The Renfrew Center Foundation
FOR EATING DISORDERS

Perspectives

A Professional Journal of The Renfrew Center Foundation

The 30th Annual Renfrew Center Foundation Conference for Professionals
(Virtual)
Begins Friday, November 13, 2020
See page 3 for details

Contributors

A Word from the Editor

This is a special year for The Renfrew Center, and so we begin with reflections from **Sam Menaged, JD,** Founder and President, who shares his excitement about multiple anniversaries for the first residential eating disorder treatment center. Two fascinating recollections highlight Renfrew's implementation of a new evidence-based treatment which began almost by accident, according to **Doug Bunnell,** formerly VP & *Perspectives* Editor, as he recalls reading an article on a transdiagnostic protocol for treating emotional disorders. As **Gayle Brooks,** VP and Chief Clinical Officer describes, the article stimulated the creation of Renfrew's Unified Treatment (UT), in a journey from serendipity to innovation. **Rebecca Berman's** description of Alicia, a young woman with multiple and complex issues captures therapy with the UT.

We also include two outstanding articles from past issues. **Susan Kleinman** poignantly recounts using the "cues and signals from within my own body when responding to patients." Finally, one of our most memorable essays by **Amy Banks** reveals how taking risks and "being more vulnerably human will help another person."

We hope you enjoy reading this special issue while staying safe and healthy during these challenging times.

Marjorie Feinson, Ph.D.
EDITOR

A Message from Samuel Menaged, JD

Founder and CEO of The Renfrew Centers

While I am not a regular contributor to The Renfrew Center Foundation's *Perspectives*, I am pleased to have this opportunity to share my thoughts with you on a few topics close to my heart.

2020 brings with it the 35th Anniversary of Renfrew's founding as the country's first residential eating disorder treatment center dedicated exclusively for girls and women. We are also marking another milestone, the 30th Anniversary of the establishment of our non-profit The Renfrew Center Foundation, under whose auspices the inaugural edition of our *Perspectives* journal was published. These two anniversaries warrant great cause for celebration, especially for all those who have played a critical role in maintaining Renfrew's position of leadership in the eating disorder field.

I am not only referring to our clinical staff and employees, but to all of you who have supported us, entrusted your patients to us, lent your voice to launch new and creative ideas at our Annual Conference, made contributions to our Scholarship Fund, and put your full confidence in our treatment programming.

As I reflect upon this landmark anniversary, my thoughts bring me back to an earlier time in my career when I was facing a dilemma—whether to continue my work as an attorney or take a high-risk opportunity to open the country's first residential eating disorder treatment center, eating disorders being a field in which I knew almost nothing. My father's frequent words about work ethics and determination came to mind … "There is nothing you can't accomplish if you just work to fulfill your potential." I took on that challenge and have never looked back.

Like a mantra, I repeated those words to myself many times when moving through critical business situations. For example, in 1995 when Managed Care took aim at residential treatment centers and condensed our six to eight-week length of stay down to just ten days, I was able to use that as an opportunity to work with my senior staff to devise a complete continuum of care offering clinical options that were less intensive, allowing us to admit patients and step them up or down within our system. We began to open outpatient centers throughout the country and a whole new paradigm was born.

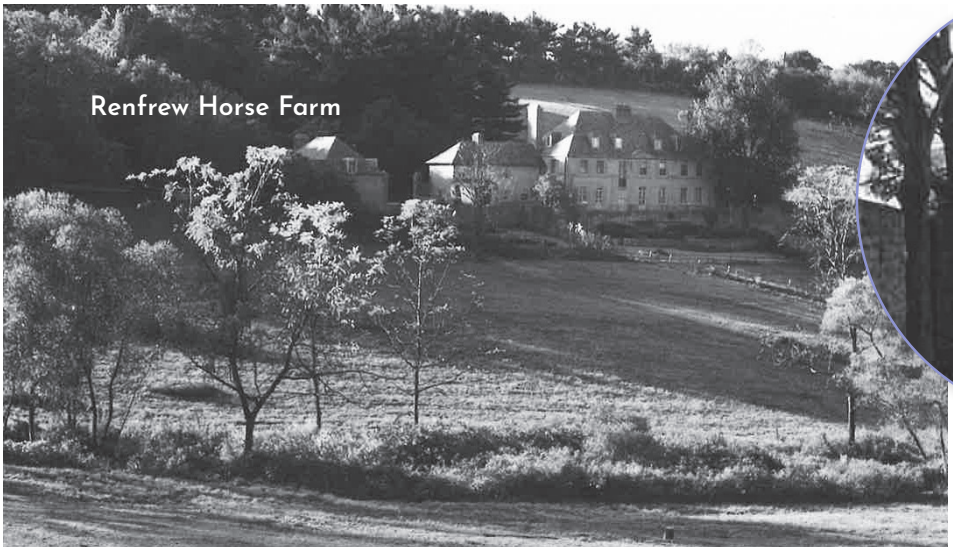
The most recent challenge to Renfrew came with the onset of COVID-19. This pandemic has tested the very core of the mental health and medical fields worldwide and I take great pride in the manner Renfrew has risen to respond. My belief that we had the potential to find a strategy by which our patients at all of Renfrew's 19 sites could receive care, amid social distancing and quarantines, led to the formation of The Renfrew Center COVID-19 Task Force to ensure safety from contagion.

Within one week of receiving information from official sources, we launched a comprehensive virtual platform to seamlessly meet the needs of all patients at our non-residential sites and created training manuals for all Renfrew clinicians and employees. It is ironic that, despite social distancing and the use of a virtual connection with our patients, we have been able to stay true to the essence of the feminist relational model we initiated those 35 years ago. Our professional and support staff have, day-after-day, continued to provide care for our patients whose threshold for anxiety, fear of the unknown and isolation has been greatly heightened by the on-going media bombardment that exacerbates their symptoms. I recently came across the following quote and was struck by its relevance to our on-going COVID-19 experience:

"Hard times don't create heroes. It is during the hard times when the 'hero' within us emerges" (Riley, R).

When we hear the words 'heroes' or 'first responders,' we generally think of the police, fire fighters, or dedicated medical personnel who put their lives at risk to tend to those who are stricken with COVID-19. I have an addition to that list— namely those dedicated individuals working 'round the clock' with our patients, providing them the safety and security so essential to keeping them from being deterred on their path to recovery. To all of them, and to all of you practitioners in the field who are equally deserving of admiration for your commitment to your eating disorder patients at this difficult time in history, thank you.

I look forward to an opportunity in the future to celebrate Renfrew's 35th Anniversary with you in person. My best regards and hope you continue to stay safe and well.


Renfrew Horse Farm


Original Renfrew Gazebo

The 30th Annual Renfrew Center Foundation Conference for Professionals

Friday, November 13, 2020 - Monday, December 14, 2020

VIRTUAL

REGISTRATION INCLUDES:

- Up to 31 CEs/CMEs
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LESSONS LEARNED

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Lori Gottlieb, MFT
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Soledad O'Brien
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Questions?

Please contact Kaitlin McFadden at kmcfadden@renfrewcenter.com

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Beginning the Journey

Douglas W. Bunnell, Ph.D., FAED, CEDS

In 2005, when The Renfrew Center was considering a significant expansion of non-residential treatment programming, I was in the somewhat unique position of being directly involved, not only in the development of the new clinical programs, but also in the direct management of our research and clinical quality process. With Renfrew's two long-established residential treatment centers, I was responsible for ensuring our new partial hospitalization sites were working with the same basic treatment protocols as our established sites.

Although we had already initiated a process that was systematically integrating evidenced-based eating disorder treatments into Renfrew's signature feminist-relational model and had established a group of senior clinicians and external researchers to help guide that work, I was especially worried about consistency issues. We needed to be able to have clients move through a continuum of care that might involve, for instance, an initial admission to the new partial hospitalization program (PHP) in Nashville followed by a residential admission to Florida and then, an eventual step down back to Nashville. Establishing that type of integrated treatment experience required clinical consistency. It also meant my team and I needed to develop, train, launch and supervise brand-new clinical teams in multiple cities. The clinical protocols at the established sites had been developed and refined over many years. The new sites needed an immediate and clear conceptual connection to the "motherships" (residential sites) that would be the common language across the whole system.

At the same time, I was also the editor of *Perspectives*, a role which provided me the opportunity to review the ED literature with an eye for new developments in clinical interventions. Christopher Fairburn's Oxford group had developed and tested a transdiagnostic model for eating disorders (Fairburn, 2009). I also was interested in looking outside of the eating disorder literature, encouraged by people like Strober and Johnson (2012) who were stressing the importance of comprehensive conceptual models that incorporated research on depression, developmental psychology and, particularly, anxiety.

I remember coming across a reference to David Barlow's team and their work on the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (Barlow et al., 2011). In a frantic search for a lead article for the next issue of *Perspectives,* I thought there was nothing to lose by reaching out to Dr. Barlow to see if someone on his team might be interested in writing up a brief summary of their research. I was very surprised to get a quick response from my "cold call" email, and Dr. Barlow told me some of his colleagues were also interested in exploring how the UTP might be adapted to work for individuals with eating disorders. He and his associate, Dr. Christina Boisseau, wrote the original piece on the UTP that was published in *Perspectives* (Winter, 2011).

While I was intrigued by the potential that the UTP had to help us with our consistency challenge, I really had no grand design in mind when we published that article. I remember being excited, perhaps annoyingly so in our Clinical Leadership discussions, but felt restrained by not having an established mechanism for a thorough program revision. I also recall urging our non-residential site Clinical Directors to obtain copies of the UTP clinician manuals. I placed an order for multiple copies and had them delivered directly to the Clinical Directors at each of our non-residential sites.

During my last year at Renfrew, 2011, Dr. Gayle Brooks, Dr. Susan Ice and I created a Clinical Excellence Board (CEB) that laid out a process for revising and evaluating Renfrew's clinical program. The CEB included researchers and clinicians and reinforced a direct connection to the corporate administration. At the time I left Renfrew, the UTP was still largely an 'under the radar' set of clinical concepts and interventions that had yet to be fully integrated into the established clinical protocols.

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Douglas W. Bunnell, Ph.D., FAED, CEDS, is a clinical psychologist in Westport, Connecticut and New York, New York. He has specialized in the treatment of people with eating disorders for the past 30 years. Dr. Bunnell is a past board chair of the NEDA and recipient of their Lifetime Achievement Award. In addition to his private practice, Dr. Bunnell has helped to design, develop and manage PHP and residential programs in his work with The Renfrew Center and Monte Nido & Affiliates. He is a Fellow of the Academy for Eating Disorder and Certified Eating Disorder Supervisor for IAEDP. Dr. Bunnell is a co-editor, along with Dr. Margo Maine and Dr. Beth McGilley, of *Treatment of Eating Disorders: Bridging the Research Practice Gap.*

A Journey from Serendipity to Innovation:

Implementation of The Renfrew Center Unified Treatment Model for Eating Disorders® and Comorbidity

Gayle Brooks, Ph.D., CEDS-S

Serendipity has been defined as "that happy ability to find something that is better than what we think we are looking for." It requires not only the human capacity to find our way to places where there are people, ideas and things that provide us with what we have been have seeking, but also a state of mind which allows us to recognize the opportunities which lie among the spontaneous happenings in life. Science of serendipity involves "the right people bumping into the right people with the right attitude and right behavior. But it is not just luck, it takes hard work to get conditions right for innovation" (Kingdom, 2012). As I think back on how Renfrew successfully accomplished the largest, wide-scale implementation of an evidence-based treatment model in an eating disorder multi-site system, I can clearly see the important role serendipity played.

Before there was success, however, there was failure. In 2005, Dr. Michael Lowe, a long-time research consultant to Renfrew and Dr. Doug Bunnell, VP, Renfrew Foundation attempted to systematically implement an evidence-based CBT intervention within "treatment as usual" at one of Renfrew's partial hospitalization sites. Despite the researchers' best intentions, this experiment could be rightfully described as an epic failure. The many trials and tribulations of this scientist-clinician venture are well documented in their paper (Lowe et al., 2011). The great thing about failure, particularly when it is epic, is that it is also a powerful teacher. While there would be several years before another attempt was made, there were many lessons learned that helped to lay the groundwork for our eventual success. The most significant lesson pointed to the essential need to build infrastructure to not only lead the effort, but most importantly, to promote buy-in from the top to bottom and across the organization. Over the following years, we established the Clinical Excellence Board comprised of the top clinical leaders and administrators within Renfrew, our research consultant and an appointed Advisory Board of consultants who were experts and leaders in the field. The goals of the CEB and Advisory Board were to improve quality and coordination of care, identify best practices and standardize treatment across therapists, disciplines and sites. In addition, we established a training department under

my direction, with its own budget and dedicated staff who eventually became responsible for spearheading the implementation of The Renfrew Center Unified Treatment Model for Eating Disorders® (UT).

While having an infrastructure in place was a necessary foundation, we still found ourselves perplexed over which direction to head. We engaged in a phase of exploration which involved assessing various evidence-based treatment models for 'goodness of fit.' We knew we wanted to implement evidence-based practice (EBP), but we did not know if it was conceptually possible to integrate EBP into our core relational-cultural treatment approach which we were determined not to abandon. In addition, it was difficult to determine which evidence-based model was best for our complex treatment environment and patient population. No one model seemed sufficient or flexible enough and the thought of training staff on multiple evidence-based models seemed an impossible task.

One day, I had a fateful call with Michael Lowe during which I lamented "how am I going to train over 300 staff at 18 sites on multiple evidence-based treatments up to a level of high fidelity and competency? Somebody has to have grappled with this before!" As soon as I said this, I suddenly remembered the Renfrew *Perspectives* article (2011) detailing David Barlow's work with the Unified Protocol published two years earlier.

> *The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders is an emotion-focused, cognitive-behavioral treatment designed to be applicable to mental health conditions that involve a prominent emotional component such as mood, anxiety, or somatic symptom disorders (UP; Barlow et al., 2011). The UP is based on psychopathology and emotion science research indicating that emotional disorders share underlying patterns of emotion dysregulation and emotion avoidance, which maintain and exacerbate the various symptoms of different disorders as well as overall emotional distress (Wilamowska et al., 2010). As a transdiagnostic approach, the UP aims to promote improvement in multiple disorders concurrently by targeting the core underlying mechanisms that maintain disorders, through a variety of emotion-focused techniques (Barlow et al, 2011).*

Michael concurred that Barlow's transdiagnostic model might be just what we were looking for. He also stated that he actually knew David, and as it just so happens, David was going to be presenting a keynote on this very subject at the 2013 ICED conference in Montreal in two months. This moment proved to be one of many points along our journey where serendipity seemed to spring forth.

Michael arranged a meeting with Dr. Barlow at the conference. Much to our surprise and pleasure, David brought his protégé, Dr. Heather Thompson-Brenner, who had extensive experience treating eating disorder patients with the UP at Boston University's Center for Anxiety and Related Disorders (CARD). There was a synergy from the moment we all met together. David demonstrated generosity of spirit, as he freely shared his expertise and access to his model. He joined our Advisory Board and Heather joined the Renfrew Training Department as a consultant.

The more we learned about the UP, the more convinced we became that it provided that 'goodness of fit' we were searching for. The UP was judged by the leadership to be a good philosophical fit with the existing culture of The Renfrew Center because it is emotion-focused. In addition, it is principle-based, not overly complex, which lends itself to ease of training. The fact that it is transdiagnostic made it appropriate for our complex patient population. The treatment model is modular so it was scalable to varying levels of care and adaptable to a staged approach, providing the degree of flexibility needed for Renfrew's complex treatment environment. Its unified and coherent case conceptualization promoted coordination of care across therapists, disciplines, sites and training practices. We had found what we were searching for. What we didn't realize, though, was that through the challenging process of implementation, we would discover innovation.

We learned early on that implementing something new did not necessarily mean you had to lose or abandon your roots. As much as most of us therapists would like to believe we are relational by nature and by default in the work we do, we discovered this was not necessarily the case. Evidence-based approaches often are criticized for coming across as cold, disconnected and formulaic. This criticism is not unfounded, especially if that is the way the treatment is carried out. Connection in a therapeutic relationship is essential to client outcome, and this requires skill and intentionality on the part of the therapist. It requires both a nuanced understanding of the human condition and explicit intervention. To this end, the UP evolved over time to become the Renfrew Unified Treatment Model (the UT), a careful and intentional integration of our feminist-relational model and the latest in evidence-based psychotherapy. We started by asking ourselves, "can feminism and relational-cultural theory co-exist with evidence-based treatments?" We found the answer is not only, "yes," but "it must."

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Dr. Brooks served as the eating disorders specialist in the HBO film *Thin*, has appeared on *Good Morning America* and has been featured in the following publications: *The New York Times*, *People Magazine*, *Essence Magazine* and *Perspectives*, The Renfrew Center Foundation's journal for professionals.
Dr. Brooks is a member of the iaedp Board of Directors and former Co-Chair of the Academy of Eating Disorders Diversity Special Interest Group.

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

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- To the field of eating disorders through researching best practices to help people recover and sustain recovery.

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Alicia's Experience with UT Therapy

Rebecca Berman, LCSW-C, CEDS-S, MLSP

As clinical trends indicate that our patients have become more and more complex, our treatment must face the challenge of addressing the many facets of their clinical presentation. Renfrew's UT's transdiagnostic approach cuts across DSM-5 disorders and targets core mechanisms, not specific disorders. It is ideal for treating eating disorders as it recognizes the complexity of our patients and treats the whole person by addressing both the eating disorder and co-morbid symptoms. It does this by explicitly targeting core underlying and maintaining mechanisms of emotional dysregulation, intolerance and experiential avoidance.

Specifically, therapy based on UT protocols is designed to restore physical and emotional health, heal relational disconnections and achieve sustainable change by:

- understanding and dealing with the emotions that drive disorders;
- developing greater awareness of emotions as they occur—particularly their function and interactions with physical sensations, thoughts, and behaviors;
- exploring underlying core appraisals while increasing cognitive flexibility;
- practicing specific skills in response to emotional experiences as they occur;
- undertaking difficult things without using typical avoidance strategies to cope.

The experience of one of our patients illuminates the UT approach.

Alicia is a 23 year-old woman who entered in-patient treatment with Anorexia Nervosa, binge/purge type, Generalized Anxiety Disorder and Major Depressive Disorder. Upon intake, Alicia reported that she keeps a rigid schedule of working out, attending nursing school during the day, going back to the gym after class, tutoring high school students, and studying. She eats the same foods daily, consisting of all pre-made meals and makes sure to keep her calories low. During her binge-purge episodes, she binges up to 4,000 calories and immediately purges, an average of three days a week. Two years ago, Alicia's mother died of heart disease which prompted her interest in nursing. Alicia has always had a fear of failure and believes, at her core, she will never be 'enough.' She concluded her intake assessment by stating she was exhausted, but felt like she had to keep moving.

Alicia's avoidant and emotion-driven behaviors, including restricting, binge eating, purging, keeping a rigid and busy schedule, eating only certain foods, isolating, and exercising, would be used to create a clinical conceptualization and treatment plan according to The Renfrew Center Unified Treatment Model for Eating Disorders® (UT). Her therapist learned that because of Alicia's social anxiety, she refuses to go out with friends, refuses to eat in front of people and often stays home alone. Becoming more depressed and lonely, she would end up binge eating and purging so as not to feel sad. This routine became a cycle that was difficult to break and was a key maintaining factor for her eating disorder. Alicia's therapist also needed to help her understand that her mom's death, her own fear of death and her grief were connected to her eating disorder and would be addressed simultaneously.

Alicia and her mom had developed a strong relationship, and her fondest memories of her mother were when they were cooking together. To escape feeling her grief, she avoided cooking. Additionally, Alicia verbalized that as long as she was on the go, particularly exercising, she didn't have time to be sad.

Given Alicia's complex clinical picture, a transdiagnostic model was essential in helping her learn emotional experiences are made up of thoughts, physical sensations, urges and behaviors and that all emotions serve a function. As Alicia's emotional awareness improved, her team worked with her to concurrently build her emotional tolerance. This included her ability to feel her emotions without engaging in avoidant or emotion-driven behaviors. Alicia learned emotions peak and naturally come down on their own, without her having to do anything to avoid, change or react to them. Alicia also explored the antecedents to her strong emotional experiences and became skilled at identifying the short and long-term outcomes of acting or not acting on her emotions.

Consistent with the UT model, Alicia was routinely encouraged to tolerate the discomfort of her emotions and explore her automatic appraisal of 'I am a failure' and 'I will never be enough.' Her therapist assisted her in building cognitive flexibility by coming up with alternative appraisals. While Alicia learned thoughts cannot be un-thought, she also understood she could have the troubling thought, and still meet her nutritional needs. She experienced how multiple thoughts can exist at the same time. By participating in a variety of exposures designed to build tolerance to physical sensations, Alicia also increased her tolerance for emotional experiences. Some of her exposure experiences included cooking meals, introducing feared foods, going out to eat with a friend, having unstructured time, and writing and sharing a story about her mom.

As Alicia's treatment reveals, client-driven emotional exposures are designed to increase clients' emotional tolerance and confidence so they can do other things they find similarly difficult. The exposures support them in mastering the ability to experience the emotions without avoiding them. Studies on the implementation of experiential avoidance outcomes have shown clients make greater improvements during treatment, as compared to 'treatment as usual' (TAU), and that they continue to improve after discharge, including a decrease in depressive symptoms. Most importantly, Renfrew patients treated with the UT model are more likely than patients receiving TAU to maintain the treatment gains on eating disorder symptomatology during 6-month follow-up (Thompson-Brenner et al., 2018). The UT protocol provided to Alicia enabled her to leave treatment knowing she had additional skills and resources to do difficult things consistent with experiencing long-term, sustainable change.

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THE RENFREW CENTER'S ALUMNI RESOURCES

The Renfrew Center's commitment to each patient's recovery does not stop at discharge. Recovery is a journey that cannot be navigated alone. Renfrew recognizes the vital importance of alumni staying connected to a community where thoughts, feelings and experiences can be shared and supported.

Since it was founded in 1985, Renfrew's experience with more than 85,000 patients has given us the wisdom, resources and clinical expertise to provide our alumni with opportunities for lasting recovery. Through a wide array of **free** alumni services and resources, every patient receives ongoing support that reaches far beyond the actual grounds of our 19 treatment facilities.

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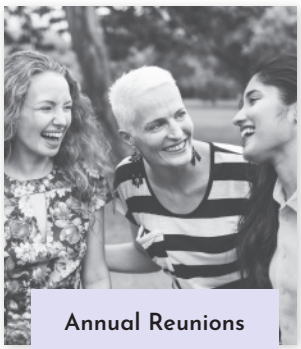

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Learning to Trust My True Self: A Work in Progress

Susan Kleinman, MA, BC-DMT, NCC, CEDS-S Reprinted from the Winter 2017 issue

Update from the Author: *As I look over my essay, I feel grateful that I took the risk in writing about this experience and sharing it with others. I still vividly recall how I felt that day in the "after-meal" session and the difficult experience I endured with adolescent boys who let me fall on my "backside."*

Many lessons were included in this essay. First, to feel empathy for my younger self – the Susan who returned day-after-day to work and continued to put herself "out there." Also, these experiences may benefit students and new clinicians in ways that bring more freshness and creativity into their work. Finally, although the descriptions I shared are from years ago, I would not change a thing. My struggles and willingness to risk "not knowing" in order to be open to understanding my patients as unique individuals, has made me a more honest, insightfully embodied clinician today. Any risk I take as a clinician is not even close to the risks patients take in trusting themselves to open up and express what otherwise might remain buried deep within.

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

I walked into the community room, as usual, to facilitate a special part of a group called 'after meal.' 'After meal' was designed to be one of the only times patients could complain about food; their anxiety would permeate the entire room. I would come in for the last fifteen minutes and provide them with what was called "Susan's soothing session," essentially, a relaxation experience. This particular day, 'after meal' was being facilitated by a practicum student and the patients were 'eating her up alive.' I was greatly relieved I wasn't in her position. As I quietly walked into the room, I immediately noticed the tension. While I empathized with the student's dilemma, I realized she was really stuck. Recalling the many times I had been in her shoes, I was grateful I wasn't there now—at least not yet.

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

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

"I'm going to need a volunteer, but first I will show you what we're going to do. Does anyone have a pillow that I can borrow?" When somebody tossed me a pillow, I explained: "I am going to take a deep breath in and a deep breath out, lift the pillow above my head and then bring it down to the floor and just let go of it —whoosh—just like that and then take another deep breath in and out." When I did that, one of the patients who had worked with me before wanted to try it and, so we worked together letting go of the pillow, pausing and breathing.

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

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

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

In reflecting on this experience, I believe the practicum student was not succeeding because she was trying to engage the patient group with a rigid agenda that did not respond to or address their needs. The patients could not become fully engaged, as they were fully preoccupied with their own unrest. Likewise, the student could not be fully centered because the resistance she faced blocked her own ability to be fully present. The risk for me in this situation was to be able to shift from one presentation style to another without knowing the outcome.

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

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Risk-Taking by Therapists

Amy Banks, MD Reprinted from the Winter 2017 issue

Update from the Author: *As I re-read and reflect on the piece I wrote for Perspectives, 'Becoming a Vulnerable Therapist' – I am struck by how important the human to human connection is in our work, especially during the time of COVID. As the pandemic roars on, people's social interactions are curtailed and impacted by a decrease in mirror neuron functioning and smart vagus stimulation from wearing masks. Some people are simply home bound and isolated because of health vulnerabilities. In this setting, the "real" interactions with therapists are essential to break the isolation. However, what makes the risk taking even more risky for therapists is that we are feeling a very similar vulnerability and isolation. At the very time we need to have our frontal lobes helping us handle the intense feelings of helplessness, our affective systems are the most overloaded – for many of us the overload is not only from the pandemic, but from the divisiveness and violence we are seeing in our country.*

There is no easy answer here – therapists cannot become superhuman and, in fact, that is likely to lead to more burnout, stress and less ability to be present and take the risks needed to help our clients grow. I have observed that, in far too many settings, supervision is not valued (i.e. the therapist is not paid for time in supervision). In these times of universal and extreme stress, each of us need to reach out to colleagues and stay connected. It is simply too much for anyone to do alone; our capacity to heal through relationship will be the key element in holding onto our humanity.

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

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

I am a risk-taker naturally; I believe it fits my dopamine driven personality. I suspect I spend a little too much time thinking about my next adventure (cage diving with great white sharks in Australia is high on the list) and not enough time enjoying the present moment. However, the risks that can be helpful in therapy are not the type most people think about in life. It is not about climbing mountains or running marathons; it is often about exposing your soft underbelly to another human being with your fingers crossed and your heart racing and, trusting that stepping out of the role of expert and into the role of human being may be just the thing needed to take the healing work to the next level. The kind of risk taking I usually thrive on requires me to pretend I am invulnerable; the kind I believe can help my clients is where I sit in my own insecurity and worry and believe that my being more vulnerably human will help another person.

Mel has been in treatment with me for five years, the last year of which has been filled with vulnerability and risk on my end. Mel was raised by a sadistic father and an exceedingly self-absorbed mother and learned early in life that who she is mattered not at all in her house. In this environment, a very powerful relational template was formed, one that told her she was essentially invisible, that her feelings did not matter and that her parents had absolute impunity for any of the rather horrific things they did to her. Naturally, as she grew into adulthood, this template was the basis for all relationships. In her bones, she believed the only way she could get any love was by hiding her most wounded self deep behind a wall. Her reality was that no one would want to see this vulnerability or neediness; her value was in what she could do or give to others. In this relational

state, she was profoundly stuck, despairing and hopeless, often suicidal, even as she built a family and a career that was the envy of those around her.

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

Truth is, I didn't quite know exactly what would help Mel and it was then that we stumbled upon one of my strategies of disconnecting from my vulnerability and from the relationship—an overzealous desire to "fix" things, to cauterize the hemorrhaging, to relieve the pain. This is what I had been taught in medical school—it is unacceptable to watch someone bleed out in front of you, it is your job and your responsibility to stop it in any way possible. But underneath this superficial understanding of my desire to "fix" things was a much more painful reality—a history of trying to "fix" my own mother, who had been crippled by a traumatic event in our family, long before I had the skills to help. In order to help my client, I had to risk looking at this and more importantly, to feel the terror and grief that lived underneath my need to "fix" people.

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

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

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

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