The Renfrew Center Foundation
FOR EATING DISORDERS

Perspectives

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The 28th Annual Conference Update is included in this issue.

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Contributors

A Word from the Editor

Marjorie Feinson, Ph.D.
EDITOR

Rarely do we encounter the concepts of 'humor' and 'therapy' in the same sentence, but that is precisely what we are doing in this issue of *Perspectives*. Consistent with Renfrew's commitment to focus on cutting-edge topics seldom addressed in the professional literature, this issue is devoted to **clinicians' experiences with humor** and their impact on the therapeutic process.

Humor, especially positive types of humor such as anecdotes, jokes, puns and cartoons, has been shown to be an effective therapeutic tool for promoting client growth and change. And yet, there are aspects of humor, such as satire and sarcasm, that may have unintended negative consequences. Clearly, humor is not monolithic but, rather, a complex and dynamic phenomenon. "It is like an umbrella with many spokes branching out from its central core."[1] The framing questions we provided to our contributors were intended to explore some of the many spokes:

- *What circumstances have motivated you to introduce something humorous into a session?*
- *How did humor impact or alter the therapeutic process?*
- *How do you know if your client will be receptive to humor?*
- *Have there been situations in which humor had a negative effect?*
- *How do you respond when a client initiates dark humor or humor that distracts or distances from the issue?*
- *How do you handle humor that offends you or when a client rejects your humor?*
- *Does your use of humor ever reflect your own anxiety or a need to change the subject?*
- *It has been said that humor is the 'best gift' therapists can offer their clients. Do you agree?*

We are extremely appreciative to have received thoughtful – and amusing – contributions from six clinicians. We begin with **Vicki Berkus, M.D., Ph.D., CEDS, F.iaedp,** a practicing psychiatrist for over 25 years, who provides a delightful essay about humor in her life and practice. "Today, my dogs, Punim (a morkie) and Shekel (a lasa-poo), are my main source of humor. I have been taking them to see patients for the last seven years and their presence brings a level of interaction that I couldn't achieve on my own."

Beth Riley, MSW, LISW-CP, CEDS, an eating disorders therapist for over 21 years, finds that lightness and laughter emerge when her clients begin talking about their pets including not only dogs and cats but, also, snakes, turtles and rats. More seriously, however, she also shares her reaction to a mistake she made when she found herself "instinctively laughing when a client shared a story about a drunken escapade... I knew immediately that I should not have laughed but, instead, should have taken it seriously from the start."

Rev. Steven Wiley Emmett, Ph.D., an ordained minister and clinical psychologist, provides an astute exploration of the topic as he writes: "I have come to learn in nearly four decades of work in this 'impossible profession', that the simple, spontaneous act of sharing something genuinely funny can be incredibly cathartic and potentially more helpful than elaborate interpretations or interventions. Most importantly, Steve also reminds us that "It is often in the moments when we transcend our training, trust our intuition and are most authentic that we can best contribute to the ongoing welfare of the people we work with in therapy."

The next two articles are by **Christina Weiss, LMFT, MPHC,** a therapist who specializes in somatic experiencing and her colleague, **Ashley Lytwyn, MS, RDN, LDN,** a dietitian and nutrition therapist. They describe their interactions with Mackenzie, a young woman, who had been struggling with an eating disorder for over eight years. Christina explains: "When Mackenzie connected to an authentic felt-sense of laughter and aliveness, her immediate somatic defense was to default back to her depressed state… This hypervigilant response gives a false sense of security, because the body remains on guard."

According to Ashley, there was one occasion when Mackenzie explained that eating "the bread is going to make me fat, and if I'm fat I will be all alone." Ashley responded: "So bread is preventing you from connecting with others, interesting?" As Mackenzie heard these words, she chuckled and put her head in her hands. The laugh made her realize she was sitting with these absurd thoughts in her mind, that they were "… limiting her from moving forward in her life."

Finally, we present a poignant and prescient exploration of humor from **Judith Ruskay Rabinor, Ph.D.,** an experienced psychologist, psychotherapist, author and writing coach. Bonnie is an 85 year-old member of Judy's binge eating group which has been meeting since 2002. One evening, Bonnie voices her concerns and fears about not remembering names. Everyone began trying to provide her with supportive endorsements of how well she was aging. Even Judy provided a humorous quip which she begins to question.

"Why did I spontaneously come up with a funny line at the moment I did? What would have happened had I stayed with Bonnie's concern about memory loss? Did she or others feel dismissed? Upstaged? Did I abandon Bonnie's concern because the topic personally scares me? …"

To learn about Judy's responses to these penetrating questions, we invite you to read – and enjoy – not only her article but all the others that, together, enhance our understanding of the complex and dynamic role of humor in therapy.

Warmest wishes,
Marjorie

[1] Samuel T. Gladding & Melanie J. Drake Wallace. (2016) "Promoting Beneficial Humor in Counseling: A Way of Helping Counselors Help Clients." *Journal of Creativity in Mental Health* Vol. 11 (1), pp. 2-11. Umbrella concept attributed to Collicutt and Gray, 2012.

How Humor has Helped in My Career

Vicki Berkus, M.D., Ph.D., CEDS, F.iaedp

I find that humor can be the one way to get through the day when the option of staying in bed with the covers over my head is not a real option. I have been a practicing psychiatrist for over 25 years and I don't think a day has passed without humor being a central part of my practice. Today, my dogs, Punim (a morkie) and Shekel (a lasa-poo), are my main source of humor. I have been taking them to see patients for the last seven years and their presence brings a level of interaction that I couldn't achieve on my own.

I always check in with patients and ask if they are OK with the dogs being in the room. 99% of the time, they are relieved that they aren't immediately under the microscope because the pups are craving their attention. I never know how the interaction will help, but I have learned that if I wait, something good will happen. One of the most recent events involved a patient named CJ who was sobbing and talking about how worthless he was when Shekel walked over to the couch, jumped up on his lap and started to give him kisses. CJ stopped crying, looked up at me and I simply said: "Shekel didn't get the memo saying how worthless you were." CJ got it and I couldn't have planned it better. He was able to see that at age 26, his life wasn't over.

The dogs love being part of a group and I will organize a group of eating disorder patients on the floor in a circle and not tell them in advance what is going to happen. I will open the door and the two pups will charge in giving kisses and then the squeals will start. I will let it go on for about two minutes before I grab the dogs and ask "who in the last two minutes has thought about your eating disorder?" All the patients are still focusing on the pups and shake their heads no. We then process how good it felt to have two minutes without "Ed in their head."

I asked one of the patients, Marion, who was holding Shekel in her lap, to scream at Shekel what she says to herself every day in her mirror. Marion was horrified; she agreed to say the words, but not yell at him. Marion started by telling Shekel that he wasn't worth being seen, that he had no value, he was gross and fat and was hated by everyone. In the middle of her speech with tears running down her face and the rest of the group tearing up, Shekel gave the biggest yawn I have ever seen and they all burst out laughing. I could then process with them how he could let her hateful words wash over him and just be comfortable in his body and in her arms. I pointed out that he has had a lot of positive things said to him which probably helped. It didn't hurt that his little face was lit up and he was enjoying all the attention.

Punim is shaped like a Buddha with a big round belly. He was being held by Janie who weighed over 400 pounds and had been in treatment for about 60 days. This was the first time she had ever held a dog and been able to sit on the floor. She was able to feel his body and enjoy his attention. I pulled out a bag of dog treats and Punim immediately jumped off her lap and headed for the treats. He was funny in that nothing else existed for him in that moment but getting a treat. The group processed what he had given up for the treat (being held, getting cuddles, feeling connected) and Janie started to cry saying that she did the same behavior. She would isolate from her friends and stay home to binge. Punim then proceeded to pitch a royal fit because he wanted more treats and the group started to laugh at his determination to put his wants above everything else he could have had from the group. We were able to talk about how his choice at that moment kept him stuck.

I have found that humor is a great way to get a point across. I would take the dogs to the lodges where the patients stayed. One day I asked one of the patients to open the door to the parking lot because the pups wanted out. She looked at me: "but they could get hit by a car or run into cactus or get hurt." The group agreed that the dogs didn't have the awareness to stay safe. I compared it to wanting to leave treatment and start their recovery before they were ready; they all groaned, knowing that was the lesson I was communicating using the dogs. We could laugh in the moment and use it as a teaching moment.

Humor has allowed me to stay somewhat sane and keep an open mind in spite of all the suffering I see. It is something that the patient can learn from, it can be used without incurring high costs and connect me on a level that is pure human in so many ways. It is hard to keep a straight face when one of the pups lets loose with gas and we both start choking and laughing. I have ended many a session for that sole reason. The patients always seem to come back and ask about the pups before they say 'hi' to me.

Vicki Berkus, M.D., Ph.D., CEDS, F.iaedp, is a board-certified psychiatrist currently living in Newport Beach, California. She is the past president of iaedp (International Association of Eating Disorders professionals) and currently on the Board. Dr. Berkus has been the medical director for several programs around the country that treat eating disorders. She has brought telemedicine to several facilities and is dedicated to providing treatment to patients who do not have substance abuse or eating disorder professionals in their area.

Laughter in the Therapy Room: Lessons I've Learned

Beth Riley, MSW, LISW-CP, CEDS

When I was initially approached about writing an article for *Perspectives*, I felt honored and excited. Then I was informed that the theme of the issue was about humor in therapy. I have written a lot of articles on eating disorders, but typically they are related to the serious side of the illness such as warning signs or medical complications. I almost said 'no' since the topic was out of my comfort zone; however, my therapist-self knew I had to work through the uncomfortable.

I have a ritual of walking mindfully in my yard when faced with a decision or starting a new project. During one of my walks, I realized I might have some insight on the humor topic. My instinct was to write about all the laughter I shared with my clients over the years. Then it occurred to me the topic was more complex.

My first exposure to the use of humor in a therapeutic setting was during a social work field placement with hospice. I shadowed hospice nurses and social workers during home visits. These clinicians seemed to have an uncanny ability to combine seriousness and levity. One moment, the room would be weighed down in sadness and, shortly after, everyone would be laughing hysterically from a joke the worker had told. I remember being shocked when one of the hospice workers joked with a patient about how the patient was saving money on haircuts since she was bald. Another time, a social worker kidded with a patient about not having to go up and down the stairs anymore since the bed was in the living room. Learning to use humor with patients was not a technique I had been taught in social work school and I remember thinking it was distasteful. I did not realize, until later in my professional life, the valuable lesson I learned about inserting humor into even the most serious situations to help provide relief and levity.

My experience has taught me that the key to using humor effectively is by understanding each client's unique set of circumstances. In the early stages of treatment, most of my clients are unable to access or express their authentic feelings. Many may only feel comfortable expressing the positive emotions like happiness. There are those clients who are obviously suffering but, when asked how they are feeling, they reply, "I'm great" or "I'm fine." Some clients are completely shut down while there are others who are all about the laughter. Some of the laughter is real, but others laugh because they are nervous or trying to cover up other emotions such as sadness or anger. They use laughter to avoid.

One of my clients who suffered from major depression and Other Specified Feeding or Eating Disorder (OSFED) had a habit of laughing nervously every time she brought up the topic of her parents. She had been emotionally abused by her parents, but had never processed the trauma. I worked with her on recognizing her emotions, developing coping skills, increasing her support system and boundary setting. Eventually, she was able to get in touch with her sadness, grief and feelings of abandonment and stopped laughing when she brought up her parents. She had a great sense of humor which I would try to connect with when she would start spiraling into a cycle of shame or negative self-talk. I recall one particular session during her birthday week when she was experiencing a lot of sadness and grief. I wanted to find a way to help her find some relief. I began discussing her pets and when she told me a story about waking up from a nap with her cat staring into her face; we both laughed and her mood immediately shifted.

I have found that one of the best ways to bring laughter or joy into a session is through talking about pets. I worked with a client who suffered from severe PTSD, dissociation, major depression and an eating disorder. I tried using every tool I knew to reach him, but it was a struggle getting through on certain days. I finally stumbled on a way to connect by bringing up his kitten. His mood would instantly brighten. As he talked about her antics that week, we found ourselves laughing and the connection was palpable. I've shared laughs about snakes, turtles and even rats.

It is difficult to get a client who is shut down to laugh, just as it is challenging to help a client who is laughing inappropriately connect with their deeper emotions. I worked with a middle-aged woman who was a binge eater and had been sexually abused as a child. She was an extravert who would walk into the office and have the receptionist and anyone else waiting in the lobby laughing within minutes. After working with her for a few months I helped her feel safe enough to get in touch with her sadness and anger. We started by increasing her coping tools with DBT skills. I then used EMDR to process the deep seeded emotions and, by the time she was ready to terminate therapy, she was able to express all of her emotions appropriately. She had not only discovered what it was like to feel authentic happiness and joy, but she was also able to express her sadness.

Since many of my clients have trauma histories, I teach them grounding skills, including Dialectical Behavior Therapy (DBT), before we get to feelings; otherwise, accessing the feelings can be overwhelming. In the first session, I like to introduce breath work and suggest that they use the phrase "I am" for the in breath and "at peace" for the out breath. I help them work up to ten minutes a day of breathing/meditation and find that many like to use apps such as "Mindfulness" or 'Calm'. DBT "observing" and "describing" skills can also be helpful to calm the brain. I might take them on a silent walk in the parking lot to show them how to observe the sky, birds and trees.

I find that many of the over-controlled clients haven't laughed in a long time. I often assign them homework such as watching a funny movie or doing something that helps them get in touch with their inner child before the onset of the eating disorder (i.e. go to the park and swing or go to the zoo and stand in front of the monkey exhibit.) One of my clients chose to go to an amusement park with her family and she had a huge grin on her face as she told me about the fun she had riding the roller coaster.

I use a lot of Acceptance and Commitment Therapy and find cognitive diffusion a great technique for helping the over-controlled clients access humor. I encourage clients to create songs or silly phrases to use when they are struggling with eating disorder thoughts. One client decided to sing "The eating disorder thoughts go round and round" to the tune of "The wheels on the bus go round and round" whenever she was caught in a negative thought loop.

There are certainly times in working with eating disorders when humor is not appropriate. I recall an intense initial session with the family of a teenage daughter. I had to give the father the news that he would need to refrain from running with his daughter during dinner and would instead be asked to sit down and eat with his family. He was furious and let me know it by glaring at me and leaving the session without even shaking my hand. Weeks later, he came into my office and thanked me for encouraging him to eat dinner with his family. I decided it was appropriate to add some humor and made a funny joke about his icy stare during our first encounter. The laughter instantly dissolved any previous tension and, in that moment, we became united in the fight for his daughter's recovery.

I've definitely made plenty of mistakes as a therapist. I remember instinctively laughing when a client shared a story about a drunken escapade during which she danced on a table and walked home alone late at night completely intoxicated. I knew immediately that I should not have laughed but, instead, should have taken it seriously from the start. She had recently undergone bariatric surgery and had a family history of alcoholism. Given that I was familiar with her history and knew the risk of addiction following bariatric surgery, it was inappropriate for me to have joined in her laughter. Fortunately, I caught myself and was able to confront her behavior and redirect the session to help her figure out how to have fun in her life without alcohol or binge eating. She ended up discovering a love of paddle boarding, hiking and skiing.

Looking back on my 21 years as an eating disorder therapist, I realize that what I learned as a Hospice Social Work Intern was that the appropriate use of laughter and humor can help the therapist and client navigate some of the most difficult issues. When I am no longer laughing with my clients, I know it is time for me to find some humor in my own life. Fortunately, sometimes all it takes is a play session with my hyperactive golden doodle, Jasper, and his squeaky toy to get me going.

Beth Riley, MSW, LISW-CP, CEDS, is the CEO of Riley Wellness Group. She has worked in the eating disorder field for 21 years as a therapist, mentor, educator, entrepreneur and consultant. She holds an undergraduate degree from Stanford University, a Master's in Social Work from the University of South Carolina and a Certificate in Executive Leadership from Cornell University.

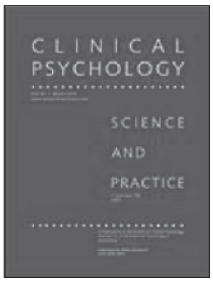
The Renfrew Center for Eating Disorders

Patient Outcome Data Published in Prestigious Peer-Reviewed Journals

The Renfrew Center's Research and Training Departments' latest research findings are now published in two prominent academic journals!

The first, *Clinical Psychology: Science and Practice,* is a highly regarded peer-reviewed journal that published our multi-year project to adapt and implement Renfrew's evidence-based treatment, The Renfrew Center Unified Treatment Model for Eating Disorders®, across all levels of care.

This ground-breaking article is titled: *Evidence-based implementation practices applied to the intensive treatment of eating disorders: Summary of research and illustration of principles using a case example.*



The second, *Psychotherapy Research*,is the official journal for the APA Society for Psychotherapy Research. The peer-reviewed article summarizes key treatment outcomes from the implementation of The Renfrew Center Unified Treatment Model for Eating Disorders®.

This noteworthy article is titled: *Implementation of transdiagnostic treatment for emotional disorders in residential eating disorder programs: A preliminary pre-post evaluation.*

Key results show:

- Training and implementation efforts of the Unified Treatment Model for Eating Disorders® (UTM) at all Renfrew locations was successful.
- Patients treated with the UTM continued to show improvements in decreased eating disorder symptom use and depression at the six-month follow-up.
- Emotional avoidance, anxiety sensitivity and mindfulness improved more by discharge for patients treated with the UTM.

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The Best Medicine: Thoughts/Reflections on the Uses of Humor in Treatment

Rev. Steven Wiley Emmett, Ph.D.

Patient: DOCTOR! DOCTOR! I have a terrible ringing in my ears. What should I do?

Doctor: DON'T ANSWER!

Who doesn't enjoy a good laugh? Like yawns, is there anything more universal or contagious? Frankly, until now I hadn't given the intriguing topic of humor and therapy much, if any, thought. And, incredibly, none of my psychology courses ever once touched on this essential aspect of human existence. So, to directly address the question of how and to what extent I integrate humor into the counseling session, I'll share an experience I had recently while speaking via phone with a long time, basically bedridden client whose early onset anorexia has left her battling excruciating chronic pain.

Somehow the topic of psychological testing arose and a (slightly ribald) joke came to mind. I shared it with Bonnie* who laughed with such gusto that I responded in kind. "It feels so damn good to laugh, I rarely do" were her exact words. Instinctively, I knew she would enjoy such humor since she had often professed that laughter brought her more effective and rapid relief than all of her medications combined—without the nasty side effects! We have shared many laughs over the years and Bonnie has expressed that this reciprocal humor helps keep her feeling close to me, gives her an emotional boost and facilitates a valuable distance from her incessant misery.

This gut instinct to humorously engage is something I undoubtedly would have suppressed earlier in my career, perhaps out of concern about appearing 'unprofessional'. I have come to learn, in nearly four decades of work in this 'impossible profession', that the simple, spontaneous act of sharing something genuinely funny can be incredibly cathartic and potentially more helpful than elaborate interpretations or interventions. It is often in the moments when we transcend our training, trust our intuition and are most authentic that we can best contribute to the ongoing welfare of the people we work with in therapy.

When preparing this article, I immediately thought of a client from long ago. But why did she come to mind? Jude was quite somber throughout her valiant struggle to overcome bulimia during our challenging therapeutic journey together. As I pondered this, a memory gradually emerged. In our last session together she shared that the most helpful aspect of therapy had been the occasional hugs she requested and received at the end of some of our meetings; they had helped undercut her debilitating body shame. Upon further deliberation, an understanding of my rather perplexing association with this article's theme slowly surfaced. On many levels, what I learned from this experience with Jude was often recapitulated in psychotherapy when humor presented itself. What I've come to realize is that judicious use of humor in the midst of psychotherapy constitute a sort of verbal, 'cognitive hug'. Much like an appreciation of what an actual embrace signifies to an individual in a treatment setting, humor provides myriad opportunities to bolster a therapeutic alliance, facilitate perspective shifts and aid in creating more precise understanding of underlying psychodynamics.

In the final line of E.M. Forster's early 20th century novel, *Howard's End*, there is a phrase that undergirds my philosophical approach to counseling: "only connect". Productive psychotherapy with another human being absolutely requires formation of a trusting bond. One constructive way to help forge such an intimate union is through the vehicle of humor. A basic tenet of effective communication and alliance creation with an audience is to begin with a joke or humorous anecdote. It can put both the presenter and listeners at ease and research has shown that we naturally feel better about both ourselves and the speaker when sharing in

something amusing. However, as with all aspects of therapy, particularly at its outset when understanding of another is just developing, I believe it is critical to sensitively and continuously assess the cognitive style and world view of a person before leavening the interactions with humor. I look to the experts in this arena—standup comics—for guidance. Their sage advice: know your audience and watch your timing.

It's important to employ humor in such a way that it stimulates greater awareness, loosens rigidity and presents opportunity for a broader self and world perspective. While a relationship incorporating humor can take many forms, I suggest going with what's most natural. I'm personally comfortable with gentle self-deprecation. I find this approach helps break down subtle barriers inherent to the hierarchical nature of therapy while also providing a model facilitating the all-important ability to laugh at oneself and one's problems. It also offers a liberating alternative to the perfectionism plaguing those crippled by a restrictive eating disorder as well. I remember one time when I came late to a session due to a lost set of keys. As I humorously regaled my young client with the amusing consequences of my forgetfulness, a sly smile crossed her face as she remarked, "It's good to see you're human Dr. E." That observation informed the ensuing session, one filled with a delightful recounting of our mutual imperfections.

Another element in helping individuals get unstuck involves closely examining the various ways in which humor is used as either a coping mechanism or a defense. Consider Brian, an emotionally damaged young man from a dysfunctional broken family. At the conclusion of his third month of therapy I noted Brian's determination to maintain a superficial façade and his automatic reversion to humor whenever we began exploring the toxic chaos of his formative years: "I imagine it felt fairly safe when people were laughing at you; it must have been a great hiding place". With that simple insight, and Brian's hesitant acknowledgment of its accuracy, the therapy soon deepened. Additionally, humor can be utilized as a useful diagnostic tool for better understanding potentially confounding psychodynamics like transference and countertransference. For example, whenever I detect a subtly sarcastic quality in either my or my client's tone, I stop and take notice since sarcasm is often thinly veiled anger cloaked in humor. Goethe's observation gets to the heart of this matter: "People show their characters in nothing more clearly than in what they think laughable."

In ending these reflections, I'm reminded of a memorial service in which the minister spoke of a wise, but long-winded professor who once let his students in on a secret during a lengthy lecture: "I frequently insert the phrase 'and in conclusion' while speaking to people-- I've found it gives them hope". Thereafter, during his moving eulogy, the clergyman would occasionally utter "and in conclusion". All of us, despite our profound collective grief and sorrow, erupted in soul-soothing laughter every time the phrase was repeated. Perhaps more than anything else, this anecdote captures the essence of why I firmly believe humor has an intrinsically important place in the therapeutic encounter. When woven naturally into the narrative fabric of the psychotherapeutic process, it introduces healing threads of light, breaching walls of emotional isolation, challenging rigidly held beliefs, providing solace and connecting individuals to what is the foundational, life-sustaining aspect of existence itself: hope.

**All names changed to preserve privacy*

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www.Humormatters.com

www.AATH.org (Association of Applied and Therapeutic Humor)

Rev. Steven Wiley Emmett, Ph.D., is co-founder of The Renfrew Center. An ordained Unitarian Universalist minister and clinical psychologist, Steve is a former Peace Corps volunteer who has written extensively on the mind-body interface. He lives and practices in Hingham, MA.

Connecting to Aliveness and Intimacy through Laughter

Christina Weiss, LMFT, MPHC

"Laughter is a sunbeam of the soul." – Thomas Mann

Most clients at our center are struggling with both eating disorders and addiction. Many come to treatment feeling broken and overwhelmed – their aliveness a distant memory, if ever felt at all. Their bodies are often frozen and stuck in depression, fear and trauma. Many clients report they cannot remember the last time they had a deep authentic laugh.

A young woman, "Mackenzie," came to us following six-weeks of eating disorder inpatient treatment. She was referred for continued-care around her substance use disorder and trauma and to help maintain structure around her eating behaviors at partial hospitalization.

Mackenzie had a history of repetitive, inescapable sexual assault, although she remembered it mostly in body memories and developmental trauma - including attachment disruptions and transgenerational trauma. She had a core false belief she was bad, significant self-hatred and an introjected critical self which was often destructive and neglectful. She came to us with flat affect, frozen in her depression and completely disconnected from her aliveness. Mackenzie had been struggling with an eating disorder for over eight years. Although in remission following family-based therapy for a couple years, it had roared its ugly head when she found herself in a trauma-response. She also struggled with addiction, mostly alcohol, for about five years. She was bright, articulate and pleasant. When she smiled, she lit up the room.

As a somatic attachment therapist trained in somatic experiencing, I am often observing opportunities, or windows of transformation, for clients to connect to their felt-sense and aliveness. Laughter is a tool that may be utilized for such embodiment. Not only does it provide the potential for rapport and attunement in the therapeutic relationship, it also provides a window into one's aliveness and felt sense.

Laughter was undeniably Mackenzie's vehicle to connect with others; it was also transformative in moving her away from a depressive state and obsessive eating disorder thoughts. During one of our initial sessions together, Mackenzie spontaneously laughed over a comment she had made. I was surprised as this was not a typical behavior of hers. I noticed when she connected to this part of herself, the part that could be light and playful, her gaze softened, her eyes were more oriented to the room (not fixated) and her body was less rigid and more relaxed. Interpersonally, when she laughed and smiled, it was contagious and I felt drawn to connect with her more.

I guided Mackenzie to notice these more fluid inner sensations as they arose. We stopped and paused and became more aware of what was happening in her body during this less rigid state. She reported finding an open-ness, mostly in her chest and throat. She noticed, "a sort of tingling" sensation. She smiled, pleased to find this space within herself and then, almost immediately, reported being frightened. Her smile changed to distress and she reported noticing a part of her that "wants to run away." Engaging with this impulse to move, I asked her where she sensed the desire to run? She shared she felt it in her feet and belly. I inquired, "I am curious, if you could give your body permission to move in whatever way it wanted, what would it do?" She shuffled her feet and pushed her arms outward for a moment and then slowly returned to a rigid and collapsed posture.

When Mackenzie connected to an authentic felt-sense of laughter and aliveness, her immediate somatic defense was to default back to her depressed state. Most people, especially those who are traumatized, tend to focus and rely on negative interoceptive cues. This hypervigilant response gives a false sense

of security, because the body remains "on guard." It is a self-protecting phenomenon for the body to remain hypervigilant in fight-flight, or freeze mode, during perceived threat; for someone in a trauma-response and with attachment insecurities, this is almost constant. Mackenzie's ability to tolerate an interested state in connection with me was too threatening at that moment and her instinct, or survival technique, was to go away. A depressed, withdrawn body state was a safe place for her because she did not run the risk of being disappointed or unmet. I now knew where we would do much of our work together.

As Mackenzie re-engaged with her depressive state, she wanted to talk more about her self-hatred and desire to no longer live. For her, there was safety in that body state; the other was too unfamiliar. I explained to Mackenzie she could speak about her depression and hopelessness but, as she did, we may also want to slow down and pause, becoming aware of how these feelings and sensations move and change within her body.

As Mackenzie spoke about this part of herself, I could see the activated freeze-response in her body. I invited her to notice this shift within herself. And then, with an understanding that laughter may be the window into her aliveness, helped her to navigate from this rigid state by reintroducing laughter into the room. She allowed my lead and was courteous in laughing at my attempts at humor. We paid attention to the bodily sensations within these shifts and how it felt in the interpersonal relationship. My goal was to align with her in the laughter, creating a less rigid space and more room for intimacy and trust between us. I also wanted her to become aware that she had the ability to be present to these changing states and help bring more interest and hunger to her authentic sense of aliveness and safety in the here and now. Melanie R. Rudolph, a certified Laughter Yoga Teacher expressed;

"Laughter celebrates aliveness. It gives our cells permission to dance, breathe, live and become radiant and alive. It connects us with people. With laughter. In one second, we go from strangers to friends."

As the team became more aware of Mackenzie's connection to laughter, we encouraged this part of her and, eventually, she was able to be more present in group. Laughter also facilitates group cohesiveness because its members experience a shared space of intimacy. One of the best things I hear from clients is when they have had the opportunity to laugh with their peers. Many express having laughed, "like I haven't in years." There is an intimacy that develops in the therapeutic community through shared authentic laughter. Blaine Greteman, a writer and professor of English at the University of Iowa eloquently explains:

To laugh in a painful or distressing situation isn't to avoid emotional reckoning but to gain the perspective needed to make the experience productive, to see the dilemma as part of the somewhat absurd human drama, and to seek fellowship in the society of the living.

For Mackenzie, as she continued to connect more and allow space for this part of herself, I observed her going from complete shutdown and being withdrawn, to bringing laughter to some of her peers. She began sharing from a vulnerable and humorous space around her obsessive thoughts with food. This in return helped her peers to take things more lightly. Knowing she had a history with Improv, I asked Mackenzie if she would lead a few impromptu Improv groups in which she flourished. Her aliveness became palpable and she was allowing more time and space for it. Although at times laughter may be used as a defense, or used to cover shame and embarrassment, it is also a window to the soul and a starting point to re-connect with one's felt-sense. As it was for Mackenzie. It helped move her from a frozen-rigid depressed state to a state with more flexibility, connection and aliveness.

Christina Weiss, LMFT, MPHC, is a licensed therapist in California and has worked in various capacities in the eating disorder field for the past 15 years. She is trained in Somatic Experiencing and is currently on the eating disorder treatment team at Breathe Life Healing Center, a trauma-based, co-occurring eating disorder and substance use disorder program in Los Angeles, CA. She also has a private practice in the South Bay.

Using Laughter to Work with Obsessive Thoughts Around Food

Ashley Lytwyn, MS, RDN, LDN

Working as a dietitian and nutrition therapist, it is imperative that I bring a lightness into topics that discuss a darker, disordered, relationship to food. Humor can be healing in the therapeutic process, but may also be used as a deflection and barrier in recovery. As I have navigated the appropriate times to bring humor into my work or challenge clients who use humor inappropriately, two cases come to mind.

I had the pleasure of working alongside Christina, with our client "Mackenzie." Mackenzie stands out to me because one of the biggest breakthrough moments we had was when laughter was introduced into our session. It deepened our rapport and relationship and I was able to witness a progression that shaped the course of our work together.

Mackenzie was a very 'stuck' client. As a woman in her 20s, she was constantly obsessed with thoughts on the thin ideal and weight loss. One afternoon, about two weeks into our work together, we had a scheduled exposure lunch where clients are asked to eyeball portions and plate their own meal, versus having the culinary staff plate a pre-portioned meal for them. As she walked into the lunch room for the beginning of the challenge, she stood frozen with her hands clenched and her eyes down as I asked her to "plate a balanced meal". These four words, so easily slipping out of my mouth, created a panic response similar to what someone with a healthy autonomic nervous system might exhibit if witnessing a snake on their front porch. Her peers, who were already introduced to this challenge, began to create their own meals. Mackenzie watched in awe at how effortless their actions appeared, which deepened her feeling of being overwhelmed. She began comparing her resistance to their level of perceived comfort and ease.

When we processed this after the meal, she began to explain all of the racing thoughts that emerged in her head. She was cautious about her choice of words, mentioning she didn't want to say anything that might 'hold her back' from progressing in treatment and ultimately keep her in treatment longer – the horror! She stated she was embarrassed that she had these resistant thoughts and guilt began to build as she compared herself to her peers.

I took the initiative to bring humor into the room, to make light of something so heavily present. I asked, "What specifically are you thinking?" She responded: "I just can't eat that food, I can't eat the carbs, or the full-fat dairy, or the fats. I feel like I'm going to die if I eat that." I paused a moment and thought about the times a decade earlier, in my own eating disorder, where I would have thought the same things. I nodded my head gently and let her know I understood what she was saying. I said, "One time I died when I ate cheese too." She looked me squarely in the face, her eyes wide with a stoic look, paused for a moment, and then burst out in laughter. I started to laugh along with her.

I didn't intend it to be such a ridiculous statement, but how it organically came out of my mouth opened up a new door for us. When I asked her what other thoughts she might have, she said: "Oh, the bread is going to make me fat, and if I'm fat I will be all alone." I asked her, "So bread is preventing you from connecting with others, interesting?" Each time I reflected these racing thoughts back to her, she chuckled and put her head in her hands. The laugh made her realize she was sitting with these absurd thoughts in her mind, that they were stewing, festering, and growing, and limiting her from moving forward in her life.

I explained the necessity of getting these thoughts out. "Speak them out loud and write them down on paper. Be curious about the words and the meaning behind them." She was then able to

integrate this into our subsequent work together and also brought it into group therapy. This opened up a dialogue with her peers, allowing them to connect through humor and also release the tiny, yet mighty, false thoughts that have grown into a part of their core false beliefs.

Alternatively, an aspect of humor that may enter the space when talking about food or body, is its use as a deflection or a defensive action. I notice this when working with clients who say hurtful and self-deprecating statements about themselves or their eating disorder behaviors, but cover up the loaded statement with a laugh. This action can be used to instill laughter in others, to brush off the discomfort that is coupled with the hurtful thought and, ultimately, minimize pain. It is a way to normalize both socially and culturally constructed self-deprecating statements about one's body.

John, a 32-year old software developer, began to express his relationship to food and his body and how his methamphetamine abuse lent itself to continued eating disorder patterns, even during short periods of sobriety. When he first introduced himself to the others in the group, he stated he knew he was the 'chubby guy.' He laughed as he said this, which sparked chuckles and murmurs from the others in the group.

I asked John why, among all the other qualities he possesses, does he use the word 'chubby' as his personal descriptor. He shared that if he says it out loud first, then he is calling out what everyone else in the room is thinking. He said it is easier to be the one to say it, rather than hear it from someone else when least expecting it. He wanted to 'excuse his body' while showing he recognized what went unsaid. I asked him what it might be like to introduce himself using other descriptors that have nothing to do with his body size or food behaviors. He told me this felt too uncomfortable for him to not excuse his body before he began speaking in front of others. It had been a deeply embedded defense mechanism to ward off the pain and shame he carried with him throughout his life. He minimized it, stating, "It isn't a big deal because 'chubby' isn't a bad word."

It was difficult to support John in changing this self-deprecating talk but, ultimately, he realized how hurtful and harmful it could be as he was challenged to imagine saying that about his sister or his best friend. He realized humor was being used as a mask and barrier to connecting to others' keeping others at arm's length so they could not hurt him. As this barrier began to fall, he realized he could let others in and the relationship would not be influenced based on body size.

Humor can be used in many different ways in treating clients with eating disorders and addiction. It can be extremely useful in moving a client who may be stuck, but can be harmful when used as a self-defense mechanism to staying disconnected. Recognizing that humor is bringing healing is imperative in creating a supportive, cohesive environment of recovery.

Ashley Lytwyn, MS, RDN, LDN, is the Director of Nutrition at Breathe Life Healing Center and calls herself a 'dietitian who doesn't diet'. She believes in the ability to make peace with food and your body. In addition to her work at Breathe, she has a private practice, focusing on eating disorders, disordered eating, and chronic dieting. She presented recently at The Renfrew Center Foundation's Annual Conference on "Unquenchable Hungers: The Connection Between Substance Abuse and Eating Disorders."

Humor as a Pathway into – and out of – Pain.

Judith Ruskay Rabinor, Ph.D.

"What did we learn from Freud? If it's not one thing, it's your mother." – Robin Williams

"What on earth went on in your group tonight?" my husband asks. We are having dinner and he is referring to my binge-eating group that's met for sixteen years on Tuesday nights at 5:30 pm. "It sounded like you were having a hilarious time," he said. "What was so funny?"

My office is in our Manhattan apartment and, although two closed doors separate my therapy office from our living space, his curiosity was piqued by what he described as "raucous laughter." He was correct. Notwithstanding the fact that the group had initially coalesced that evening around a dark and dreary theme, we had ended a somber group with everyone laughing. It was a humorous quip I made that flipped the mood.

The therapeutic use of humor is not a new idea. Sigmund Freud saw humor as a means of expressing unconscious desires and fears. Viktor Frankel, a holocaust survivor, suggested that humor has the capacity to lift the human experience above suffering. An old supervisor of mine recommended I help clients see their life through the eyes of a cartoon character to bring levity to life's hardships.

So join me in my office as we examine the healing power of humor.

* * *

Back in 2002 when our binge-eating group began, we focused, for the most part, on over-eating. *What were the emotional issues that triggered binge eating?* As members became less symptomatic and developed deeper levels of self-awareness, trust and intimacy, triggers and self-regulation strategies held less of a center stage.

This group session had begun with Marie, age 75, talking about her husband Jack's deteriorating health. Jack, diagnosed with Parkinson's disease had suffered a terrible fall. A broken shoulder and long rehab followed his hospitalization. Marie was already worn out. Now, he faced Alzheimer's. "How are you managing as a caregiver?" I asked Marie, shifting the focus from Jack back to her. She shook her long blond hair. "Often I'm kind and gentle but sometimes, when I've had it, I become a bitch—or even worse—a witch."

Group members offered words of empathy: care-taking family members was a familiar theme. Three of the six people present that Tuesday evening had lost parents during the sixteen years we had met and one had a chronically ill spouse. I had shared some of my own trials as a caregiver to my mother, who had struggled with Parkinson's disease for a decade before her death, six years prior to the present meeting.

Next, Eloise, a tall brunette also in her mid-seventies, gave an update on her cancer treatment. She was drained and exhausted from the chemo. Thankfully she wasn't binging. Cancer was another topic familiar to the group. Sam, a 67- year-old beloved group member had died a decade earlier from metastasized lung cancer.

76-year-old Ben spoke next about the retirement package he'd been offered by his accounting firm. "The package isn't bad but retirement? I don't have a lot of hobbies, except over-eating," he said. The group laughed. "Really, work has consumed me for decades. I'm going to have to revamp my life," he said grimly. "Being useless has never been my M.O." He sighed. "Now what?"

Minutes before the group was to end, Marie spoke up again. "I don't know what I'd do without you guys. You are all dear to me, and our group is so special." Her remark triggered others to articulate the support they got from one another.

"Sixteen years… a lot of history," I commented after listening to the others. The group had journeyed from being composed of mostly 50-year-olds to, now, a group mainly of 70-somethings. Four of the six members present had been in the group since our first meeting sixteen years earlier. "We are moving through life together," I added.

"I'm 85! —The oldest one here," said Bonnie. "I think I'm doing pretty well except— I am continually losing names. I run into people I've known for years and I remember them, but can't always remember their names! My memory is fading and it's scary!" Everyone began speaking at once, sharing memory loss

moments- cell phones, eyeglasses, keys, birthdays of loved ones, library books. The group was abuzz.

"This happens to me, too! And I'm only 76!"

"Me too and I'm not even 70"!

"Age is just a number. 85 are the new 65." More laughter.

Beth, the youngest person in the group spoke up. "Seriously, I hope my mind is like yours when I'm 85," she told Bonnie. "How many 85-year-olds can drive 300 miles" Ben said, jumping in and referencing Bonnie's lengthy weekend drives to her daughter's Vermont home. More supportive endorsements of how well Bonnie was aging followed:

"And you still do you own taxes!"

"You are my role model!"

Bonnie persisted. "You are all so kind, but truly, I hate losing names. It's embarrassing!" she paused. "And I'm terrified: what's happening to my mind?"

Then the group was silent.

I paused. Took a deep breath. Then, I gave myself permission to follow my spontaneous urge.

With a straight face, I turned to Bonnie. Then I gazed at the group members, slowly. I made eye contact with everyone. "I'm going to make a promise," I said seriously. "It's a commitment. If we are all still here and still meeting ten years from now, I'll supply the name tags so none of us will be embarrassed when we can't remember each other's names."

Peals of laughter broke out. Of course, I laughed too. When the laughter died down, I said: "What's in a name, anyway? Maybe it won't even matter if we remember each other's names—as long as we can remember each other's stories. After all, it's our stories that bind us together."

* * *

Writing this article has offered me the opportunity to reflect on the role of humor in our group. Most of us are aware that laughter releases endorphins, the feel good hormone which reduces tension and stress. Joking with patients and allowing them to feel a kinship can offer a remedy to long-standing frustration, pain and isolation, the issues most people with eating disorders struggle with. Our work is serious, but when we, as therapists, are able to laugh at ourselves and accept the absurdities and unknowable aspect of life, we offer our clients a unique gift.

My humorous quip had its positives: it was certainly a bonding moment. As a group leader, I generally disclose my feelings about what happens in the group, yet, I rarely disclose my personal experiences outside the group. This quip was an unusual "me, too" moment. It leveled the playing field. "Life is tough, aging is hard and unpredictable, and we are all in this together" was my message.

Second, I communicated that it's ok to verbalize our unknown fears, i.e., *what will I be like when I'm a decade older? I normalized the fear of aging*.

Third, I communicated that, although aging will inevitably take its toll, we can survive, and thrive. My message was "We will adapt. I will be here for you. At least I will try. I am an anchor."

In writing this article, I was pushed to question my own motivation. Why did I spontaneously come up with a funny line at the moment I did? What would have happened had I stayed with Bonnie's concern about memory loss? Did she or others feel dismissed? Upstaged? Did I abandon Bonnie's concern because the topic personally scares me? Perhaps I had an unconscious need to step away from the dread of deterioration, frailty and uselessness—the topics raised.

As my own questions multiplied I noticed a pit in my stomach, for aging is a topic rarely off my radar. My inbox too often carries the subject line "sad news" and, frequently, I find myself mourning a deceased friend or colleague, perhaps even younger than I am. Conversations with friends are increasingly filled with medical concerns. One good friend typically ends phone conversations with the line, "Don't buy green bananas." Another has incorporated a telling phrase as part of her email signature, "The road ahead is shorter than the road behind." On a more personal note, my husband has been coping with a painful backache and we have been educated by innumerable medical experts to face the truth: back pain, like an assortment of other medical maladies, is increasingly prevalent and predictable as we age. Acceptance is key.

I wondered: did I make a humorous remark as a way of avoiding my own feelings of grief, anxiety and frustration around aging? Was my quip a mistake?

Fortunately in life and in therapy, mistakes are always opportunities for exploration and repair.

The following group session offered me an easy segue for investigation. Marie had arrived wearing a heart monitor. A "scary incident" had sent her to her cardiologist. Once again, we were plunged into the world of aging anxieties.

I had an opening and I took it.

I asked if there was more that needed to be said about Bonnie's concern with memory loss. When no one spoke up, I made a confession: I might have unconsciously sidestepped

this daunting topic. While no one admitted to feeling slighted or put off, I was glad to have planted a seed: therapists, as well as patients, often have a hard time sitting with what is truly painful and frightening.

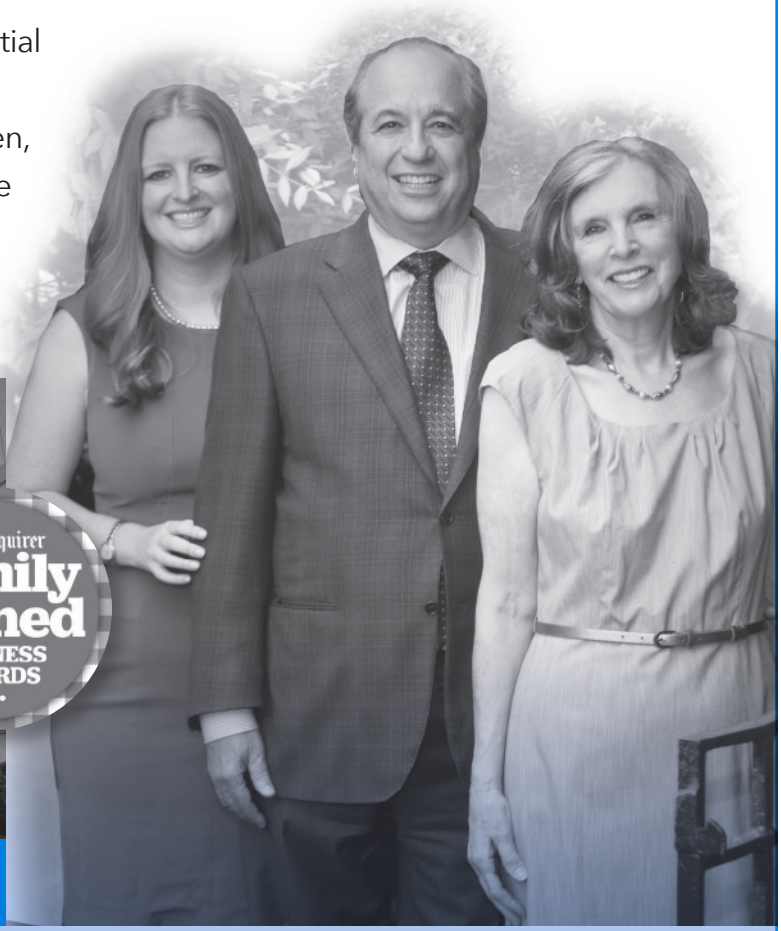
Until recently, I hadn't spent much time thinking about the value of humor in healing. Writing this article pushed me to think about my work through a new lens. One principle that has guided my work forever is a quote from Psalms, "Joy shared, twice the gain, sorrow shared, half the pain". Humor is a pathway into pain. It allows us to share it all. A joke well told can lighten the load, facilitate bonding and humanize us as therapists. It can communicate, as Sullivan taught, "We are all simply human."

Judith Ruskay Rabinor, Ph.D., is a psychologist, psychotherapist, author and writing coach. She is the author of *A Starving Madness: Tales of Hunger, Hope and Healing in Psychotherapy*, a book about divorce, *Befriending Your Ex After Divorce: Making Life Better for You Your Kids and Yes, Your Ex* and is currently writing a book about mothers and daughters (working title: *Mining & Mending Our Connections with Our Mothers*.) She is in private practice in New York City where she sees individuals, couples, families and groups and runs a supervision group for mental health professionals treating eating disorders.

The Renfrew Center is Named 2018 Family Business of the Year!

The Renfrew Center, the nation's first residential eating disorder facility dedicated exclusively to the treatment of adolescent girls and women, was awarded Family Business of the Year in the large business category by the *Philadelphia Inquirer* for its business impact, community involvement, innovation, and growth.

Family-owned and operated since 1985



Vanessa, Sam and Pamela Menaged

Virtual Therapy Groups

Offered in California, Connecticut, Florida, Illinois, New York, and Texas

These **online, weekly therapy groups** offer structured care to adolescent girls and women who are working towards recovery from an eating disorder.

These groups actively engage participants with each other to explore the emotions and relational functions of their disordered eating. Individuals also develop strategies to improve their communication skills and achieve recovery focused goals. **Group curriculum is informed by the empirically based Renfrew Center Unified Treatment Model for Eating Disorders.®**

The Renfrew Center
FIRST IN EATING DISORDERS

Participants need to have access to Wi-Fi and a device such as a smart phone, computer or tablet with a camera and screen.

Interested individuals can call 1-800-RENFREW to schedule an online assessment.

Your Donation Makes a Difference

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

Your Donation Makes A Difference...

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

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

Tax-deductible contributions can be sent to:

The Renfrew Center Foundation
Attn: Kelly Krausz
475 Spring Lane, Philadelphia, PA 19128

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

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

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The Twenty-Eighth Annual Conference Update

On behalf of the 2018 Conference Committee, thank you to all of the speakers, attendees and Renfrew staff who contributed to the enormous success of this year's event. A strong feeling of community and connection among all participants was pervasive throughout the weekend in workshops, networking events, meals, and the Friday evening dance party. With the highest overall attendance in recent years, the Conference also broke the record for the percentage of those experiencing the conference for the first time. Another "first" this year was the inaugural presentation of the David H. Barlow Poster Award for Research Excellence.

The Conference theme, ***Feminist Relational Perspectives and Beyond: Cultivating Hope in an Age of Disconnection,*** highlighted the importance of recognizing the intersection of the eating disorders work we do and the effects of the political, social and cultural environments in which we practice. The power and passion of the speakers rekindled and awakened our role as change agents whose voices matter in determining what lies ahead for our field and our society. The energy and zeal in the audience was palpable and every Keynote presentation received a spontaneous standing ovation!

Monica Lewinsky's intimate rendering of her journey from shame and self-loathing to rising and leading a global anti-bullying campaign was mesmerizing. She, herself, was an authentic testament to strength and fortitude.

Heather Thompson-Brenner, PhD, skillfully moderated a panel with **Amy Banks, MD** and **Stephen Wonderlich, PhD,** each presenting research on the integration of eating disorders research and feminist theory—confirming that not only is it feasible, but essential.

Rebecca Traister, journalist and author of the timely best-seller *Good and Mad: The Revolutionary Power of Women's Anger,* offered a historical perspective on the suppression of women's anger as well as her assertion that in this #MeToo culture, women refuse to be silenced.

Ron Taffel, PhD, closed out the Conference with an enlightening look into the world of millennials. Through video clips of therapy sessions and excerpts from patient journals, he offered strategies to meet the innermost needs of this technology-raised population in order to communicate and, thus, foster the therapeutic alliance.

Planning is now underway for the 29th Annual Conference, ***Feminist Relational Perspectives and Beyond: Discerning Truth,*** to be held from November 8-10, 2019. This update includes photos from the Conference as well as a form to order CDs if you were unable to attend or missed specific workshops.
A Call for Proposals can be found on pages 20-21.

Many thanks, once again, for making the 2018 Conference a great success.
We hope to see you next year!

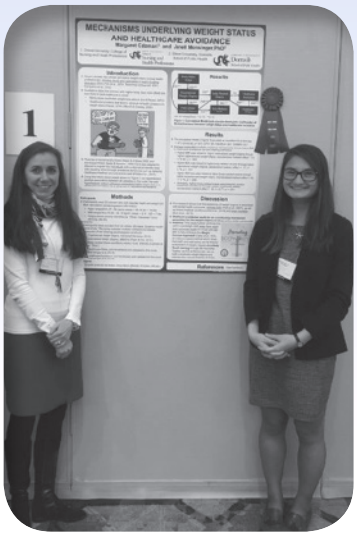
Judi Goldstein

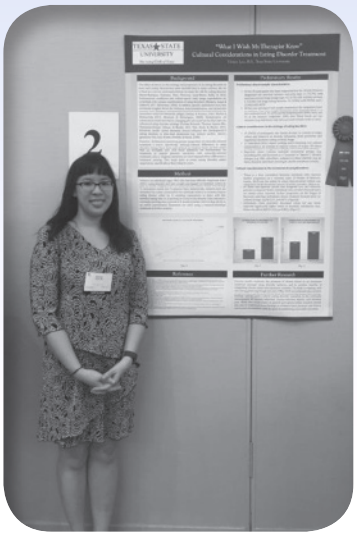
Judi Goldstein, MSS, LSW
Conference Chair

"This Conference was tremendous and so well organized. It was packed with research and practical applications, incredible staff and keynote speakers who were beyond, beyond! I'll be back next year."

"Perhaps the best Conference yet! Amazingly timely and passionate."

"This Conference was life changing, well worth my time and travel!"





29TH ANNUAL RENFREW CENTER FOUNDATION CONFERENCE FOR PROFESSIONALS

2019 Call for Proposals

Feminist Relational Perspectives and Beyond: Discerning Truth

NOVEMBER 8-10, 2019 • PHILADELPHIA AIRPORT MARRIOTT

DEADLINE FOR SUBMISSIONS:

WORKSHOP PROPOSALS – MARCH 1, 2019
POSTER PROPOSALS – JUNE 28, 2019

As we continue to address the challenges we face as a professional community, we recognize the importance of discerning truth in our current climate of "fake news", unsubstantiated claims and slanted rhetoric. These forces have contributed to rising levels of distrust and vulnerability among our clients with eating disorders. Conference 2019 will examine the ways in which we, as clinicians, can help clients develop skills to enhance critical thinking, emotional regulation and relational connection. At the same time, it is incumbent upon us to explore our own biases and capacity for taking others' perspectives, utilizing empirically-based, justice informed science and research.

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

Other topics to be addressed:

- Debunking myths about eating disorders, health and wellness
- Media literacy
- The effects of trauma and abuse on the brain
- Therapies that integrate change and acceptance skills
- Mindfulness
- Special populations and lifespan issues
- Countertransference and boundaries
- Living and recovery in a cyber-age
- Social justice and marginalization
- Activism and advocacy

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

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

Conference Overview:

- Keynotes
- Workshops
- Poster Presentations
- Networking Events

Workshop Submissions:

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.

Required Components for Workshop Proposals:

The following information MUST be uploaded as part of your submission:

- Title
- Abstract (150 words max)
- Brochure Description (50 words max)
- 3 Learning Objectives
- Presentation Outline
- Presenter Information (CVs, bio, etc.)
- Workshop References (5 minimum in APA format, 3 of which must have been published within the past 5 years)
- Workshop Timeline

Presentation Guidelines:

1. Presentations must relate to the Conference theme and meet stated learning objectives.

2. Handouts MUST be provided to attendees. This could include PowerPoint slides, bibliography and/or resources. All accepted presenters must submit handouts by October 11, 2019.

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.

6. Presenters are required to submit signed disclosures once accepted onto the program. These are required by credentialing boards and will be sent to you once you have been accepted to the 2019 program.

If all the above are not submitted, application will not be processed.

To Submit a WORKSHOP PROPOSAL

Please visit *www.renfrewconference.com* to complete an online application.

Workshop Proposal Notification

Workshop Proposals must be submitted by March 1, 2019 by 11:59 pm EDT. No submissions will be accepted after this deadline. Only one proposal per person should be submitted either as a primary or secondary presenter.

Poster Submissions:

Poster presentations allow presenters to share new research findings on eating disorders and approaches to treatment. Posters that describe quantitative or qualitative research studies are welcome. Posters describing systematic literature reviews are also invited, as long as the review is strongly data/evidence based. If accepted, authors will present their findings visually on a poster board and are expected to answer attendee questions during the Poster Session on Saturday evening. The poster session will feature the work of both senior and junior investigators. Graduate students are encouraged to submit proposals!

We are excited to announce that the second annual **David H. Barlow Poster Award for Research Excellence** will be presented to the early career professional with the most outstanding poster submission to The 2019 Renfrew Center Foundation Conference. This award will be given to a graduate student or a professional within 3 years of receiving their degree whose conference poster describes work that will have the strongest impact on understanding, treating, and/or preventing eating disorders.

Required Components for Poster Proposals:

The following information MUST be uploaded as part of your submission:

- Title
- Abstract (300 words max)
- Handout Description (50 words max)
- Presentation Outline – objectives, methods, results and discussion
- Presenter Information (CVs, bio, etc.)

Presentation Guidelines:

- Presentations must relate to the Conference theme and meet stated learning objectives.

If all the above are not submitted, application will not be processed.

To Submit a POSTER PROPOSAL

Please visit *www.renfrewconference.com* to complete an online application.

Poster Proposal Notification

Poster Proposals must be submitted by June 28, 2019 by 11:59 pm EDT. No submissions will be accepted after this deadline.

Please contact Kavita Patel at *kpatel@renfrewcenter.com* if you do not receive a confirmation email after 24 hours of submitting your proposal.

If you have any questions please contact Kavita Patel at *kpatel@renfrewcenter.com*.

AUDIO RECORDINGS ORDER FORM

THE 28th ANNUAL RENFREW CENTER FOUNDATION CONFERENCE FOR PROFESSIONALS • November 9-11, 2018 in Philadelphia, Pennsylvania

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

Please check your selections

KEYNOTE PRESENTATIONS

❑ KEY 2 **Psychotherapy Research for the People: Can Feminism and Science Co-Exist?**
Heather Thompson-Brenner, PhD (Moderator); Amy Banks, MD & Stephen Wonderlich, PhD

❑ KEY 4 **Hope for the Future: Reinventing the Way We Work with Millennials**
Ron Taffel, PhD

WORKSHOPS

Friday, November 9, 2018

❑ FR 2 **Christian-Based Treatment of Eating Disorders: Reconciling Self, Life and God**
Laurie Cooper, PsyD &
Edith Majors, MS, MAIS, LPC

❑ FR 3 **Finding Hope at the Intersection Between Indigenous Knowledge and Western Science**
Anita Johnston, PhD, CEDS

❑ FR 4 **Recipe for Change: Integrating the Science of Nutrition and the Science of Emotion**
Becky Mehr, MS, RDN, CEDRD, LDN &
Melanie Smith, MS, LMHC

❑ FR 5 *The Barbara M. Greenspan Memorial Lecture*
Embodied Journeys: Interconnected Pathways for Healing
Niva Piran, PhD, CPsych, FAED

❑ FR 6 **Social Justice and Eating Disorders: Let's Move Forward Together**
Marcella Raimondo, PhD, MPH & Andrea LaMarre, MSc

❑ FR 7 **Breaking Free: The Treatment of Eating Disorders and Trauma**
Rebecca Berman, LCSW-C, CEDS, MLSP

❑ FR 8 **Making Sense of Behaviors: Understanding Autistic Spectrum Disorder, Sensory Processing Dysfunction and Eating Disorders**
Kim Clairy, MS & Rachel Lewis-Marlow, MS, EdS

❑ FR 9 **Hidden Voices: Understanding the Nuances of Eating Disorders in African American Women, Men and Children**
Carolyn Coker Ross, MD, MPH, CEDS &
Lesley Williams, MD, CEDS

❑ FR 10 **Understanding Teen Eating Disorders: Meeting New Demands for Multifaceted Treatment**
Cris Haltom, PhD, CEDS & Mary Tantillo, PhD, PMHCNS-BC, FAED, CGP

❑ FR 11 **Intersectional Treatment of Body Image: Embodied/Cultural Curious Therapists**
Robin Hornstein, PhD

❑ FR 12 **Promoting Body Trust® in Your Work**
Dana Sturtevant, MS, RD & Hilary Kinavey, MS, LPC

Saturday, November 10, 2018

❑ SA 1 **The Invisible Crisis: Eating Disorders Among Asian American Women**
Hue-Sun Ahn, PhD

❑ SA 2 **Functional Analytic Psychotherapy: Increasing the Potency of the Therapeutic Relationship**
Whitney Graff, PsyD

❑ SA 3 **Nourishing Self-Care: Using Culinary Experiences to Facilitate Eating Disorders Recovery**
Leah Graves, RDN, LDN, CEDRD, FAED

❑ SA 4 **Role of Weight Dysregulation in Understanding and Treating Eating Disorders**
Michael Lowe, PhD & Adrienne Juarascio, PhD

❑ SA 5 **Beyond Picky Eating: The Other Eating Disorder that Doesn't Quite Fit - ARFID**
Jaclyn Macchione, MOT, OTR/L &
Tracey Stassi, RD, LDN

❑ SA 6 **Bringing Men into the Conversation: Transforming a Misogynistic #MeToo Culture**
Margo Maine, PhD, FAED, CEDS; Marvice Marcus, PhD &
Douglas W. Bunnell, PhD, FAED, CEDS

❑ SA 7 **Radically Open DBT: Openness, Flexibility and Connection in Recovery**
Heidi Dalzell, PsyD, CEDS & Kayti Protos, MSW, LCSW

❑ SA 8 **Dual Diagnosis: Diabetes and Celiac Disease in Eating Disorders**
Trish Lieberman, MS, RD, CDE, LDN &
Julie Cooper, MS, RD, LDN

❑ SA 9 **Assessing and Managing Suicide Risk in Individuals with Eating Disorders**
April Smith, PhD & Shelby Ortiz, BA

❑ SA 11 **Keeping Hope Alive: Working with Severe and Enduring Anorexia Nervosa**
Laura Weisberg, PhD

❑ SA 12 **The One that Got Away: Women's Choices, Women's Voices**
Natasha Weston, MS, LPC

Sunday, November 11, 2018

❑ SU 1 **Treatment and Recovery from Eating Disorders and Related Illness: "What's Love Got to Do With It!"**
Michael E. Berrett, PhD

❑ SU 2 **Discovering Connection in a Disconnected World**
Jaime Kaplan, PsyD

❑ SU 3 **Unquenchable Hungers: The Connection Between Eating Disorders and Substance Abuse**
Ashley Lytwyn, MS, RDN

❑ SU 4 **Treating the Mother: Eating Disorders in Pregnancy and Postpartum**
Jennifer McGurk, RDN, CDN, CDE, CEDRD-S &
Christine Knorr, LCSW

❑ SU 5 **Culture Jamming: Creative Resistance to Toxic Culture in Eating Disorder Recovery**
Sondra Rosenberg, ATR-BC

❑ SU 6 **Millennials Rising! Therapeutic Relationship Skills for Dysregulated Patients and Changing Sensibilities**
Ron Taffel, PhD

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