his depression was, and how nothing has helped. He would ask for suggestions of what he could do differently, what he could try that he has not tried before, and even what alternative treatments there might be (that could support his limited financial resources AND be effective). I started feeling as helpless and hopeless as I imagined he was feeling.

One day, Carl shared that he had been having sexual fantasies about me. He was mildly tearful and initially struggled to maintain eye contact. I maintained what I perceived to be a neutral, yet compassionate stance. I thanked him for his willingness to be open and share, explored the reactions he anticipated/feared/hoped for by sharing, and "normalized" his feelings as a component of the therapeutic process. One comment he tearfully made while reminding me that he understood the boundaries of our relationship was, "I would never be good enough to be with someone like you." We addressed the meaning of this statement to him as well as the familiarity of it.

Shortly thereafter, for the next few sessions, Carl appeared significantly lethargic and with minimal verbal communication, at one point appearing to doze for 15-20 minutes. I believed I was demonstrating patience, holding the relationship space, not forcing. I concluded I was supporting Carl in his resistance to talking, with the intention of later helping him move him through it. I was unfortunately supporting him out of the office – Carl soon informed me he had located a new therapist he was transitioning to, with the hope that she may provide a new approach to treating and alleviating his depression.

In all honesty, I was initially proud of how I approached Carl's sexual transference. However, supervision helped me to recognize that I placed the burden on Carl to initiate communication regarding his intense emotional experiences, which he was ill-equipped to do. Additionally, I was approaching our relationship from moment to moment as opposed to contextually (which, of course, often parallels how our clients approach their feelings and relationships). I therefore failed to fully recognize – and then assist him – in moving through his superego resistance and sense of deservingness. I failed to give him the resources to hold on to the fantasy as long as he needed to AND remain in this relationship; to feel worthy of the emotions that being in a safe relationship evoke.

Establishing and maintaining compassionate and consistent relationships with our clients is often considered to be the hallmark of successful therapy. It can also be a delicate dance due to our clients'– as well as our own reactions to – resistances that arise. I am continuously learning and re-learning the timing and pacing for creating connections based on the needs (and resistances) of each individual client. And I am reminding myself to hold onto the context of the entire relationship and its developmental journey. I also have learned to appreciate my failures and value myself as a clinician, a teacher and an individual. This comes with gratitude to my excellent and compassionate supervisors, peers, and clients who honor and recognize my own humanity, so that I may continue to learn and grow.

Karen Trevithick, Psy.D., CEDS is a certified eating disorder specialist and clinical psychologist in Denver, Colorado. She is currently in private practice and is an adjunct faculty member at the University of Denver. Karen has more than 15 years of experience developing and coordinating intensive treatment programs for clients struggling with eating disorders.

The Slippery Slope of Failure

Andrew Seubert, LMHC, NCC

Writing about failure in my practice of 40 years has been a challenge because 'failure' is a judgment-based perception, at least in my experience and in my inner world. In psychotherapy, the meta-outcome for clients with eating disorders is an enhanced and authentic sense of self-worth facilitated by, but not totally dependent on, specific goal achievements. As therapists, however, what does it say about us if goals are not achieved or if client self-esteem is only marginally increased? Have we failed? Are we to be defined as failures, incompetent, not good-enough?

I consider failure a restricted perception that should not be applied to the larger process of soul-shaping and heart-releasing that is psychotherapy. This is particularly true of the daunting therapeutic tasks we face when working with trauma and eating disorders. Of course, we journey with our clients towards objectives and goals. Our treatment plan is the map; the therapeutic *process and relationship* are the territory. The map, albeit necessary, is not the territory. When we forget this, we are more susceptible to seeing unmet goals or therapeutic missteps as failure.

My attitude towards 'failure' has been formed by three areas of experience. The first influence was spending almost a decade in a Catholic seminary during which time I was gratefully introduced to the experience of *authenticity and spirituality*. The second was years of training in music therapy and Gestalt therapy, both of which stressed the power of attending to the living, relational process in any given moment, *the moment as it is without judgment*. The last was my own therapeutic process in struggling with the *fear of failure*. I grew up in a family of four children, raised by a single mother who worked full-time as well. With very little attention to go around, I was able to garner some by achieving in school and striving to be perfect (strongly encouraged by the nuns and priests). 'Failure' experienced as imperfection or disapproval lurked hungrily around every corner. My therapy was to stop feeding it.

As a specialist in trauma, PTSD and eating disorders, I encounter blocks, impasses and coming-up short on goals. It's the twists, turns and reversals of this work that can bring up the specter of 'failure', a word I prefer to replace with "time to recalculate" or "I wonder what door will open next?" However, when a strategy, intervention or goal is not successful and is viewed as 'failure' by the clinician, it can readily morph into the shame of *being* a failure, a very slippery slope, rather than the hope of possible opportunity. And this shame can go viral and be taken on by our clients.

JB was a 40- year-old mother of two who struggled with anorexia nervosa. In one session JB began to process a memory of being teased at the age of seven by her two siblings. Several minutes into EMDR processing she proclaimed: "I can't feel anything. Like there's a wall!" The processing was stuck and that door remained closed for almost a year.

"Are you sure you can help me?" she asked.

That last question had, in the past, often thrown me into self-doubt. If I had experienced that long year as 'failure', JB would most likely have done the same. After all, nothing was working and I was supposed to be the 'expert'. If I can't 'fix' her, than what does that say about her? Internally, I could feel the twinges of shame and anxiety. In order to continue, I worked hard to manage and examine my emotional reactions and self-doubt.

"Who is putting up that wall?" I asked, and eventually a door opened to an internal system of dissociated parts, a protective system that required understanding and collaboration before processing could begin again. And begin again it did, but only after sidestepping the 'failure' trap, stepping through a new door and getting to know and better understand JB's inner world.

Telling the truth to my clients when we need to change course, when I don't know the next step, have missed a cue, or have come up short regarding outcomes is an honest and powerful example for the client. It enhances trust and, paradoxically, confidence in the therapist. And it invites the client and therapist, as a collaborative team, to find their way out of the impasse, as illustrated in another moment with JB.

"If ever I feel happy, that will make me fat," she told me. Of course, this made no sense to me, but it *felt* absolutely true to her. Even though JB was on board with healing the memories associated with her eating disorder, she was blocked both cognitively and emotionally. However, we never called it failure. In time, with much wondering and exploration together, we realized that we were communicating on the wrong level. Once again, the impasses were coming from dissociated parts or ego states that could not be reached with adult logic. The frustrating sessions became opportunities to explore more deeply the source of her emotionally driven 'logic'.

Some of my most difficult 'failures' have been the times when I really didn't know enough about trauma or dissociation, but was unaware of what I didn't know or too embarrassed to own it. Eventually, I realized that I felt more alive when telling the truth and being transparent with my client, than when I was holding onto the identity of the-therapist-who-knows.

Donna is possibly the most chronically anxious client I have encountered in my 40 years of practice. Nothing has taken the edge off her anxiety and panic attacks. She cannot sleep for more than a few hours and is unable to eat. Her voice quivers when she speaks, and she is slowly becoming agoraphobic. Medications do not work and none of the skills I have taught her bring much relief. Neurofeedback is too expensive and not covered by insurance.

"I'm at a bit of a loss," I say at times. "I'm not giving up, but I'm not sure which direction to take next."

"Do you think I'll ever get better?" she asks.

"I believe it's possible, but I'm still not sure what to suggest."

"But you won't give up?"

"Not at all. And remember that regardless of how long this takes us, you're worth it."

Donna and I were on a difficult road with impasses, but we agreed to travel together. Despite disappointing and frustrating periods, it was the unwavering recognition of Donna's self-worth, experienced in the therapeutic dyad, which kept our shortcomings from ever being considered a 'failure.' To this day, I still come to roadblocks where the only thing I can do is be open with clients about the complexity and intransigence of the impasse and to see one door closing as another one opening…and remind them that they are so worth the effort.

There are only two instances in which I've found that 'therapeutic failure' applies. The first occurs when we abandon ourselves to shame by interpreting and labelling our mistakes, imperfections or limitations as failure, rather than opportunity. In a sense, 'failure' is forgetting who we Be. The second instance occurs when, in our own shame, we abandon hope and vision for our clients. We, as therapists, must keep both alive for them until they can do so for themselves, discard their failure story and remember who they Be.

It is often our *being* with the client, rather than what we do, that heals. With complex clients we are challenged to take the humble stance of knowing that we can make a difference while still being unable, at times, to get it all done. We are challenged to accept the limits of what we can do and what our clients are capable of and willing to do. Acceptance is awareness without (negative) judgment and requires therapeutic humility. Understood this way, therapeutic humility is realistic self-appraisal without judgment, making space for therapeutic self-compassion and hope.

Andrew Seubert, LMHC, NCC, is the co-founder of ClearPath Healing Arts Center in Corning and Burdett, N.Y. A licensed psychotherapist for 35 years, he has an extensive background in Existential-Gestalt Therapy and in music therapy, and provides EMDR consultation and training for clinicians. Andrew specializes in working with trauma, posttraumatic stress, eating disorders and the integration of spirituality and psychotherapy.

Renfrew Research Published in Prominent Journal!

The Research and Training Departments of The Renfrew Center are pleased to announce that the initial report of our multi-year project to adapt and implement evidence-based treatment across all levels of care – residential, day treatment and intensive outpatient – has been published in the highly regarded peer-reviewed journal, ***Clinical Psychology: Science and Practice.***

A link to the article can be found on the research page of Renfrew's website, www.renfrewcenter.com.

The Highlight Reel

Billy Mann as totally inspired by my friend, Brian Harper

Regardless of what Super Bowl team you rooted for, everyone I know either celebrated or appreciated the new Super Bowl champion Philadelphia Eagles. Nothing like an underdog rising! If you don't care about the Super Bowl, the story here is still relevant.

Nick Foles, the quarterback who led the Philadelphia Eagles to their first Super Bowl victory ever, has been on an unexpected tear. After leading the Eagles through the postseason, Foles put on one of the best Super Bowl performances in history, despite the fact that he was practically an invisible backup quarterback only a few months ago. Foles took over as the starter in December after Eagles superstar quarterback Carson Wentz tore his ACL. What really made Foles stand out is his humble, down-to-earth manner. He's slow to accept credit, happier to defer glory to his coach and teammates.

But in a recent interview, Foles highlighted another factor that led to his recent success: the ability to embrace failure.

"I think the big thing is don't be afraid to fail. In our society today, Instagram, Twitter, it's a highlight reel. It's all the good things. And then when you look at it, you think like, wow, when you have a rough day or [you think] your life is not as good as that, you know, you're failing. MVP Foles continued, *"You know, failure is a part of life. It's a part of building character and growing. Without failure, who would you be? I wouldn't be up here if I hadn't fallen thousands of times. Made mistakes. We all are human, we all have weaknesses...I think when you look at a struggle in your life, just know that's just an opportunity for your character to grow. And that's really just been the message. Simple. If something's going on in your life and you're struggling? Embrace it. Because you're growing."* Foles has got it so right.

The takeaway:

As much as the Foles story may seem about football, it's not. It's about collaborating. It's about our private struggles. It's about perception vs. reality. It's about failing and being called to action especially when you might enter feeling unnoticed or unworthy. Ultimately, it's about winning without spinning.

2018 Webinar Series for Professionals

September 26th – A Guide for Therapists: Transforming Clients' Food Misconceptions
Presented by: **Heather Russo, MA, MFT, CEDS**
Regional Assistant Vice President and Site Director at The Renfrew Center of Los Angeles

October 24th – Guilt, Denial, Surprise, Compassion: Helping Families Navigate their Emotions to Enhance Recovery Support
Presented by: **Ashley Moser, LMFT**
Site Director at The Renfrew Center of Charlotte

December 12th – How Religious Beliefs Can Be Utilized To Enhance Treatment for Those of Jewish and Christian Faiths
Presented by: **Sarah Bateman, LCSW**, Liaison to the Jewish Community at The Renfrew Center & **Edith Majors, MS, MAIS, LPC Intern**
Primary Therapist at The Renfrew Center of Dallas

All webinars are FREE and run from noon to 1 PM EST.
To register, please visit www.renfrewcenter.com.

For myself, I try to be as transparent as I can about the challenges I face in my life. As a songwriter, I know you can write 100 songs and often only one gets cut when you think 99 are amazing. As a parent and partner, you want 365 days a year to be perfect and amazing, but when you face disabilities with your children like I do, you know nothing is color by numbers… Pretty sure we all know that life doesn't work that way. This year, I've witnessed too many friends struggle with challenges – health challenges, emotional challenges, financial challenges, political challenges… so much weighing on us and on top of that is our social media that commands us to be "awesome all the time" or, as the Super Bowl MVP rightfully calls our feeds, a perpetual 'highlight reel.'

Along with those efforts comes inevitable failure. But that failure is what enables me to learn. So, it may be time for a perspective change. Instead of limiting myself or becoming overly concerned with how I might be viewed by others, I focus on my growth. Mistakes and failures aren't the end of the world; rather, they're learning opportunities that provide depth in my playbook. Embrace them. Learn from them. Use them to grow. There's no telling where you'll end up. And the best news is, I am changing – we are all changing… And as scary as change can be, our true "friends" won't just "LIKE" us online, but they'll love us through it all, on and off the field, the charts, the stream and the screen.

Spring is here! Fly Eagles Fly!

Billy Mann is an award-winning American songwriter, producer, philanthropist and founder/CEO of Manncom Creative Partners. Over a 25-year period, Mann built his career working with legendary artists like P!nk, John Legend, Celine Dion, Backstreet Boys, Cher, David Guetta, Kelly Rowland, Jessica Simpson, Ricky Martin, Art Garfunkel, Sting, Helene Fischer, Burt Bacharach and Sheryl Crow. Since his first Top 10 in 1995, Mann continues to achieve Top 40 hits around the world with cumulative album sales of over 125 million.

Brian L. Harper is currently the CEO of Rouse Properties, a real estate investment company in New York City. Rouse currently has a portfolio which consists of over 24 million square feet across 22 states in the U.S. In 2017, Mr. Harper was named a National Board of Director of Autism Speaks. He has over 18 years of experience in the real estate industry and holds a BA from the University of Kansas.

Your Donation Makes a Difference

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

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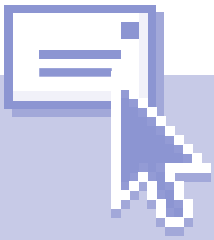

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