The Renfrew Center Foundation
FOR EATING DISORDERS

Perspectives

A Professional Journal of The Renfrew Center Foundation

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As *Perspectives* continues to grow, an Advisory Board has recently been formed. This group of experts will help us continue to provide the thought-provoking topics and insightful content that you, our readers, value.

A Word from Our Editors

This past year has been uniquely challenging for us all. Coincidentally, the theme we had selected for this issue of *Perspectives* — Clinician Stuck-ness — reflects the uncertainties, challenges and concerns that touch our lives so deeply today. In fact, this topic proved to be one of the most complex that we, at *Perspectives,* have addressed. Nevertheless, each of the contributors eagerly embraced the theme and effectively utilized the "framing questions" we provide with each issue. They were:

- What does stuck-ness mean to you? How does it feel?
- How is your experience of getting stuck (and unstuck) similar to or different from the experience of your client?
- What conditions or issues contribute to your becoming stuck?
- How does your stuck-ness as a clinician impact the therapeutic relationship?
- Do you consider stuck-ness as useful, helpful, inconvenient, intrusive?
- Are there any specific aspects of this theme that are of special importance for your readers?

We thank our writers for their forbearance and ultimate success in rising to the occasion.

This issue begins with a riveting case study by **Roy Erlichman** who describes his long and often frustrating journey with Sarah. His description of the ups and downs of the journey contains many invaluable insights for clinicians: "The case of Sarah was one that went well. Not all do. I have had others that have disappointed me, even caused despair. But knowing that feeling stuck can be both meaningful and useful encouraged me to stay the course."

As an introduction to her work as a Nutrition Manager at Renfrew, **Samantha Goss** provides many insights regarding her own stuck-ness with clients. She begins with the following: "While writing this article I came across an interesting quote by Robert M. Pirsig that captures the value of stuck-ness in my relationship with my patients: *"stuck-ness shouldn't be avoided. It's the psychic predecessor of all real understanding."*

Mazella Fuller, an experienced therapist who works with university students, explains a source of her own stuck-ness: "As the only Black member of the treatment team, from time to time I had to defend my interventions or recommendations as 'cultural concerns.' Institutional and systemic barriers among treatment team members limited my ability to challenge some of the proposed treatment options. Sometimes external barriers impacted the process of providing culturally competent care."

Karen Samuels, a Cultural/Relational therapist, provides a vivid and timely description of her challenges of dealing with body image disturbance and body awareness via tele-health: "So without the physicality of our bodies and with focus on eye contact and sitting calmly with stillness, I find myself searching for creative tools to make connections... This has not been without great frustrations and challenges; feeling stuck behind a camera lens robs me and my clients of an embodied connection. We are talking heads, reduced to shoulders, neck and head."

In considering her challenging experiences with two clients, **Mary Bellafatto** raises an essential question and provides an illuminating insight: "How do the experiences with Emily and Susan speak to me as a clinician regarding stuck-ness? First and foremost, they helped me to know myself. This is important due to the parallel process. Whatever is happening with the client is in some ways happening with me; whatever is happening with me is also happening with my client."

As these essays collectively reveal, clinician stuck-ness may be an essential aspect of the therapeutic process as it contributes to an enhanced understanding of our clients' experiences of stuck-ness.

Warmest wishes,

The Editors

On Not Knowing

S. Roy Erlichman, Ph.D., CAP, CEDS-S, F.iaedp

To be stuck is to not know. It may be synonymous with not understanding or perhaps a defense against such feelings as helplessness, failure, confusion or inadequacy. It may be momentary or long lasting. In my experience, feeling stuck is implicit in the process of treating complex emotional issues and is important in helping clinicians better understand our patients and ourselves.

In fact, feeling stuck is but one of many countertransference responses that arise in the practice of psychotherapy. For me, feeling stuck, much different from being stuck, is inevitable and confirms the realistic limitations on what I can know or accomplish in my work. This may leave me with thoughts and feelings that may differ dramatically from what a patient expects, fantasizes or demands of me or that I expect of myself.

In the treatment of eating disorders, there is little that restores health promptly and little that consistently eases or resolves moments of stuck-ness, both for patient and clinician. Healing demands time; and as another aside, do we yet have a clear, universal definition of healing or cure?

And then there is Sarah.

In her early forties Sarah presented with a fascinating history. Well-educated, she had served in the U.S. government for years and was married to an accomplished man. She had no siblings. Both parents had passed away. When I asked how I could be helpful, Sarah clearly told me she wanted to be rid of her anxiety, her intractable depression and what she referred to as 'unusual thoughts' that intruded in her life. I did not know what they were nor, in the early sessions, did I ask. To do so then felt premature. I could wait.

In the first months of our work, Sarah was cooperative. She came to her sessions on time, spoke openly and paid her bills reliably. One day, for reasons I did not understand, I felt a nagging, uneasy feeling and decided to explore with Sarah how our sessions were going. Actually, I asked her, "How am I doing?" I did not direct my question to her as a command or personal criticism, but instead invited her to speak about me and how I was doing as her therapist. In other words, if she chose to, she could speak critically or positively without recrimination. That was my hope.

Sarah said that our work was going well, but the positive feelings she verbalized did not match the feelings I experienced. Telling me all was going well was simply not the case. Something was wrong, but I did not know what. When feelings and thoughts don't match, I wonder why.

I wonder when patients are too kind, too effusive in praising a therapist's work – or too critical. Are we hearing what is true or what is self-protective and therefore safe? Does the patient fear retaliation, rejection or abandonment? Likewise, I question when patients displace rage on me undeservedly for behaviors, thoughts or comments that I neither had nor engaged in, but the patient attributes them to me any way. What if I think I am being helpful,

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but in the mind of the patient I may feel or be of little value. How to respond? Experience and theory have taught me that the prudent thing is to accept and say little or nothing.

From time to time such questions arose when Sarah would ask for exercises or techniques to help ease the stressors she felt. If I were being as helpful as she said, I wondered why the need for more tools and techniques? What was I missing? What was I failing to do? At first these requests felt reasonable. Technically, they were. We discussed breathing exercises, pausing exercises, yoga, meditation, books to read, visualization – but to no avail. Nothing helped.

What did become clear was that Sarah had no interest at all in exercises or techniques—to the contrary in fact. What I realized later was that Sarah was determined that somehow she would compel me to understand and feel the intensity of the emotional pain she experienced every day—and for which she had no words, because there were no words. These were preverbal memories. As time passed, she would use colors to describe early childhood experiences – for example, that the pain of her anxiety was fiery red or that her depression was cold gray. She required that I feel these feelings and somehow save her from them.
She never said this because she had no words. I simply intuited her message.

Through many sessions, I felt I had become an amalgam of the mother and father who are supposed to 'simply know' what their child needs. Magically, these parents turn on the light when it is dark, change diapers when they are wet, and feed and love their child naturally and easily. While the infant does not yet have a verbal language, she does know the sounds and feelings of such love and in time, grows to accept it with trust and confidence. Sarah never knew this experience.

For a long time, I continued not knowing what to say to Sarah. Clearly my presence was more important than my words and, like Sarah, I had none. As I was asking Sarah to walk across her own 'bridge over troubled waters' and put her thoughts and feelings into language, I had to do the same. What I knew was what I felt — an empty, sad, raw state that often left me frustrated and uncertain and frequently ashamed and embarrassed. I was supposed to be an agent of hope in Sarah's life, but, in truth, I felt myself a failure. Yet we persisted.

And then came that special moment, the epiphany in which the elements of our work gradually were seamed together. What appeared to have happened is that my inner world had evolved into a narcissistic mirror of Sarah's. The insecurity that I felt as a therapist mirrored the insecurity she felt as both child and patient. The rage she displaced onto me was the rage that her parents displaced onto her. Feeling like a failure as a therapist was the feeling she felt as a child. Blaming me for failing her in our work was the blame she experienced for not satisfying her parents' endless demands for achievements, too lofty for the most gifted of us. What was imposed on her was imposed on me. There was no love in their messages and Sarah felt this. Nor would I get any love or appreciation. I would suffer, too, until I understood.

More months passed. Sarah persistently railed on about my lack of understanding and what she labeled 'my lack of proper compassion.' "Just like my parents," she said. Repeatedly, she reminded me I was a failure as a therapist and wondered why she ever came to see me. But interestingly—and I grew increasingly curious about this—no matter how fiercely she complained, she continued to come to our sessions and invariably on time. She paid her bills as we agreed and responsibly handled the details of appointment changes. She now periodically requested more sessions, not fewer. This seemed contradictory. If she so loathed and criticized me, why continue treatment? Certainly she could find another therapist more effective than I. In truth I hoped there was. I was tired.

As Sarah spoke more openly, we studied together how I had become so disappointing, and what I had done to warrant her rage. Had anyone ever listened to her, accepted her dark feelings and her 'unusual thoughts?' Was there a safe way to talk about the real relationship she had with her parents and others whose lives touched hers? Were her parents the good people she described or were they as detached, punitive and toxic as they seemed to me? I continued to ask questions, study Sarah's replies with her, and to the best of my ability, rendered neither judgments nor interpretations. Better, it seemed, for her to arrive at her own conclusions independently, without criticism, pressure or editorializing on my part.

Sarah's voice grew clearer, louder and braver. In one tender conversation, she confirmed tearfully that she was indeed a brutalized child who had never been allowed to feel or speak. As she felt increasingly safe displacing hateful feelings onto me—as a substitute in the transference for her parents—she talked more freely about her memories, feelings, perceptions and dreams. At times, this process felt interminable, and yet it grew increasingly informative and relieving to us both. As the rage lessened, a brighter self gradually emerged. Through many agonizing sessions, what became true was that Sarah had grown up with parents who were diametrically different from the parents she had first described. They had nearly destroyed her mind and her soul.

As an infant, Sarah learned that her obligation was to do her parents' bidding without question. To do otherwise was to manifest disloyalty for which she would be punished. To be silent was to be safe and loyal—the good child. Later in treatment, when speaking no longer terrified her, she needed to confirm with certainty—know—that I would tolerate her rageful feelings and behaviors. If I could do that and remain non-punitive, that would confirm that I could be believed and trusted. Her perceptions, memories and feelings were to be valued, not scorned.

Doing nothing or little, waiting for Sarah to guide me—in her own language and at her own pace—was to do more. Slower was indeed faster.

Sarah and I worked together for several years. Feeling stuck, uncertain and unknowing colored the course of our relationship. Curiously, I do not recall ever feeling hopeless. I have often wondered why. In retrospect it seems to me that Sarah's determination to have the life she rightfully deserved gave me both hope and courage.

Sarah did prosper in our work, although I frequently wondered if I could. As treatment advanced, she reported significant improvements in her relationships with others. Her career blossomed. She no longer spoke of her depression, anxiety or unusual thoughts. Her marriage became a source of confident, loving mutuality. After treatment ended, Sarah periodically would call me or send a card to let me know that she was doing well in her new world. She invariably asked how I was, an important step for someone who for years barely acknowledged my existence.

The case of Sarah was one that went well. Not all do. I have had others that have disappointed me, even caused despair. But knowing that feeling stuck can be both meaningful and useful encouraged me to stay the course.

Helping Sarah to restore her 'wounded self' required that I hear her 'disguised cries for help,' her perceptions and feelings about life and reality, whether real or imagined. When I accepted her perceptions, which frequently defied reason or my own perspective, I believed—actually felt—that this gave her a sense of unqualified acceptance, of feeling understood, and emotion—I believed—which she may have never experienced before.

In other words, the sense of interpersonal acceptance may have little to do with the issues at hand, but far more to do with feeling valued or devalued by another. Whether correct or incorrect, logical or not, I find that a patient's words are the offspring of their mind, a verbal representation of the self. To have them accepted and valued is to be valued. For me to argue with these perceptions may be experienced as rejection, possibly a replication of her traumatic experiences as a child. Here again, one more adult, her doctor now, who may listen but not hear. Clearly relational trust is not legislated in therapy, but cultivated, earned over time, just as the infant internalizes over time that their parents will be reliable, present, loving objects.

For me personally, it was a privilege to share Sarah's journey. Often, I wish I could know more, do more and feel less ignorant and uncertain. However, to borrow from Donald Winnicott, like parents we can only be 'good enough.' It is easier, though, to be good enough when we accept that feeling stuck and not knowing are rightful elements of what we do and who we are.

Dr. S. Roy Erlichman, Ph.D., CAP, CEDS-S, F.iaedp has an extensive career in eating disorders treatment. He is a Certified Eating Disorders Specialist and Fellow through the International Association of Eating Disorders Professionals (iaedp) and has served as President of the Board of Directors. In 2019, he received the Who's Who In America Lifetime Achievement award for clinical contributions and in 2016 was awarded the iaedp Lifetime Achievement Award for service. Dr. Erlichman has written numerous professional articles, presented at conferences throughout the country and is an Associate Editor of *Perspectives*.

Navigating Stuck-ness

Samantha Goss MPH, RDN, LDN

While writing this article I came across an interesting quote by Robert M. Pirsig that captures the value of stuck-ness in my relationship with my patients: *"stuck-ness shouldn't be avoided. It's the psychic predecessor of all real understanding."*

As a Nutrition Therapist working in the eating disorder field for more than a decade, I still sometimes feel like I am on a roller coaster ride. Over the years, I have had patients and loved ones ask me why I chose to work with individuals with eating disorders. I often wish I had a simple cut-to-the-chase answer. However, I, too, have pondered this question more times than I can recall. The reality is that behavior change is challenging and helping someone navigate away from something that seems to be working for them can feel like an uphill battle. I believe that most clinicians who choose to work with these brave individuals do so because they genuinely care about people getting well. However, there are some frustrating aspects to this therapeutic relationship that can

help us and our patients grow if we view it through a fresh lens. The term "stuck-ness" is often perceived by clinicians in a negative light because it is intrusive and inconvenient. I compare the state of being stuck as being at a crossroad. You can see the direction that would benefit your patient's recovery, but they are unwilling or feel incapable of moving towards that path. As a result, frustration and helplessness set in and, ultimately, it begins to feel as if I am working harder than they are. As a clinician I've learned that getting stuck should never be overlooked or avoided; rather, it presents unique opportunities for clinician self-exploration and ultimately, growth.

The first couple years of working in a residential treatment setting were challenging. I prayed for patience because I often left work feeling frustrated, wondering if I made an impact or a difference in the patients' lives. I would never imagine that a part of my growth would be the result of the complex, sometimes challenging, relationships that developed with my patients.

Amy was diagnosed with bulimia in her teens and hospitalized several times. I had the opportunity to work with her on a few occasions while in residential treatment. One of Amy's most intense fears was getting to a particular weight. Inevitably, she would start restricting or engaging in maladaptive behaviors to avoid reaching that dreaded number. As a result of her fears, she would disclose half-truths about her symptom use. Many of our sessions felt like déjà vu.

One of the roadblocks that led to my feeling stuck was her questionable behaviors. I felt like some days I was playing detective, trying to sort through truths from mistruths. As a result, I found it difficult to connect with Amy and it was incredibly challenging to trust what she was telling me. It created an atmosphere of suspicion with each session leaving me feeling frustrated. I wrestled with what the lack of connection could mean. I did not want Amy to think that I didn't care or that I was giving up on her. I also did not want to feel ineffective.

At the same time, how could I truly form an alliance without trust? I recall pushing harder or being more confrontational if I suspected Amy were not being truthful. Unfortunately, she responded by either being defensive or shutting down. When she finally spoke, she would have a lot of "I don't know" or "you can't help me" responses. A couple of times, she walked out of the sessions because she believed I was accusing her of something she wasn't doing. I continued to roll with her resistance despite my frustration and lack of trust.

I started weekly supervision with a therapist which helped me understand and dissect some of the challenges Amy and I experienced that led to this state of stuck-ness. Supervision provided support and enabled me to view those challenging issues from a different perspective. In those early days, it was difficult for me to discuss my internal frustrations towards my patients, but I finally opened up to her about my lack of connection with Amy. I learned that my inability to connect with Amy was warranted, but in no way meant that I was an inefficacious nutrition therapist.

There were two insights that emerged from these supervision sessions that enhanced my connection with Amy and fostered my growth as a clinician. First, I realized that perhaps I had projected some of my own unrealistic expectations onto her. This was a game changer for me because I was always focused on what was keeping Amy stuck and rarely on the role that I played in the process. She would try to bargain her way into eating only what felt safe. Whenever we approached challenges from her fear foods list, she would rationalize why all those foods were unhealthy. I encouraged her to test out recovery by doing things differently than she had in previous treatments, but my efforts were futile.

Internally, I felt that after so many treatments she 'should' be able to 'lean into' or 'tolerate' her distressing emotions. After all, she had done this work long enough to know what this journey required. I judged her efforts because they were not aligning with my expectations for her progress in treatment. My personal expectations for her created a barrier in the process, so it was no surprise that I felt frustrated. After I recognized this problem, I tried to meet Amy at her personal starting line by helping her set small measurable goals. I thought of it as a marathon race instead of a sprint. I also worked on being more understanding and empathic, instead of judging her efforts, even if they felt minimal to me. Over the years, I've gotten better at adjusting expectations because the reality is recovery is hard work; the journey is never linear.

The second thing that improved my connection with Amy and helped us get unstuck was transparency. Stuck-ness can sometimes feel like the elephant in the room, but over the years I have learned to be more transparent with my patients. In one of my sessions, I disclosed to Amy some of my frustrations and asked for any thoughts on how we might move forward. This was one of the most uncomfortable discussions I had with her because I was being vulnerable. I recalled telling her: "I feel that we are at a crossroad and I'm not sure what direction we are going. Do you have any thoughts on how you can move forward?" From what she shared, I realized that her frustration mirrored mine. Amy's motivation coming into treatment was always high. She felt that she should be able to do what I was asking her to do because she was familiar with treatment expectations. To make matters worse, she felt that by continuing to restrict, she was letting herself

down, and letting me down, as well. She expressed frustration towards herself in her food emotion journal which manifested as constant self-bashing.

I validated Amy's concerns and acknowledged her efforts to be open with me. By being more candid with her about what I was experiencing, I realized that it allowed her to start sharing more about her challenges with separating herself from her rigid food beliefs. I became less confrontational and encouraged her to verbalize her fears, whether in person or in her food emotion journals instead of acting it out through her eating disorder behaviors. Most importantly, I assured her that her efforts will not be judged.

My supervisor once said an encouraging message, and it has stuck with me through the years. She said that growth is sometimes painful, but if I can work through the challenges, this will help me become a better clinician. Looking back, I cannot help but wonder if things would have turned out differently if I avoided the stuck points that I encountered with Amy. As a "predecessor of all real understanding" stuck-ness became—paradoxically—a navigation tool that guided both Amy and me to explore aspects of this therapeutic relationship that were often challenging.

Over the years, I have encountered several clients like Amy. What I have learned about myself has helped me answer that nagging question of why I chose to work with individuals who have eating disorders. In my journey with these courageous individuals, I can now embrace stuck-ness—not as an annoying, intrusive barrier to avoid or ignore, but rather, an opportunity for transparency, compassion, and self-exploration.

Samantha Goss MPH, RDN, LDN is a Registered and Licensed Dietitian with a Master's degree in Public Health. She is a member of the Academy of Nutrition and Dietetics. Ms. Goss is the Nutrition Manager at Renfrew's residential treatment center in Coconut Creek, Florida. She has over a decade of experience providing nutrition therapy for eating disorders and is passionate about guiding individuals on their journey to better health.

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Stuck on the Journey

Mazella Fuller, Ph.D.

As an experienced clinician, I appreciate the invitation to write about 'stuck-ness.' Interestingly, I found 113 synonyms for it, but the one that resonated most was 'the inability to move forward.' Both personally and professionally, I try hard to live life as a forward-looking and forward-thinking journey. And yet, my understanding of 'forward' may differ greatly from that of my clients.

My work with Katy and Ivy, which I discuss in this article, often left me feeling stuck and conflicted. There were many moments in which I could not alleviate the painful symptoms of their eating disorders. As a therapist and a feminist, I was stuck as well—not wanting to see them suffer, but unable to provide rapid cure. My life as a social worker has been focused on the values of self-determination, care and cooperation. These values were not helping now.

As the only Black clinician on the university treatment team for clients with eating disorders, I feel a special sensitivity to the issues of women in general, and more personally, to the needs of Black women. I have had to manage the complexities and cultural nuances of treatment and often find that my voice and understanding of Black women may differ from the views of the treatment team. As a Black clinician, I need to be certain that my words are heard; I recognize that one treatment model cannot be universalized. At the same time, I needed to blend a cooperative, open-minded spirit with persistence to support my clients' needs and the unique challenges they face as emerging young adults of color.

My clients, Katy and Ivy, are two young women who battled anorexia nervosa. This illness is a challenge, not only for me but, I believe, for most therapists. While brief, the following vignettes illustrate resistance and stuck-ness that I experienced, as did my clients. With both young women, their issues occurred in the broader context of identity development, academic performance anxiety and a reliance on food—starvation—as a stabilizing and anxiety-reducing mechanism.

Katy, an 18 year-old first year student, came to me for treatment of anorexia nervosa. She reported feeling isolated, anxious, socially unsupported and exhausted, even after long hours of sleep. She complained that therapy had not been helpful and that previous therapists had not held her accountable for behaviors she could have changed. Perhaps they felt stuck too!

The Eating and Body Image Concerns group is a multi-disciplinary treatment team of therapists, dietitians, physicians, and fitness specialists. I was Katy's therapist; she also worked with a psychiatrist and dietitian. The treatment team was my personal 'village' and often helped me to address Katy's rage.

Katy challenged us in many ways. Her eating disorder was serious, often overwhelming in our efforts to stabilize her immediate, pressing health needs. I found it difficult to manage my feelings of frustration as I saw her consistently make poor decisions, decline cognitively, and refuse proper nutrition.

As the only Black member of the treatment team, from time to time I had to defend my interventions or recommendations as 'cultural concerns.' Institutional and systemic barriers among treatment team members limited my ability to challenge some of the proposed treatment options. Sometimes external barriers impacted the process of providing culturally competent care. I worked hard to manage my professional and ethical concerns about providing care to women of color. My awareness of macro and micro demands allowed my relationship with Katy to continue.

Behaviorally, Katy would keep her appointments with me but find ways to skip appointments with the dietitian. She avoided discussing her pain and deeper feelings and would blame clinicians or her family for her distress. I was unsure how to protect our fragile relationship or her fragile self.

The challenges of working at a university counseling center, utilizing a brief therapy model, are many. There are specific guidelines, for example, for clients with BMIs lower than 18. Sometimes treatment options felt as inflexible as the eating disorder itself. In Katy's case, we had established an early trusting relationship, but when the 'rules' requiring me to refer her to inpatient treatment were imposed on her (and me), I felt stuck. Katy thought that I understood her needs. Clearly, she would have worked harder with me had we been able to talk through her concerns and worries. But the protocol said no; treatment was to be inpatient. This was a moment of feeling stuck, unsure.

Katy and I discussed this and the need to fulfill campus and insurance regulations. Katy was shocked and disappointed, even

though she knew she was a healthcare risk. Still, in her mind, I had not kept my promise. The saving grace for me was that I needed to keep her safe and on a path to recovery. 'Above all, do no harm.'

Ivy is a nineteen year-old, college sophomore and woman of color, determined to make her family proud of her accomplishments at an elite university. However, Ivy's anxiety and stress from her family's excessive expectations drove her to find relief in anorexia nervosa. I soon learned that I was not only her therapist, but also a woman of color who modeled the possibility of professional success. In spite of her attachment to me, it appeared that Ivy could not progress.

Ivy attended meetings with the treatment team, but they did not help. Here, too, I felt stuck. How could I help? The feeling of being stuck pushed me to advocate harder for Ivy, to find additional resources - that led her to seek out a dietitian, physician and therapist in the community. Increased care led to clinical progress and steps to recovery. Feeling stuck was helpful to both Ivy and to me. It prompted me to understand and find the care she needed to get well.

Unquestionably, feeling stuck is part of the patient's recovery process and part of the therapist's process too. I experienced feelings of frustration. I felt my competence was tested. I was continually reminded of the importance of the therapeutic alliance. Ivy flustered me with mixed messages, missed sessions and numerous other stressors. I faced clinical questions and challenges from my colleagues and addressed biases that, in my opinion, had no rightful place in the work we do. While the treatment team frequently provided a collaborative space for me to process my own struggles, I often felt that being stuck was lonely, but necessary, and integral to the work I was doing—and still am. It is important for readers not to overlook that stuck-ness added greatly to my understanding of what patients, such as Katy and Ivy, experienced on the path to health and meaningful living and forced me to examine my own feelings and responses.

Mazella Fuller, Ph.D., is a clinical associate on staff at the Counseling and Psychological Services of Duke University. She is a certified member and approved supervisor (CEDS-S) of the International Association of Eating Disorder Professionals (iaedp™). Dr. Fuller is the Co-Founder of African American Eating Disorders Professionals (iaedp). She is the Co-Editor of Treating Black Women with Eating Disorders: A Clinician Guide and is also the Co-Founder and Principal of the Institute for Antiracism and Equity.

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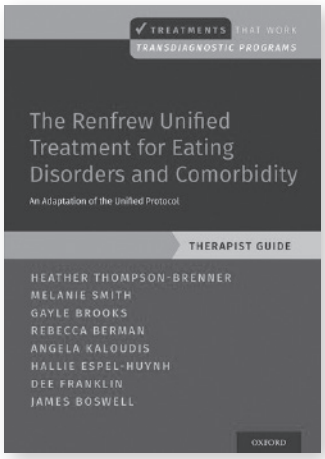

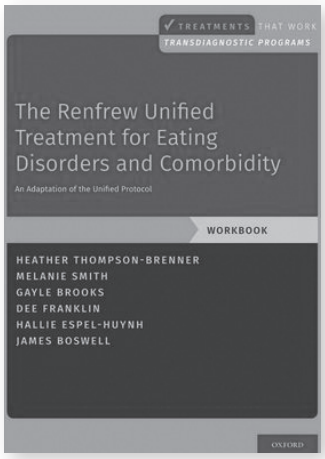

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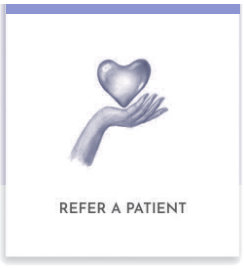

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This exciting update includes a variety of features for professionals including:

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- Virtual tours & videos
- Professional resources
- Interactive quizzes
- Weekly blog posts
- Alumni testimonials
- *Perspectives* (bi-annual journal)
- Live chat
- ***And more!***

Can I Move? Stuck-ness in the Age of COVID.

Karen Samuels, Ph.D., CEDS

As a seasoned psychologist working with eating disorders and body image disturbance, my awareness of our bodies in the room has been critical. Working on tele-health has dramatically altered that felt sense. So without the physicality of our bodies, and with focus on eye contact and sitting calmly with stillness, I find myself searching for creative tools to make connections in the world of tele-health. This has not been without great frustrations and challenges; feeling stuck behind a camera lens robs me and my clients of an embodied connection. We are talking heads, reduced to shoulders, neck and head.

As a Relational/Cultural therapist, the question of stuck-ness speaks directly to the relational flow of moving from connection to disconnection, back towards growth-fostering connection. In therapy and in life, stuck-ness describes the experience of being frozen, unable to move towards, or away from isolation. This year of COVID quarantine meant trading my cozy office for the overnight switch to tele-health in March, 2020. With it came challenges of numerous "stuck" moments, adapting to new ways to understand myself and hold relational rapport with clients through the lens of our screens.

Early in the pandemic, Charlotte, a 32 year old recently divorced woman, asked to "meet in the office face-to face, no one needs to know." Forced to decline a variety of her requests for exceptions took me by surprise, and created a stalemate. Despite my decision and clear explanations, Charlotte continued to push back. Why was it so difficult for her and why did I feel stuck? The world was frozen in this universal shutdown and I felt similarly.

While following rules is my nature, it became clear to me that for Charlotte, and some other clients, the quarantine was optional. If she kept asking, surely I would eventually accommodate her requests. The situation had become a tug of war. Appreciating the loss of 'in-person' meetings made sense to me. Indeed, a cluster of my clients believed, like Charlotte, that demanding my presence would accomplish it. As I wrestled with these demands, I also knew that conceding was never an option. With the help of one of my time-honored practices, I began to understand that a handful of clients would terminate therapy, a reality that I came to accept and that allowed me to exit from the ongoing tug-of-war.

For many years, writing has been my key to work through stuck-ness. Lifelong journaling has been a dedicated practice; there are rows of journals dating back to the mid-1970s, full of youthful misadventures, travels and self-reflection. During these months of pandemic, journaling has been my lifeline to record observations, themes that emerge like waves of ebb and flow. This outlet has been the pressure valve release for my clinical challenges, frustrations, rage at current conditions and love affair with solitude. My journal helped me shift from uncertainty and doubt, to claim my equipoise, slumber and dream of creative strategies to reignite the therapy. On March 27, 2020, my journal entry:

> *"A full week home, never getting in a car, and therapy sessions by video conference. My body hurts with the pain from sitting perfectly still to stay in the center of the screen for my clients. Sitting "frozen" in front of a camera for eight or nine hours a day is EXHAUSTING!"*

Stuck-ness reminds me of the scene in Butch Cassidy and the Sundance Kid when Robert Redford's Sundance is asked if he can shoot. He responds, "Can I move?" If forced to stand perfectly still, Sundance couldn't hit his target across the field. Sitting perfectly still in front of the tiny screen of my tablet feels much the same.

In my office, my chair is on wheels and can change directions, depending on where my clients are sitting. We would exchange eye contact, but often they would gaze at the antique butterfly quilt on the wall behind me, the plants or waterfall. I would focus on them, but also notice their body language, reach for my mug, hand them the box of Kleenex. We certainly were not so intently focused on the facial gaze from the shoulders up! So one of my places of stuck-ness was sorting out how to keep focus on my clients, to keep focus on my clients, to move more naturally and to invite them to do so, as well. "Can I move?" is the metaphor for how working through screens calls upon me every day to find my flow toward healing relationships. A rhythm has emerged gradually as sitting in the front of a screen has become the new normal.

Helen, a client nearing 60, struggles with working from home at a demanding job, and reports her ED recovery slipping. Every Sunday evening, she falls into deep despair at the prospect of signing onto her computer for work the next morning. Her plans

for mindful self-care, meal preparations, and online yoga to close a restful weekend, take a nosedive as she dreads the work week. Helen would send me emails on Sunday repeatedly seeking reassurance that I understood this is her 'trigger time.' Initially, I was unsure of whether to reply to her emails. It was a question of holding a boundary. I felt stuck between wanting to support her and also needing to protect my weekends from being encroached upon. Given the pandemic, I determined a simple acknowledgement of her email would help me help her. It became an accepted routine that feels true; supporting the relational connection.

During this pandemic, I have been grief-stricken for my family, friends and colleagues who were suffering or have died. The fragility of life and mortality has been ever present. When asked by my clients, "Do you know anyone who has died of COVID?", I have often felt stuck. My relational guidepost is, "honesty without empathy (for your listener), can be cruelty." Some clients sensed the gravity in my demeanor. What therapeutic benefit comes from sharing sobering news? What would be lost by not? Could I be authentic and protect them from my own losses? This was imperative, but incredibly challenging. Some days, my heart was especially heavy, full of grief, yet still showing up. As remembered from early training; never self-disclose unless it is in the best interest of my clients. My solace has been found in the compassionate care of my friends who are also therapists. We share this dilemma of grieving personally and supporting our clients through their multi-layered losses. This year has brought universal grief for the connections lost.

So I practice daily reminders to hold respect for my future self. These are teachable moments. I am going to understand and discover things I don't know yet. Moving towards hope, my capacity to lean in and learn from others; these have been the heartbeat of moving through stuck-ness and my own grief.

Anticipatory anxiety, dread and despair have been consuming for most of my clients. Maintaining my own "flow" of radical self-care/empathy was essential for me; therapeutic relationships depend on my equilibrium. Each week, as I review my clients' clinical concerns, I find myself beleaguered with new dilemmas. While this is not unique, the capacity to move back towards connection has become an added test during a pandemic. For example, Charlotte would frequently ignore time warnings to end sessions and would provoke an argument at the close, parting with, "I'm hanging up on you for not being helpful!" When asked why she closed each appointment with such disagreement, she would look at me blankly, but she was spot on; I was not helpful and we both knew it.

Not being in the room with Charlotte posed a challenge and contributed to my feelings of being stuck. How to reconnect tested my skills. I desired to reach through the screen to ascertain what would break through her wall of pain and isolation. Instead, I validated her by saying that it was clear she was disappointed with my responses; clearly we were not connecting. I suggested she might benefit from a referral to another therapist, a talk with her physician about her health, and a possible admission to a higher level of care. She rejected every offering. It was like a weekly train wreck; she would meet and tell me how unhelpful it was to talk to me. We were both stuck.

The ways in which I can be most responsive are often nonverbal: physical posture and quality of presence, leaning in or sitting back, silence, facial expression, synchronized breathing, listening to the trickle of the fountain, and the waves of the sound machine. Mutual empathy is conveyed in the therapeutic alliance; yet the screen hampered my capacity to navigate these murky waters. The connection is that unique place of 'meeting' where my client is seen, heard and supported. My efforts to reach through the screen and 'hold' the connection failed. I felt deskilled and out of ideas. I was shut out, at an impasse to hold a safe place, and understood this was precisely how Charlotte experienced her life and her therapy with me.

How do we determine when tele-health is ineffective or unsuitable? This has been perhaps the biggest contributor to my being stuck. My ethical dilemma and stuck-ness arise from working with clients like Charlotte who need in-person therapy. Is it abandonment to discontinue tele-health, when it's clearly the wrong modality? I lost sleep over this dilemma, sought peer consultation, supervision, and legal guidance. Still my turmoil continued. I humbly submit, not everyone benefits from virtual therapy. My colleagues and consultation group helped me find the wisdom to move forward and refer Charlotte to in-person options.

The frequency of rageful clients blasting me for empathic failures has been unrivaled. My threshold has worn thin. This time is unique: the same global stressors are experienced by therapists and clients. Staying grounded has depended upon my meditation and mindfulness practices. Since I am deeply involved and intertwined with others, my conclusion is: by leaning on one another, we hold ourselves and one another up.

Some days I want to echo my own upset, mired in the muck of uncertainty. Instead, I close the computer, go for a walk and listen to the birds, the breeze through the trees, and breathe deeply.

Karen Samuels, Ph.D., CEDS is a clinical psychologist in Flagler Beach, Florida, and founded COPE: Community Outreach to Prevent Eating Disorders in 2001. Her work is dedicated to assisting forgotten and invisible populations. Utilizing Relational Cultural Theory, she trains family physicians in collaborative care for Eating Disorders, offers middle school Media Literacy outreach programs and specialized Eating Disorders treatment for women at midlife and beyond. Dr. Samuels was awarded the 2014 NEDA Westin Family Award for Activism/Advocacy.

Finding Hope through Stuck-ness

Mary Bellofatto MA, LMHC, CEDS, TEP, ISEPII

I have been a therapist for almost 45 years and am very familiar with the word stuck-ness. The feeling of confusion, and wondering what to do next, or questioning myself with, "Am I doing this correctly?" Even worse, waiting for the Imposter Police to come and arrest me for being an imposter. This article would be several pages longer if I listed all the courses I have taken to stay on the cutting edge of what's new, necessary, and beneficial. No matter how much training, what type of training, how long one has been in the field, or what level of skills, getting stuck in my relationship with clients is part of the journey.

There are many stories I could share, but the one that taught me so much about stuck-ness was a patient who I will call Emily. I was stuck because I was expecting Emily to be like other clients with bulimia and a history of sexual abuse. Treatment protocols were being followed, which included close monitoring, supervised eating, buddy system in place, and daily groups, along with individual sessions. Emily refused to discuss her abuse, was quiet, withdrawn, and only spoke when spoken to. Emily seemed lost in her own world and did not respond to multiple attempts to engage or to connect. This was the Emily I encountered in group one day as I was co-leading with one of my therapists.

I was stuck with Emily; I felt angry, frustrated with all the effort and no results. I had shared my stuck-ness in supervision, only to find that her primary and body image therapist also felt stuck. The feedback I got was to continue to hold space for her and give her time. Frankly, I was tired of holding space, not only for her, but for a number of other struggling clients. In a supervisory role, I was also holding space for 10 therapists, and in that space I think I shut down.

Emily refused to share in group. One day she jumped up and said, "I am going to be sick" and ran in the bathroom. Afterward, sitting on the floor with her, I could feel my anger dissipate as I forgot about what I was feeling; I could feel her anger and emotional pain.

I asked Emily, "If your body could speak, what would it say?" She stated, "It would say my stomach cannot hold all the anger you keep pushing down regarding your abuse from your father." I asked if she was willing to try a different technique to reduce the anger without the shame. The shame came from feeling that if she could purge enough, that the porcelain God would give her enough control to manage each day.

That day, the journey of true connection and trust began for me and for Emily. I realized how important it is to know where I am with the client, and to know what I am telling myself about the client. Feeling Emily's anger helped me to get unstuck, to join her with compassion and connect to her fear and hopelessness. Those were the emotions I was feeling about my ability to help her. At that moment, I felt a glimmer of hope and direction, which was the beginning of her finding her voice. That was the day I joined Emily, allowing her to be where she was, without judgement, and to start connecting to her present warm-up of dealing with her emotions. It was also the gift I got from stuck-ness for myself; stay in the moment, stay in touch with my feelings, and hold space for the client—regardless. Emily gave me the gift of unstuck-ness.

Looking back on this event years later, I realized as I looked through the lens as a psychodramatist that I had joined the client. J.L. Moreno, the father of psychodrama, believed there were no such things as resistance and stuck-ness, but rather a lack of warm-up. I was not warmed up with Emily. I had gotten lost in my agenda, in waiting for her to comply with what I wanted. I had to go where she was and join her comfort level with her dysfunctional warm up. In that moment of sitting on the floor with her, my stuck-ness disappeared. I truly saw Emily, felt her pain and was the support she had longed for. It was the beginning of her allowing me in and the beginning of her healing journey. Seeing the raw emotions, the shame, and encountering her with grace and acceptance, was the invitation to board the lonely island of fear and paralysis she inhabited.

Susan was another client that I experienced stuck-ness with. Susan was a single mother who was struggling with anorexia. Susan was referred to me as a second choice. Her family had arranged an intervention and insisted she go into residential care, which she refused. The goal was to work with Susan in an intensive outpatient setting and then consider the next steps.

I felt a sense of dread, fear, and being overwhelmed with the expectation and control from Susan's family. I also felt a strong sense of urgency with Susan's low weight and the impact she was having on her children. The first few sessions, I felt helpless and not sure how to reach Susan, due to her being emotionally shut

down. I tried to find a way to connect but was emotionally shut out. Susan gave me only minimal information; she was shut down, resistant, and controlling. I felt baffled, frustrated, anxious, and stuck. I also felt anger toward myself for the lack of progress, anger toward the family for the constant pressure, and the need to connect with someone for direction.

I called a body image therapist friend for supervision and her first suggestion was to invite Susan for a walk. A simple but profound suggestion. Yet, in my stuck-ness I had limited my creativity just like our clients do in their need for control. Susan and I begin to have walking therapy and I noticed a small shift in her ability to open up. With movement, she became less stilted and started slowly sharing more of her life with me. I was surprised to find she was angry with me because she did not want therapy and angry with her family for the pressure and control they were putting on her; she felt alone and not sure what to do next. It clicked for me when I realized we were in a parallel process. The client was exactly where I was. Realizing this and remembering that a body in motion knows something different than a body seated, I began to find activities that involve the body like painting, art projects, and role reversals.

In these activities, Susan shared how much she missed her deceased grandmother, who was the only person she felt truly loved and nurtured by. I asked if she had any objects that her grandmother had given her or that were meaningful to her. Her eyes lit up as she talked about a beautiful bowl that had belonged to her Nana. I asked if she would bring it to our next session. The bowl became her grandmother's emotional plea as she role reversed with the bowl. Speaking as her grandmother, she said, "Susan, I see the condition of your body, I know how weak you are in your body and I want you to be able to be a good Mother to your children, and to do that, you need to eat." The bowl became the nurturing bowl from which Susan started to slowly eat. We would share snack time in my office together, and this became a tool to start the refeeding process. Susan was learning how to trust and how to receive help. She also seemed willing to accept residential care as the next necessary step for a full recovery.

How do the above experiences with Emily and Susan speak to me as a clinician regarding stuck-ness? First and foremost, they helped me to know myself. This is important due to the parallel process. Whatever is happening with the client is in some ways happening with me; whatever is happening with me is also happening with my client.

These are some of the questions I had to ask myself: Am I in my body? What am I feeling? What are my expectations? What is my warm-up for the session? I need this important information to learn to bracket issues that come up in session that are about me and discuss in supervision. I also know that it is important that I have done my own emotional work and show up as emotionally healthy as possible. This is essential if I am going to model and keep healthy boundaries. I need to be able to show up in session in the present moment where I am most connected to my body, my emotions and my intuitiveness. This ability allows me to be present in the here and now, where I can double, mirror, role reverse, and tune in to the cues my clients are sending emotionally, physically, and spiritually. This often requires physical movement, where I gain new insight as I connect with my mind and body. I must remind myself how much wisdom and knowledge the body holds and that tuning into my body allows me access to that wisdom.

Mary Bellofatto MA, LMHC, CEDS, TEP, ISEPII
has a private practice in Naples, FL, and specializes in addictions, eating disorders and psychodrama. She is known for experiential workshops and intensives promoting healing from the inside out, with individuals, couples and families. Having over 40 years experience in the field of addictions, eating disorders and relationships, Mary has also worked extensively with première treatment centers in staff trainings, strategic planning and program development. Before moving to Florida, Mary directed a Pastoral Counseling Center in Massachusetts and worked with area-wide Pastors, their churches and leadership.

The 30th Thirtieth Annual Conference

The 2020 Conference Committee thanks all of the speakers, attendees and Renfrew staff who helped make the 30th Annual Conference so special. It was a joy to have colleagues and friends from around the world come together for our first ever virtual program—and this year's attendance of nearly 800 was our largest, with more than half joining us for the first time! While we were not able to connect in person and experience the warmth and camaraderie which this Conference is so well known for, we hope this digital platform made it easier than ever to leave you with new and creative ideas to enhance your practice.

This year's theme, ***Feminist Relations Perspectives and Beyond: Lessons Learned,*** explored what we have been asking ourselves in this unusual time. The unforeseen events of 2020, including a pandemic and widespread social and racial injustice, created a perfect storm for those who suffer from eating disorders, and brought new challenges to the clinicians who care for them. It's clear that we must reflect on how we can take what we've learned from this time of upheaval to better help those who depend on us.

We're grateful for the accomplished and celebrated speakers who pivoted with us to this year's digital platform. An exciting new program format featured three powerful live-streamed keynote presentations, live-streamed networking events and 18 pre-recorded workshops. With access to the Conference Portal open for an entire month, we were very pleased to provide our attendees more time than ever to access educational opportunities from the comfort and convenience of their preferred location!

Bestselling author **Lori Gottlieb, MFT** opened the Conference on Friday morning with an important discussion on breaking through shame to fully access our feelings, and the life-changing benefits of sharing our stories with one another. We know our virtual audience appreciated her perspective of considering therapy—from both sides of the couch.

Later in the afternoon, **Cynthia M. Bulik, Ph.D., FAED** presented a clinically-focused keynote on the current state of knowledge on how genes and the environment act and interact in influencing risk for eating disorders. Attendees were able to take away concrete examples in which genetic discoveries can be used to inform treatment development and incorporate this information into their own clinical practices.

Saturday morning, our live presentations concluded with a keynote by celebrated journalist and champion of diversity, **Soledad O'Brien.** Through the power of story-telling, Soledad shared the lessons which have influenced her commitment to bringing the under-voiced into the national conversation, and empowered our audience to become advocates for justice themselves.

Through the Conference's final day on December 14, attendees had access to 18 on-demand, 1.5 hour workshops led by industry experts on a variety of riveting topics. Trauma, social justice issues, marginalized populations and virtual treatment are just a few of the important subjects attendees were able to learn about in their own time frame.

The committee is already hard at work planning for the Foundation's 31st Annual Conference, 2021 Perspectives On Feminism, Eating Disorders and Beyond, beginning November 12, 2021. We look forward to sharing more information about this special event with you in the coming months.

A sincere thanks to you all, once again, for making the 2020 Conference a great success. We hope to see you next year!

Judi Goldstein

Judi Goldstein, MSS, LSW
Conference Chair

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