The Renfrew Center Foundation
FOR EATING DISORDERS

Perspectives

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A Word from Our Editor

Surprising moments often occur during therapy and yet, little is written about how clinicians handle or respond to these moments. Surprises come in many forms and have multiple impacts. They can derail a session, knock a clinician off balance or provide important information going forward. To better understand unexpected events, we are devoting this issue to *the element of surprise in the therapeutic process*. Specifically, contributors explore their experiences with events that occurred during therapy that surprised or startled them, events that were spontaneous and totally unexpected. Some of the issues associated with this theme include:

- What events have occurred during therapy that surprised you, startled you, stunned you, or taken you aback?
- With whom did the surprise originate? Was it something that your client revealed—or something that you said or did that triggered an unexpected reaction?
- How did you handle the surprise? How did your client handle the surprise?
- How did you understand the surprise?
- What impact did the surprise have on the therapy? On your relationship with the client?
- Are there circumstances when you used surprise as a therapeutic tool?

We begin with a fascinating essay entitled *"Thank you for being a therapist who makes big mistakes"* from **Gloria Dada,** a seasoned clinician from El Salvador who shares being "speechless, surprised, embarrassed, sorry" when confronted by her client, Esther. During the third session: Gloria was asking many questions when Esther stopped her sharply: "I told you I feel depressed when we first spoke... and I'll tell you why I feel depressed: because people treat me just like you are doing right now!" Although she was not surprised when Esther failed to show up for her next session, what Gloria did subsequently may surprise you.

In *"When Surprise, Curiosity, and a Little Bit of Shock Come Together,"* **Kathryn Cortese,** a licensed clinical social worker, provides us with a vivid and detailed description of her reaction to her client. "I knew I held a place of esteem in Caroline's world, but my first surprise in our relationship came in the form of a gift – a framed, matted, pencil sketch" which she subsequently hung in her office. "We explored this surprise through our therapeutic kaleidoscope and concluded this act held important information about our connection."

"Smart Watch Therapy" by **Holly Finley,** founder/clinical director of Eating Disorders Treatment Center, contains a fascinating surprise in a session with Katie. "During one of our last sessions my smart watch "dinged" to tell me I had received a text. Katie was startled and blurted out, "Oh, that must mean my session is over!" Her face flushed and she was visibly upset. The text alert had triggered her. I instantly flashed back to reports from patients whose previous therapists used an alarm to end a session. I had always thought this was a terrible practice, so I found myself

shaken, defensive and I was tempted to alleviate her feelings, and my own guilt for her discomfort." Holly's description of how she turned this incident into a teachable moment is compelling.

In *"Twenty-one Years of Surprises,"* **Kourtney Gordon,** a Registered Dietician from Florida, shares a shocking surprise from a colleague that she vividly recalls occurred at the beginning of her career: "I will never forget my first Dietetic Conference. I was fresh out of my internship and working in an Eating Disorder Treatment Center, excited to share my desires of being in a field I felt so passionate about. I was at our facility booth … [when] it happened, my confidence shattered, my hope questioned as a colleague stated, "I will never work with that population, no one ever gets better."

Finally, our readers are in for a lovely surprise. We are re-publishing a very special essay from the past by **Jackie Szablewski** entitled *"Listening In-to-It: Intuition in the Psychotherapy Process."* This essay not only contains an awesome surprise, but we also are providing **a Spanish translation by Maricarmen Diaz Juarez** in the hopes that it informs the work of a larger network of eating disorder clinicians.

Warmest wishes,

Marjorie Feinson, PhD

Thank You for Being a Therapist Who Makes Big Mistakes

Gloria Dada, MA, MSc, PhD

Someone once asked me what I liked most about working as a psychotherapist. Without much thought, I replied that it is a job in which it is impossible to get bored. We have training based on scientific knowledge and empirically grounded techniques. And yet, each client represents a new challenge, in which we must fit the pieces in a unique and creative way. And, of course, it is widely known that establishing a good therapeutic alliance is essential for the good outcome of each process.

As a specialist in eating disorders, in many cases it is important to quickly arrive at a diagnosis and design a treatment that allows the process to begin early. But, sometimes, the symptoms and signs are there in front of us, and yet they do not have much to do with what the client wants and needs to achieve in psychotherapy. If we think we are working with "a case of Anorexia Nervosa" or "Bulimia", and forget that we are actually working with "Sally", or with "Fred", or with "the Stevens family", it is almost inevitable that the alliance will be compromised. And even worse if what we think is Anorexia Nervosa or Bulimia, may not at all be what we are dealing with.

Many years ago, in my early days of working with eating disorders, I got a call from Esther, a young adult and smart woman. She wanted to make an appointment and claimed to be extremely depressed. She felt very lonely, and little understood by the people around her, including her family. "It's like no one is interested in really seeing me." Esther came to the clinic, and I saw an extremely thin woman come in, the scepter skin, dry and sparse hair revealing her scalp. During the initial assessment, of course, I looked for signs of Anorexia. Esther flatly denied wanting to keep a slim figure, and in fact commented that her thinness was a problem for her. She claimed to have a metabolic problem that, although she had consulted many doctors, they had never been able to explain. "I must eat very small portions of food", she explained, "otherwise my stomach does not tolerate it and I vomit it." It is known that those who suffer from an eating disorder rarely come to consultation for this problem, and that many tend to deny or give false information to "hide" the disorder, for fear that, if they are treated, they will have to weight gain. And I, at that time, young and enthusiastic, was like someone who has a new hammer and tends to see everything that is pointy as a nail, willing to use her beloved tool.

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On the second appointment, scheduled for shortly after lunchtime, Esther showed up with a cracker, and asked me if she could eat it during our appointment. She hadn't had lunch and felt a little weak. I was puzzled that she wanted to eat in front of me, but I thought maybe she was putting me to the test. I asked a lot of questions about diet, body image, habits in general... Until, during the third session, Esther stopped me sharply. "I told you I feel depressed when we first spoke... and I'll tell you why I feel depressed: because people treat me just like you are doing right now! I know that my physical appearance can be shocking, and that people worry about me. And no one can see beyond my fragile body, looking to it as the cause of all my problems."

I was speechless, surprised, embarrassed, sorry. She was right: here I was, doing what everyone else did, and I too had left her alone in the therapy room itself. At the end of the session, I thought I wouldn't see her again, and that it was entirely my fault. In fact, Esther didn't show up to her next appointment, and she didn't respond to my assistant's attempts to reschedule. My initial surprise turned into guilt and shame. After all, during our encounters it had been me who, as in a bad story, had repeated the same thing that so many previous characters had done. I didn't want the story to end the same way this time, with Esther feeling angry, and probably very sad and lonely. I wanted my guilt to be transformed into responsibility, and shame not to paralyze me but to prompt me to make one more attempt to intervene positively.

Trying to make a closing intervention, I decided to write a letter to Esther. In it I told her how much, in such a short time, she had taught me. I recognize it was very brave to have told me that I was making things hard for her, and that I greatly appreciated her honesty. I also acknowledged that I had been caught off guard by her words: I expressed that while I thought I was helping her and caring for her, I had actually made her feel judged. I accepted my mistake, without trying to sweeten or minimize it. It could not be justified. And I ended up saying that her clarity had given me the strength to be able to write that letter to her. Her strength. And it was true: Esther was a strong person.

The next day, Esther showed up at my clinic. She didn't have an appointment scheduled, but she asked to talk to me for five minutes. When she came in, she told me that she had received my letter, and it had taken her by surprise. "People, even my partner, have apologized many times when I try to make them see how I feel. But their "I'm sorry" is always followed by a "but" in which they blame me or my thinness for their lack of empathy. You didn't, you apologized without the "yeah, but…" part".

After reading my letter, Esther showed it to her partner. As he read it, tears began to flow. His feelings were reflected in my words. And being able to talk about my failures allowed him to talk about his own. He told Esther that I was right, that she is a strong woman, the strongest he knows, and that many times the helplessness of seeing her body consumed terrified him. What Esther felt as rejection or indifference, had finally been named as fear, fear of losing her because she was very important in his life. And that was followed by a conversation in which he told her so many things that he admired about her, and that Esther hadn't heard for a long time.

After telling me what had happened, Esther laughed (for the first time since I met her) and told me "The best thing you could have done for me was screw up the way you did! Otherwise, we might never have had that conversation at home. So, I thank you for being a psychotherapist who makes big mistakes."

She had done it again: Esther had given me a great lesson that I would never forget. I am a psychotherapist who can be wrong. That's not surprising at all. What I find amazing is that, many times, it is not the theories or interventions in which I have been trained that can make a difference. It's my honest human nature. Being able to talk openly about my emotions, and how they had changed (from surprise, to shame, to guilt) helped my client understand the internal processes in others, as well as opening up conversations with her loved ones. In this way, Esther was more compassionate about others' reactions, and more open about her own feelings.

By the way, months later Esther was diagnosed by an internationally renowned doctor, who was visiting the city for a conference. Indeed, she suffered from a rare disease related to thyroid function. According to the doctor, only a dozen cases were known with this condition around the world. "I always knew," Esther said smiling as she broke the news to me, "I'm unique and special." Again, she was right.

Gloria Dada, MA, MSc, PhD is a Founding Partner and current Clinical Director at Arborétum (Psychological Treatment Center) in San Salvador, El Salvador. She has worked with clients and families affected by eating disorders for nearly two decades. Her research in the field has led to numerous articles, and has lectured nationally and internationally on clinical psychology, eating disorders and their treatment.

When Surprise, Curiosity, and a Little Bit of Shock Come Together

Kathryn Cortese, LCSW, ACSW, CEDS

We both understood how I was often cast in varying degrees as a mother figure, instilled with the idealized and demonized traits any surrogate could have. She was an emotionally bruised seventeen-year-old, diagnosed with depression and bulimia, in her third year of therapy. I was her second therapist after her warring parents rejected the first. I found Caroline to be insightful, seeking answers, and "a good kid."

Our therapeutic relationship was solid and allowed her to explore her complex attachment issues within the safety of the therapy room. Her accessible anger would manifest with a raised voice, some impressive cursing, and pointed sarcasm. The state of her soon-to-be-divorced parents' relationship was over-burdened with the sad, but often-seen list of challenges: financial disagreements over alimony, child support, not sending payments on time, custody issues, communication impasses, and in-person, telephone, and on-line arguments. All of these were openly and bitterly shared with my client by both parents.

It was common for Caroline to describe her anxieties about any up-coming interactions between her parents with vivid details. She was often the shoulder her mother used to lean on --- except when she was the object of scorn and rejection based on anything from a housekeeping complaint to a less than stellar grade from school. Over time, she concluded she would never marry and believed romantic relationships to be a dark, complicated area of life she would prefer to avoid.

The family home had been sold and Caroline and her mother lived in an apartment in a new community that forced a transfer to a different high school. Any spare time after school was needed for studying and working to supplement the money available to her and her mother. As a result, her adolescent social life was limited. She could readily identify a maternal aunt as a stable force in her life. Although they often spent time together, it wasn't ever enough to replace the carefree nature of her old high school friends or to overshadow the weight of the family problems she carried with her.

I knew I held a place of esteem in Caroline's world, but my first surprise in our relationship came in the form of a gift—a framed, matted, pencil sketch. The variegated greys filled the page to reveal a lovely group of blossomed, round flowers with individual petals, uplifted leaves, and stems with delicate buds. This unexpected present offered a therapeutic treasure for us. Why grey? "I like to use pencil." But why grey? Because that was the color of her world. Why flowers? They make me smile and because they get a chance to grow in the sunshine. Why me? Because you're always here for me. Why now? Not an easy one to answer. The possible explanations to this curiosity included, "because I had time this weekend," "because I was bored, "because I was thinking of you."

Of course, gifts given to a therapist open ethical concerns. This heartfelt, surprise "gift" from Caroline represented much more than a framed sketch. First question inside my mind, as with any gift given to a therapist is, "Do I keep this?" The answer was easy – yes. I recognized this "gift of self" was much more than a sketch borne from boredom. We explored this surprise through our therapeutic kaleidoscope and concluded this act held important information about our connection. I was touched in a gently emotional way. I was delighted Caroline valued what we had. I was thoughtful about her vulnerability and her ability to trust to be cared about.

After our verbal exchange which was therapeutically informative, I asked her how she would feel if I hung her gift in my waiting room. I told her I believed this gesture warranted additional respect. She was thrilled at the idea and after she left, I hung it with a smile. Whenever I viewed it after that, I saw it as one of the special rewards of doing therapy.

There was nothing unusual about the day when Caroline arrived wearing her comfortable-looking teenage clothing, hair in a ponytail, and a smile on her face. My office setting is still a strong image in my mind. She was across from me on the classic black therapist's love seat, and I sat in my ergonomic chair listening attentively. We were in the midst of addressing some of her recent bulimic symptoms and their possible underpinnings when she became very quiet. She twisted her torso a bit as she glanced down at the carpet and shuffled her feet. With a startling posture change, the next surprise arrived. She raised her head, looked me square in the eye and unloaded, "You sit over there—on your big throne, like you're the king and you have all the answers and I'm just nothing over here!" A mighty impressive diatribe!

These jam-packed sentences opened some important doors for us. Although my heart rate probably jumped a bit, my first verbal response was, "Tell me more." This offered her time to spend with her emotions and develop words to express them. She was fed up with her parents' immature behaviors and how she had to listen to their explosions while being a subservient, "good girl." She wanted to know when it would be her turn to let loose and tell them what she wanted them to hear. She cited the unfairness of their privilege and wondered about her rights.

My next question was, "Did I come across as arrogant and pompous? " Caroline explained that right then that was how it seemed. Her words were angry, yet her body spoke of fragility and sadness. As she continued with confused tears, her vulnerability became more exposed with words describing her powerlessness and her desire to not use her symptoms. Manifesting a painful expression, she told of her wishes for a different life that could keep her far away from the emotions she felt. After a pause, she shared how these feelings felt like body hatred and self-disgust. This juncture was quite intense as Caroline saw, at least in this moment, the connection between these strong emotions and their ability to morph into self-loathing. Part of our session allowed time for me to praise her ability to not only be openly angry and know she wouldn't be rejected, but also be encouraged to find those words that needed to be shared. My impression was that this was a foreign and surprisingly new context for her.

This interaction offered us a special exchange. Caroline used questions to really test the waters of safety when it came to her anger. "How come you can just let me talk and act like this?" I explained that she wasn't being abusive and we were then able to sit with the validity and significance of her rage as she noted what forbidden territory this was. "Do you want me to come back?" This wonderful question allowed us to look deeper into our therapeutic relationship and the fact that her anger didn't frighten me. More to the point, I could be there for her, hence, she didn't have to be alone when this emotion arose. I can't overstate how meaningful this "surprise" was for both of us.

Kathryn Cortese, LCSW, ACSW, CEDS, began working as a psychotherapist with individuals with eating disorders in 1989. She is committed to the belief that recovery is real, support is essential, and hope matters. In 2013, along with her son, Michael, Kathy purchased the Gürze Catalogue. To provide education and support, they offer their website, edcatalogue.com, the annual digital ***Gürze/Salucore Eating Disorders Resource Catalogue,*** a monthly ENewsletter featuring articles specifically written for this as well as a Book Interview, the ED Pulse, and a podcast series, ***ED Matters.***

Smart Watch Therapy

Holly Finlay, MA, LPCC, CEDS-S, F. iaedp

My husband gave me a smart watch last Christmas. Now I had never typically worn a watch, so I wasn't expecting one as a gift, but I thought I'd try it. My hope was that the smart watch's features could help me to stay organized. Around the same time, one of my previous patients, Katie O., had relapsed and chose to return to treatment. I had seen Katie initially when she was fifteen for bulimia nervosa, and she was now twenty-one.

At fifteen, Katie's mother insisted she get treatment for eating disordered behaviors, extreme anxiety, depression, and cutting. Katie, feeling compelled by her mom to get help, was hesitant to talk about her life. She presented with alexithymia and felt mortified to be in therapy. She had never admitted to herself that she had an eating disorder, much less talked about it with others.

Slowly, as we developed a rapport, she began to open up about her feelings. She expressed anger at her mother for putting her into treatment. But when she felt the discomfort of the anger, she would say, "but I can understand why she did it, she's really worried about me." It took many months for Katie to learn to tolerate her distress when she talked about her feelings. She felt plagued by guilt and fear of retribution for betraying her family. However, as she learned that it was safe to be open with me in session, she expressed painful feelings of being unsupported, rejected, and abandoned when she was younger by both parents during their divorce.

Katie was nine years old when her parents divorced. Initially, her relationship with her parents was fairly normal. Katie and her mother stayed in the family home and her father moved out. Her father travelled often during her childhood, so Katie was accustomed to his absence. When she went over to his house, Katie had Daddy's attention as his little girl and felt comfortable in both households.

When Katie was ten, both parents remarried, and Katie had to adjust to new stepparents. Her mother's new husband was very easygoing and did not assume much of a parenting role. Conversely, dad continued to travel, and when he was away, his new wife took on the role of being the parent to Katie. Even when her dad was home, he relinquished his parenting role to the stepmother.

Katie's stepmother was controlling. She lacked empathy for the adolescent Katie. In fact, when Katie entered puberty, her stepmother became competitive with her for her father's attention. She used guilt and shame to manipulate her and drive a wedge between Katie and her father. Once, for example, when he came home from a long trip, Katie excitedly ran out to the driveway to greet him. The stepmother shamed her by telling her how rude and inappropriate it was for Katie to do that because it was usurping her role as wife. Katie was humiliated and sent to her room. Katie tried to please her stepmother, but she always seemed to be in trouble in her father's household.

Katie's stepmother began to punish her with repeated and excessive groundings. Eventually, she was spending entire weekends restricted to her bedroom when she was supposed to be with her father. Sadly, Katie's father did not protect her from the stepmother's punitive behavior. To make matters worse, both her father and stepmother were highly opinionated about eating only healthy foods. When Katie's pubescent body began to change, both of them made negative comments about her weight gain. Katie was only allowed to leave her room to join the family for the "healthy" dinners, so when she was hungry, she went to the kitchen to snitch food. Katie began bingeing on forbidden foods and purging in hiding. She also became severely depressed and anxious and began cutting herself to dissociate from her imprisonment. After each visitation, Katie told her mother about what was going on. Her mom encouraged her to go back and give dad a chance. She did not give Katie the support she needed, and Katie felt abandoned.

One day, when her father was out of town, her stepmother caught Katie throwing up in the bathroom and immediately shamed and grounded Katie. Katie called her mother to come get her to avoid yet another weekend in her room, and that's when her mother put Katie in therapy with me.

As our work together evolved, Katie was able to both identify and express her painful feelings through role-play. Eventually, before her 18th birthday, Katie told her dad she was through with the visitations. She avoided her father for about 6 months and eventually, he realized she was no longer a child. Over time, he began to change his expectations of her. He also demoted his wife from the primary parenting role and the couple allowed Katie to separate and individuate. By learning to use her voice and set boundaries, Katie's symptoms were ameliorated, and our initial work was concluded.

So, how does Katie's story relate to my new smart watch?

After Katie returned to therapy a few years later, we began working to identify the meaning underlying her current relapse with bulimia nervosa. During one of our last sessions my smart watch "dinged" to tell me I had received a text. Katie was startled and blurted out, "Oh, that must mean my session is over!" Her face flushed and she was visibly upset. The text alert had triggered her.

I instantly flashed back to reports from patients whose previous therapists used an alarm to end a session. I had always thought this was a terrible practice, so I found myself shaken, defensive and I was tempted to alleviate her feelings, and my own guilt for her discomfort. I felt compelled to assure her that the alarm was simply a text alert. I was concerned that the alarm would damage our therapeutic relationship, and she would revert to her old habits of suppressing her feelings. The opportunity to discuss feelings of hurt, shame, and rejection, would be lost. I felt torn between my need to assuage her difficult feelings and my professional desire to offer her an opportunity to explore her responses. I tolerated the discomfort, contained my own startle response, and asked her how she would feel if I used an alarm to end the sessions.

Initially, she said, "Oh, I guess that would be fine."

I was sure she was just appeasing me, so I pressed her to dig deeper and confront her reaction more honestly. She thought about it, and meekly said "Well, I wouldn't like it because I would feel pressured to quickly cram everything in and I wouldn't want to start talking about anything new for fear of being interrupted by the alarm."

I concurred and said, "Yes, you could feel devalued and think I was done with you and was kicking you out of here. What would that be like for you?"

"Well, I know you're a very busy woman and you need to move on to other people."

Although I wanted to reassure her that I valued our time together, I said "So, you get the feeling I might be too busy for you. That sounds painful. I wonder what else you might experience."

"Well, you probably have a lot of other patients who are sicker than me."

"So, there is a part of you who feels like you aren't sick enough to be here, or that you don't deserve to be here."

"Yes, I know you have a waiting list."

This conversation shows the importance of being able to tolerate difficult feelings. I hated being lumped into a group of therapists who used an alarm, but our conversation opened up a window to Katie's prior experience of abandonment and rejection. In response to the alarm, she used her old coping mechanisms to tolerate her uncomfortable feelings: people-pleasing, denying her feelings, and promptly disconnecting.

The alarm also exacerbated Katie's feelings of worthlessness. The message she felt was "You are worth no more than 60 minutes of my time and because time is up, there is no room for further discussion." This reminded her of the lack of empathy and the punishment she experienced when her dad remarried. For Katie, the alarm reinforced a rigid mode of communication, encouraging abrupt disconnection and acting-out behaviors. When therapists use an alarm to do the dirty work of ending the session, they rob the patient of practicing discussion within the relationship to disengage organically. I have always encouraged my eating disordered patients to use their voices and talk about their feelings. Her perception of the alarm turned me into a hypocrite. Consequently, I opened up the discussion about the meaning conveyed by the alarm, which was the antithesis of using a third party (alarm) to speak for me.

At session's end, I was so relieved to tell Katie that the noise was simply a text alert, and not an abrupt way to shut her down and close the session. It hurt for her to think of me as someone who placed my time above my patient's needs, and I was grateful for the opportunity to dig into her response and clear the air between us.

Surprisingly, a simple noise from the smart watch served as a natural, albeit disturbing, trigger. It led to insight into Katie's painful history, revealed the meaning of the relapse and taught her to discuss difficult feelings while tolerating a potentially precarious transitional moment.

I still wear the watch, but I use it as a tool to therapeutically explore, not ignore, feelings.

Holly Finlay, MA, LPCC, CEDS-S, F. iaedp, has been an Eating Disorders Practitioner for 30 years in Albuquerque, NM. As the Founder/Clinical Director of Eating Disorders Treatment Center (EDTC), she offers many levels of treatment to the community. Holly is on several committees for the International Association of Eating Disorders Professionals (iaedp), a Certified Eating Disorders Specialist, Fellow of iaedp, and past president. She also provides training and lectures in the community.

Twenty-one Years of Surprises

Kourtney Gordon MS, RD/LD, CEDRD

I will never forget my first Dietetic Conference. I was fresh out of my internship and working in an Eating Disorder Treatment Center, excited to share my desires of being in a field I felt so passionate about. I was at our facility booth, ready to share the insight I had learned so far, along with unconditional gratitude I held in being able to "give back" and help others.

Then it happened, my confidence shattered, my hope questioned as a colleague stated, "I will never work with that population, no one ever gets better." I don't even remember what I said back, I was so stunned and surprised by that comment. My body was the first part of me to respond: I felt all excitement drain from my spirit and I wanted to hide. It was hard for me to believe that someone in my own profession held such little hope. My surprise next triggered my thinking – "Is this how everyone feels, that there is no hope, so why bother trying?" I didn't want to accept this – I wanted back the excitement and confidence that, only minutes before, had made me feel so alive. I realized I had a decision to make, namely, do I accept what my colleague shared with me and give up on believing in recovery or do I fight the message that the surprise brought with it and focus on my own belief system? Slowly, I began to recall the reasons that led me to pursue this field, the excitement I felt at my first iaedp™ conference and how I ended up where I was now working. I decided to engage in probably the most difficult challenge I had ever faced; I decided to refuse being knocked off base by the surprise and stand my ground. From that moment, I knew I wanted to prove those colleagues wrong. I wanted to make a difference and help those most suffering know I believed in them. I wanted to use "surprise" as something my patients felt when they realized that recovery was something within their grasp and they were on the road to getting better. I wanted them to use "surprise" as they recognized they were fighting the fight against one of the most deadly of mental illnesses and winning.

Fast forward to today, almost twenty-two years into my career. I can honestly say this work is still my passion. For this *Perspectives*, I was invited to share my thoughts on "surprise in the therapeutic process" and I can say that day many years ago at the Dietetic Conference is when I felt initial surprise that someone in this field did not believe in recovery. Perhaps, it was their own insecurity about working with eating disorders; maybe it was their own internal biases that kept them from being able to "see" their client beyond the illness. While treating someone with an eating disorder is a challenge, it also has been the most rewarding experience of my life in recovery. Yes, I am a recovered clinician and through my own past demons, I have been able to do the most extraordinary recovery work with some of the most fragile, yet worthy and capable human beings..

Surprise can be defined as "an unexpected or astonishing event, fact, or thing". In thinking about this idea, and my last two decades working with clients, I'm reminded of so many wonderful "surprises" starting with my own capabilities of working as a recovered clinician. I have guided some of the most vulnerable and scared individuals into a world where they are no longer afraid of food or their body - I have vivid memories of these journeys. To be transparent, there have been times where I felt like there was no hope and that there was just no way into the fortress of a brain hijacked by an eating disorder. And then it hits me, I have the best "superpower"; I have my lived experience and my journey to pull from as a unique empathy point.

My major surprise, number two, is that something so personal and what once felt so shameful, has turned into my blessing, my strength, my expertise in connecting with clients. I have the capacity to use snapshots of a life I barely remember (and will never bring back) to help clients know they don't have to be afraid anymore. They can eat food and be nourished, have their life back and no longer be a prisoner to something wishing them harm.

He was 12 years old. I met him over the phone during the initial admitting call. A very frail, weak, boyish voice answered my many questions to decide if he could come to us for treatment. He was in the hospital, feeding tube in place providing every nutrient to his body. He was lucky to be alive. Just a few weeks prior, he was at his lowest point ever. He was on the soccer field out of town assisting his team to a victory, yet no one noticed the skeleton of a boy on the field, a boy who almost lost his life. Later he arrived, tube feed in place, eyes sunken, low voice, terrified and I remember him saying to me "I think I want to have this feeding tube for the rest of my life." My heart sank and I knew we had a long road ahead to empower and strengthen his healthy self away from the eating disorder. I took a depth breath and thought to myself, "Ok, we can do this, I can do this". I expressed to him that we were going to work together to say good-bye to his eating disorder and he would walk out the front doors to his family without his feeding tube.

Being a Dietitian, my brain started pondering the many ways the two of us could embrace eating together—"baby steps". We started with raisins, one at a time. I remember sitting at the table eating raisins with him, coaching him with each bite that this was what his body needed and so desperately wanted—to be normal and be a kid. Eating, something so natural to many, was agonizingly painful for him, to the point of panic. We did this for many months with different foods and meals. All the while, I was challenging his eating disorder's belief of living a normal life but not eating food and having a tube provide sustenance.

I have found that another "superpower" I carry is patience, as this process took months, months of tears and meltdowns and catastrophic thinking from his starved brain. As if by magic something clicked, and as he began to allow himself more food, his body began to look more like a teenage boy, and his thinking shifted - he became open to the idea of eating. He allowed himself to take in foods his brain found scary and his willingness to eat was enhanced when he began to realize he could get taller by the mere act of ingesting food. His coin out, his peers younger and older sending him off with encouraging words. With tears, I recounted the day his frail frame entered our building and the immense gratitude I had that he was going to make it, he was going to survive, he was going to be able to be a regular teenage boy and be with his friends and go to school. His eating disorder was not going to steal his life!

This year he will be a high school senior, 6 inches taller than he was when in the throes of his illness and he is thriving. He is one of the many stories I carry over these almost twenty-two years that keep me doing this work, that help me quiet those doubtful colleagues early in my career. While not all recovery stories have fulfilling endings, there are enough of these in my life to keep me believing and knowing that recovery is possible - an eating disorder is not a life term. It's no "surprise" to me that the one thing I share consistently with each of my patients is that there is hope, they can recover, and I will never give up on them.

Kourtney Gordon MS, RD/LD, CEDRD has worked in the field of Eating Disorders for over 22 years both in Residential and Private Practice settings. She has been with Fairwinds Treatment Center since 2000 and serves as the Clinical Dietitian and Eating Disorder Program Manager. She has been the President for the local iaedp Tampa Bay Chapter since 2012 and has participated on the iaedp Board since 2020. She also is participant in REDC and sits on the Standards Committee.

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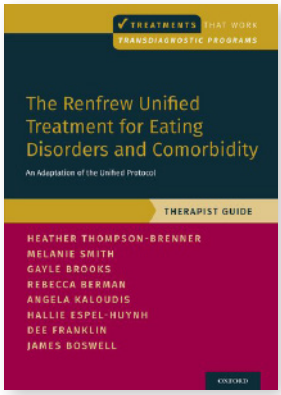

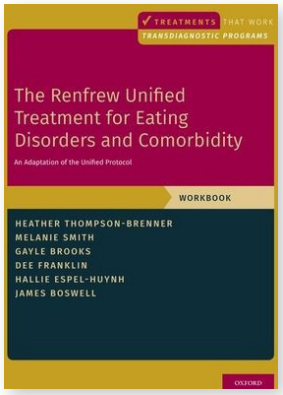

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Article reprint; Winter 2015 Perspectives. Continue to page 16 for the Spanish version of this article.

Listening In-to-It: Intuition in the Psychotherapy Process

Jacqueline K. Szablewski; MTS, MAC, LAC

Grandma takes another deeper breath as she returns her coffee cup to its saucer. *She reaches for the green babushka. In a move expertly choreographed over years of time, she covers her head. As gently as her kiss on my cheek, she ties the knot below her chin. Leveraging her weight with the help of her cane she raises herself from the red kitchen chair. To me she announces, "Okay, Jackson – time to go."*

We travel in comfortable silence to the family church. We park where we have always parked for as long as I can remember in the six years I have had thus far. We walk together up the five front steps to the vestibule. I let go of her left arm to which hand she moves her cane. She dips the fingers of her right into the holy water and blesses herself before she enters, as do I. Another deep breath and in we walk to the third pew on the left. Genuflect to enter it and then kneel.

The first few minutes are about acclimating the senses: incense and melting wax, gladiolas, Jean Nate, breakfast toast; pages rustle; a purse clasp snaps; greetings in soft voices. A baby cries. I feel my stomach rumble and then the old pipe organ warming to its first notes. Open stained glass window ushers in the morning chill. Reverently mimicking my Grandmother, I take another purposeful breath and close my eyes. Now the listening … inside… the images that rise.

Decades later, in another city in another state, my Grandmother gone from this world too long a while, I settle my tea cup in the sink, take the deep breath that assists me in slinging my bag over my left shoulder, grab my lunch sack and the handles of a worn soft sided brief case with my right hand, assert to the dog that it's time for me to go and I head out the door… for work…

Nearing a quarter century as a master's level mental health clinician with 15 years in private practice, I reflect often on this early template of attuning, attending, listening in, out, in between, and relating with authenticity, reverence and humbleness. This template has been added to, of course, through all the life experiences that came after. Sometimes directly and sometimes despite its neglect, it has been impacted by schooling, training, supervision, certifications, workshops, colleagues and therapy. Most especially though, in the professional realm, it has grown through the sharing of therapeutic relationships in the consulting room.

There are places that are sacred beyond those designated for formal worship or religiosity. I believe they exist within each of us: the "still small voice"; the truth that has no reason to shout; the intuitive voice particular to the vessel it resides in that brings us to itself.

In many clients I have been privileged to see over the years, there has been an initial distancing from their intuitive voices. Often symptoms and the underlying mechanisms of the eating disorder, substance use disorder or both, while initially likely serving to protect, add layers and miles and time complicating or blocking its access. A central theme of recovery then, becomes recovering this aspect of the self, even if meeting it consciously for the first time. Deciphering, discerning, untangling that which has masqueraded as, or grown over into, the sacred space of the intuitive becomes essential to the process. For our intuitive sense, unbraided from our addictive tendencies, is crystalline. It behooves us to listen, see, learn its voice and, at the least, get curious about it.

In the words of one client:

"It's like clearing a recording of static, background noise, and overlays to really hear the message… I mean a year ago I heard from a friend that my ex was dating someone new. We had broken up three months earlier and that is what got me into therapy… She told me this news while we were eating lunch --she was supposed to be my support person for lunch one day a week. Immediately, I put down my fork. I heard my insides say, 'I am not taking another bite… ever. I'm too fat already and it's time to be done with all this recovery crap.'

I had a flash of seeing myself on a run and at the liquor store stocking up for the evening activity… I was convinced that's

what my gut was telling me to do and that it was exactly the right thing… Now I get that that was some of my overlay, my static automatic reaction. For the real stuff, the real message, I gotta hang in there, listen deeper, see me again…

Another client likens her process to, "clearing a path through the overgrown forest to come upon the ancient city of HOME and the treasure inside… binging-purging-drinking-drugging, it only keeps me in the forest longer… and I get tired and out of resources."

Within the deep listening attuned presence of the therapeutic relationship, the various modalities, techniques and approaches we might use ourselves and choose to employ with the people we see, each have something useful, even vital, to offer in clearing channels for intuitiveness. Meditation; mindsight practices as described by Dan Siegel* and others in the realm of interpersonal neurobiology (IPNB); the integrative aspects of various somatic modalities, EMDR and others; mindful awareness, radical acceptance, values identification, affect regulation, distress tolerance, thought watching, interpersonal skills also included in ACT, DBT, CBT are among the resources available for clearing our static and honing our antennae. Within the milieu of the therapeutic relationship, they all are helpful in assisting clinician and client to relate better—deepening and potentiating compassionate connection within self, with other and amidst the space in between. It is as if we, in our relational connectivity are synapses in a divine consciousness.

With channels cleared for access, the intuitive sense becomes divine. It encompasses while distinguishing itself from clinical wisdom. It speaks in images and impressions. It bades me in-to the sacred space of the in-between, into the void wherein we find the vulnerability that begets creativity. In the case of my client, Marianna, I found an old hand-held fishing net.

Marianna, a 32-year-old courageous woman, had been attending therapy for about two years to facilitate her recovery from eating disorder, substance abuse and underlying trauma. She had thus far been able to increase her food intake, decrease her exercise, significantly reduce her purging, and discontinue misuse of prescription drugs. She was medically stable and within her weight restored range. She had had a successful course of EMDR earlier on including resource installation. Marianna worked from home and continued to exhibit great difficulty in developing friendships and interests outside of her home, despite both of these being initial motivators for treatment and recovery.

Our most recent session had been particularly intense with affect and heavily imbued with water imagery. Marianna had been panicked that she might return to old behaviors as she talked about feeling like her "head was just above water…" and how lately she felt like "the only thing (she) could do was tread water." She had cried throughout most of the session and remarked how her tears "could fill a river all their own." Despite our exploration, processing, and grounding prior to close, Marianna left unsure about moving any further in her recovery if it meant challenging herself any more in the social realm. She wondered if it wouldn't "just be best" to retreat again into the "old behaviors that were a more familiar home."
On my side of the office door, I noticed an escalation in my own anxiety and since then, thought of her several times throughout the week. Some thoughts were intentional and others spontaneous. I recognized the former as driven by my anxiety, as a disproportionate desire to control and prevent her from relapsing. In tandem with the latter was the inexplicable flash of a nearby catch-and-release fishing pond.

With similar compassionate and playful curiosity as to what Marianna had been practicing, I wondered what this might be about and from whence it came. Was it something about me—more of the occasional "carryover" anxiety to which I could be prone? Was it my intuition trying to open the space for a particular intervention with Marianna? Was it my intuitive sense telling me I needed to go for a swim? Certainly, I could see the obvious links in language and imagery. I could note again the Jungian interpretation of water as symbol of the unconscious. Knowing Marianna's faith background, I could register water as signifying rebirth and transition. I could consider the possible threading back to themes of what safety might feel like if the eating disorder identity and symptoms were less available to her. Through the instrument of my visceral embodiment, I could feel the ebbs and flows of her fear and imagine what it might be like for her at this point in her recovery. During the week I marked these wondering wanderings on the tablet of my mind

On the day of her next appointment, I awoke compelled to retrieve the old fishing net from my basement storage closet as if the image of the catch and release pond had brought me to it. Intuition at work. Since I, as yet, had no clinical rationale for including the net in Marianna's session or process, my clinical wisdom suggested it be placed in the corner of the office, unobtrusively leaning between the wall and the trash can.

I had no way of knowing that partway into the session, as Marianna attempted a three pointer with a collection of wadded tissue, she would spy the net, ask to hold it, and flail it like a tennis racquet; that she would smile with a different kind of tears and tell me about Saturdays in the spring with her grandfather when she was young…at the catch and release pond…when she was less afraid of water and more trusting of her ability to navigate it. I had no way of knowing, nor did she, until she told both of us that "safer than any safe place (she) had thought of or remembered before, were these times" with her grandfather, who let her net the fish from his line, detach the hook and safely return them to the water.

I invited Marianna to adopt the net. She accepted it and has used it, as she has her intuitive sense, many times since… at the catch and release pond and with those who have become her beloveds in the larger waters of a larger life.

I open my office door to greet the client who has arrived for her session. With a nod to me and a half smile, she raises herself from the waiting room chair. We stop at the office tea table. We each pour a cup of water and in we walk. First there is the acclimation of the sense …

We begin the listening in together.

Jacqueline Szablewski, MTS, MAC, LAC,

formerly a psychotherapist and counselor specializing in eating disorders and addictions recovery retired from the field after 27 richly fulfilling years. She currently maintains a private practice in her second chosen career of Wellness Coaching, while providing respite caretaking for beloved family members. Jackie is co-author of Recipe for Recovery: Necessary Ingredients for the Client's and Clinician's Success in *Treatment Of Eating Disorders: Bridging the Research-Practice Gap.* She remains a staunch advocate and supporter of persons in recovery and the people who aid them on the journey.

Escuchando el interior: la intuición en el proceso psicoterapéutico

Jacqueline K. Szablewski; MTS, MAC, LAC *Translation by Maricarmen Díaz Juarez*

La abuela vuelve a respirar profundo mientras coloca su taza de café en su platito. Alcanza su pañoleta verde y con un movimiento hábilmente coreografiado durante años, *cubre su cabeza. Tan suavemente como un beso en mi mejilla, ella ata el nudo debajo de su barbilla. Impulsando su peso con la ayuda de su bastón, se levanta de la silla roja de la cocina. Me dice, "Está bien Jackson, es hora de irnos."*

Nos dirigimos en un cómodo silencio a la iglesia familiar. Nos estacionamos donde siempre lo hemos hecho desde que recuerdo, en los seis años que tengo hasta ahora. Subimos juntos los cinco escalones de la entrada hasta el vestíbulo. Le suelto el brazo izquierdo y tomo la mano con la que mueve el bastón. Sumerge los dedos de su mano derecha en el agua bendita y se persigna antes de entrar, al igual que yo. Otra respiración profunda y nos dirigimos a la tercera banca de la izquierda. Hacemos una reverencia para entrar en ella y nos arrodillamos.

Los primeros minutos son para aclimatar los sentidos: incienso y cera derretida, gladiolas, Jean Nate, pan tostado para el desayuno; el pasar de las páginas; el cierre de un bolso; saludos en voz baja. Un bebé llora. Siento como un retortijón en el estómago y el viejo órgano de tubos se calienta con sus primeras notas. El vitral abierto hace que llegue el frío de la mañana. Imitando con reverencia a mi abuela, vuelvo a respirar con determinación y cierro los ojos. Ahora la escucha... el interior... las imágenes aparecen.

Décadas más tarde, en otra ciudad de otro estado, mi abuela se ha ido de este mundo hace demasiado tiempo, coloco mi taza de té en el fregadero, respiro profundamente para poder colgarme el bolso sobre el hombro izquierdo, tomo la bolsa del almuerzo y las asas de un gastado portafolio blando con la mano derecha, le digo al perro que es hora de irme y salgo por la puerta... al trabajo...

Al estar cerca de cumplir un cuarto de siglo como clínica de la salud mental a nivel de maestría, con 15 años en la práctica privada, reflexiono a menudo sobre este primer modelo de sintonizar, atender, escuchar dentro, fuera, entre, y de relacionarme con autenticidad, respeto y humildad. Este modelo se ha ido ampliando, por supuesto, a través de todas las experiencias de vida que vinieron después. A veces directamente y otras veces a pesar de la negligencia, se ha visto impactado por la escolarización, la capacitación, la supervisión, las certificaciones, los talleres, los colegas y la terapia. Sin embargo, muy especialmente, en el ámbito profesional, ha crecido a través del intercambio de relaciones terapéuticas en la consulta.

Hay lugares que son sagrados más allá de los designados para el culto formal o la religiosidad. Creo que existen dentro de cada uno de nosotros: una " pequeña vocecita ", la cual no tiene por qué gritar; la voz intuitiva pertenece al recipiente en el que reside y nos lleva a nosotros mismos.

En muchos clientes que he tenido el privilegio de ver a lo largo de los años, ha habido un distanciamiento inicial de sus voces intuitivas. A menudo, los síntomas y los mecanismos implícitos del trastorno alimentario, del trastorno por consumo de sustancias o de ambos, aunque en un principio- probablemente- sirvan para proteger, añaden capas, millas y tiempo que complican o bloquean su acceso. Un tema central de la recuperación se convierte entonces en la mejora de este aspecto del yo, incluso si se encuentra conscientemente por primera vez. Descifrar, discernir, desenredar lo que se ha disfrazado como el espacio sagrado de lo intuitivo, o se ha convertido en él, se vuelve esencial para el proceso. Porque nuestro sentido intuitivo, libre de nuestras tendencias adictivas, es cristalino. Nos corresponde escuchar, ver, aprender su voz y, al menos, sentir curiosidad por él.

En palabras de una cliente:

"Es como limpiar una grabación de estática, ruido de fondo y superposiciones para escuchar realmente el mensaje. ... Hace un año me enteré por una amiga de que mi ex estaba saliendo con alguien más. Habíamos terminado tres meses antes y eso fue lo que me llevó a la terapia... Me contó esta noticia mientras almorzábamos -se suponía que era mi persona de apoyo para el almuerzo un día a la semana. Inmediatamente, dejé el tenedor. Oí que mi interior decía: 'No voy a probar otro bocado... nunca'. Ya estoy demasiado gorda y es hora de acabar con toda esta tontería de la recuperación'. Tuve un destello de verme corriendo a la tienda de licores abasteciéndose para la actividad de la tarde... Estaba convencida de que eso era lo que mi instinto me decía que hiciera y que era exactamente lo

correcto... Ahora entiendo que eso fue algo de mi superposición, mi reacción automática estática. Para las cosas reales, el mensaje real, tengo que aguantar, escuchar más profundamente, verme de nuevo..."

Otra clienta compara su proceso con "abrir un camino a través del bosque cubierto de maleza para llegar a la antigua ciudad de HOME y al tesoro que hay dentro. ... atracones-purgas-alcohol-drogas, sólo me mantiene en el bosque por más tiempo... me canso y me quedo sin recursos".

Con la presencia de una escucha sintonizada de la relación terapéutica, las diversas modalidades, técnicas y enfoques que podemos utilizar nosotros mismos y que elegimos emplear con las personas que vemos, cada una de ellas tienen algo útil, incluso vital, que ofrecer para despejar los canales de la intuición. La meditación; las prácticas de mindsight descritas por Dan Siegel* y otras en el ámbito de la neurobiología interpersonal (IPNB, por su siglas en inglés); los aspectos integradores de varias modalidades somáticas, EMDR y otras; la conciencia plena, la aceptación radical, la identificación de valores, la regulación afectiva, la tolerancia a la angustia, la vigilancia del pensamiento, las habilidades interpersonales también incluidas en ACT (TAC, Terapia de aceptación y compromiso), DBT(TDC, Terapia dialéctica conductual) y CBT (Terapia cognitiva conductual) son algunos de los recursos disponibles para eliminar nuestra estática y calibrar nuestras antenas. Dentro del entorno de la relación terapéutica, todos son útiles para ayudar al clínico y al cliente a relacionarse mejor, profundizando y potenciando la conexión compasiva con uno mismo, con el otro y en el espacio intermedio. Es como si nosotros, en nuestra conectividad relacional, fuéramos una sinapsis con una conciencia divina.

Con los canales despejados para el acceso, el sentido intuitivo se vuelve divino. Engloba a la vez que se distingue de la sabiduría clínica. Habla en imágenes e impresiones. Me hace entrar en el espacio sagrado intermedio, en el vacío donde encontramos la vulnerabilidad que engendra la creatividad. En el caso de mi cliente, Marianna, encontré una vieja red de pesca.
Marianna, una mujer valiente de 32 años, llevaba unos dos años asistiendo a terapia para facilitar su recuperación de un trastorno alimentario, del abuso de sustancias y de un trauma subyacente. Hasta el momento había logrado aumentar su ingesta de alimentos, disminuir su ejercicio, reducir significativamente sus purgas y suspender el uso indebido de medicamentos recetados. Estaba médicamente estable y dentro de su rango de peso restaurado. Anteriormente había tenido un curso exitoso de EMDR que incluía la creación de recursos. Marianna trabajaba en casa y seguía mostrando una gran dificultad para desarrollar amistades e intereses fuera de su hogar, a pesar de que ambos eran los primeros motivos para iniciar el tratamiento y la recuperación.

En nuestra sesión más reciente había sido particularmente intensa en cuanto a afectos y fuertemente impregnada de imágenes de agua. A Marianna había entrado en pánico de que pudiera volver a comportamientos anteriores mientras hablaba de sentir que su "cabeza estaba justo sobre el agua..." y cómo últimamente sentía que "lo único que (ella) podía hacer era mantenerse a flote". Lloró durante casi toda la sesión y comentó que sus lágrimas "podrían llenar un río por sí solas". A pesar de nuestra exploración, procesamiento y aterrizaje antes del cierre, Marianna se fue insegura de seguir avanzando en su recuperación si eso significaba desafiarse más en el ámbito social. Se preguntó si no sería "mejor" retirarse de nuevo a los "viejos comportamientos, los cuales eran un lugar más familiar".
Al otro lado de la puerta de la oficina, noté una escalada de mi propia ansiedad y, desde entonces, pensé en ella varias veces a lo largo de la semana. Algunos pensamientos fueron intencionados y otros espontáneos. Reconocí a los primeros impulsados por mi ansiedad, como un deseo desproporcionado de controlar y evitar que recayera. Junto con esto último se produjo el inexplicable destello de un estanque de pesca cercano.

Con la misma curiosidad compasiva y divertida sobre lo que Marianna había estado experimentando, me pregunté de qué podría tratarse y de dónde provenía. ¿Se trataba de algo relacionado conmigo, o más bien de la ansiedad ocasional a la que puedo estar propensa? ¿Era mi intuición la que intentaba abrir un espacio para una determinada intervención con Marianna? ¿Era mi sentido de la intuición el que me decía que tenía que ir a nadar? Ciertamente, pude ver los enlaces obvios entre el lenguaje y las imágenes. Pude notar nuevamente la interpretación Jungiana del agua como símbolo del inconsciente. Conociendo los antecedentes de fe de Marianna, pude registrar al agua como significado de renacimiento y transición. Podría considerar la posibilidad de volver a los temas de qué tan segura se sentiría si la identidad y los síntomas del trastorno alimentario estuvieran menos disponibles para ella. A través de mi propia experiencia, pude sentir los altibajos de su miedo e imaginar lo que podría ser para ella en este momento de su recuperación. Durante la semana tuve estos pensamientos dando vuelta en la tablet de mi mente.

El día de su siguiente cita, me desperté obligada a recuperar la vieja red de pesca del armario del sótano, como si la imagen del estanque de pesca me hubiera llevado a ella. La intuición en acción. Como no tenía, al menos en ese momento, ninguna justificación clínica para incluir la red en la sesión o el proceso de Marianna, mi sabiduría clínica sugirió que se colocara en un rincón de mi oficina, apoyada discretamente entre la pared y el bote de basura.

No tenía forma de saber que, a mitad de la sesión, mientras Marianna intentaría anotar algunos puntos con su colección de pañuelos de papel en el bote de basura, divisaría la red, pediría

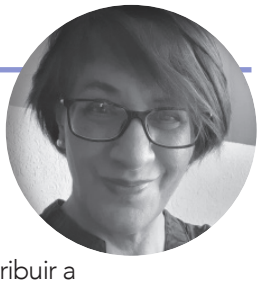
sostenerla y la agitaría como si fuera una raqueta de tenis; que sonreiría con otro tipo de lágrimas y me hablaría de los sábados de primavera con su abuelo cuando era joven... en el estanque de pesca... cuando tenía menos miedo al agua y más confianza en su capacidad para navegar en ella.
Yo no tenía forma de saberlo, ni ella tampoco, hasta que dijo que: "más seguro que cualquier lugar seguro (que ella) había pensado o recordado antes, eran estos momentos" con su abuelo, que la dejaba sacar los peces de su caña, soltar el anzuelo y devolverlos al agua sin peligro.

Invité a Marianna a adoptar la red. Aceptó y la ha utilizado, al igual que su sentido intuitivo, muchas veces desde entonces... en el estanque de pesca y con aquellos que se han convertido en sus seres queridos en las aguas más grandes de una vida más grande.

Abro la puerta de mi despacho para saludar a la clienta que ha llegado para su sesión. Con una inclinación de cabeza y una media sonrisa, se levanta de la silla de la sala de espera. Nos detenemos en la mesa de té de la oficina. Cada una se sirve una taza de agua y entramos. Primero es la aclimatación de los sentidos...

Comenzamos a escucharnos.

Jacqueline Szablewski, MTS, MAC, LAC,
una psicoterapeuta y consejera de adicciones con licencia en la práctica privada en Boulder, Colorado, quienes se especializa en transiciones de vida, trastornos alimentarios y recuperación de adicciones. Combinando la psicología, la consejería y las religiones del mundo con una concentración autodiseñada en consejería pastoral, Jackie obtuvo su maestría en Estudios Teológicos en la Universidad de Harvard. Es coautora de Recipe for Recovery: Necessary Ingredients for the Client's and Clinician's Success in *Treatment Of Eating Disorders: Bridging the Research-Practice Gap.*



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

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