

PERSPECTIVES

A Professional Journal of The Renfrew Center Foundation

Summer 2007



Contributors

Patricia DeBarbieri, EdD, LPC
and Beth Kendall

Page 1

Cindy Boone McQuown,
MAEd, LPCC, LICDC

Page 5

Jo Paine, RD, LCADC

Page 7

Angela S. Redlak, PsyD,
Rose LeDay, PhD
and Charee Boulter, PhD

Page 9

Dovid Schwartz, PsyD, LCSW
and Rabbi David Dewick

Page 11

Dea Silbertrust, PhD, JD

Page 13

Nancy Zucker, PhD and
Franca Alphin, MPH, RD, LDN

Page 15


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A Word from the Editor

Full and lasting recovery from an eating disorder is often hard for our clients to attain – and can be even harder for us to define. We know that symptom stabilization and weight restoration are essential factors in the recovery process, but what else needs to happen both in (and out) of the therapy office? How can we, as clinicians, help shape our clients' environments in order to encourage true recovery?

Although, for many, *true* recovery begins in the therapy office, it is important for us to look beyond that environment and recognize how to incorporate recovery into other real world settings for our clients. As we look beyond the therapy setting, we may encounter unique ethical and boundary scenarios that require us to think differently about the role we play in our patients' recoveries.

This issue of *Perspectives* is dedicated to exploring a variety of ways we can extend the reach of the recovery process. As always, please send feedback and input on topics for future issues to letters2ed@renfrewcenter.com.



Doug Bunnell, PhD
Editor ■

Bridging the Communication Gap Between Therapists and School Personnel Working with Students Recovering from an Eating Disorder

Patricia DeBarbieri, EdD, LPC and Beth Kendall

Eating disorders have become the third leading chronic illness among adolescent females in the United States (Fisher et al., 1995). In a 2003 literature review, Hoek and van Hoeken found that 40 percent of newly identified cases of anorexia are present in girls 15-19 years of age. According to the National Eating Disorders Association, the majority of people with severe eating disorders do not receive adequate care, with only one-third of people with anorexia nervosa, and six percent of people with bulimia nervosa, receiving mental health care. Much of what happens, or fails to

happen, for youth around identification, intervention, referral and treatment of eating disorders, happens in middle and high school settings. Yet, the interaction among professionals within schools and the mental health community is often inadequate. Schools wonder how to have more open interactions with therapists who are treating their students. Therapists wonder how they can effectively shape the academic environment to better meet the needs of their patients. How can community mental health professionals and school pupil personnel professionals work together to assist students in their recovery from an eating disorder?

Every community has a system of public education that includes all of the elementary, middle and high schools that serve the youth in that community. Each school may be different, but the public school system in every community has similar aspects that can be helpful in bridging the school and community mental health gap. In order to have the greatest impact, it is helpful for therapists to know the optimal contact person in that system. Professional educational staff include the pupil personnel professionals; the school social worker, school psychologist, school counselor (formerly known as the guidance counselor), and the school nurse. Therapists need to identify the most appropriate professional contact. These school professionals work to support student social and emotional health in ways that positively impact student learning. These are the professionals who, along with teachers, will make up the multidisciplinary team working with any recovering student. The number of pupil personnel professionals in any system differs, as do their roles. Many of the services offered by these professionals may overlap, depending on the particular system. Yet, in all situations, the support staff address all issues that impact student learning. Safety and impact on learning are the two issues to which schools respond. According to Jly Lozier-Oman, a school social worker in Connecticut, "Making a case for the impact an eating disorder has on student learning is key to shaping the academic environment for your client. Schools are only responsible for issues that impact student learning. That is the public school model."

In order to shape the academic environment to benefit your clients, each therapist needs to help schools understand how eating disorders negatively impact learning for their middle and high school clients. This may manifest as an inability to attend or concentrate, as lethargy, depression, and non-engagement in class discussions and with peers in work groups, or through the inability to complete assignments because of fatigue or compulsivity. Eating disorders do not fit the definition of a special education disability, so schools may not be motivated to develop a treatment plan. An eating disorder may not disable a student academically, but therapists need to work with school staff to establish how the eating disorder

negatively impacts learning for their client and to identify supports to counteract this negative impact.

Accomplishing this may not be as difficult as it sounds, since what most pupil personnel professionals say they want from a therapist is guidance and communication. They need guidance regarding which in-school interventions would support the student's efforts in recovery, and communication about the impact of the eating disorder on learning and behavior. This collaborative process is most effective if the therapist is able to secure a release of information from the parents and then contact one of the pupil's school professionals - either the school counselor, school psychologist, school social worker or school nurse, to request an interdisciplinary team meeting.

The purpose of a team meeting may vary, but, in general, it should focus on giving school personnel tools and direction for working with the recovering client. The multidisciplinary team usually consists of one or all of the pupil personnel professionals, one or more teachers, and perhaps a coach and/or administrator, depending upon the needs of the student. The therapist may then make some recommendations. The therapist needs to make the case for why the student may need these services to be safe, or to be able to learn. The school will let you know what is available, what they can provide, and what they cannot provide. As an example, a therapist may recommend that her client be excused from a particular academic requirement until her nutritional status has stabilized. Therapists can be instrumental in the development of a specialized educational plan that reflects the current status of her client's cognitive and emotional functioning. Managing an eating disorder has become more challenging due to increased incidence, the increasing ethnic and socioeconomic diversity of patients, and the range of psychological presentations accompanying an eating disorder (Rosen & Neumark-Sztainer, 1998). In addition, there is still widespread denial of the severity of this illness and its prevalence among our youth. Many school systems do not acknowledge the problem within their communities and this obviously makes the collaboration among community mental health professionals and school professionals more challenging. Therapists may need to educate the

school's multidisciplinary team about the nature of an eating disorder and the client's needs. Offering an in-service presentation to school pupil personnel professionals, in addition to, attending multidisciplinary team meetings is often an effective model in achieving this goal.

School Based Health Centers are another very useful resource for therapists when working with their more challenging patients, because they offer a standard model of care that is holistic. These centers provide more in-depth services than the traditional school setting. School Based Health Centers are located in the school setting and are available in many, but not all, public school systems. Licensed Clinical Social Workers and Nurse Practitioners at these centers work together on a daily basis to manage acute and chronic health care conditions such as eating disorders. Because these are trained mental health clinicians, they can collaborate most effectively with community therapists regarding daily, real-time, in-school behaviors. School Based Health Centers offer medical monitoring, a diagnostic medical workup, and the ability to monitor medication. They may also offer individual, family, and group therapeutic services, and ongoing connection to the school community in which they are based. Rhona Weiss, Program Director of a School Based Health Center in Connecticut, and member of the Executive Board of the Connecticut Association of School Based Health Centers, suggests that "a real strength of these centers is the ability to offer therapists consultation around specific cases; feedback as to how the student is presenting herself in school, and additional therapeutic services to assist with the student's recovery."

Given the negative short-term and long-term health consequences (Polivy, 1996), the increased prevalence of disordered eating (Hoek & van Hoeken, 2003; Fisher, et al., 1995), given the short- and long-term health consequences, and the high risk for a chronic outcome, early intervention is essential (Rome et al., 2003). Primary prevention has been widely suggested and endorsed (Piran, 1997). Since the primary focus for teachers is on academic curriculum, school counselors focus on the social emotional curriculum that supports learning. The Comprehensive School Counseling Program is a national

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model for the expanded services of the school (formerly guidance) counseling program (Campbell & Dahir, 1997).

The philosophy of a Comprehensive School Counseling Program is proactive, preventative and collaborative. It is tied to the mission of the school and the school district. It is an integrated part of the total education process designed to help students learn efficiently and to reach their full potential. A Comprehensive School Counseling Program contains an organized and planned guidance curriculum for all students within the school. This curriculum encompasses both content areas and sequence throughout grades. Therapists should understand how services are delivered via this model in order to effectively interface with these services and help shape the academic experience of their recovering clients. Therapists, in my opinion, should look for opportunities to lobby for primary prevention programming in the schools.

The Comprehensive School Counseling Program model is structured around four components: Program Foundation, which includes the mission, philosophy and goals of the Comprehensive School Counseling Program; Program Management, which outlines the calendar, schedules and duties of the School Counseling Program staff; Program Accountability, which includes methods of assessing the effectiveness of the Comprehensive School Counseling Program; and the Delivery System, which includes all direct services to students offered through the Comprehensive School Counseling Program model. These direct services to students include; individual counseling, psycho-educational support groups, planning with individual students around career and academic issues, crisis counseling, peer mediation, consultation, and/or referral to additional resources. This component also includes a guidance curriculum of lessons taught in classes for all students throughout the grades.

A Comprehensive School Counseling Program model operates within four domains:

- 1) The Personal/Social domain, which includes respect for self and others, goal setting and attainment, and survival and safety skill development.
- 2) The Academic domain, which includes skills for learning, which will lead to school success and academic success.
- 3) The Career domain, which includes the investigation of careers, and the relationship

between school and work that will lead to career success.

- 4) Local, State and Federal Initiatives, such as the No Child Left Behind Legislation and the counselor's role in any strategies or initiatives mandated through a 504 plan or a Planning and Placement Team (PPT) meeting.

These are the areas where therapists can impact school services for their clients. If an initiative such as a psychoeducational support group for enhancing self-image or social emotional skill development, or individual counseling to enhance stress management and coping skills, is mandated as part of a 504 plan or PPT outcome, the school is legally bound to provide these services. Therapists can ask parents or school officials to be included in a Planning and Placement Team meeting and, therefore, have direct input into shaping the academic environment of their client.

Prevention messages and lessons can be integrated into the guidance curriculum. These messages may address coping strategies to promote social and emotional learning, enhance resiliency, improve self-esteem and help girls resist the cultural forces that encourage maladaptive body preoccupation, unhealthful eating and dieting.

The key to success in bridging the gap between therapists and school pupil personnel professionals is the identification of avenues to collaborate, communicate and integrate services. Therapists can use methods outlined here to work with school pupil personnel professionals in shaping the academic environment to meet the needs of their recovering clients.

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Crossing the River: Integrating Solution Focused Interventions and Stages of Eating Disorder Recovery

Cindy Boone McQuown, MAEd, LPCC, LICDC

How can you tell when treatment is over and, more importantly, how do you know when to return to treatment after a period of recovery? Often times a third-party reimbursement determines when treatment is over, instead of emotional, physical and behavioral indicators of recovery. Having better definitions of what characteristics best predict recovery, and what distinguishes partial recovery from complete or full recovery, can assist in treatment planning, relapse prevention and assuring better treatment coverage. Yet, defining "recovery" is tricky business. The DSM-IV includes diagnostic criteria for anorexia with restricting and non-restricting sub-types, bulimia, with purging and non-purging sub-types, and eating disorder NOS, and includes provisional criteria for binge eating disorder. DSM-IV-TR updates incorporate personality disorder comorbidity.

While serving as a guide to formal diagnosis, specific indicators of the course of recovery are lacking. One study of recovery rates for anorexic patients showed 35 percent had full recovery, 38 percent had partial recovery, 21 percent had poor recovery outcomes, and 6 percent died (Fichter & Quadfleig, 1999). In a review of research for bulimia and recovery rates, 50 percent of those studied were at full recovery, with 30 percent partially recovered and 20 percent experienced no recovery (Keel & Mitchell, 1997). No diagnostic specifiers are in place, as for alcohol dependence, that address the uneven or partial recovery course from an eating disorder. Alcohol dependency diagnosis includes course specifiers that account for the recovering person who is not at full criteria, but remains at some partial diagnostic criteria and can still benefit from treatment. It is possible to not meet full criteria for one of the eating disorders, yet to also not have sufficient recovery to remain symptom free. The recovery process for an eating disorder client is less like flipping a light switch and having a dark room become light, but more like having a rheostat, which gradually brightens the room. And though there may be

enough light to see, it may not be enough light to see everything, let alone to prepare for emergencies when the electricity goes out. Recovery needs to be considered a process as opposed to an event, with markers along the way to demonstrate what progress is being made, as well as what goals remain to be met.

Recovery is best considered a progressive event, during which eating disorder symptoms are replaced with increasingly stronger, more self-enhancing coping resources. For the eating disorder client, the recovery process is a series of steps, each step increasing the opportunity for full recovery and reducing the risk for relapse.

Step 1. *Needs eating disorder to survive, not able to use/not aware of alternatives*

"Can't swim, letting go of the life preserver to be rescued seems like a lose-lose proposition."

Step 2. *Aware of alternatives, eating disorder more familiar, preferable means of survival*

"I can move toward the lifeboat, but I'm keeping hold of my life preserver."

Step 3. *Eating disorder used to survive, costs begin to outweigh survival value, experiments with alternatives*

"I'm out of the water. I'm on dry land. I can let go of the life preserver as long as I stay away from the water...life preserver is getting annoying, carrying it everywhere, might be nice to be able to get near water, actually go in on a hot day, without carrying it around...considering swimming lessons."

Step 4. *Alternatives are experienced as options, increased coping ability*

"Learning to swim frees me from worrying constantly about being around, on, or in water. I develop a skill and feel good about using it."

Step 5. *Uses alternatives in conjunction with eating disorder, begins to recognize underlying issues*

"I still have anxiety about flying and take the life preserver, but I have begun to see that my worst fears are not usually the ones

that happen. I get through things that scare me and challenge me without using the life preserver."

Step 6. *Gradual increase in proportion of healthy alternative use versus decrease in eating disorder behavior*

"I find myself feeling more free. I actually notice that I get through challenges and didn't even think of the life preserver, let alone, bring it with me."

Step 7. *Develops strong sense of self, heals from pain of past, able to face the present and future in adaptive, self-enhancing ways*

"I can't imagine ever having been afraid of the water." Now a strong swimmer, even in the roughest water and may develop resources that she shares to help others.

Treatment emphasizes the progress the client is making, building on small incremental steps toward changes and amplifying her part in that process. The process also prepares for relapse, setting the stage for a rapid response if it does. Relapse is not seen as failure, but as an indication of needing to strengthen coping resources.

What does recovery at each step look like? Some achieve symptom-free status while others are only partially symptom free. The concept of first order change and second order change (Watzlawick, Weakland & Fisch, 1974) can help to further define recovery in partial and full symptom-free forms. First order change is an attempt to solve a problem that only results in more of the problem. Watzlawick, Weakland & Fisch (1974) outline three ways in which problem situations are mishandled and characterize first order change as situations in which action is necessary but not taken, action is taken when it should not be, or action is taken at the wrong level. The end result is "more of the same;" the attempted solution is the problem. In the addiction field, the term "dry drunk" indicates this type of change. There is no alcohol use, but no lifestyle change that supports continued non-use, and, more importantly, there is not awareness of why lifestyle change is needed.

In the earlier stages of recovery, a client may no longer meet full criteria for an eating disorder, but she may not have the kind of recovery needed to remain symptom free. For the eating disorder patient, first order change is exemplified by change on the physical level without corresponding change in other areas, perhaps gaining weight in order to be discharged from treatment and the idea that physical change is the equivalent of recovery. First order change is at work when a client shifts from the dangerous features of one disorder, like anorexia, but develops the characteristics of another, like bulimia. It is seen when the anorexic patient is eating and gaining weight, but then develops purging behaviors to control weight. The anorexic client who eats, maintains her weight and is medically stable may only be complying with contingencies that allow her to participate in sports activities. Patients with bulimia who are not vomiting but only eating food that is "diet" or non-fat, may be stuck at this level of change as well. Given that restrictive dieting and dietary restraint may lead to the development of eating disorders (Fairburn, et al., 2005) this behavior, though perhaps a step along the road to recovery, cannot be the end goal. Change may have occurred, but nothing has changed.

Long-term recovery requires second order changes in lifestyle and self, in which food has ceased to be the issue. The expression, often heard in 12-step recovery programs, "Food is not the problem, living life is the problem" or "I did not have an eating problem, I had a living problem," illustrate the shift in focus that exemplifies second order change. This is the transition from symptom replacement to a place where symptoms are no longer needed. The person now has resources, supports, and skills that render the symptoms unnecessary. Key features of the eating disorders, fear of food, weight, and eating, perfectionism, impulsivity, inadequate emotional regulation, irrational thinking, body loathing, are recognized and acknowledged. The eating disorder is not a source of shame, but a powerful source of crucial information about an emotional need. Co-occurring conditions are recognized, accepted, and managed. The client now has a full understanding of how to turn on her "light" on her own, and, further, she understands how to change the light bulb, and when to seek professional assistance if changing the light bulb doesn't fix the problem.

Second order change is where full recovery occurs and this is the goal of treatment and support. Recognizing a client's stage of change can help them understand the course of recovery, and may be a very important part of facilitating full recovery. Diagnostic language, coupled with research regarding the long-term recovery rates for those in partial versus full recovery would be useful. It is also important to recognize the complexity of the eating disorders, as well as to understand that not all eating disorder clients are the same. Factors that influence recovery include dual disorders both on Axis I and II, the client's history of trauma, the person's current support network, the presence of addictions, and the length of time that the person has had an eating disorder.

Recovery requires ongoing action and attention, not only to overcome the eating disorder symptoms, but also to maintain the changes once the eating disorder symptoms have been eliminated. Active symptoms, however, do not necessarily mean that recovery is not happening. Sometimes, in spite of the action, the client may experience circumstances that evoke symptoms. It is his/her response that makes the difference between ongoing recovery and relapse.

Recognizing the warning signs of relapse, taking warning signs as an opportunity to act to better care for oneself, represent an active, self-enhancing response to the re-emergence of symptoms. Seeking appropriate help, whether that means increasing one's practices of managing stress, returning to counseling, seeking medication or adjusting to one's medication, can be signs of strength, self-awareness and recovery.

Full recovery occurs on physical, mental, emotional, social and spiritual levels. Changes in all of these areas to reach recovery can translate into a lifetime of work. Without change in all these areas, the risk of recurrence stays alive.

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Alternative Definitions of Recovery: A Nutritional Perspective

Jo Paine, RD, LCADC

Disordered eating behaviors look different with each client. They can meet criteria for a DSM diagnosis but may also involve yo-yo dieting, chronic dieting, restricting with rules and rituals, compulsive eating, chronic obesity, adaptations to bariatric surgery, binge eating, laxative and diet pill abuse, drug abuse, and excessive exercise. They often involve a more fundamental obsession to change one's body, or a desperation to be 'out of body.' With this great diversity, the clinical focus lies not only on food but also on self-regulation and responsibility.

We all are dependent upon food. We use it for a multitude of reasons, only one of which is to sustain life. But when food and its accompanying behaviors become the 'enemy' or the 'exclusive companion,' then something basic to our humanity has been interrupted. The following are basic premises, gifts if you will, for being human. I regard any interruption in these premises as 'disordered.'

We were born lovable and capable.

We were born loving our bodies.

We ate when we were hungry and stopped when we were full.

Reintroducing clients to these basic human attitudes begins the journey of healing and recovery.

Let me introduce three composite clients: Mary was referred to me due to pervasive negative self-talk and body hatred. She is a mature adult, with a stable weight over IBW range. She is a working woman, balancing time and energy with a spouse and children. When first seen, she exudes hatred of her body and can find no moment of self-tolerance.

Bethan is a single young adult and an athlete, who is compelled to enter treatment by her parents. She is ever driven to 'win' at whatever she begins and to excel in all aspects of her life. She is below IBW and consumes food based on a restricted and rigid food plan. She maintains her weight by controlling her eating when working out and using binge/purge behaviors during down time.

Agnes, a late teen of normal weight, is very verbal and insists on many special food items, claiming she cannot eat a variety of commonly accepted foods. She has a strong

smell/sight-based aversion to these foods. Agnes feels deep shame about these aversions and, as a result, has isolated herself from family and friends.

A therapy group with patients like these three represents a wide diversity of behaviors. Each group psychotherapy session begins with a unifying exercise in which every client shares something relevant about herself or about her day or state of mind. This repeated exercise helps to establish and then sustain group cohesion and connectedness, within which participants learn about themselves. We learn who we are not in isolation but in relationship with others. At this early stage some will just put their story out to the group, while others may "hide."

Once all are engaged, concepts of healing are introduced. The first concept lays the foundation for all the rest and comes from the question, "Who makes you do it?" Whatever the behaviors and attitudes, it must be established that no one force feeds them, no one prohibits their eating, no one steals their food, no one controls their bodily functions or makes them criticize their bodies or themselves. This begins the development of a self concept...and with this comes responsibility, and with responsibility, comes choice.

Honoring the client's right of choice about their food or related behaviors begins from the first session. They have the right to purge, or not. They can binge eat, restrict, act out in other harmful ways, as long as choice is involved. This takes time and energy by the therapist, but it is critical to teach the concept. When this is demonstrated by the therapist, they begin to internalize the concept and own a 'self-identity.' If they don't like who they are today, they can change. This is the choice. Even 'bad' choices provide an opportunity for learning. Everyone makes bad choices at times. No one is perfect and no one has a perfect body, so we can't expect the client to be any different.

Clients often struggle to find fault with this concept. They often say, "That is just the way I am." Many do not have hope or trust in the concept of change. It takes persistence and time to integrate this concept. The process can often lead to moments of anger and frustration. For some, it is an unbearable

concept, at least initially, but most come to recognize it as an essential truth.

Bethan: If I am self responsible, then I am making choices that are harming me and I am living with those consequences today. I don't like this.

Jo: What choices would you like to make differently?

Bethan: Throwing up is getting me into a lot of trouble. Why can't I just stop?

Jo: Well, your journal last week showed Wednesday as being a purge-free day. What was different about that day?

Bethan: I just felt different.

Jo: How was it different?

Bethan: I didn't get any mail from home and I was just "in the day."

Jo: How great was that! What worked for you that day? Talk to us about it.

Bethan then gets an opportunity to find language that fits for how she felt. Peers give their impressions and add to Bethan's experience of that day. The days with purge behaviors are ignored. Attention is put on the success. She will come to the place of healthy choice faster if she is not criticized or shamed. The more success she feels capable of, the more often she will choose it.

Mary: But I am fat and ugly. What does that have to do with choice?

Jo: Do you have all your limbs?

Mary: Yes.

Jo: Can you walk, talk, pee and poop?

Mary: Yes.

Jo: OK. What good can you say about yourself now?

Mary: Well, I guess I can say I have all the working parts.

Jo: Excellent! That is your beginning.

Peers then get to give Mary feedback about what they see as assets. She hates hearing it, grimaces. But peers are truthful and point out factual truths. To help Mary become more comfortable in group, individual sessions were scheduled to help her identify the source of her self-hatred. It was helpful to use the empty chair. Initially, I would instruct her to sit in that chair when I heard self-hatred and self-criticism. After several sessions, she would go to that chair, speak out the negativity and then return to

her own chair to talk about what happens when in THAT chair. She soon recognized the source and then openly shared in group her struggle to change.

Agnes: What about me? I just want to throw up when I see these foods. I can't bear to eat them!

Jo: How long have you felt this way?

Agnes: Since I was a kid. I have always hated...I can't stand to see it, much less eat it.

Jo: Your peers seem to understand. Have you shared with them your thoughts about these foods?

Agnes: Yes, some of them know about it. I can eat with them if no one takes that food.

History of these aversions was explored in individual session and found to be related to early childhood abuse. She did a trauma workshop for this and did not bring it to group. Her aversions remained, but she was able to 'give back' the shame to the perpetrator and went on to celebrate a whole new sense of self.

The process of change can be taught in many ways. I describe the disordered behaviors as a four-lane concrete highway that is traveled on automatic pilot; cruising without much thought. One stays on the highway because it is familiar and meets a need. Then, there is a roadblock called intervention, followed by another called treatment. There are two choices here: one, comply to satisfy others, and two, "Maybe I can change, maybe I can really have a life."

"Getting off the highway" takes a tremendous amount of emotional and physical energy, and courage to confront the past and face the uncertain, unknown future. It is often scary, painful, and frustrating. Clients experience a sense of failure in their imperfect attempts to change. It's easy to forget that no one is perfect when learning something new. Mistakes are made. Detours and obstacles are always part of learning a new way. Returning to old ways also happens. The key is to experience the new way, and

then have that experience reinforced over and over again. That is my job as a therapist. Slips and slides are a part of growing and learning.

The crucial part of making change is sustained and trusted encouragement along the way. We are on the sidelines, giving our patients kudos every single step of the way. Every bit of reinforcement is needed to establish new behaviors and new pathways of thought. Each report of change is celebrated, as is each new positive thought. One less purge in a week is celebrated. That is how we learn to walk. Step by step, falling as we go, but getting up again, always moving ahead. Even if they are back on the 'highway,' if they keep coming to appointments, they want to get well. They need us to be hopeful for them.

So, meal by meal, thought by thought, one moves forward, forging each new step, trial and error, establishing new ways, which, when used often over time, become the main highway.

Suppose a client has been doing well over some weeks, and next time in group she has slipped. She is talking self-hatred again, the food is off, it is all wrong. She can't stand herself, "See, I told you I couldn't do it." They are the first to hate themselves; unforgiven and worthless in their eyes. In comes the supportive acknowledgement, reminding them of the detours and obstacles of learning... "Just keep moving forward, start new now, learn from what happened. You can do this!"

Agnes, having acknowledged the abuse and confronted its horrors, moved forward with a mature, confident self-concept, still avoiding some foods, but now with compassion for herself that allowed her to honor her aversions.

Bethan took her athleticism to heart. She learned to eat wholesome foods for her physical needs and to support her activities. She separated out the many abuse issues, which were tied to the bulimic behaviors. She expressed a desire for a 'flexible food plan' and was successful with the trial and error method.

Mary learned that she is lovable and capable, but it doesn't mean she is free of the 'condemning voice.' That voice grew weaker and weaker as she confronted it with her affirming statements and self-acceptance.

My goal is to give clients back those basic human rights mentioned at the beginning and to watch them as they move toward self-acceptance in their ability to say:

"I am lovable and capable or I am OK today, or I accept me today."

"I love my body or I accept my body today. Or, my body may not be perfect but for today, it's ok."

"I eat when I am hungry and stop when full, most times. Sometimes there isn't enough and I'm still hungry. Sometimes it tastes so good I eat more. Sometimes I just feel like eating cake. Sometimes I miss a meal because I didn't plan well. Sometimes I am happy with my food choices and sometimes, 'I can't believe I ate that!'"

These affirming statements remind us and our clients of our value, and increase our self-worth and/or self-esteem. When we are confident and feel valued, our choices are more likely to be ones to support this new sense of self. This new journey for clients is often referred to as Recovery. It starts each day anew. It requires daily attention and daily commitment. It allows for errors, mistakes, bad judgments, which do not damage our self-worth. We just keep moving forward, with a deep desire for this new life, forgiving failures as part of growing.



Jo Paine, RD, LCADC has a client-base consisting of in-patient drug/alcohol addiction treatment facilities; and specifically those dually diagnosed with disordered eating behaviors.

The Phase Flow Approach: An Integrated Recovery Model

Angela S. Redlak, PsyD, Rose LeDay, PhD and Charee Boulter, PhD

The Renfrew Center of North Carolina is currently piloting an Integrative Recovery Model called the Phase Flow Approach. This program was modeled on the level system utilized at the Renfrew Center of Florida residential treatment program. In designing this new program, we focused on two essential treatment challenges. How can patients gradually re-establish responsibility for their treatment and recovery and, secondly, how can we extend the reach of treatment into the patient's home, work and school environments? The Phase Flow Approach was designed to create a nurturing, structured, and autonomy supporting, treatment milieu that incorporates the phase, or level, systems more commonly associated with residential and inpatient programs.

According to the APA Best Practice Guidelines (2006), most inpatient programs establish a milieu that provides "emotional nurturance," along with a combination of reinforcers that connect privileges to observable treatment goals such as target weights and behaviors. The Renfrew Center of Florida utilizes a similar treatment philosophy and incorporates a level system as part of their residential program. The patient gains or loses privileges and autonomy as she progresses through the program, meeting weekly with the treatment team to make these determinations.

A patient's progress and recovery is often fluid and shifting. They may move forward and back across levels of autonomy and progress. In this model, patients can shift back and forth between the four phases: Body Center, Mind Center, Spirit Center, and Integrative Recovery. The overall goal of the Phase Flow Approach is to increase the patient's autonomy by creating unique, measurable, attainable, and individualized therapeutic and nutritional challenges in the treatment milieu, and to extend these challenges into her natural environment based upon her treatment progress. Weekly, the patient is provided with a tangible document known as an "agreement," which indicates progress and mutually devised goals for each day of the week. In essence, the Phase Flow Approach extends the reach of care into the natural environment with core therapeutic healing assignments, as well as individualized

goals, which the patient is asked to complete during free time. The patient receives self-reinforcement through mastering therapeutic challenges as she moves through the various phases. The patient also receives feedback from staff and peers and is asked to give herself feedback regarding her overall progress on a weekly basis. The "agreement" also serves as a self-monitoring tool, which promotes patient accountability and solidifies communication and expectations between the patient, family, and treatment team.

The entry level, or Body Center Phase, focuses on stabilizing basic health and safety needs. As they progress, patients move through the Mind Center Phase. This phase addresses behavioral, emotional, and relational aspects of recovery with a particular focus on maintaining self-directed motivation for treatment and recovery. In the third, Spirit Center Phase, patients focus on issues of personal growth, relational connection, and development of a sense of self-purpose. The final, Integrative Recovery Phase, focuses on maintaining and supporting recovery at the outpatient level of care. Most patients move back and forth through the different phases while in treatment. Progress is envisioned to be overlapping, circular and integrative in nature, allowing for a part of progression forward to involve a regression backward. Each setback acts as a propellant forward like the familiar "one step back, two steps forward." A step backward provides an opportunity to rehearse skills and/or to learn new skills to enhance the progression in the next phase.

The theoretical foundation of the model is an integration of theoretical assumptions from Dialectical Behavior Therapy (Linehan, 1993), Prochaska and DiClemente's (1992) Stages of Change, Maudsley Method (Lock, le Grange & Agras, 2001; le Grange & Lock, 2007), Maslow's (1943) Hierarchy of Needs. To help increase motivation and decrease drop out rates, the Phase Flow Approach incorporates ongoing teaching and uses concepts such as the Stages of Change with staff, patients, and family members (Tantillo, et al., 2001). The patient is asked to evaluate her motivation toward recovery on a regular basis and this helps the team and family members identify ways to approach and

support the patient where she is in her recovery process.

The conceptual focus for the **Body Center Phase** is *Substantially Supported Autonomy*. This corresponds with the patient's essential needs for structure and staff support. One of the goals of the Body Center Phase is to help the patient acknowledge the illness and start thinking about change in ways that correspond with the Pre-Contemplation to Contemplation Stages of Change defined by Prochaska & DiClemente (1992). Treatment focuses on the medical, nutritional, safety and emotional stability of the patient. The Body Center Phase also corresponds to Phase I "Weight Restoration or Re-Establishing Healthy Eating" of the Maudsley Approach (Lock, le Grange & Agras, 2001) and to Linehan's (1993) Dialectical Behavioral Therapy model. All three emphasize the need to address life-threatening behaviors, therapy interfering behaviors, and affect regulation before moving into more insight-oriented therapy. It also relates to Maslow's Hierarchy of Needs, which clearly emphasizes basic safety and physical needs before moving on to higher level psychological functioning. Each phase acts as the foundation and an integral component of the next phase.

The **Mind Center Phase** core concept is *Supported Autonomy*. At this phase, the patient assumes more autonomy contingent on her overall recovery progress. Goals for the Mind Center Phase include a deepening acknowledgement of the impact of the disease and personal commitment to her recovery program. This phase corresponds to the Contemplation-Preparation Stages of Change (Prochaska & DiClemente, 1992). Treatment focuses on psycho-education, which includes basic eating disorder education, nutrition education, body image issues, genetic aspects of eating disorders, the role of the environment, culture, media, and the role of the family in recovery. It also focuses on skill development such as basic coping and interpersonal skills, introduction to relapse prevention, identifying resources and supports, and starting to identify underlying developmental and relational issues. This stage closely parallels aspects of Phase II of the Maudsley based models (Lock, le Grange & Agras, 2001) in that general concerns with regards to family can be

brought forward for review and processed in therapy. The Mind Center Phase also relies on concepts linked to Linehan's (1993) Stage 2, which focuses on emotional work and Stage 3, which focuses on addressing general problems in living, adjustments, coping skills and relapse prevention. Linehan suggests that patients are ready for more insight-oriented therapy once there has been a stabilization of mood and crisis management skills have been developed. Finally, the Mind Center Phase also relates to Maslow's (1943) Love & Belonging and Esteem needs in that the patient is challenged to work more on emotionally-based relationships and her self-esteem. This lays the groundwork for developing a sense of belongingness and self-acceptance, which is dealt with more in Spirit Center Phase.

The **Spirit Center Phase** focuses on helping the patient integrate her newly learned skills into her natural environment. The Spirit Center Phase core concept is *Guided Autonomy*. At this time, the patient, relying on the support from staff and patients in the therapeutic community, begins to practice her new skills at home, work, and school. Many of these skills apply to relationships and patients are encouraged to take new risks in their ongoing connections to people outside of the program. This includes families, friends, colleagues and classmates. Treatment focuses on exploration and self-discovery of underlying issues and spiritual meaning. The primary challenge is to help patients learn to redefine their sense of self without an eating disorder. Therapy also focuses on continuing her relapse prevention strategies and learning

how to be self-sufficient in the recovery progress. This phase corresponds to the Preparation-Action stage of Prochaska and DiClemente's (1992) Stages of Change and Phase III of the Maudsley method (Lock, le Grange & Agras, 2001) It also continues to focus on developing Maslow's final three needs: Love & Belonging, Esteem, and, in addition, the makings for Self-Actualization.

The last phase in this model is the **Integrative Recovery Phase**. This phase is typically addressed in ongoing outpatient psychotherapy where the patient utilizes therapy as a support and a means to continue self-exploration and become more autonomous in using her new skills and insights to manage her eating disorder recovery. The patient is expected to be in the Action and Maintenance Stages of Change (Prochaska & DiClemente, 1992) and utilizing her relapse prevention plan to sustain recovery. This phase parallels nicely to Linehan's Stage 4 "Incompleteness" that focuses on the desire for joy, freedom, connection, meaning making and spiritual growth. This phase focuses on promoting *Full Autonomy* without the eating disorder and on engaging the patient in continuous cognitive, behavioral, relational and emotional change processes that promote recovery and prevent relapse. Treatment continues to center on: use of relapse prevention, resources, natural supports, self-exploration of deeper psychological issues, personal growth, purpose, belongingness, autonomy, and maintaining healthy relationships. This phase ideally parallels with Maslow's (1943) last stage of Self-Actualization.

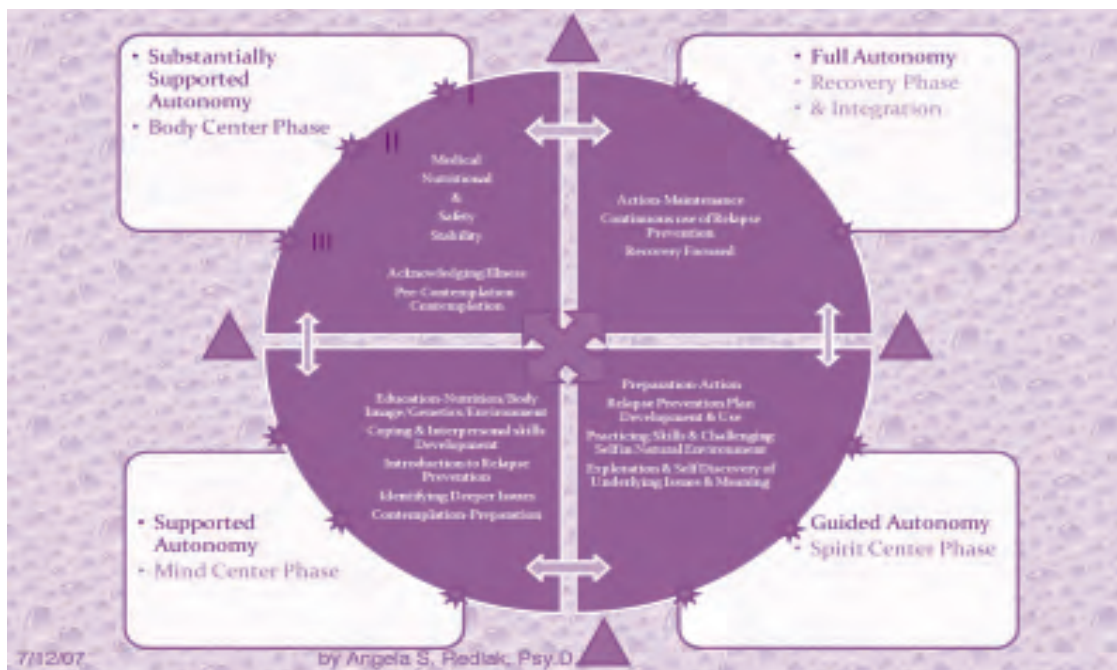
The Phase Flow Approach creates a therapeutic milieu in which patients gradually re-assume greater autonomy over their recovery. As they re-establish their ability to manage their own treatment needs, patients move through a phase approach that links eating disorder thoughts, feelings and behaviors to related challenges and concerns in their relational and psychological worlds. Patients can move back and forth across the phases in recognition that recovery from an eating disorder is rarely a straightforward process. The model also provides consistent structure along with opportunities for highly individualized treatment challenges, both within and outside of the therapeutic sessions. Linking patients to treatment outside of program hours is a fundamental challenge in outpatient treatment. We will be evaluating how this model addresses that challenge.

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Mentoring: A Novel Model for Supporting Recovery

Dovid Schwartz, PsyD, LCSW and Rabbi David Dewick

Brooklyn, New York has long been known for its large population of Jews of every stripe and color. Many of these Jews, particularly those of the Ultra-Orthodox and Chasidic communities, lead relatively sheltered lives, removed from the influences of the media such as movies, TV shows, and pop music. One might think, therefore, that this community is protected from the plague of eating disorders, very often blamed on Hollywood's emphasis on external beauty and its promulgation of waif young actresses and models.

Though no reliable research has been conducted in Brooklyn's Jewish communities in regard to the prevalence of the eating disorders of anorexia and bulimia, conversation with the communities' leaders will confirm that cases of young Orthodox women (and men) with eating disorders exist in a number proportionate to those in the general population.

For a variety of reasons that cannot be elaborated upon due to space limitations, the Orthodox Jewish community has always had some resistance to mental health services. This resistance makes it much more difficult to come to terms with and treat an eating disorder, particularly since eating disorders, more than any other psychological disorder,

require a multifaceted and interdisciplinary approach to recovery (Bruch, 1978).

Over the past few years, the Orthodox Jewish community has come to acknowledge eating disorders as the life-threatening disease they are and has looked to therapists for advice and treatment. Every aspect of an Orthodox Jew's life is guided by his/her religion, and it is often difficult to find a therapist who understands and respects this strong cultural identity. Consequently, families seeking help for their daughter struggling with an eating disorder usually have to "settle" – either by opting to use a therapist who does not fully understand their lifestyle and ideals, or by choosing second-rate care from individuals with little training in eating disorders. Obviously, neither of these options provide an ideal solution and such treatment often ends in disaster.

As someone involved with the needs of the Jewish community, Rabbi Dewick recognized this problem. Experience with numerous strugglers and conversations with mental health professionals confirmed that it was necessary to provide the Ultra-Orthodox and Chasidic communities with the resources needed to combat this serious disease. Consequently, Rabbi Dewick founded Magen Avrohom, an organization

geared to help the strugglers attain the proper treatment.

But Rabbi Dewick realized that treatment in the form of therapy once or twice a week was not enough. Rabbi Dewick explains:

"In most cases of eating disorders, the struggler is dealing with a two-fold problem. The first is an emotional hurt and the second is the manifestation of that pain in the form of not eating (or bingeing and purging). By becoming so obsessed with food and not eating, the struggler is able to focus on something aside from the deeper, inner pain that she can think of no other way to deal with. While, this is obviously not a healthy way to cope with emotional problems, to the struggler, being anorexic/bulimic serves as a narcotic as her true pain is negated in light of her new obsession" (Personal communication, 2007).

Therefore, when treating an eating disorder, the recovery process must be two-fold. The fact that a young woman is not eating is a symptom of her emotional pain. Since that symptom can lead to death, it is imperative that the symptom be ministered to even before the actual cause - the emotional pain - is located and treated.

Treating the symptom, however, without treating the cause is often ineffective. With

physical ailments, such as a brain tumor, the patient can be treated and whether she wants it or not, can then be cured from the ailment. However, with a psychological illness, the patient must **want** to be cured or else she will continue to refuse to eat and the treatment will be ineffective. A patient needs someone to help her through the three revolving stages of an eating disorder: denial, acceptance but no motivation, and the struggle to overcome. A therapist is not enough. A struggler needs a staunch supporter, a cheerleader to encourage her to battle, to let her know that someone cares and will always be there for her.

It was for this reason that Rabbi Dewick conceived the idea of a mentor program with each struggler being assigned to one mentor and each mentor mentoring only one struggler. The mentors are not therapists and are by no means a substitute for therapy. The mentors are there to supplement therapy and ensure its success. A struggler has a wound and professional medical treatment is what can heal this wound. However, with all wounds, care must be taken to ensure that, even while the wound is being treated, it does not get infected, rendering the treatment ineffectual. The regular contact with the mentor can be likened to the “cleaning” of the wound, which allows the treatment to achieve the desired results.

When looking at eating disorders from a family system model as a psychosomatic illness, the issues of enmeshment, overprotectiveness, rigidity and conflict avoidance are the classic issues dealt with in therapy (Fishman, 2004). Interestingly enough, this mentoring program indirectly touches upon all four of these issues. A girl who is enmeshed with her parent(s) begins to develop a relationship with this outside-of-the-family mentor. This individual becomes a new source of psychological comfort. Since the mentor shares the same cultural identity as the struggler and the struggler’s family, the mentor is not viewed as a threat to either the struggler or her parents, and there is minimal resistance from the family. As the parents experience this shift, they gradually relinquish their psychological overprotectiveness of their daughter as they see that she now has another individual with whom she can share her feelings. All the conflicts that this girl is experiencing can now be expressed to her mentor who identifies with the struggler and her background.

Again, it must be underscored that these mentors are not therapists. They are regular,

caring people who undergo a thorough training which gives them an understanding of their role in a struggler’s recovery process. They are there to listen, to care and to encourage. A mentor is someone who offers a non-judgmental listening ear, someone with whom the struggler can develop a healthy emotional relationship. Quite often, individuals with eating disorders are struggling with relationships and feel empowered and in control because of their love/hate relationship with food. By developing a healthy interpersonal connection with her mentor, the struggler is able to fill the relationship void, thereby aiding the struggler’s recovery from her unhealthy relationship with food.

Strugglers usually talk with their mentor two or three times a week. The conversations are not focused on food or body image, but rather on relationships, conflicts and feelings. Magen Avrohom tells its mentors to serendipitously bring out the following four points by way of casual conversation and personal example:

1. That not everything in life works the way we want it to work out, nor can we always have everything we want. The mentor can relate to stories about how things in her own life did not go as she would have liked, yet she accepted and dealt with the situation she faced. She also expresses the Jewish principal that G-d is almighty. We must acknowledge that he is the One who is truly running the show and we must accept that certain things are beyond human control.
2. That it takes courage to do things that are difficult, but the efforts will yield great results.
3. That the struggler is a person of value. In most cases, strugglers are suffering from low self-esteem. The mentor helps boost self-esteem by constantly reinforcing the struggler’s talents and worth.
4. That one should be in touch with their emotions. Mentors often talk about feelings. For example, when discussing their day, a mentor may say: “When my boss yelled at me, I felt angry/depressed/underappreciated.”

In general, a struggler and her mentor never meet in person. This anonymity fosters a relationship that is not affected by

outward appearances and false pretenses. The mentor is thereby able to fully give over her word straight from the heart, which, in turn, enters into the heart of the struggler.

The obvious question one would ask about such a program is whether it is applicable to the general population or something that is only needed and useful to the somewhat insular Ultra-Orthodox and Chasidic communities.

From our understanding, mentoring programs such as Big Brothers/Big Sisters have been around for over 60 years. A mentoring program designed to help individuals with eating disorders is basically an extension of a pre-existing program and can be utilized effectively regardless of the struggler’s religious affiliation.

For our work in this particular field, we believe that most clinicians would probably agree on the following two facts:

- Fact #1: Eating disorders treatment is very difficult.
- Fact #2: Eating disorders aren’t simply about food, but rather about relationships, which is played out with food.

Knowing and accepting these two facts, a mentor program could be another welcome solution to the multifaceted and interdisciplinary approach most clinicians consider crucial. As treatment is extremely difficult, any additional therapeutic input can play a critical role in the struggler’s recovery.

Perhaps the effectiveness of a mentoring program can best be conveyed by the following letter, recently received from a former struggler: “Looking back, I don’t think I would have managed through this difficult crisis alone. I, a young wife and mother, battled with anorexia and bulimia for the past 15 years of my life. It was only 2 1/2 years ago that I finally spoke up and reached out for help. Magen Avrohom has kindly provided this help, connecting me with the right medical professionals and providing me with a warm and caring mentor. Our steady phone calls made me feel that there was someone there for me, who understood what I was going through and felt my inner pain and turmoil. I was able to confide in her what I could not have told other people. I learned to express my emotions, fears and anxiety, to take care of myself, and to live a more focused life. . . From the depth of my heart, I thank you for providing me with my mentor and granting me a new lease on life.”

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Rabbi David Dewick is the Founder of Magen Avrohom, an organization that assists strugglers and their families by providing them with guidance, support groups, and the mentor program as mentioned in this article. Rabbi Dewick first encountered eating disorders over 20 years ago, when he was called upon to assist a struggling friend.

Doing Right by Our Clients: A Core Ethical Dilemma in the Treatment of Eating Disorders

Dea Silbertrust, PhD, JD

The primary purpose of all mental health treatment is to help clients recover from the disorders that brought them to treatment. For eating disorders, recovery encompasses restoration of weight, cessation of bingeing and/or purging behaviors, resolution of distorted cognitions related to eating, weight and shape, and improvement in the client's quality of life (Crow, 2007). Usually it is assumed that the therapist and client jointly agree on the goals and basic treatment approach that hopefully will lead to recovery. However, with many eating disordered clients this is not a simple task.

Some clients are pressured into treatment by family, friends or physicians. Other clients enter treatment willingly because they want to make changes in their lives, but those changes may not include their eating behaviors. Still other clients profess a sincere desire to change their eating behaviors, but only if they can be assured that they will not gain a pound. Virtually all clients are ambivalent about giving up their eating disordered behaviors, and some outrightly refuse to change these self-destructive patterns.

All clinicians who work with eating disordered clients are faced with an ethical dilemma: how to attend to the well-being of clients who resist recovery from a potentially life-endangering disorder, while respecting the clients' right to autonomy and self-determination. The paradox of working with clients with anorexia, bulimia, and binge eating disorder is that clinicians are faced with caring for people who seem determined not to get better (Strober, 2004).

The Justification for Paternalism

The dilemma faced by treatment providers is described by moral philosophers as the problem of determining when paternalism is justified. Paternalism is the belief that it is sometimes ethical to intervene in the life of another person who does not desire such intervention because it will protect the person from harm. From the Latin *pater* meaning father, paternalism is the principle of acting towards others in a manner similar to that of a father with his children.

The ethics of acting in such a manner arise in societies that value an individual's right to make his own choices and decisions. This principle of respect for individual autonomy is a cornerstone of democracy and liberal thought. It is also one of the fundamental principles underlying our healthcare system. The ethical codes of all mental health professions contain reference to the importance of the right of clients to make their own treatment decisions. For example, the current code for psychologists (APA, 2002) lists five general principles that articulate the moral values of the psychological community which underlie specific ethical provisions (Fisher, 2003). Principle E is Respect for People's Rights and Dignity, which includes the fundamental right to self-determination.

Individual autonomy is not limitless. All societies allow others, including the government, to restrict autonomy in order to protect people's welfare. For instance, most states have laws requiring the use of seat belts even by competent adults who might choose not to wear a seatbelt. But even if an individual values his comfort more highly than his safety, the state will override this

preference in order to protect his health and the health of other citizens. This principle is also highlighted in the professional ethics codes, such as Principle A: Beneficence and Nonmaleficence in the APA code (APA, 2002). This means psychologists strive to do good by promoting the welfare of others and minimizing harm, a principle that harkens back to the Hippocratic Oath written in the 4th century BC.

Whether it is ethical to infringe on a client's autonomy because we believe it will benefit the client depends in part on the importance we assign to people's welfare as compared to their right to self-determination. A distinction is often made between weak and strong paternalism. Weak paternalism legitimizes interference with the means an individual chooses to achieve her ends, if those means are likely to defeat those ends. In the seatbelt example, if a person prefers safety over comfort then it is ethical to force them to wear seatbelts. Strong paternalism, on the other hand, states that people may be confused or mistaken about their ends and, therefore, it is ethical to prevent them from achieving those ends. Thus, if a person would rather have unrestricted movement in his car than have greater protection in an accident, the state may make him wear a seatbelt because his ends are irrational and may cause pain or monetary losses to others. (Giordano, 2005).

Paternalism and Eating Disorders Treatment

Most articles on ethics in eating disorders treatment are written by clinicians outside the US and focus on complete treatment

refusal by clients with severe anorexia (Goldnor, Birmingham & Smye, 1997; Griffiths & Russell, 1998). Cases involving involuntary treatment and force feeding are compelling and clearly illustrate the issues involved in balancing client autonomy and welfare protection. Fortunately, however, these cases are also rare. The same dilemma, albeit in more subtle forms, occurs in the more common context of treatment resistance (MacDonald, 2002).

The recognition of this core dilemma goes back at least 20 years and is especially apparent with eating disordered clients because the issue of control is central to their symptom constellation (Giordano, 2005). One of the paradoxes of eating disorders is that one of the client's initial goals is to attain a sense of mastery and control over herself and her life. But what begins as an attempt to feel more in control ends up taking over and often leaves the person feeling more out of control than ever. One way to assist in recovery is to help the client find more authentic ways of feeling in control, thus lessening the need to focus exclusively on controlling weight and food intake. Treatment resistance is not just stubborn irrationality, although it can feel like that to family members and treatment providers; it is an attempt to ease intense psychic distress (Strober, 2004).

Working with clients with serious eating disorders can tax the patience of most clinicians. The various ways clients resist attempts to help them, often result in clinicians ineffectively responding with persuasion, coercion or manipulation, including threatening hospitalization or insisting on (versus suggesting) weight gain or cessation or purging (MacDonald, 2002). The frustration, anger and helplessness evoked by these clients can lead therapists to take a more paternalistic stance with their clients, a stance that is likely to elicit more resistance. In the case of chronic anorexia, a clinician's pushing for change can lead an already fragile client into a potentially fatal backslide (Strober, 2004).

So, how do the ethical demands of respect for client autonomy and protection of client welfare help the clinician determine a course of treatment? The best way of dealing with this dilemma is to continually engage the client in a discussion of goals and treatment methods. The more control a client feels in treatment, the less likely the client will be to try to maintain a sense of control by resisting treatment. Taking an unnecessarily paternalistic

approach with a client, perhaps in part because of one's countertransference reactions, can have a deleterious effect on treatment by encouraging clients to give voice to their concerns through their symptoms (Rathner, 1998).

This does not mean treatment is always openly collaborative. Treatment for many disorders, including anorexia and bulimia, involve some measure of convincing clients they want something different than they think they want. Motivational interviewing, for example, deals with this by highlighting the discrepancy between the clients' stated goals and the problem behavior. This practice helps guard against the therapist exerting undue influence or imposing her values on the client (Miller & Rollnick, 2002).

Conclusion and Recommendations

Ethical issues do not arise only when we are stopped in our tracks by an ethical crisis; they are woven into our clinical work and deserve our frequent attention. Nor do ethics involve the mechanical application of a set of rules enacted by a professional association. Both ethical and clinical decisions are driven in part by the moral values that underlie other thoughts and behaviors. Attending to these core values and the attendant ethical dilemmas improves the care we give our clients and deepens the satisfaction we derive from our work.

There is no specific set of guidelines for determining how to balance protection of client autonomy and protection of client welfare, with eating disordered or other clients. This balancing act will coexist with the constant clinical demands of working with our eating disordered clients. It is not necessary to constantly engage in formal ethical decision-making; this can be saved for the emergence of a specific ethical concern. Rather, it helps to remain mindful of the underlying issues that exert a powerful but often unseen influence on our treatment strategies and clinical interventions.

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Increasing Parent Support: Empirical and Pragmatic Considerations on an Outpatient Basis

Nancy Zucker, PhD and Franca Alphin, MPH, RD, LDN

There has been a welcome, albeit long overdue, increase in the trust and responsibility that clinicians and researchers are imparting to parents for the care of their child with an eating disorder. However, with this added change comes the responsibility for clinicians to increase resources in support of parents. This is a matter of great importance, given reports of the significant psychological burden parents experience when their child has an eating disorder; research has indicated the degree of burden exceeds that of families of children with other chronic illnesses such as psychosis (Treasure, et al., 2001). This article summarizes options for group parent education and support and highlights issues with the implementation of these resources in an ongoing clinical practice. This article is by no means comprehensive, but rather highlights prototypical interventions from a variety of treatment modalities.

Alternative Group Formats to Provide Parent Support

Psychoeducation Seminars

Group psychoeducation seminars are a standard part of many eating disorder programs. Traditionally, these seminars take the format of a lecture series in which a variety of professionals (therapists, nutritionists, psychiatrists, etc.) speak on their area of expertise, thereby providing parents with general, as opposed to tailored, information regarding eating disorders. Often these are attended by both the individuals with the eating disorder and the parents. While the stated intent of these groups is educational, they may provide support, as well. Some programs make this an expected part of the treatment process, and there is some empirical support to do so. Group psychoeducation for eating disorder treatment has been reported to decrease parent variables such as expressed emotion (Uehara, et al., 2001), a variable that has been demonstrated to negatively impact the success of a family-based intervention. A further benefit to this group is practicality. Each lecture is usually an independent entity permitting individuals

to enter the lecture series at any time. This format allows a program to have ongoing services, rather than waiting for a group of available participants. One potential drawback to these groups may be that they do not provide parents with supportive accountability, i.e. a social network that can guide them in their specific tasks of helping their child. To date, this is just speculative, as research exploring the independent effects of psychoeducation groups is limited, but needed.

Multi-Family Groups

A more recent entry into the arena of parent support is multi-family groups for eating disorder treatment. These groups, as described by Eisler and colleagues (Dare & Eisler, 2000) differ markedly from psychoeducation seminars in that their stated function is treatment. These groups are designed to serve as an alternative treatment modality for the management of adolescents with eating disorders and other mental and physical disorders. As described for eating disorders, families meet for day-long sessions for several consecutive days and then return intermittently for follow-up sessions. There are several potential advantages to this type of format, including numerous opportunities for vicarious learning from observing the actions of other parents, live opportunity for the practice and enhancement of new skills during multi-family meals. Perhaps more importantly, they provide intensive support at a critical point of intervention in the child's illness, for instance when the parents are initiating the treatment process. Providers have yet to learn how acceptable this format will be for families in the United States receiving outpatient care, although there is evidence of acceptability of this model in the UK (Lemmens, et al., 2003). However, given the appeal of providing intensive treatment in a format that may greatly enhance parent support, this model may prove highly desirable for many families.

Parent Groups

Parent-training groups are treatment groups for parents, i.e. a therapeutic format in which parents meet with other parents on a regular basis to learn strategies to manage their child's illness while having assigned practice to implement novel strategies (Golan, Kaufman & Shahar, 2006) (Zucker, et al., 2004) (Barlow & Parsons, 2003). Parent groups have an extensive research history supporting their utility in the treatment of externalizing disorders such as ADHD and, more recently, to internalizing disorders such as childhood anxiety (Shortt, Barrett & Fox). How do these groups differ from a standard psychoeducation seminar? First, parent groups are conducted like a traditional therapeutic group in that attendance is mandatory, they are time-limited, and there is homework assigned between groups. Usually a group of parents begin the therapeutic group together, thereby sharing the experience of caring for their ill children. These additions may increase both the degree of support and accountability parents experience as they get to know the same group of people over time, while the group keeps them focused on treatment goals.

There are several benefits to parent groups. First, given the ongoing nature of these groups (e.g. 16 weeks for some), parents receive ongoing support and a vehicle for accountability for disorder management. Further, as expressed emotion has been cited as an obstacle in family-based treatment, a parent-only format provides a safe container for unhelpful communication patterns. In fact, parents have often reported that they value the opportunity to express their frustrations about managing the illness in a group of parents they know have empathy for their position. Finally, they may serve a family systems function as this parent-only format may strengthen the marital partnership. Notably, these benefits relate largely to group process issues while group content may add other benefits.

PARENT BOOKS

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There are a number of different parent curriculums. Treasure, Smith and Crane (2007) formalized a curriculum for parents of adult children to be published this summer in the eating disorders program utilized at Duke, which is targeted to illness management, while addressing potential management barriers such as perfectionism, expressed emotion, and emotion regulation (Zucker, 2006). There are numerous other books for parents of children with eating disorders (see column to the left). While not designed specifically to serve as group curricula, the information in these works may be amenable to group presentation (although this has not been formally tested). As in many therapeutic modalities, we have much to learn about the relative importance of content regarding therapeutic process in producing change.

Parent groups sometimes serve as an adjunct to other treatments such as family therapy. We are currently experimenting with a group format, the adolescents in one group with the parents in another, followed by a joint concluding session for goal setting. It is too early to know the utility of this format, yet, from a systems perspective, the adolescent group may function as the sibling subsystem from more family-based treatments. There is clearly much work to be done, not only in learning of supportive formats for parents, but also in how to integrate such structures into the adolescent's or adult's care.

Some Cautions

Teaching skills can increase a parent's sense of agency, provided he/she does not mistakenly hear that there is only one right way. Parents are so eager for information and so thrown off balance (Palmer, et al., 2003) by their child's illness that they may lose parental self-efficacy (Eisler, 2005). In such circumstances, it is very easy to unintentionally create a perception of the therapist as "all-knowing." This may cause parents to rely increasingly on the therapist's advice rather than on their own skills. One way of avoiding this is to present a variety of options and alternatives and have parents design their own plan based on what they think would work in their family. This tactic, combined with caution to provide information and not directives, should assist parents in their efforts, while hopefully not undermining their confidence.

In sum, there are numerous opportunities for creating vehicles of parent support. This article concludes with some tips parents have found helpful over the years. Take the ones you like, and leave the ones that don't quite work for you, your family, or your practice! All in all, we have as much to learn from parents as they have to learn from us. Combined knowledge undoubtedly makes the strongest team.

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PARENT TIPS

1. Listen.....Without Fixing.

A parent's role is in constant evolution. When children are infants, the task is clear. While certainly not easy, at least when children are infants a parent knows he/she has to solve all problems, as the child does not have the capacity. The tough part as children age is determining when to lean in and fix the problem and when to hold back and allow them to struggle through and find their own solutions. Parents have found that one way out of this dilemma is sometimes to ask questions such as, "Do you need my advice or do you just want me to listen?" These types of questions can sometimes clear up confusion.

2. Remember the Dance of Parenting.

But what about for children who struggle to ask for help even when they need it? That's where experience and the *dance of parenting* (the leaning in and stepping back required of parents) comes into play. Stepping back and seeing if children are able to handle things is a good way to test if they are ready. If they are sinking, sometimes the hardest thing as a parent is to watch them struggle a bit so they can learn. However, if struggling too much, we might need to lean in. That's why it's a dance. What can you learn about your own dance style? Ask yourself if any of your strategies would be worth tweaking. If not, keep dancing.

3. Learn Your Limits.

Many individuals who struggle with disordered eating have difficulty setting personal limits (knowing when to stop). As a result, their effort toward goals may interfere with their health and quality of life. To help them with this, we may have to first help ourselves. Taking an honest look at how we balance our responsibilities to ourselves, our families, our work and our relaxation may lead to opportune areas for new learning, particularly if you feel that things are very unbalanced. Why is this important? It's hard to take care of others if your own care is suffering. In addition, children need an example of what healthy adulthood can look like. Fortunately or unfortunately, we serve as their glimpse into adulthood. We want to make sure it's a world they want to enter into. What can you learn about yourself? Think about whether your balance strategies are working. If you are feeling burned out or stretched too thin, it may be worthwhile to attempt new strategies and see if you can find a more optimal solution.

4. It's a Process. Try it. Tweak it. Learn and Grow.

5. Model Professionalism, Not Perfectionism.

Professionals accept mistakes with dignity, rise from falls, and laugh at themselves.

6. Learn from Mistakes Rather than Beat Yourself Up about Them.

We learn much more from trying new things and failing, rather than from doing the same thing over and over.

7. Surf the Wave.

We use the metaphor of a wave to get comfortable with emotional experience. One quick tip, acting from the top of the wave (i.e. at the height of emotional intensity) rarely turns out very well. Come down from the wave, regain logic, and then reason through solutions.

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