The Renfrew Center Foundation
FOR EATING DISORDERS

Perspectives

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Contributors

A Word from Our Editor

The theme we've selected for this current issue focuses on a particularly intriguing topic: **'The Clinician's Process: Working with Clients who Induce Strong Feelings.'** As the title indicates, our contributors were asked to explore an important aspect of the therapeutic process, namely, how they experience and continue to work with clients who trigger strong feelings. By strong feelings and emotions, we include a full range of feelings, from positive to negative and all that fall in between. Accordingly, we provided several framing questions to indicate the range of personal reflections we hoped would be addressed:

- What types of strong feelings have your clients triggered in you?
- Are there specific issues or experiences that induce strong feelings more than others?
- How do you proceed when you realize you are experiencing strong feelings? What specific steps do you take in response to your strong feelings?
- How do your strong feelings impact the therapeutic relationship?
- Do you consider having such strong feelings as useful, helpful, inconvenient, intrusive?

Three seasoned clinicians accepted our invitation to grapple with this theme and have contributed thought provoking and illuminating essays. **Dr. Emmett R. Bishop** provides a compelling piece entitled "Imperturbability and Equanimity with Our Clients, NOT!" In it, he describes how he "stumbled at times because I was not tracking the influence of my own emotions on the clinical decisions being made. One prominent example of this was my treatment of Larry, a patient with bulimia and HIV. In sessions, he reported, with a cavalier manner, his sexual relations with multiple persons at public spas. At this revelation, I experienced strong feelings of disgust and anger that I suppressed at his callous disregard, engaging in sexually promiscuous behavior that could give HIV to others. He ignored my admonishment of his jeopardizing the health of unsuspecting partners, perhaps trying, in his own way, to preserve his relationship with me. That denial served both of our emotional needs. He didn't have to recognize his therapist's rejection and I avoided admitting that I wasn't helping him."

Dr. Karen Erlichman's essay is entitled **'Mother Loss, Grief and Mutual Healing between Therapist and Client.'** In it she provides a poignant description of how her mother's death impacted her work with clients: "While my mother was dying, I was flying back-and-forth from coast to coast during a very short period of time. This had an impact on my work schedule, and understandably, induced many feelings in my clients and in me." When one of her clients also lost a parent, "I was acutely aware of feeling empathy as well as sorrow, deeply resonating with Riley's caregiver burnout and the vulnerability and isolation that comes with loss. These emotions were also compounded by the effects of being a professional caregiver during the global COVID pandemic and the larger context of collective loss. Recognizing the potency of my feelings, I consulted with a colleague to ensure that I was not over-identifying in a manner that could potentially harm the client or the therapeutic relationship."

Dr. Judy Rabinor begins her essay, **'The Unexpected Gift of My Freudian Slip'** with a vivid description:

"Elegantly dressed in a long black wool coat with a lush fur collar, Ella swept into my office that windy November morning, 'I've come to a decision,' she said. 'I'm leaving Al when Jeremy goes to college next September. I'm getting divorced.'

'Ella, we have a lot of work to do this year before you make the biggest mistake of your life.'

Ella gasped. So did I. I'd meant to say, 'We have a lot of work to do before you make the biggest *decision* of your life.' Instead I'd said she'd be making a *mistake*.

It took me a moment to realize what had happened. Trying to recover my balance, I remained silent. Beads of sweat broke out on my forehead, announcing my shame. I was sure my face was beet red. How could I have made such a blunder? And what to do now?"

We hope these essays are meaningful as you experience strong feelings sparked by your clients.

In addition to my enthusiasm regarding the thoughtful essays above, I am very excited to announce that, with this issue, *Perspectives* is launching a wonderful addition to offer our readers, namely, an essay translated into Spanish. Our decision to add this feature is consistent with Renfrew's longstanding commitment to expanding education to a more inclusive community of eating disorder professionals. Toward that end, an outstanding translation by Maricarmen Diaz provides Spanish speaking clinicians with enhanced access to a recent and riveting case study by Dr. Roy Erlichman (Summer, 2021). The essay, focused on clinician stuck-ness, not only describes the ups and downs of a long and often frustrating journey with his client, Sarah, but also contains many invaluable insights for clinicians who may find themselves stuck while trying to help their clients.

With warmest wishes,

Marjorie C. Feinson, Ph.D.

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FOR EATING DISORDERS

Imperturbability and Equanimity with Our Clients, NOT!

Emmett R. Bishop MD, FAED, F.iaedp, CEDS

I recall hearing more than once during my medical school days, echoes of Sir William Osler, the father of modern medicine, counseling the traits of imperturbability and equanimity for the successful physician. I thought that good advice in those days, but my many years of experience in treating eating disordered patients has taught me otherwise. Working with these clients was not part of my professional training but that work certainly trained me to be a better physician and therapist. To paraphrase another quote of Sir William, those who know eating disorders, know psychopathology and its many manifestations. Each client presents the therapist with a different constellation of traits and symptoms which evokes a corresponding set of responses in the professional who treats them. You may not think of them as gifts at the time they occur, but they have the power to transform your work in significant ways. I would like to describe a couple of those emotionally difficult, but transforming moments in my professional life.

It is not possible to work with eating disordered patients without encountering, at some point in your career, the total array of strong emotions, both positive and negative. Both types of emotions can cause you to stumble at times. I am thinking about the client who makes you feel good with their sexual seductiveness or the one who elicits feelings of disgust or horror with immoral or unethical behavior. If you don't understand the relationship you have with your own emotions, it will be difficult to navigate these sometimes-turbulent waters of the therapeutic relationship. I have certainly stumbled at times because I was not tracking the influence of my own emotions on the clinical decisions being made.

One prominent example of this was my treatment of Larry, a patient with bulimia and HIV. In sessions, he reported with a cavalier manner, his sexual relations with multiple persons at public spas. At this revelation, I experienced strong feelings of disgust and anger, that I suppressed, at his callous disregard, engaging in sexually promiscuous behavior that could give others HIV. He ignored my admonishment of his jeopardizing the health of unsuspecting partners, perhaps trying, in his own way, to preserve his relationship with me. That denial served both of our emotional needs. He didn't have to recognize his therapist's rejection and I avoided admitting that I wasn't helping him. Although I felt a therapeutic imperative to work with a challenging patient (my trademark), in retrospect, I sabotaged the therapy by unconsciously communicating strongly negative emotions through irritability and coldness that we both avoided putting on the table. I said non-verbally what I should have put into words for us to process.

Larry's desperate need to connect with others probably maintained his abhorrent behavior, from my perspective, and, also, his involvement with me in therapy. Eventually, however, he abandoned treatment like many patients with bulimic traits who need more immediate rewards and positive feedback. The avoidance motivation of my emotions had accomplished their goal. It was not easy to admit that I had failed to help him and to accept that possibly some other therapist could have done a better job. What I learned from this, was that I was not the imperturbable therapist my medical school image demanded and that my own aversive reactivity deprived both my patient and me of the opportunity to practice the important skill of relationship repair. As the therapist, it was incumbent upon me to track the influence of my feelings and to contain them with awareness of how they motivated my behavior, not often an easy task when emotions are intense. Emotions frequently have action tendencies which take you in the opposite direction of where the therapy is headed or should be going.

I have had to ask myself, "What do I believe about my emotions?" From my training I know that emotions are not going to kill me, at least in the short term. However, emotions are not logical, they are associational. You hear expressions all the time like, "he died of a broken heart" or "the profligate behavior of her son killed her." I don't think that I am immune to such influences, but over the years I have come to an awareness and to accept them as part of my many facets. The acceptance of the emotional hand I was dealt has had the unintended result of attenuating both those feelings as well as the power of their action tendencies to direct my behavior. The point is that everyone has beliefs about

how their emotions function and the need to know whether these mental experiences are pushing them toward or away from their therapeutic objectives.

Another therapeutic gift came from a challenging client with bulimia and borderline personality. She made it impossible for me to maintain my façade of imperturbability. She had the intense need for me to feel and reflect her pain. Her life had been a series of unsuccessful relationships and sexual trauma. It was her great intellect that made me want to "save" her for the good things she seemed capable of doing. However, despite my efforts to maintain my equanimity, she induced intense emotional responses in me during therapy sessions and in distress calls after hours. She would accuse me of not understanding the pain she was experiencing, of not taking away the rage she felt toward her mother and the men who had used and abused her. She would scream at me on the phone or in the office to the point that the staff waited outside the door awaiting the moment they needed to barge in to rescue me. I questioned myself about whether I could endure the terrible mélange of feelings that welled up in me during those times. It was necessary to resist the urge to shut her up with some lightening-force statement aimed at inhibiting her outcry with even more painful emotions. Fortunately, my therapeutic side prevailed, and I listened, expressed my feelings, and reflected back my understanding as I was supposed to do. Ultimately, this strategy led to a repetitive process of relational repair that served us well over numerous ruptures occurring over the course of her therapy. Over several years of treatment, both of us developed the reassuring belief that we could overcome any ensuing fracture in our therapeutic work.

The theme of this issue of *Perspectives* brings into focus that it is not only the psychological processes of the persons who seek treatment, but also those of the clinician that should come into play. Process-based psychotherapy means that we must consider how multiple mental processes are operative in the consultation room. I have tried to convey how one of those processes, experiential avoidance, functioned to sabotage the therapy from both sides. In the first case, my need to avoid my internal conflict exceeded the pull of the therapeutic imperative and the therapy failed. At the time, I felt relieved but so unaware of my role as to not feel any guilt. That came later. In the second case, the therapeutic imperative prevailed and I was able to contain the intense emotions and engage in some work that enhanced, in both of us, our skills of relational repair. For which I am extremely grateful. It served me well as I went on to treat some of the most difficult and challenging sufferers of eating disorders a clinician can face, and I must say without imperturbability or equanimity. There is hope for all of us.

Emmett Bishop, Jr., MD, FAED, F.iaedp, CEDS is a Founding Partner of the Eating Recovery Center in Denver, Colorado. He has written numerous articles, book chapters and a treatment monograph and has lectured nationally and internationally on eating disorders and their treatment. He received the iaedp CEDS Lifetime Achievement Award in 2014 and was also honored by the Eating Disorders Foundation for lifetime achievement in 2020.

Mother Loss, Grief and Mutual Healing between Therapist and Client

By Karen Erlichman, DMin, LCSW

I have worked with many clients who have experienced death, loss and grief, including the death of a parent. I usually feel able to create a trustworthy container in which people attend to their own grief, however complicated, and integrate the experience despite mainstream culture's truncating and pathologizing of authentic expressions of mourning.

The experience of my own mother's dying had a powerful impact on my life, including my work with clients. While my mother was dying, I was flying back-and-forth from coast to coast during a very short period of time. This had an impact on my work schedule, and understandably, induced many feelings in my clients and in me.

I remember one morning, standing in the kitchen talking on the phone with a long term client, "Leah," reassuring her that I would still be available to meet with her virtually or by phone during my geographic absence. She said to me unequivocally, "I want to say to *you* what you have said to *me* for so many years: it's important for you to take care of yourself too. I can take care of myself while you are gone. Please take care of you."

Leah and I were having a human-to-human conversation as well as client-to-therapist. I had an opportunity to support her in integrating what she and I have been working on for so many years. In addition, I was also hearing my own words, beliefs and values reflected back to me: the freedom to care for oneself and to attend to one's own needs and feelings with as much compassion as possible.

I had been in communication with my clients during those difficult weeks, often having to cancel and reschedule appointments depending on the trajectory of my mother's decline. It was emotionally complicated, and I felt deeply committed to maintaining ethical boundaries with clients, particularly during perhaps the most difficult emotional experience of my adult life.

A few days after my mother died, I reviewed my calendar and selected a date to return to work that felt respectful to my clients (who had been so patient and flexible), while at the same time honoring my own capacity to manage acute grief.

I vividly remember my proposed date of return to work: January 9. I sent an email to each of my clients informing them that I would be returning to work on January 9 and confirming our regular standing appointment days and times. This was further complicated by the fact that I had lost my office while my mother was dying because the building was sold. A colleague very kindly offered the use of his office several days a week until I could secure a new permanent office. This was another loss for me as well as for my clients, who now had to adjust to a new location as well.

Within a day or two after sending that email, two of my clients replied with almost identical language, "I know it is not my job to take care of you. However, when my own mother died I did not take enough time off work to fully deal with my grief, and I can never go back and redo that. You are not taking enough time off. I hope you will consider extending your time a little bit to take care of yourself." Once again, this shined a floodlight on the intersubjective field, and the genuine human encounter between daughters whose mothers had died.

I contemplated those emails for several hours. While it is true that I would never want a client to feel responsible for taking care of me, especially those who had been profoundly parentified as children, I also know that there is genuine mutual caring between therapist and client, and that this was an important moment for me to consider their needs, *my* needs, and the appropriate ethical thing to do. I did, in fact, extend my bereavement leave for an additional week. When I returned to work, I thanked each of those clients for their kindness and invited any exploration or conversation needed. The gift of their kindness will always be with me.

What were the feelings induced in me? Grief, sadness, vulnerability, guilt, fear of overburdening clients who were actually in treatment to receive care, curiosity about what healing might be possible for them and for me. People come to therapy to be cared for, and in many cases, to repair attachment traumas from childhood in which their caregivers did not or were unable to care for them, whether due to addiction, mental illness, trauma, poverty or other reasons. It felt important for me to affirm and model healthy boundaries with my clients and to attend to my own induced feelings in other ways (consultation with peers and

mentors, self-reflection, journaling, meditation, to name a few examples). By caring for myself, I was also prioritizing those ethical boundaries and caring for them.

For several years, I had been serving as a mentor and consultant for an organization called The Dinner Party that serves young adults who have experienced significant grief and loss. Several of my clients had actually contacted me for therapy because of my involvement with TDP. Two of those young women, who were coincidentally friends, sent me a flower arrangement with a note of sympathy.

My first emotional reaction was that I was incredibly touched by their kindness and caring. In therapy we simultaneously maintain and transcend our roles as client and therapist. While I was prepared to invite a conversation about the gift, I also knew that they had wisdom to share.

What was it like for me to remain present and attentive to my multifaceted emotional response? What would be the "best" way to respond to the gift? Mindful of the legal prohibition against accepting gifts from clients, I allowed myself to enjoy the beauty of the flowers themselves and the kindhearted, authentic expression of compassion from my clients before I gave the flowers away to a neighbor. Somehow, gifting the flowers to my neighbor satisfied my need to "follow the rules" and not accept a gift if it would compromise the ethical integrity of the therapeutic relationship. It also made it possible for me to receive, rather than reject, the expression of their compassion which allowed them to experience some attachment repair.

Some of the feelings that arose in me during this time were sorrow, love, guilt, anxiety, determination, willingness, compassion, faithfulness.

Now, years later, a client named "Riley" has just accompanied their mother across the threshold of death and described feeling quite unmoored by this loss. They were also a professional and personal caregiver in several aspects of their life and were truly struggling with a particular codependent loneliness. Riley was discerning how much time to take off from work, and how to reconnect with family and friends while still feeling bereft and a bit adrift.

I was acutely aware of feeling empathy as well as sorrow, deeply resonating with Riley's caregiver burnout and the vulnerability and isolation that comes with loss. These emotions were also compounded by the effects of being a professional caregiver during the global COVID pandemic and the larger context of collective loss.

Recognizing the potency of my feelings, I consulted with a colleague to ensure that I was not overidentifying in a manner that could potentially harm the client or the therapeutic relationship. My colleague invited me to attend to my emotional response in a quiet, slow, patient way. She also matched that tone and intention, and offered a generous, spacious block of time to support me in internal reflection. She did not give unsolicited advice nor attempt to "fix" the situation. This allowed a deeper layer of my own grief to emerge, which also fostered greater clarity about my work with Riley.

I asked Riley if I might briefly share some of my own personal experience. Because we had been working together for many years, there was a strong foundation of mutual trust and respect. I also invited Riley to let me know if at any point in the conversation my personal sharing were to become disquieting to them.

"That would be so helpful," Riley responded.

I took an audible breath and shared an abbreviated version of extending my bereavement leave, underscoring the genuine human experience of losing a parent: "Every person needs the freedom to choose the parameters and process of their own grieving as best they can. So it's important that you choose what is right for you."

We sat together several minutes in silence, as we have so often done. Not scary, awkward silence, but one that allows the person to listen inside themselves to hear and sense one's own voice of truth.

My spirituality is also a resource for insight and clarity about feelings that arise in my work with clients. I feel held by a greater Source as I am working with others. There may be feelings and conditions without clear resolution in my own mind, but there is a divine flow that carries everything. Mindfulness is at the heart of my clinical work, and I have a fierce commitment to attend to my own feelings and reactions so that they facilitate *rather than contaminate* the client's own experience.

Karen Lee Erlichman, D.Min, LCSW provides psychotherapy, spiritual direction, So(U)L coaching and mentoring in San Francisco, employing a mind-body-spirit approach to wellness. She is a longtime community faculty member at the University of California-San Francisco in the Department of OB/GYN and Reproductive Sciences. Karen has served on the Professional Advisory Group for the Spiritual Care Services Department at UCSF Medical Center for the past seven years.

The Unexpected Gift of My Freudian Slip

Judith Ruskay Rabinor Ph.D.

Elegantly dressed in a long black wool coat with a lush fur collar, Ella swept into my office that windy November morning, "I've come to a decision," she said. "I'm leaving Al when Jeremy goes to college next September. I'm getting divorced."

Ella had married at 18, had never worked outside the home, and was a devoutly religious woman in a community that frowned upon divorce.

"Ella, we have a lot of work to do this year before you make the biggest mistake of your life."

Ella gasped. So did I.

I'd meant to say, "We have a lot of work to do before you make the biggest *decision* of your life." Instead I'd said she'd made a "*mistake*."

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It took me a moment to realize what had happened. Trying to recover my balance, I remained silent. Beads of sweat broke out on my forehead, announcing my shame. I was sure my face was beet red. How could I have made such a blunder? And what to do now?

Ella jumped in. "You think divorcing Al is making the biggest mistake of my life?"

I felt my face burning. "I'm not sure what I think," I said sheepishly. "But I have to admit it's what I said."

"Maybe you just made a Freudian slip?" Ella said.

"Maybe," I replied, stalling for time. My head began to pound. "Let me tell you what happened this weekend," Ella said. She began cataloguing Al's faults— chronic lateness, an insulting, authoritarian manner. A red flag went up in my mind.

"I need to interrupt you," I said, not wanting to derail our conversation. What had happened between us - my Freudian slip—was primary.

Freudian slips are important. They often reveal unconscious thoughts and feelings too dangerous to articulate. What was the meaning of my slip? Could my slip be about me—after all, I'd divorced a decade earlier, and although, I didn't think my divorce was a mistake, I had to face the fact that my slip meant something—either about me or Ella. Secretly I'd been rooting that Ella and Al could work out their relationship—was my bias at the root of my slip? I was under the microscope, wishing I could escape. But escape was not an option. Acknowledging and exploring what had happened between us was now my responsibility.

"You are correct—I made a slip and it's important we think about it," I said, intentionally stressing the "we."

"Big deal", Ella said, shrugging off my comment. "To me, you made an innocent mistake. One thing—I don't want to forget to tell you: last night I binged over left over cold spareribs and I wasn't even hungry. And I don't even like spareribs."

The cold spare-ribs binge signaled trouble. As I sat in the silence, I was flooded with thoughts. Could her decision to divorce have triggered this binge? And what about my Freudian slip?

Suddenly a painful memory from a decade earlier emerged...

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Recently separated from my husband of fifteen years, I was driving my children to Boston for Thanksgiving. A light snow was falling steadily. The icy road terrified me. At that moment, it dawned on me that being married had sheltered me from all kinds of anxieties, snowy roads the least of them.

As I was navigating the highway, my thirteen-year- old son piped up from the backseat. "Mom, why do we have to go to Boston?"

"Yeah, Ma, why?" my nine-year-old daughter chimed in.

"We're going to be with our family," I answered trying to be cheerful. "Family," Zach echoed. "Ma, where's dad going to be tonight?"

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Sitting with Ella, I cringed. A heaviness set in as I recognized how my divorce had been far more painful than I'd ever anticipated. At 39, I had no way of appreciating the complex and long reaching ramifications of getting divorced: how unsettling a divorce is to young children; how complicated it is to negotiate the details of joint custody; the loneliness of holidays when my children were with my ex; the pain of recognizing how I had relied on my ex for so many aspects of daily life. Certainly, my Freudian slip "warning" came from my own experience but, was my experience relevant to Ella's decision or had my own painful feelings simply leaked out?

As I sat in the quiet, uncertain where to go, what to say, I took a deep breath and within a moment, I heard a little voice within. It was the voice I used with my own patients, reminding them, and now me, to inhale and exhale, deeply and fully, to breath in

and out. The words, "nothing to do, nowhere to go" echoed. Suddenly I felt lighter. Maybe I could help Ella be more curious.

"Are you willing to do an experiment?" I asked. In response to her affirmative nod, I lowered my voice, slowed down my pace, and asked her to take a couple of slow deep breaths with me. When I sensed we were in sync, I led her through a guided imagery:

"Let's imagine time has passed. Now, your divorce in finalized. Imagine it's Thanksgiving. All of your children have come back home. Are they with you or Al? Who is carving the turkey?" I paused. "And next, comes Christmas. Now it's time to trim the tree. Where are your kids on Christmas morning?"

Ella's face dropped. "I never thought about this," she said, and we spent the rest of the session talking about the complex realities of divorce.

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After our session, I felt unsettled. Although my intervention seemed to have saved the day, I couldn't stop feeling awash in confusion and shame about my slip. Fortunately for me, my monthly dinner with my 'support sisters' was scheduled for the next night. I'd been meeting regularly with four therapists I'd trained with; now we were in a monthly support group. I texted in advance: *So glad we are meeting and I need time —it's urgent.* In the comfort of my collegial peers, my understanding of my Freudian slip deepened as my story poured out. Their questions opened up new windows on my divorce experience.

My mother's response when I'd announced my divorce became our focus.

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It was a cold evening night when we sat in her living room: I'd come over to tell her my marriage was over. The expression on her face and her words were memorable.

"Judy dear," she said. "Marriage is hard and men are difficult, but I want to tell you something: there's not a thing wrong with your husband. He not only supports you and the children but he loves them dearly!" she added. "Leaving him will be difficult. Your son is a teenager and boys need their fathers. And how do you know you will ever meet anyone better, anyway?"

The insights from my support sisters were invaluable:

"It sounds like you mothered Ella the way you were mothered. Although you were mad at your mother then, it sounds like you now understand that she spoke from a caring and worried place."

"Perhaps you were the worried mother Ella needed."

"Isn't mothering our patients OK? Aren't we always reparenting?"

"I know how activated I get when my own issues are triggered. You are reminding me of a slip I once made!"

"Perhaps you gave Ella a gift in the only way you knew how to at that moment."

Grounded in empathy and self-compassion, I left our meeting with new tools, personal as well as professional. How fortunate for me to have this support to help me cope with my shame.

According to shame researcher expert, Brene Brown, shame is the feeling that washes over us, making us feel small, flawed, and never good enough. When patients speak of shame, I often quote Brene's words from her TED Talk about the helping benefits of disclosing shameful feelings and experiences.

"If you put shame in a petri dish, it needs three ingredients to grow exponentially: secrecy, silence, and judgment. If you put the same amount of shame in the petri dish and douse it with empathy, it can't survive." (Brown,Ted Talk 2010).

In retrospect, while I had routinely encouraged clients to share their shame with others, I realize that I feared exposing my own professional glitch. In more recent times, I have pondered how therapists often hide their uncertainty, insecurity and their own sense of imperfection and/or frailty behind the curtain of therapeutic anonymity. Why? Fear of tarnishing one's reputation? Not living up to impossible standards? How odd, since there is probably not a therapist reading this who has forgotten or mixed up a significant event in a client's life or double booked a therapy session. Is there some way that laboring beneath a standard of perfectionism induces guilt if not shame in so many of us therapists?

While the relationship between a therapist and a client is unique and unlike any other relationship... it is also like every other relationship – imperfect, inexact and subject to glitches, imperfection, blunders and improvements. Therapy is not scripted and while we are hopefully grounded in theory, we act spontaneously all day long, session after session. Exploring my Freudian slip did not end with my peer consultation group, but led to a deeper level of reflection. Eventually, I found solace in writing about it and ultimately it inspired me to write a book about co-parenting after divorce. What we need to remember is that therapeutic mistakes are inevitable, normal and, in fact, can be opportunities for personal and professional growth. It is only when they remain hidden that they linger, fester and can create long lasting damage.

Judith Ruskay Rabinor, Ph.D. is a clinician, workshop leader, speaker, consultant to the Renfrew Center Foundation and author of three books: *A Starving Madness: Tales of Hunger, Hope and Healing in Psychotherapy* (2002); *Befriending Your Ex After Divorce: Making Life Better for You, Your Kids and Yes, Your Ex* (2012); and *The Girl in the Red Boots: Making Peace with My Mother* (She Writes Press, 2021) from which this essay is excerpted.

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Sobre el no saber

S. Roy Erlichman, Ph.D., CAP, CEDS-S, F.iaedp. *Translation by* ***Maricarmen Diaz***

Estar estancado es no saber. Puede ser sinónimo de no entender o quizás una defensa contra sentimientos como la impotencia, el fracaso, la confusión o la incapacidad. Puede ser momentáneo o duradero. Según mi experiencia, sentirse estancado está implícito en el proceso de tratamiento de problemas emocionales complejos y es importante para ayudar a los clínicos a comprender mejor a nuestros pacientes y a nosotros mismos.

De hecho, sentirse estancado es solo una de las varias respuestas de contratransferencia que surgen en la práctica de la psicoterapia. Para mí, sentirme estancado es muy diferente a estar estancado, es inevitable y confirma las limitaciones realistas sobre lo que puedo saber o lograr en mi trabajo. Esto puede dejarme con pensamientos y sentimientos que pueden diferir drásticamente de lo que un paciente espera, fantasea o exige de mí o de lo que yo espero de mí mismo. En el tratamiento de los trastornos alimentarios, hay muy poco que restablezca la salud con rapidez y poco que alivie o resuelva sistemáticamente los momentos de estancamiento, tanto para el paciente como para el clínico. La recuperación exige tiempo; y, por otra parte, ¿tenemos ya una definición clara y universal de la recuperación o la curación?

Y ahí está Sarah.

A sus cuarenta y tantos años, Sarah se presentó con una historia fascinante. Bien educada, había servido en el gobierno de Estados Unidos durante años y estaba casada con un hombre exitoso. No tenía hermanos. Ambos padres habían fallecido. Cuando le pregunté en qué podía ayudarle, Sarah me dijo claramente que quería librarse de su ansiedad, de su depresión intratable y de lo que ella denominaba "pensamientos inusuales" que se inmiscuían en su vida. Yo no sabía cuáles eran, ni en las primeras sesiones, pregunté. Hacerlo entonces lo sentí prematuro. Podría esperar.

En los primeros meses de nuestro trabajo, Sarah se mostró colaborativa. Acudía a sus sesiones con puntualidad, hablaba con franqueza y pagaba sus facturas con regularidad. Un día, por razones que no entendía, sentí una sensación de incomodidad y decidí explorar con Sarah, cómo iban nuestras sesiones. En realidad, le pregunté: "¿Cómo lo estoy haciendo?". No le dirigí mi pregunta como una orden o una crítica personal, sino que la invité a hablar de mí y de cómo lo estaba haciendo como su terapeuta. En otras palabras, si lo quería, podría hablar de manera crítica o positiva sin recriminaciones. Esa era mi esperanza. Sarah decía que nuestro trabajo iba bien, pero los sentimientos positivos que verbalizaba no coincidían con los que yo experimentaba. Decirme que todo iba bien simplemente no era el caso. Algo iba mal, pero no sabía qué. Cuando los sentimientos y los pensamientos no coinciden, me gusta preguntarme por qué.

Desde mi experiencia, me pregunto cuándo los pacientes son demasiado amables, demasiado efusivos al elogiar el trabajo del terapeuta, o demasiado críticos. ¿Estamos escuchando lo que es verdad o lo que es autoprotector y, por tanto, seguro? ¿El paciente teme represalias, rechazo o abandono? Del mismo modo, me cuestiono cuando los pacientes desplazan la rabia hacia mí inmerecidamente por comportamientos, pensamientos o comentarios que yo no tuve ni realicé, pero el paciente me los atribuye de cualquier manera. ¿Y si creo que estoy siendo útil, pero en la mente del paciente puedo ser de poco valor? ¿Cómo responder? La experiencia y la teoría me han enseñado que lo más prudente es aceptar y decir poco o nada.

A veces surgían estas preguntas cuando Sarah pedía ejercicios o técnicas que le ayudaran a aliviar los factores de estrés que sentía. Si estaba siendo tan útil como ella decía, me preguntaba por qué la necesidad de más herramientas y técnicas. ¿Qué era lo que me faltaba? ¿En qué estaba fallando? Al principio, estas peticiones parecían razonables. Técnicamente, lo eran. Hablamos de ejercicios de respiración y descanso, de yoga, meditación, de libros para leer, de visualización... pero fue en vano. Nada ayudaba.

Lo que sí quedó claro es que Sarah no tenía ningún interés en los ejercicios o las técnicas, sino todo lo contrario. Más tarde me di cuenta de que Sarah estaba decidida a obligarme a comprender y sentir la intensidad del dolor emocional que experimentaba todos los días, y para el que no tenía palabras, porque no las había. Eran recuerdos preverbales. Con el paso del tiempo, utilizaba los colores para describir las experiencias de su infancia: por ejemplo, que el dolor de su ansiedad era de un rojo intenso o que su depresión era de un gris frío. Ella exigía que yo sintiera esos sentimientos y que de alguna manera la salvara de ellos.

Nunca dijo esto porque no tenía palabras. Simplemente intuí su mensaje.

A través de muchas sesiones, sentí que me había convertido en una amalgama de la madre y del padre, quienes se supone "simplemente saben" lo que su hijo/hija necesita. Mágicamente, estos padres encienden la luz cuando está oscuro, cambian los pañales cuando están mojados y alimentan y aman a su hijo/hija con naturalidad y facilidad. Si bien el bebé aún no tiene un

lenguaje verbal, sí conoce los sonidos y sentimientos de tal amor y, con el tiempo, crece para aceptarlo con confianza y seguridad. Sarah nunca conoció esta experiencia.

Durante mucho tiempo, seguí sin saber qué decirle a Sarah. Está claro que mi presencia era más importante que mis palabras y, como Sarah, yo tampoco las tenía. Mientras le pedía a Sarah que cruzara su propio "puente sobre aguas turbulentas" y pusiera en lenguaje sus pensamientos y sentimientos, yo tenía que hacer lo mismo. Lo que sabía era lo que sentía: un estado vacío, triste y crudo que a menudo me dejaba frustrado e inseguro y, con frecuencia, avergonzado y apenado. Se suponía que yo debía ser un agente de esperanza en la vida de Sarah, pero, en realidad, me sentía un fracaso. Sin embargo, persistimos.

Y luego llegó ese momento especial, la epifanía en la que los elementos de nuestro trabajo poco a poco se fueron uniendo. Lo que parecía haber ocurrido es que mi mundo interior había evolucionado hasta convertirse en un espejo narcisista del de Sarah. La inseguridad que sentía como terapeuta reflejaba la inseguridad que ella sentía como niña y como paciente. La rabia que desplazó hacia mí fue la misma que sus padres desplazaron hacia ella. Sentirme como un fracaso como terapeuta fue la sensación que ella sintió cuando era niña. Culparme por fallar en nuestro trabajo era la culpa que ella experimentaba por no satisfacer las interminables demandas de logros de sus padres, demasiado elevadas para los más dotados. Lo que se le impuso a ella se me impuso a mí. No había amor en sus mensajes y Sarah lo sentía. Tampoco recibiría amor ni aprecio. Yo también sufriría hasta que lo entendiera.

Pasaron más meses. Sarah se quejaba persistentemente de mi falta de comprensión y de lo que ella llamaba "mi falta de compasión adecuada". "Igual que mis padres", dijo. En repetidas ocasiones, me recordaba que yo era un fracaso como terapeuta y se preguntaba por qué venía a verme. Pero interesantemente -y cada vez sentía más curiosidad al respecto-, por mucho que se quejara, seguía viniendo a nuestras sesiones e invariablemente a tiempo. Pagaba sus sesiones como acordamos y manejaba responsablemente los detalles de los cambios de sus citas. Solicitaba periódicamente más sesiones, no menos. Esto parecía contradictorio. Si me detestaba y criticaba tanto, ¿por qué continuar el tratamiento? Seguramente podría encontrar otro terapeuta más eficaz que yo. En realidad, esperaba que lo hiciera. Estaba cansado.

A medida que Sarah hablaba más abiertamente, estudiamos juntos cómo me había vuelto tan decepcionante, y qué había hecho para justificar su ira. ¿Alguien la había escuchado, aceptado sus oscuros sentimientos y sus "pensamientos inusuales"? ¿Existe una forma segura de hablar de la relación real que tenía con sus padres y con otras personas cuyas vidas influyeron en la suya? ¿Eran sus padres las buenas personas que describía o eran tan distantes, punitivos y tóxicos como me parecían? Seguí haciendo preguntas, estudiando las respuestas con ella y, lo mejor que pude, no emití juicios ni interpretaciones. Parecía que era mejor que ella llegara a sus propias conclusiones de forma independiente, sin críticas, presiones u opiniones de mi parte.

La voz de Sarah se hizo más clara, más fuerte y valiente. En una tierna conversación, confirmó con lágrimas en los ojos que, efectivamente, era una niña maltratada a la que nunca se le había permitido sentir o hablar. A medida que se sentía cada vez más segura desplazando los sentimientos de odio hacia mí, como un sustituto en la transferencia de sus padres, hablaba más libremente sobre sus recuerdos, sentimientos, percepciones y sueños. A veces, este proceso parecía interminable y, sin embargo, era cada vez más informativo y liberador para ambos. A medida que la rabia disminuía, surgía gradualmente un yo más brillante. A través de muchas sesiones agonizantes, lo que se hizo evidente fue que Sarah había crecido con padres diametralmente diferentes a los que había descrito al principio. Casi habían destruido su mente y su alma.

De pequeña, Sara aprendió que su obligación era cumplir las órdenes de sus padres sin cuestionar. Hacer lo contrario era manifestar una deslealtad por la que sería castigada. Estar en silencio era seguridad y lealtad, la buena niña. Más adelante en el tratamiento, cuando hablar ya no la aterrorizaba, necesitaba confirmar con certeza -saber- que yo toleraría sus sentimientos y comportamientos rabiosos. Si podía hacer eso y no ser punitivo, eso le confirmaría que podría creer y confiar en mí. Sus percepciones, recuerdos y sentimientos debían ser valorados, no despreciados.

No hacer nada o poco, esperar a que Sarah me guiara -en su propio idioma y a su propio ritmo- era hacer más. Más lento fue de hecho más rápido.

Sarah y yo trabajamos juntos durante varios años. Sentirme estancado, inseguro y sin saber qué hacer marcó el curso de nuestra relación. Curiosamente, no recuerdo haberme sentido nunca desesperanzado. Con frecuencia me he preguntado por qué. En retrospectiva, me parece que la determinación de Sarah de tener la vida que legítimamente merecía me dio esperanza y valor.

Sarah prosperó en nuestro trabajo, aunque yo me preguntaba con frecuencia si podría hacerlo. A medida que avanzaba el tratamiento, manifestó mejoras significativas en sus relaciones con los demás. Su carrera floreció. Ya no hablaba de su depresión, ansiedad o pensamientos inusuales. Su matrimonio se convirtió en una fuente de confianza y amor mutuo. Después de que terminó el tratamiento, Sarah me llamaba periódicamente o me enviaba una tarjeta para hacerme saber que estaba bien en su nuevo mundo. Invariablemente me preguntaba cómo estaba, un paso importante para alguien que durante años apenas reconoció mi existencia. El caso de Sarah fue uno de los que salió bien. No todos los casos son así. He tenido otros que me han decepcionado, incluso me han desesperado. Pero saber que sentirse estancado puede ser significativo y útil me animó a mantener el rumbo.

Ayudar a Sarah a restablecer su "yo herido" requería que escuchara sus "gritos disfrazados de ayuda", sus percepciones y sentimientos sobre la vida y la realidad, ya fueran reales o imaginarios. Cuando acepté sus percepciones, que a menudo desafiaban la razón o mi propia perspectiva, creí -en realidad

sentí- que esto le daba una sensación de aceptación sin reservas, de sentirse comprendida, y una emoción -creo- que tal vez nunca había experimentado antes.

En otras palabras, la sensación de aceptación interpersonal puede tener poco que ver con los temas a resolver, pero mucho más con el hecho de sentirse valorado o desvalorizado por otro. Sean correctas o incorrectas, lógicas o no, me parece que las palabras de un paciente son el fruto de su mente, una representación verbal del yo. Que los acepten y los valoren es ser valorado. Que discutiera estas percepciones puedo ser experimentado como un rechazo, posiblemente una réplica de sus experiencias traumáticas de niña. Y he aquí de nuevo, un adulto más, su médico, que puede oír, pero no escuchar. Está claro que la confianza relacional no se decreta en la terapia, sino que se cultiva, se gana con el tiempo, al igual que el bebé interioriza con el tiempo que sus padres serán objetos confiables, presentes y amorosos. Para mí, personalmente, fue un privilegio compartir el viaje de Sarah. Con frecuencia, desearía poder saber más, hacer más y sentirme menos ignorante e inseguro. Sin embargo, retomando a Donald Winnicott, al igual que los padres, sólo podemos ser "suficientemente buenos". Sin embargo, es más fácil ser lo suficientemente bueno cuando aceptamos que sentirnos estancados y no saber son elementos legítimos de lo que hacemos y quiénes somos.

Dr. S. Roy Erlichman, Ph.D., CAP, CEDS-S, F.iaedp tiene una extensa carrera en el tratamiento de trastornos alimentarios. Es un especialista certificado en trastornos de la conducta alimentaria y miembro de la International Association of Eating Disorders Professionals (iaedp) y ha desempeñado como President of the Board of Directors. En 2019, recibió el Who's Who In America Lifetime Achievement premio a las contribuciones clínicas y en 2016 fue galardonado con el iaedp Lifetime Achievement Award por su servicio. El Dr. Erlichman ha escrito numerosos artículos profesionales, presentados en conferencias en todo el país y es Associate Editor of *Perspectives*.

Maricarmen Díaz is an attorney and professor of law in Mexico. She also is a professional translator specializing in eating disorders, who believes that her work can contribute to the recovery of Spanish-speaking patients.

Maricarmen Díaz es abogada y profesora de Derecho en México. Ella también es una traductora especializada en trastornos alimentarios, que cree que con su trabajo puede contribuir a la recuperación de pacientes que hablan español.

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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, 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*.

THE 31ST ANNUAL RENFREW CENTER FOUNDATION CONFERENCE

The 2021 Conference Committee extends thanks to all the speakers, attendees and Renfrew staff who participated in our 31st annual event. ***2021 Perspectives on Feminism, Eating Disorders and Beyond*** welcomed the highest number of attendees in our Conference history, including 31 Scholarship recipients.

Gabourey Sidibe
Award-Winning Actress & Author

The Opening Keynote presentation, *A Conversation with Gabourey Sidibe*, interview with Dr. Gayle Brooks, was lively and personal as Gabby shared lessons learned about how she harnessed her experiences of pain, shame and rejection to develop confidence and resilience. Later on opening day, Drs. Bryn Austin, Michael Levine and Margo Maine shared their *Bolder Model of Prevention for Clinicians, Researchers and Advocates*. The final Keynote, *Doing Race Differently: RCT, Neuroscience and the Hope for Change*, featured Amy Banks, MD and Maureen Walker, PhD, highlighting the role systemic racism plays in shaping our brains, bodies and communities as well as the importance of clinicians to meet the needs of diverse populations.

Bryn Austin, Sc.D

Michael Levine, PhD

Margo Maine, PhD

Amy Banks, MD

Maureen Walker, PhD

The Conference also featured 5 live Master Classes, 9 networking events as well as morning exercises and 16 on demand workshops which were available for 6 weeks, offering up to 36.5 CEs/CMEs. The program included many presentations on diverse populations, weight stigma and body image issues, social justice and the treatment of eating disorders from adolescence through mid-life. The range of topics provided attendees with a wide variety from which to choose, creating a rich Conference experience.

The Conference Program Committee has begun planning for our 32nd Annual Conference, ***Responding to a Changing World: Treating Eating Disorders with Compassion and Inclusion***, beginning on November 11, 2022. We look forward to sharing more information about this special event with you in the coming months. Once again, a sincere thanks for making the 2021 Conference a great success. We hope to see you then!

Judi Goldstein, MSS, LSW
Conference Chair

SAVE THE DATE: November 11, 2022

The Renfrew Center Foundation's 32nd Annual Conference for Professionals

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Exploring the Increasing Intersection of Eating Disorders and Substance Use

Presented by: Jessica Hansford, LPC, CAAD • Site Director, The Renfrew Center of Radnor

Wednesday, May 11, 2022

Walking the Talk: Relational-Cultural Theory in Action

Presented by: Amy Banks, MD • Member, The Renfrew Center's Advisory Board

Wednesday, June 15, 2022

Medical Evaluation of Suspected Eating Disorders

Presented by: Brandon Z. Erdos, MD • Medical Director, The Renfrew Centers

All webinars are held from 12:00 pm - 1:00 pm (ET). For more information or to register, please visit: www.renfrewcenter.com/events.

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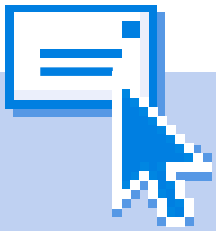

Emails to the Editor

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