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Chapter 1 : Cognitive behavioral therapy - Wikipedia

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The coordination of interpersonal variables spans a range of timescales and has been associated with longer-term cognitive and affective aspects of interpersonal interaction; e. This question is particularly relevant for studies of embodied social interaction during psychotherapy. Although the idea of looking at the dynamics of social interaction in therapeutic contexts goes back to work started in the s Watzlawick et al. The cost and effort of sustained long-term experiments in conditions that are difficult to control, however, means this exciting area of research is still very much under development. A valuable example study is the work by Ramseyer and Tschacher The authors investigate correlations between interpersonal body motion coordination and therapeutic outcome. While the former is easily measurable and occurs at the scale of seconds or less, the latter condenses a broad set of factors based on therapeutic experience and corresponds roughly to a timescale of whole sessions and longer. Taking this work as an example, we propose to briefly examine the possible explanations for these correlations across such qualitatively different measures and timescales. Ramseyer and Tschacher use motion energy analysis to record the amount of individual head and upper body movements in patient-therapist during the first few minutes of a session. Both therapeutic process and therapeutic outcome are assessed using a series of questionnaires. Based on the results, the authors suggest that body synchrony between patient and therapist may predict relationship quality and therapeutic outcome. In a related study Tschacher et al. Thus, it may be seen as a manifestation of the therapeutic alliance, that is, the emotional bond in the therapeutic relationship that allows pursuing shared goals and overcome resistance to change. Within the acknowledged limitations of these studies such as the lack of qualitative assessment of movements , it seems plausible that bodily synchrony could be related with some kind of affective resonance and thus with therapeutic alliance. However, the force of such results does not always emerge from prior hypotheses regarding theorized relations between interpersonal synchrony, affect, and outcome Salvatore, ; Koole and Tschacher, ; Kleinbub, It is sometimes assumed that intercorporeal synergies signal positive interpersonal affect, but this is not always the case, nor is positive affect always a sign of therapeutic progress. We think that a theory of embodied intersubjectivity underlying working hypotheses and result interpretation also needs to be made as explicit as possible Galbusera and Fellin, In this context, taking an enactive standpoint could be a fruitful way to complement these analyses and the formulation of testable hypotheses. We repeat that the situation is rather general and that the work by Ramseyer and Tschacher is particularly useful for making this visible. Embodied intersubjectivity, from an enactive perspective, is always directly or indirectly linked to processes of participatory sense-making De Jaegher and Di Paolo, , i. One of the implications of this view is that coordination breakdowns and their joint recovery mark important events of shared sense-construction in an interaction; and by implication the more cognitively and affectively demanding the interactive scenario, the more significant and numerous we should expect such events to be. In support of this view, strict synchronous behavior seems to be modulated by the complexity of joint action contexts and is often less clearly manifest in more complex shared tasks Wallot et al. In view of this, we propose that a more informative measure for this relation is the quantity and quality of transitions between different states of coordination rather than the absolute values of intercorporeal synchrony. Transitions out of and into states of coordination can indicate how participants deal with breakdowns and recoveries in their interaction indicating passages between different phases of the dyadic relationship. Indeed, the attempts to be emotionally attuned with the other is often manifested in the ongoing endeavor of following coherence in interpersonal coupling. This endeavor explains the coping with continuous changes in the relationship and thus, the participatory sense-making process by which the relationship is co-constructed. Transitions between

moments and kinds of coordination, rather than the absolute amount of synchronization, may better reflect changes in the psychotherapeutic relationship. Even though not all transitions in bodily synchrony are necessarily a sign of breakdown-recovery episodes, nor are all breakdowns manifested as bodily coordination transitions, looking also at transitions rather than only at average absolute values of synchrony, may provide good indications of moments in which habitual patterns of behavior change. For example, the moment in which patients acquire a new insight about themselves may be accompanied by a reduction of gesturing and backchanneling in the conversation. In giving a dynamical systems account of therapeutic change, we need to distinguish between first-order and second-order changes Gelo and Salvatore, First-order change encompasses every perturbation in the coupling in which the system remains organized around a quasi-stationary mode of functioning. Second-order change, instead, implies a reorganization of the components that lead to a shift to a qualitatively new pattern of relating, such as a rupture, a resignification of the therapeutic alliance, and so on. Unlike average amounts of synchrony, the study of transitions in coordination patterns can help to understand such first and second order changes in therapeutic relationships reflecting the relational resilience, that is, the capacity of the dyadic system to recover readily and adaptively from adversity and dispute and move from one quasi-stationary regime to another. In short, the enactive perspective questions the notion that the relation between bodily synchrony and longer term affect and cognition is always that of a direct mapping from one domain to the other. Arguably, the amount of synchrony is not linearly correlated with therapeutic alliance or other affective phenomena such as rapport between mothers and infants, e. Prolonged absolute synchrony would be counterproductive for therapeutic change, as would the almost total lack of it. We would not expect a therapist that follows or mimics the movements of the patient to be very successful. Breakdowns and destabilizations are not contingent phenomena the participants could do without; they are instead necessary for changes, particularly second-order changes, to occur Gelo and Salvatore, We also question the idea that a moderate level of synchrony is, as such and by itself, good for therapeutic outcome because we do not think that the relation between shorter and longer timescales in participatory sense-making are those of a direct mapping. Indeed, as Paxton and Dale report, the interplay between high and low level constraints e. If moderate levels of synchrony correlate with positive outcomes in some cases, we hypothesize, this is also because those actual cases are likely to show significant transitions in coordination too. Therapy sessions with a high absolute synchrony in the first half followed by extremely low synchrony in the second, averaging a moderate level, seem unlikely to be effective. Synchrony may reflect the fact that metastability in the relationship is being sustained, but in order to explain significant changes, such as the attainment of clinical goals, we should study the susceptibilities to breakdowns and the capabilities for recovery of metastable dynamical conditions that give rise to new configurations of patterns of interacting. We believe that in giving a compelling account of how alliance is constructed, in addition to synchrony, we should also study phenomena at different timescales along therapeutic processes, laborious though such a study may be. Regardless of the clinical approach used, therapeutic processes encompass a diversity of therapeutic phases in which different relational patterns predominate Searles, ; Westerman et al. There might be, for instance, an alliance building phase, an emotional support phase, a narrative phase, and so forth. We should expect that these different qualities will be manifested at the level of intercorporeal coordination patterns. They suggest that emotional support is greater during the first sessions whereas reflective activities are more common in later stages. We can predict that these different enacted skills have a significant effect on coordination patterns. Indeed, a conversation-type effect e. It is known that in any psychotherapeutic approach there are individual differences in the intervention style which are relevant for the construction of therapeutic alliance Ackerman and Hilsenroth, ; De Re et al. This variability is not to be averaged out, since it is revealing of alternative paths to therapeutic progress, with potentially different dynamical signatures. A strong alliance may be a background enabling condition for the patient to rehearse new behavioral patterns within the therapeutic relationship. However, this cannot be triggered without some confrontation by the therapist to old behavior patterns. Switches in the therapeutic role are also likely to imply a shift in coordination patterns. To sum up, we suggest

that an enactive theoretical background can be useful to frame coordination studies in psychotherapeutic dyads. We hypothesize that the relation between bodily coordination and longer timescale phenomena, such as affect and therapeutic alliance, would be better accounted for in terms of transition dynamics rather than by absolute measures of synchrony. Testing this should not be methodologically onerous. It may be possible to start by defining and recording the amount and type of synchrony transition events in existing or similar datasets. At the same time, we suggest that a more complete picture requires us to explore the relation between different timescales in the therapeutic process, that is, between different therapeutic phases and styles of interventions. EG wrote the first draft of the manuscript. ED wrote relevant sections of the manuscript. Both authors contributed to manuscript revision, read and approved the submitted version. Conflict of Interest Statement The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest. Complexity matching in dyadic conversation.

Chapter 2 : Pedro Salinas. (Book,) [theinnatdunvilla.com]

Therapeutic confrontation has been defined as the process by which a therapist provides direct, reality-oriented feedback to a client regarding the client's own thoughts, feelings or behavior (Forrest,).

George Mason University -Fairfax Virginia Spring Introduction From to , the South African government implemented and enforced an institutionalized system of racial segregation, known as "apartheid. The new government established the Truth and Reconciliation Commission TRC , a court-like body intended to investigate human rights violations perpetrated during the apartheid regime. It thereby aims to answer the following question: It will discuss the meanings of reconciliation, retributive justice and restorative justice as well as describe their main concepts and principles. This paper will conclude with a brief summary of the main points of this paper and a final conclusion. Reconciliation and Justice in a Transitional Context In countries that have witnessed violent conflict and gross human rights violations it is critical that the past be dealt with for a society to move forward towards a unified and harmonious future and avoid a relapse into conflict. In his book Building Peace: Finally, reconciliation recognizes the need to redress the wrongs that were done and at the same time promotes the idea of a "common, connected future" Lederach, , p. One of the fields that address this task is that of transitional justice, which encompasses procedures such as trials, truth commissions, and reparations programs. Retributive Justice Retributive justice is tied to the idea that the perpetrators of crimes should be brought before criminal trials and, if found guilty, punished. Llewellyn and Robert Howse , p. Critics of retributive justice point out that there are several problems with this approach: In countries that are undergoing major political changes, a legitimate rule of law may not yet be fully developed. As pointed out by Alfred Allan and Marietjie M. In regard to the idea of individual culpability being a way to overcome the problem of vengeance between groups, Llewellyn and Howse , p. The authors argue that war crime trials are neither suited to investigate the extent to which a person acted on free will, nor do they sufficiently explore the moral complexity of specific situations Llewellyn and Howse, , pp. Against the argument that trials through criminal procedure offer the possibility of an acceptable and credible impartial account of past events, Llewellyn and Howse , p. This however is not always possible given the large number of people that were likely responsible for or supportive of past injustices. Restorative justice is often defined in contrast to retributive justice. In his book Changing Lenses: Furthermore, rather than viewing the process of justice as a dispute between offenders and state law â€” which in most cases leads to a win-lose outcome â€” the process of restorative justice involves all stakeholders in a conflict â€” including the larger community â€” in identifying obligations and solutions, thus promoting dialogue and mutual agreement and contributing instead to a win-win outcome Braithwaite, ; Zehr, Instead of punishing perpetrators by means such as fines, penalties or confinement, restorative justice seeks to reintegrate them into society. It recognizes that in order to heal, people need to be able to tell their stories and hear the stories of others. Like retributive justice, restorative justice is not immune to criticism. Clamp and Doak , p. Another problem concerns the language of restorative justice. Clamp and Doak , pp. Furthermore, Clamp and Doak , p. The TRC was established with the aim of achieving these goals. A series of public debates concerning the TRC legislation in and , gave the notion of healing increasing importance Leebaw, , p. Finally, Leebaw , p. Structure and Proceedings of the TRC Seventeen commissioners â€” among whom seven women â€” were selected from various racial, religious, social and professional backgrounds to run the TRC Leebaw, , p. The TRC was composed of three committees: It provided forums in which victims could relate their stories. According to Allais , p. Those who chose not to participate in this process could still face prosecution Allais; ; Leebaw, Moreover, victims could question perpetrators and oppose amnesty Allais, , p. Its final product was to be a detailed report about the accounts of victims and perpetrators and the circumstances in which human rights violations were committed ibid. The latter is undoubtedly a major problem that needs to be dealt with. Similarly Allais , p. Therefore, Allais , p. In this sense, justice â€” as understood by retributivists â€” sometimes had to be sacrificed for the

pursuit of other goals, such as peace, stability, healing and the restoration of relationships. Another major criticism of the TRC is that it failed to give victims adequate reparations Allais, ; Stanley, Allan and Allan , p. Furthermore, reparations â€" however unsubstantial â€" can be considered an important symbolic gesture. As argued by Leebaw , pp. As mentioned in section two of this paper given the transitional context, the lack of institutional and social structures to sustain retroactive prosecutions, as well as the scale and political nature of the crimes committed, the ANC chose to grant amnesty to perpetrators as a way to facilitate democratic change and investigate the truth Allais, ; Leebaw, Thus, it can be argued that restorative justice was used as a tool to forego the difficulties of implementing a retributive form of justice and facilitate political change. As suggested in previous sections, it is not always possible to punish wrongdoers, nor is it necessarily always the best option. However, as argued by Clamp and Doak , p. Furthermore, one should keep in mind that each post-conflict case is different, and that just because one method might work in one transitional society does not mean that it can be applied exactly the same way elsewhere. The TRC sought to provide a clear picture of the past, to promote reintegration and reconciliation, to establish a human rights culture, as well as to facilitate a peaceful political transition. To fulfill these goals it adopted a restorative approach rather than a retributive one. The TRC chose to depoliticize past crimes in order to facilitate the political and social transition form the old system to the new. It was argued that the process failed to provide adequate reparations for victims, but that the show of remorse of perpetrators who publicly took responsibility for their actions can be considered an important symbolic gesture. Furthermore, it was argued that restorative justice was used as a tool to forego the difficulties of implementing a retributive form of justice and facilitate political change. Furthermore, it was argued that one must take into consideration the uniqueness of each post-conflict case, not only in applying restorative principles to transnational justice but also in assessing them. In conclusion it can be said that restorative justice is a useful approach that can complement and even replace traditional retributive approaches. However, its theory and application must be further developed in order for it to gain strength as an approach to post-conflict reconciliation processes in transitional societies. Behavioral Sciences and the Law, Vol. Doing Justice Intelligently in Civil Society. Journal of Social Issues, International Criminal Law Review. Sustainable Reconciliation in Divided Societies. United States Institute for Peace. Institutions for Restorative Justice: The University of Toronto Law Journal. South Africa July 26, Evaluating the Truth and Reconciliation Commission. The Journal of Modern African Studies. A New Focus for Crime and Justice.

Chapter 3 : Virtual Humans | Computational Neuropsychology and Simulation (CNS) Lab

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These findings are based on data of low quality. There was no clear difference between the groups, and, at present the meaning of this in day-to-day care is unclear. There was no clear difference between the groups. The meaning of this in day-to-day care is unclear. Older individuals in particular have certain characteristics that need to be acknowledged and the therapy altered to account for these differences thanks to age. Because smoking is often easily accessible, and quickly allows the user to feel good, it can take precedence over other coping strategies, and eventually work its way into everyday life during non-stressful events as well. CBT aims to target the function of the behavior, as it can vary between individuals, and works to inject other coping mechanisms in place of smoking. CBT also aims to support individuals suffering from strong cravings, which are a major reported reason for relapse during treatment. The results of random adult participants were tracked over the course of one year. During this program, some participants were provided medication, CBT, 24 hour phone support, or some combination of the three methods. Overall, the study concluded that emphasizing cognitive and behavioral strategies to support smoking cessation can help individuals build tools for long term smoking abstinence. It should be noted that individuals with a history of depressive disorders had a lower rate of success when using CBT alone to combat smoking addiction. CBT therapists also work with individuals to regulate strong emotions and thoughts that lead to dangerous compensatory behaviors. Cognitive behavioral therapy CBT has been suggested as the treatment of choice for Internet addiction, and addiction recovery in general has used CBT as part of treatment planning. Watson The modern roots of CBT can be traced to the development of behavior therapy in the early 20th century, the development of cognitive therapy in the s, and the subsequent merging of the two. Groundbreaking work of behaviorism began with John B. During the s and s, behavioral therapy became widely utilized by researchers in the United States, the United Kingdom, and South Africa, who were inspired by the behaviorist learning theory of Ivan Pavlov , John B. Watson , and Clark L. Skinner and his associates were beginning to have an impact with their work on operant conditioning. Beck was conducting free association sessions in his psychoanalytic practice. The therapeutic approaches of Albert Ellis and Aaron T. Beck gained popularity among behavior therapists, despite the earlier behaviorist rejection of " mentalistic " concepts like thoughts and cognitions. In initial studies, cognitive therapy was often contrasted with behavioral treatments to see which was most effective. During the s and s, cognitive and behavioral techniques were merged into cognitive behavioral therapy. Pivotal to this merging was the successful development of treatments for panic disorder by David M. Clark in the UK and David H. Barlow in the US. This blending of theoretical and technical foundations from both behavior and cognitive therapies constituted the "third wave" of CBT. This initial programme might be followed by some booster sessions, for instance after one month and three months. These are often met through " homework " assignments in which the patient and the therapist work together to craft an assignment to complete before the next session. It is also known as internet-delivered cognitive behavioral therapy or ICBT. CCBT has been found in meta-studies to be cost-effective and often cheaper than usual care, [] [] including for anxiety. CCBT is also predisposed to treating mood disorders amongst non-heterosexual populations, who may avoid face-to-face therapy from fear of stigma. However presently CCBT programs seldom cater to these populations. It has been proposed to use modern technology to create CCBT that simulates face-to-face therapy. This might be achieved in cognitive behavior therapy for a specific disorder using the comprehensive domain knowledge of CBT. This technique was first implemented and developed on soldiers overseas in active duty by David M. Rudd to prevent suicide.

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Chapter 4 : SAGE Books - Developing Person-Centred Counselling

Therapists assume that a confrontation may induce insight and can strengthen the therapeutic relationship either directly or indirectly through the repair of a rupture in the alliance. Read more.

Virtual Humans Virtual humans are artificially intelligent AI agents that control computer generated bodies and can interact with users through speech and gesture in virtual environments. Advanced virtual humans are able to engage in rich conversations, recognize nonverbal cues, analyze social and emotional factors and synthesize human communication and nonverbal expressions. Building virtual humans requires fundamental advances in AI, speech recognition, natural language understanding and generation, dialog management, cognitive modeling and reasoning, virtual human architectures and computer graphics and animations. All of these technologies need to be integrated together into a single system that can work in unison, be expandable, flexible and plug-and-play with different components. In the CNS Lab, there are three primary projects using virtual humans. The work focuses on developing an automated language-based assessment system that we term AVANT AVatar-Administered Neuropsychological Testing that is primarily self-administering with clearly presented directions to a patient using both visual illustrations and avatar-based verbal instructions. The team aims to demonstrate the implementation of speech recognition using a virtual clinician that is sufficiently accurate to permit computer administration of verbally-based neuropsychological tasks including word-list learning, confrontation naming, and aural comprehension. Virtual Patients are clinically relevant virtual human agents that have been applied to the training of clinicians. At UNT, interactive agents portray a patient with a clinical or physical condition and can interact with a clinician in an effort to teach interpersonal skills. Virtual Patient VP technology has evolved to a point where researchers may begin developing mental health applications that make use of virtual reality patients. The current work reflects lessons learned by Dr. We developed an approach that will allow novice mental health clinicians to conduct an interview with a virtual character that emulates a character with a DSM IV TR disorder see Parsons et al. These early virtual patients were used in a number of USC Departments: Psychiatry; Psychology; and Social Work. The current work at UNT, however, moves beyond this earlier work to focus more on differential diagnosis and therapeutic interaction. Further, the current format is massively deployable and uses software that enables rapid creation of virtual humans. The Social Cognition Task is a collaborative project amongst three labs: Here are some representative pubications: An initial validation of virtual human administered neuropsychological assessments. Annual Review of CyberTherapy and Telemedicine, 15, In Mehdi Khosrow-Pour Ed. Piloting, validating, and applying a virtual eye-gaze task to measure social cognition responses. Attention and Social Cognition in Virtual Reality: The effect of engagement mode and character eye-gaze. Virtual Reality, Presence and Social Cognition: The effect of eye-gaze and narrativity on character engagement. Measuring social cognition in a virtual world. Synthetic Environments for Skills Training and Practice. Constructive Articulation Between Communities pp. Virtual environments for the assessment of social exclusion in Autism: Enhancing fidelity and anthropomorphism. Vitznau, Lake Lucerne Switzerland. A comparison of 3D versus 2D virtual environments on the feelings of social exclusion, inclusion and over-inclusion. Annual Review of CyberTherapy and Telemedicine, 14,. Academic Psychiatry, 36, Paradigm Shift in Neuropsychological Assessment. New Communication and Identity Paradigms pp. Social and Organizational Aspects pp. Techniques and Effective Practices pp. Building Embodied Conversational Virtual Patients. Virtual Environments for Clinical Psychologists. The Clinical Psychologist, 64, Lecture Notes in Computer Science, , Studies in Health Technology and Informatics, , Studies in Health Technology and Informatics. Amsterdam, The Netherlands, September , Porto, Portugal, September , Annual Review of CyberTherapy and Telemedicine, 6, Cyberpsychology and Behavior, 10, Journal of Virtual Reality and Broadcasting, 8,

Chapter 5 : Domestic violence - Wikipedia

Self-disclosure, Confrontation, Cohesion and Universality, Instillation of Hope, Willingness to risk and to trust, Caring and acceptance, Power and empowerment, Catharsis, Cognitive component, Commitment to Change, Freedom to experiment safely, Humor.

April Article Write Us Religious and spiritual beliefs and practices are important in the lives of many patients, yet medical students, residents and physicians are often uncertain about whether, when, or how, to address spiritual or religious issues. Physicians in previous times were trained to diagnose and treat disease and had little or no training in how to relate to the spiritual side of the patient. In addition, professional ethics requires physicians to not impinge their beliefs on patients who are particularly vulnerable when seeking health care. No physician could be expected to understand the beliefs and practices of so many differing faith communities. At first glance, the simplest solution suggests that physicians avoid religious or spiritual content in the doctor-patient interaction. As with many issues, however, the simple solution may not be the best. Research indicates that the religious beliefs and spiritual practices of patients are powerful factors for many in coping with serious illnesses and in making ethical choices about their treatment options and in decisions about end-of-life care Puchalski, ; McCormick et al. This article inquires into the possibility that within the boundaries of medical ethics and empowered with sensitive listening skills, physicians-in-training and physicians-in-practice may find ways to engage the spiritual beliefs of patients in the healing process, and come to a clearer understanding of ways in which their own belief systems can be accounted for in transactions with patients. Research shows that religion and spirituality are associated positively with better health and psychological wellbeing Puchalski, ; Koenig, ; Pargament et al. How pervasive is religiosity in the United States? Religious belief and practice is pervasive in this country, although less pervasive within the medical profession. In , approximately These surveys remind us that there is a high incidence of belief in God in the US public. It also appears that physicians as a group are somewhat less inclined to believe in God. Clearly, physicians are not inquiring about spirituality to nearly the degree that patients prefer Puchalski, ; King et al. Why is it important to attend to spirituality in medicine? Religion and spiritual beliefs play an important role for many patients. When illness threatens the health, and possibly the life of an individual, that person is likely to come to the physician with both physical symptoms and spiritual issues in mind. Religion is generally understood as a set of beliefs, rituals and practices, usually embodied within an institution or an organization. Persons may hold powerful spiritual beliefs, and may or may not be active in any institutional religion. Many physicians and nurses have intuitive and anecdotal impressions that the beliefs and religious practices of patients have a profound effect upon their existential experiences with illness and the threat of dying. Recent research supports this notion. When patients face a terminal illness, religious and spiritual factors often figure into their coping strategies and influence important decisions such as the employment of advance directives, the living will and the Durable Power of Attorney for Health Care. Considerations of the meaning, purpose and value of human life are used to make choices about the desirability of CPR and aggressive life-support, or whether and when to forego life support and accept death as appropriate and natural under the circumstances Puchalski et al. He identifies specific forms of religious struggle that are predictive of mortality. A study of religious coping in patients undergoing autologous stem cell transplants also suggests that religious struggle may contribute to adverse changes in health outcomes for transplant patients Sherman et al. Referral of these patients to the chaplain, or appropriate clergy, to help them work through these issues may ultimately improve clinical outcomes Pargament, et al. How should I take a "spiritual history"? Medical students are usually introduced to the concept of spiritual inquiry in courses such as "Introduction to Clinical Medicine. Students-in-training are often hesitant to ask questions that they regard as intrusive into the personal life of the patient until they understand there are valid reasons for asking about sexual practices, alcohol, the use of tobacco, guns, or non-prescription drugs. Religious belief and practice often fall into that "personal"

category that students-in-training sometimes avoid, yet when valid reasons are offered by teachers and mentors for obtaining a spiritual history, students readily learn to incorporate this line of questioning into the patient interview. Often, the spiritual history can be incorporated into what we may now want to call the "bio-psycho-social-spiritual" patient history. Students are taught to make a transition by simply stating something like the following: If you are comfortable discussing this with me, I would like to hear from you of any beliefs or practices that you would want me to know about as your care giver. If the patient says "no" or "none" it is a clear signal to move on to the next topic, although it is often productive to ask before leaving this topic if other family members have spiritual beliefs or practices in order to better understand the family context and anticipate concerns of the immediate family. One patient-family described gratitude for their church community who brought meals to their home in a period when one parent was at work and the other was at the hospital with a sick child, leaving no one to cook for the other siblings. Others spoke of a visit from a priest, a rabbi, or a minister during their hospitalization as a major source of comfort and reassurance. One patient, self-described as a "non-church-goer," described his initial surprise at a visit from the hospital chaplain which turned into gratitude as he found in the chaplain a skilled listener with a deep sense of caring to whom he could pour out his feelings about being sick, away from home, separated from his family, frightened by the prospect of invasive diagnostic procedures and the possibility of a painful treatment regimen. Some find it helpful to have a clear approach or structure in mind when opening a discussion on spirituality with a patient or taking a spiritual history. A group at Brown University School of Medicine has developed a teaching tool to help begin the process of incorporating a spiritual assessment into the patient interview which they call the HOPE questions: Sources of hope, meaning, comfort, strength, peace, love and connection. Personal spirituality and practices E: When things are tough, what keeps you going? P Are there spiritual practices or beliefs that are important to you personally? E Are there ways that your personal beliefs affect your health care choices or might provide guidance as we discuss decisions about your care near the end of your life? How can respect for persons involve a spiritual perspective? The principle of respect for persons undergirds our duties as health care professionals to treat all persons fairly, to safeguard the autonomy of patients, and to limit the risks of harm by calculating the burdens and benefits of the care plan. Likewise, it is reinforced in religious hospitals whose mission is to care for persons as "children of God," regardless of socio-economic standing. Such caring implies care for the whole person, physically, emotionally, socially and spiritually. How should I work with hospital chaplains? It is heartening to know that the physician is not alone in relating to the spiritual needs of the patient, but can enjoy the team work of well trained hospital chaplains who are prepared to help when the spiritual needs of the patient are outside the competence of the physician. Board Certification Objective Requirements: Stephen King, personal communication, Need date Chaplains play an important role in a team approach to caring for patients. The onset of serious illness or accident often induces spiritual reflection as patients wonder, "what is the meaning of my life now? Practical questions concerning the permissibility of procedures such as an autopsy, in vitro fertilization, pregnancy termination, blood transfusion, organ donation, the removal of life supports such as ventilators, dialysis, or artificially administered nutrition and hydration, or employment of the Death with Dignity Act, arise regularly for persons of faith. In many cases, the chaplain will have specialized knowledge of how medical procedures are viewed by various religious bodies. The chaplain is also prepared to respond to patients experiencing religious struggle through expert listening and communication skills. The chaplain is a helpful resource in providing or arranging for rituals that are important to patients under particular circumstances. Some patients may wish to hear the assurances of Scripture, others may want the chaplain to lead them in prayer, and still others may wish for the sacraments of communion, baptism, anointing, formerly, the last rites , depending upon their faith system. In one case, a surgeon called for the chaplain to consult with a patient who was inexplicably refusing a life-saving surgical procedure. The conference with the chaplain opened the door for this patient to accept the care plan that she had refused earlier. In another case, a neonatologist summoned the chaplain to the NICU when it became apparent that a newly born premature infant was not going to live and the parents were

distraught at the notion that their baby would die without the sacrament of baptism. Sometimes, in the fast moving delivery of health care, the chaplain, by his or her job description, is the only one on the team with sufficient time to follow up on these important patient needs and concerns. What role should my personal beliefs play in the physician-patient relationship? Whether you are religious, or nonreligious, your beliefs may affect the physician-patient relationship. Care must be taken that the religious physician who believes differently than the patient, does not impose his or her beliefs onto the patient at this vulnerable time. In both cases, the principle of respect for the patient should transcend the ideology of the physician. Our first concern is to listen to the patient. Physicians are autonomous agents who are free to hold their own beliefs and to follow their consciences. They may be atheists, agnostics, or believers. It is clear that religious beliefs are important to the lives of many physicians. Medicine is a secular vocation for some, while some physicians attest to a sense of being "called" by God to the profession of medicine. For example, the opening line from the Oath of Maimonides, a scholar of Torah and a physician incorporates this concept: In a much earlier time in the history of the world, the priest and the medicine man were one and the same in most cultures, until the development of scientific medicine led to a division between the professions. After Descartes and the French Revolution it was said that the body belongs to the physician and the soul to the priest. In our current culture of medicine, some physicians wonder whether, when and how to express themselves to patients regarding their own faith. The general consensus is that physicians should take their cues from the patient, with care not to impose their own beliefs. In one study reported in the Southern Medical Journal in , physicians from a variety of religious backgrounds reported they would be comfortable discussing their beliefs if asked about them by patients Olive, The study shows that physicians with spiritual beliefs that are important to them integrate their beliefs into their interactions with patients in a variety of ways. These interactions were more likely in the face of a serious or life-threatening illness and religious discussions did not take place with the majority of their patients ibid. Obstacles to discussing Spirituality with Patients Some physicians find a number of reasons to avoid discussions revolving around the spiritual beliefs, needs and interests of their patients. Reasons for not opening this subject include the scarcity of time in office visits, lack of familiarity with the subject matter of spirituality, or the lack of knowledge and experience with the varieties of religious expressions in our pluralistic culture. Many admit to having had no training in managing such discussions. Others are wary of violating ethical and professional boundaries by appearing to impose their views on patients. Nonreligious physicians have expressed anxiety that a religious patient may ask them to pray. In such instances, one could invite the patient to speak the prayer while the physician joins in reverent silence. On the other hand, some physicians regularly incorporate spiritual history taking into the bio-psycho-social-spiritual interview, and others find opportunities where sharing their own beliefs or praying with a particular patient in special circumstances has a unique value to that patient. These and a myriad of other questions have religious and spiritual significance for a wide spectrum of our society and deserve a sensitive dialogue with physicians who attend to patients facing these troubling issues. Often, such questions are initiated in doctor-patient discussions and may trigger a referral to the chaplain. How can we approach spirituality in medicine with physicians-in-training? The UW School of Medicine was an early leader among medical schools in addressing the topic of patient-spirituality. In an elective course, originating in Spring, , "Spirituality in Health Care," the range of topics goes beyond simply teaching spiritual history taking. Students are encouraged to practice self-care in order to remain healthy as providers for others, and to give intentional consideration to their deep values and their own spirituality as components of their spiritual well-being. The purpose of this interdisciplinary course is to provide an opportunity for interactive learning about relationships between spirituality, ethics and health care. Some of the goals of the class are as follows: To heighten student awareness of ways in which their own faith system provides resources for encounters with illness, suffering and death. To strengthen students in their commitment to relationship-centered medicine that emphasizes care of the suffering person rather than attention simply to the pathophysiology of disease, and recognizes the physician as a dynamic component of that relationship. To encourage students in developing and maintaining

a program of physical, emotional and spiritual self-care, which includes attention to the purpose and meaning of their lives and work. McCormick, Until recently, there were all too few medical schools that offered formal courses in spirituality in medicine for medical students and residents.

Chapter 6 : Spirituality and Medicine: Ethical Topic in Medicine

Resolving Therapeutic Alliance Ruptures: A Task Analytic Investigation A Task Analysis PI: Patient Withdrawal Marker I In this clinical illustration of the rupture resolution process, the patient beÂ- P2 T2 P5 gan the next session without making any reference to the previous session.

Book Plugs Liberation Theology Reading List With the generous help of several of my theology friends and other academic colleagues, I have put together a list of classic, contemporary, and secondary texts on Liberation Theology. The numeric list does not indicate ranking, prominence, or suggest an order in which the books should be read. The book descriptions below are copied directly from Amazon. The Spiritual Journey of a People. This spiritual experience is the well from which we must drink. From it we draw the promise of resurrection. God-Talk and the Suffering of the Innocent. How, in the face of so much suffering among the human innocent, can we talk about God? Theodicy is, of course, the business most central, intellectually, to liberation and theology, and Gutierrez is first and foremost a liberationist Christian. In doing so, the author, by analogy, states movingly and potently the spirituality of Latin American Christians today. Just an instructive, compassionate, graceful book, and one lacking in all politics save that of our shared humanity. The Violence of Love. The book brought a new perspective to theology in the United States. Cone contends that theology grows out of the experience of the community; the community itself defines what God means. Western European theology serves the oppressors; therefore theology for African-Americans should validate their struggle for liberation and justice. In seven brief chapters, he argues passionately that God must be on the side of oppressed black people and develops the concept of a black God, noting: Cone responds to these commentaries in an afterword. The interplay among text, commentaries, afterword and preface provides a lively discussion and analysis of developments in black liberation theology over the past two decades. The book should be read for the clarity with which it demonstrates the relationship between theology, oppression and liberation, and for its historic importance in raising the consciousness of its readers about the possibility of viewing God from a black perspective. Anyone concerned about U. It is particularly suitable for university and seminary libraries. God of the Oppressed. Responding to the criticism that his previous books drew too heavily on Euro-American definitions of theology, James Cone went back to his experience of the black church in Bearden, Arkansas, the tradition of the Spirituals and black folklore, and the black history of struggle and survival, to construct a new approach to the gospel. In his reflections on God, Jesus, suffering, and liberation, Cone relates the gospel message to the experience of the black community. But a wider theme of the book is the role that social and historical context plays in framing the questions we address to God, as well as the mode of the answers provided. Revised, including a new introduction by Cone, God of the Oppressed remains invaluable for scholars, students, clergy, and everyone concerned with vital, contemporary God-Talk. A View From the Victims. In that book Sobrino examined the identity of Jesus in relation to his message, his interlocutors, and the conflict that led to his death. In this second volume he takes up the Resurrection of Christ, the Christology of the New Testament, and finally the christological formulae of the early church councils. The provocative title of these essays plays on a traditional Catholic slogan: Fundamental Concepts of Liberation Theology. This book features a series of essays focusing on the history and key concepts of liberation theology. Part I deals with history, method, and distinctive features of liberation theology. Part II deals with the systematic contents of liberation theology. Leonardo Boff, Introducing Liberation Theology. It then goes on to show how the Christian faith can be used as an agent in promoting social and individual liberation, and how faith and politics relate. Juan Luis Segundo, Liberation of Theology. Segundo is primarily concerned with the liberation of the theological process, and notices a problem with the way theology is done that constricts liberation theology from flourishing in Latin America. Additional essays, which complement those in the original edition, expand upon the issues by dealing with gender and sexuality and the important matter of epistemology. In the light of a more conservative ethos in Roman Catholicism,

and in theology generally, liberation theology is often said to have been an intellectual movement tied to a particular period of ecumenical and political theology. These essays indicate its continuing importance in different contexts and enable readers to locate its distinctive intellectual ethos within the evolving contextual and cultural concerns of theology and religious studies. This book will be of interest to students of theology as well as to sociologists, political theorists and historians. Ivan Petrella, Beyond Liberation Theology: In so doing, he challenges a number of established pieties: The end result is a wake up call for liberation theologians everywhere and a radical new direction for liberation theology itself. With heartwarming, terrifying, and humorous stories, Brown shows the strength and significance of one of the outstanding developments in religious faith today and for the future. A Liberation Spirituality for North America. A Liberation Spirituality for North Americans explores how those living inside the oppressive structures of the First World can be freed from false ideologies to achieve personal and socio-political conversion. Using the story of Moses and the Exodus, the book presents a spirituality of conversion for the privileged and develops a connection between the liberation of the oppressed and conversion of the privileged. Radical Religion and Social Movement Theory. In this book, Christian Smith explains how and why the liberation theology movement emerged and succeeded when and where it did. Longing for Running Water: Beyond God the Father: From Genesis to the writings of contemporary theologians, she exposes the misogyny which still continues to flourish in Christianity. Is God a White Racist? A Preamble to Black Theology. In this powerful examination of the early liberation methodology of James Cone, J. Deotis Roberts, and Joseph Washington, among others, Jones questions whether their foundation for black Christian theismâ€”the belief in an omnibenevolent God who has dominion over human historyâ€”can provide an adequate theological foundation to effectively dismantle the economic, social, and political framework of oppression. Refusing to be rendered invisible by the dominant discourse, the contributors to this volume show the unexpected and original ways in which U. Theology, Politics, and the Body of Christ. The author develops a theology of the political, which presents torture as one instance of a larger confrontation of powers over bodies, both individual and social. The analysis of torture therefore is situated within wider discussions in the fields of ecclesiology and the state, social ethics and human rights, and sacramental theology. The book focuses on the experience of Chile and the Catholic Church there, before and during the military dictatorship of General Augusto Pinochet Ugarte, Cavanaugh has first-hand experience of working with the Church in Chile, and his interviews with ecclesiastical officials and grassroots Church workers speak directly to the reader.

Chapter 7 : Liberation Theology Reading List | PER CARITATEM

The IVET (see Fig. 1a) is a face-to-face therapy, based on direct confrontation with a real phobic stimulus (i.e., cockroaches or spiders). This type of therapeutic activity involves both the therapist and the client interacting with a real animal in order to expose the client to his/her phobic stimulus, work on his/her irrational thoughts, learn new behavioral patterns, and improve his/her.

The intention was to offer an extension to thinking about person-centred counselling beyond the introduction offered in Person-Centred Counselling in Action. Thereafter, Person-Centred Counselling Training deepened exposition on the development of the person-centred specialist. These four texts do not duplicate one another â€" each has a place sequentially in the development of the person-centred counsellor. This second edition retains most of the sections from the original book, though all have been revised, some extensively, to reflect developments in the past eight years. Only two sections have been completely dropped. In total, words and 50 references have been added to the book in this second edition, but it is still written as a thoroughly practical text â€" one which offers 30 focused seminars to help the person-centred counsellor to develop her practice. Part of this popularity is its positioning in the sequence of four, but a lot has to do with the style of writing which attempts to communicate complex ideas simply and also to retain in its writing that most important ingredient of person-centred counselling â€" its attention to the humanity of the endeavour. Compared to this exciting portrayal the person-centred counsellor presents a somewhat quieter image. In many ways person-centred counselling does not fit so-called Western culture where the notion of being helped to heal oneself is attractive only in the margins of society and where expertness in the pursuit of authority over others is a goal at every level of societal functioning from commerce through academia to the criminal fraternity. It is commonly supposed that the person-centred approach has no goals for the client beyond that which the client has for himself. This is of course nonsense. There is at least an implicit aim behind all person-centred working: Furthermore, it is expected that this gain will, in some degree, carry forward to be exercised by the client in his future life. Perhaps the most central concept in the person-centred approach is conditions of worth. Throughout the socialisation of the child he is faced with the fact that his worth as defined by other people is dependent on whether he measures up to particular conditions. If these conditions for his worth are particularly oppressive, inconsistent or ambiguous the roots will be laid for difficulty in adulthood as he attempts valiantly but in vain to live up to the conditions. Sometimes the difficulty which the [Page xii]person experiences in adulthood is only indirectly related to the conditions of worth but more to do with the way the young person adjusted his or her living to exist within the constraints of the conditions. In other words, the very adjustments which the person made to survive difficult early circumstances might become the source of later problems as those adjustments fail to work effectively in adult life. Another central concept which follows on from conditions of worth is locus of evaluation: As mentioned earlier, an implicit aim of person-centred working is to help the client to internalise his locus of evaluation. Helping another person to internalise his locus of evaluation is not achieved by exercising power over him but by creating a relationship in which the client may take responsibility for himself. The singular genius of Carl Rogers, the founder of the approach, was in enunciating and evaluating the relationship conditions in which that client empowerment might be optimised. Rogers laid down six such therapeutic conditions. Currently the most accessible account of these conditions is presented in Kirschenbaum and Henderson For constructive personality change to occur, it is necessary that these conditions exist and continue over a period of time: Two persons are in psychological contact. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious. The second person, whom we shall term the therapist, is congruent or integrated in the relationship. The therapist experiences unconditional positive regard for the client. Because empathy and unconditional positive regard could be clearly defined, the naive presumption has developed that a simple portrayal of these conditions is what is required of the person-centred counsellor. New students of person-centred counselling and those who are

trained by non-specialists in the approach often labour under the misapprehension that all they need to do is to exhibit empathy and unconditional positive regard. The student in these circumstances is thrown into some degree of chaos by the simultaneous demand for congruence. The task then for the developing person-centred counsellor is quite momentous â€" she has to become the kind of counsellor who genuinely feels a deep valuing and interest towards her clients, no matter how varied the clients may be. This heralds the true challenge of person-centred training: This book does not go into detail on any of the above aspects of person-centred theory and practice but assumes that the reader will have familiarity with these basics. The reader is referred to the earlier Sage publication: Person-Centred Counselling in Action, second edition Mearns and Thorne, for a thorough grounding in the approach. The present book has been compiled in such a way as to offer no duplication with that earlier text but to invite the reader to explore the middle reaches of the approach. Much of this section presumes considerable personal and professional development on the part of the counsellor. Highly practical advice is also given on the handling of difficult personal material aroused during training. The fifth and final part of the book is perhaps the most important in offering areas for future development: The person-centred approach has long had an uneasy relationship with psychodiagnostic terms, which it rightly regards as unnecessary and even somewhat obtrusive in relating to the individual client. However, it is important for the person-centred counsellor to be able to relate with these terms if she is to function within a clinical setting. Pre-therapy is one of the most important developments in the last twenty years of person-centred work, offering as it does a meaningful basis for working with largely neglected client groups. The author considers that the training period for a person-centred counsellor is somewhere between [Page xv]three and five years, regardless of the length of the actual training course, which tends to vary from one year full-time to three years part-time. Whether that basic training is completed within one year of completely intensive work or three years during which the work can be better integrated with practice, there should still follow some years during which the counsellor is in an embryonic phase as a person-centred practitioner. The reason for this choice is simply one of maintaining consistency within the series. The training of the person-centred practitioner seeks to equip her to function at whatever depths are required by each new client. The same policy is adopted for the use of pronouns as that which has been well received in Person-Centred Counselling in Action, second edition Mearns and Thorne, Obvious exceptions to this exist in some of the reproduced case material, where to change the sex of the client or the counsellor might radically alter the material. This text does not seek to be politically correct in terms of the choice of material or the language which is currently prevalent in Britain. This particularly applies to some of the terms used in the pre-therapy sections 29 and It was deemed to be disrespectful to change language which was perfectly appropriate in the culture from which it originated. This issue of political correctness was also considered in relation to the material presented in Section Some consultations suggested that the client material described in this section should not be published lest it give the impression that accounts of the sexual abuse of infants and ritualised sexual abuse are over-emphasised. The author decided not to censor this material on those grounds but wishes to make it clear that he is of the opinion that these abuses are if anything under-estimated rather than over-estimated in modern society The book contains a considerable amount of client material. Extreme care has been taken to preserve both the confidentiality and the anonymity of the clients. Permission has been obtained to reproduce any parts which could have been identifiable by the client himself and [Page xvi]changes have also been made to ensure that there are no features which might be identified by other persons. Furthermore, a strict policy has been observed of not using material from clients with whom work was current at the time of writing. Although clients are usually quite happy that such material be used, it can have unforeseen effects upon the therapeutic relationship. In Search of Self. British Association for Counselling and Psychotherapy. Two Accounts of a Journey Through Madness. Stipsits eds , Client-Centered and Experiential Psychotherapy: A Paradigm in Motion. Lambers eds , Person-Centred Therapy: Cooper eds , The Plural Self.

DOWNLOAD PDF BEYOND CONFRONTATION: THE THERAPEUTIC TASK, BY R. R. RUETHER.

Chapter 8 : The Berrigans. (Book,) [theinnatdunvilla.com]

Behavioral research has revealed deficits in the development of joint attention (JA) as one of the earliest signs of autism. While the neural basis of JA has been studied predominantly in adults.