



**1841 Broadway (@ 60<sup>th</sup> St.), 4<sup>th</sup> Floor, New York, NY 10023-7603**  
**Phone 212-333-3444 Fax 212-333-5444**  
**Email [csab@icpnyc.org](mailto:csab@icpnyc.org) web [www.csabnyc.org](http://www.csabnyc.org)**

Dear Colleague,

The Center for the Study of Anorexia and Bulimia, a division of the Institute for Contemporary Psychotherapy, is currently accepting applications for our **Two Year Training Program in the Theory and Treatment of Eating Disorders**. Eligible applicants must have a graduate mental health degree, a state license and malpractice insurance, and be actively conducting psychotherapy.

If you would like to apply, please complete the attached forms and return them with a \$75.00 application fee. Please arrange to have two letters of reference mailed to us. Once your application has been received, it will be reviewed by members of the CSAB Training Committee. Eligible applicants will be contacted to schedule an interview with a CSAB supervisor or faculty member.

We look forward to hearing from you!

Sincerely,

Lauren Palumbo  
CSAB Program Administrator

## **Specialty Training Program in the Psychotherapy of Eating Disorders**

The Center for the Study of Anorexia and Bulimia is a non-profit organization dedicated to providing meaningful help to those suffering from eating disorders. A division of the Institute for Contemporary Psychotherapy, the Center for the Study of Anorexia and Bulimia was established in 1979 to meet three objectives: effective treatment, specialized training, and increased community awareness. As part of our commitment to training, we have developed this comprehensive program that combines didactic and clinical seminars, supervision, and guest lectures.

This program is based upon the conviction that eating disorders represent maladaptive efforts to resolve profound psychological conflicts or deficits. Eating disorders are multidimensional problems that include intrapsychic, interpersonal, physiological, and sociocultural aspects. It is our philosophy that effective treatment must be responsive to all of these components as they are expressed in each case.

Heavy emphasis is placed upon expanding the therapist's theoretical and technical expertise. Knowledge of biological, medical, and sociological factors is also stressed. The goal of the program is to enable the therapist to create a therapeutic environment, which will lead to symptom relief and the resumption of the patient's psychological and physiological development.

- The program is open to a limited number of qualified mental health professionals who wish to expand their training in the treatment of eating disorders. A personal interview, as well as two references from previous supervisors is required.
- A certificate will be awarded upon successful completion of the program
- Classes and supervision are scheduled from 5:30 – 9:00pm every Monday, from September through June.
- One weekly session of individual supervision is also required for 44 weeks per year.
- A minimum of 120 clinical hours is required to complete the program.
- Trainees are required to offer three hours per week during which they are available to see clinic clients. One hour must be either in the evening after 5:00pm or on Saturday.
- Trainees may also use private clients to fulfill the requirements of the training program pending approval from the Director of Training and the individual supervisor.
- Throughout the program, trainees are required to participate in group supervision one hour per week through July.
- An application fee of \$75.00 is required; please enclose with completed application.
- Tuition is \$3,200.00 per year, which includes library use, group supervision, and membership in the Society for the Institute for Contemporary Psychotherapy; a minimal charge for course readings each term is additional.

**CENTER FOR THE STUDY OF ANOREXIA AND BULIMIA**  
**1841 Broadway, 4th floor**  
**New York, NY 10023**  
**(212) 333-3444**

<b>APPLICATION FOR SPECIALTY TRAINING PROGRAM          IN THE PSYCHOTHERAPY OF EATING DISORDERS</b>
---

Name: \_\_\_\_\_ Date of Birth    /    /   

Social Security Number: \_\_\_\_\_ Application Date: \_\_\_\_\_

Address (Home): \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_

Address (Office): \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_

How did you hear about our program? \_\_\_\_\_

**Graduate Educational Record**

School	Dates	Major	Degree	Date Graduated

**Postgraduate Training**

Institution	Courses

New York State License/Certificate Number: \_\_\_\_\_

If none, check here:







**Personal Psychotherapy**

**Please list your most recent therapist first:**

**Therapist** \_\_\_\_\_ **Dates:** \_\_\_\_\_ **Hrs\Wk:** \_\_\_\_\_

**Therapist** \_\_\_\_\_ **Dates:** \_\_\_\_\_ **Hrs\Wk:** \_\_\_\_\_

**Therapist** \_\_\_\_\_ **Dates:** \_\_\_\_\_ **Hrs\Wk:** \_\_\_\_\_

**Professional Affiliations**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**References**

**Please list the names, addresses, and titles of two supervisors familiar with your clinical work, and request that each send us a letter of recommendation.**

1. \_\_\_\_\_
2. \_\_\_\_\_

**Please tell us how you learned about our training program?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_