PERSPECTIVES

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The 18th Annual Renfrew Conference Update & CALL FOR PROPOSALS For The 2009 Conference Are Included In This Issue. See Page 22 For Details.

A Word from the Editor

This is an exciting time in our field. New research on the brain has started to suggest novel approaches to the treatment and understanding of eating disorders. Yet, even with refined knowledge about the nature of these illnesses, treatment will continue to require a range of relationships with therapists, nutritionists, families and friends.

The articles in this issue represent some of the breadth of our work. Three articles address new research on brain functioning, cognitive processing, and a new generation of psychotherapy. The remaining articles deal with the relational and experiential aspects of treatment including a piece on enhancing the relationship between researchers and clinicians.

I hope you each find something new and interesting in this issue. Please send your ideas and comments to dbunnell@renfrewcenter.com

Doug Bunnell, PhD
Editor ■

Contributors

Is Anorexia Nervosa an Eating Disorder?

Walter H. Kaye, MD

A recent court ruling in New Jersey supported insurance company payment for eating disorder treatment on the basis that these were biological disorders, and thus should have insurance parity consistent with other severe disorders. This ruling was based on considerable literature that may have included a recent position paper from the Academy for Eating Disorders on this topic. The concept of biological underpinnings has profound importance for our patients in terms of their access to treatment. But does this also have an influence on how we understand and treat eating disorders?

There are two sides to the biology of anorexia nervosa—there are initiating biological factors and there are sustaining biological factors. Sustaining factors refer to biological disturbances that occur secondary to weight loss and malnutrition. These have been extensively described in the literature. They involve alterations of most organ systems in the body and are a consequence of severe malnutrition. For the most part, they normalize after recovery; however, they do have a major impact on behavior and mood and tend to make symptoms worse.

Perhaps the most important question is whether there are biological factors that cause eating disorders in the first place. We now recognize that eating disorders are highly heritable because they are genetically transmitted in families. However, it is very unlikely that eating disorders are due to a single or even a few genes. Rather, the development of an eating disorder may be related to certain temperament and personality features, such as anxiety, perfectionism and obsessionality. These tend to occur in childhood before the onset of anorexia nervosa and persist in a milder form even after recovery. These factors may create a vulnerability for developing an eating disorder. Many women in our society diet and seek to lose weight, but fewer than half of one percent develop anorexia nervosa. Having such personality and temperament factors may be necessary to develop an eating disorder.

Among the very puzzling features of anorexia are the characteristic eating behavior and weight loss. Most people in our culture struggle to lose a few pounds. Typically, the recidivism rate is very high—over the course of time most people who lose weight revert to their pre-diet weight. What is uniquely different with people with anorexia is that they can eat a few hundred calories every day for many years and do not have a drive to eat and gain more weight. It has not been clear whether people with anorexia nervosa have a primary disturbance of appetite, or whether altered eating behavior is secondary to anxiety, obsessionality, body image distortion, or any of the other symptoms that occur in eating disorders.

In order to understand more about eating disorders, our group at the University of California, San Diego is following up on our initial study of appetite regulation reviewed here. Appetite regulation is very complicated. It involves the integration of signals from many systems, including the gut, hormones, the peripheral autonomic system, the hypothalamus and higher brain centers. Where should we look to determine whether there is some physiological contribution to altered appetite in anorexia nervosa? Our group thought it would be best to study higher brain pathways because these higher brain centers modulate the rewarding, as well as the negative aspects, of food consumption, which in turn have a very important influence on how much we eat. For example, if you do not eat for a couple of days, food seems to become more rewarding, tastes better, and is more pleasurable. If you are satiated, food is less rewarding. As another example, if you eat a small piece of chocolate cake, it may taste very pleasurable at first. However if you are asked to eat that whole chocolate cake, the pleasure would soon turn to disgust.

Our research design involved using a simple probe, the taste of sucrose, a sugar, and looked at brain imaging response. We studied people who had recovered from anorexia nervosa to avoid the confounding effects of weight-loss and malnutrition. Much is known about pathways for tasting sweetness. There are taste receptors on the tongue that recognize a sweet taste. From there the signal goes to the brainstem, then to a lower part of the brain called the thalamus, and then to the anterior insula, which is a part of the brain that is thought of as the primary sensory cortex. The anterior insula registers whether we taste something as sweet, independent of whether we experience it as pleasurable. Other related areas of the brain, such as the anterior ventral striatum (where the nucleus accumbens, or "reward" center, is located) and the orbital frontal cortex, are important for judging the pleasurable or nonpleasurable aspects of that food.

We found that people who had recovered from anorexia nervosa had a reduced response to the taste of sugar in the anterior insula and some of these related "reward" areas of the brain compared to women who never had an eating disorder. What does this mean? Other studies have shown that when people are fasted, the anterior insula and orbital frontal cortex become more active as part of the signal in the brain telling us that we are hungry and we need to eat food. When we eat food, this signal diminishes. It may be that people with anorexia nervosa are not getting the right signal. Very simply put, the brain may not register a strong signal in response to being hungry. This may be due to an altered sensing of a sweet taste or a diminished reward in response to a palatable food. Another important finding was that in healthy comparison women, we found a strong relationship between how pleasurable they thought the sweet taste was and how active their anterior insula became on brain imaging. However, we did not see this relationship in people with anorexia, providing further evidence that there is something altered about the sensory hedonic modulation of food intake in anorexia nervosa. These findings may provide new insights into why people with anorexia nervosa are able to restrict food and lose weight successfully.

Another important aspect of this study is that the anterior insula has a much more important role than just the sensory hedonic aspects of taste. The anterior insula plays a key role in terms of interoceptive awareness, that is, the self-awareness of internal body states. In other words, alterations in parts of the body, such as the stomach or the lungs, or pain receptors in the skin, activate the anterior insula as a signal that something has changed. For example, if you hold your breath and you develop a very severe hunger for air, your insula lights up as a way as saying there is something aversive going on in the body. There is something wrong and you better do something about it (e.g. breathe). This raises the question about whether puzzling symptoms in anorexia, such as body image disturbance or denial of the seriousness of low weight, may be potentially related to altered insula response to body signals.

Finally, now that we are beginning to have a better idea of the neurobiologic contributions to anorexia nervosa, this forms a foundation on which to develop specific and improved treatments. We are conducting follow-up studies at the University of California, San Diego to both replicate these imaging findings and develop a better understanding of the relationship between brain and biology. We are recruiting women who have recovered from anorexia nervosa and bulimia nervosa who might be interested in participating in the study. If you are interested, please call 858-366-2525 or email: edresearch@ucsd.edu You can obtain a PDF of the paper discussed above at http://eatingdisorders.ucsd.edu.

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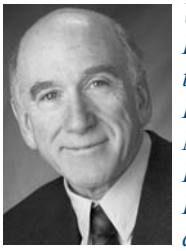

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The Nia Technique: Through Movement We Find Health

Lori Lynn Meader, LCSW

Twelve years ago, I walked into my first Nia class. Filled with women of all ages, shapes and sizes, the room was soon vibrating, bodies twirling, wiggling, clapping and laughing. I knew immediately that this class was like no other I had ever experienced. Something about this movement was very healing. I felt such freedom and joy in my body, moving in ways that were simple, yet profound. What I discovered in that first class, and in intensive trainings throughout the years, is that Nia truly integrates mind, body and emotions in a beautiful, harmonious way.

Nia ("Neuromuscular Integrative Action") developed by Debbie and Carlos Rosas, (pronounced "NEE-uh" and in Swahili means "with purpose") is a kinesthetic experience that incorporates movement styles from the martial arts, healing arts and dance arts (Rosas, 2004). Nia movement is a powerful way of facilitating the connection between mind and body, a mindful-moving-meditation, and somatic therapy.

As therapists specializing in the treatment and prevention of eating disorders, we support our clients who grapple with symptoms, uncover pain and trauma. We help them to experiment with alternative behaviors, and we work with them to forge healthy relationships—all of this going on behind closed doors in the psychotherapy office. Over the years, I have increasingly incorporated body-centered modalities such as Focusing Techniques, Pesso-Boyden System Psychomotor (PBSP), Eye Movement Desensitization and Reprocessing (EMDR), Somatic Experiencing, and various other mindful meditation practices. The proverbial "closed door" can swing wide open when these body-mind techniques are combined with our verbal psychotherapies.

The Body's Way

In order for movement to play a healing role, the energy and intention behind it must come from pleasure. Grounded in science, craft and art, *The Body's Way* (Rosas, 2004) asks that we find the 'path of least resistance.' Dynamic ease, the ability to perform movements with maximum efficiency and minimal effort, is experienced as a distinct physical sensation. 'Neuro' relates to nerve impulses that trigger and activate the mind, both the thinking (left) and imaginative (right) sides of the brain. 'Muscular' relates to the body, and to physical actions that result in flexibility, mobility, strength, agility and balance. 'Integrative' relates to the whole-body interplay that develops through the 'action' of Nia movement and its unique sensory-based teaching/learning style. Neuromuscular efficiency feels like grounded energy, effortless power, elegance and grace. Nia also galvanizes the blend of masculine (power and precision) and feminine (emotional and fluid) energy. Our culture tends to diminish creativity and intuition as it overvalues rationality and achievement. Creativity can be best appreciated through the medium of the body, which offers its information via subtle and nuanced sensations (Heckler, 1993). The blending of these yin and yang forces, results in strength, ease and expressiveness.

Nia blends beautifully with eating disorder treatments. In attending to emotions, thoughts and the body, Nia embodies an appreciation of the whole person. In Nia, we practice conscious moving through heightened awareness. In psychodynamic psychotherapy, the unconscious becomes conscious, allowing clients the opportunity to change behaviors, form stronger relationships, and make more satisfying choices. Psychodynamic work fuses with Nia philosophies in the exploration of and trust in relationships, between therapist and client, and between the client and her body. Nia concepts offer a new way for clients to trust in how their bodies function, how to listen to bodily cues, and how to experience pleasure instead of criticism while moving. For example, Jane, a client who has lost a significant amount of weight, continues feeling "heavy." In session, I encourage her to show me how "heavy" moves. We both slouch, heads down, gravity pulling us towards earth. I ask what this movement evokes, "This is how I walk through the world. Never making eye contact, kind of ashamed." I invite her to feel her spine lengthen and to allow her imaginary cape to brush the floor. We make eye contact as we move about the room. Tearful yet relieved, Jane realizes her "heaviness" has more to do with shame and ambivalence about being seen rather than weight. She wonders how it might feel to walk this way out in the world.

Nia boosts self-esteem and mood more than does exercise alone. Furthermore, a 1997 study published in the *Journal of Women's Health Issues* found that Nia relieved anxiety and depression more effectively than aerobics. Moving lifts the spirit, causing the brain to release mood-lifting neurotransmitters, and endorphins, brain chemicals that promote satisfaction, even euphoria. Proteins are produced within brain cells that spur the growth of new neurons and new cell connections, literally making minds more supple (Svoboda, 2007). In a study at the University of London, researchers assigned patients with anxiety disorders to one of four therapeutic settings: a dance class, an exercise class, a music class,

or a math class. Only the dance class significantly reduced anxiety. Moreover, moving to music activates the brain's pleasure circuits. "On a physiological and psychological level, humans like order and form, and the rhythm of dancing to music provides that satisfying patterning," says Miriam Berger (2007), a dance professor and dance therapist at New York University. There is restorative power in all types of music, and Nia's intoxicating triad of Music-Movement-Magic suggests that sound precedes a feeling of being seduced to move. This blend creates the magic that is difficult to explain detached from the actual experience.

I am in no way suggesting that eating disorders can be danced away. We all know the seriousness of working with those with life-threatening illnesses. Many of our body-obsessed clients have horrific trauma histories, making living in the body a dangerous place. The tendency to bodily and emotionally compartmentalize leaves our clients feeling fragmented. Rejected parts can be learned from and integrated (Reeves, 1999), and body wisdom increases as systemic movement is embodied. Introducing Nia has enlivened the work my clients are doing by adding slow-paced, well-attuned, whole-being movement to their repertoire. Moving the Nia way, emotions are located, identified, expressed and, most importantly, tolerated. Tolerance of feelings makes them more accessible for work in the therapy room. Moving the body in loving and respectful ways opens the door into unacknowledged wants and needs, something our eating disordered clients find uncomfortable and often intolerable. Nia invites a sense of curiosity, play and acceptance.

Guided By Sensation – A Case Example

Maggie, a therapy client struggling with compulsive eating, is desperate, isolated and lonely as she goes through the painful process of divorce. She wonders if her weight has contributed to the deterioration of her marriage. In session, it is clear she is talking about her feelings, not necessarily feeling them. She is racing, her breathing shallow and forced. I bring her attention to this and she begins to slow down. I offer a gentle invitation into her body. "See if you have a sense, there in the middle of your body, of what wants our attention now…" (Cornell, 1996). After a few deep breaths, she says, "This is uncomfortable because my belly is sticking out when I breathe." I encourage her to sense her belly from the inside, "Wow, it does feel better when I don't suck it in." Looking to me for direction, I invite her to sound, asking what that place in her belly might sound like if she squeezes it very tightly and then releases whatever sound it might want to make (Pesso, 1973). She surprises herself with what sounds like a wail and she begins to cry. With this release, she speaks now from the place in her body that feels sad and alone, and allows feelings of loss and grief of her failed marriage. She describes feeling tied up in knots. "What a powerful image. Let's move that." As she gets up and moves, turning her feelings and images into motion, she senses the knots loosening. "There is a part of me NOT tied up. Part of me feels free of this stale relationship." Being more connected to her body, she differentiates between the knotted sensation and hunger. I introduce Nia, and its expressive aspects that help process feelings that can be difficult to deal with in conscious, verbal terms. Although hesitant, she is intrigued.

In her first Nia class, Maggie looks shy and self-conscious. As the music begins, we step into the space, leaving distraction and criticism behind. "We breathe to energize movements and promote relaxation. Sense any tightness and imagine muscles letting go of bones. Simply breathe and sense your body as a whole." The focus shifts to the feet, "The hands that touch, connect and are rooted deeply in earth." Imagery ("stir a giant bowl of soup" or "pick an apple off a tall tree") helps students become more animated, less mechanical in their movements. It also allows what is bubbling under cognitions to blossom organically (Halprin, 2002). Using simple steps and visualization, moves are internally directed, guided by sensation.

Improvisation or FreeDance, one of Nia's 13 basic principles, promotes creativity and self-expression. I invite spontaneous, free-form movement, as we remember what it was like to let loose and skip around a playground, squealing with delight. Sound gives expression to and vibrates the body. By producing sounds, we express emotion and release tension (Olsen, 2004). The power of "Hey!" or "Yes!" and the tranquility of "Ahh" enables participants to let go of inhibitions. Jan Russell (2008), Nia Black Belt and author of "A Cure For Shame" in November's *MORE* magazine, describes overcoming strong resistance to making noise. "I'd felt foolish shouting while kicking and punching. I recognized I was scared of the sound of my own voice resonating through my body. Now these exclamations feel explosive and powerful. The physical expression of emotion—sadness, elation, anxiety or tranquility—is my way of staying close to my heart." She goes on to say, "Growing up, I felt my body was inherently flawed. Now, I dance Nia for sheer pleasure. My masochistic, shame-filled attitude about my body is transforming through Nia's invitation of self-discovery."

After years of attending Nia classes, Maggie describes a new fullness in her body, not the familiar emptiness that pushes her into impulsive eating. Tearfully, she describes being able to move her hips without shyness or shame. Maggie now makes an effort to connect with others. Dancing bonds people, according to Robyn Flaum Cruz, President of the American Dance Therapy Association. MRI scans show that simply watching someone dance activates the same neurons that would fire if you yourself were doing the moves. So when one dancer's movement expresses joy or sadness, others often get to experience it as well, fostering empathy (Svoboda, 2007). Nia invites compassion and gratitude, for self and others. "As class ends, we imagine healing energy going out into the world, helping me to remember that it's not always about me, that I am part of something bigger." She goes on to say, "I have gone from feeling numb to feeling alive, focusing on how my body wants to move rather than on results."

Perhaps the most important shift is letting go of perfection. "I now give myself permission to mess up, and it actually feels good. Sometimes I cry while I dance, and I can't believe I'm okay with that!" Nia, combined with psychotherapy, has helped Maggie learn to integrate thinking with intuition, self-care with creativity, and to develop awareness of and trust in her body, emotions and sensations. Now, when she cannot find words in session, she uses movement and

sensation to guide her. "I've actually learned how to listen to my body and sense my energy and mood, and move in harmony with that in session, in class, and everywhere. I still struggle with loneliness, but I can dance my grief with the support and in the presence of others. Fat days are few and far between. I'm a curvy woman, and no experience has ever made me feel so good about my body."

Dancing Through Life

Through expressive movement, Nia as a healing modality for those struggling with eating disorders, self-esteem and body image issues has proven invaluable. As a psychotherapist, Nia philosophies help me to be guided by sensation and stay present, in my body and with my clients. I can no longer imagine working solely through talking. Like other mind/body approaches, this practice deepens over time. Nia awakens the wish to heal, and offers a sense of greater clarity, assertiveness, hope, peace and compassion.

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Individual Therapy for Eating Disorders: Getting a Good Start

William N. Davis, PhD, FAED

The most common treatment modality for the eating disorders anorexia nervosa and bulimia nervosa (whether or not presenting symptoms meet full DSM IV criteria) is outpatient individual psychotherapy. Yet, this particular form of treatment, as it exists and is practiced in the offices of countless clinicians, is rarely studied and seldom articulated in the professional literature. By implication this means the most popular, most utilized treatment for anorexia and bulimia may also be the least understood and least described. Recently, Witton, Leichner, Sandhu-Sahota & Filippelli (2007) asked eating disorder patients and their families to list their priorities for future research. Not surprisingly, both groups ranked individual psychotherapy as most important. In other words, consumers of therapeutic services for eating disorders are most interested in furthering knowledge about the type of treatment with which they are most familiar and upon which they are most dependent.

There is some information available about the quality of individual therapy and patient outcome across all presenting problems. Broadly speaking, a number of authors—clinicians and researchers alike—have reached the conclusion that a positive therapeutic alliance is the single most important factor in promoting successful treatment (e.g. Safran & Muran, 2000; Diener, Hilsenroth & Weinberger, 2007; Miller & Stiver, 1997; Norcross, 2002; Horvath & Bedi, 2002). More specifically, therapist characteristics such as empathic sensitivity, support, a positive and caring attitude, responsiveness, and appropriate self-disclosure are thought to be related to a positive alliance, and in turn, to successful outcomes.

In contrast, there is virtually no research on the importance of the therapeutic relationship during outpatient individual therapy for eating disorders; however, Bunnell concluded a survey of the literature on the therapeutic alliance by saying "it seems reasonable that the ability to engage and sustain patient motivation, which is likely the result of a positive therapeutic relationship, strongly influences length and outcome of (eating disorders) treatment" (2008, p. 80). And several authors have asserted that the essential ingredients in a positive therapeutic relationship with eating disorder patients are no different than those recognized as critical in any psychotherapy (Bloomgarden, 2008; Garner, Vitousek & Pike, 1997).

Unfortunately, as all eating disorder clinicians come to know, it is not so easy to establish and maintain a positive therapeutic relationship with an anorexic or bulimic patient. This is due to a special problem that is relatively unique. In contrast to other psychotherapy patients, eating disorder patients often don't want to be helped and consequently don't respond the same way to the efforts of individual therapists who offer empathic sensitivity, support, a caring attitude, compassion, acceptance and the like. In fact, even though eating disorder symptoms can be at least as draining, burdensome and terribly painful as the symptoms of other mental health problems, they are also fiercely protected and defended. Individual therapy for anorexia or bulimia must almost always address strong ambivalence to the goals of treatment. This is because, most obviously, these goals raise the dreaded specter of fatness, and less obviously, the difficult need to deal with problems that seem unsolvable. In a way, the dissolution of this resistance is the crux of eating disorders therapy. Successfully addressing it goes to the core of recovery; failing to do so promotes relapse and chronic illness. Given this ambivalence, and assuming the significance of a positive

therapeutic relationship and the various therapist characteristics that foster it, the best way to conduct a successful eating disorders treatment becomes more complicated, even more formidable than it might otherwise be. The actual challenge is to develop and sustain a positive alliance in the face of active/passive/loud/quiet/obvious/subtle resistance. Constructed in relational terms, the treatment challenge becomes one of promoting the therapeutic relationship in the face of the very strong and enmeshed relationship a patient has developed with her eating disorder.

To illustrate the difficulties involved in establishing a positive therapeutic relationship consider the first few sessions that take place between a 17-year-old recently diagnosed anorexic patient and her well-intentioned therapist. During initial inquiries the therapist asks a great many questions and gathers what seems to be important developmental and etiological information from an apparently compliant patient. Even though several efforts to explore the dynamics that surround dieting don't seem to go anywhere, and in spite of the fact an initial interpretation about the connection between father's anger and increased exercising is met with a quizzical frown, the therapist is pleased. He/she feels confident that, over time, maintaining a stance of quiet interest, sensitivity and caring concern will lead to a positive connection, which, in turn, will enable a collaborative approach to the question of how the patient developed anorexia nervosa.

Now imagine a sort of filter or thick mist surrounding the consciousness, attention and interest of the anorexic patient. The mist separates her some from the office environment and the presence of the therapist, leaving her subject to intrusive, repetitive thoughts about her most recent weight, upcoming meal and exercise regime, and dimming her capacity to think much about what the therapist is doing. At one point she hears something about her father and wonders what that has to do with anything. She is relieved (and also somehow sad) that the therapist doesn't seem to know much about what she is experiencing. Vaguely, it annoys her that he/she keeps on asking questions, as if she has to help him out, but actually it seems better that way. It feels a little safer. For a moment she pauses to consider that he/she seems so steady and quiet and pleasant, and sort of passive. This seems good. Maybe she can avoid having to talk about anything to do with her dieting plans, or about that really scary thing that happened with her boyfriend six months ago. And maybe it also means the incessant voice inside her head won't get angry and insist that she do more and more restricting. After several sessions she thinks it's a good idea to stay in the therapy. This way her parents will be satisfied, and as long as the therapist stays so nice and accepting, nothing much can happen.

Although this hypothetical vignette is somewhat of a caricature, an individual therapy that starts in this fashion is probably not off to a good start. The fact is, even a skilled, well-experienced therapist who practices in a warm, sincere, sensitive and caring way may not be able to establish a positive therapeutic relationship with an eating disorder patient. The key here is to take the special problem posed by anorexia and bulimia seriously. If there is strong ambivalence about treatment, it will be necessary to do something different from what might usually be done while working with a more "ordinary" psychotherapy patient, and especially so during the initial sessions of the treatment. In this regard, it seems useful to imagine the therapist characteristics that encourage a positive therapeutic relationship as necessary, but by no means sufficient, ingredients for conducting effective treatment with eating disorders.

The concepts of active engagement and worthwhile engagement describe two other ingredients that may be crucial to successful psychotherapy for anorexia or bulimia. The terms are add-ons. In other words, they delineate therapist behaviors that add on to, or serve as catalysts for, the benefits that typically accrue from therapist characteristics which encourage a positive therapeutic relationship. Active engagement is a process concept, and in part, a way to express and communicate beneficial therapist characteristics. Worthwhile engagement is also a process term insofar as it requires active therapist intervention. At the same time, however, it emphasizes content, that is, a particular focus or goal for therapist behavior.

When an eating disorder patient is deeply absorbed in an internal relationship with the vicissitudes and nuances of her symptoms, the therapist will need to *actively engage* the patient. Only in this way will the patient really notice, and only in this way will the therapist have a chance to make a relational impact. This means an initial challenge for eating disorder therapists is not the collection of appropriate or apparently significant information about a patient, and not even the instigation of what seems to be a meaningful exploration about important issues—however significant these pursuits may eventually become. Instead, it is precisely to find a way to "disturb" the resistance that envelops eating disorder patients. From a relational perspective this is to get beyond and between the powerful, enmeshed, often tyrannical relationship a patient has developed with her disorder. At the beginning of treatment in particular, the therapist needs to work actively to attract the patient's attention so that she will notice and take into account the other person in the room. Remaining respectful of appropriate boundaries, therapists can perhaps do this best by acting in a non-traditional manner. Doing so can get a patient thinking and wondering about her therapist, in and out of sessions. The effect is to create a relational space that contains the therapist, a good start on the way to forging a genuinely positive therapeutic relationship.

So, for example, during initial sessions, a therapist might take an especially active interest in something the patient says, adding information from his/her own life that is relevant and asking for the patient's reaction, creating an actual conversation rather than an "examiner and examined" interaction. Or the therapist might make a point of commenting in a kindly and curious way about some aspect of the patient's appearance or a momentary facial expression, startling the patient but capturing her attention. Or the therapist might interrupt a patient's account of some upsetting event with an active expression of sympathy and concern, even a suggestion about what the patient could do next, suggesting his/her willingness to be a mentor of sorts and engaging the patient's interest in what else the therapist has to offer. Or, a therapist might softly and gently, but also abruptly and out of context, tell a patient that she is terrified of betraying her symptoms, making her suddenly more aware of this person who seems to understand something no one else does. The actual content of these examples is not so much the point. It is the *active* spontaneity, the "non-plannedness," the unexpectedness of the therapist's behavior that is especially salient. Expressed within the context of a sensitive, supportive and caring attitude, this kind of active engagement can infiltrate eating disorder resistance and contribute to the development of genuine patient-therapist contact and a truly beneficial therapeutic alliance.

Invariably as an eating disorder begins and then asserts itself, it serves a valuable psychological purpose. The symptoms of anorexia or bulimia come to be experienced as necessary, even in spite of the torment they produce. Consequently, in order for the therapeutic relationship to have a beneficial impact, it must offer more than the disorder. In relational terms, individual psychotherapy is not likely to have a positive outcome unless the therapeutic relationship becomes more valuable than the relationship a patient has with her eating disorder. Worthwhile engagement means a therapist looks for and takes advantage of opportunities to demonstrate the value, the benefit, the practical real "pay off" of therapy. Doing so mutes the dominance of the eating disorder relationship, disrupting a patient's conviction that she "needs" her symptoms, and encouraging her to risk depending upon a real life relationship as a means to navigate her world.

Especially at the beginning of treatment, and even more so when an eating disorder is severe or entrenched, traditional clarifications and psychodynamic interpretations—the "tools" of much outpatient psychotherapy - are rarely experienced as worthwhile by a patient. More often, they feel irrelevant or somehow dangerous, leading to apparent acknowledgment and then studious avoidance. In contrast, a therapist who, for example, actively demonstrates his/her knowledge of the internal experience of anorexia and bulimia offers a patient valuable, albeit somewhat threatening information. This kind of intervention is possible because the experiential course of an eating disorder is remarkably similar (Davis, 2008). A therapist who lets a patient know that he/she knows about what's "really" going on can provide a beacon of hope in the midst of a despairing sense that life will never get normal again; and at the same time a grudging respect for this person who might actually know enough to be a competent adversary.

Concrete, often practical interventions, more so during the beginning of treatment, are the crux of the matter: those that communicate a willingness to help in a way that has immediate value; and those that establish the competence and resources of the therapist. The actual interventions will vary from the needs of one patient to the needs of another, from practicing how to interview for a job, to how to fill out a college application, to how to refuse a boyfriend's advances, to how to stand up to an intrusive mother, and so on. The treatment goal is to prove the therapeutic relationship can be a very, very important source of support for a patient, a "safe haven" that can feel even safer, and certainly more gentle, than the suffocating folds of an eating disorder. Consequently, in the context of a warm, accepting and caring attitude, therapeutic interventions that are experienced as worthwhile are likely to help treatment get off to a good start. Little by little they will cause patients to question whether they need to depend on their eating disorder; instead, perhaps there is more to learn and more to gain from relying on the relationship they are developing with their therapist.

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Acceptance and Commitment Therapy: Principles and Potential for Use with Eating Disorders

Adrienne Juarascio, BA & Meghan L. Butryn, PhD

Over the past 50 years, there have been three waves of scientifically-based psychotherapy development. The first two waves were behavior therapy, developed in the 1950s, and cognitive therapy, developed in the 1970s (Ost, 2008). Behavior therapy and cognitive therapy have merged into what is now called Cognitive Behavior Therapy (CBT). In the last 10 to 15 years, a number of treatments have begun to extend traditional CBT. These treatments have been loosely grouped together as the third wave of behavior therapy, and share a focus on the context and functions of cognitions (Hayes, 2004). In contrast to traditional CBT, which focuses directly on changing cognitions that distress the client, third wave therapies tend to focus on mindfulness and acceptance of distressing cognitions (Hayes, Stroshal & Wilson, 2003). One of the most widely practiced third wave therapies is Acceptance and Commitment Therapy (ACT). Because it proposes that an individual's reaction to a cognition is changeable while the cognition itself is not, ACT aims to teach clients how to accept possibly upsetting cognitions, as well as other subjective internal experiences (e.g. feelings or sensations; [Hayes et al., 1993; Hayes, 2004]). Attempting to control unwanted subjected experiences is thought to be not only ineffective, but occasionally even counter-productive, because the struggle to control them can actually increase the distress they produce (Hayes, 2004). Therefore, clients are taught how to be aware of their internal experiences, while not being hindered by them as they try to achieve their life goals.

One goal of ACT is to reduce experiential avoidance (e.g. target the unwillingness to have certain thoughts, feelings, sensations, memories, or urges). ACT teaches clients ways to change their relationship with these internal experiences rather than changing the experience itself. Clients are taught to obtain some distance (or defusion) from internal experiences (Hayes, Stroshal & Wilson, 2003; Hayes, Luoma, Bond, Masuda & Lillis, 2006). Because ACT views some human suffering as normative, the goal of treatment is not to get rid of all suffering, but to help clients engage in a full and meaningful life even when distressing thoughts, feelings, or other experiences occur. To accomplish this, ACT helps clients identify goals and values and take committed action towards engaging in behaviors that are consistent with them.

Since the ACT paradigm was developed in 1999, there have been over 40 studies published on its effectiveness (Hayes, 2008). ACT has demonstrated efficacy with many problems, including chronic pain (McCracken & Eccleston, 2006), smoking cessation (Gifford et al., 2004), psychosis (Bach & Hayes, 2002), depression (Zettle & Hayes, 1986), obsessive compulsive disorder (Twohig, Hayes & Masuda, 2006), and social anxiety disorder (Dalrymple & Herbert, 2007). However, more studies need to include active comparison groups, compare ACT to gold-standard CBT programs, and be conducted by investigators without an allegiance to ACT (Hayes et al., 2006; Forman et al., 2007).

Although the efficacy of ACT has been researched for a large variety of mental illness, we know of no published studies that have investigated its use with eating disorders (of note, Heffner and colleagues (2002) did publish a case study in which ACT was successfully used to treat a 15-year-old with anorexia nervosa). There are theoretical reasons to believe that ACT might be especially effective for those with disordered eating. Eating disordered behaviors can be conceptualized, in part, as an attempt to reduce anxiety about food and weight. For instance, a client may be anxious because she feels bloated or has the thought that she looks fat. In an attempt to make that feeling or thought go away, she may decrease her consumption of food, increase her exercise, or purge. Although these behaviors may in the short-term make this feeling or thought go away, repeatedly engaging in such behaviors will have negative consequences (e.g. they may be detrimental to her health, impair her concentration, cause tension in relationships, and reduce her engagement in social or community activities). Clients also may engage in behaviors such as binge eating to avoid, control or suppress other internal experiences like sadness or boredom. In the long-term, these behaviors do not improve the quality of life nor do they reduce distress. ACT asks clients to evaluate the consequences of their behaviors and consider alternative ways of responding to these internal experiences. The client can become willing to experience them and gain psychological distance from them without needing to engage in a behavior that will temporarily control the internal experience. By teaching clients how to change their relationship with distressing internal experiences and how to decrease experiential avoidance, problematic weight and eating-related behaviors might be reduced.

Many clients with eating disorders are ambivalent about behavior change. Engaging patients in treatment is a key aspect of treatment. Enhancing motivation for treatment is especially important. ACT may be well-suited to address this because ACT asks clients to evaluate how well their current approach to their internal experience is working. ACT helps the client to identify what they value in life and determine whether or not their behaviors are helping them move in these valued life directions. An ACT therapist can help frame behavior change as something that connects to the client's broader life goals.

The order of ACT treatment sessions is flexible. Therapy can begin by having clients evaluate the workability of the strategies they have been using to deal with problems, such as "fear of fatness." Clients will typically conclude that some of the strategies they are using are not effective (e.g. losing some weight does not make a fear of fatness go away for a client with anorexia nervosa). Metaphors and experiential exercises are frequently used in ACT (Hayes et al., 1999). For instance, a Chinese Finger Trap exercise can introduce a basic principle of ACT. A Chinese Finger Trap is a woven tube of straw. An individual can put both index fingers into the tube, one on each end. Once the fingers are inserted, trying to pull them out just makes the tube tighter—the only way to make room is to push the fingers farther in. A parallel can be drawn between the trap and attempts to get rid of feelings of fatness. Struggling with those feelings can create additional distress and the most workable solution (which eventually provides more freedom and behavioral flexibility) is to adopt an attitude of acceptance.

Similarly, the Thoughts on a Leaf exercise can be used to help a client practice mindfulness (Hayes et al., 1999). The client is instructed to imagine her thoughts as leaves floating down a river. For example, the client may have the thought that her stomach is too big or that she cannot stand to feel so full. The client is instructed to be aware of her thoughts as they float down the river, without judging the content of the thoughts or trying to change them. Through this exercise she can practice gaining distance from thoughts and recognizing that thoughts are simply a form of internal experience, not necessarily a truth. Another way of helping a client gain distance from thoughts is to have them preface thoughts with the phrase, "I am having the thought that…" and saying, "I am having the thought that my stomach is too big," rather than simply, "My stomach is too big" can help a client recognize that thoughts are simply internal experiences and that she does not need to react to them—she can simply be mindful of a thought without needing to act to make it go away.

A client's values and goals can be a focus throughout treatment and distress tolerance can be framed not as an end in itself, but as a means to the end of engaging in valued behaviors. For example, a client with an eating disorder may value education and thus have the goal of attending college. The therapist can work with the client to help her recognize that she is more likely to achieve this goal if she is, for example, healthy enough to attend high school regularly. The Bus Driver metaphor illustrates this point (Hayes et al., 1999). In this metaphor, the client is a bus driver, moving towards her values and goals (e.g. education and college), but in the back of the bus are "passengers" that represent upsetting internal experiences (e.g. urges to binge or purge, thoughts about the importance of thinness) that can complicate the trip. The passengers may come up to the front of the bus occasionally to try to get her to change her direction and she may feel tempted to pull the bus over to deal with them. But the client can continue moving in a direction that is consistent with her values, even with the passengers on the bus still on board. The client and therapist can discuss how she can practice this skill in her life (e.g. spending the evening studying while at the same time having the urge to excessively exercise instead). By increasing her psychological flexibility the client can engage in a full range of behaviors that are consistent with her values; the pursuit of thinness or avoidance of distressing internal experiences do not need to solely dictate which behaviors she engages in.

The use of ACT with eating disorders has much promise but empirical research must be conducted to determine its effectiveness. At its roots, ACT is a type of behavior therapy, and therefore standard behavioral approaches to eating disorders (e.g. exposure, self-monitoring) can be integrated within the treatment. Other models of psychotherapy also may be compatible with this approach. The authors and their colleagues at Drexel University are currently conducting a small pilot at The Renfrew Center to determine if adding weekly, group-based, ACT therapy to intensive outpatient treatment improves outcome. If results of pilot studies such as this provide preliminary evidence of effectiveness, larger trials of this new treatment will likely be conducted.

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Cognitive Remediation Therapy: Changing How Patients with Eating Disorders Think

T.J. Raney, PhD

Caregivers and clinicians alike are painfully aware that individuals with eating disorders think about themselves and their food, weight, and size in fundamentally different ways than people without eating disorders. High relapse rates and chronicity in this patient group may be explained in part by the fact that behavioral symptoms can be addressed repeatedly, while the problematic thoughts and cognitive biases often continue unchanged. Exciting new research has found that when you look beyond what patients think and examine how patients think, there are some consistent patterns to the cognitive strategies and biases of eating disorder patients. These cognitive patterns often resemble those of patients with autism spectrum disorders (Lopez, Tchanturia, Stahl et al., 2008). Cognitive Remediation Therapy (CRT) for eating disorders borrows intervention strategies from the schizophrenia literature and similar sources to help eating disorder patients see the world more flexibly and better appreciate the "big picture" of their situation (Davies & Tchanturia, 2005). If CRT is successful in helping patients change how they fundamentally think, it may open the door for clinicians to be more effective in changing distorted body image, reducing obsessions, and decreasing peer comparisons.

Set-shifting refers to a process of executive functioning that allows a person to shift from one cognitive strategy to another as needed for a task. This set-shifting flexibility allows a person to identify when a change in strategy or change in response might be appropriate rather than continuing without making adjustments. Failures to shift sets often manifest as rigidity in thinking or problem solving, or perseveration of responses in the face of evidence that the response is in error. A recent systematic review and meta-analysis of the literature on set-shifting in eating disorder patients found that women with either anorexia or bulimia have impaired set-shifting performance compared to healthy controls, with anorexic women showing the largest deficits (Roberts, Tchanturia et al., 2007). Similarly, anorexic women who were weight restored exhibited problems with cognitive flexibility in many (Tchanturia, Morris et al., 2004; Holliday, Tchanturia et al., 2005; Roberts, Tchanturia et al., 2007) but not all studies (Gillberg, Rastam et al., 2007). Non-eating disordered siblings may also show similar set-shifting deficits, suggesting a stable trait that may be implicated as a risk factor for development of eating disorders (Holliday, Tchanturia et al., 2005).

Another cognitive feature studied recently in eating disorder patients is the concept of central coherence, which is the tendency for a typical adult to process information in a global or "big picture" way rather than focusing solely on the details. This is the tendency to see the forest as a forest rather than as a group of proximally located trees. Weak central coherence refers to an information processing bias toward looking at local or detailed information rather than processing information globally. Several of the hallmark features of anorexia reflect a bias toward the details of body weight, shape, (e.g. body image distortion, repeated checking of body circumference, focus on the number on the scale, focus on sensations of fullness) or appearance and a relative disregard of the global state, overall health and long-term implications of the illness.

Studies examining weak central coherence generally agree that women with anorexia consistently score very low on tasks that require global processing to integrate information. They score similar to or significantly better than healthy controls on tasks that benefit from very detailed or local processing. In a review of central coherence studies in eating disorder patients, the authors described a variety of commonly used assessment instruments, largely borrowed from the autism spectrum disorders research field (Lopez, Tchanturia, Stahl et al., 2008). These instruments each assessed detail-focused strategies and global-focused strategies. The speed and accuracy at the tasks determined the strength of a participant's particular bias. Interestingly, the participant's BMI did not seem to dramatically impact performance on these tests, and the weak central coherence bias persists after weight restoration, suggesting a stable trait, independent of eating disorder pathology. This suggests that these cognitive biases may be an endophenotype underpinning the development of anorexia (Lopez, Tchanturia, Stahl et al., 2008).

Women with bulimia also demonstrate a tendency to use detail level information and they do poorer at global, gestalt integration. While very similar in this regard to women with anorexia, one study found that women with bulimia process the details more quickly and less accurately than women with anorexia, suggesting that, for at least a subgroup of women with bulimia, anxiety, impulsivity or attentional issues may confound the problem (Lopez, Tchanturia, Stahl et al., 2008).

Effective long-term interventions for eating disorders may be enhanced if treatment addresses these problematic thought processes, not just their thought content. Cognitive Remediation Therapy is an intervention that uses neuropsychological tasks to promote cognitive flexibility and global information processing. It is hypothesized that the tasks comprising CRT retrain the neural pathways of the brain through repeated practice and teach the individuals adaptive strategies to offset their inherent rigidity and detailed focus (Tchanturia, Davies et al., 2007).

Kate Tchanturia and colleagues at the Institute of Psychiatry in London have published a series of case studies and pilot groups using the CRT treatment module created for use with schizophrenic patients which they adapted for use with patients with eating disorders. The intervention is structured as 10 individual sessions each lasting approximately 45 minutes in which a program of neurological tasks are taught and rehearsed. Some tasks are geared toward increasing cognitive flexibility, such as Stroop and illusion exercises. In the Stroop, a person is presented with the word "blue" that is colored green and is asked to state the color of the word (green), not the color it names (blue). A series of such colored words is presented and the delay a person experiences in naming the color indicates cognitive inflexibility. The illusions exercises have examples of images that can be viewed two ways, such as the faces and the vase illusion, and patients are prompted to see both ways. Other tasks are intended to encourage patients to process

information more globally. Examples include describing geometric shapes, giving directions on maps, and condensing letters to summarize bullet points. In total, 15 different tasks are used, with approximately six practiced in any given session, and each session has progressively more challenging activities (Whitney, Easter et al., 2008). In addition to the feedback regarding the tasks themselves, the therapist discusses the tasks with each patient and grounds the task in real world experiences by asking how the lessons from this session may be applied to the eating disorder or to other areas of their life. By stimulating discussion at that level, the intention is to facilitate the generalization of the cognitive strategies beyond the treatment setting.

The results in the case studies have been consistent and promising. Patients who complete CRT demonstrated improved set shifting and cognitive flexibility with medium to large effect sizes (Davies & Tchanturia, 2005; Tchanturia, Whitney et al., 2006 ; Tchanturia, Davies et al., 2007; Tchanturia, Davies et al., 2008). These improvements in how they thought seem to be independent of BMI. In a previous study, patients in treatment were given the same cognitive assessments before and after gaining weight. They received treatment as usual without CRT. Despite the fact that the average BMI improved from 13.8 to 18.3, those patients did not demonstrate improved cognitive flexibility as a result of refeeding (Tchanturia, Davies et al., 2008).

In addition to the demonstrated changes in cognitive styles, patients reported that CRT was acceptable, beneficial, and, at times, a welcome relief from the disorder-specific focus on weight and eating. One patient stated, "I feel it (CRT) did improve my psychological health through challenging the characteristics of the illness, which are mainly rigidity and perfectionism." Another noted, "I have come to understand that many of them (rules, rituals and beliefs) are linked to anorexia so resolving one without the other will not improve my chances of recovery alone, but will simply shift the issues to another area." Some patients did note in early case studies that CRT did not seem relevant to their illness, so efforts to process the activities in terms of real world activities were introduced in subsequent trials (Whitney, Easter et al., 2008).

Before CRT can be presented as an effective treatment strategy for eating disorders, rigorous clinical trials with extended follow-up assessments are necessary. Yet at this early stage in its development, CRT is an exciting addition to the treatment options available to clinicians. One aspect of CRT that will be attractive to therapists is that patients who are reluctant to acknowledge or change their eating disorder may be more willing to engage in CRT because it does not directly challenge the patient to change their eating disorder behaviors. And, by completing CRT, patients may engage in traditional treatment strategies more readily as a result of their increased cognitive flexibility. Many patients have told me, "I am sick of constantly worrying about this and just wish I could change my thoughts and feelings... but I don't want to gain weight."

To date there is not strong evidence that standard treatments for anorexia, especially in older teens and adults, are effective. The cyclical pattern of refeeding and relapse is familiar to most clinicians. If CRT can effectively adjust the way patients think, allowing for more flexibility and "big picture" awareness, then clinicians may find that the more refractory aspects of the eating disorder presentation may be addressed more effectively. For a patient who lives and dies by the number on the scale and sees herself as either fat or thin, CRT may open the door to a more global sense of self and to alternative views of herself. Traditional cognitive restructuring methods might prove to be more beneficial if the patient is more flexible in her thinking. It is not uncommon for patients to tell clinicians, "I see the evidence and can come up with a more rational belief, but I just can't let go of seeing it my way."

Distorted body image may be conceptualized as an imbalance or skew in the thoughts, emotions, values and expectations associated with the mental representation of a person's body. Failing to address distorted body image while refeeding a patient may simply set the patient up to be more distressed about weight gain. If CRT can assist an individual in being able to think flexibly about the importance of appearance, to pull away from the individual imperfections and to experience the overall gestalt of her body, traditional cognitive behavioral strategies can build on that improved perspective and expedite the transformation into improved body and self-acceptance.

Some patients will actually describe their eating disorder as a "really bad solution" to an existing problem, that the eating disorder emerged as something they could control rather than feeling out of control. CRT may also enrich our clinical practice by changing perspective on an individual's underlying issues, or problematic core beliefs. If patients become more flexible in the way they see the world, and are better aware of the complexities of the big picture, it is possible they will experience their environment as less threatening, more manageable and less overwhelming. With that shift, their sense of being flawed may also wane.

While CRT is not likely to be the cure to what is clearly a complex and multi-faceted disorder, it might be a catalyst that allows the numerous treatment strategies currently in use to become more effective and ultimately help us achieve the level of treatment success that has eluded us to date.

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Beyond Talk Therapy, Let's Eat: The Use of Therapeutic Eating Events in the Treatment of Eating Disorders

Sondra Kronberg, MS, RD, CDN

As a nutrition therapist, I have worked in the field for the past 30 years. Over time, I have learned that bringing the food directly into the treatment facilitates healing in an extraordinary way. While initially this came naturally to me as a nutrition therapist, I have trained psychotherapists, parents and friends to be supporters in eating events with clients suffering from eating disorders. Join me in my office with Barbara.

Barbara is a 40-year-old client struggling with anorexia. I have been working with her for two years. Since her recent return from a residential treatment center, her eating has become increasingly restrictive. Despite Barbara's attendance at our aftercare group and twice a week therapy with both her psychotherapist and with me (her nutrition therapist), she is quickly spiraling downward. To refresh and reinforce what she learned in the treatment center, I encourage Barbara to participate in a weekly structured and supervised eating event. She listens with trepidation and eventually agrees.

Nutrition therapists and psychotherapists must be willing to witness and embrace the reality of our patients' lives by working directly with food. The uniqueness of the treatment for eating disorders is that it must embody and model healthy behaviors regarding food, weight and shape. It is idealistic to think that entrenched coping mechanisms, identity and thinking patterns can be resolved solely by talking and listening. Actions involving and engaging food are essential. Without directly interacting with the food, symptoms and eating behaviors, a wealth of information and opportunity is lost. Entering the lion's den of food and eating, demands courage, training, and support. This engagement can be daunting, either as a clinician or as a family member supervising their loved one's meals. It is also a parallel process. We must ask of ourselves what we ask of clients; the courage to take hard, scary and uncomfortable actions to facilitate change and foster growth.

Eating with clients and their families or friends, either in our offices or in other public venues, is the most accurate way of getting a true picture of the disordered behavior, its power, and the anxiety it commands. Each eating event is individualized, multidimensional and constantly revised to meet the challenge of the moment. Therapeutic eating events are opportunities to observe or model behavior. They can increase awareness and accountability, while also providing a challenge and opportunity for change. Events are aimed at making actual changes in food quantity, quality, variety and manner of eating through a variety of exposure techniques. They also provide opportunities to explore the impact of social context on the individual's difficulties with eating. An event might include any or all parts of planning, shopping or cooking that end in eating together. It could be an event where food is brought into my office or events where we eat out in different milieus. We may share a fear food, binge food or favorite food. Family social occasions are also opportunities for a family-supported eating event. I have even visited and eaten at campus cafeterias with clients to ease the anxiety that accompanies starting college. Each event requires preparation. Using guidelines and specific strategies, the therapist and client develop a plan for the location and purpose of the event. The anticipation of the planned challenge, and the anxiety of change, is often overwhelming. It is necessary to reinforce trust and to review the guidelines and ground rules in order to promote a sense of safety. It is this safety which ultimately enables the client to relinquish the safety provided by her eating disorder. On the foundation of this safety, clients can take the risk of the exposure to the feared food or context. Graduated increases in the intensity of the exposure usually lead to diminished anxiety and symptomatic behavior. Processing the event is important to the success of the challenge.

- *What would you like to see happen at this event?*
- *Who would you like to support you?*
- *What are your fears?*
- *Who are you concerned about? Me? You?*
- *How will eating with me strengthen/weaken your efforts?*
- *How would it be different if we ate out?*
- *What would make it better for you?*
- *What do we need to do to make this a helpful experience for you?*

Barbara and I finally agreed that the purpose of this eating event would be to go to an unknown restaurant to order and eat a new food from the menu that would be prepared differently. I selected the restaurant, since making that decision was still too anxiety producing for Barbara to make on her own.

The "eating disorder nutrition savvy" therapist, family or friend not only needs to appropriately model but also needs to know how to respond effectively to the barrage of eating disordered thoughts, feelings and questions which will undoubtedly accompany the eating event. It is not always the action which is most difficult or troubling, but the amount of torment and anxiety that precedes it, as well as the feelings of guilt and shame that follow. Eating event supporters need to be prepared to manage these common reactions in order for the challenge to be productive. The sufferer's eating disorder can turn even the most positive of events and accomplishments into a negative experience.

As Barbara and I approached the restaurant, I was aware of both her anxiety and my own. I wondered what awaited us inside the doors. Would I know what to say? Would I be able to read between the lines? Could I contain her anxiety or even my own? Would I fail her in some way?

I stood back as Barbara chose the table and the seat she desired. My silence and stance gave her the space to make a choice that met her needs and it also conveyed my confidence in her ability to do so. The waiter approached with a huge book-like menu and we both took in a deep breath of courage as the challenge began. I cautioned the waiter that we would need a significant amount of time, hoping to make Barbara feel attended to and more at ease.
Armed with broad stroke responses that de-emphasized number and details and emphasized desire and creativity, I helped her navigate the menu. I offered supportive "eating disorder nutrition savvy" dialogues to counter her food fears, quantity distortions, misconceptions about nutrient requirements, and heightened body sensations, as necessary. These seemed to help temper her mounting anxiety and distorted beliefs. We worked together to keep a tenuous balance between her urge to flee and her desire to succeed.

Supervising of eating events and managing the level of anticipation and angst that often develops requires training and patience. The most important guideline is that there be no collusion with the eating disorder. Family members and friends, even professionals, need to be trained as to what this actually means and how to remain neutral and strong. Dialogues which support the client's healthy self must be learned. Strategies and tools for helping supporters or supervisors are imperative as the tenacity of the eating disorder is likely to create enormous frustration, anger and hopelessness.

Back to Barbara. Finally, after much negotiation, she ordered the special of the day, the Tilapia, "blackened." A new fish cooked a new way. Step one accomplished. Huge! As we waited for the food to arrive our dialogues continued. We both sat in our own anxious anticipation. When the food arrived, Barbara carefully scrutinized the plate. She looked for my approval on portions, explored to see what was hiding under the potato, and reorganized the fish. Accompanying the fish was a large salad with a substantial amount of oily dressing. I knew immediately this was a problem. I focused her on the fish, as that was the primary goal. I did not want this salad distraction to negatively affect the purpose of this event. I supported her eating everything else included in the meal and applauded her effort and accomplishment. Then I raised the bar, "Okay, now what about the salad?" At which point, she looked at me with murder in her eyes and said, "I am not eating that! It is drowned in oil. If you make me eat that I will gouge your eyes out!" I had to think quickly. She had completed the agreed upon task. I processed the moment and then I gave her a choice, "either the salad or a piece of bread with butter on it." Feeling that she had a choice was important. She chose the bread. Then came my *outside of the box thought*. I trusted my intuition. I decided to casually eat the salad doused in oil off her plate. I ate her salad!

We paid the bill, according to previously agreed upon guidelines, processed the importance of not engaging in any compensatory behavior as the day progressed, and then left the restaurant. The next day, I received the following email from Barbara:

Dear Sondra,
I know on Friday I said I wanted to gouge your eyeballs out when you suggested that I eat the salad with the dressing, but I went to a new restaurant tonight and survived! I guess going to new places with you helps me make attempts without you every once in a blue moon. Are you ready for this?
We ordered a chopped salad and they put on lots of dressing. I ate it!!! I thought of you eating my salad yesterday and saw that you didn't die from it. Pretty amazing, huh?
I thought you might like to know...
Thanks. See you Tuesday,
Barbara

Eating disorders are creative adaptations that serve as a self-regulating mechanism designed to preserve the status quo. Over time, the eating disorder behaviors lead to an immobilization akin to being trapped on the ledge of a steep mountain, equally terrified to move forward and tortured about what lies below. Nowhere is it more evident than how the sufferer interacts with food. Food and eating are organized with rigidity and consistency to provide a sense of security and control. The thoughts, feelings and behaviors that ensue, produce narrow channels for navigating life. Barbara's response to my request that she eat the oily salad clearly depicted a clear threat to her sense of security.

I believe it is critical to model appropriate eating and a healthy relationship with food within our therapeutic alliances. How could we omit these goals with a population that has such unrealistic and distorted food realities? Was this what I was thinking when I ate her salad? I took a gamble and followed my gut, hopeful that my actions had modeled healthy eating, or at least acceptable healthy eating! Barbara's e-mail validated that they had.

Ultimately, treatment and recovery rely on our ability to create safe places and trusting relationships that foster connections through which growth and change can occur. If our relationships remain "too safe" or comfortable, the therapy can foster a

"stuckness" that maintains the status quo by colluding with the eating disordered thoughts and behaviors. The client, therapist and treatment team can all get stuck on a ledge together. Successful treatment requires that we use the trust and the safety of the therapeutic relationship to highlight the discrepancy between what exists and what is desired. We must help patients challenge the comfort, and facilitate action, in order to move through the "stuckness."

Yvonne Agazarian (Agazarian & Gantt, 2000) teaches that you must move the client to the edge of the unknown and sit together on the edge of the unknown. Eating events are such an edge for therapists and families, as well as patients. It is the edge of the unknown when a family shows up at my office with a pot of spaghetti sauce, an adamant anorexic daughter, and my beautiful white linen wallpaper. It is the edge of the unknown when my client and I go to a diner for the first time and the waiter spills the dripping oil from her dish on my brand new leather bag. It is the edge of the unknown when a client takes his first bite of a feared food or brings in a binge food to eat together in my office. Promoting actions through the power of a therapeutic connection helps our patients heal.

Therapists should construct and process each event collaboratively, as you would all therapeutic events. Meet your clients where they are and help them move one step forward. New places, new experiences and definitely new foods, often trigger the need for the old eating disorder coping behaviors. Watch for overload, either changes in anxiety or impulse. Tune-in and work to balance with your words, actions and your connection, the client's desire to succeed with her fear of failing. As with any traumatic re-expression, go slow, follow the guidelines and be careful. You are not just going out to eat or casually sharing food with someone. Process and pay attention to the before, during and after of the event. The event has the potential to be either re-traumatizing or a corrective experience. Know what your goals are and know what your client's and your own limits are for each experience.

The opportunity to eat with our clients, or to train others to do so constructively, is a powerful tool. Psychotherapy, in which the clients are describing the eating disordered behavior, meals or eating episodes and the feelings that ensue, is also essential. Yet, we develop critical insights by being present and observing the eating disordered behavior in action. Providing your client with the opportunity to observe "normal eating" choices, emotions, patterns, food selections and responses to food as happened at this event with Barbara, are transforming experiences that normalize eating and inspire change. I encourage all clinicians dealing with eating disordered patients to push their own envelopes beyond talk therapy in order to access the enormous potential of integrating therapeutic eating events into your work.

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Why Bother With Father?

Joe Kelly

Every father and stepfather make a huge difference in his daughter's life, whether he realizes it or not—and whether professionals working with families realize it or not. Dad is the first man his daughter knows. With that potent position of "First Man" comes the ability to set the standard of masculinity for her—a norm that ultimately can be stronger than what anyone else tells her.

We all know that girls and women are relentlessly marketed to act and look a certain way, otherwise no man will notice them. A strong cultural myth for females is the notion that "unless a man notices you, you have no value." As First Man, a father or stepfather can blast that lie to smithereens. He can show in words, attitude and action that he values his daughters—and all the women he knows—for who they are, what they do, what they care about—not for how they look.

No other person in a girl's life holds such an influential position on this question. And, dads do the same for boys—who are deeply damaged by the culture's lie that the size of a woman's cleavage is more important than the size of her heart, brains, or spirit.

When fathers truly listen to daughters, we reduce the odds that our girls will be caught in a cultural straight-jacket that limits her options and behavior because of her gender. Dads can fight the effects of the gender straight-jacket by never requiring or expecting our daughters to wear it when they are with us – and thus helping them feel a freedom they may not have elsewhere.

Our impact as fathers on our daughters is astounding. Many fathers may sense this truth, but most do not fully understand it. Often, we can't understand our daughters at all. Having grown up as boys, we are in the dark about what it's like to be a girl. I've spent more than 15 years talking with and listening to North American dads (and their daughters)—tens of thousands of them

from every ethnic, socio-economic and geographical background.

These voices illustrate the immense power of the daughter-father relationship, how influential this relationship is from the very beginning of a girl's life, and the influence a father-daughter team can have on everyone around them.

We don't hear much talk about the influence of fathers on daughters. It's much more common to hear about how girls are influenced by their mothers. But all it takes is a moment's reflection to start realizing the huge impact dads have on every daughter. It's normal and natural that a girl wants to know what's interesting to, or gets the attention of, members of the opposite sex. That's important knowledge for her to have even if she never dates a boy or marries a man, because she lives in a world half-full of boys and men.

Where will she turn first for this information? Most often, she'll turn to the first member of the opposite sex she gets to know: Dad. Even a stepfather, while not necessarily the first male a girl knows, has huge influence because he spends so much time with her. So, the way we fathers act toward our daughters and the other females in her life is what she will expect from boys and men. In all of these, we represent to her the richness, honor and value of being a man. When we are true to her and true to the best in our masculine heritage, she will learn to respect men and treat them as equals. She will learn to gravitate toward men who respect her ,while turning away from men who threaten, violate and abuse. That's good for both a daughter and her father. Perhaps that's what's behind the old (although hetero-sexist) cliché: When a girl grows up, she marries her father.

Nevertheless, girls, their families, and our communities are suffering from the lack of healthy father involvement. What are some of the prices girls pay?

A few years ago, I was a keynote speaker at the Georgia state conference for professionals working with girls in the juvenile justice system. When I finished, the first comment came from a middle-aged African-American man, who stood and said:

"I've been working in "juvey" facilities and group homes for more than 20 years. I can say this about every single girl who has ever crossed the threshold at one of those facilities, regardless of race, class or background: she got there—got into serious trouble—because she was looking for her Daddy in all the wrong places."

Every girl has father hunger (see Margo Maine's outstanding *Father Hunger: Fathers, Daughters and the Pursuit of Thinness*)—she longs to get attention and connection from her dad. Logic, experience and common sense tell us so.

Dads have great influence on their daughters and many choices about how to use it. We can send our daughters down their life roads with clear and healthy expectations for men, or leave our daughters lost in tangled underbrush, confused about what to accept from men. At minimum, dads must be an integral part of our daughters' lives, not abandoning them to wander into the world of boys, men, and the larger culture without our example of strong, supportive and nurturing masculinity. Our example is the road map our daughters use to discover relationships (romantic or not) with boys and men we'd be proud to have as sons and brothers.

Fatherly influence reaches many parts of a daughter's life. Involved fathers show daughters ways to navigate the world outside the family, are role models of independence and competency, and are a moral anchor for them.

When dads first reflect on the enormity of this influence and responsibility, it can seem overwhelming—even oppressive. As one dad told me, "If I screw up, that means she's going to spend the rest of her life with a screw-up. I don't want that!" It's crucial to tell fathers not to despair or give up. Dads can do the job well, even if they sometimes feel like they're completely in the dark.

Genuine fathering is a unique and powerful contribution to a daughter—one that Will Glennon, in his book *The Collected Wisdom of Fathers*, describes as a miracle:

True fathering is not the physical act of planting a seed, it is the conscious decision to tend and nourish the seedling. Real fathering is not biological—it is the conscious choice to build an unconditional and unbreakable connection to another human being. Once that choice is made, it cannot be unmade.

That bond is especially powerful when it comes to a daughter's self-image. As entrenched as beauty myths and body image problems are, fathers can counter them. Fathers can work and play with their daughters to protect and build their self-esteem. That self-worth, no matter its source, is a girl's most potent immunization against the pox of eating disorders and distorted body image.

Fathers can teach daughters the most important lessons in the seemingly offhand ways. In casual day-to-day conversation, they can make observations and provide an antidote to unrealistic portrayals of physical beauty. Listen to this dad's approach:
I tell them things like, "Do you know how many people in this world look like the person on the cover of this magazine? Eight?" My girls need to know early on that, even if my wife and I were the "right build," most likely they will not look like the magazine model. May as well tell them now and move on to what is more important.

Dad can consistently point out characteristics he finds appealing, especially when they belie the cultural standard of female "perfection:" the lovely laugh lines on the face of a daughter's grandmother, the distinctive nose on her teacher, or the great quadriceps of her favorite track star.
Once dads and daughters start looking, they'll soon discover alternative role models everywhere. We can combine our family history with our First Man influence to combat warped media images and keep our daughters in touch with reality, just as this dad does:

My daughter said she was tired of being teased because she had so many freckles. So I said, "Let's get out Grandpa's old slides. Look at all these freckles; everywhere you look, women in our family have freckles. Here's a real strawberry face -- your great, great aunt Catherine who was married less than a year before her husband ran off. Know what she did? Got a job at a big New York restaurant chain and worked her way up to become V.P.—quite a feat for a woman in the 1950s!"

In a quick and natural turn of conversation, this dad showed his daughter that freckles are "the way it is" in her clan, that her foremothers were women of accomplishment, and that there are plenty of colorful, fascinating stories in her very own family—stories more interesting than Miley Cyrus or the celebrity-du-jour. He put her in touch with important truths about who she is and from whence she comes.

In addition to helping daughters find effective new role models, fathers have the

power to nurture a transformation of her body image into a stronger, healthier, more active version. Dads might have to overcome a common misperception first, that of thinking of one's daughter as delicate or fragile:

> *I've been very nervous ever since my daughter came into this world. I think I would know how to raise her better if she was a son. I think that girls are more delicate and precious. I feel that she is like a very fragile vase sitting at the edge of the table waiting for someone to carelessly knock it down. And once it falls, there is no way to keep it from breaking. I'm afraid that I will turn out to be a very strict and restricting father.*

A daughter is not a fragile vase. Ironically, the more Dad treats her like one, the more fragile she will be. Think about how different things would look if this father changed the image of his daughter from porcelain vase to a lithe, flexible, warm, powerful, living, breathing being.

Suddenly, fathering a daughter becomes a lot more fun! Dads can substitute an obsession with how her body looks with an appreciation for what it can do. He can chase around with his daughter, play catch, dance, and have a good time.

As boys, most men grew up challenging and pushing each other physically. We grew up loving to wrestle, work, play catch, build things, play cards, shoot hoops and make puns. We learned much of this love of using our bodies in fun ways from our fathers, big brothers, uncles, grandfathers, cousins and male friends. This love of physicality is one of the most valuable gifts we fathers give our daughters.

We fathers are often more willing to let our children take physical risks than moms. That's good! It stretches our kids, helps them deal with fear and makes them feel more body competent. Dads need to wrestle with her, play word games with her, run, build things together, toss the football, listen to her and treat her as a whole person... not as a vase poised to fall and break.

The biggest challenge for dads of daughters is maintaining a strong connection as girls get older and emerge as sexual beings. Sports and physical activity can be a natural way for dads to meet that challenge, especially because our daughters need healthy, affectionate physical touching from their fathers and stepfathers.

Professionals working with families can use sports as a way to motivate healthy father engagement—engagement that can reinforce a daughter's sense of self and body competence. Why are sports so effective in motivating dads?

Men grow up steeped in sports. Thanks to Title IX, modern generations of girls have sports interests. This gives fathers and daughters a whole new field on which to connect and communicate, especially during times that may be otherwise difficult.

> The benefit for Dad: Sharing and teaching. Pride in her accomplishments.
>
> The benefit for Daughter: Father's attention and affirmation. Deeper knowledge and experience with sports and physical activity.

But to effectively mobilize and utilize fathers, therapists and other professionals (especially females) must go beyond the use of relatively simple tactics like this.

Professionals must learn how to understand the father hurdles that result from how we acculturate boys and men. In general, we raise boys to be emotionally illiterate. This phenomenon (in which both men and women are complicit) leave many men ill-prepared for effective parenting—an occupation that demands emotional literacy.

Of course, degrees of emotional illiteracy don't prevent men from actually having strong degrees of emotion, especially regarding their children.

Certain feelings about a child's development trigger visceral reactions in fathers, and thus can be great motivators for them – and their involvement. I think of these as hot buttons you can use to hook and motivate dads—along with healthy father-daughter relationships. Fathers and children are drawn to the personal benefits—or exposed to personal dilemmas—when education and activities address these hot buttons. Below are some examples (survey your father clientele to discover additional hot buttons to which they relate).

Pride

Ask a dad for the "most memorable" moment of his fatherhood, and he'll describe a time when he felt most proud. Proud of his child's accomplishments and qualities, or proud of his own parenting accomplishment. Daughters sense this and want to win Dad's pride.

> The benefit for Dad: I want to be proud of you. Don't let me down.
>
> The benefit for Daughter: I want to make you proud and keep your trust.

Performance

Men and boys are acculturated to judge themselves and others on their actions and accomplishments. Women and girls are acculturated to judge themselves and others by how well relationships are maintained. This can make for prickly misunderstandings between dad and daughter. But a father's emphasis on performance can also provide valuably high expectations and motivation for his daughter.

> The benefit for Dad: I expect you to do well. I expect a lot from you.
>
> The benefit for Daughter: I will stretch and take risks to meet your expectations and win your praise.

Sexuality

Especially with daughters, dads fear that girls will be manipulated by boys (or men) into inappropriate sexual activity. One of a father's greatest struggles is accepting that his daughter emerges into a sexual being and takes a sexual partner. This creates powerful dilemmas for both dad and daughter—dilemmas that a professional can leverage to reveal and heal deeper issues in the relationship.

> The dilemma for Dad: Don't do anything sexual or express any desire.
>
> The dilemma for Daughter: Why don't you trust me?

Ways of the world

Fathers are more likely to work (and work longer hours) outside the home. They are more likely to manage family finances. Fathers often represent the "outside world" to their children. While this tends to keep fathers emotionally separate from kids, it is also a valuable heritage to openly share with a daughter, helping her be ready for the evolving role of women in the "outside" world. Dad can do take-my-daughter-to-work (and financial literacy) every day.

> The benefit for Dad: I can help her avoid poverty, vulnerability, or unhealthy dependence. I can help her to succeed.
>
> The benefit for Daughter: He can help me learn to manage responsibility, work and money. I want to experience passion like the passion Dad feels for his work and/or hobbies.

Those of us who work with dads must never underestimate the profound influence that stepdads and dads have in the lives and self-image of daughters. Sadly, dads and stepdads still remain an untapped (or, at best, marginally tapped) resource in prevention, treatment and recovery. The reasons for this are too complex to explain in this article, but they include male emotional illiteracy and cross-cultural communication barriers between females (who comprise much of the helping professions) and males (who populate all of the fathering profession).

In researching my book, *Dads & Daughters®: How to Inspire, Support and Understand Your Daughter*, I conducted lengthy, in-depth interviews with more than 130 U.S. fathers and stepfathers from widely divergent backgrounds. They talked for hours about their relationships with their daughters. But fully half of these men said that the *first person* they had ever spoken with about the experience of being a father was me—a relative or complete stranger.

Many people find this hard to believe, but my years conversing with, writing about and speaking about fathers only reinforces this sad fact of father silence. It's not that dads lack for things to say (most interviews for the book ran 2-3 hours each), but it doesn't occur to most men to speak about their fathering experience—or for other people to ask fathers about it.

This is crucial to remember when working with fathers: the word he speaks to you may be—literally—the first words he's ever spoken about being a dad. Professionals need to have reasonable expectations about how much insight and articulation he can bring to those early conversations.

Fathering hurdles make it difficult for family professionals (like therapists, dietitians, physicians, etc.) to work with dads. But the difficulties are no excuse for shirking the responsibility and necessity of involving fathers and stepfathers in the treatment and recovery of their children, no matter their age.

Unless professionals actively and continually engage fathers when working with children and families, they are working with one eye closed and one hand tied behind their backs.

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Research and practice in clinical psychology: Different ways of knowing

Yelena Chernyak, MS, Amy Neeren, PhD, Doug Bunnell, PhD, Laurel Greberman, ATR-BC, MBA, LPC, & Michael Lowe, PhD

Over the last several decades, the field of psychotherapy (and clinical psychology in particular) has striven to achieve unification between research and practice. However, the goal of integrated research and practice remains elusive. Part of the reason for this divide is that sources of knowledge (or "ways of knowing") used by researchers and clinicians to identify effective therapeutic practices are so different.

Empirical study, utilized by clinical researchers, represents one fundamental way of knowing (i.e. determining what techniques or approaches are most effective for particular problems). More than just a collection of facts, scientific inquiry consists of a set of assumptions (treatment models) and rules (research methods) for deriving reliable and valid knowledge about the natural world—including psychopathology and psychotherapy. The research perspective emphasizes a continual process of hypothesis generation and testing to build psychological knowledge and continually evaluate and revise psychotherapeutic approaches based on quantitative outcomes. On the other hand, clinical researchers often do not sufficiently acknowledge that scientific knowledge about psychotherapy is still rudimentary—although it sounds contradictory, research findings may be both indispensable yet insufficient for conducting maximally effective therapy.

An alternative way of knowing, used by many practicing clinicians, is based on (often unvalidated or poorly validated) clinical theories, clinical experience, and clinical intuition. That is, clinicians' "way of knowing" integrates their accumulated knowledge and clinical experience, together with their interpretation of individual cases. This approach permits a fuller view of the subtleties and complexities of individual, real-world cases.

Clinicians and researchers, like all human beings, are vulnerable to erroneous subjective judgments and biases. An example of a documented common clinical error is the confirmation bias, whereby clinicians tend to remember treatment successes and forget treatment failures, thereby overestimating the effectiveness of therapy (Nickerson, 1998). Researchers are also prone to biases as shown, for example, by the fact that ostensibly impartial research on drugs that is funded by a drug's manufacturer produces more promising results compared to studies funded by other sources. An overarching goal of scientific research is an attempt to minimize such errors, regardless of the theoretical orientation to which a therapist subscribes. However, most therapists have little awareness of the numerous biases in clinical judgment they are susceptible to. When we go to medical doctors, our faith in their expertise is substantially based on the assumption that they have been educated in the latest scientific knowledge about disease and its treatment. As scientific knowledge about psychopathology and psychotherapy expands, we believe the same will apply to mental health professionals.

Bridging the Researcher-Clinician Gulf

The two ways of knowing (outlined above) often seem to be irreconcilable. However,

the two are less at odds than they may seem. Many clinicians may be surprised to find out that empirical studies are not limited to specific treatment protocols, but to improving the process of psychotherapy itself. Research has supported the importance of the therapeutic alliance as a source of change in treatment. Some clinicians may also feel that their therapeutic armamentarium will diminish if they more fully acknowledge the biases and errors they are prone to. However, the purpose of research is to deliver more and better tools to the hands of clinicians. Practice guidelines based on empirically supported treatments can be adapted by each clinician in combination with their existing repertoire of skills. This approach does not intend to strip clinicians of their unique approaches, but allows them to bolster what they can offer to their patients and to practice increasingly effective psychotherapy.

There is both an art and a science to clinical practice. These separate ways of knowing each contribute invaluable components for the delivery of effective interventions. Science is often tentative, providing continuously evolving results that may be difficult for the practicing clinician to keep current with. However, integrating the knowledge that does come out of empirical studies should enhance the positive effects of the psychotherapeutic process. Since therapy for mental disorders —like that for physical disorders—is ultimately an outcome-based enterprise, practicing therapists (and their patients) can only benefit from the incorporation of procedures shown to enhance outcome.

Often times, practicing psychotherapists believe that research is unable to guide clinical practice in any significant way because the methods used to treat mental disorders are too far removed from actual practice to be of value. Although it is true that research protocols favor homogenous samples of individuals and highly controlled conditions, researchers are moving toward applying these findings to 'real-world' clients.

There is an increasing emphasis on closing the research-practice gap by: 1) translating highly controlled research to practice settings; 2) conducting more research in practice settings, and 3) conducting more research on the realities that practicing clinicians face with their patients. An example of this approach has been implemented by Dr. Michael Lowe and his colleagues at Drexel University and at Renfrew, based on a NIMH grant developed by Dr. Lowe and Dr. Bill Davis. The research project, which was recently completed at the Intensive Outpatient Program (IOP) at The Renfrew Center, has made progress in bridging the two, seemingly irreconcilable perspectives reviewed above. It is summarized next.

The NIMH-funded study at Renfrew's Intensive Outpatient Program
The Clinical-Research Perspective

The vast majority of controlled psychotherapy outcome studies for eating disorders have used highly-controlled "efficacy" designs, leaving open the question of the real-world applicability of their findings. Efficacy studies have found cognitive-behavior therapy (CBT) to be the treatment of choice for bulimia nervosa (BN) and CBT may hold promise for anorexia nervosa (AN) as well. The overarching goal of this NIMH-funded study was to demonstrate the feasibility of adapting therapeutic procedures developed in CBT efficacy studies to The Renfrew Center's Intensive Outpatient Program (IOP). We implemented an effectiveness paradigm (that utilized existing therapists and accepted all IOP patients for inclusion in the study) to evaluate the usefulness of CBT treatment in Renfrew's IOP. Treatment outcome research is rarely conducted in such real-world clinical treatment settings and yet, the vast majority of eating disordered patients are treated in these settings.

Our intervention was referred to as "Normalization of Eating" (NOE), which is a central component of CBT. The original goals of the NOE intervention were to: a) promote and maintain a regular pattern of food intake that would reduce dieting and bingeing and maintain or increase body weight; b) identify specific fear-based practices or beliefs that underlie avoidance of food and eating; c) design behavioral tasks to be implemented during supervised IOP meals and at home via homework assignments to gradually expose patients to feared foods and behaviors, and d) teach cognitive therapy techniques so patients could learn how to challenge their own extreme and irrational thoughts about food, eating, and weight. Additionally, patients were gradually and increasingly exposed to their feared foods both inside the IOP during evening meals as well as at home. We also incorporated a pre- and post-meal check-in time within the already existing IOP groups to check on the progress of patients' food-related goals at home and their food-related goals for the IOP meal each evening (pre-meal group) as well as the progress on their food-related goals during the IOP meal (post-meal group).

The methodology of the study was divided into two phases. The first phase was "Treatment as Usual" (TAU)." No changes were made to existing IOP treatment during this phase, but comprehensive assessments of eating disordered symptomatology were conducted at admission and discharge so the effects of TAU on symptoms could be measured. This phase lasted one year, during which about 50 patients were assessed. Phase 2 involved introducing NOE procedures into the IOP treatment and training staff in their administration. Drs. Lowe and Neeren started working with IOP staff two months prior to the transition to Phase 2. Our original goal was to conduct NOE training and supervision of staff for 4 months. However, both the staff and the researchers encountered a variety of challenges in training on NOE procedures. NOE training and supervision, therefore, continued throughout the entire one-year NOE treatment phase. Dr. Lowe and his research team held weekly training sessions with the IOP staff to discuss the overall conceptualization of CBT and the importance of implementing NOE procedures as well as how to implement the techniques. Within these training sessions, the researchers often engaged in role-playing strategies as a way of illustrating the techniques.

The treatment staff had not been involved in the development of the study and this posed considerable difficulties in teaching and administering the NOE treatment. Furthermore, most staff had been trained in psychodynamic and relational treatments and were largely inexperienced with formal CBT procedures. Many of the cognitive-behavioral techniques that the researchers wanted to employ required an explicitly directive approach—as patients' thoughts and assumptions regarding food were to be continually challenged through cognitive restructuring and through behavioral "experiments." IOP therapists were now being asked to encourage patients to test their assumptions about food, eating and body weight. This shift to a more directive and focused exploration of thoughts and behaviors took considerable time and effort of the parts of the

researchers and the clinical staff. The researchers also found that existing IOP procedures needed ongoing modification and refinement to fit within the study's protocol.

This NIMH-funded study ended in July 2008. Dr. Lowe and his research team have analyzed the data that were collected pre- and post-treatment to measure patients' degree of symptom change during the course of both the TAU and NOE treatments. The data analyses compared the degree of change in patients' symptoms between these two treatment phases. The results from Dr. Lowe and his research team indicate that patients' eating disorder symptoms (e.g. drive for thinness, weight and shape concerns, dieting, binge eating) during the TAU phase showed relatively small improvements (ranging from 5-25 percent from initial levels). The addition of NOE procedures into treatment resulted in similar modest changes; in other words, the degree of symptom improvement among patients in the NOE phase did not improve patients' treatment outcome relative to the TAU phase. It is unclear whether the lack of meaningful differences between the TAU and NOE phases was due to the fact that we were unable to sufficiently implement the NOE treatment, or because the elements of NOE did not enhance treatment. Nevertheless, both the researchers and Renfrew IOP clinicians learned a great deal from this experience. The clinical site found some of the NOE procedures to be beneficial to patients and therefore have incorporated some of these techniques into the IOP and Day Hospital programs at Renfrew. Dr. Lowe and his research team learned a great deal regarding the clinical realities of treating patients with more severe and complex eating disorders. More specifically, his team came to appreciate the challenges of working with treatment-resistant patients who are not usually included in existing research on eating disorders treatment. Finally, much has been learned about how to implement research studies within functioning clinical sites similar to Renfrew.

The Clinical Perspective

The Renfrew clinical programs originally grew out of a feminist-relational perspective that explicitly values collaboration and interdependence. Ironically, albeit unwittingly, the process involved in implementing this study was, tongue in cheek, distinctly, masculine and hierarchical in that it seemed imposed by authority rather than developed in collaboration. The project leaders had met with the IOP staff in the very early planning stage but few of the staff at the onset of the study had any awareness of the project. The clinical staff were asked to make substantial changes in the way they delivered therapy and, perhaps, more importantly, in how they conceptualized their patients' difficulties. We know how important the initial engagement process is for the success of psychotherapy. In retrospect, we've come to appreciate the parallel significance of the early collaboration between researchers and clinicians.

Most, if not all, of the IOP patients had significant psychiatric co-morbidities and many, if not all, were at least somewhat ambivalent about their commitment to therapy and change. This ambivalence is characteristic of most patients with eating disorders. Many of the clinical staff were skeptical about the relevance of NOE techniques for addressing the challenge of engaging and stabilizing these often emotionally and physically fragile women. In the initial treatment as usual phase, the development of a safe, containing, and predictable therapeutic milieu was the clinical focus for most patients. Therapists were expected to help patients identify and secure other sources of connection outside of the program with the expectation that increasing social and relational support would lead to a decrease in symptom severity. Food and eating-related topics were usually addressed within a dynamic and relational context, although nutritional and mealtime support therapies did deal with explicit food-related challenges and goals. With the clinical focus on self-regulation, distress tolerance and containment, the staff aimed to identify and manage emotional "triggers" for eating disorder symptoms rather than addressing specific cognitive distortions or specific behavioral targets (e.g. food restriction). In Phase 1, therapists tried to help patients steer away from the emotional triggers; in Phase 2, the NOE approach called for a voluntary, deliberate and gradual exposure to triggers. This "trigger" issue became an essential point of contrast between the treatment-as-usual approach and the experimental NOE approach.

The researchers led a weekly training session for the clinical staff. They also attended IOP sessions on a regular basis to observe the group sessions. Their observations formed the basis of the subsequent training session. Both the researchers and the staff labored to make these sessions productive and collaborative. On bad days, however, they could start to resemble a seminar led by ivory tower academicians with a classroom of advanced graduate students taking an unpopular but required course. The clinicians wanted concrete guidance about what to say and do but the discussions often stayed on an abstract level. At times it seemed that the researchers interpreted the clinicians' frustration as frank resistance to the more directive aspects of the NOE approach. The clinicians, in contrast, often felt that they needed more information. They were struggling to manage the needs of their patients using techniques with which they were unfamiliar. Over time, both groups made significant adaptations. The researchers modified the NOE protocols to fit the existing program structures while the clinical staff gradually became more adept at integrating a NOE perspective into their therapeutic interventions.

The study and the training seemed to end just as it was really starting. The end, however, has in fact become a starting point. The clinical staff has enthusiastically incorporated many of the concepts and techniques introduced in the course of the NOE program. They have instituted a regular food challenge group modeled on the study protocols and have reported that the IOP patients find this group particularly helpful. In the food challenge group, patients selected a food that created anxiety. Patients would develop a specific goal in regards to that challenge food (e.g. "My goal tonight is to eat half of the Reese's Peanut Butter Cup). During the group, staff would ask patients what their thoughts were regarding their food. They would then work with the patients to challenge their beliefs about their feared food in order to meet the specific food goal.

The Renfrew IOP Clinical Supervisor was asked to summarize her perspective on the study and its impact on her program. True to her background as a creative arts therapist and a dynamically oriented psychotherapist, she chose to respond with this metaphorical summary:

On a cold December afternoon, two parents, NIMH and Renfrew, made arrangements for a blind date. Both parties were anxious and excited to embark on an experience that had potential to be mutually

beneficial. The moment arrived, eyes met, expectations and needs for this new relationship were discussed. Some doubts and questions were raised. Others were not expressed at all to ensure that this relationship would have a successful start.

As the relationship progressed, both parties became more acquainted with each other; quirks became evident, resistance to change regarding philosophical beliefs also emerged, frustration ensued but never once was a break-up discussed. Instead, both parties continued to build a strong foundation.

After nearly two years of dating, the time had come to celebrate the union. Both parties then worked independently to write their vows, which included compiling all of the information obtained throughout the years, reflecting on the memories; what worked, what didn't work, lessons learned and capturing the emergence of a deep respect for each other, ensuring a partnership for years to come.

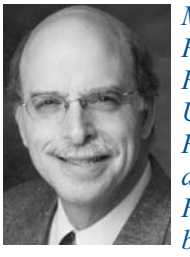
Although it was two and half years in the making, during the early summer of 2008, Renfrew and the researchers were proud to announce the birth of the "Food Challenge Group." Over the past several months, with proper nurturance and guidance, the group continues to develop, trying new techniques and introducing a multitude of challenges. The parents are proud of what they have accomplished, both clinically and professionally.

***Yelena Chernyak, MS** is an advanced graduate student in Drexel University's doctoral clinical psychology program. Ms. Chernyak's dissertation research focusing on the motivations for dieting among women with eating disorders is conducted in collaboration with The Renfrew Center. Her clinical interests include treatment of obesity and eating disorders.*

***Amy Neeren, PhD** is an Assistant Visiting Professor at Haverford College and Junior Research Consultant for The Renfrew Center and has been involved with the Research Department since Sept. 2006.*

***Doug Bunnell, PhD** is Vice President and Director of Outpatient Clinical Services at The Renfrew Center. Dr. Bunnell is a former President of The National Eating Disorders Association and Founding Member and Fellow of the Academy for Eating Disorders.*

***Laurel Greberman, ATR-BC, MBA, LPC** is the Clinical Supervisor at The Renfrew Center of Radnor, PA. A trained creative arts therapist as well as a psychotherapist, she has over 10 years experience working with women with eating disorders.*



***Michael Lowe, PhD** is Professor of Clinical Psychology at Drexel University and Senior Research Consultant at The Renfrew Center. He specializes in bio-behavioral research on dieting, obesity, and eating disorders. His eating disorders research examines the role of dieting and long-term weight suppression in the pathogenesis of bulimia.*

Your Donation Makes a Difference

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

Your Donation Makes A Difference…

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

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

Tax-deductible contributions can be sent to:
The Renfrew Center Foundation
Attn: Debbie Lucker
475 Spring Lane, Philadelphia, PA 19128

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

- ❑ Treatment Scholarships
- ❑ The Barbara M. Greenspan Memorial Fund - supports a lecture at the Annual Conference for Professionals
- ❑ Area of Greatest Need

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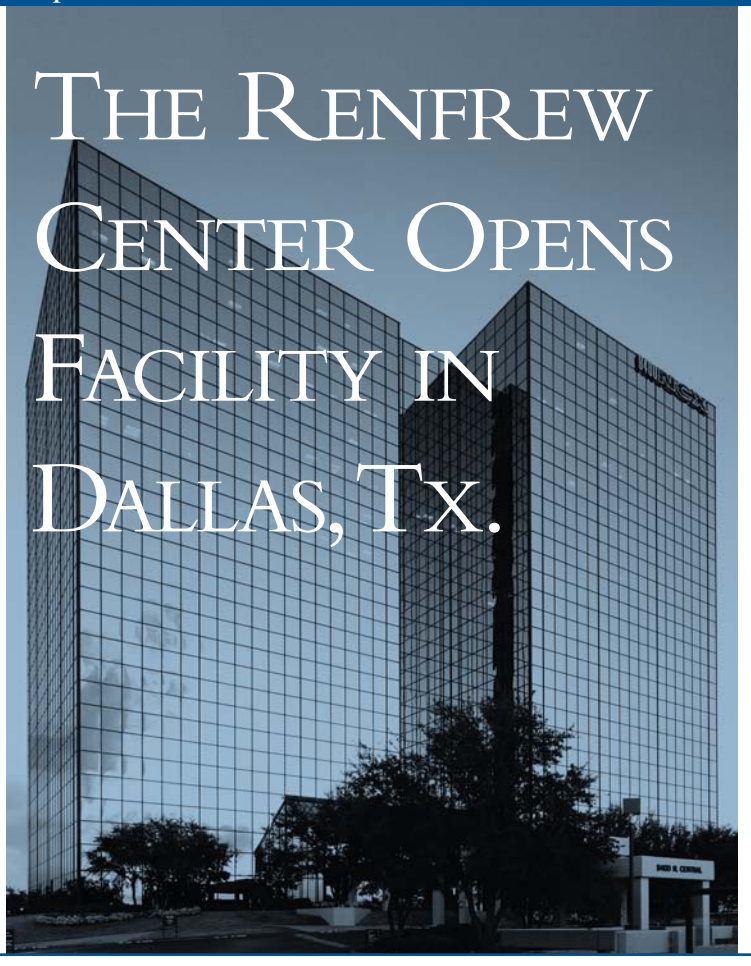

The Renfrew Center Opens Facility in Dallas, Tx.

The Renfrew Center is pleased to announce the opening of a new site in Dallas, Texas.

Programming offers a comprehensive range of services including:

- Day Treatment Program
- Intensive Outpatient Program
- Group Therapy
- Individual, Family, and Couples Therapy
- Nutrition Therapy
- Psychiatric Consultation

The Renfrew Center of Texas is located on 9400 North Central Expressway Dallas, TX 75231

For more information, call 1-800-RENFREW or visit www.renfrewcenter.com

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For more information, call 1-877-367-3383 or visit www.renfrew.org

The Eighteenth Annual 18th *Conference Update*

The Renfrew Center Foundation FOR EATING DISORDERS

Thanks to all of the attendees, speakers and Renfrew staff who participated in the 2008 Renfrew Center Foundation Conference. The weekend was filled with tremendous energy and excitement as we welcomed almost 700 professionals, about half of whom were attending for the first time. "The Power of Therapeutic Relationships," our conference title and theme, captured the essence of Renfrew and the sense of community we attempt to create each year. Enthusiasm was evident at all the networking events and receptions, as well as morning activities and special breakfasts. We welcomed many more physicians and nurse practitioners this year, as we were able to provide continuing medical education.

The Keynotes and workshops received among the highest evaluations in our 18-year-history. In her outstanding Keynote, Jane Fonda shared personal stories and the lessons she has learned throughout her life about relationships, the drive for perfection and her battles with eating disorders. She also addressed the impact of culture on the development of young girls and their self-esteem. On Saturday, Dr. Christopher Fairburn gave an excellent presentation on the Broader Implications of the Research on CBT for Eating Disorders and offered strategies focused on eating disorder behavior and ways to develop a highly individualized plan for patients. Our closing Keynote on Sunday, delivered by Dr. Amy Banks, brought together contemporary relational/cultural theory with current neurobiology as she spoke about how to engage, connect and create change in patients.

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

Next year's Conference, "Feminist Perspectives and Beyond: The Art and Science of Eating Disorders Treatment," will take place from November 12th-15th, 2009.
A CALL FOR PROPOSALS can be found on PAGE 24.

We look forward to seeing you next November!

Judi Goldstein, MSS, LSW
Conference Chair

"Perfect combination of experiential, interactive and didactic workshops."

"The Conference was very comprehensive and explored the theme of relationships in great depth."

"Powerful presentations!"

"The experiential workshops were particularly meaningful and helpful to me and my practice."

"Speakers were engaging, knowledgeable and connected to the audience!"

"I may have to make this an annual tradition!"

CALL FOR PROPOSALS

THE 19TH ANNUAL RENFREW CENTER FOUNDATION CONFERENCE

Feminist Perspectives and Beyond:

The Art and Science of Eating Disorders Treatment

November 12-15, 2009
Philadelphia Airport Marriott

In the past, the efforts of dedicated clinicians and researchers have contributed to significant progress in the treatment of eating disorders. Currently, a great deal is known about the qualitative—intuitive, spontaneous and sensitively nuanced—aspects of treatment that promote recovery, and a large body of information is available regarding specific, concrete interventions that, similarly, tend to enhance healing. By now, it is clear that successful treatment encompasses both the art and science of eating disorders treatment.

The task ahead is perhaps less a search for major new breakthroughs and more a determined pursuit of refinement and integration. The therapeutic challenge may be one of learning how to make more effective use of what we already know.

Accepted Proposals Will Address:

- Understanding and treating EDNOS, the most common eating disorders diagnosis
- Integrating evidence-based interventions and relational therapies
- Adapting therapeutic techniques to the changing clinical picture
- Therapeutic breakthroughs – unique or repeatable events?
- Providing motivation and skills to help therapists and clients move beyond their "comfort zones"
- Combining different treatment models to enhance outcome
- Planning and implementing successful effectiveness studies
- Models for productive psychotherapy supervision
- Therapist Self-Care

Conference Format

- Keynotes
- Full-Day Trainings
- Poster Presentations*
- Two-Hour and Three-Hour Presentations
- Networking Receptions

***Poster Presentations:** For the 2009 Conference, the Committee is interested in soliciting poster presentations that document new research findings and fresh approaches to clinical work. The Poster Session will take place on Saturday, November 14th and will feature the work of both senior and junior investigators in the field. Graduate students are particularly encouraged to submit poster proposals. Any poster that describes novel research or clinical data will be considered for inclusion in the session. Questions about poster format should be addressed to Dr. Douglas Bunnell at dbunnell@renfrewcenter.com

DEADLINE FOR SUBMISSION: MARCH 13, 2009

Please submit (A) Cover Letter, (B) Abstract, (C) Biographical Sketch, and (D) Presentation Experience as indicated below:

Only one proposal per person

A. Cover Letter: Attach a cover letter that includes the following:

1. Title of proposal presentation.
2. Type of proposed presentation: Full day workshop, Three-hour workshop, Two-hour workshop, Poster.
3. Presenter(s): Maximum of **two** presenters (**no** exceptions).
   i. Lead presenter's name, address, degree, phone number, fax number, email address and social security number.
   ii. Additional presenter: same as lead presenter.
4. Requirements for audiovisual equipment.
5. Presentation format (primarily didactic, interactive or experiential).
6. Presentation content (primarily theoretical, clinical/case examples or research/experimental).
7. Suggested audience level for the presentation (beginner, advanced).

The Conference Committee particularly welcomes workshop proposals that are **interactive**, and those directed towards an **advanced** audience.

B. Abstract: Attach a description of the presentation that includes the following:

1. An extended abstract that describes major ideas, themes and aims of the presentation (**150** words maximum, **no** exceptions).
2. A brief summary abstract for inclusion in the Conference brochure (**50** words maximum, **no** exceptions).
3. Three behaviorally measurable learning objectives that are achieved by the presentation.

C. Biographical Sketch: Attach a description of your professional experience in the following order:

current title and affiliation; relevant publications; relevant organizations; private practice location and area of expertise (**100** words maximum; **no** exceptions).

D. Presentation Experience:

Provide a list of professional presentations you have done within the past **two** years. Please inform us if you are presenting or submitting this proposal to another eating disorders conference in 2009.

PRESENTATION GUIDELINES:

Please adhere to the following guidelines:

1. Integrate relevant clinical examples.
2. Do not plan to only read or lecture, including Power Point presentations.
3. Presenters are encouraged to be interactive with their audience.
4. All presentations **must** relate to the Conference theme and stated learning objectives.

Submit a proposal by electronic mail, and only within the body of the email. Both LAST name of the lead presenter MUST be in the subject line. Attachments will not be accepted or opened.

SEND THE PROPOSAL TO THE FOLLOWING MEMBERS OF THE CONFERENCE COMMITTEE:

jgoldstein@renfrewcenter.com
wmndavis@comcast.net
dbunnell@renfrewcenter.com
jrrabinor@aol.com
aressler@renfrewcenter.com

DECISIONS OF THE PROGRAM COMMITTEE WILL BE MADE BY MAY 8, 2009.

Please Note: Some proposals submitted for a workshop may be accepted as a poster presentation.

AUDIO CD AND MP3 ORDER FORM

The 18th Annual
Renfrew Center Foundation Conference

November 13-16, 2008 – Philadelphia, PA

"Feminist Perspectives and Beyond:
The Power of Therapeutic Relationships in the Treatment of Eating Disorders"

☑ PLEASE CHECK THE CDS YOU WISH TO ORDER

TH 1
❑❑❑❑ (4 CD Program)
Clinical Implications and Applications of Psychoneurology:
Translating Neuroscience to the Consulting Room
Francine Lapides, MA, MFT

The stress of daily living causes mind-brain-body systems to dysregulate, resulting in symptoms such as depression, anxiety and addictive relationships to substances or behaviors. This full day workshop describes contemporary research in neuroscience that suggests emotional healing takes place primarily in the circuitry of the right hemisphere, which is dominant for attachment, intense emotionality and the knowledge of how to be in relationship. This research supports the recent shift from a neutral, analytic style of psychotherapy to more intersubjective, relational approaches, and emphasizes the importance of relationship-based healing, which occurs beneath the specific interventions of differing theoretical models.
Didactic, Interactive, Experiential, Beginner

TH 2
❑❑❑❑ (4 CD Program)
Beyond Compulsive Eating: Turning to Yourself Instead of Food
Carol Munter

During infancy, food relieves the physical distress of hunger and promotes peaceful sleep. As a result, throughout life, food has the potential to feel soothing, even when the distress is psychic rather than physical. This full day workshop describes the Overcoming Overeating treatment of compulsive eating which emphasizes the importance of returning food to its original purpose, a means to satisfy physiological hunger, and helping adults to feed themselves "on demand." Gradually, this approach enables the compulsive overeater to build psychic infrastructure, think about her problems rather than eat about them, and turn to herself instead of food. Reading Overcoming Overeating and/or When Women Stop Hating Their Bodies in preparation for the workshop is recommended.
Didactic, Interactive, Advanced

TH 3
❑❑❑❑ (4 CD Program)
The Power of Collaboration in the Treatment of Eating Disorders: The Physician's Perspective
Shawn Gersman, MD, Mitchell Cohen, MD, Christopher Chambers, MD, David Hahn, MD, Jeffrey Bronstein, MD, Franci Kraman, MD, Phyllis Greenwald, MD and Susan Ice, MD

This full day workshop presents in-depth discussion and debate about four aspects of eating disorder treatment relevant for all providers and of particular significance for physicians working the field. Topics to be addressed include Pharmacotherapy; Diagnostics; Tertiary vs. Secondary and Primary Care; and Managed Care. At the end of this activity, participants should be able to examine the complications inherent in prescribing medication for eating disorder patients; review the spectrum of eating disorder diagnostics, including EDNOS; identify the difference between primary, secondary and tertiary care; and assess how provider and managed care can best work together.
Didactic, Interactive, All Levels

TH 4
❑❑❑❑ (4 CD Program)
Calming The Inner Critic
Jane Shure, PhD, LCSW and Beth Weinstock, PhD

Anyone struggling with an eating disorder lives with a harsh inner critic that thwarts freedom of expression, creates guilt and fear, feeds self-destructive behavior and diminishes self-esteem. This full day workshop describes the original, protective function of the inner critic, presents strategies to help clients give up old patterns of self-sabotage and develop a powerful inner coach that encourages self-affirmation. Discoveries in neuroscience, which support this therapeutic approach will be explored. Additional topics include the inner critic and negative self-talk of the therapist. Case examples and experiential exercises are presented to strengthen therapeutic skills in working with these issues.
Interactive, Experiential, All Levels

TH 5
❑❑❑❑ (4 CD Program)
Training Caregivers in the New Maudsley Method of Shared Collaborative Care

Janet Treasure, MD

Family members are primarily responsible for taking care of individuals with anorexia nervosa, but frequently they lack the skills and resources to be constructive. Instead, interpersonal processes develop which serve to maintain the eating disorder. This full day workshop describes a manual-based intervention to help family members manage eating disorder symptoms effectively, by training them to moderate expressed emotion, improve communication with motivational interviewing and conduct functional analyses of family behavior patterns. Evidence to support this intervention is presented, as well as an interactive demonstration.
Didactic, Interactive, Experiential, All Levels

FR 1
❑❑ (2 CD Program)
Building Alliances in Group and Family Therapy
Carolyn Costin, MA, MEd, MFT

Group and family sessions provide a unique opportunity to establish and share preferred identities. This workshop demonstrates specific practices to elicit a broader sense of a client's identity and values, build alliances with therapists, family members and peers, and increase the client's motivation for change.
Interactive, All Levels

FR 2
❑❑ (2 CD Program)
Embodiment and the Therapeutic Relationship
Lisa Brown, MA, LMFT

Body-based psychotherapeutic approaches are a necessary and vital aspect of the recovery process. Using experiential and interactive methods, this workshop helps clinicians to address their own embodiment as a way to facilitate somatic aspects of the therapy process.
Experiential, Interactive, Advanced

FR 3
❑❑ (2 CD Program)
The Treatment of Eating Disorders: What Do Men Have to Do with It?
Leigh Cohn, MAT, CEDS, Margo Maine, PhD, FAED and Douglas Bunnell, PhD

Men play a vital role in the treatment of eating disorders. They are fathers, husbands, brothers, sons, friends, and therapists of women who are suffering; and, increasingly, they are patients. This multimedia presentation describes how to involve men in recovery and why the incidence of male eating disorders is growing.
Didactic, Interactive, All Levels

FR 4
❑❑ (2 CD Program)
Soul to Soul: Bringing Authentic Presence into the Therapeutic Relationship
Anita Johnston, PhD

This workshop teaches clinicians to find authentic presence within themselves - that soulful place where conflict is paradox, and symptom and symbol are one, in order to create a therapeutic relationship where metaphoric language is spoken, symptoms are understood as messages, and disordered eating is seen through new eyes.
Didactic, Interactive, Advanced

FR 5
❑❑ (2 CD Program)
The Treatment Team as Therapeutic Relationship
Lisa M. Pearl, MS, LDN, RD, GCEC

Effective multidisciplinary treatment of eating disorders requires a team of collaborating professionals. This presentation explores two aspects of team work that contribute to recovery but are rarely discussed: the relationship patients have to the holding environment of the team, and the nature of relationships within the team.
Interactive, Didactic, All Levels

FR 6
❑❑ (2 CD Program)
THE BARBARA M. GREENSPAN MEMORIAL LECTURE
Don't Ask Me to Forgive You:
A Radical Approach to Healing Intimate Wounds
Janis Abrahms Spring, PhD

Forgiveness is considered the gold standard for recovery from interpersonal injuries. In real life, however, hurt parties often can't or won't forgive, particularly when the offender is unrepentant or dead. This workshop, especially relevant for the treatment of trauma, offers a radical, new alternative to forgiveness - a profound, life-affirming, healing process called Acceptance. Participants will learn concrete steps for healing victims of trauma, including how to de-shame the injury, release obsessive preoccupations with the abuse, integrate an appropriate share of responsibility for what went wrong, and decide what kind of future relationship is best to have with an offender.
Didactic, Interactive, Experiential, All Levels

FR 7
❑❑ (2 CD Program)
Take off the Blinders: Moving from Sensitivity to Appreciation
Gayle E. Brooks, PhD and Rose LeDay, PhD

Can therapist sensitivity to diversity issues establish true, authentic connection with clients who are perceived as

substantially different? This workshop is designed to explore the impact of diversity on therapist/client relationships, including the influence of value systems, the process of building rapport, and the distinction between diversity "sensitivity" and diversity "appreciation."
Interactive, Beginner

FR 8
❑❑ (2 CD Program)
The Maudsley Family Meal: Teaching Families to be Therapeutic Feeding Agents
Marcia Herrin, EdD, MPH, RD, LD

Despite the growing acceptance of the Maudsley Approach, clinicians often have very little specific guidance to offer parents. This workshop will focus on how to help parents with specific refeeding issues. Participants will have the opportunity to observe and play a part in a coached meal experience.
Didactic, Interactive, Experiential, Advanced

FR 9
❑❑ (2 CD Program)
The Mindful Therapist: Developing Mindfulness Skills as Part of the Therapeutic Process
Kimberli McCallum, MD

Patients with eating disorders are often in an "un-mindful" state, preoccupied with weight, and anxieties about past or future concerns. This workshop presents a model for incorporating mindfulness into psychotherapy, including a review of relevant research, strategies to increase the mindfulness skills of therapists and implications for countertransference.
Didactic, Interactive, All Levels

FR 10
❑❑ (2 CD Program)
Engaging the Reluctant Client
Thomas J. Shiltz, LPC, CSAC

"Chronic" eating disorder clients who have been resistant to treatment are often mired in the precontemplation stage of change. This workshop uses stage of change theory to discuss the essential elements that must work together to help chronic clients progress to later stages of recovery.
Didactic, All Levels

FR 11
❑ (1 CD Program)
Her Story, My Story
Joanne Theobald, MSW, LCSW

This interactive presentation explores positive and negative implications for treatment when therapists have had an eating disorder. Topics to be discussed include the ethics of revealing an eating disordered history, the impact of self-disclosure on the therapist and the therapeutic relationship, and strategies for therapist self-care.
Interactive, Experiential, Advanced

FR 12
❑❑ (2 CD Program)
In Relationship: A Contemporary Psychoanalytic Approach Along the Continuum of Care
Anne Wennerstrand, MS DTR, LCSW and Catherine Baker-Pitts, PhD

This workshop explores feminist relational psychoanalytic theory and the treatment of eating disorders along the continuum of care. Topics to be addressed include the co-creation, subjective experience, and dynamic understanding of the therapeutic relationship when issues of power, powerlessness and control are expressed in eating symptoms.
Didactic, Advanced

K-1
❑ (1 CD Program)
KEYNOTE PRESENTATION
The Broader Implications of the Research on CBT for Eating Disorders
Christopher Fairburn, DM, FRCPsych, FMedSci

The research on cognitive behavior therapy for eating disorders has implications which go beyond this specific field. In his keynote presentation, Dr. Fairburn will address four topics to illustrate these implications. These include: 1) the advantages of adopting a transdiagnostic perspective; 2) "complex patients" and complex treatments; 3) the value of unexpected findings; and 4) the importance of the therapeutic relationship. It will be argued, with the support of empirical data, that with regard to each of these topics, certain widely held assumptions are likely not to be valid.

SA 1
❑❑ (2 CD Program)
Intertwined Souls: Reflections on the Psychospiritual Therapeutic Relationship
Rev. Steven Wiley Emmett, PhD and Carolyn Costin, MA, MEd, MFT

There is a deeper spiritual dimension inherent in every therapeutic alliance. This workshop explores the dynamics of a psychospiritually-based therapeutic relationship. Topics to be discussed include the rich interplay between mind, body and spirit that informs soulful therapy, compassion, reverence/gratitude, faith and risk, mindfulness/prayer, forgiveness and non-attachment.
Didactic, Interactive, All Levels

SA 2
❑❑ (2 CD Program)
The Art of Endings in Nutrition Counseling: Issues of Ending Meals, Ending Sessions, and Ending Treatment
Molly Kellogg, RD, LCSW

Clients gain skill with ending meals appropriately when nutritionists model ending with skill and respect. This practical workshop will provide language, strategies and support for dietitians to strive for excellence in handling endings of all kinds. We will explore breaks in treatment, messy endings, satisfying endings and more.
Didactic, Interactive, Experiential, Intermediate/Advanced

SA 3
❑❑ (2 CD Program)
The Use of Therapist Self-Disclosure in the Treatment of Patients who have Eating Disorders
Patricia Lees, PhD

Two types of therapist self-disclosure during eating disorders treatment are self-disclosing statements and self-involving statements. This workshop distinguishes between the two statements, describes how each can either enhance or damage the therapy process, and explores the therapeutic implications of both.
Interactive, Experiential, Didactic, All Levels

SA 4
❑❑ (2 CD Program)
Meaning Matters: How the Quest for Personal Meaning, Meaning in Life and Meaningful Relationships Enhance Eating Disorder Recovery
Wendy Oliver-Pyatt, MD and Stacey Nye, PhD, FAED

There are multiple sources of meaning that can promote recovery from an eating disorder. This workshop uses principles of existential psychotherapy, self psychology and relational therapy to explore how the integration of personal meaning, meaning in life and meaningful relationships can enhance eating disorders treatment and recovery.
Didactic, Interactive, Experiential
Intermediate/Advanced

SA5
❑❑ (2 CD Program)
Presentation of Eating Disorders in Diverse and Atypical Populations
Jennifer E. M. Rasmussen, PsyD

Symptom presentation in overlooked populations can inform research and practice with eating disordered clients of all backgrounds. This workshop provides information about the prevalence and characteristics of eating disorders among prisoners, the gay, Lesbian, bisexual and transgendered communities, and ethnic minorities within the US and cultural groups around the world.
Didactic, Interactive, All Levels

SA6
❑❑ (2 CD Program)
An Integrated Approach to Parenting Education Group: Learning How to Move from Disconnection to Better Connection in the Treatment of Eating Disorders in Adolescents
Mary Tantillo PhD, RN, CS, FAED and Ann Flosdorf-Mitchell, LCSW-R, ACSW, MAEd

This workshop presents a model for parenting group informed by family-systems, relational-cultural, and stages of change theories. It describes the group format and therapist interventions that help parents identify disconnections experienced in relationship with their child and learn skills that facilitate reconnection, re-feeding, and recovery.
Didactic, Interactive, All Levels

SA 7
❑❑ (2 CD Program)
Body Checking, Body Avoidance and Feeling Fat
Christopher Fairburn, DM, FRCPsych, FMedSci and Suzanne Straebler, APRN-Psychiatry, MSN

Body image problems are most prominent in the eating disorders and body dysmorphic disorder. This workshop describes the over-evaluation of shape and weight, body checking and body avoidance, and "feeling fat." The presenters will illustrate how these characteristics contribute to the maintenance of body image concerns, and present an integrated, cognitive behavioral approach to their modification.
Didactic, Interactive, Beginner

SA 8
❑❑ (2 CD Program)
The Circle is Sacred: Sourcing Therapeutic Power in Feminist Oriented Group Therapy
Beth Hartman McGilley, PhD, FAED and Kelly Cunningham MS, LCPC

Feminist-oriented group therapy attempts to identify and eradicate oppressive physical, social and political forces by providing sacred healing grounds where self-awareness and transformation can occur. Using videos, didactics and patient descriptions, this workshop provides an overview of the fundamental aspects of feminist group therapy vital for clinical effectiveness.
Didactic, Interactive, All Levels

SA 10
❑❑ (2 CD Program)
The End of Resistance: When the Family Becomes the Patient
Laura K. Ratner, LCSW-C, BCD

Palpable ambivalence often characterizes the eating disordered patient's relationship with psychotherapy. When therapists shift their engagement from the individual to the family, treatment can become more rewarding and effective. This workshop explores specific ways to create a primary alliance with family members and utilize it to reduce patient resistance and support recovery.
Didactic, Interactive, All Levels

SA 11
❑❑ (2 CD Program)
How Hypnosis can be Employed to Establish a Realistic Body Image in the Eating Disordered
Bart Walsh, MSW, LCSW

Hypnosis lends itself to aspects of eating disorder treatment, as anorexia nervosa clearly displays trance phenomena. Changing any element of an eating disorder may inspire beneficial shifts in other parts of the disorder. This presentation illustrates hypnotic approaches designed to establish a reality based body image over a relatively brief treatment sequence.
Didactic, Experiential, Intermediate/Advanced

SA 12
❑❑ (2 CD Program)
"That session made me hungry": Using Countertransference Effectively for You and Your Client
Sandra Wartski, PsyD and Katherine A. Fellner, PhD

This workshop explores typical countertransference reactions to eating disorder patients, together with techniques for managing countertransference and integrating reactions effectively into sessions. In addition, strategies for self-care are presented, including ways to rejuvenate, build resilience and refocus on the rewards of recovery.
Didactic, Interactive, Intermediate/Advanced

K-2
❑ (1 CD Program)
Closing Remarks
Samuel E. Menaged, JD
President of The Renfrew Center Foundation and The Renfrew Centers
KEYNOTE PRESENTATION
The Connected Brain
Amy Banks, MD

Almost thirty years ago, the founding scholars of The Stone Center, Jean Baker Miller, Irene Stiver, Judith Jordan and Jan Surrey, theorized that healthy psychological growth and development happened through and toward relationship. This was a radical departure from prevailing theory that emphasized the importance of developing increasing levels of separation and individuality. In the present day, as new technology becomes available to measure brain and body function, the field of neuroscience offers convincing support for relational theory and clinical practice. This keynote presentation brings together contemporary relational/cultural theory with current neurobiology, to explore ways in which we are "hardwired to connect," and to consider how our biological systems get hijacked by psychiatric disorders, such as addictions and eating disorders.

SU 1
❑❑ (2 CD Program)
The Heart of Change: What Really Moves Us?
Amy Banks, MD

What creates growth-fostering change in a therapeutic encounter has been greatly debated. Is it the well-timed interpretation, repetitive cognitive reframing or simply the relationship itself? This workshop explores how we change by examining the final common pathway of change - the development of new neural pathways in our minds and bodies.
Interactive, Advanced

SU 2
❑❑ (2 CD Program)
Building Connections between Families, Friends and Professionals
Cris Haltom, PhD

Caregivers and loved ones are an essential resource in eating disorder treatment. This workshop describes the Parent Partner Program, a community based program designed to help professionals, family and friends build awareness, create a caring and knowledgeable community of experts and foster a healing environment for those suffering with disordered eating.
Experiential, Interactive, All Levels

SU 3
❑❑ (2 CD Program)
Finding Your Voice Through Art: A Self-Discovery Journal for Use with Clients with Eating Disorders
Mindy Jacobson-Levy, MCAT, ATR-BC, LPC and Maureen Foy-Tornay, MA, ART-BC, LPC

This workshop introduces a self-discovery designed to address feelings that masquerade as disordered eating behaviors. To be used independently or during/between therapy sessions, it contains stage sensitive, user-friendly tasks that pair art making and journaling to help clients regain internal control while maintaining self-expression.
Didactic, Experiential, All Levels

SU4
❑❑ (2 CD Program)
Money, Empowerment and Recovery: How Beliefs about Money Impact the Therapeutic Process and Our Clients' Recovery
Kathleen Burns Kingsbury, LMHC, CPCC

Just as with food, relationships with money start early in life and shape decision making on a daily basis. This workshop addresses how to assess a client's relationship with money, how it impacts treatment choices and how to work with money-related issues in the context of the therapy relationship.
Interactive, Advanced

SU 5
❑❑ (2 CD Program)
Aging Patients, Aging Therapists: Long Term Therapeutic Relationships in the Treatment of Eating Disorders
Karyn L. Scher, PhD

As therapists age, and progress in their lives, so do their recovering clients. This workshop addresses therapeutic relationships that span decades, and describes ways they dovetail with evolving stages of adult development. Topics include countertransference issues and strategic interventions for patients who return, remain chronic, or maintain health in "well" visits.
Didactic, Interactive, All Levels

SU 6
❑❑ (2 CD Program)
Personality Disorders and Eating Disorders for RDs: How Personality Disorders Influence Nutrition Counseling - and What to Do Differently
Jessica Setnick, MS, RD, CSSD

Personality disorders, whether diagnosed or not, can undermine the ability to connect with clients and promote the behavior change necessary for recovery. This presentation describes strategies for facilitating nutrition counseling in patients struggling with eating and personality issues. Emphasis is placed on borderline personality disorder, safe communications and maintaining boundaries.
Didactic, Interactive, Advanced

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