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# PERSPECTIVES

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A Professional Journal of The Renfrew Center Foundation

Winter 2010



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The 19th Annual Renfrew Conference Update & Save the Date  
For the 2010 Conference Are Included In This Issue.

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## A Word from the Editor

Clinicians in our field are challenged to integrate what is known with what is new, and we hope these articles help on both fronts. The Winter 2010 issue of *Perspectives* includes both novel and familiar topics. The articles on the phobic model, substance abuse, and intuitive eating provide new perspectives on these familiar areas of our work. The articles on Emotion Acceptance Behavior Therapy and Motivational Interviewing introduce us to novel efforts for addressing eating disorder psychopathology. The final article is a unique and subjective description of how mindfulness might be used to improve our treatment options. We hope these articles stir some thought. Please send your ideas and comments to [dbunnell@renfrewcenter.com](mailto:dbunnell@renfrewcenter.com)

Doug Bunnell, PhD  
Editor ■

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## Understanding The Complex Relationship between Eating Disorders and Substance Use Disorders

**Bethany L. Helfman, PsyD & Amy Baker Dennis, PhD**

Eating disorders (ED) co-occur with substance use disorders (SUD) at an alarming rate. Prevalence data suggests that roughly 50% of individuals with an ED are also abusing drugs and/or alcohol, which is more than five times the abuse rates seen in the general population (The National Center on Addiction and Substance Abuse [CASA], 2003). Not only are there high rates of substance abuse (SA) among women with ED, women who use alcohol and drugs demonstrate high rates of disordered eating. In particular, 30-40% of women with an alcohol use disorder (AUD) and 16.3% of women with SUD report a history of an ED (Blinder, Blinder & Samantha, 1998; Taylor, Peveler, & Hibbert, 1993) as compared to the .9 to 3.5% of women found in the

general population (Hudson, Hiripi, Pope, & Kessler, 2007).

The co-occurrence of these disorders yields a complex clinical picture with high rates of mortality. In fact, a meta-analysis by Harris and Barraclough (1997) revealed that patients with anorexia nervosa (AN) and bulimia nervosa (BN) had higher rates of suicide than any other psychiatric disorder, a rate 23 times greater than what is seen in the general population. In a recent study of 6,000 Swedish women with AN, Papadopoulous and colleagues (2009) found that compared with the general population, AN subjects were 19 times more likely to have died from substance abuse (SA), primarily alcohol. Among all ED, the binge-purge subtype of anorexia nervosa (ANBP)

is associated with the highest risk of death (Bulik, et al., 2008).

Given the complicated nature of these disorders and the increased risk of fatality, it is surprising to note that ED professionals have not routinely integrated SA treatment into their paradigms nor have SA professionals adequately incorporated ED treatment into their practices. It is all too common for clinicians to simplify these cases by focusing merely on one aspect (their specialty) of the patient's presentation. Regrettably, by narrowing one's treatment focus, clinicians may inadvertently prolong suffering as these patients vacillate between these two disorders. There are substantial costs and consequences to the individual and the health care field that are cumulative across the lifespan when we fail to adequately treat these patients (Kessler, et al., 2003). It is therefore vital that clinicians in both fields acquire knowledge of the other, and that treatment approaches of both specialties be incorporated and studied.

A complicating factor in the understanding of this co-morbid group is the fact that many randomized controlled treatment trials (RCT) conducted in the ED field exclude subjects with SUD from their studies (Gadalla & Piran, 2007). As a result, we know of no empirically supported treatments for this co-morbid population.

Even when evidence-based practices are identified by researchers, considerable difficulties remain in disseminating those results to the practitioner in the field. The polarization between researchers and clinicians is particularly evident in the SA field where, despite large federally funded research initiatives, published practice guidelines and manualized protocols, a majority of traditional 12-step programs fail to offer EBT, such as behavioral couples and family therapy (BCFT), which is available in only 4% of the country's SUD programs (Fals-Stewart & Birchler, 2001). Additionally, research indicates that addiction is a chronic, relapsing disorder that can be managed, but not cured. Yet in clinical practice, addiction is often treated as if it were an acute disorder requiring crisis intervention, and relapse is seen as a failure of treatment. These findings suggest that treatment providers require

additional training to effectively treat their current population, let alone these co-morbid conditions.

Few treatment centers undertake the evaluation and treatment of co-morbid ED and SUD. In fact, research suggests that a mere 21.7% of private SA centers offer ED treatment (Roman & Johnson, 2004). A study by Gordon and colleagues (2008) of 351 publicly funded addiction treatment programs found that while half of the programs screened for ED, only 29% admitted complex ED cases. Of these programs, very few attempt to treat the co-morbid ED. When treatment is attempted, the medical model of addiction is often the protocol to treat both disorders (Gordon, et al., 2008).

It is fair to say that few topics in mental health carry as much heated debate as those of EBT in general and SA treatment in particular. EBT are, at the present time, the best we have but their superiority has also been hotly debated. Norcross and colleagues (2006) encapsulate this debate by stating "defining evidence, deciding what qualifies as evidence and applying what is privileged as evidence are complicated matters with deep philosophical and huge practical consequences" (p. 7). For example, RCT, used to identify an EBT, rarely take into account other factors such as clinician qualities, which have been implicated in determining patient outcome. Additionally, certain treatments lend themselves more readily to RCT methodology (CBT for example) than alternative approaches such as humanistic or psychodynamic.

We strongly support the use of EBT in the treatment of both ED and SUD. First, both disorders are protracted illnesses that require a significant commitment of time and financial resources by patients and their families. Consumers should expect that clinicians who identify themselves as "specialists" would be highly skilled and would utilize the most efficacious treatment interventions available. Second, all patients and families deserve access to the best available treatments. RCT have repeatedly demonstrated that EBT approaches work far better than random approaches. These treatments are identified through rigorous research and point to a specific psychological approach or pharmacologic intervention that reduces or eliminates

symptoms of a particular psychiatric illness better than other forms of treatment or no treatment at all. Once identified, clinical treatment manuals are developed and designed to provide a clear road map for clinicians by outlining goals, decision points, strategies and timelines.

While there are no data on a specific EBT for this co-morbid population, there is an extensive body of evidence for the use of EBT for each population separately. Yet significant controversy remains in the SA field between "traditionalists," followers of the self-help and recovery movement, and the "revisionist culture," academic researchers interested in developing EBT for SUD (Wallace, 2009). Many addiction treatment programs continue to treat based on a 12-step, psychosocial model which is often delivered in group settings. However, the past decade has witnessed an enormous emphasis on the study and utilization of EBT for SA. Examples of EBT for the treatment of SA include cognitive behavioral therapy (CBT) and motivational enhancement therapy (MET), which have been manualized by The National Institute on Drug Abuse ([www.drugabuse.gov](http://www.drugabuse.gov)) and BCFT. Additionally, several pharmacological interventions have also been approved by the FDA as adjunctive treatments for SUD.

Researchers in the ED field, have also identified the most efficacious treatments for AN, BN and binge eating disorder (BED). Maudsley, or family-based therapy (FBT), and ego-oriented individual therapy (EOIT) have been found effective in the treatment of adolescent AN. Cognitive behavioral therapies (CBT, enhanced CBT or CBT-E, and dialectic behavior therapy or DBT), and Interpersonal Therapy have demonstrated specific clinical effectiveness in the treatment of BN and BED. To date, psychological interventions are the only EBT for ED, however several psychopharmacological agents have been found effective in reducing target symptoms.

Another important issue to consider with the ED/SA patient is how treatment should be delivered. In an integrated approach, the same providers treat comorbidities concurrently. This model requires a thorough understanding of the relationship between the co-morbid

conditions. For example, does the ED trigger the SA? Do they occur concurrently? Or do they function in the service of each other (i.e. amphetamine abuse in the service of the ED)? Integrated models have been proposed for SA and other psychiatric illnesses (i.e. schizophrenia, bipolar disorder) but not for ED.

Sequential treatment, on the other hand, focuses on the most acute disorder first and is often conducted with multiple providers or in different locations. Differences in theoretical orientation, staff training, and treatment protocols can make continuity of care difficult. Data from the SA literature suggest that when co-morbid diagnoses are treated concurrently and integrated on-site, treatment retention and outcome improve (Saxon & Calsyn, 1995; Weisner, Mertens, Tam, & Moore, 2001).

A considerable amount of cross-training between disciplines and specialists needs to take place in order to use an integrated treatment model. We have found that clinicians in the ED field are often not well trained in the diagnosis or treatment of SUD and are therefore ill-prepared to treat this co-morbid condition concurrently. They are not familiar with the philosophy or vernacular of AA/NA and do not fully comprehend to the complexities of the 12-step program. Similarly, clinicians in the SA field are not always skilled in the treatment of ED and other serious psychopathology or familiar with psychopharmacological interventions.

Given the current chasm that exists between both the ED and SUD fields, we strongly encourage the research community to study this co-morbid population. To date, there are no formal connections between the ED and SA professional communities. Philosophical differences and disagreements on treatment approaches have interfered with our ability to effectively serve this group of patients. At the same time, clinicians in the field are encouraged to adopt a perspective of change. Clinicians, like our patients, are often resistant to change, preferring to practice whatever technique they know best whether or not it is efficacious for their population. It is our hope that this article will energize both the ED and SA fields to strive for improved communication, research, and willingness to learn and practice evidence-based techniques with

the goal of enhanced patient outcomes. We look forward to a time when every major national conference on ED or SA will include workshops on the other specialty, and when graduate and medical schools will train their students on the complexities of co-morbid conditions. It is our hope that collaboration between these two fields and well-funded research will lead to an increase in both outpatient and inpatient treatment centers that have the comprehensive expertise to alleviate the suffering of these patients. Finally, we recognize our limitations in providing the answers to many of the problems inherent in treating this population. We hope that this article stimulates thought and, ultimately, provokes action in the field.

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## Motivational Interviewing in the Treatment of Eating Disorders

**Carmen Bewell-Weiss, MA & Jacqueline Carter, PhD**

A famous adage suggests that every journey begins with a single step, and this sentiment is especially pertinent to therapy directed towards changing maladaptive patterns of thoughts and behavior. Clinicians who work with individuals with eating disorders (EDs) know well that not only is it difficult to help patients to take that first step, but that the next step (and the one after that) is often just as hard. Because clients often present with marked ambivalence about change, an initial step towards seeking treatment may not actually result in recovery. The client's waxing and waning motivation to change may not only have a negative impact on recovery, but it can also lead to frustration on the part of the clinician. Thus, as Geller and Drab (1999) have suggested, the "mismatch between treatment focus and client readiness may cause a well-intentioned therapy to deteriorate into an entrenched battle between therapist and client over food and weight" (p. 260). It is crucial then to not only be aware of clients' intentions and motivation to recover from their eating disorder at all points in the treatment process, but also to actively increase that intention whenever possible.

### Motivational Interviewing

Motivational Interviewing (MI) is a non-judgmental, client-focused style of therapy, where the goal is to increase the client's intrinsic motivation to change by maximizing the client's sense of autonomy and sense of responsibility for his or her health. It is a therapeutic approach

designed to resolve ambivalence and facilitate readiness to change and may therefore be a particularly effective addition to the treatment of eating disorders. MI (Miller & Rollnick, 2002) was originally designed from within the field of addictions to help enhance motivation to recover from substance use disorders. Its aim is to explore and resolve ambivalence about change by helping clients acknowledge both the pros and cons of change by normalizing the experience of ambivalence, and by helping the client situate his/her behavior within the context of his/her values and goals. Importantly, the interaction between the therapist and the client is considered to be as important a determinant of the individual's motivation to change as is something intrinsic within the client him/herself. Thus, rather than conceptualizing resistance as a client characteristic, in MI, resistance is seen as an indication of a mismatch between the therapeutic intervention and the client's readiness to change. Resistance on the part of the client is viewed as a useful warning to the therapist to switch strategies—to validate the client's concerns about making changes, rather than pushing for behavioral change, as this would likely be met with more resistance.

MI facilitates a movement towards behavior change by encouraging the client to put the pros and cons of change in the context of his/her values and goals. By doing so, the client may conclude that the problematic behaviors are not, in fact, meeting his/her goals, and s/he may be

more likely to abandon these ineffective behaviors and look for other ways to achieve these goals. MI is not a non-directive approach, as the therapist has a clear intention about where s/he would like the client to end up, and tries to amplify the client's reasons for change when possible. However, the intent is for the client to become an advocate for change, which allows him/her to choose the strategies employed to achieve the change goals, and enables the client to take ownership of the changes that s/he has made. In so doing, the value of the change process may be increased—past research has demonstrated that behavior change attributable to internal sources (driven by intrinsic motivation) occurs more often and is longer-lasting than behavior change attributable to an external source (Geller, Drab-Hudson, Whisenhunt, & Srikameswaran, 2004). As Miller and Rollnick (2002) argue, people are "more persuaded by what they hear themselves say than by what other people tell them." Allowing the client to advocate for change may also minimize power struggles between the client and therapist, because the therapist no longer needs to argue with the client or convince him/her to change. Thus, MI may be helpful in promoting a positive therapeutic alliance, which has been shown to be not only particularly difficult to maintain in ED treatment, but also an important predictor of treatment outcome (Constantino, Arnow, Blasey, & Agras, 2005).

### A Motivational Interviewing Prelude to Intensive Eating Disorder Treatment

Our group at Toronto General Hospital and York University in Toronto recently conducted a study evaluating the clinical efficacy of a brief MI intervention delivered to a transdiagnostic sample of patients on the waitlist for either inpatient or day hospital treatment at the Eating Disorders Program at the Toronto General Hospital. Participants were randomized to either four sessions of individual MI or a waiting list control condition. A semi-structured MI treatment manual was developed by the first author. The manual provides suggestions for how to introduce the MI treatment and explore the client's history and current symptomatology using MI principles. A distinction is made between two phases of MI treatment—exploring ambivalence and preparing for change. The first phase is appropriate for clients with marked ambivalence, and includes techniques aimed at allowing the client to identify both the pros and cons of changing. In this phase, a number of MI techniques are outlined:

- *Decisional Balance* to identify the pros and cons of both changing and staying the same.
- *Writing a Letter to the Eating Disorder as a Friend/Enemy* to identify the costs and benefits of changing and beginning to connect with the emotions involved in change.
- *Identifying the Client's Values* to determine whether there are discrepancies between the client's current actions and what is important to him/her.
- *Looking Forward* ask the client to describe potential future scenarios if s/he decided to change or if s/he continued with the disordered eating behavior.
- *Looking Backward* ask the client to describe life before the eating disorder.
- *Importance and Confidence Ruler* used throughout treatment to quantify the client's motivation to change and belief in his/her ability to change.

Only after the client begins to demonstrate clear resolution of ambivalence and expresses a willingness to move towards change should the second phase strategies be employed. This phase is aimed at preparing for and supporting the

client through actual change. Thus, one important technique in this phase is the creation of a detailed treatment plan (clearly outlining the client's reasons and desires for change, and what s/he will do to bring about the change). Just as important in this phase is to increase the client's belief in his/her ability to change by exploring personality traits that the client possesses that will be useful in changing. Clients with eating disorders often have a great number of positive personality traits, not the least of which is extremely strong willpower, that have allowed them to engage in behaviors that the general population would typically avoid (i.e. dieting to an extremely low weight, engaging in purging behaviors, etc.). It is important for the therapist to bring these abilities to the client's attention and brainstorm the ways in which they may be maximized so that change can be realized. Doing so may also demonstrate to the client that s/he do not have to lose the important part of themselves that distinguishes them from others; they just need to change the behaviors that they use to display these character traits. Thus, in the second phase, the client and therapist work together to build the client's confidence in his/her ability to change and outline exactly how that change can be realized.

The treatment manual was created in an effort to facilitate measurement of the effectiveness of MI in the treatment of eating disorders, and outlines not only the techniques involved in MI, but also a suggested order in which the techniques could be implemented. However, the basic philosophy of MI (i.e. following the client) runs somewhat counter to these efforts. Thus, throughout the treatment manual, therapists are encouraged to follow the techniques insofar as they suit the needs of the particular client, and, when in doubt about the next action, let the client guide the choice of technique, rather than simply following the next step in the manual.

Preliminary results showed that participants in the MI condition were more likely to successfully complete the subsequent intensive treatment program than those in the treatment-as-usual condition (Bewell-Weiss, Mills, Westra, & Carter, 2009). In fact, with each additional session of MI, patients had almost double the chance of completing the later treatment program. The MI condition was not particularly time consuming on the part of either the

therapist or the participant, and when participants were asked informally what they thought of the sessions, their responses were very positive about the experience. Thus, it seems that including an MI intervention may be an especially useful and economical addition to an intensive, hospital-based treatment program.

### Treatment Implications and Conclusions

Eating disorders are associated with significant costs and consequences. The individual suffering with the disorder is at significant risk of health problems that can lead to death, s/he can lose social relationships, may not be able to pursue occupational goals, and often suffers from various co-morbid psychological symptomatology associated with, and potentially caused, by his/her eating behavior. In addition, treating EDs is extremely expensive and patients with anorexia nervosa who are discharged while still underweight have been shown to have higher rates of rehospitalization and higher levels of symptoms at follow-up than those who completed treatment programs with weights in the healthy range (Baran, Weltzin, & Kaye, 1995; Lock & Litt, 2003). With such significant costs, successful intensive treatment completion is of the utmost importance. The results of the present study suggest that a short pre-treatment of MI is not only reasonably inexpensive to offer and agreeable to both the clinician and the patient, but it is also associated with better subsequent treatment outcome, which may have significant value from both the perspective of the well-being of the client and from a health economics standpoint.

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## Eating Disorders – Dangers and Phobias

**Julie Lesser, MD, Elke Eckert, MD & Joel Jahraus, MD**

The complications of eating disorders are well-recognized, including physical and behavioral changes (Devlin, Jahraus & Dobrow, 2005; Kerem & Katzman, 2003). There is evidence that anorexia nervosa patients, particularly at very low weight, have both structural and functional brain changes. Resting brain imaging studies have confirmed that low weight anorexics have enlarged ventricles and widened sulci suggesting diffuse brain atrophy, as well as reductions in both gray and white matter. Neuropsychological research has demonstrated that cognitive dysfunction is a common feature of anorexics at low weight, and these cognitive deficits may be associated with brain abnormalities (Chui, Christensen, Zipursky, et al, 2009). One study found reduced dorsal cingulate cortex volume in low weight anorexics, which correlated with deficits in perceptual organization and conceptual reasoning (McCormich, Keel, Brumm, et al, 2008). Although all these alterations appear to be at least partly reversible with weight restoration, some data suggests that at least some of these brain changes may persist after weight recovery and may even be related to severity of illness and to outcome.

The amygdala in the temporal lobe of the brain, and more broadly the whole limbic system, plays an important role in fear/phobic responses. Functional imaging studies suggest an exaggerated fear response in anorexics. In one study, anorexics showed more anxiety and more

activation of the amygdala/limbic fear network compared with healthy controls after viewing high calorie foods compared with low calorie foods (Ellison, Foong, Howard, et al, 1998), and in another study there was more activation of the fear network in anorexics compared with healthy controls after viewing heavier images of themselves (Seeger, Braus, Ruf, M., et al, 2002). Thus, the limbic system, particularly the amygdala, is likely involved in the high anxiety and extreme fear responses to food and weight issues in patients with eating disorders.

Patients with all types of eating disorders frequently report high levels of arousal or sensitivity, described as feelings of disgust, connected to aspects of body image or sensations. These experiences are usually linked with compensatory escape behaviors that are maintained by negative reinforcement. Dietary restriction, common in eating disorders, is an example of an avoidance behavior which typically occurs in response to specific rules and core beliefs, in some ways similar to avoidance behaviors in other anxiety conditions such as obsessive compulsive disorder, agoraphobia, social phobia or specific phobia.

There are such high rates of co-morbid anxiety disorders in patients with eating disorders that the anxiety disorders are viewed as a vulnerability factor for the onset of eating disorders. The rates of

anxiety disorders are similar in all three subtypes of eating disorders, AN, BN and EDNOS, with up to two thirds of patients reporting one or more anxiety disorders during the lifetime, with onset typically during childhood. If not actually diagnosed with an anxiety disorder, ED patients often have other traits connected to anxiety such as perfectionism and harm avoidance. Recent data from the Genetics of Anorexia Nervosa study (Dellava, Thornton, Hamer, Strober et al, 2009) show an association between childhood anxiety and fearful behaviors with caloric restriction and low BMI in anorexia nervosa. Atypical presentations of anorexia nervosa, especially in young children, may be associated more directly with specific phobias for choking or vomiting. Malnutrition itself may be associated with anxiety and activation of a fear response, as identified in the Minnesota starvation study (Keys, et al, 1950), and a low BMI in childhood is a risk factor for the development of an eating disorder later in life.

Eating at regular intervals and gradually reintroducing feared foods is central to behavior change and recovery. Most treatment approaches, whether it is emphasized or not, incorporate this key element of exposure therapy. There is an emphasis on self-monitoring and evaluation of cognitive distortions. Successful treatments involve learning new coping strategies and problem solving skills to contain anxiety and prevent a return to avoidance behaviors.



In considering treatment interventions such as family-based treatment, cognitive behavioral treatment and dialectical behavioral therapy for eating disorders, it is useful to consider the principles of exposure therapy for phobias, and it is often helpful to use this framework in discussing the approach to treatment and in setting goals with patients and families.

Phobias are considered excessive fears, and the different types (including social phobia, agoraphobia and different categories of specific phobia) vary in age of onset. Maintaining factors for phobias share similarities to factors which maintain an eating disorder. Three components maintain a phobia: the cognitive (phobic thinking and beliefs), the behavioral (typically avoidance, such as more subtle forms of avoidance such as excessive reliance on safety signals, including reliance on staff helpers and familiar routines), and the physiological (distress responses associated with the feared situation or object). Causes of phobias include genetic factors and environmental influences, with direct and indirect (vicarious or instructional) conditioning, often combined. Negative life events, negative attributional styles, and avoidant coping strategies predict fear responses in children, but these are moderated by the type of information (negative or positive) given to children. Another model focuses on non-associative fear responses, such as innate fears found in normal development, with phobias viewed as occurring as a result of enhanced genetic fear responses or deficits in modulating responses. Perhaps malnutrition itself is a moderating factor, since, clinically, the fears and avoidant behaviors associated with eating disorders tend to increase as the nutritional state deteriorates, and to lift or improve as the malnutrition resolves.

Exposure therapy for phobias targets cognitive distortions and biases with the learning of new, non-dangerous meanings (Craske & Barlow, 2007). Phobic thinking typically involves overestimates of danger and catastrophe thoughts such as not being able to cope with or tolerate the feared situation. The main intervention involves approaching the feared object or situation, hence the term exposure, so that the individual learns that nothing bad will happen and that he or she is able to tolerate and cope with the situation. Strategies in exposure therapy include

contingency management procedures, modeling, systematic desensitization and cognitive or self-control procedures (Craske, Antony & Barlow, 2006). One self-control procedure designed to help in childhood fears is called the STOP technique, which stands for **S**: feeling *Scared*, **T**: having the *Thought* that... **O**: some *Other* thought or behavior, and **P**: *Praise* (myself) for coping (Silverman & Moreno, 2005). Teaching this technique has been helpful in our program when an impasse occurs over eating specific foods, either at home or in the hospital. Exposures are designed so that corrective learning occurs.

Structured behavioral interventions for eating disorders on an inpatient unit often include components of exposure therapy in the milieu rules and contingencies set up for the dining room, for gaining privileges, and in establishing criteria for discharge. If a patient struggles to complete an item planned for a meal, a replacement is offered, but the goal is to stop taking the replacements for regular foods. When a patient continues to take excessive amounts of replacements, explaining the nature of avoidance and phobic thinking is typically the most helpful intervention. There is a higher risk of relapse following discharge from the inpatient unit if a patient returns to avoidance behaviors such as avoiding high density foods. Patients who receive a cognitive behavioral therapy intervention following discharge from an inpatient unit show higher rates of recovery (Attia & Walsh, 2009). In many programs, a transition from the inpatient unit to a partial hospital or intensive outpatient program helps prevent a return to avoidance behaviors.

Cognitive behavioral treatment focuses on recognizing and changing the overvaluation of being thin, which is connected to the fear of becoming fat or overweight (Agras & Apple, 1997). The process of weight exposure helps the individual begin to tolerate anxiety while looking at his or her weight and plotting it on a graph. The data provides a context for understanding trends in weight gain over time and for establishing what are considered healthy weight ranges (Fairburn, 2008). The patient learns that nothing dangerous will happen to his or her weight by following a pattern of regular eating. Patients use self-monitoring logs to evaluate typically

phobic thoughts, and homework involves challenges such as breaking specific rules, with an emphasis on increasing reflective capacity to recognize the eating disorder mindset or the associated perfectionist mindset, and using active problem solving strategies to confront and change thoughts and avoidance behaviors.

Dialectical behavior therapy has been adapted for eating disorders with a focus on improving regulation of emotions for patients with co-morbid borderline personality disorder, severe or complex eating disorders, and for binge eating disorder and bulimia nervosa (Wisniewski, Safer & Chen, 2007). There is an emphasis on self-monitoring, active problem solving, and skills training; specific targets include avoidance behaviors, with the provision of validating (reinforcing) responses for behavior change. Binge eating and restricting are viewed as escape behaviors, which may become negatively reinforced. Exposure protocols in dialectical behavior therapy for eating disorders include: commitment strategies to prevent specific behaviors, regular eating and weighing interventions, and the use of diary cards to monitor behaviors and use of adaptive coping skills. Coaching calls are used to help implement problem solving strategies, with the timing of the calls designed to reinforce changes in behavior, instead of reinforcing avoidance or escape behaviors.

In family-based therapy, parents are placed in charge of the regular eating intervention (Lock, LeGrange, Agras, & Dare, 2001; LeGrange & Lock, 2007). The family receives education about the risks of malnutrition and the nature of the eating disorder. There is a separation of the illness from the individual (e.g. "*I know this is your eating disorder talking...*") and a focus on helping the parents address changes and concerns about eating. This approach emphasizes active problem solving strategies to minimize behavioral problems and expressed emotion (criticism, hostility and emotional over-involvement) (Pereira, Lock, & Oggins, 2006). The parents are trained directly to view their role as helpers, because negative interactions, such as a critical stance, will impede progress. There is an emphasis on validation strategies such as praise, positive reinforcement, and empathy, similar to principles of dialectical behavior.

There is also a specific focus on confronting behavioral avoidance, as in cognitive behavior therapy for eating disorders.

Given the recent findings in brain research confirming the activation of fear centers and responses in patients with eating disorders, therapists may find it particularly helpful to frame treatment more directly as an exposure therapy intervention.

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# Emotion Acceptance Behavior Therapy: A New Treatment for Older Adolescents and Adults with Anorexia Nervosa

Jennifer E. Wildes, PhD

The absence of evidence-based treatment interventions for older adolescents and adults with anorexia nervosa (AN) is one of the most serious issues in the eating disorders field. Although family therapy has shown promise in the treatment of younger adolescents who have been ill for a relatively short time, this approach generally is not recommended for individuals age 17 years and older who comprise the majority of AN patients (Bulik, Berkman, Brownley, et al., 2007). For underweight individuals, nutrition rehabilitation aimed at normalizing eating behaviors and restoring a healthy body weight is the cornerstone of recovery. However, there is expert consensus that nutrition rehabilitation alone is insufficient to promote lasting improvements in anorexic psychopathology (Agras, Brandt, Bulik, et al., 2004).

Psychotherapeutic interventions that combine nutrition rehabilitation with support, psycho-education, and other active therapeutic ingredients may hold promise in the treatment of older adolescents and adults with AN. Preliminary reports have suggested the utility of cognitive behavior therapy (CBT) in preventing relapse among weight-restored AN patients (Carter, McFarlane, Bewell, et al., 2009; Pike, Walsh, Vitousek, et al., 2003). However, the results from one study indicate that CBT may not be the optimal approach for treating underweight individuals with AN (McIntosh, Jordan, Carter, et al., 2005). In the current U.S. care environment, few AN patients are fully weight-recovered at discharge from intensive treatment programs. Moreover, many individuals with AN do not have access to structured treatment settings that provide nutrition rehabilitation or address eating disorder psychopathology. Thus, there is a critical need for the development of effective outpatient interventions for underweight individuals with AN.

## Emotion Acceptance Behavior Therapy

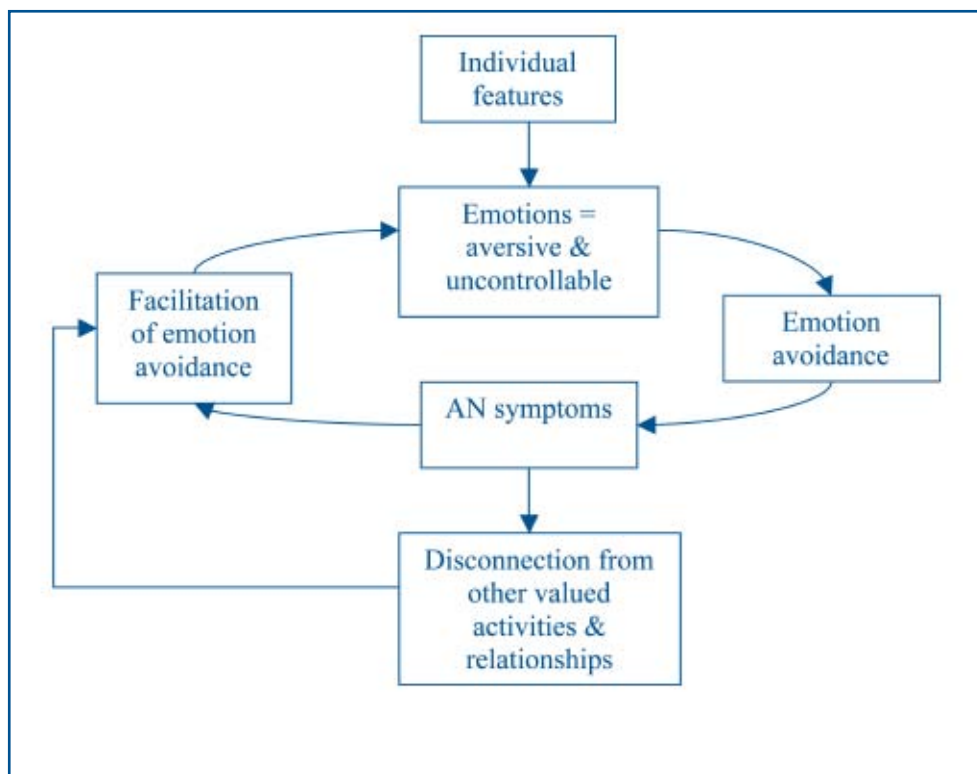
Emotion acceptance behavior therapy (EABT) is an outpatient psychotherapeutic intervention designed specifically for older adolescents and adults with AN. The principles of EABT derive from empirical

work on the psychopathology and treatment of AN, clinical experience, and the general psychotherapy research literature. Consistent with other recent clinical formulations of AN (e.g. Schmidt & Treasure, 2006), EABT is based on a conceptual model that emphasizes the role of anorexic symptoms in facilitating avoidance of aversive emotions (see Figure 1). Specifically, the EABT model postulates that people with AN often are characterized by individual features, such as inhibited or harm avoidant personality traits and problems with anxiety and mood disturbance, that shape their experience of emotion as aversive and uncontrollable. This negative experience of emotion results in “emotion avoidance,” that is, the desire to avoid experiencing or expressing physical sensations, thoughts, urges, and behaviors related to emotional states. Anorexic symptoms (e.g. extreme dietary restraint, purging, excessive exercise, ruminative thoughts about eating, shape, or weight) are hypothesized to serve the function of facilitating emotion avoidance by a) preventing patients from experiencing emotions and b) reducing the intensity and duration of emotional reactions.

The EABT model assumes that emotion avoidance poses two main problems for individuals with AN. First, although AN symptoms may be effective at reducing emotions in the short term, over the long term, efforts to avoid emotion may have the paradoxical effect of increasing the frequency and intensity of aversive emotional reactions (Moses & Barlow, 2006). Consequently, AN patients may become trapped in a cycle of emotional vulnerability, avoidance, and disordered eating. Second, because patients spend so much time focused on AN symptoms, valued goals in other areas of their lives are neglected. Thus, the primary treatment targets in EABT are: 1) AN symptoms, 2) emotion avoidance, and 3) disconnection from other valued activities and relationships.

## Conducting EABT

The EABT approach to treatment combines standard behavioral interventions that are central to the clinical management of AN (e.g. weight monitoring, prescription of regular, nutritionally-balanced eating) with



psychotherapeutic techniques designed to increase emotion awareness, decrease emotion avoidance, and encourage resumption of valued activities and relationships outside the eating disorder. EABT is heavily influenced by what has been termed the “third generation” of behavior therapies (Hayes, Luoma, Bond, et al., 2006), examples of which include Acceptance and Commitment Therapy (ACT), Dialectical Behavior Therapy (DBT), and Mindfulness-Based Cognitive Therapy (MBCT). Third generation behavior therapies are distinguished from traditional behavioral and cognitive-behavioral approaches by an increased emphasis on the context and function of psychological phenomena. Thus, EABT focuses on helping patients to identify the functions served by AN symptoms, including the connection between AN symptoms and emotion avoidance, and to adopt alternative strategies (including cultivating a willingness to experience/tolerate uncomfortable emotions and other avoided experiences) in the service of reconnecting with other valued activities and relationships.

### Structure of Treatment

EABT is a manualized, individual, outpatient psychotherapy for patients age 17 years and older with AN. Sessions are offered 1-2 times per week for a minimum of 40 weeks. Weekly treatment is contingent on weight stabilization (i.e., no weight loss for > 2 weeks and medically stable) and sustained improvements in other eating disorder symptoms (e.g. purging). Although individual therapy sessions are the primary vehicle for change, EABT is designed to be provided in the context of a multidisciplinary eating disorders treatment team. In addition to meeting with their therapist, patients enrolled in EABT receive weekly medical monitoring from a nurse or nurse practitioner and meet monthly with a psychiatrist. Patients and therapists also consult with a registered dietitian for assistance with meal planning. Finally, patients and therapists may schedule adjunctive psycho-educational or supportive sessions that include family members or supportive others. However, family therapy is not a component of the EABT intervention.

### Session Topics and Therapeutic Tools

EABT is divided into 3 phases; however, content across therapy sessions is overlapping, and the phases are not intended to be distinct. All sessions include a weight and symptom check-in (conducted by the nurse), review of the past week from the patient’s perspective, and validation of the patient’s concerns about gaining weight and reducing eating disorder symptoms. Although the focus of EABT is intended to be on issues that the patient identifies as relevant and important (as opposed to symptom management), therapists emphasize that this focus can be maintained only when eating disorder symptoms are at a level that does not interfere with crucial psychological work (e.g. stable weight, normal lab values). Thus, close monitoring of eating disorder symptoms is prescribed for patients whose symptoms are not stable with the expectation that this focus will diminish over the course of treatment. Some patients struggle with the idea of stabilizing symptoms or have difficulty reducing eating disorder behaviors. In these cases, the focus of therapy sessions turns to symptom management and motivation enhancement, with an emphasis on helping the patient identify discrepancies between her/his eating disorder symptoms and other valued goals and relationships. Additional therapeutic strategies employed during each phase of EABT are outlined below.

**Phase 1.** As in other psychotherapies, the initial sessions of EABT focus on orienting the patient to treatment and building a therapeutic relationship. A major aim of Phase 1 is for the therapist and patient to develop a shared understanding of the patient’s illness with a particular emphasis on the relation between eating disorder symptoms and the patient’s experience of emotion. The EABT model is introduced, and the patient and therapist work together to develop a personalized model that reflects the patient’s history, symptom functions, and values. At the close of Phase 1, the patient and therapist collaborate to set treatment goals for: 1) weight gain/reduction of eating disorder symptoms, 2) acceptance of emotions and other avoided experiences, and 3) participation in other valued activities and relationships.

**Phase 2.** The focus of Phase 2 is helping the patient meet her/his treatment goals using psychotherapeutic techniques adapted from third generation behavior therapies. The patient and therapist work collaboratively to determine the focus of sessions and to select therapeutic tools that address the patient’s needs. Three of the tools employed most frequently in EABT (e.g. mindfulness exercises, self-monitoring, and graded exposure) are described below. The patient’s progress in meeting goals for weight gain/symptom reduction also is evaluated during Phase 2 and additional goals are set, as clinically indicated.

*Mindfulness exercises* are used to help the patient observe, describe, and tolerate feelings, thoughts, and physical sensations related to aversive emotional states. At the beginning of treatment, mindfulness exercises are used to assist the patient in connecting with the present moment by, for example, observing and describing her/his surroundings or through deep breathing techniques. Later on, mindfulness exercises focused more specifically on the experience of emotion (and related thoughts/physical sensations) are incorporated both in-session and as between-session homework.

*Self-monitoring* involves recording experiences (e.g. emotions, activities, food intake) that occur between treatment sessions. The purpose of self-monitoring in EABT is to help the patient identify links between AN symptoms and emotional reactions or disconnection from other valued activities and relationships. For example, daily activity monitoring is used to evaluate the amount of time the patient is spending on eating disorder symptoms versus other valued activities and relationships, and to set goals for increasing participation in other valued domains.

In *graded exposure*, the patient and therapist develop a hierarchy of feared experiences related to a particular stimulus and develop a plan for helping the patient increase her/his contact with these experiences. For example, exposure may be used to help the patient increase willingness to enter situations that provoke aversive emotional reactions (e.g. social settings) or to address concerns more directly related to disordered eating (e.g. fear of physical sensations related to swallowing/choking).

**Phase 3.** The final 4-6 sessions of EABT focus on relapse prevention and issues related to termination. The patient's personalized model of AN is reviewed and updated and plans for continuing acceptance and value-based living are discussed. The patient and therapist also collaborate to develop a personalized plan for relapse prevention based on the course of therapy.

### Summary

In summary, EABT is a new treatment for older adolescents and adults with AN that is based on a conceptual model emphasizing the role of anorexic symptoms in helping individuals avoid aversive emotional states. EABT incorporates standard behavioral interventions that are central to the clinical management of AN with empirically-supported third generation behavior therapy techniques that have shown promise in the treatment of other chronic, refractory psychiatric conditions (e.g. borderline personality disorder). Our research group has been fortunate to receive funding from the National Institute of Mental Health to conduct a pilot study of EABT, and data collection is underway. The results of this study, which we anticipate will be available in early 2011, will guide our future work on the development of interventions for older adolescents and adults with AN.

*EABT was developed by Dr. Wildes and Dr. Marsha Marcus at the Center for Overcoming Problem Eating at Western Psychiatric Institute and Clinic, University of Pittsburgh Medical Center.*

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## Intuitive Eating in the Treatment of Eating Disorders: The Journey of Attunement

**Evelyn Tribole, MS, RD**

Patients with eating disorders are virtually the polar opposite of Intuitive Eaters. Intuitive Eaters possess three core characteristics, the ability to (Tylka, 2006):

- Eat for Physical Rather than Emotional Reasons.
- Rely on Internal Hunger and Satiety Cues.
- Unconditional Permission to Eat.

Growing research indicates that Intuitive Eaters eat a diversity of foods, are optimistic, have better self-esteem, and healthier body weights without internalizing the thin ideal (Tribole, 2009).

What is the best way to facilitate the attunement needed to become an Intuitive Eater? This article describes when and how to implement Intuitive Eating for patients recovering from an eating disorder.

### Nutrition Rehabilitation Phase I: Intuitive Eating is Contra-Indicated

*"Broken Satiety Meter."* When an individual is in the throes of an eating disorder, she is not capable of accurately hearing biological cues of hunger and fullness. In this situation, I tell my patients, their "satiety meter" is broken, a

consequence of complex interactions of mind-body biology and malnutrition. Chronic malnutrition results in compensatory slowing of digestion in which patients experience early and prolonged fullness.

Additionally, it is hard for binge eaters to recognize "gentle fullness," when painful binge cycles prevail. For the bulimic patient, the sensation of fullness is often distorted by the cessation of purging behaviors (such as vomiting or laxatives), which can cause temporary bloating. Amplifying the problem is the neuro-chemical cascade triggered by stress



and anxiety about eating issues which, in turn, may blunt hunger and cause nausea.

**Nutrition Rehabilitation.** In the beginning of treatment, nutrition rehabilitation usually requires some sort of eating plan (often under the direction of a nutrition therapist). This is similar to when a cast is needed to support the healing of a broken arm. The cast provides structure and support, but it is not lifelong, nor the destination in recovery. The cast is used until the bone is strong enough on its own. Similarly, a meal plan serves as structure and support, until there is biological restoration. For a low-weight patient, this includes weight restoration.

**Nourishment as Self-Care.** The body has been through nutritional trauma and needs consistent nourishment with adequate calories. In this phase, nutrition rehabilitation is a form of necessary self-care, regardless of the absence of hunger or the presence of early fullness. This proscriptive eating phase is somewhat mechanical because, in this early stage, a patient's willingness alone is usually not enough to assure adequate intake.

**Boundaries: The Role of the Schedule of Eating**

Creating a schedule of eating (*with the patient*) helps contain "eating anxiety" by establishing a predictable expectation of when to eat. Eating regularly helps foster body rhythms, which include hormonal patterns that help the body gear up for digestion.

In an outpatient setting, I like to establish a built-in flexibility of 30 minutes for each agreed upon eating time. For example, if the patient agrees to eat lunch at 12:00, then eating between 11:30 and 12:30 is acceptable. But if that 30 minutes of flex-time is up, the patient needs to stop-and-drop (the other tasks at hand) and feed her body. This is an important concept, because it helps the patient establish her self-care (nourishment) as a non-negotiable priority. For example, she might need to tell her friends she must eat first, before shopping (rather than visa versa). This often requires learning and practicing assertiveness skills.

During this phase, gentle hunger cues begin to emerge. Keep in mind that the occurrence of regular hunger cues varies and is determined by many factors including:

- Duration of eating disorder.
- Severity of malnutrition.
- Intensity of anxiety and fear about eating.
- Motivation for Recovery.
- Medications (which can distort hunger and satiety cues).

**Phase 2: Identifying, Normalizing and Responding to Satiety Cues**

It is vital that satiety cues are normalized before further exploring Intuitive Eating. The challenge lies beyond "hearing" the range of physical hunger and fullness cues. Patients need to learn how to respond

appropriately to these cues when they arise. This also means developing the ability to distinguish between physical and emotional cues.

As a person's hunger and fullness cues resurface, it's not unusual for fears and distorted beliefs to arise in-tandem. For example, some patients distort and mislabel the sensation of fullness as "proof" of overeating. Consequently, they may fear any fullness and label it as "bad" or "wrong." Or, some patients might believe that achieving fullness means eating just until the hunger goes away, but not a single bite more.

In this stage it is helpful to explore the

**How Intuitive Eating Principles Apply to Eating Disorders**

Core Principle	Anorexia Nervosa	Bulimia Nervosa/ Binge Eating Disorder
Reject the Diet Mentality	Restricting is a core issue and can be deadly.	Restricting does not work and triggers primal hunger, which can lead to binge eating.
Honor Your Hunger	Weight Restoration is essential. The mind can not function and think properly. You are likely caught in an obsessional cycle of thinking and worrying about food, and have difficulty making a decision. Your body and brain need calories to function. Your nutrition therapist will work with you to create a way of eating that feels safe to you.	Eat regularly—this means 3 meals and 2 to 3 snacks. Eating regularly will help you get in touch with gentle hunger, rather than the extremes that often occur with chaotic eating. Ultimately, you will trust your own hunger signals even if they deviate slightly from this plan.
Make Peace with Food	Taking risks, add new foods, when ready. Do this gradually, take baby steps.	Take risks, try "fear" foods, when ready and not vulnerable. Vulnerable includes over-hungry, overstressed, or experiencing some other feeling state.
Challenge the Food Police	Challenge the thoughts and beliefs about food. Take the morality and judgment out of eating.	Challenge the thoughts and beliefs about food. Take the morality and judgment out of eating.
Feel Your Fullness	You can't rely on your fullness signals during the beginning phases of recovery as your body likely feels prematurely full due to slower digestion.	A transition away from experiencing the extreme fullness that is experienced with binge eating. Once regular eating is established, gentle fullness will begin to resonate. Note: if you are withdrawing purging, especially from laxatives, you may temporarily feel bloated which will distort the feeling of fullness.
Discover the Satisfaction Factor	Frequently, there are fears or resistance to experiencing the pleasure from eating (as well as other pleasures of life).	If satisfying foods and eating experiences are included regularly, there will be less impetus to binge.
Cope with Emotions without Using Food	You may often feel emotionally shut down. Food restriction, food rituals and obsessional thinking are the coping tools of life. With re-nourishment, you will be more prepared to deal with feelings that emerge.	Binge eating, purging, excessive exercise are used as coping mechanisms. You can begin to take a time out from these behaviors to start experiencing and dealing with feelings.
Respect Your Body	Heal the body image distortion.	Respect the here and now body.
Exercise	You will likely need to stop exercising. Learn to remove the rigidity of nutrition—where there is a strict adherence to "nutritional principles", regardless of their source.	Over-exercising can be a purging behavior. Moderate exercise can help manage stress and anxiety.
Honor Your Health	Recognize that the body needs: Essential fat Carbohydrates Energy Variety of Foods	Learn to remove the rigidity of nutrition. There is a strict belief as to what constitutes healthy eating, and if this belief is violated, purging consequences can ensue (if bulimic). Recognize that the body needs: Essential fat Carbohydrates Energy Variety of Foods

\*from Tribole, E. & Resch, E. Intuitive Eating, 2nd ed (2003). New York: St. Martin's Press.

patient's understanding and beliefs around hunger and fullness. What is the expectation around satiety cues? What might "normal" cues feel like? What did these cues feel like before the eating disorder developed? What fears arise for the patient about the idea of responding appropriately to hunger and fullness cues? It is also important to emphasize that there is no single "correct" way to experience these biological cues.

*Dealing with "False-Labeling" of Body Cue Experiences.* In general, there is a three-step process to normalizing satiety cues:

1. Develop ability to identify physical cue.
2. Normalize the physical cue—confront the distortion (or fear) about the physical cue.
3. Respond appropriately to cue.

Every eating experience is an opportunity to learn about the body. For example, if for some reason the patient did not eat enough food at a meal—did she get hungrier sooner? (Usually, yes). Did she think about food more often? (Usually, yes).

Or, if she ate beyond comfortable fullness, did she feel satisfied and sustained for a longer period of time? (Usually, yes). Were there fewer thoughts about food? (Usually, yes).

### Phase 3: Indicators of Readiness for Intuitive Eating

While many patients would like to jump into Intuitive Eating, it is best to look for readiness indicators before proceeding. Is the patient able to:

- Recognize that the eating disorder is about something deeper—weight and eating are symptoms?
- Tolerate risk? As a person begins to heal both physically and psychologically, she is able to take and tolerate risks with eating.
- Tolerate being uncomfortable? Trying new eating experiences can be temporarily uncomfortable.
- Recognize (and manage) needs and feelings? If an individual is not able to identify her needs or cope with feelings, she may continue to use eating disorder behaviors such as restricting food, over-exercise, or binge eating as coping strategies.
- Value Self-Care? Is she willing to feed herself in the absence of hunger,

which may arise from ordinary life stressors?

- Recognize vulnerability—such as being too hungry, too tired, too stressed and so forth?

*Intuitive Eating Trial.* In the beginning, it is best to explore a one or two-day Intuitive Eating trial to determine if the patient is truly ready to eat on the basis of her biological cues. During this time, it is helpful to explore these issues:

- Were you able to honor hunger/fullness cues in a timely manner?
- How did you respond to hunger cues?
- How did you respond to fullness cues?
- Was there a part of you that was thinking it was an opportunity for you to eat less? And, more importantly, did you act on that thought?
- If you were scared about an upcoming event (such as eating dinner at a restaurant), did you compensate by eating less?

During this trial, a patient might discover that she doesn't feel ready, and she may opt to continue on her existing meal plan. It's important to emphasize that this is not failure. Rather, it usually reflects a patient's desire to protect her recovery. It is important to move at an emotionally comfortable pace (assuming she is eating adequate calories). Moreover, it is still possible to move forward with other Intuitive Eating principles within this framework—such as working on permission to eat any food. Patients often express feeling safer trying new food challenges within the framework of an eating plan.

There is no right or wrong way to proceed.

The challenge is to create more eating experiences that build self-trust. What does the patient need in order to feel safe? What types of foods and meals feel satisfying and sustaining? What types of foods would provide more social connectivity? For example, would the ability to eat pizza without anxiety allow more social interaction with her friends?

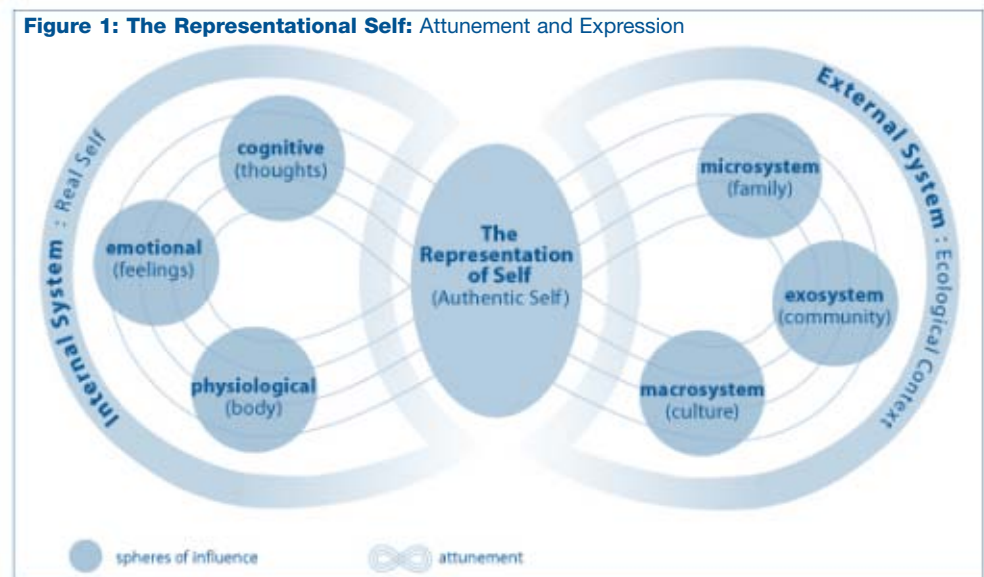
*Exploring Unconditional Permission to Eat.* The ability to eat any food is an important component of recovery and Intuitive Eating. Eating becomes emotionally neutral—without moral dilemma or shame—where the patient understands that one food, one meal, or one day of eating does not make or break health or weight. When guilt is removed from eating, it is easier to be attuned to the needs and experiences of the body.

Furthermore, habituation studies show that the more a person is exposed to a food, eating becomes less distressful (Epstein, 2009).

A promising study from the University of Notre Dame applied the Intuitive Eating principles to 30 women with diagnosed binge eating disorder (Smitham, 2008). After eight, 90-minute, weekly sessions, binge episodes decreased significantly—80% of the women no longer met the diagnostic criteria for the disorder.

### The Model: Integrating Intuitive Eating for Eating Disorder Recovery

Cook-Cottone (2006) developed the Attunement Representation Model to conceptualize the integration needed for an individual's recovery from an eating disorder. This integration also aligns with



Intuitive Eating. This model defines attunement as the dynamic integration of a person's inner and external worlds. A person with an eating disorder is skewed or mis-attuned toward the expectations of others (such as cultural expectations of thinness). See figure 1.

*Internal System.* Ultimately, Intuitive Eating is an individual's attunement with food, mind and body. The Intuitive Eating principles fall primarily within the internal system of the attunement model, which consists of a person's thoughts, feelings, and physiology (biological sensations of the body).

### Thoughts

Principle 1. Reject the Dieting Mentality

Principle 3. Make Peace with Food

Principle 4. Challenge the Food Police

Principle 8. Respect Your Body

### Feelings

Principle 7. Honor Your Feelings without Food

### Physiology (Body)

Principle 2. Honor Your Hunger

Principle 5. Respect Your Fullness

Principle 6. Discover Satisfaction

Principle 9. Exercise—

Feel the Difference

Principle 10. Honor Your Health with Gentle Nutrition

*The External System* consists of family, communities, and culture. These external influences include food traditions, cultural beauty standards and public health guidelines.

The last two principles of Intuitive Eating pertaining to exercise and nutrition, are components of both the inner and external systems and are excellent examples of the dynamic integration needed to achieve authentic health.

For example, a person can integrate exercise recommendations for health while being attuned to the experience of her body. This type of physical activity is also called "mindful exercise" (Calogero & Pedrotty, 2007) where exercise:

- Is used to rejuvenate the body, not exhaust or deplete it.

- Enhances the mind–body connection and coordination, and does not confuse or dysregulate it.
- Alleviates mental and physical stress, not contribute to and exacerbate stress.
- Provides genuine enjoyment and pleasure, not to provide pain and be punitive.

The pursuit of exercise is about feeling good, not about calories-burned or used as a penance for eating.

Similarly, health can be honored with gentle nutrition. For example, a family may desire to eat locally-grown foods with a low carbon footprint. If a person is truly inner-attuned, she can integrate this value without resorting to an eating disorder behavior or mind-set.

A person recovered from an eating disorder can eat within this dietary framework, while paying attention to hunger, fullness, satisfaction and so forth. If, however, a person enters this realm too soon, there is a risk for the new mindset to be embraced as another rigid set of rules, fueling old eating disorder thinking and behavior. Timing and readiness are the keys.

Ultimately, when a person recovers from an eating disorder, she trusts her inner body wisdom. She is at peace with her mind and body, and finally, enjoys the pleasures of eating without guilt or moral decree.

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**Evelyn Tribole, MS, RD**, has written seven books and co-authored *Intuitive Eating*. Ms. Tribole specializes in eating disorders in Newport Beach, CA. She also teaches *Intuitive Eating*

*PRO skills to health professionals.*

For more information, visit [www.EvelynTribole.com](http://www.EvelynTribole.com)



## Breathing Underwater

Terry Nathanson, LCSW, LMT

Holding a 3 oz. Dixie cup with two almonds and an apple wedge inside, I glance around the room. The meditation room is full with a curious excitement. With 21 spiritually seeking overeaters, I'm attending a workshop on how to recover from holiday bloat.

"The morsels in your cup will become a part of you," the workshop leader says, softly guiding us into a conscious eating experience.

I've seen and heard the cliché "we are what we eat" hundreds of times before on book jackets and lectures. In the Eating-n'-Motion® workshops I lead, I have said it. Now, the richness of Susan's words shimmer in my body as a perennial truth. Eating literally makes food a part of me. This almond will become my skin, muscle, and bone very soon.

As I began to inhabit the subtlety of my experience a realization struck me. We are what we eat, and it is in the 'how of eating' that we encounter who we really are and the essence of our being human. To eat is to enter into an intimate partnership with life. In moments, this partnering will include making a vow. A vow of intention beyond language itself.

Simply said, to eat is to live and not to eat is to die. At its deepest level to be born, to incarnate, is to be hungry and full.

"Eat as if it were a moving meditation," Susan says. "Be aware of your hand as it brings the almond up to your mouth."

Sitting on oversized floor pillows, the atmosphere in our circle is full and plush. Slowing down my fast food style of devouring, each miniscule movement takes on a new significance. It's as if the bend in my elbow, the reach of my finger, the touching of the almond, were my first and my last.

"Remember, this is your mouth, your hand, your body," I tell myself. Unfastening the parched safety latch of my lips, I seat the almond on my tongue. I can feel the ... "Stop," Susan tells everyone. Slamming on the brakes, my upper lip already molded to my almond's rutted surface, sticks in adherence. Its dryness bonds to my skin, sucking out the remaining moisture like a paper towel dropped on top of a kitchen spill.

Reflexively licking across the adhesive seal the almond falls onto my tongue. Like driving with the emergency brake on,

tension between my impulse to chew and inhibit thicken into a muscular articulation of choice that embodies the hinge of my jaw.

Funny thing—mindfulness. Time begins to change on you. A moment seems like forever, which can be a delight or hell. "Okay, now bite and notice something new." My bite splits the almond into halves. The invisible boundary defining otherness cracks under the shearing pressure of my desire. Snap... a whiff of bitter almond ignites an updraft at the back of my throat drawing the almond's aroma upward into my nasal passages. My tongue follows the trail in quick pursuit.

I need to swallow badly. It's sort of like having to pee. "Don't swallow just yet," Susan tells us, with the knife-like precision that could separate light from darkness. She's encouraging us to just sense rather than think or act. "What the hell," my agitation shouts back at her in silence. "Let's eat!"

"Mastery with emotional eating is mastery of the swallow," Susan says. Now, that piece of wisdom is worth the price of patience. I like that, but give me a break... I want to swallow!

Sliding against the almond's grainy smoothness changes into the feel of raw sandpaper. My cat, Zoë comes to my thoughts when she's meticulously licking my thumb. How soft her tongue is in one direction and pleurably raspy in another. An interesting mixture of longing and frustration vice my belly into an all too familiar knot of self-deprivation that swells up into my rib cage.

This exercise is taking forever and I'm pissed. It's Susan's fault. She's so controlling. So much for falling in love and trying to impress the workshop leader with how conscious I am. Married and divorced all in three minutes. Talk about gulping!

I did my mindful eating bit. I get it, all right! So let's eat. Get to the next step already! I want to gulp now!

My mind's amperage is turned up so high I can't shut off the sizzle. I'm not really having thoughts, but a formless kind of restlessness. I've experienced these feelings other times when I have brought a quieting presence to my every day ordinariness. Being this intimate with my mouth, rather

than losing myself in the object of my desire—food, spice and everything nice, is nerve racking.

Mind scrambles to get back online again. "Maybe it's your gluttony of wanting more Terry, or the nostalgic reverie of almond mush sliding down your esophagus in a victorious swallow. "Naa... It's just a damn almond." "Get real" mind's second in command back-up critic demands with harsh chastisement.

Being a good workshop participant, I guide my attention back in a Zen kind of way. Embedded in my frustration is a whisper of "just be with what is, feel sensations as they arise." I get distracted by the young guy's toes across from me playing with the soft green carpet.

Holding off on the 'rush' of gratification that a good ole quick gulp delivers, illumination explodes! Inherent in the pleasure of every mouthful lives its shadow side of loss. To have means to lose and therefore, not have... which is to have it all. The Buddhist Heart Sutra on the nature of impermanence is in every chew. Crap, I just want to eat. I do not want reality with a capital 'R' linked to pleasure and satisfaction. I might as well binge if that's going to be the case.

Reality is secretly sandwiched between gluttony and deprivation. Here resides the disillusionment of 'forever more' and my avoidance of limitation. Enjoyment that is inclusive of sorrow, satisfaction that holds both fullness and emptiness, is hard for even the most advanced eater to swallow.

Much of what I have mistaken as my rush-flush love for food and comfort has been confused with my gastronomic strategy to end all suffering—stuffing myself silly. So much for the sanctity of hedonistic overindulgence! And to add insult to incarnational injury, all this revelatory non-duality is another attempt to find refuge from the erupting anxiety of change. What eater wants to feel loss in every bite? Not the smartest of advertising slogans. Reality is not exactly a big selling ticket at McDonald's or during my prime time 11:30 PM refrigerator raids.

I'm tenser than ever now! The clock by the window reads 2:00 PM. It's been two minutes or more exactly, three and a half chews into an almond since we started

‘eating.’ I’m in some Sartre-esque dining room experience sitting at a table with the Buddha and the devil. “Food is food,” Buddha says, compassionately smiling. “Just swallow and enjoy, there’s more where that came from,” says the devil.” Or was that the Buddha?

Swallow man, swallow already...save yourself, some part of me yells from above the water line. You’re drowning. “Let me out” reverberates silently between my gritting teeth and tongue. Judgments punch at my soft palate hard. I can’t even taste anymore. In fact, I am not sure I ever really tasted. Flailing in terror, some part of me grabs onto my mind to make sense of this senselessness. I am going under for the third time.”

“Everyone breathe,” Susan lovingly whispers, from the shore-line of here and now far away in the distance. “Separate out the mashed almond from your saliva,” she encourages the group. “Use your tongue to push the pulp to the side of your mouth and let your self taste.”

My inner eye pivots in a quick one-eighty. Its fixation on the no-exit sign of hopelessness releases with a sigh. My mouth full with saliva is ready to burst through my lips any second now. I had no idea I was literally foaming at the mouth.

Muscular contractions have been pulsing in my throat in a struggle to neutralize my gag reflex. When my dentist waits too long in suctioning the basin of my throat during drilling a filling, I feel the same thing. This survival reflex has saved me from swallowing a fate worse than an almond many times before in my life.

“Swallow whenever you are ready,”

Susan gently suggests. “Whoa!” My terror dissolves immediately in the flush. It is as if I woke up from a dream where I was face down in a tub of water. Sitting up back into my body, resuscitates myself and a long needed “ahhhh” remedies my throat and chest in a bath of soothing vibration. This is a relief well beyond the sensuous ‘slide’ of finely masticated almonds making nice on their way down to my belly, thank you very much. Tectonic plates of being have shifted under the identity of who I thought I was as an eater. My embodied nature as animal, human and divine is unfolding quickly.

Sharing all this with Carol, one of the workshop participants sitting next to me, my mouth dilates with excitement. A restricted flow of saliva has been freed up from a history of having to swallow my aliveness. I had not realized how easy I was. Just a little in-real-time connection and my mouth reaches high tide again. Surf’s up with an urgent undertow not to feel my urgency. I want to go to my default program which has been to hide from my revelations, longing and transparent vulnerability and swallow—‘all gone’. I experiment with inhibiting my tendency to gulp a bit longer.

“Carol,” saliva seeping out of the left corner of my mouth, “I swallow my aliveness so as not to be flooded with feeling. This is why I gulp my food before really savoring. It is happening right now.” My true enjoyment and pleasure never breaks into the surface tension of my awareness. Carol empathically nods. A ‘pop-up’ memory suddenly emerges into my awareness. I grew up in fear of my mother swallowing me up whenever I excitedly expressed my aliveness, my individuality.

It’s as if she needed me more than I her.

As I see Carol’s eyes tear up, I know I am the one who has been swallowing my excitement. I have been living in ‘once upon a time,’ as if it were reality. “It’s like learning to breath underwater,” I tell Carol, joy radiating through my face. “This is me.” She smiles and hugs me.

In my own element, I am breathing underwater. Fifty years later, I am in my own experience, here and now. No one, snack or meal can take me from myself except for me.



*For over 25 years Terry Nathanson, LCSW, LMT has helped clients with eating difficulties and self-nurturance. As an eating coach, Terry blends Gestalt, Internal Family Systems, and eastern contemplative traditions with established body-mind approaches— all to support clients in establishing their healthy relationship with food.*

*Founder of Eatingmatters of New York, Terry leads workshops at Renfrew’s annual conferences, the Omega Institute and Kripalu Yoga Center. Eating consultation, one-on-one sessions, and appetite re-training intensives, are available for professionals.*

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 OF EATING DISORDERS**  
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 FRIDAY, APRIL 16, 2010

**BINGE EATING DISORDER  
 AND WEIGHT LOSS SURGERY**  
 PRESENTED BY: SANDY ARIOLI, RN, LMHC  
 FRIDAY, APRIL 23, 2010

**EATING DISORDERS,  
 MOOD DISORDERS, AND  
 PHARMACOLOGICAL INTERVENTIONS**  
 PRESENTED BY: SHAWN GERSMAN, MD  
 MONDAY, MAY 3, 2010

**THE RELATIONSHIP BETWEEN  
 TRAUMA AND EATING DISORDERS**  
 PRESENTED BY: ANGELA REDLAK-OLCESE, PSYD  
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# The Nineteenth Annual Conference Update



On behalf of the 2009 Conference Committee, I would like to extend thanks to all of the speakers, attendees and staff for making Renfrew's 19th Annual Conference a great success. This year, we welcomed hundreds of professionals from all over the U.S., Canada, Australia, Italy, Israel and Brazil.

The Conference theme, **The Art and Science of Eating Disorders Treatment**, featured presentations on a wide variety of topics ranging from traditional and experiential therapies to neuroscience and the link between mind, brain and body. Workshops addressed the role of the therapist and the integration of various therapeutic approaches and evidence based treatments into the recovery process, as it has become more essential than ever for clinicians to be embedded in many theoretical worlds.

Dr. Joan Borysenko delivered a personal, inspirational Keynote which addressed the psychospiritual development of women during the major stages of the feminine lifecycle. Her presentation was described by many attendees as uplifting, empowering and thought-provoking. Dr. Daniel Siegel, our Saturday Keynote speaker, examined well-being through the lens of science. He clearly articulated complex material in a fascinating, understandable manner, interweaving science and spirituality while validating the relational work that takes place throughout treatment. Our closing Keynote Panel, moderated by Dr. Bill Davis, brought together seasoned clinicians - Dr. Kathryn Zerbe, Dr. Jim Lock and Carolyn Costin, for a discussion of treatment issues from their different perspectives. The interactions among the panelists and questions from the audience were enlightening and provided practical answers to many of the challenges most clinicians face with eating disorder clients and families.

Throughout the weekend, there were also numerous opportunities for professionals to enjoy the camaraderie of networking and reconnecting with colleagues, as well as attending special breakfasts and evening events. We greatly appreciate those of you who participated with such enthusiasm!

Next year, The Renfrew Center Foundation will celebrate its 20th Annual Conference for Professionals. We are greatly looking forward to this milestone event. A preview of what we have planned can be found on PAGE 20.

This update includes photos from the conference as well as a form to order CDs if you were unable to attend or missed some workshops. Many thanks again for making Conference 2009 such a great success and we hope to see you next November!





*“What I love most and carry with me from each conference is the rejuvenation, the replenishment and the sense of community with others who do this work. Thank you!”*

*“Great conference, great food, great colleagues.”*

*“This is the best conference I’ve attended in my 10 years of practice.”*

*“It was a therapist’s heaven.”*



# SAVE THE DATE!

**THE RENFREW CENTER FOUNDATION  
CELEBRATES ITS  
20th ANNUAL CONFERENCE FOR PROFESSIONALS**

## *Feminist Perspectives and Beyond: Honoring the Past, Embracing the Future*

**Philadelphia Airport Marriott  
November 12-14, 2010**

To commemorate this milestone, Renfrew has planned three days of invited presentations by outstanding leaders in the field. The Conference 2010 program will address significant aspects of eating disorders theory, treatment, prevention, and research.

### **KEYNOTE PRESENTATIONS**

**Gloria Steinem**

**Craig Johnson, PhD and Michael Levine, PhD**

**Cynthia Bulik, PhD**

### **TOPICS TO BE EXPLORED INCLUDE:**

- Traditional Therapeutic and Complementary Approaches
- Body Image
- Treatment Issues
- Co-morbid Conditions
- Family & Group Work
- Neuroscience/Attachment
- The Therapeutic Alliance
- Genetics
- Diagnoses and Etiology
- Integrating Evidence Based Guidelines & New Research Findings into Treatment

**A Call for Proposals and Posters will resume in 2011.**

**For more information, please visit [www.renfrew.org](http://www.renfrew.org)  
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## AUDIO CD AND MP3 ORDER FORM

### The 19th Annual Renfrew Center Foundation Conference

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\*PLEASE READ NOTES ON THE NEXT PAGE\*

#### Thursday All Day Workshops

#	Presenter(s)	Workshop	CD
TH1	Bellofatto	The Therapist's Toolbox	\$50
TH2	Shure and Weinstock	Wired for Connection...	\$50
TH3	Courtois	Treating Complex Traumatic Stress Disorders	\$50
TH4	Kronberg, Love & McLeroy	Beyond Talking: Using Therapeutic Eating Sessions...	\$50
TH5	Pedrotty-Stump, Calogero, Cover, O'Melia & Reel	Treatment of Exercise Issues in Eating Disorder Clients	\$50

#### Friday Workshops

#	Presenter(s)	Workshop	CD
FR1	Butryn & Forman	Introduction to Acceptance & Commitment Therapy...	\$20
FR2	Gerstein & Barber	The Imperfect Therapist...	\$20
FR3	Hall, Levine & Mifsud	About Men: As Cultural Victims, ....	\$20
FR4	Kellogg	The Language of Change for Therapists and RDs	\$20
FR5	Weiner & Mehler	Medical/Therapeutic Treatment of Anorexia Nervosa...	\$20
FR6	Zerbe	The Resilient Therapist: Transference & Countertransference	\$20
FR7	Dagg & Little	Fed Up: Get Fed! Family Eating Disorder Recipes	\$20
FR8	Feinson & Wyshogrod	Reclaiming Inner Wisdom: Mindful Approaches...	\$20
FR9	Freizinger & Balz	Managing the Chaos: Dialectical Behavior Therapy...	\$20
FR10	Nye	In Treatment: An Inside Look at a Case of Anorexia Nervosa	\$20
FR11	Scarano-Osika	EDNOS in Teens...	\$20
FR12	Walsh	Eating w/ Your Genes Off? Epigenetics & Anorexia Nervosa	\$20

#### Keynote Presentations

#	Presenter(s)	Workshop	CD
Friday	Borysenko	Psychology, Biology & Spirituality of Feminine Lifecycle	\$20
Sunday	Davis, Costin, Lock & Zerbe	What Makes A Difference? Perspectives on the Art & Science of Eating Disorders Treatment	\$20

**Saturday Workshops**

#	Presenter(s)	Workshop	CD
SA1	Bloomgarden & Mennuti	The Therapeutic Relationship...	\$20
SA2	Bunnell & Lowe	Bringing Research into Practice...	\$20
SA3	Kearney-Cooke	Real Girls, Real Pressure...	\$20
SA4	Lelwica	Beyond the Religion of Thinness: Spiritual Needs...	\$20
SA5	Matz & Frankel	The Diet Survivor's Circle...	\$20
SA7	Feibish & Brendler	A Model of Supervision...	\$20
SA8	Ice, Kraman & Wingate	East Meets West: A Medical Approach...	\$20
SA9	Lock	Family-Based Treatment of Adolescent Eating Disorders	\$20
SA10	McGilley, Maine, Ressler	Yours, Mine & Ours...	\$20
SA11	Torres & Dauser	The Use of Story as a Shamanistic Tool...	\$20
SA12	Seubert	The Case of Mistaken Identity: Ego States and EMDR...	\$20

**Sunday Workshops**

#	Presenter(s)	Workshop	CD
SU1	Brady-Rogers	Neuroscience, Spiritual Practices & Transforming the...	\$20
SU2	Baratka & Hudgins	The Therapeutic Spiral: A Model for Treating Trauma... Disorders	\$20
SU3	Levine & Ethridge	Working Towards Recovery and Balance: ...	\$20
SU4	McLain	Do What I Say, Not What I Do: Self-Care and the Prevention...	\$20
SU5	Nathanson	It's More than Mindfulness: Integrating East & West	\$20
SU6	Schaefer & Berrett	Beyond Recovery: How Clinicians Can Teach Clients the Art...	\$20

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**The Renfrew Center is celebrating its 25th Anniversary as the country's first residential eating disorder treatment facility.**

Renfrew is the first and largest eating disorder treatment network in the country and has treated over 50,000 women with eating disorders. We provide a comprehensive range of services in PA, FL, NY, NJ, CT, NC, TN, TX, MD and Guatemala, an independent affiliate.

**In 2010, Renfrew will be hosting a 25th Anniversary celebration at each of our sites!**

- Florida - April 2010
- New Jersey - May 2010
- Philadelphia - June 2010
- Connecticut - September 2010
- New York - October 2010
- North Carolina - December 2010

**Continued through 2011:**

- Texas - February 2011
- Tennessee - March 2011
- Maryland - April 2011

**We hope you will join us in celebration of this great milestone!**

For more information, please call 1-800-RENFREW or visit our web site at [www.renfrewcenter.com](http://www.renfrewcenter.com)

**The Renfrew Center Opens New Facility in Bethesda, MD and an Independent Affiliate in Guatemala.**

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*AKASA is located in Guatemala, Central America.*

For more information, please call 1-800-RENFREW or visit our web site at [www.renfrewcenter.com](http://www.renfrewcenter.com)

**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:**

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The opinions published in *Perspectives* do not necessarily reflect those of The Renfrew Center. Each author is entitled to his or her own opinion, and the purpose of *Perspectives* is to give him/her a forum in which to voice it.



# L O C A T I O N S

**1-800-RENFREW**  
[www.renfrewcenter.com](http://www.renfrewcenter.com)

## NORTHEAST SITES

### **Philadelphia, Pennsylvania**

475 Spring Lane  
Philadelphia, PA 19128

### **Radnor, Pennsylvania**

320 King of Prussia Road  
2nd Floor  
Radnor, PA 19087

### **New York, New York**

11 East 36th Street  
2nd Floor  
New York, NY 10016

### **Ridgewood, New Jersey**

174 Union Street  
Ridgewood, NJ 07450

### **Wilton, Connecticut**

436 Danbury Road  
Wilton, CT 06897

### **Bethesda, Maryland**

4719 Hampden Lane  
Suite 100  
Bethesda, MD 20814

## SOUTHEAST SITES

### **Coconut Creek, Florida**

7700 Renfrew Lane  
Coconut Creek, FL 33073

### **Charlotte, North Carolina**

6633 Fairview Road  
Charlotte, NC 28210

### **Nashville, Tennessee**

1624 Westgate Circle  
Suite 100  
Brentwood, TN 37027

### **Dallas, Texas**

9400 North Central Expressway  
Suite 150  
Dallas, TX 75231

## INTERNATIONAL

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