The Renfrew Center
FIRST IN EATING DISORDERS

Perspectives

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The 27th Annual Conference Update is included in this issue.

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CONTRIBUTORS

A Word from the Editor

"On paper, the structure of my day is reliable enough that I rarely write it down. In reality, though, it's highly unpredictable; its true nature dependent on the lives, experiences, ambitions-realized and challenges faced by my clients since I last saw them."

That observation of a clinical psychologist (The Guardian, 1/30/15) led us to wonder about the nature of unpredictable events and how clinicians respond to them. Is it possible that such challenging experiences, while unexpected, might be welcomed – and integrated – into the therapeutic process? Paradoxically, if therapy's goal is to encourage growth and change, often in the context of risk-taking, might unpredictable events actually become a predictable part of therapy? To explore this theme further, we invited five clinicians to describe their responses when something unpredictable – totally unexpected – occurs during therapy. What makes certain events unpredictable and what impact does it have on the clinician, the client, the relationship and the treatment process?

We are pleased to include in this issue five interesting and diverse essays that explore some of the following questions:

- *What do you consider an unpredictable event or experience?*
- *What were your personal reactions at the moment and after having time to process it?*
- *Did you share it with your client and how did you make that determination?*
- *Did you share it or consult with colleagues?*
- *How did this event influence your relationship with the client and your treatment objectives?*

We begin with an intriguing essay by **Caryl James**, a clinical psychologist from the island of Jamaica, who describes her surprise when a client's father unexpectedly showed up and revealed that she (Caryl) was being manipulated by his daughter, 18-year-old Sam. That event had a major impact not only on Sam's treatment, but also on Caryl's decision to actively include fathers in all aspects the treatment process.

Next, **Angela Wurtzel**, an analytically trained therapist from California, provides a vivid description of her countertransference reactions when Karla, her client of 10 years, suddenly decided to stop treatment. Then, just prior to the ending of treatment, an additional unpredictable event occurred as Karla requested to meet with Angela every day!

Carolina Gaviria, a multi-lingual therapist from Florida, describes working with Laura, a 48-year-old immigrant from Mexico. When she suggested that Laura make a drawing of what she was experiencing her clients acknowledged that the drawing contained a secret that she had never disclosed to anyone. Carolina's essay sensitively describes the aftermath of this surprise admission.

Jennifer L. Gaudiani is a physician who provides us with important insights into some of the medical aspects of treating patients with serious eating disorders. Her detailed description of 20-year-old Bob who was being admitted "for what I had thought would be a routine medical stabilization" turned out to be anything but routine.

Finally, **Ann Kearney-Cooke**, a well-known and seasoned therapist, acknowledges how her response to Sandy's secret caused a rupture in the therapeutic relationship. Ann ends her essay with a gentle reminder that "you don't have to be perfect for a good therapeutic outcome. However, you have to be willing to acknowledge your mistakes and be as genuine as possible to provide a new way for patients like Sandy to be in her current relationships."

Enjoy!

Marjorie Feinson, Ph.D.
EDITOR

Unpredictable Moments and Unpredictable Rewards: Treating Eating Disorders in Jamaica

Caryl James, Ph.D.

In January of 2009 I returned from my pre-doctoral internship at Renfrew to Jamaica, my home country. In the United States, I enjoyed the luxury of training and had become accustomed to having the resources of a first world country at my disposal. I even may have even been naïve enough to think that the same would apply in my own country. Despite unique challenges, including a general lack of resources, returning home has resulted in significant personal and professional development.

I began to treat eating disorders along with my teammate, a physician specializing in adolescent health. As the only trained eating disorder professionals in Jamaica, we merge our skill sets and use a team approach to deliver treatment. Our journey has involved many challenges and with limited resources, we have had to become particularly creative with our treatment approach. Consequently, we have had quite a few memorable and even unpredictable moments, which, upon reflection, have served to inform our practice and drive our research in a major way.

I soon discovered that the adjustment from adequate to scarce resources was not going to be my only challenge. Little did I know that my method of treating patients was about to take a major shift, one that would transform their lives as well as drastically influence my professional approach. With a slow but steady flow of patients, I spent some time developing a formula that was proving to be effective in treating patients. This took a lot of dedication and included a year of certification with the International Association for Eating Disorders Professionals (iaedp) by closely examining my clients' special needs and meetings with my colleague, I began to identify the practices that seemed appropriate and appeared to be working. I eventually felt that we had acquired sufficient skills and tools to adequately provide for our patients. We were proud of our work and the impact it was having on our patients. As often happens in a small country, news about our work spread quickly.

One morning, I was awaiting the arrival of an 18-year-old female patient, Sam, for an individual session when she appeared – unexpectedly – along with her Dad. At first, I thought that he was just dropping her off, but then they both

entered the office. Sam sat on one end of the couch and her Father on the other. I decided to take a moment to gather myself (they may have been doing the same) as there was considerable tension in the room. I also needed some time to work through my own feelings of being somewhat thrown off as I was not prepared to have them both in the session. Up to that point, Sam had been doing quite well. Considering that she had previously been to several treatment facilities overseas with little improvement and had been working with me for approximately six months, I was encouraged by her progress. We had been working on uncovering the source of her illness in addition to developing emotional regulation skills to help her cope with the impulse to binge and purge. Sam had even taken time off from school to respond to her illness and, given her progress, we were hopeful that she would be ready to return to school for the next academic year.

The silence in the office broke when I mentioned my surprise at seeing Sam's Dad and asked him if he was planning to join us. Her Father proceeded, in no uncertain terms, to call out his daughter on manipulating her treatment. He indicated that she had been pretty good at masking her symptoms since she had been bingeing and purging more than she had been reporting. He felt it was necessary to come to the session and let me know what she really had been doing.

I was a little taken aback even though I was well aware that deception (lies, secrecy, and manipulation) often accompanies eating disordered behaviors. Even Sam's Mother, who had been at home with her while she recovered, reported that her daughter was making progress. Since her Father spent less time with his daughter due to work demands, I queried if his observation was merely a slipup, that it might not be an accurate and complete reflection of her progress. Slowly, the information unfolded. Even though Sam initially reacted with denial, anger and resentment to her Dad's assessment, she eventually came clean and admitted her eating disorders behaviors. Her Dad subsequently joined us for a few father-daughter sessions, which allowed Sam the space to take an honest look at the shame associated with her illness, while receiving her Father's unconditional love.

It is now five years later and Sam continues to improve; she is no longer engaging in eating disordered behaviors. Currently, our work centers mostly on resolving the occasional body image concerns and managing her anxiety when under stress. Though Sam expresses dismay about how much the illness has taken from her, she reports a renewed approach to life. For the first time, she feels able to live and embrace life as might be expected for a young adult; she no longer feels shackled by the chains of her disorder.

Sam and I often reflect on that day her Father came to the session. It was a turning point in her life and in her treatment. It was also a major turning point in my professional career. In retrospect, my partner and I realized that the involvement of fathers in the treatment of two previous patients with anorexia nervosa had significantly and positively affected the treatment outcomes. However, it was only after the experience with Sam and her Father that we decided to make a change. That experience led us to conclude that involving fathers in the treatment process can be exceedingly impactful. Since then, we have been including fathers especially in the refeeding process. Their practical and logical approach has made significant contributions to supporting their children as they work through the anxiety associated with the illness. Now we actively include fathers in all aspects the treatment process and the results continue to be extremely positive.

In conversations with patients who decided to return home for local treatment, I began to understand that a deep underlying desire to connect with a team that had a similar cultural background. I also realized that it was not only the patients who sought connection and assistance from professionals with a similar background, but also the parents. Moreover, I gradually recognized that initially, I had taken for granted the powerful impact of culture in patients' and parents' openness to treatment. Much of this awareness developed directly as a result of my work with Sam and her Father.

There are many blessings to practicing in a developing country, though it may present unpredictable moments. These moments may be challenging and possibly even frustrating and discouraging. However, if met with openness, they also can inform and spark therapeutic approaches such as, in this case, where the role of fathers in the treatment of eating disorders can occur despite the cultural context of a matriarchal society.

Caryl James, Ph.D., *is a clinical psychologist, eating disorder specialist and lecturer at the University of the West Indies, Mona. She has researched various psychopathologies such as Post Traumatic Stress Disorder (PTSD), eating disorders and depression in the Caribbean. She is an advocate for raising eating disorder awareness in the Caribbean and works diligently with eating disorder sufferers and family members.*

The Mystery of Karla

Angela R. Wurtzel, LMFT

Karla and I have been working together weekly for 10 years with predictable "vacation" days, as she refers to our weeks without sessions. They are predictable because Karla consciously incorporates cancellations into our schedule to rebel against me – in her mind I do not see this subtle defiance – and deny what our relationship stands for and requires: talking, thinking and feeling.

Since the outset of therapy, Karla has intimately discussed her fantasy life with me. This reflects her growth. Her current fantasy is to retire from being a mother, wife and teacher and move to an island alone, sit on the beach, have servants tend to her needs and not have to do, think or feel anything.

Within a context with which all her thoughts, feelings and memories are open to discussion but not necessarily action, therapy had progressed well. However, in the Spring of 2016, Karla arrived for her session and declared that she had decided to stop coming. I listened carefully to Karla's thoughts about terminating therapy. She believed she had done as much work as she could, which was quite a bit, interpersonally and psychologically, to develop as a person. Her eating disorder persisted, she said, because she wanted it to. Her older daughter had left for her second year of college and her younger daughter would be leaving home next year. She and her husband of 24 years soon would become empty-nesters and she was reserving and deserving time for herself. Karla said her fantasy had changed and now included a move to a beach front home in which she envisioned that her husband would be coming with her rather than escaping alone.

This was a stunning moment for me, unexpected and seemingly contrary to the cooperative openness that had characterized our work together for so long. Recognizing the intensity of her resistance, I was not sure how to respond. Experience and training have taught me not to act, but to listen. I decided to comply with her wish to end therapy – join her determined resistance for the moment – and we devised a plan to reduce sessions to every other week. Eventually, at the beginning of June, 2016, her therapy would end.

I consciously chose to respond cautiously, limitedly, as I was not clear what this precipitous behavior actually meant. However, I felt confident that the mystery of her decision would be revealed in time. I also wondered whether this unexpected moment may have unconsciously mirrored another of Karla's fantasies, which was to have secretly and literally ended her Mother's life by unplugging her life support machine while she laid in a hospital bed. I was alarmed when Karla expressed this fantasy early in therapy and I consulted with a trusted supervisor. We explored my concerns: Was I afraid of Karla's potential to hurt me? I said no but did I really mean yes?

Analytically trained, I conceptualized Karla's fantasy as retaliatory and murderous; in contrast, Karla felt her fantasy would have relieved her mother of the burden of a painful life. The murderous act was self-interpreted as kindness. Now, I realized I could use her fantasy to understand what may have been leading Karla to symbolically "stop my life" (as if I were her mother) by stopping her therapy and potentially relieving us both of a painful therapy life together. Perhaps I needed to step up and provide Karla with a reinforced therapeutic frame that would allow both her and me to tolerate murderous and frightening thoughts and feelings. I decided to listen, and observe and provide a safe holding environment for her. Even though I felt resistant to her ending our work together, I did not comment on the advisability of ending treatment. The less I said the more she said.

And then came the next unpredictable event. When Karla arrived for her second to last session she was despondent. Her face expressed deep sadness and self-reproach and she could barely speak without sobbing. Karla said she had messed-up at work as a junior high teacher of 25 years and reported being shaken by her actions, the consequences and her psychological state. I listened gingerly, without pressing her to tell me what had happened although I was

extremely curious. Karla described feelings of being lost and ashamed. Now she wanted to see me every single day. I was taken aback by her request as she was about to terminate a lengthy therapeutic relationship. Here again was an unexpected shift in her thinking – seemingly "from left field."

Now I became alert to Karla's potential capacity to hurt herself or someone else by "pulling the plug." I considered her request earnestly but was skeptical to agree immediately, because on one day she wishes to terminate therapy and the next she wants to 'consume' me every day. Also, I have learned that while persons with eating disorders often struggle to request anything, their requests often are disguised as pathways to deeper thoughts and feelings. If I grant her wishes, am I colluding with her? Helping her? Hurting her? Shaky at the time of our meeting and knowing I would be able to speak with a supervisor in the next 24 hours, I told her I would consider her request and call her the next day. These unexpected events told me I needed to understand before acting or else I may be agreeing that impulse-driven behavior is acceptable and even healthy.

When I presented the situation in supervision, I explored my feelings of concern, confusion, and irritation. I began to understand that there is meaning in Karla's seemingly capricious request to meet with me every day. It felt sincere and served a function, yet, I did not know what this unpredictable appeal and change in our relationship would mean or foreshadow. As promised, I called Karla the next day and we arranged a schedule for that week to meet four times. Still depressed, Karla had a lighter step and said, "I guess you talked to whoever you talk to in order to help you make these decisions. And I said, "Yes, I did." I asked Karla if she had any questions about how I made my decision, and she said, "No. But, I am very appreciative of your response and willingness to meet with me."

In thinking about this essay, I can reflect and observe that I had initially aligned with Karla's resistance when she wished to end treatment. Later, I chose not to interpret Karla's desires or interpret conscious associations for her because the purpose of her request to meet more frequently and not terminate therapy was therapeutic in and of itself: Karla was asking for something she needed in clear and direct words.

When I told her that I would consider her request and that I wanted to do the right thing for her, I was communicating to her that I had taken her seriously and that I was not going to act precipitously.

The transference shifted after this event. Karla now relates to me more as an aligned, helpful and kind therapist, rather than as a Mother out to harm her, who withholds the vital emotional needs she deserved as a child. Now, Karla demonstrates more security and confidence in her decision-making and lifestyle and engages more lovingly with her husband and children. She has increased her capacity to consider the feelings and needs of others, while simultaneously acknowledging her own emotional experience and not denying what she truly values and needs.

My countertransference reactions have altered remarkably. Karla inspires me to feel proud of our work and the knowledge that it has been of value. For many years, I felt used, frequently discarded or trivialized by Karla. This reflected the feelings Karla had experienced from her mother.

Recently, Karla discussed with me her new 'fantasy' in detail. She and her husband would live in a home in our current town, with a personal assistant, a chef and several maids. Her current yoga teacher would come to her home every day. Karla would have a personal driver for everything except for therapy. She would drive herself to see me. When she told me this fantasy, her openness demonstrated to both of us how much she had matured and integrated people in her life, the importance of the relationships, and how much she would really like to be taken care of. My internal reactions were feelings of reward, happiness and validation that our work did help her use her fantasies to create a richer reality. The unexpected experience of being fired renewed and brought new energy to our work together.

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Sitting with Uncertainty

Carolina Gaviria, LMHC, NCC

Unpredictable moments in therapy often contain vital information and may lead to a deeper therapeutic process. Hearing stories that touch us in ways that we didn't expect can bring light to struggles that we may need to address. In contrast, unpredictable moments about taboo and forbidden topics may prompt uncomfortable emotional responses for us as therapists.

The story of how I sat with the discomfort of uncertainty while my client experienced a pivotal moment in her recovery represents such a moment. Laura, a beautiful 48-year-old woman immigrant who moved to the United States from Mexico at the age of 23, started restricting at a very early age. When she turned eight, she decided to become as 'light as a feather.' This was how she responded to her ballet teacher telling her she needed to lose weight in order to be 'really light' in order to get the nice parts in the upcoming holiday recital. Laura recalled her excitement about having her parents see her dance, especially because she felt she didn't get much attention at home. The fifth child in an upper class family, her father worked hard to support the family while her mother, who suffered from chronic depression and spent days in bed bingeing and sleeping, stayed home with the children.

From an early age, Laura was aware of what she ate and how happy she felt when family and friends noted she was losing weight. Finally, she was getting the attention she craved. At age 13, when it became difficult for Laura to restrict, she began purging. Purging also became a vehicle to release some of the stress caused by her perceived awkwardness, her parents' lack of attention and the demands of wanting to be a dancer. She remembered how proud she was of being really skinny and the compliments she received at her special 13th birthday party. At the same time, she also remembered being "miserable, depressed, anxious, lonely and buried in a deep hole of shame" about her relationship with food and her body.

Laura suffered in silence for many years and then, as a teenager, her eating disorder was compounded by psychiatric diagnoses. During her long journey of visits to different therapists and psychiatrists in the U.S. and abroad, Laura never mentioned her eating disorder. Nor was she asked about her relationship with food or her body. She kept her eating disorder a secret until, finally, when the bingeing and purging worsened along with her mental health, she finally disclosed it and was referred to me.

Laura came for an initial assessment with her father and barely made eye contact with me; yet, I could 'feel' her fear and confusion. Since she had active auditory hallucinations and a history of suicide attempts and psychiatric hospitalizations, seeing her on an outpatient basis was a big risk for me. She was also actively bingeing and purging and refused residential treatment. Despite the complexity of her disorder, I decided to work with her after she committed to two weekly therapy sessions and to having her parents involved in her therapeutic process. During the first year of therapy, she managed to discontinue the purging, but the bingeing and emotional eating continued along with the auditory hallucinations and anxiety. The anti-psychotic medications she was on also contributed to significant weight gain and her body image worsened.

Although Laura refused to attend group therapy or complete recommended homework, I continued the individual sessions twice a week with a focus on her auditory hallucinations. Because I find it helpful for clients to have concrete tools to help them process feelings, I often suggest they make a drawing of what they are experiencing. A concrete representation of what they are struggling with also helps me understand them better while enabling the client to externalize her pain and see it from a safe distance.

Laura came up with a complicated drawing of a circle with different lines each one representing a voice. She explained that the circle represented a 'bubble' with a boundary that separated her mind and body from the outside world. In the middle of the circle was a dark spot that she identified as a 'knot.' She indicated that the knot would develop when there was a problem or a need to contain information she didn't want to reveal. She then acknowledged that she had a secret that she had never disclosed. Following this admission, we sat in silence for a few minutes.

This was an unpredictable moment and one that would change the course of Laura's treatment. Since she had denied a history of trauma, I was surprised by this new revelation and wondered what the secret would be about. She sat there staring at me, examining my face and waiting for my feedback. Despite my surprise (shock), I managed to reassure her that her secret was safe with me. I also acknowledged

her courage and her honesty. She smiled and said: "If I talk about this secret, I will die." At that point, I didn't ask any questions but I suspected that her secret had something to do with her family and how she was protecting them from the pain of the truth she was hiding.

After this session, my thoughts were racing and I went home thinking about Laura and what her secret might be. It was hard to imagine how much pain she was carrying in order to protect her secret. I decided to present Laura's case in my monthly peer supervision group where I received feedback about the importance of the therapeutic alliance, how to support my client and what questions to ask and not ask. "What do I know? What information is missing? What are the connections between what I know and what I don't know?"

Unpredictability and the unknown make everyone feel anxious and therefore less able to process information accurately. I knew I had to allow time for both of us to process this event. Also, and important for clinical evaluation, the more anxious someone is, the harder it is for them to accurately recall and describe thoughts, feelings and experiences. But most importantly, when a client is anxious it is more difficult to form a positive relationship, the true vehicle for therapeutic change. I considered her symptoms and decided to sit with the discomfort of the unknown. For now, letting her know that she could trust me was enough.

I understood the risks of encouraging Laura to talk about her secret and the importance of respecting her pace. At the same time, I also knew how not talking about what she was protecting was keeping her sick. In the past, I would address this dilemma with clients and often, they would feel safe enough and had enough self-regulation skills to deal with the emotionality of revealing a secret. With Laura, however, I suspected she was not ready and also, that talking about what happened to her was not something she ever considered.

In the following session, I provided a summary as I always do and asked her where she wanted to go from there. She processed her feelings – both pride, for acknowledging she had a secret, and fear, for recognizing this truth. She noted that her voices increased and asked to turn to a different subject. I followed her lead, knowing that she now had a new understating of her struggle. I felt honored to hold space for someone who was so vulnerable, to experience her pain, shame and fear. At this moment, that was enough.

Carolina Gaviria, LMHC, NCC, *A mental health professional for more than 17 years, Carolina works with children, teens and adults who struggle with eating disorders, negative body image, trauma, and addictions. Carolina is fluent in English, Spanish and German and has presented at national and international conferences on eating disorders, depression, anxiety and stress management. Carolina is a board member at iaedp South Florida chapter.*

Stand by Your Patient

Jennifer L. Gaudiani, MD, CEDS, FAED

I used to work in a specialized hospital unit that provides multi-disciplinary, definitive medical stabilization to adults with critical malnutrition. On admission day, the whole team would descend, one by one, to welcome and become familiar with the new patients. We'd formulate a plan, and over the course of a couple weeks, I'd watch patients who arrived in multi-organ failure from anorexia nervosa begin to bloom (well, at least bud) back into their real selves. Skin would start to glow again, muscles would recharge, bone marrow would come back online, laboratory values would stabilize, and the brain would calm and connect. Surprises would come in the form of how any given body would respond to the deprivations of extreme malnutrition or purging, and how any given temperament would bear with the "insults" of supported rest and nutritional rehabilitation. But with a population of otherwise healthy adults who just happened to have extreme versions of eating disorders, we didn't often see concurrent, general medicine-type illnesses in our patients.

It was 3pm, late for a new admission intake to start. The day had been action-packed from the moment I had arrived that morning at 5:30. I looked at my watch briefly as I walked down the hall, calculating whether I could get home before it was time for the nanny to leave.

I chatted with the nurse just outside the door, who had a concerning first set of vital signs to share with me. Temperature 102°F. Pulse 120 at rest and up to 180 when he got out of bed. What in the world? These are not the vital signs of a young man with severe anorexia nervosa. Something else was up. Before even meeting him, I added on a couple more labs to his admission panel and ordered blood cultures. I stepped into the room after a tap on the door. "Hi, Bob, welcome," I said warmly. "I'm Dr. Gaudiani. Call me Dr. G."

He sat on his hospital bed, jeans loose on an emaciated frame, torso boxy and gaunt under his t-shirt. His facial skin was waxy and taut, clinging to his skull, with a thatch of brown hair above. Those eyes, sunken as they were, shone warm and brown as he smiled and offered his hand. As I grasped his hand it was hot and sweaty, the bones feeling loose under the skin due to muscle wasting. Not the cold (but equally friendly) handshakes I was used to.

Bob (not his real name) was a 20-year-old admitting for what I had thought would be a routine medical stabilization. I hadn't had a chance to review recent primary care records prior to admission. I knew from his intake that he had a history of Crohn's disease, which is an autoimmune process where the body attacks the intestinal tract, causing intermittent severe inflammation, diarrhea, and pain. Although he hadn't been on any medication for it for the past year, he hadn't noted any flares.

I settled into the chair next to Bob's bed, ready to hear his story. I wanted to get to know him as a whole person, in the context of his eating disorder. I also needed to hone in on why a man who should be chilly, with a slow, hibernating heart rate, was instead burning up with a fever. Bob told me about his past, and then said that for the past four weeks he'd developed right groin pain, which prevented him from engaging in his beloved running. His primary care doctor was focused only on his low weight, and spent most of their time together begging Bob to enter treatment. For the groin pain, an exam had revealed nothing, labs had been drawn, and he had referred Bob to a physical therapist, figuring the injury had evolved from overuse and muscle wasting. However, Bob said he'd been having drenching night sweats and palpitations for the past few weeks as well. And the physical therapy hadn't helped. He was frustrated and had felt missed by his medical team at home. "They blamed everything on my anorexia," he concluded, "but I had the sense there was something else wrong."

While we were talking, Bob's admission labs came back. His erythrocyte sedimentation rate (ESR), a marker of systemic inflammation, was an eye-popping 98 mm/hr. His white blood cell count, a marker of infection, came in sky-high at 18 K/uL. A guy with this level of malnutrition should have an ESR of 5 mm/hr, and if anything, bone marrow suppression, with a white count of about 2 K/uL. My mind spinning, I examined him. I focused on the site of Bob's pain. Just above his jutting hip bone, where there should have been abdominal skin sloping smoothly away into a concave tummy, I gently palpated a fluctuant, tender mass. Fluctuant is the word we use to describe something that feels like a combination of Jell-o and bubble wrap. The leg could barely move without causing intense pain. Yes, this was very concerning.

And Bob didn't have much reserve, given his malnutrition. His respiratory rate was already high, panting through the heat of his fever and the physiologic stress of whatever it was that was infected. If I didn't do something quickly, he'd tire out soon from wasted respiratory muscles, and end up on the respirator. His mom handed me a packet of records from the primary care physician, which I flipped through at the bedside. Oh man…three weeks ago, Bob's white blood count had been 10.5, normal by the lab parameters, but already more than five times what it should have been in the context of his anorexia nervosa. His pulse was documented above 100 several times, and his temperature was noted to be above 100°F too. No mention of these were made in his notes. It had all been missed.

"Ok," I said. "I'm pretty sure you have some kind of infection going on. Your instincts were right. Thank goodness you admitted today. We need to figure this out tonight, because your body isn't going to hang in there much longer. It's working really hard right now to keep you alive, and this infection is putting a huge strain on you. I'm going to make some calls and get this going as fast as I can."

I asked the nurse to start IV fluids to support his heart and blood pressure, and I called a colleague in the orthopedics department. "Hey Mark, it's Jen. I've got a guy on my eating disorder service who might have an infection in his bone or his hip joint," I said. "Or maybe his abdomen, I don't know. What do you think is the best first study to get? "We agreed to start with an urgent cat-scan. I called the radiologist and pleaded for a stat study. My former hospital program is located within an inner-city trauma hospital, and not infrequently, our scanners were being used for victims of a major motor vehicle collision. Luckily, the CT scanner was free.

I started to feel the adrenaline and even elation of managing a medical crisis, connecting with colleagues to make things happen for a sick patient. Years ago, when my first daughter was a newborn, and I was on maternity leave from my chief residency in internal medicine, I distinctly remember rocking

and nursing her one night. Her bright round eyes showed no signs of sleep, and I wished in that moment that I could get paged for a nice case of flash pulmonary edema, a medical emergency in which a patient must receive an urgent sequence of medications or end up on life support. So concrete and manageable, so solvable, unlike this fuzzy-headed, beloved, and very awake creature in my arms.

I accompanied Bob to his CT, texting my husband on the way to ask him to get home earlier than usual to watch our daughters, as I'd be delayed indefinitely. I hovered eagerly over the tech's screen as Bob slid out of the CT donut. The radiologist and I looked at it together. An enormous, 20 cm (about 8 inch) abscess blared at us from the middle of his right psoas muscle, which is a longitudinal muscle connecting the side of the lower spine to the inside of the thigh bone. A huge infection there would definitely give you groin pain.

I called a friend of mine who was on call for interventional radiology that night. "Brandt," I said. "You won't believe this. I have a kid we admitted today for his anorexia, and he's septic with a big goomba (medical-speak for abnormality of unknown origin) in his psoas. He's teetering on the edge of going to the ICU, and he needs it drained tonight. Can you fit him in, please?" The triage gods were with me again, and Brandt readily accepted, so I went to update Bob. "Good news," I said, "You were so right that something was going on. I think you must've had a Crohn's flare and not known it, and your colon developed a teeny hole in it. Bacteria oozed out into that muscle and set up shop. We're going to drain that pus right now, get you on great antibiotics, and you're going to feel so much better." He smiled wanly, exhausted and overwhelmed by it all. "I'll be with you the whole time, ok? I'm not going anywhere." He nodded and closed his eyes, chest rising and falling rapidly.

In the sterile interventional radiology suite, Brandt pulled an entire bag of pus out of the abscess, leaving a soft catheter in place to keep draining any more infected fluid. It was 10 pm. I placed orders for two strong antibiotics with the post-procedure nurses, explaining in detail what had happened so far. Bob was asleep, but his pulse was down to 100 after the IV fluids, and his fever and respiratory rate had already improved. I called his parents and updated them.

I drove home that night around midnight, wired from the urgency of it all, from the joy of sticking with Bob through the ordeal, and from the fun collegiality of everyone pulling together as a team to help him. The bright lights of occasional cars made me rub my eyes, contacts sticky and dry. I had missed seeing my daughters all day. That gave me a deep ache in my heart. But I was deeply satisfied and fulfilled at the same time. I had told Bob's story quickly, efficiently, countless times, to countless professionals that evening. Everyone involved in his care needed to know the essentials. That retelling process felt fresh every time for me. The dynamic connection, looping each person in, harnessing them to a sense of caring, urgency, and advocacy for Bob, felt like it recharged an essential part of my soul. "Here we all are," the underlying current between me and each of my colleagues seemed to say, "late at night, working in tandem towards helping one person get what he needs right when he needs it. We're in this together, and we're doing worthy work."

If that primary care doc had known that patients with severe malnutrition typically have bone marrow suppression, a slow heart rate, and a low body temperature, he would have realized far earlier that a systemic infection was brewing. I contemplated that if Bob had gotten to the hospital even a few days later, he probably would have died. I knew I wouldn't speak ill of his outpatient doctor to him and his family the next day. Speaking negatively of other hardworking team members isn't productive, and can be harmful to patients. After all, the whole point was that Bob was being admitted to a center of expertise, and I wouldn't expect his doc to have this knowledge base.

We live in a world of hospital shift work, and that's just the reality. I was a Hospitalist for a decade, and I benefitted from going home at the end of each shift to be with my family, content in the knowledge that the night doctor would manage any goings-on. I could have said, that late afternoon as I admitted what I thought would be a routine patient for medical stabilization, "Well, it's late. I'll ask the overnight doc to follow up on these labs. The nurses will watch him tonight. I have to get home to my family." If I had done that, Bob probably would have ended up in the ICU, or might not have made it. Absolutely nothing beats advocating for these precious people you've gotten to know, being there to support them, and seeing your patients through, personally.

Jennifer L. Gaudiani, MD, CEDS, FAED, *is the Founder and Medical Director of the Gaudiani Clinic, and outpatient internal medicine clinic that treats adolescents and adults with eating disorders and disordered eating from all over the country. Dr. Gaudiani did her undergraduate work at Harvard, medical school at Boston University, and her residency and chief residency at Yale. She was one of the leaders at the ACUTE Center for Eating Disorders at Denver Health for eight years.*

Repairing a Rupture in the Therapeutic Relationship

Ann Kearney-Cooke, Ph.D.

After nine months of therapy for anorexia nervosa, Sandy, a 50-year-old divorced woman said, at the beginning of a session, that she was a afraid to tell me something about herself that she had never told anyone before. She shared that she was ashamed of herself because she was gay. Growing up Catholic in a conservative family, Sandy learned that being gay meant you were sick, unnatural, and a sinner. She described how she did what was expected of her in life – married a man, had children, lived the suburban lifestyle, but she was miserable. She loved raising her kids but, as they became more independent and it was just she and her husband most of the time, she began obsessing about her weight, controlling her food and became anorexic. She divorced her husband five years ago and realized the anorexia was getting out of control. That's when she sought therapy with me.

As therapy progressed she began to understand the function of the anorexia – to keep her sexual feelings under control, decrease shame, and look asexual. I told her it was courageous of her to share this with me. Unlike what she learned growing up, I shared that sexual preference is biologically determined and natural. I shared research that supports this and reminded her that homosexuality has been practiced for thousands of years; it's part of who you are, inborn, not something learned or adopted. I shared that we love who we love and no one has the right to judge us for that.

I thought the session went well. The hallmark of shame is silence, and sharing this with me was the beginning of a journey towards self-acceptance and wholeness.

I was surprised when Sandy came into the next session and shared that she was disappointed and sad after the last session. She found the information I shared about the biological basis of homosexuality cold and distant. She didn't feel understood by me and didn't feel the support she needed. "I can tell in your world being a lesbian is seen as natural, but that was not true in my world."

A rupture had occurred in the therapeutic bond. As she shared her secret, she needed me to be present, empathic, and attuned to the shame and fear she was experiencing. She felt alone in the treatment room which triggered feelings of disappointment and loss. It reminded her of when her mother always said, "don't worry, everything will be okay." But things were not okay. Instead of taking in all the levels of what she was saying based on my knowledge of her history, I responded based on my beliefs. She needed for me to stop talking and to listen to her with an empathic ear.

The most important part of repairing a rupture in treatment is for the therapist to be able to acknowledge that he or she made a mistake and to apologize to the patient. The therapist should encourage the patient to give voice to whatever accompanying feelings they are experiencing because of the empathic failure of the therapist. Then the therapist can help the patient identify and process the thoughts and feelings triggered by the therapist's mistake. With these steps, the therapeutic relationship between the therapist and patient can be preserved and, in many cases, even thrive after a rupture occurs.

I wish I could say that this happened when I was a younger, less experienced therapist, but it happened last year. Even skilled and seasoned therapists can make mistakes in treatment. Through our subsequent work, we were able to repair the rupture and Sandy is still working hard to overcome her eating disorder. She is beginning to break free from social constraints and live her life on her own terms.

Sandy, similar to many of my patients, has taught me important lessons. Unintended things happen in therapy because we are all imperfect. But I need to be aware that my beliefs about issues like homosexuality, politics, etc. are not always the norm; there are still many lesbian women and gay men who are shamed and rejected because of their sexual preferences. Sandy didn't need me to say, "Everything will be okay, being a lesbian is natural and here is some research to back this up." She needed me to separate my own beliefs and be fully present and attuned as she shared the shame and fear she experienced because she was a lesbian.

When a task force put together by the American Psychological Association Society of Clinical Psychology set to identify empirically supported

treatments they found, "The therapy relationship makes substantial and consistent contributions to the outcome independent of the type of treatment." I believe as therapists we need to be trained in empirically validated treatments like dialectical behavior therapy, interpersonal psychotherapy, and cognitive behavior therapy. But I don't think that is enough. An attuned therapist offers patients not just skills to overcome eating disorders, but ways to heal early attachment wounds that may play a role.

As I found out with Sandy, you don't have to be perfect for a good therapeutic outcome. However, you have to be willing to acknowledge your mistakes and be as genuine as possible in order to provide a new way for patients like Sandy to be in their current relationships.

Ann Kearney-Cooke, Ph.D., *is a* New York Times *bestselling author, psychologist, and researcher specializing in the treatment of eating disorders. She was a Distinguished Scholar at the Partner for Gender Specific Medicine, Columbia University for the Helping Girls Become Strong Women Project. She received the NEDA Craig Johnson Award for Clinical Practice and Training and has been on national television shows like the Today, Good Morning America and CNN.*

Your Donation Makes a Difference

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

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:
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Attn: Kelly Krausz
475 Spring Lane, Philadelphia, PA 19128

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❑ Area of Greatest Need ❑ Research
❑ Barbara M. Greenspan Memorial Lecture at The Conference

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The Renfrew Center
FIRST IN EATING DISORDERS

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

Opening Spring 2018

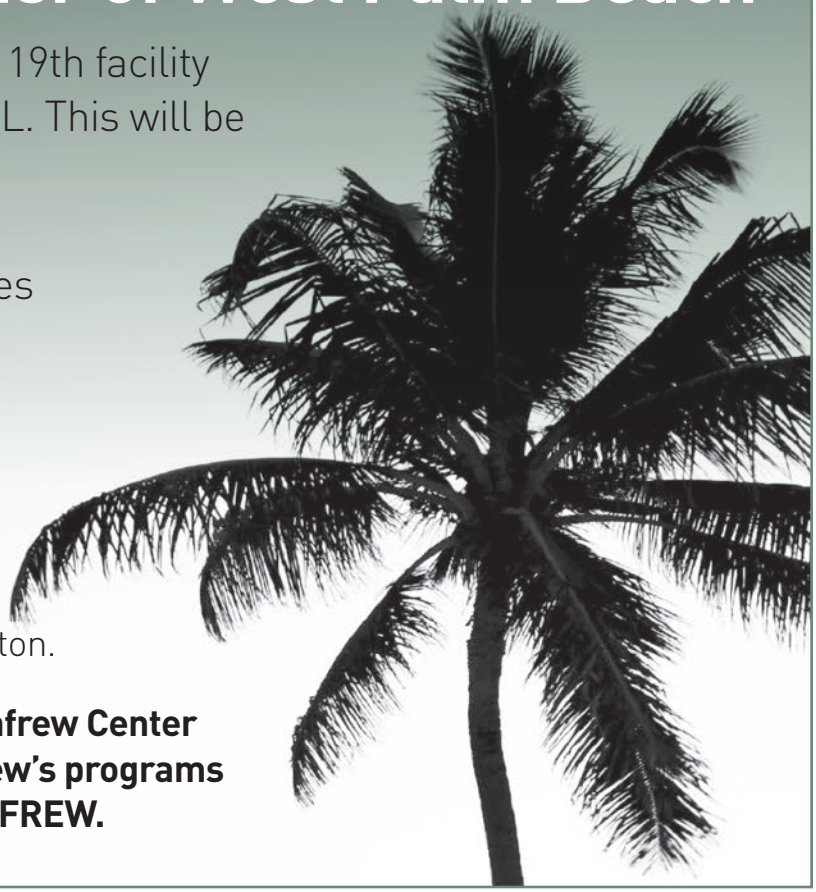
The Renfrew Center of West Palm Beach

The Renfrew Center will open its 19th facility nationally in West Palm Beach, FL. This will be Renfrew's third facility in Florida.

Programming will consist of a comprehensive range of services including:

- Day Treatment
- Intensive Outpatient
- Group Therapy

Residential programming is offered at The Renfrew Center of Florida in Coconut Creek, just south of Boca Raton.



For more information about The Renfrew Center of West Palm Beach or any of Renfrew's programs and services, please call 1-800-RENFREW.

2018 Webinar Series for Professionals

The Renfrew Center Foundation is proud to offer online training seminars for healthcare professionals. Our clinical experts have developed cutting-edge presentations, which explore the many issues surrounding the treatment of eating disorders. They will provide a variety of perspectives, tools and tactics to more effectively treat this complex illness.

February 28, 2018 Weight Issues in the Recovery Process - Why Is This So Complicated?
Presented by: Becky Mehr, MS, RD, LDN

March 28, 2018 Permission to Pause: Supporting College Students in Pursuing a Higher Level of Care
Presented by: Lori Ciotti, LICSW

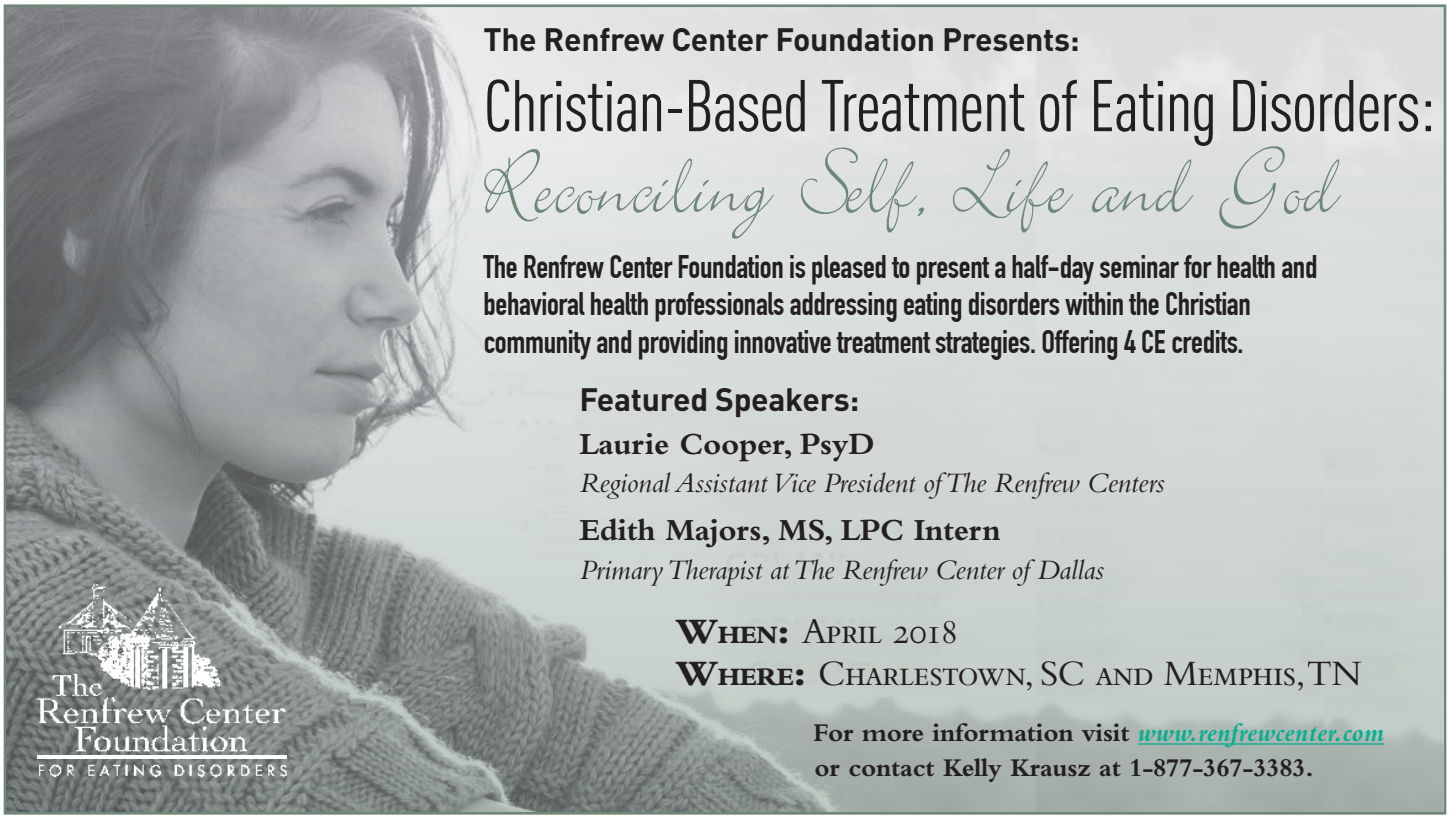
April 25, 2018 Breaking the Silence: Understanding the Complexities of BED and Identifying Effective Interventions
Presented by: Laura McLain, PsyD

May 16, 2018 Family Therapy - Inviting the Family to Dinner
Presented by: Mira Franco, LCSW

All webinars are FREE and run from noon to 1 PM EST.

To register, please visit *www.renfrewcenter.com*.

The Renfrew Center Foundation
FOR EATING DISORDERS



The Renfrew Center Foundation Presents:

Christian-Based Treatment of Eating Disorders:

Reconciling Self, Life and God

The Renfrew Center Foundation is pleased to present a half-day seminar for health and behavioral health professionals addressing eating disorders within the Christian community and providing innovative treatment strategies. Offering 4 CE credits.

Featured Speakers:

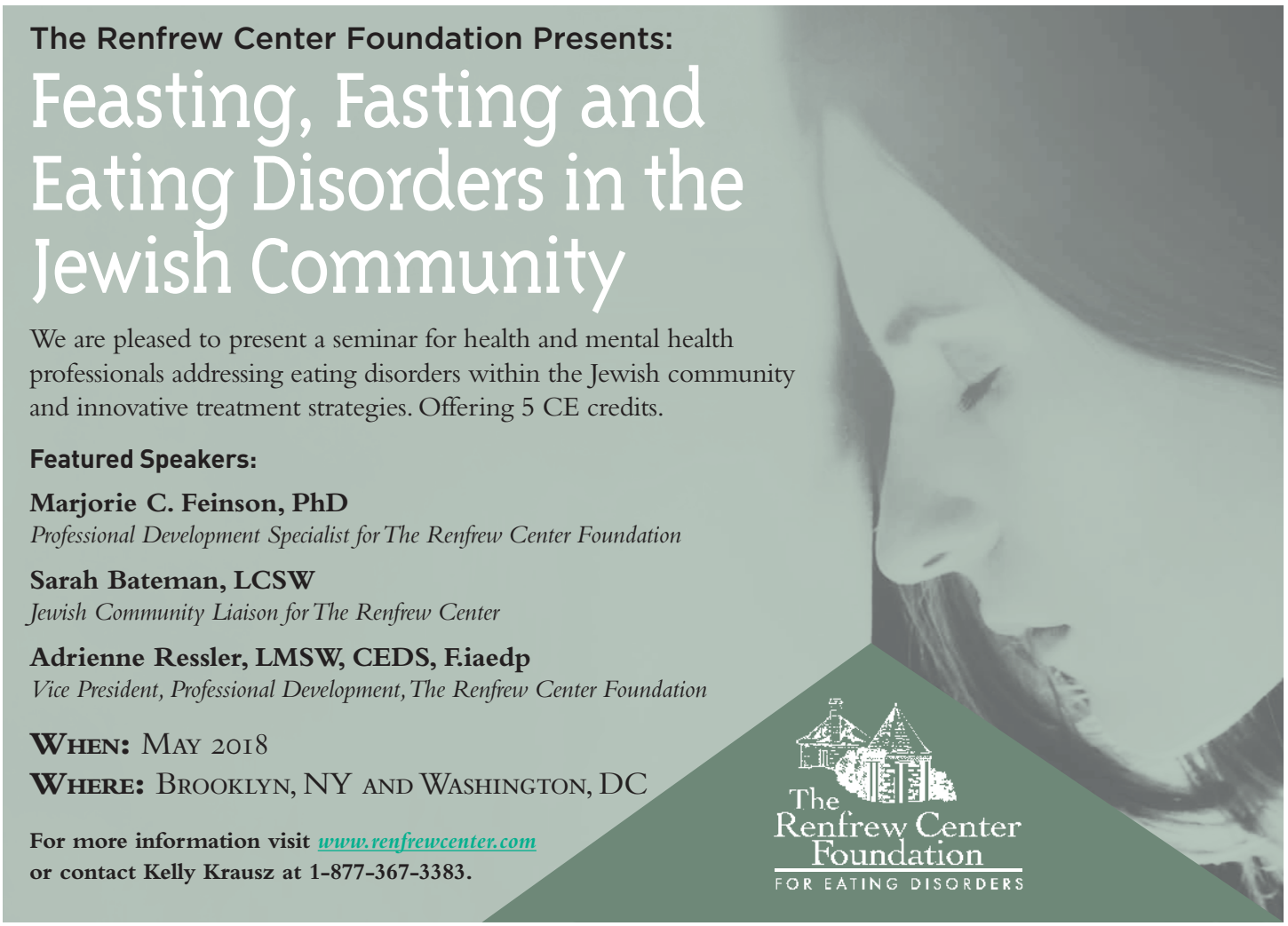
Laurie Cooper, PsyD
Regional Assistant Vice President of The Renfrew Centers

Edith Majors, MS, LPC Intern
Primary Therapist at The Renfrew Center of Dallas

When: April 2018
Where: Charlestown, SC and Memphis, TN

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

The Renfrew Center Foundation
FOR EATING DISORDERS



The Renfrew Center Foundation Presents:

Feasting, Fasting and Eating Disorders in the Jewish Community

We are pleased to present a seminar for health and mental health professionals addressing eating disorders within the Jewish community and innovative treatment strategies. Offering 5 CE credits.

Featured Speakers:

Marjorie C. Feinson, PhD
Professional Development Specialist for The Renfrew Center Foundation

Sarah Bateman, LCSW
Jewish Community Liaison for The Renfrew Center

Adrienne Ressler, LMSW, CEDS, F.iaedp
Vice President, Professional Development, The Renfrew Center Foundation

When: May 2018
Where: Brooklyn, NY and Washington, DC

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

The Renfrew Center Foundation
FOR EATING DISORDERS

The Twenty-Seventh Annual Conference Update

The 2017 Conference Committee extends sincere thanks to all the speakers and attendees who joined us this year for ***Feminist Relational Perspectives and Beyond: Integrating Science, Creativity and Clinical Intuition***. Record numbers of young professionals new to the eating disorders' field were in attendance as were those attending the Conference for the first time. Particularly exciting was the fact that participants traveled to Philadelphia, not only from across the U.S., but from Canada, Italy, Israel, China and Brazil as well. The evaluations were among the best we have received in our 27 year history, indicating great enthusiasm about the program, networking receptions and events. The program itself offered an excellent mix of experiential, interactive and didactic workshops and the range of topics provided something for everyone. Highlighting the program were four superb Keynotes. On opening day, **Patrick Kennedy**'s speech on the future of mental health, electrified the audience. On Saturday, **Janet Treasure, OBE, Ph.D.**; and **Adele LaFrance, Ph.D.** provided a comprehensive overview of theory, practice and research on the New Maudsley Model and Emotion-Focused Family Therapy, and offered caregivers interventions, tools and support to foster genuine change in their loved ones. Later that day, **Roxane Gay, Ph.D.**, author of *Hunger: A Memoir of My Body*, gave us an intimate look at how the impact of trauma and being a woman of color and size shaped her relationship with food and her body. Sunday, the closing keynote provided an amazing Research Panel, each speaker examining research in the treatment of eating disorders and the impact on communities overlooked in the research. Borrowing from feminist and social justice perspectives and enlivened through their own experiences, the panelists included **Gayle Brooks, Ph.D.**; **Rachel Calogero, Ph.D.**; **Melissa-Irene Jackson, BS**; **Marcella Raimondo**; and Moderator **Beth McGilley, Ph.D.**

Planning is currently underway for the 28th Annual Conference, ***Feminist Relational Perspectives and Beyond: Cultivating Hope in an Age of Disconnection*** to be held from November 9-11, 2018. A CALL FOR PROPOSALS may be found on page 16.

This update includes photos from the 2017 Conference as well as a form to order audio recordings if you were unable to attend or missed some of the workshops.

Many thanks, once again, for making the 2017 Conference a great success. We hope to see you next year!

Judi Goldstein

Judi Goldstein, MSS, LSW
Conference Chair

"Thank you for infusing my weekend with energy and ideas to take back to my practice!"

"My best experience out of all the conferences, ever!"

"These keynotes keep getting better!"

28TH ANNUAL RENFREW CENTER FOUNDATION CONFERENCE

2018 Call for Proposals

Feminist Relational Perspectives and Beyond: Cultivating Hope in an Age of Disconnection

NOVEMBER 9-11, 2018 • PHILADELPHIA AIRPORT MARRIOTT

DEADLINE FOR SUBMISSION: MARCH 2, 2018

Many eating disorder clients are experiencing unprecedented levels of stress and anxiety in a polarized society where anger, prejudice, loss of civility, bullying and threats to personal safety create an atmosphere of distrust and disconnection. Practitioners are tasked with helping clients navigate their way through emotionally-charged times by providing them with optimism, prompting dialogue that supports diverse needs and creating a sense of community. Managing our own concerns and reactions is a critical challenge for therapists today.

Conference 2018 will focus on evidenced-based strategies, clinically relevant research and development of skills for building resilience including emotional tolerance, self-care, interpersonal connection, radical empathy and selective disengagement.

Additional topics to be addressed:

- *Social justice*
- *Intersectionality*
- *Diverse populations*
- *Substance use*
- *Trauma*
- *Ethics*
- *Treatment interventions*

Accepted proposals should focus on one of the Conference's four core program tracks:

- Feminist Relational
- Evidence-Based Practices
- Diversity
- Skill Development

Conference Format:

- **Keynotes**
- **Workshops:** Workshops should offer practical skills for clinicians and/or an examination of theoretical concepts in a particular subject area. Workshops will be 2 or 3 hours in duration.
- **Networking Receptions**
- **Poster Presentations:** Poster presentations allow presenters to share new research findings on eating disorders and approaches to treatment. These may include research studies (exploratory studies, single subject or group case studies, or randomized controlled studies), reviews of current research and/or discussions of theoretical issues in the field, to be displayed visually on poster board. If accepted, authors are expected to present their findings and answer attendee questions during the Poster Session on Saturday evening. Graduate students are encouraged to submit proposals.

General Information:

- All accepted presenters will be required to complete a disclosure form.
- All accepted presenters must submit handouts by October 12, 2018. Handout submission is MANDATORY.
- Only ONE proposal per person should be submitted – either as primary or secondary presenter.

Presentation Guidelines:

1. Presentations must relate to the Conference theme and meet stated learning objectives.
2. Handouts MUST be provided to attendees. These could include power point slides, bibliography and/or resources.
3. Whenever possible, integrate relevant clinical examples and case material.
4. Plan to be interactive with attendees; time must be allotted for questions and answers at the end of the presentation.
5. Do not plan to read your presentation.

Proposal Submission Procedure:

- All proposals must be submitted at ***www.renfrewconference.com***
- If you have questions about submitting your proposal or technical difficulties, please contact Kavita Patel at ***kpatel@renfrewcenter.com***
- **The deadline for submission is MARCH 2, 2018 by 11:59pm EST. No submissions will be accepted after this deadline.**

Required Components of Proposals:

The following information must be uploaded as part of your submission.

- Title
- Abstract
- Brochure Description
- 3 Learning Objectives
- Presentation Outline
- Presenter Information (CVs, bio, etc.)
- Workshop References
- Workshop Timeline

CONFERENCE COMMITTEE DECISIONS WILL BE MADE BY MID-APRIL, 2018.

AUDIO RECORDINGS ORDER FORM

THE 27th ANNUAL RENFREW CENTER FOUNDATION CONFERENCE FOR PROFESSIONALS

November 10-12, 2017 in Philadelphia, Pennsylvania

Please check your selections

KEYNOTE PRESENTATIONS

- ❑ KEY 2 Collaborative Care in the Treatment of Eating Disorders Across the Lifespan: Lessons Learned from Research and Practice
  - Janet Treasure, OBE, PhD, FRCP, FRCPsych & Adele Lafrance, PhD, CPsych
- ❑ KEY 4 Research Gaps & Promising Practices: A Feminist, Social Justice Inquiry
  - Beth Hartman McGilley, PhD, FAED, CEDS; Gayle E. Brooks, PhD; Rachel Calogero, PhD, FAED; Melissa-Irene Jackson, BS, BA & Marcella Raimondo, PhD, MPH

WORKSHOPS

Friday, November 10, 2017

- ❑ FR 1 The Practice of Resting and Digesting – Therapeutic Restorative Yoga in Recovery
  - Ann Saffi Biasetti, PhD, LCSW, E-RYT-500
- ❑ FR 2 Therapy and Activism: From Individual to Collective Healing
  - Carmen Cool, MA, LPC & Hilary Kinavey, MS, LPC
- ❑ FR 3 The "Third Party": The Effect of EDs on Attachment in Couples
  - Fran Gerstein, MSW, LCSW, BCD & Frani Pollack, MS, LSW, PhD
- ❑ FR 4 Beyond the Acronym: Understanding LGBTQIA+ Needs in Clinical Practice
  - Rebecca Newman, MSW, LCSW
- ❑ FR 5 Embodied Recovery: Trauma-Informed, Relationally-Oriented and Somatically-Integrated
  - Paula Scatoloni, LCSW, CEDS, SEP & Rachel Lewis-Marlow, MS, EdS, LPC, LMBT
- ❑ FR 6 "I Can Do Hard Things." Building Emotional Tolerance in ED Treatment – Part I
  - Melanie Smith, MS, LMHC & Dee Franklin, MA
- ❑ FR 7 Targeting the "Internal Tyrant" in ED Treatment
  - Ilene V. Fishman, LCSW, ACSW
- ❑ FR 9 The Intuitive Therapist – Integrating Evidence-Based Practices with Transpersonal Psychology Principles
  - Dorie McCubbrey, PhD, MSEd, LPC, CEDS
- ❑ FR 10 Clinical Supervision: Guidelines for Working with ED Patients and Their Families
  - Judith Ruskay Rabinor, PhD & Judith Brisman, PhD
- ❑ FR 11 "I Can Do Hard Things." Building Emotional Tolerance in ED Treatment – Part II
  - Melanie Smith, MS, LMHC & Dee Franklin, MA
- ❑ FR 12 What Motivates Change? Translating Theory into Practice
  - Dana Sturtevant, MS, RD

Saturday, November 11, 2017

- ❑ SA 1 The Many Faces of ARFID: Let's Get This Recognized and Treated
  - Karen Beerbower, MS, RD, LD, CEDRD
- ❑ SA 2 Body Justice: Understanding the Intersection of Body Oppression and Social Justice
  - Melissa A. Fabello, MEd & Sonalee Rashatwar, LSW, MEd
- ❑ SA 3 Treatment of Binge Eating Disorder and Body Image
  - Ann Kearney-Cooke, PhD
- ❑ SA 4 Clinical Intuition to Enhance a Creative Practice: The Beginner's Mind – Part I
  – Terry Marks-Tarlow, PhD
- ❑ SA 5 The Embodiment of Interpersonal Neurobiology in the Treatment of ED
  - Christine Schneider, PhD, LCSW & Alexandra Solaro, MA, LPC
- ❑ SA 6 Collaborative Care: Increasing Supportive Efforts, Decreasing Therapy-Interfering Behaviors
  - Janet Treasure, OBE, PhD, FRCP, FRCPsych & Adele Lafrance, PhD, CPsych
- ❑ SA 7 Radically Open DBT: Openness, Flexibility and Connection in Recovery
  - Ellen Astrachan-Fletcher, PhD, CEDS
- ❑ SA 8 Tackling Taboo Topics with African American Clients
  - Paula Edwards-Gayfield, MA, LPCS, CEDS; Charlynn Small, PhD, LPC, CEDS & Mazella B. Fuller, PhD, MSW, LCSW, CEDS
- ❑ SA 9 Medical and Psychological Issues in the Wise Women Years
  - Jennifer L. Gaudiani, MD, CEDS, FAED & Margo Maine, PhD, FAED, CEDS
- ❑ SA 10 Creative Brain-Based Clinical and Nutritional Treatment of EDs
  - Laura Hill, PhD & Sonja Stotz, RD, LD
- ❑ SA 11 Clinical Intuition to Enhance a Creative Practice: Flowering into Wisdom – Part II
  - Terry Marks-Tarlow, PhD
- ❑ SA 12 Bringing Men to the Table: Research, Practice and Experience
  - Andrew Walen, MSSW, LCSW-C, LICSW, CEDS & Jerel Calzo, PhD, MPH

Sunday, November 12, 2017

- ❑ SU 1 Tools for Treating Eating Disorders in the Jewish Population
  - Rachel Bachner-Melman, PhD
- ❑ SU 2 Maudsley Myths and Collaborating with Families
  - Laura Collins Lyster-Mensh, MS & Lauren Muhlheim, PsyD, CEDS-S, FAED
- ❑ SU 3 Do You "Like" Me: Social Media Use, Body Image and EDs
  - Nicole Hawkins, PhD, CEDS
- ❑ SU 4 Living in This Queer Body: Treating Gender Nonconforming Patients
  - Asher Pandjiris, LMSW, MA & Jessica Kosciewicz, MS, RD
- ❑ SU 5 Interpersonal Psychotherapy, the Best Kept Secret in Psychology
  - Cindy Goodman Stulberg, DCS, CPsych & Ronald Frey, PhD, CPsych
- ❑ SU 6 Evolving Field, Evolving Clinician: Effectively Integrating the New with the Old
  - Sandra Wartski, PsyD, CEDS

2017 Renfrew Center Foundation Conference for Professionals Recording Order Form

– Share the Information with Colleagues & Clients who Could Not Attend
– Listen to the Sessions You Did Not Attend
– Review the Sessions You Did Attend

FULL SET – CONFERENCE SPECIALS

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2016 Renfrew Conference Full Set of Audio Recordings	_____		$49.00	$ _____
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Emails to the Editor

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

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The opinions published in *Perspectives* do not necessarily reflect those of The Renfrew Center. Each author is entitled to his or her own opinion, and the purpose of Perspectives is to give him/her a forum in which to voice it.

LOCATIONS

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Philadelphia, PA 19128

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

Other Locations:

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50 Glenlake Parkway
Suite 120
Atlanta, GA 30328

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Towson, MD 21204

Bethesda, Maryland
4719 Hampden Lane
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Bethesda, MD 20814

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