The Renfrew Center Foundation
FOR EATING DISORDERS

Perspectives

A Professional Journal of The Renfrew Center Foundation • Summer 2019

The 29th Annual Renfrew Center Foundation Conference for Professionals

November 8-10, 2019
See page 5 for details

Contributors

A Word from the Editor

Is embracing relapse an oxymoron? This is the topic we asked our writers to grapple with in this issue of *Perspectives*. In contrast to academic studies that examine various aspects of relapse, such as 'relapse risks,' 'relapse prevention,' and 'stages of relapse,' we decided to focus on clinicians' experiences with relapse and how relapse might have a positive impact on recovery. Specifically, we indicated our interest in examining the implications of relapse for the clinician, the client and the treatment process by considering the following questions:

- *What does 'embracing relapse' mean for you?*
- *What experiences have influenced your view of relapse?*
- *How do you respond to relapse? Does relapse ever induce feelings of failure?*
- *How might relapse be helpful for both you and your client?*
- *How does relapse impact the course of treatment? What generally happens in the aftermath of relapse?*
- *Do you believe that relapse is consistent with a 'good enough' recovery?*

We are pleased that six clinicians accepted our invitation and have presented essays that are both enlightening and introspective.

We begin with an engaging episode by **Judith Ruskay Rabinor, Ph.D.,** a seasoned psychotherapist and author. She provides an illuminating description of how her therapy group helped one member whose relapse was being triggered by a Persian rug! "'I'm afraid I'm relapsing,' Marni said tearfully, kicking off the group. After many months of binge-free 'sobriety' her eating had 'gone crazy' again. Now our therapy group was trying to unravel the pieces of the puzzle: how—and why—an out of control binge resulted from feeling angry with her 84-year-old mother, Elsa."

Next, we have a poignant essay from clinician **Carolie Meccico, LCSW, MAC, CEDS,** who shares how discouraging her client's relapse was for her, as well as the client. "Each relapse discouraged me and reinforced my doubt of my client's commitment to recovery and my ability to assist her. I seemed unable to predict her vulnerability to relapse and unable to help her maintain the recovery gains she made. She expressed worry that I would 'fire' her from treatment for not 'getting better.' Little did she realize that I had never considered firing her. Rather, I had seriously considered firing myself as her clinician as I was obviously doing something wrong."

Rosanna Mauro de Maya, MS, RD, CEDRD-S, a nutrition therapist, describes treating Ana, a woman in her thirties who had been battling with bulimia since she was a teenager. Rosanna provides a striking explanation of responding to client resistance. Ana had been warned that dietitians were no

good and said in the first session: "I do not know what you intend to do for me, as I will never recover—I am doomed to die like this." "I explained to Ana that we would be working as a team, and that there would be no judgment, criticism or fatalistic prognosis. I immediately introduced her to the concept of relapse—and the beauty of recovery..."

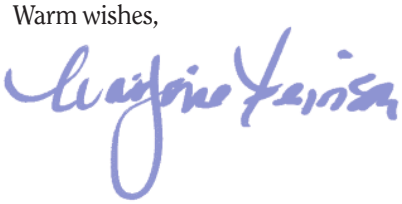
Our next essay comes from clinician **Patricia Adlerman, MSW, LCSW,** who vividly shares an experience of client relapse as opening up a new path of recovery. Following inpatient treatment and an initial relapse, Jane, a 31-year-old medical professional with many degrees and a family, returned to intensive outpatient treatment and disclosed her relapse to her support team. "Jane's relapses continued for several weeks. They got worse, and she became less transparent with her support team. Until one day, her primary therapist, along with her husband, confronted her in a loving manner with a very important question. Was she really prepared for the responsibility of a medical career, a two-year-old son and a spouse?"

Charlynn Small, Ph.D., CEDS, a licensed clinical psychologist, has spent the past twenty years working primarily with college students. Early in her career, she was counseling Bill, a young man who had a history of struggling with bulimia. Bill hadn't told anyone because about the bulimia because "he was embarrassed that he couldn't stop doing these things he thought only women did. Relapsing when he did enabled Bill to learn that he actually did have a true medical concern that could be treated. We worked together until he graduated and by that time, his behaviors had remitted."

Our final contribution illustrates another aspect of relapse, namely shame. **Michael Weiner, Ph.D., MCAP,** explains that his first experience "happened a long time ago, at the beginning of my personal journey as a person in recovery and as an addiction professional." His essay presents a compelling challenge to clinicians: "...I've been at this a while. I've seen lives change and families come together. Along the way I've felt frustration with how relapse has been managed and how shame has persisted. It's up to us to do a better job and to eliminate whatever shame we create. We create a lot. Do we have the courage to change the things we can?"

As these essays collectively reveal, recovery is not a linear process of success upon success. Rather, slips, setbacks and relapses may be integral features of recovery. Uncovering secret and shameful aspects of relapse with trusted and skilled professionals may enable clients to gain a deeper understanding of themselves, their vulnerabilities and the development of new behaviors and coping skills that lead to more sustainable recoveries.

Warm wishes,



Marjorie Feinson, Ph.D.
EDITOR

The Persian Rug Relapse

Judith Ruskay Rabinor, Ph.D.

"I'm afraid I'm relapsing," Marni said tearfully, kicking off the group. After many months of binge-free "sobriety," her eating had "gone crazy" again. Now our therapy group was trying to unravel the pieces of the puzzle: how–and why– an out-of-control binge resulted from feeling angry with her 84-year-old mother, Elsa. Being distressed at her mother was an old theme for Marni, one she'd worked on for much of her life.

"I couldn't believe she did this. When I walked into her apartment, I immediately noticed my favorite rug was gone—and I went wild. She'd given it to the Salvation Army! I went crazy and went right to the phone and called to see if I could get it back. And guess what the woman I spoke to said? 'That Oriental was a beauty. It's no wonder it sold within an hour after it was dropped off.'"

Marni's face winced as she repeated the words of the woman at the Salvation Army. The rug was from Marni's family home in Wisconsin. A six-month bout with cancer had recently taken Marni's 85-year-old father. Elsa had quickly sold the Wisconsin home, downsized into a NYC condo and was now preoccupied with lessons from Marie Condo, the decluttering guru. To Marni, the rug was a precious heirloom. She had specifically told her mom that if she ever decided to get rid of it, Marni wanted it for her new apartment.

"When your mom saw you were upset, what did she say?" I asked. "Did she remember how attached you were to this rug?"

"As usual, she pooh-poohed me. 'That old rug—it was a big nothing'" was her response. When Marni protested, instead of an apology, she was told, "Get over it! It was worn out and shredding, hardly worth a dime!"

"How upsetting," I said, wanting Marni to sit with her feelings and hoping to validate her pain. Marni's face fell. For a moment I thought she would cry. But then, she visibly went into another state. "But what's wrong with me? It was just a rug! To think that I'd order a pizza at 12 midnight and stay up until 3 a.m. wolfing it down all because of a rug!"

Just as I was thinking how easy it was for Marni to turn against herself, Lenora, our oldest group member, interrupted. Her eyes flashed. "This isn't a rug story, Marni. It's a story about feeling ignored and overlooked."

Lenora paused. "I want to tell you something, Marni, something I've felt for a long time. I never wanted to hurt you, but I'm not going to hold back now. I think you don't want to hold your mother responsible for who she is and the inappropriate things she does. And this is not the first time I've seen her be self-absorbed!"

Marni's eyes opened wider. So did mine. In the eighteen years I'd been running this group, rarely did anyone speak so vehemently about another person's mother!

"What do you want to tell me, Lenora?" asked Marni. Lenora paused before responding and when she spoke, her voice was low, but strong. "Your mother can be selfish. And ruthless." Marni's eyes widened.

"Ruthless is a strong word, Lenora," I said.

"It is," Lenora agreed. "I'll tell you what's bugging me. I remember your mother at your 60th birthday," she said, referencing a recent party she and the group had attended.

"She looked beautiful, didn't she?" smiled Marni. "Did she do something wrong?"

"She is beautiful," Lenora said, "She was strikingly beautiful in that drop dead, gorgeous, white eyelet dress. The way it fitted her, I wondered if it was custom made."

"Maybe," Marni interrupted. "She has an amazing seamstress she's been going to for years. Maybe Joann made it"

My stomach lurched. How easy it was for Marni to deflect attention away from the direction Lenora was heading. Although Marni was a beautiful woman, for many years, she had talked about feeling unattractive. Daughters often need to get permission from their mothers to be attractive, sexual beings. I wondered where Lenora was headed.

"Seeing your mother in that dress at your party really bothered me. Frankly speaking, it was almost inappropriate." Marni was silent while Lenora continued.

"Your mother acted inappropriately. I remember seeing her prance from table to table introducing herself to everyone, shaking hands, smiling, chatting and finding out how the party was going."

Marni gasped "Inappropriate; what do you mean?

"I mean that she looked and acted like it was her party—that the party was for her!"

"No," said Marni, appearing aghast.

"Yes," said Lenora. "And the way she caroused around the room, greeting all the guests…"

"So what about that?" asked Marni. Lenora paused.

"That was your role Marni, it was your party." Lenora's voice was stern. "She was usurping your position, Marni."

"Don't be ridiculous," Marni said, "My mom is just friendly, maybe a bit overly so. She just wanted to say hello to everyone. She's known some of my friends for my entire life and has great relationships with some of them. And I had some people there she didn't know, like you guys. She's heard a lot about you and wanted to introduce herself to you and meet you."

Wanting to engage the other group members, I asked: "What are the rest of you thinking, feeling, listening to this?"
"Marni," said Drew, speaking gently, "Lenora is trying to tell you something important. I was at the party and what Lenora is saying is true. Your mother upstaged you."

"Is this something you noticed—or felt?" I asked Marni.

"No, I never thought about this."

"What do the rest of you make of this?" I asked

"It's hard for you to think of your mother as out of place or selfish," said Natasha.

"I was there, too" said Larry, "Your mother's dress was an attention grabber. She's really hot for 82!"

"How are you feeling about Larry's remark?" I asked Marni, noticing her fallen face.

Marni paused. "I never really thought about this"

"Well," said Natasha. "Now that Lenora mentioned it, I'm thinking two things. First, your mother really was the center of attention—between the dress and her 'Meet and Greet' personality style, she stood out, big-time!"

Lenora nodded. "Exactly! Your mother was the belle of the ball."

The phrase jolted me. How often had my own mother, gone five years, used that very expression.

"No," said Marni. Her voice fell flat.

A bit lost in my own thoughts, I suddenly realized I needed to stay present to help Marni and the group process what was going on here.

"Can I help you slow down, look around the room and take in what people are saying?" I asked Marni.

Marni nodded. "Take a moment, go inside and allow what has been said to sink in. Remember being at your 60th birthday party, seeing your mother in her white eyelet dress; it sounds exquisite," I said, deliberately wanting to heighten Marni's feelings. "And take a look at what you were wearing."

Marni opened her eyes. "I was wearing a black dress—nothing special."

"Take a moment and allow these images to float up," I said, "See what floats up for you as you see the black dress, nothing special… a white eyelet dress—custom made, perfect fit… an old Persian rug. Sometimes there are important messages in small details."

Marni began to cry. "I'm feeling sick," she said sadly.

"So, can you take a moment—you don't have to say anything, just be with feeling sick. Notice where in your body 'sick' lives. Allow yourself to feel sick and sicker and see where your mind goes."

Suddenly Marni smiled at the group and began talking in an exuberant, animated voice. "I'm thinking about ordering the pizza," she said and began laughing. "I know it's crazy, but I see how happy this made me that night!"

A light bulb went off in the group, a beam that began with Marni and rippled through the others. For the remainder of the session, the group focused on the all too familiar dynamic that Marni had just walked us through. Rather than face the pain of sitting with uncomfortable feelings (being sad or mad), planning a binge was a distracting, energizing and an enlivening experience.

"I almost didn't come tonight," Marni admitted as the group was coming to a close. "But thank goodness I did. I was so ashamed of my binge and feared I was spinning into a real relapse.

"So glad you did," I echoed.

The rest of the group centered on helping Marni—and other group members—face how unexpected encounters with uncomfortable feelings can all too easily trigger a binge. So often shame inhibits and silences our patients. But fortunately, Marni had been able to override the impulse to stay away from group.

When a patient relapses, shame is an expected reaction. Helping patients express shame—the sense that there is something wrong with us—is the first step in healing. Naming and labeling it as a "temporary state" normalizes it as only one part of who we are. Self-compassion is a powerful antidote to shame. Here are a few interventions that will help patients develop self-compassion while dealing with relapse, triggers and shame:

1. Help patients identify triggers. This can be tedious, but worthwhile.
2. Help patients treat themselves as "small wounded children in need of comfort."
3. Remind patients they are not alone, to reach out to someone they can depend on for comfort: a friend, relative or even a therapist. A therapist's voice on a recording can serve as an anchor or a safe harbor.
4. Teach patients that relapses are to be expected and should be met with mindfulness. Practicing a mindful response to a relapse is a helpful tool.
5. Remind patients that we are all imperfect and that relapses are teaching moments.
6. Help your patients learn the lessons their relapse offers.

Relapse and the shame surrounding it are inescapable parts of the recovery process. Prepare your patients for this phase of treatment. This session was a reminder that every relapse is an opportunity to help our patients learn how to dig down and access deeper levels of self-awareness.

Judith Ruskay Rabinor, Ph.D., is a psychologist, psychotherapist and the author of *A Starving Madness: Tales of Hunger, Hope and Healing in Psychotherapy* and *Befriending Your Ex After Divorce: Making Life Better for You Your Kids and Yes, Your Ex.* She is currently writing a book about mothers and daughters. Dr. Ruskay Rabinor is in private practice in New York City where she sees individuals, couples, families, and groups. She runs a consultation group for mental health professionals and is now offering writing groups for therapists.

THE 29TH ANNUAL RENFREW CENTER FOUNDATION CONFERENCE FOR PROFESSIONALS

FEMINIST RELATIONAL PERSPECTIVES AND BEYOND: DISCERNING TRUTH

As we continue to address the challenges we face as a professional community, we recognize the importance of discerning truth in our current climate of "fake news," unsubstantiated claims and slanted rhetoric. These forces have contributed to rising levels of distrust and vulnerability among our clients with eating disorders.

Conference 2019 will examine the ways in which we, as clinicians, can help clients develop skills to enhance critical thinking, emotional regulation and relational connection. At the same time, it is incumbent upon us to explore our own biases and capacity for taking others' perspectives, utilizing empirically-based, justice informed science and research.

Featured Speaker:

LISA LING

Executive Producer & Host of CNN's *This is Life with Lisa Ling*

Open Heart, Open Mind

November 8-10 | 2019

Philadelphia Airport Marriott

18 CEs/CMEs

Discerning Truth will focus on cognitive and psychological flexibility, neuroscience and the developing brain, compassion, and the healing qualities of the therapeutic relationship.

REGISTER NOW: WWW.RENFREWCONFERENCE.COM

The Renfrew Center Foundation
FOR EATING DISORDERS

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

Relapse: A Recovery Paradox

Carolie Meccico, LCSW, MAC, CEDS

My career began in the late 1980s in the field of addictions recovery, where relapse was a common occurrence. The early days of my practice were fraught with relapse issues and feelings of inadequacy and frustration for my clients, and dread for me.

As one example, Annie was a 28-year-old, delightful client I had worked with for some time. She had a dual diagnosis of binge alcohol abuse and anorexia nervosa, restricting type. She appeared to be motivated in treatment and would experience brief periods of abstinence from both restricting calories and binge drinking. However, she was unable to sustain these periods of abstinence for longer than a few weeks when she would briefly return to restricting calories and consuming alcohol. These periods would be followed by longer relapses into these behaviors. Each time, she expressed feelings of shame and guilt, and the relapses sabotaged her hopes and motivation for recovery.

Each relapse discouraged me as well and reinforced my doubt of her commitment to recovery and my ability to assist her. I seemed unable to predict her vulnerability to relapse and unable to help her maintain the recovery gains she made. She expressed worry that I would "fire" her from treatment for not getting better. Little did she realize that I had never considered firing her. Rather, I had seriously considered firing myself as her clinician as I was obviously doing something wrong. I could not seem to help her maintain even small successes for more than a few weeks at a time. The traditional psychoeducational approaches and cognitive behavioral strategies I was using seemed ineffective.

I then consulted with a more experienced mentor. Together we considered the reasons for my failure to help her. I recognized my countertransference issues in my doubts about her willingness to recover and my feelings of frustration when she relapsed. This led to unrealistic treatment expectations. My reaction was to set treatment goals according to my priorities. In doing this, I missed an opportunity to engage her in a client-centered collaboration. My mentor helped me to understand relapse as an unconscious resistance to recovery, not simply an unwillingness for full participation in treatment. I also learned that relapse could be useful as a lens through which both of us could view her unique recovery process.

Subsequently, I was introduced to Terence Gorski, a relapse prevention specialist and his Developmental Model of Recovery and Relapse Prevention Model[1]. This model defines addiction recovery as a progressive developmental process with relapse occurring unconsciously, automatically and periodically throughout various stages of recovery. Each stage has specific growth-oriented tasks, and relapses are managed as "learning experiences." This helps clients learn how to begin constructing a relapse prevention plan early in the treatment process. It provides information about relapse predictors, known as "triggers," which may make clients vulnerable to relapse. Strategies for relapse management can then be collaboratively developed to decrease the frequency and duration of relapse experiences.

Applying this model in my work with Annie provided a framework from which she and I could understand her unique relapse issues at each recovery stage. Because of her relapse fatigue, she feared making choices regarding the direction her treatment should take. It was, however, crucial for her to see the difference between her perceptions and my assessment.

For example, I believed it was necessary to address both the eating disorder and binge drinking simultaneously. This was because Annie's pattern of relapse was to restrict caloric intake to speed the effect of the alcohol. Adopting a client-centered approach within Gorski's framework, I encouraged her input into the treatment plan. Annie chose the tasks she wanted to complete first. The first task she chose (with medical input) was establishing abstinence from alcohol. She identified and set the treatment goals to accomplish this.

This model helped Annie and me to understand that relapse triggers, if managed correctly, are opportunities for both of us to gain insight into the hierarchy of treatment needs and identify potential relapse issues. My dread of relapse began to change into respect for the process and the insight gained from each experience, and Annie began to express renewed hope.

Incorporating acceptance and commitment therapy (ACT)[2] into Annie's treatment greatly accelerated her progress. I did this because the goal of Gorski's model is to teach clients new ways of thinking and behaving in high-risk situations. ACT is a mindfulness-based approach that promotes insight into certain character traits that may support dysfunctional or avoidant

reactions in high-risk situations. Specifically, utilizing ACT concepts like "experiential avoidance" assisted Annie in understanding the impact of repressing undesirable internal experiences on her recovery. Building acceptance and tolerance for uncomfortable thoughts, emotions and sensations involved in recovery strengthened her confidence and motivation. Practicing mindfulness provided her with a way to examine the personality traits that supported her thoughts, feelings and behaviors in relapse. She gained insight without shame. She was able to maintain focus in the present and make positive recovery choices while experiencing a decrease in the frequency and duration of relapses.

At the time I was working with her, there was no empirical or operationalized definition of eating disorder recovery. Defining full recovery from eating disorder remains somewhat controversial today. "Positive change," as Annie understood it, meant she no longer needed the alcohol or the eating disorder to avoid or control her life. When her treatment goals were met, she was abstinent from alcohol for at least one year. She was not restricting calories and was physically, behaviorally and emotionally stable. Both Annie and I defined this as "recovery" and she chose to leave treatment at that time.

Another client had a different definition of recovery. Ella was 34 years old with a chronic history of anorexia nervosa (restricting and purging type) and a long history of relapse. Ella had struggled with anorexia since late adolescence and been to several outpatient clinicians prior to becoming my client. She also spent three weeks in residential treatment but left against medical advice. She came to my practice skeptical she could "get better," while describing herself as "a lost cause" that several clinicians had given up on. This was an early indication of her identity as a "failure" and that she had lost hope for recovery. Such is the aftermath of relapse. Yet, here she was, once again, in treatment.

Utilizing Gorski's model with ACT, I began to work with her despite her initial resistance to the idea of relapses as useful "learning experiences." For example, she described relapse as an experience that was out of her control and always resulted in treatment failure. Additionally, she consistently resisted identifying her wants and needs in treatment and would express distrust in her ability to identify these, based on past treatment failures. In this manner, she could avoid moving forward in recovery. Chronic relapse had resulted in Ella's denying her ability to recover. Even the word, recovery, was a relapse trigger and she subsequently relapsed again.

Again, incorporating ACT techniques and a client-centered approach, Ella and I formed a treatment plan. Gradually, a cognitive shift occurred, and Ella began to commit to change and continue treatment. She gained an understanding of relapse as a learning experience along with identifying triggers that led to past relapses. She also developed insights into her character traits that had previously sabotaged treatment and supported avoidant behaviors. She became committed to making "positive change." In this manner, ACT supported what she learned about relapse triggers from Gorski's model. She could then plan management strategies and set new goals in treatment. Ella experienced a renewed hope and trust in herself to succeed in treatment. She embraced a positive identity of herself. She also trusted that I would not "give up" on her, and together, we formed a collaboration committed to recovery.

Ella continues in treatment and has been abstinent from restricting caloric intake, excessive exercising and the abuse of laxatives and diuretics for approximately one year. Although she continues to struggle with emotional and cognitive lapses regarding body image, she now understands these issues as measures of her progress in managing relapse. She describes this stage of her recovery as the healthiest she's been since adolescence and considers it "a good enough place for now."

In summary, recognizing the dualism of relapse as both resistance to recovery and important stratagem promoting recovery has helped me become a more effective clinician. Utilizing relapse as a learning opportunity in each client's unique treatment experience helps me to effectively assist the journey into recovery.

References:

(1) Originally Published In: *Alcoholism & Addiction Magazine*: Relapse - Issues and Answers: Column 3: How to Develop A Relapse Prevention Plan: By Terence T. Gorski, September 25, 1989; 708-799-5000, www.cenaps.com.

(2) Hayes, S.C, Strosahl, K.D., & Wilson, K.G. (2012). *Acceptance and commitment therapy: The process and practice of mindful change* (2nd edition). New York, NY: The Guilford Press.

Carolie Meccico, LCSW, MAC, CEDS, is a Licensed Clinical Social Worker, Masters Addiction Counselor and an iaedp Certified Eating Disorder Specialist. She graduated from the University of Utah Graduate School of Social Work in Salt Lake City, Utah. She has an eclectic outpatient mental health practice in South Ogden Utah and in Southeastern Idaho.

Unraveling the Gift of Relapse

Rosanna Mauro de Maya, MS, RD, CEDRD-S

A quick search in the dictionary offers the following definition of relapse: "Suffer deterioration after a period of improvement." At a simple glance, this seems somewhat discouraging and emphasizes the negative side of relapse. Would it be more constructive for a patient suffering from an eating disorder to view relapse with fright and a sense of failure or, rather, to shift the view to one that can help him/her grow? In this sense, it seems that embracing relapse is an oxymoron–that deterioration is actually a necessary experience for growth and learning.

As clinicians, we are taught and trained to fix, cure, remove ailment and restore health. The responsibility of the process is, to a certain degree, put on ourselves. No wonder facing relapses can be quite challenging for us!

At the beginning of my career, relapse had the power to make me question my efficacy as a nutrition therapist and could even spiral me down the road of lingering with inadequacy and frustration. From that time, I remember Christina, who had been in residential treatment for restrictive anorexia nervosa. After discharge, she was having a hard time going back to her normal routine and had begun restricting several of her meals. To my regret, I acted judgmentally when I started questioning her as to why she insisted in hurting herself—despite everything I was doing for her! In a sense, I processed her restrictive behaviors as an attack on me and experienced substantial countertransference. In my view, I had taught her the step by step process she needed to follow to prevent relapse. By engaging in the restrictive behaviors, I felt she was letting me down. I was making the process about me as a clinician and was missing her own suffering and struggle! I pushed Christina so hard to commit to not restricting anymore, that she actually cancelled a few of our upcoming nutrition therapy sessions. Once she resumed therapy, we processed her relapse and my reaction to it. I disclosed a little about my frustrations and that I was willing to put my own feelings aside to help and accompany her throughout the process, no matter what.

By embracing relapse, the patient can create awareness of what is happening here and now and view herself from a distinctive perspective. By guiding my patients, holding their hands and walking with them through the ups and the downs, along uncharted territories, relapse offers a possibility for transformation. I often use an analogy to illustrate relapse to my patients: If you were watching a young girl (a younger version of yourself or your daughter) learn how to ride a bike, and she suddenly lost her balance and fell, what would you do? Would you tell her: "I think biking isn't for you after all. You should quit because you're no good." Or would you patiently and compassionately remark: "Don't worry about it, this happens to everyone; it's part of the learning process. Let's see what you can do differently next time and chances are, you'll do better." Same experience, different response, distinctly different results. The same is true with relapse and eating disorder recovery. Which approach would you prefer?

A constructive view of relapse implies that I adjust my vision so my patients can become more empowered and gain independence and self-accountability. Sometimes, patients have been exposed to experiences that bring them shame or judgment. This may happen when a person with atypical anorexia nervosa is told "Your weight is fine, you can't be sick," or when a patient with binge eating disorder is told by her doctor "to just stop eating and use willpower." By shifting my view to an embrace of relapse, I am better able to understand the challenging nature of the disorder and sit with the patient as she is, regardless of clinical presentation or number of relapses.

I have found that working with relapse is a deeply powerful experience in the recovery process and to navigate through it, as an eating disorder nutrition therapist, I try to:

- Be sensitive to the bias sometimes present around eating disorders and the possibility that my patients may have been exposed to it.
- Have an attitude of curiosity.
- Bring an open heart and a willingness to connect with my patient.
- Be mindful and aware of my own reactions, sensations and emotions regarding relapse.
- See the patient as a whole—as mind, body and spirit converge to create health and well-being.
- Have a whole bunch of compassion and empathy, as this experience is powerful and likely to bring out intense feelings and sensations in both my patients and myself.
- Offer a sense of support and direction to provide the structure and guidance necessary to move forward despite setbacks.

My own experience with an eating disorder during my teen years taught me a lot about relapse. As an overachiever and perfectionist, I was used to getting things done my own way and excelling in almost everything I did. To my surprise, this didn't apply to the eating disorder! It wasn't until I shifted my view of relapse from an experience of failure and loss to one that allowed me to get to know myself and to acknowledge my own journey, that I learned about resilience, persistence and triumph. My relapse didn't take me back to the beginning, but, rather, allowed me to reconstruct my way armed with new tools and a new vision of my reality. Rising after every relapse taught me to believe in myself and my inner voice, and to challenge my personal constructs about what could and couldn't be achieved.

Unfortunately, some of my adult patients, who have battled for years with their eating disorders, have often been labeled as "chronic" and "incurable." This leaves them with a sense of powerlessness, shame and lack of hope. Ana, who was in her thirties when I first met her, had been battling with bulimia since she was a teenager. She had a long line of therapists but had decided to quit after her last relapse. She had never visited a nutrition therapist, in part, because she was warned that dietitians were no good. Although she was done with trying, she came to me as a favor to her family.

I vividly remember something she said in our first session: "I do not know what you intend to do for me, as I will never recover—I am doomed to die like this." Clearly, she felt no hope and believed her behaviors defined her. She felt addicted to the eating disorder, and she would count the number of days she was clean (of behaviors)—only to repeatedly disappoint herself when she purged or restricted. She felt no possibility of reclaiming her life.

I explained to Ana we would be working as a team, and there would be no judgment, criticism or fatalistic prognosis. I immediately introduced her to the concept of relapse—and the beauty of recovery, which could be at her grasp—with hard work and intention. Over the next years, we worked together to rebuild her confidence in herself and to understand the meaning of her behaviors. She had been living with the eating disorder for so long that she had disconnected from herself and her eating identity. For me, eating identity is a term I use to describe one's own preferences, instincts about food (likes and dislikes) and a special way of honoring one's body through food.

Ana patiently started to weave together the fine threads of loving self-care. For example, she began allowing herself to be flexible with her food choices, truly connecting to what she liked and disliked and letting go of guilt and negative views of food. Thus, she began feeling true pleasure while she ate. She also was able to reconnect with her body's hunger and satiety signals, which allowed her to strengthen her intuition and eat accordingly. Relapses, though quite frequent at the beginning of Ana's recovery, evolved over time from frightening and disheartening events to opportunities for exploration, unraveling and reconnecting. Despite setbacks, Ana kept coming back. She made a point to remind me that if she hadn't given herself another chance after relapse, she would never have had the possibility of recovering and reclaiming her life back.

Like the butterfly endures a metamorphosis from its earlier caterpillar stage, by embracing relapse my patients undergo a transformation that allows them to become the best version of themselves. I hope to help them unravel this gift.

Rosanna Mauro de Maya, MS, RD, CEDRD-S,
is a Registered Dietitian with a Master's degree in Group Psychology and is a certified integrative health coach with more than seventeen years of experience as an eating disorders nutrition therapist in Costa Rica. She is a Certified Eating Disorders Specialist and authorized iaedp supervisor. She is currently the President of the International Chapter of iaedp and has presented nationally and internationally on the topic of the integrative treatment of eating disorders.

Relapse Can Open Up New Paths of Recovery

Patricia Adlerman, MSW, LCSW

Relapse can create an increased sense of transparency and self-disclosure. As a professional in the field of behavioral health and addictive disorders for over 30 years, with a personal recovery history, it remains evident that the clinician must possess a strong ego strength, and a non-judgmental skill set in order to not interpret the relapse as a failure in the recovery process.

From treating many acute clients, I've learned if an individual can remain honest about relapse into destructive behavioral patterns, this transparency can be embraced as a significant step in the healing process. It has been a part of my practice to affirm an authentic response to relapse as believable hope! I have not and do not support clients carrying shame and guilt with them and defining themselves based on the number of relapses they have experienced during their recovery journey. Instead, I help them to develop humility, honesty and authenticity in order to avoid future setbacks. Sometimes, it is helpful to reframe the relapse as a setback. I often utilize setbacks as a tool to teach clients and remind myself there have been issues that have been overlooked.

For instance; I recall the situation of Jane, a 31-year-old medical professional with many degrees and a family. She had both binge eating disorder, that involved very strenuous exercise, including many triathlons, and a history of alcohol abuse. During an inpatient treatment experience that lasted for 90 days, the entire staff provided positive weekly reports to my case management team. However, upon discharge and within a 48-hour period, she was drinking, binge eating and hiding her alcohol while she continued to see patients in her practice. Her husband suspected she was binge eating and purging again.

Following her initial relapse, Jane returned to intensive outpatient treatment and disclosed her relapse to her support team. Her husband, who was informed as well, remained very disappointed and overwhelmed. In addition, his trust level continued to decrease due to the fact one evening, he left their two-year-old son with her while taking a break with friends. He could not understand why she did so well while in the inpatient treatment setting.

Jane's relapses continued for several weeks. They got worse, and she became less transparent with her support team. Until one day, her primary therapist, along with her husband, confronted her in a loving manner with a very important question. The content of the question consisted of whether she really was prepared for the responsibility of a medical career, a two-year-old son and a spouse? Jane was accustomed to achieving many outstanding accomplishments. Her expectations for herself were exceedingly high, and she measured her value on these accomplishments.

In response to this question, Jane broke down sobbing and admitted that her relapses were her way of admitting the responsibility she had in her life had become too overwhelming to manage on a daily basis. She was fearful everyone would identify her as weak and a failure, both in her professional life and to her family.

Jane's honest insight into her relapse helped her to define her personal choices and her future path. Would she be willing to realize a new design for her life by accepting her limitations, in addition to reducing her work load? As weeks passed, Jane continued to try controlling her relapses; she became more depressed and inconsistent with managing her recovery. After many months, she returned to intensive outpatient treatment and agreed to begin making the necessary changes in order to save her life and her family. Jane began working part-time in her medical practice and engaged with her recovery supports several times weekly. Her husband participated in an intensive workshop to address his conflicting feelings. They eventually separated for a year, and are still living apart, but working toward restoring their family back to health.

Of course, some relapses produce greater degrees of unmanageability and damage to the client's life. Some clients have been near death while others have minor setbacks due to poor choices in a toxic relationship or employment. Some have lost their professional licenses, which fortunately client Jane did not experience during her relapse periods.

Often, as insight-oriented recovery evolves, we know that learning must often take the form of discomfort. Therefore, relapse often equals discomfort, which can lead to significant changes or shifts in behavior. This behavior can be precisely what the client needs in order to advance or progress to the next step in the recovery process.

Most relapses are in the form of regression to unhealthy behavior patterns of the past. Some, however, may morph into new dysfunctional patterns that resemble past family trauma

interactions. These may include coping mechanisms such as over spending, workaholic behaviors or alcohol abuse. The eating disordered client may relapse into these other forms of addictive behaviors.

Without question, I have frequently learned far more about my clients after a relapse than during their initial inpatient treatment. The relapse patterns of my clients often remind me of the need for increased empathy. Several relapses, if unwoven with clinically sophisticated tools, uncover a complex trauma history which has been the client's primary reason for relapse. Without this information, I would be missing valuable client data.

Following a relapse, some clients have not returned to treatment for fear of being shamed. Often, as recovering professionals, we must be able to humbly admit the relapse/error/setback and move past the difficult experience. If I am not able to teach my clients the importance of letting go and moving on in a positive direction, then I must examine my own recovery and skill set.

If a client has not been willing or able to identify his/her relapse and openly discuss the situation within our session, then it may suggest the client is not be ready to proceed toward new phases of recovery. I believe in helping the client forge through the actual consequences of the relapse. Then, and only then, will the client be willing to return to treatment with a renewed commitment to move into a deeper level of recovery.

After exploration of actual or potential consequences, some clients do not return to treatment or to therapy; they simply may not be ready. They fear what they may learn about themselves and this fear colors all their decisions. However, relapse can open up new paths of recovery. New paths of choice.

Relapse can be the pinnacle to a deeper, more meaningful recovery and life.

The choice is up to each and every one of us.

Patricia Adlerman, MSW, LCSW, is the Founder and CEO of Recovery Placement Services. She received her Bachelor's degree in Sociology and Communications from Tulane University, her MSW from Barry University and completed post-graduate training from the University of Beijing, China, Georgia State University, and University of Miami/Jackson Memorial Hospital. A licensed and board-certified psychotherapist and social worker in both North Carolina and Florida, she has been in the field of behavioral health care services for over two decades.

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

Your Donation Makes A Difference...

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

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

Tax-deductible contributions can be sent to:
The Renfrew Center Foundation
Attn: Kelly Krausz
475 Spring Lane, Philadelphia, PA 19128

Please designate below where you would like to allocate your donation:

❑ Treatment Scholarships ❑ Training & Education
❑ Area of Greatest Need ❑ Research
❑ Barbara M. Greenspan Memorial Lecture at The Conference

Name _____

Address _____

City/State/ZIP _____

Phone/Email _____

Below is my credit card information authorizing payment to be charged to my account.

Credit Card # _____

Security Code _____ Exp. Date _____

Credit Card Type _____

Amount Charged _____

Signature/Date _____

Embracing Relapse: For College Students, Consider it a Gift

Charlynn Small, Ph.D., CEDS

The transition from high school to college can be an awesome experience. In addition to establishing independence from parents, students need to learn how to negotiate the norms of new social groups, set healthy boundaries, and make decisions about finances, academics and career planning. Other more personal decisions include whether to engage in sex or substance use. Faced with these kinds of decisions, many of which have serious consequences, students can easily become overwhelmed.

In my 20 years of working with college students, I've observed how the decision to engage in substance use far too often results in poor outcomes. For example, early in my career, I worked with Bill, a young man who had a difficult time connecting with a core group of friends. To reduce anxiety and feel less awkward, he began drinking. He later told me that he sometimes engaged in binging and purging. And what we quickly discovered was that when the frequency of binging and purging decreased, his drinking increased, and vice versa. Bill was confused and frustrated, and I felt powerless to help him break the cycle. However, a thorough history made it clear that Bill had been struggling with bulimia for several years. He hadn't told anyone because he was embarrassed that he couldn't stop doing these things he thought only women did. Relapsing when he did enabled Bill to learn that he did have a true medical concern that could be treated. We worked together until he graduated and by that time, his behaviors had remitted.

Whether students develop eating disordered behaviors before or during college, relapsing can have an insidious and sometimes deadly impact. When students relapse, they often become highly self-critical, expressing feelings of anger, shame, hypocrisy and frustration. For instance, I am currently working with Jessica, a very bright, charismatic young woman who took some time off from school to seek treatment for severe anorexia. She returned healthier and more vibrant than she had been in over a year and continued to thrive academically and socially. In addition, she became an ambassador, educating others about the disorder and spreading messages of hope. Still, she finds some days are more difficult than others. What's most frustrating for Jessica is the development of a new disordered eating behavior – binging. When she binges, she feels like she "should be" restricting instead. She likens the conflicting experience to an "identity crisis." Jessica explained that restricting would be more consistent with her previously diagnosed eating disorder (anorexia). In contrast, she believes binging is more characteristic of someone with bulimia or binge eating disorder. I helped Jessica understand that while people with anorexia frequently experience stable remissions over time, that migrations to other eating disorder behaviors may also be likely to occur. But, whether restricting or binging, the behaviors are contrary to her message of hope, which leaves her feeling like a hypocrite. Sometimes we both feel stuck.

Many students grappling with relapse talk about feeling like failures while trying out their new independence in an unsupervised environment. I help students understand that regressions to symptomatic behaviors aren't necessarily proof of failed recovery, that this part of the healing process doesn't negate the hard work that preceded it. I try to help them understand there is opportunity in crisis. In Jessica's case, her role as a campus ambassador includes blogging, making well-attended campus presentations and supporting other events, including me writing this article. When she sees the impact of her efforts—the opportunity to bring awareness about the seriousness of eating disorders to others — it becomes a gift for herself and many others. This opportunity strengthens her resolve for recovery all the more. For college students, in many cases, relapse can and probably should be embraced as a gift.

I remember working with one middle-aged student, Charyce. She was married, with children and had struggled with binge eating for many years. She expressed concern about her inability to maintain long-term success in the Food Anonymous (FA) program. Though she lost weight and had some remissions in FA, she was constantly thinking about food (i.e., "When can I eat?" "I can't eat there, because I can't weigh or measure my portions..."), or touching food (e.g., shopping for it, chopping it up, storing it). Unhappy with her size and appearance, Charyce's goals were weight loss and weight management, which she had hoped to achieve through FA. She explained her understanding was that FA believes food addiction can be managed, in part,

by abstaining from addictive foods. Although there was never condemnation for relapses, there was no real processing of what led to them. And while support of the fellowship was comforting, she didn't feel that her disordered eating behaviors were being addressed adequately.

During many of our discussions, Charyce began to realize that job-related issues are what led to her relapses. For example, decisions were often made that affected her in which she had no input. Sometimes, projects on which she had invested much time and effort were transferred to other colleagues. Sometimes members of her team would be reassigned elsewhere. These things made her very uncomfortable, angry and anxious. To feel better, she would seek out new binge foods. If the ingredients were 'clean,' she gave herself permission to eat large portions. Dining out also gave her permission to overeat. She binged when feeling happy. Wonderful news at work gave her permission to binge. A positive performance evaluation or a well-received presentation gave her justification. And, while she felt badly about relapsing, still, she was relieved about being able to recognize the circumstances during which she was most likely to binge. And I was relieved for her, because she was better able to avoid relapses if she could anticipate when they might occur.

During relapses and when other negative events occurred, I encouraged Charyce to practice self-compassion. Specifically, I helped her learn to use positive self-talk, and to not be judgmental or self-critical because of shortcomings or mistakes, or events over which she had no control. Ultimately, she began treating herself with more kindness, using softer tones, and reacting less harshly to negative events. I also encouraged her to maintain her practice of regular self-care, such as connecting with her sister-support circle, working with her nutritionist, journaling, going to the gym, and taking short breaks while working.

Sometimes after brief remissions, students take a break from counseling, often returning when symptoms do. Others return when facing eating disorder related illnesses, some of which are quite serious. One student, Sarah, whom I had seen regularly before her relapse, was diagnosed with a gastrointestinal illness that her physician said was related to her eating disorder. She had stopped counseling until she became quite scared because her relapse exacerbated her condition, causing her great physical discomfort. When she returned, she took great care to follow all plans until she got better.

Regardless of what resources are provided, for various reasons some students find it too difficult to work on their recovery skills while in college. When they relapse, I wonder what I might have missed. I'm not new at this. I'm a frequent presenter at eating disorder conferences, and a regular conference attendee. I consult with colleagues on difficult cases in accordance with the ethical guidelines of my profession's governing organizations. I participate in webinars and other learning opportunities. I am culturally sensitive. I make referrals. Yet, I still ask myself, "What could or should I have done differently?" Finally, after a thorough review of case notes shows that I've done all that I know how to do, I regroup and prepare to share what I know with the next student.

For college students, their resolve for recovery is often rooted in what's at stake. Relapsing sometimes means trading in the independence of being responsible for one's self, as they return home to parental rules and regulations. Learning to identify triggers, anticipating circumstances in which relapse is likely, and making plans for working on recovery skills will enable students to regain their independence. Embrace relapse. Much can be learned from the experience. Consider it a gift.

Charlynn Small, Ph.D., CEDS, is a licensed clinical psychologist at the University of Richmond's Counseling and Psychological Services. She serves as Chair of the University's Eating and Body Image Concerns Team. A frequent speaker at national conferences, she is an educator and advocate for the awareness of eating disorders affecting persons of color and other underrepresented groups. Dr. Small Co-Chairs iaedp's African-American Eating Disorders Professionals Committee (AAEDP), and serves on the Board of the Richmond, Virginia Chapter of iaedp.

Rethinking Relapse

Michael Weiner, Ph.D., MCAP

I want to begin by saying that I've been at this a while. I've seen lives change and families come together. Along the way, I've felt frustration with how relapse has been managed and how shame has persisted. It's up to us do a better job and to eliminate whatever shame we create. We create a lot. Do we have the courage to change the things we can?

My first experience with relapse happened a long time ago, at the beginning of my personal journey as a person in recovery and as an addiction professional. It was sometime while I was doing what's called "aftercare." It had become clear that a person in my group had been using marijuana. He was ceremoniously, for all to see, being "therapeutically discharged." The reason for his discharge wasn't clear to me. If he were using again, wouldn't he need more help rather than none? It didn't make sense to me then; it doesn't make sense to me now.

It was an early lesson that relapse was shameful, and the shame had to be punctuated by a public humiliation.

Not a bad time to discuss the concept of a "therapeutic discharge." "Therapeutic" means that the discharge is going to be helpful in some way. Indeed, a therapeutic discharge is helpful when it becomes obvious that a patient would benefit from a different approach or setting.

However, when a patient has been told "you're not ready" or "you need to do more research," it's hardly therapeutic. "Research" means the person needs to go back out and hit a lower bottom. The impact of a lower bottom is far more likely to be horrific than therapeutic.

By now, I've been in recovery and have worked professionally as an addiction specialist for a long time. I appreciate this opportunity to explore the concept of "embracing relapse." I wish that it had happened sooner. It's as though I've always known there was something wrong with how relapse was discussed and treated. This is a freeing experience.

I'm going to describe a series of events that may not have happened in a single treatment center, or to a specific patient, but they happen far too often.

Let's consider a 35-year-old man with a substance use disorder being admitted to a residential treatment center where he has been twice before. Patients often return to the same treatment center because they are familiar with the staff and surroundings.

Let's say the treatment center is 12-step oriented and abstinence based.

In the next month or so, he will be attending weekly "relapse prevention" groups and working on another "relapse prevention" plan with his therapist. It's likely that plan will need several revisions before it's deemed to be acceptable.

He will be working a First-Step again because he obviously didn't get the "powerless" or "unmanageable" thing the last two times. His story, that he will share, now contains another failed attempt at staying "sober."

He will learn that the reason he has not been able to stay "sober" is because he did things "his way." He either didn't go to enough meetings, work the Steps, or use a sponsor. In other words, it is his fault that he relapsed. It's not possible that it had anything to do with the shortcomings of his previous care.

It's highly possible that he will be attending meetings of Alcoholics Anonymous (AA) while he is in residential care. That means he will be expected to come to the front of the meeting to pick up his third white chip. A white chip indicates starting over. Once a person does this a few times, it's referred to as "the walk of shame." As he continues to attend AA meetings, he will watch many others take the same walk and will participate in the whispering when another person starts over.

So, here's the situation. Let's say that this person has a life expectancy of another 45 years. While in residential care, he has learned how to use tools and mutual support groups to maintain abstinence.

But the expectation is that he will live the next 45 years with a chronic disease and the symptoms of that disease will remain dormant for that amount of time. If he picks up a drink or other drug, let's say after 22 years, he's expected to take another walk of shame, pick up another white chip, and start over.

The only way that a person can be successful in this model and avoid an accumulation of shameful experiences is to remain symptom free for the remainder of a lifetime. So, that's what I'm embracing right now, and it doesn't feel good.

Perhaps a word from the treatment field's most profound historian, William (Bill) White, is relevant here.

"The lapse/relapse language in the alcohol and drug problems arena emerged during the temperance movement and was linked in the public mind to lying, deceit, and low moral character–a product of sin rather than sickness" (2016).

Among the guidelines for this article is the question "what is the aftermath of relapse?" The question says something about how relapse is perceived. "Aftermath" connotes chaos. It implies a relapse is an event that has a negative impact on almost every aspect of the user's life. It implies a period of heavy use over time. "Aftermath" clearly doesn't imply an immediate intervention or anything good.

Is it that way because that's what everyone expects? Would it be that way if shame wasn't attached to it? Is it that once a person does pick up alcohol or drugs, the expectation is that the entire scenario will be acted out? Might as well go for it!

Would "aftermath" be applied to a diabetic's sugar going off the charts? Would it apply to unstable blood pressure? Of course not. I believe that it's because diabetes and hypertension are chronic diseases that are treated as chronic diseases. The diseases are managed. Symptoms sometimes become active. There are shameless paths toward getting back to wellness.

We tell people with addictions that they have a chronic disease and then we treat a series of acute occurrences. When the symptoms become active the patient is to blame. It's shameful. We need "recovery management," not "relapse prevention."

"Recovery management" simply means that addictions would be treated similar to other chronic diseases. Diabetics and people with hypertension have regular checkups over the course of a lifetime. Why not people with addictions? Annual or semi-annual check-ups performed by professionals could certainly identify issues to be worked on before symptoms reoccur. Terms such as "my first time in treatment" or "this is my third time in treatment" would not apply. Treatment for chronic diseases is continuous, not episodic.

We need to lose the term "relapse" forever. We can talk about "recurrences." We can talk about symptoms being stable or unstable, active or inactive. Anything other than "relapse."

And forget about having to start all over if symptoms become active. The person described earlier learned a thing or two while abstaining for 22 years. Perhaps he experimented with "social" or moderate drinking. Many people who have experimented learned that when it comes to addiction, moderation does not work. He has learned what people very new to recovery may still be thinking about.

Start building recovery on success rather than on failure and shame.

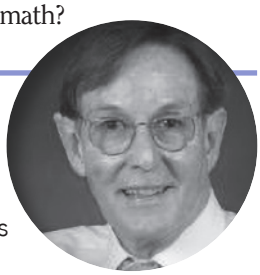
What I've written reflects my frustrations as a professional. Many lives are saved. It's true that most people don't get it the first time around, but eventually they do. I'm a product of the system.

My frustration comes because there are answers out there. Most of them do not rely as heavily on residential care and there is an emphasis on changing the language that we use daily.

It's helpful that more and more physicians are being certified in Addiction Medicine.

When my wife's blood pressure goes up, she has almost immediate access to a physician in an office, an emergency room or at an immediate care facility. No shame. My friend who is diabetic also has immediate access to an endocrinologist. No shame. Will I ever have immediate access, without shame, to an Addictionologist?

Will a time come when there is no aftermath?



Michael Weiner, Ph.D., MCAP, is in private practice in West Palm Beach, FL where he provides Lifespan Recovery Management (LRM). He also offers services as a Clinical Consultant to the Palm Beach Detox and Wellness Institute. Dr. Weiner gives talks and publishes on the lifespan treatment of addiction and the elimination of stigma.

Renfrew Research Published in Prominent Journal!

The official journal for the APA Society for Psychotherapy Research, recently published a ground-breaking article titled, ***Implementation of transdiagnostic treatment for emotional disorders in residential eating disorder programs: A preliminary pre-post evaluation.***

The peer-reviewed article in *Psychotherapy Research* summarizes the outcomes of treatment before and after the implementation of The Renfrew Center Unified Treatment Model (UTM) for Eating Disorders®, an innovative evidence-based approach for eating disorders. This noteworthy article reflects the data collected by The Renfrew Center's research and training departments.

Committed to the importance of disseminating patient outcomes to the community, The Renfrew Center's Clinical Leadership and Clinical Advisory Board have made this article "open access" so that anyone interested in reading it is able to do so.

Key findings:

- At 6-month follow-up, patients who were treated after the implementation of the UTM showed more sustained improvements in eating disorder symptoms and depression than those who were treated before the implementation of the UTM.
- Emotional avoidance, anxiety sensitivity and mindfulness improved more by discharge in the group treated with the UTM.
- Emotional avoidance continued to improve 6 months after discharge among the group treated with the UTM.

To view the article, please visit:
www.renfrewcenter.com/about/renfrew-research

The Renfrew Center Foundation
475 Spring Lane
Philadelphia, PA 19128

1-877-367-3383
www.renfrewcenter.com

Emails to the Editor

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

LOCATIONS

Residential:

Philadelphia, Pennsylvania
475 Spring Lane
Philadelphia, PA 19128

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

Other Locations:

Atlanta, Georgia
50 Glenlake Parkway
Suite 120
Atlanta, GA 30328

Baltimore, Maryland
1122 Kenilworth Drive
Towson, MD 21204

Bethesda, Maryland
4719 Hampden Lane
Suite 100
Bethesda, MD 20814

Boston, Massachusetts
870 Rear Commonwealth Avenue
Boston, MA 02215

Charlotte, North Carolina
6633 Fairview Road
Charlotte, NC 28210

Chicago, Illinois
5 Revere Drive
Suite 100
Northbrook, IL 60062

Los Angeles, California
12121 Wilshire Boulevard
Suite 601
Los Angeles, CA 90025

Mount Laurel, New Jersey
15000 Midlantic Drive
Suite 101
Mount Laurel, NJ 08054

Nashville, Tennessee
1624 Westgate Circle
Suite 100
Brentwood, TN 37027

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

Old Greenwich, Connecticut
1445 E. Putnam Avenue
Old Greenwich, CT 06870

Orlando, Florida
3452 Lake Lynda Drive
Building 100, Suite 120
Orlando, FL 32817

Philadelphia, Pennsylvania (Center City)
1528 Walnut Street
Suite 805
Philadelphia, PA 19102

Pittsburgh, Pennsylvania
201 North Craig Street
5th Floor, Suite 503
Pittsburgh, PA 15213

Radnor, Pennsylvania
320 King of Prussia Road
2nd Floor
Radnor, PA 19087

Ridgewood, New Jersey
174 Union Street
Ridgewood, NJ 07450

West Palm Beach, Florida
1515 North Flagler Drive
Suite 800
West Palm Beach, FL 33401