THE PRACTICE OF PSYCHOTHERAPY: THEORY LAUREN GENTILE . [ET AL.] pdf

1: Theory and Practice of Counseling and Psychotherapy by Gerald Corey

The Practice of Psychotherapy: Theory, Lauren Gentile, Susie Kisber, Jaime Suvak, and Carolyn West The Practice of Psychotherapy: Application, Charity Tabol and Gail Walker Ethics and Activism: Theory--Identity Politics, Conscious Acts, And Ethical Aspirations, Eleanor Roffman.

Historically, the early formulations of the psychoanalytic theory of psychopathology were cast in a traumatic mold. Freud concurrently noted the effects of traumata as the choice of hysteria or obsessional symptoms, influencing personality organization and function. He believed that trauma could be uncovered or reconstructed. In distinguishing between the cause and consequence of trauma, Freud described both the quantitative factor if the etiology of trauma and the defensive repression of the traumatic experience. Traumatic situations are generally overwhelming for an individual and inhibit their ability to cope. Trauma may have adverse effects on our neurophysiological makeup as well as our psychosocial functioning. It is well documented that one of the impacts of prolonged exposure to trauma is a decrease in cognitive ability. The brain stem to the frontal cortex is often negatively impacted. One area of particular importance is the association between frontal lobe deficits and trauma. In general, frontal lobe deficits refer to compromised abilities to inhibit impulsivity or aggression or to redirect attention from repetitive behavior. Multi-disciplinary health and development studies have illustrated the factors most closely correlated with trauma were associated with general criminal offending, a scope of mental health problems, academic failure, economic resource deficits, and early onset anti-social behavior. Most research conducted on the impacts of childhood exposure to trauma focuses on the range of psychological and behavioral impacts including but not limited to depression, anxiety, trauma symptoms, increased aggression levels, anti-social behaviors, lower social competence, temperament issues, low self-esteem, dysregulated mood, loneliness and increased likelihood of substance abuse. These children are also at higher risk for school difficulties such as peer conflict or impaired cognitive functioning. Teenage pregnancy, truancy, suicide attempts, and delinquency are also listed as impacts. Long-term physical impacts have rarely been documented, but one study done indicated that children who have experienced some form of trauma are found to have significantly higher heart rates than other children even post-event. Trauma treatment needs a focus. Mental health practitioners are faced with many problems and several possible interventions for trauma. There are many trauma-focused mental health interventions for youth that integrate elements of cognitive treatment. Judith Cohen and Anthony Mannarino. It is an empirically supported treatment model that has been evaluated and refined over the past 18 years to help children overcome trauma related to abuse, violence and grief. Cares institute While TF-CBT was primarily developed for addressing the needs of children who have suffered sexual abuse, the model has been adapted for use with children who have suffered a variety of traumatic experiences, such as physical abuse, exposure to domestic violence and traumatic grief. The TF-CBT method of therapy is highly structured and it contains both parent and child interventions within subsequent 90 minute weekly sessions. TF-CBT is a short-term treatment that lasts approximately sessions. During the first treatment component: Psychoeducation, it is important to begin educating the family about the TF-CBT approach starting from the first familial contact. Providing this information can help the family out tremendously by filling in the gaps and sending a message of hope. The Relaxation section of the process should be individualized for each child and their parent. These skills are specifically aimed towards reversing any physiological changes resulting from their traumatic experience as well as to help children achieve mastery over their stressors. Both the children and parents are allowed to choose from an array of different methods to self-soothe when they are feeling physically or psychologically stressed, ultimately providing a sense of control which they were deprived of during their original traumatic experiences. The children will then practice these techniques and report back during sessions for fine-tuning and continued practice. The Affective Modulation skills are tailored in a similar way to fit each family. Severely traumatized children are affectively constricted resulting

from the event. The therapist may then initially work with the child to expand their range of affective expression by engaging in an assortment of games themed around feelings. It is also necessary for the children and parents to gain Cognitive Coping skills or to recognize the connections among their thoughts, feelings, and behaviors relating to everyday situations. This activity provides children and parents with the understanding that they have control over their own thoughts and consequently, over their feelings as well, thus adding another tool to the toolbox which they can use to soothe themselves while experiencing trauma reminders. In this section, the child develops a trauma narrative using a medium of their choice from writing, dictation, art, poem, song, dance, or creation of a book. Creation of this trauma narrative helps the child to overcome avoidance of traumatic memories, identify their cognitive distortions through their telling of the story in their own words, and contextualize their traumatic experience into the larger framework of their life by telling the story in context with time frames. The narrative should include thoughts, feelings, body sensations, and the worst moments of the traumatic experience. This helps them to recognize that they are more than merely a victim of trauma. Once the child completes their narrative, the therapist assists them in cognitively processing any cognitive distortions associated with their negative affective states. Ideally, this cognitive processing will use the techniques which the child mastered earlier during the cognitive coping components, learning to change their thoughts. This manner gradually exposes the child to that of which they are fearful, ultimately helping the overcome their anxiety and improve their quality of life. This section follows the same general principles as other graduated exposure programs as well. TF- CBT has been provided solely for children, but evidence shows that the children experience greater benefits when their parents participate as well. During these joint sessions, the communication shifts from children speaking directly about their traumatic experiences with the therapist, to sharing this information with the parent while the therapist moves into the background. Children will typically share their trauma narrative with their parent who has previously heard it from therapist. Finally, Enhancing Safety and Future Developmental Trajectory assists the traumatized child with honing additional skills in order for them to remain safe in the future. They are then typically practiced during the last few parent-child sessions. The children and parents are then encouraged to apply the skills learned during TF-CBT treatment to other difficult situations they may encounter, not only applying to traumatic circumstances, after termination of therapy. It is important to note however, that this type of treatment is not optimal for everyone. It is not ideal for children whose primary issues are not trauma-related. It is critical for these children to determine whether or not their trauma symptoms are primary. And if not, then what other mental health problems should take precedence in their treatment. If there are co-occurring issues, it is important to provide conjoint treatment for the co-existing condition so that the TF-CBT therapist can focus solely on the trauma-specific treatment without being constantly sidetracked by co-morbidity problems. In these cases, the individual should be referred for an alternative evidence supported treatment model. The results of a pilot study are very promising in suggesting the usefulness of this approach for the treatment of PTSD and other trauma related symptoms in abused children and adults in resolving past child abuse trauma. In addition, all 4 children as well as their caregivers reported that they had learned skills to cope with current situations when their PTSD symptoms had been re-triggered. This method of practice has been used following the terrorist attacks in New York City as well as to provide treatment to individuals affected by Hurricane Katrina. Each stated in the United States is continuing to attempt to collect various types of data with regard to adoption and implementation of the TF-CBT model of treatment. In recent years, as many organizations across the world have been moving more in the direction of providing Trauma Informed Care, they have been pushing the use of TF-CBT and attempting to train all clinical staff on it. A manualized TF-CBT program which was developed and piloted in studying 4 children in New Zealand between the ages of 9 and 14, comprised psychosocial strengthening, coping skills training, gradual exposure using creative media, and special issues relevant to trauma and abuse. Psychodynamic Psychotherapy was also among the most popular forms of treatment applied to address a wide range of symptoms associated with trauma. Given current up to date findings, practice guidelines recommend a variation of CBT and psychotherapy,

incorporating trauma-focused components for treating the specific problems of traumatized and abused children. The efficacy for this treatment is well-known; primarily in children who have experienced multiple traumas. The hallmark of TF-CBT also referred to as the aspect that sets it apart from other, more traditional therapies is the gradual exposure in the trauma processing approach, linked to the idea of creating a trauma narrative. TF-CBT is unique from other therapies in several ways such as the many therapeutic components of TF-CBT from emotional regulation skills to direct discussion of the traumatic event, and even the incorporation of a trauma narrative to help the child to progress through their treatment more efficiently. It also provides more flexibility than other common treatments. TF-CBT treatment is evidenced-based rather than strengths based but like with most methods, variations can be made to accommodate a strengths perspective. An example of this practical application would be in learning relaxation techniques; the child may be a very talented reader, in which case the therapist may incorporate reading as a relaxation strategy for the child. TF-CBT is often used to help children recover from sexual abuse by encouraging them to speak freely about their trauma. The recent Penn State sex abuse scandal further exemplifies a case in which the use of TF-CBT would be appropriate, as the abuse is presumably over for those victims and they are currently safe. When an individual experiences trauma in their life, it can bring about symptoms of Post-Traumatic Stress Disorder PTSD , depression, anxiety, and overall behaviors that are disruptive to daily functioning. In children, these can cause flashbacks of the traumatic event, sleep disturbance, and avoidance. TF-CBT suggests that being open and communicative through exposure is highly effective in helping children to overcome these feelings of helplessness, anger, and so forth. TF-CBT confirms that mental health practitioners across the world are in a position to help traumatized children by being thoroughly trained in implementing TF-CBT interventions. Furthermore, the use of TF-CBT interventions may also help traumatized youth in reducing their symptoms of depression, anxiety, and problematic behaviors. It is strongly suggested that TF-CBT is more effective than attention control, standard community care, and other waitlist control conditions at reducing these symptoms. Based on the fact that the majority of traumatized children who receive TF-CBT continue to demonstrate symptom relief post-treatment and increase their coping skills as a result of the treatment elements has shown the long-term effectiveness of TF-CBT for resolving anxiety, depression, and other trauma-related symptomology. The positive treatment outcomes of current studies demonstrate not only the effectiveness of the TF-CBT approach but also that the treatment gains are clinically significant for children and their families representing a range of multiple abuse histories, cultural backgrounds, and various caregiver arrangements. It has proven to be a great success in assisting the victims ,their families, and the communities at large cope with the with undeniably high levels of stress the accompany disaster and terrorism. Trauma-Focused Cognitive Behavioral Therapy TF-CBT is one of the most widely used and effective interventions for children and youth who have experienced some type of trauma. This method is based on Humanistic, Cognitive-Behavioral, and Family Theory Evaluation of TF-CBT over a period of time including several randomized controlled trials, effectiveness studies, and ongoing studies have demonstrated that this method of therapy is helpful for children, youth and adults who have experienced sexual abuse, domestic violence, traumatic grief, terrorism, disasters and multiple traumas. Reference List Allen, J. Traumatic relationships and serious mental disorders. Neurobiology for clinical social work: Cognitive Behavioral Strategies in Crisis Intervention. Models of brief psychodynamic therapy. The reconstruction of trauma: Its significance in clinical work. The International Universities Press Inc. Honoring children, mending the circle: Cultural adaptation of trauma-focused cognitive behavioral therapy for American Indian and Alaskan native children. Journal of Clinical Psychology: In Session, 66 8 , The data behind the dissemination: A systematic review of trauma-focused cognitive behavioral therapy for use with children and youth. Children and Youth Services Review, 34 , Trauma-focused cognitive behavioral therapy for children and parents. Child and Adolescent Mental Health, 13 4 ,

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2: Table of contents for Feminist therapy theory and practice

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Prior to that, in , she cofounded and worked at Karuna: Counseling for Women and Their Friends, a feminist therapy center. She has been a member of the Feminist Therapy Institute since its inception in She sees herself as an applied theorist, weaving back and forth between theoretical frameworks and the lived experience of people, including focusing her doctoral work on understanding psychological empowerment as a theoretical framework for feminist therapy. She was raised as the oldest of six children in a white, middle-class, educated, stable Catholic family. Living in her adopted South, she struggles to keep one foot in psychology and one in social change efforts. She currently works as a practicum student at Fenway Community Health Center, where she sees members of the Fenway gay, lesbian, bisexual, and transgender GLBT community for individual counseling. She also facilitates a week coming-out support group. Lauren hopes to continue to use a feminist framework in her writing and clinical practice. She grew up Catholic in New Jersey, the oldest child of Midwestern parents who were never fully at home on the East Coast. She received her PhD from Penn State University in and taught human development at Penn State until , when she entered full-time practice as a psychotherapist psychologist , beginning in a community mental health setting and moving on to her current private practice in rural central Pennsylvania. Her experiences of herself as a woman, a mother, and a lesbian have formed the core of her personal identity. Born in South Korea, she immigrated with her family to the United States in Obtaining a well-rounded education and developing artistic talents were emphasized in this educated immigrant family. Her journey toward psychology was guided by observations of recovery and personal transformations that were left unexplained by medicine alone. She was challenged to reconsider traditional approaches to well-being and to incorporate an ecological systems framework that integrates issues of diversity and multiculturalism with feminist perspectives and value systems. She describes herself as a white, Jewish, bisexual woman who was raised upper middle class in Atlanta and was born during the civil rights movement. As a result of becoming disabled at the age of 3 and being a fourthgeneration Southern Jew, she experienced difference and marginalization while also having access to class power and privilege. Her newest book, Inside and Out: Women, Prison and Therapy, was published in Her other books include Rose Pesotta: A Gendered Journey The work goes on into the next generation. Coming of age in the s, her work has always been grounded in a social justice perspective. In addition to her private practice, she coordinates a volunteer mediation service, directs a bereavement program at three animal hospitals, teaches social justice at Fordham University Graduate School of Social Service, and serves as the therapeutic consultant for the Donor Sibling Registry. She has written essays, training manuals, and numerous scholarly articles on women and mental health. Woven around all these work projects, Liz is a devoted single parent of a year-old son named Wolfe. She is, as a social worker, devoted to and trained in the work of social justice. Laing informed her thinking and raised her feminist consciousness in ways that her formal education had not. Through reevaluation co-counseling RC activitiesâ€”a type of ongoing non-therapy, yet therapeutic, peer-helping arrangement Harvey Jackins â€”she experienced the powerful and transformative results that can occur from sharing uncensored personal stories in a safe community. In that context, she developed a heightened understanding of socially oppressive systems and the possibilities for organized personal and social change. She also realized the healing possibilities in peer groups for people who would not seek or might not be able to afford private therapy. Claudia Pitts, PhD, is a clinical psychologist who balances life as both a clinician and an academic. She works at a private practice in suburban Chicago and is on the psychology faculty at National-Louis University. She views her work as faculty, at a university with an exceptionally diverse student body, as a way to promote social justice. She frequently consults internationally,

most recently using the expressive arts to address trauma in both Palestine and Cambodia. A particular focus for her has been the international solidarity movement for peace and justice in the Middle East. Feminism grounds her clinical, academic, and activist achievements. She has been working to end sexual violence and support survivors for over 10 years. She is currently developing and presenting trainings for professionals throughout Boston communities. Suvak has been a member of FTI since and hopes to continue to work within the framework of feminist therapy as well as share the importance of it with others. Charity has worked clinically with a wide variety of individuals in hospital, outpatient, and forensic settings, and she currently works at a Veterans Affairs VA hospital in Bedford, Massachusetts. She strives to adhere to feminist principles and ethics in her therapeutic encounters and other aspects of her work, even while immersed in traditional medical-model settings. For 30 years she has walked the dual paths of feminism and spirituality and has built bridges between them. Contributors xiii Several additional members of the Feminist Therapy Institute also contributed to the development of this book through their participation in discussions at the Advanced Therapy Institute AFTI meeting in Dayton, Ohio, in Gail Anderson, Liz Margolies, and Denny Webster wrote the cases discussed throughout the application chapters. Feminist therapy was in its youth, perhaps 15 years old at best. Social workers had long politicized poverty, but it was new to politicize gender and to incorporate that perspective into the practice of psychotherapy. The handbook was a somewhat random collection of articles, with each topic a contribution to the literature, so sparse was any writing in the area. The focus was almost exclusively on gender, with some attention to sexual orientation. In the more than 20 years intervening, feminist therapy has evolved its understanding of oppression to include attention to race and ethnicity, class, disability, age, and the many other dimensions of politicized difference. Gender and sexual orientation are no longer assumed to be binary. From a primary focus on the misuse of sex as a weapon, the theory and practice of feminist therapy has become more sex-positive in general. Additionally, much of feminist thinking has been incorporated into mainstream psychotherapy training and ethics and even into legislation. Domestic violence, childhood sexual abuse, rape, and sexual harassment are more frequently recognized and reported; police and hospitals are trained to respond; and resources exist to assist those who have experienced these crimes. Professional codes of ethics encourage cultural competence and are clearer about boundary violations. Articles with a feminist perspective, once ghettoized into feminist publications, now appear regularly in mainstream professional journals. In what is perhaps both a compliment and an insult, ideas taken from xv xvi PREFACE feminist therapy but without acknowledgment have found their way into much of the literature on therapy. Rather than a collection of articles on a variety of topics, this volume is organized in a way that brings the reader through an overview of thinking in feminist therapy. Therapy in the United States is embedded in the particular culture of this country in this period of time. In addition, feminists now have allies: Next, we consider the person who comes to therapy. How do we look at who this person is in the context of her or his many identities? Then we examine psychotherapy itself with a feminist lens. The feminist therapist works at many levels simultaneouslyâ€”the individual, the relational and community, and the sociostructuralâ€”and shifts focus freely among them. Feminism has informed a variety of approaches and techniques, and this will also be discussed. Ethics and activism are central to a feminist perspective, and this is part of what sets feminist therapy apart from other approaches. A therapy theory that is grounded in an understanding of political harm as part of what brings people to therapy cannot be understood separately from political action. Finally, we put all the piecesâ€”the context, the client, practice, and activismâ€” together and consider what the integration of these elements would entail. Given all of these pieces, how do we think about what causes human suffering and what we as therapists can do about it? Each of these sections consists of two paired chapters, one looking at theory and the second describing application of that theory. Thus, we move from concept to practice in each section. In addition, we have developed three case examples, so that the practice chapters can give a human face to their discussion of what Preface xvii feminist therapy practice would actually look like. Feminist therapy is remarkably richer, more complex and nuanced, than it was 20 years ago. We welcome you as you consider what it has to offer. Women and Therapy, 20 2. Women in prison

and feminist therapy. Women and Therapy, 20 4 , 21 1. For love or money: The fee in feminist therapy. Women and Therapy, 22 3. Classism and feminist therapy: Women and Therapy, 18 3â€”4. Beyond the rule book: Moral issues and dilemmas in the practice of psychotherapy. Women and Therapy, 22 2. Women, prison and therapy. Women and Therapy, 29 3â€”4. Ethical decision making in therapy feminist perspectives. Assault on the soul: Women in the former Yugoslavia. Women and Therapy, 22 1. This page intentionally left blank Introduction: It had already touched so-inclined students and activists. Liberation movements had substantial impact, and the awareness generated then continues today. All of these factors served as notice that social values in the United States were entering a progressive era. Mental health theory and practice then were not so strongly coupled with the medical model and with empirical science. Indeed, practice was informed largely by psychodynamic theory, with pockets of humanism. In departments of psychology, clinical psychology was an uncomfortable graduate specialty with clear preference for psychometrics and demands for solid preparation in the science of human behavior.

3: Cohen et al. () Video and Filmmaking as Psychotherapy:nResearch and Practice

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5: 69 results in SearchWorks catalog

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6: Ms. Lauren N Gentile - Millburn NJ, Physician Assistant

Lauren Gentile, MS, is a third-year doctoral student at Northeastern University. She currently works as a practicum student at Fenway Community Health Center, where she sees members of the Fenway gay, lesbian, bisexual, and transgender (GLBT) community for individual counseling.

7: The Theory and Practice of Group Psychotherapy by Irvin D. Yalom

Women & Therapy Volume 33, - Issue A Minyan of Women: Family Dynamics, Jewish Identity and Psychotherapy Practice. Lauren Gentile et al. Women.

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Dr. Lauren Gentile, PhD, Psychologist, Natick, MA, , () , I work with adults, adolescents and couples on a variety of issues including depression.

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9: The Origins and Practice of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) â€¢ SJS

) or family adjustment to one's gender (Bockting et al.,). Psychotherapy may be sought to support the process of gender affirmation in the workplace, finding and adjusting to a job after.

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