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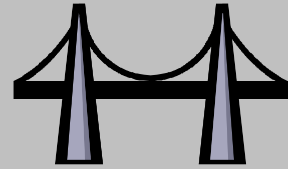
Bridge



Connecting Bay Area Professionals
Winter 2006

SPECIAL POINTS OF INTEREST:

Bridge is a quarterly journal designed to provide Bay Area helping professionals with up-to-date articles and resources to help us help others.

For more information, contact this publication at bridgeinfo@hotmail.com

Amara Brown, MFT
415-391-1741
www.camft.org/Therapists/AmaraBrown

Samantha Zylstra, MFTI
415-585-3132
www.samanthazylstra.com

Christina Fulmen, MFTI
415-820-1455
www.christinafulmen.com

Katie Cofer, MFT
415-826-2951
katiecofer@sbcglobal.net

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When Trauma Gets Triggered

What Somatic Healing Professionals Can Do

By Katie Cofer, MFT

Linda welcomed her new patient Rachel into her chiropractic office. Rachel was coming for treatment of whiplash following a car accident that had happened several weeks earlier. Based on the x-rays, the injury didn't look too severe, so Linda was anticipating a fairly rapid and easy course of treatment.

Linda did notice that Rachel seemed a little edgy as she prepared to lie down on the treatment table. The pleasant banter suddenly stopped. Rachel looked stiff and uncomfortable. Wanting to help her relax, Linda placed her hands on Rachel's back to loosen up her tense muscles with some light massage. As she did, she felt a tremor pass through Rachel's body as she stiffened even more and virtually stopped breathing. When she asked Rachel if she was okay, Rachel couldn't answer and, to her surprise, Linda saw tears trickling out of Rachel's closed eyes.

The Neurobiology of Trauma

To understand what was happening with Rachel, it is helpful

to know more about the brain's response to trauma.

In the face of danger, the instinctual structures of the limbic system jump into action before the more logical, linear cortex has even registered the alert. The amygdala sounds the first alarm and releases a flood of stress hormones which mobilize the organism for the survival responses of fight, flight, or freeze. The hippocampus conveys information between the amygdala's early-warning system and the reasoning cortex. Once the danger is past, the hippocampus tells the amygdala to shut down the stress hormone production, and the body can return to normal functioning. With prolonged stress, however, the hippocampus may go "offline" and the vital information flow between instinct and reason is interrupted.

If a person's brain and nervous system are not able to discharge the powerful energy that is mobilized, the trauma response gets imprinted in the brain and body and keeps repeating itself in a feedback loop. As in the case of Rachel, if the symptoms of traumatic stress somehow get retriggered, your patient feels as though she is reliving the trauma all over again, right there in your office.

Signs of Trauma

Rachel displayed a number of the typical physiological responses associated with PTSD (Post-traumatic Stress Disorder) as described in the DSM-VI. Any of these symptoms might be clues that a patient could be experiencing a traumatic reaction:

- Muscular tension
- Trembling
- Difficulty with breathing, or shallow breathing
- Heightened startle response, hypervigilance
- Sudden sweating and heart palpitations

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An Overview to Sexual Minorities For Professionals

By Christina Fulmen, MFT Intern

Foggy summers. Diverse cuisines. Astonishing vistas. World-renowned landmarks. We live in one of the most spectacular cities on Earth, and people from around the world want to join us here. And many of them do.

Many of San Francisco's professionals value and pride ourselves on our cultural diversity. But we may not be fully aware of some of the even less recognized types of diversity among our own clientele.

We've probably all seen the rainbow flag that flies proudly, year-round, over the corner of Castro and Market streets. San Francisco is the best city in the United States for gay, lesbian, and bisexual folks to live the lives that they want, find the relationships they want, and start the families they want. Most of us in San Francisco have become aware that we are serving the LGB community and have perhaps begun to enjoy and appreciate working with our clients who are sexual minorities. When we're chatting with our clients, we might try to remember to ask

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ꕤ Detecting an Eating Disorder ꕤ

Guidelines for the Professional
By Samantha Zylstra, MFT Intern

It is estimated that 10 million women and 1 million men in the United States currently struggle with Anorexia Nervosa or Bulimia Nervosa (Hock, 1995). These statistics do not account for anyone struggling with compulsive overeating or binge-eating disorder. Anorexia Nervosa has the highest premature fatality rate of any mental illness. (Sullivan, 1995). As professionals, it is crucial to be aware of clients who may be struggling with this illness, as well as have some tools to take the next step to healing. Remember, this is a complicated illness that is not just a cry for help. It is a disease that stems from physical, emotional, social and familial issues and all need to be addressed for treatment and prevention.

MEDICAL SYMPTOMS TO LOOK FOR:

1. Refusal to maintain adequate body weight, an intense fear of becoming fat, and feeling fat despite an obvious skeletal appearance, loss of menstrual cycle are signs of Anorexia.
2. Tooth erosion, loss of tissue and erosive lesions on the surface of teeth, changes in the color, shape and length of teeth, enlargement of the salivary glands, dry mouth are signs of Bulimia.
3. Abnormally slow heart rate, low or high blood pressure, osteoporosis, muscle loss and weakness, gastric rupture, high cholesterol, heart disease, secondary diabetes, are all medical consequences of an eating disorder.

Eating disordered clients see a fat, ugly figure in the mirror.

TALKING TO YOUR CLIENT

Introducing your suspicion of an eating disorder may save a client's life and cause you discomfort. Knowing what to do can help alleviate some of the discomfort.

The SCOFF Questions

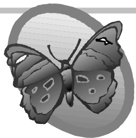
1. Do you make yourself ***Sick*** because you feel uncomfortably full?
2. Do you worry you have lost ***Control*** over how much you eat?
3. Have you recently lost more than ***One*** stone (14 lbs.) in a 3 month period?
4. Do you believe yourself to be ***Fat*** when others say you are too thin?
5. Would you say that ***Food*** dominates your life?

* Score 1 point for each yes answer. A score of 2 indicates a likely case of anorexia nervosa or bulimia. *(St. George Medical Center in London developed the SCOFF exam as a quick way to ask five questions that assist in making an initial eating disorder diagnosis.)*

- Explain to your client that you are noticing some conditions like, (provide examples), that you have seen in people who engage in behaviors such as vomiting, consuming excessive amounts of high calorie food, eating to the point of physical pain, or starvation.
- Ask your client for more information about the behaviors they believe are contributing to the symptoms.
- Provide resources for your client. Specifically ask them if they are seeking professional help and have a referral on hand to provide for them.
- Always address the suspicion privately with your client first.
- Do not become your client's savior. Do not engage in a power struggle. Simply state your observations and concern. Avoid an argument. End the conversation if your client is unable to discuss the matter. Immediately document the interaction and seek consultation.∞

For questions or to make a referral please contact **Samantha Zylstra** at 415-585-3132, or visit **www.samanthazylstra.com**

Samantha holds a certificate in the treatment of eating disorders. She runs weekly groups for people with body image issues and eating disorders as well as provides individual treatment.



From Trauma to Transformation

Powerful Therapy with EMDR

Traumatic experiences can become imprinted on a person's brain and body in such a way that they can cause symptoms like nightmares, flashbacks, disturbing body sensations, and limiting beliefs about life.

EMDR, Eye-Movement Desensitization and Reprocessing, is a powerful and well-researched therapeutic technique that helps to process and release these traumatic memories. Depending on the type of trauma, treatment can be much faster than with traditional therapy.

EMDR can also be very effective with other issues such as anxiety, phobias, depression, grief, and blocks to performance or creativity. Once these old emotional residues are cleared from the body/mind, people often experience increased aliveness and a sense of transformation in various areas of their lives.

I use **EMDR**, along with methods of body awareness, mindfulness, expressive arts, and traditional talk therapy, to help clients release emotional pain and blockages that keep them from achieving their full potential for growth and self-expression.

For more information, please give me a call:
Katie Cofer, MFT (Lic. MFC #35856)
Tel. 415-826-2951, **katiecofer@sbcglobal.net**

When Trauma Gets Triggered

Continued from the First Page

- Aches and pains such as headaches, backaches, stomach aches
- Unusually pale or cold skin
- Fatigue
- Knots in stomach, lump in throat

If you notice any of these physical symptoms, you might assess for the following common emotional reactions:

- Panic, intrusive thoughts, nightmares, flashbacks
- Irritability, restlessness, outbursts of anger
- Depression or mood swings
- Emotional numbing, detachment, dissociation
- Feelings of helplessness
- Increased need for control
- Avoidance of anything related to the trauma
- Feelings of self-blame
- Isolating behavior
- Shame
- Difficulties with concentration or memory loss

In addition – and this happened to be the case with Rachel – memories of older traumas such as childhood abuse or past sexual trauma may also be reactivated and make patients feel disoriented with regard to time and place.

What to Do – and Not to Do

In the past practitioners were encouraged to have patients re-experience the trauma as much as possible and release the feelings connected with it. But cutting-edge trauma research has shown that when trauma gets triggered, what patients actually need is help with calming down their nervous system and regaining a sense of safety and control. They need you to be clear, and to help them understand what is happening. They need to get grounded in their own bodies and reoriented to their surroundings. Although this seems counter-intuitive, what they *don't* need, at this point, is to try to process the trauma emotionally or psychologically by reliving it.

Emotional processing before a patient is truly ready can lead to retraumatization, where a patient experiences the trauma as recurring in the present without any additional resources to break the traumatic feedback loop.

Here are some possible positive interventions:

- Comment on what you are seeing. Draw your patient's attention to her body responses by making an observation like "You're really tensed up in your shoulders, huh?" This can help patients calm down and come back to the present moment.
- Tell your patient what you think is happening – that a traumatic memory is being reactivated, and that this is a normal mind-body response to trauma.
- If your patient still seems terrorized or dissociated, start to bring them back to their bodies by engaging their senses. "Look at me, and tell me what you see. Look around the room and describe it." Getting patients to verbalize like this will help them to engage the cortex and its reasoning faculties.
- Ask your patient what she needs to feel safe right now. She may need you to back off; she may not be able to tolerate bodywork right now. Giving her a sense of control over her environment can help decrease her feelings of helplessness. Don't urge her to go through with treatment if she is reluctant or hesitant; it could aggravate the traumatic response.

If your patient seems to be back in the present but still a little shaky, help her to feel more grounded by instructing her to feel her feet on the ground, to press them into the floor and feel rooted in the earth. Direct her attention throughout her entire body and ask her to feel the ways her body is being supported. Also ask your patient to take some slow, deep, diaphragmatic breaths.

> "*Unresolved trauma saps vitality and causes depression and anxiety. Release the emotional pain and blockages that keep you from realizing your full creative potential.*"

Adjunctive Treatment

These interventions should help your patient to break the trauma feedback loop and reorient herself in the present. This may in itself be enough to help her discharge the energy from the traumatic reaction and overcome the trauma response.

If traumatic stress symptoms continue past one month after the incident, there is a possibility of the patient's developing full-blown PTSD and she should be evaluated by a psychotherapist specialized in trauma. Likewise, a trauma specialist should be consulted if the trauma is more complex, particularly in cases of childhood abuse, sexual trauma, or exposure to violence.

There are several effective treatments for trauma that require special training, such as EMDR (Eye Movement Desensitization Reprocessing), Sensorimotor Psychotherapy, or Somatic Experiencing. All of these draw on the healing power of the body and the brain. EMDR is a technique for accelerating the brain's capabilities for processing traumatic material by integrating the right and left hemispheres of the brain. It does this through bilateral stimulation of the brain via one of the sensory systems (usually by means of eye movements). Sensorimotor Psychotherapy and Somatic Experiencing are body-centered approaches to trauma work that allow patients to gently sense into and release the tensions and blockages that have become locked into the body in the aftermath of trauma. All of these methods also emphasize resources, strengths, and empowerment as crucial components of healing. These therapies can be good adjuncts to ongoing bodywork and, depending on the level of severity, can be relatively short in duration.

Since working with physical symptoms and sensations is so important in the treatment of traumatized patients, as a healing professional who works with the body you are in a unique position to help patients process the effects of trauma. Knowing how to keep your cool when a patient gets retriggered and knowing when to refer for adjunctive treatment can make the difference between retraumatization and healing. ∞

Sources and Resources:

Peter Levine. (1997). Waking the Tiger: Healing Trauma.

Babette Rothschild. (2000). The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment.

www.healingtrauma.com

www.Trauma-Pages.com

Katie Cofer, MFT is in private practice in San Francisco. She specializes in work with trauma. Katie can be reached at 415-862-2951 or katiecofer@sbcglobal.net

꩜ How to Choose a Good Therapist ꩜

By Amara Glorioso Brown, MFT

Part 1: Finding a Therapist

Taking the step to begin therapy can be daunting. One has to make the decision to do it despite many barriers. Even after a person has decided that they want to make a change they must look for referrals, wade through insurance hassles, make a financial commitment, and (most difficult of all) reach out to a therapist, trusting and hoping that they will be able to help. As a therapist in private practice, friends and family often ask me for advice on finding a therapist they can trust. Many clients enter my office for the first time appearing worried and anxious and telling me of the months that it took them to call. Take heart. Most people report that starting therapy is the most difficult part. While it usually does not feel like it, making that first call to a therapist takes courage. Once a connection is made with a good therapist, most people are able to use the relationship to make positive change in their lives. In part 1 of the series "How to Choose a Good Therapist" I address some common concerns related to locating and choosing a "good" therapist. I hope this will make the process easier for you.

First, take some time to identify what you are hoping to get from therapy. Most commonly, people decide to come to therapy because something in their current lives is no longer working for them. Sometimes it is related to paralyzing feelings. Other times difficulties in relationships is the trouble or it may be a pattern of behavior you want to change in yourself. Maybe a particular issue is weighing on your mind.

Next, consider what are some of the qualities in people you find helpful. Think about people you find it easy to talk with. Do they tend to be male or female? Older or younger? Intense or laid back? Do you need someone who will listen and accept or someone who will give you a push to make changes? The more you are able to be clear about what you hope to get out of therapy and what qualities you are looking for in a therapist the easier choosing a therapist will be. Being clear about what you want from therapy will also help the therapist to be more helpful to you. In general, the more you put into your therapy, the more you will get out of it.

Where to find referrals

For the most part, the best person to get a referral from is someone who knows you and who's opinion you trust. This can be a friend or family member, a religious leader, a school counselor or a health care practitioner. I suggest securing 2 or 3 names and phone numbers to start. If the referral is from someone who is also seeing that therapist, you may want to consider how this feels. A good therapist will be able to maintain confidentiality but if you still feel uncomfortable with this arrangement call the therapist and ask them for another referral. Good therapists are glad to give referrals to other good therapists.

Many insurance plans require that you choose from a specified list of providers. If you can afford to pay "out of pocket" you will have a greater option of therapists to choose from and be more in control of beginning and ending therapy. Insurance plans usually have specified limits on the number or frequency of visits covered and may end treatment all together if they feel you no longer meet their criteria for need. If you do decide to use your insurance plan, check their provider lists for the name of a referral that you already have or try asking a doctor you see through the insurance plan for a referral to a therapist.

A lot of information about finding a therapist and starting therapy can be found on the internet. Remember that anyone can create a nice looking website or place an ad. Information found on-line or in print can be helpful when considering referrals that you have gained from a trusted source but I do not recommend using ads or websites in place of referrals.

Therapist referral services are now available in many areas. These should be used with caution. With many of these services, any therapist who pays the fee may be listed. Before using a referral service, find out what qualifications they require and to what degree they screen potential members. Some services offer to specifically match you with a therapist who is qualified to help with your specific issues and this can be helpful.

Regardless of where you find your referrals remember that you are under no obligation to anyone. You are the consumer of a service. Feel free to ask questions, gather information and make a choice that seems best for you. Therapy is a highly individualized process and a therapist that is right for one person may not be right for another.

About Degrees and Licenses

I strongly recommend finding a therapist who holds a license. While, unfortunately, the license is not a guarantee of a "good therapist", the licensing process sets minimum requirements for experience and education and is in place to protect consumers from unskilled therapists. People who practice under titles such as "counselor" or "coach" can have any amount of training and you will have little or no recourse if they do not provide ethical or professional treatment.

A therapist who is an "intern" is in the process of gaining experience towards their license. There are many good interns providing therapy, just remember that they have not yet met the requirements of experience and training. Take special note of any concerns that might come up as you are meeting with them and be sure that they are being supervised by a licensed therapist.

Below are some brief descriptions of the different licenses .

Psychiatrists – are medical doctors and have completed medical school and a residency in psychiatry. They are the only practitioners who can prescribe psychotropic medications. While some psychiatrists do talk therapy others only prescribe medications and collaborate with another therapist who provides the therapy.

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A psychiatrist will either use the title "Dr." or have "M.D". following their name.

Psychologists – have completed a doctorate in psychology, counseling or clinical psychology and have completed some post graduation experience as a therapist before gaining their license. Psychologists frequently have advanced training in research methods and testing. They also use the title "Dr." or have "Ph.D"., "Psy. D" or "Ed.D" following their names.

Marriage and Family Therapists – have completed a masters degree in psychology and hours of post graduate experience prior to licensure. They are trained to understand family systems and provide counseling and psychotherapy from a variety of orientations. They generally focus on assisting the client to achieve more satisfying relationships and alleviating the emotional or mental issue that brought them into therapy. They use the letters "MFT" following their names.

Social Workers – have completed a masters degree in social work and hours of post graduate experience prior to licensure. They engage in psychosocial diagnosis, assessment and treatment as well as client advocacy. They frequently work in hospitals, clinics and agencies as well as in private practice. They use the letters "LCSW".

About Orientation, Training and Special Techniques

Many therapists will offer information about the training that they have had or their orientation to a particular school of thought. Sorting through these terms can add greater confusion for the prospective client. A therapist may say, for example, that they have a "Jungian orientation" or a "Humanistic background" or indicate an affiliation with some other school of psychology. These statements are made to give you some idea of the way that the therapist thinks about therapy and how they work. However, what these terms mean in practice can vary greatly from one therapist to the next. In addition, many therapists will offer training in special techniques such as Expressive Arts Therapy, EMDR, Dream Work, Sand Tray Therapy etc. Techniques such as these can augment the therapeutic experience by providing ways to access material in addition to the usual talk therapy but they are not in and of themselves an indication of a "good therapist".

Studies have shown that the one factor that appears to make the greatest difference in the effectiveness of therapy is not in the training, the type of license, orientation or techniques used but in the relationship formed between the therapist and the client. Keep this in mind as you mull over the referrals that you have collected and as you get ready to make calls and set up the first appointment with a prospective therapist.

In part 2 of "How to Choose a Good Therapist" (coming in the Spring 2006 edition of The Bridge) I will address issues related to making the first phone call, what to expect in the first session and how to assess if this therapist is a "good fit" for you. ∞

Can't wait for part 2? Feel free to e-mail me, Amara Brown, at **bridgeinfo@hotmail.com** or call 415-391-1741 and I will be happy to get an advance copy to you.

Amara Brown, MFT is in private practice in San Francisco. She focuses on providing opportunities for insight and client directed positive change.

A Walk On The Wild Side

Therapy with BDSM Clients

Date: Saturday, April 15, 1-5 pm
Location: Mission Center Building, 1855 Folsom Street, SF
Cost: $75.00
Registration: Please contact Adam Zimbardo, MFT (415-280–2221 or adamzmft@mindspring.com) to reserve a spot.

If you're in practice in San Francisco, chances are that some of your clients are having experiences with consensual sadomasochism, bondage, power exchange, or dominance and submission (a category of sexual styles and practices often grouped together as "BDSM"). A working knowledge of the fundamentals of these often-misunderstood lifestyles can help you know what questions to ask, and how to provide these clients with an environment where they're more likely to disclose to you. Earn four hours of BBS continuing education credit by joining us for an afternoon of education, discussion, and exploration of this side of human sexuality.

Topics covered in this workshop will include:

- Terminology: understanding the language of BDSM
- BDSM community standards and values
- Creating a safe environment for clients to talk about BDSM issues
- Differentiating between abusive and healthy BDSM dynamics
- Working with couples in D/S relationships

Presented by Adam Zimbardo, MFT, and Christina Fulmen, MFT Intern working under the supervision of Lori E. Opal. Adam Zimbardo is a California certified provider of continuing education for psychotherapists and social workers (PCE # 3270). This workshop meets the qualifications for 4 hours of continuing education credit for MFTs and LCSWs as required by the Board of Behavioral Sciences. Refunds will not be provided for non-attendance.

Overview to Sexual Minorities

Continued from the First Page

about partners rather than about husbands or wives. We might try not to default to opposite-sex pronouns for a just-mentioned partner rather than assume. We are learning that in this city, acceptance of the lifestyles of others is a critical value, even if we still have feelings of discomfort about same-sex relationships.

But are we all aware that there are less recognized sexual minorities also, and of the ways in which that might affect our services to our clients?

Transgendered folks

Do you assume that you would have noticed if a client of yours was transgendered or transsexual? Unless you're a doctor who has direct evidence, you might be surprised. There are many women and men in this town who were not born as the same sex that they are when they walk into your office.

A quick terminology review: Transgendered is often used as an "umbrella term" to encompass all folks whose biological sex is not in complete alignment with their psychological/cultural gender. A transvestite is someone who usually thinks of his or herself as the sex that he or she was born, but likes to dress in the clothing of the opposite sex for various reasons. A transsexual is someone who is living as the sex opposite of that which he or she was born. There are also intersexed people, whose biological sex is in some way ambiguous, and who may prefer not to be strictly identified with either gender. But these terms are not carved in stone, and you may hear them used differently!

Polyamorous/nonmonogamous folks

We probably all realize that there are some promiscuous people around, but are we aware of the many other forms of non-monogamous relationships? Polyamorous relationships involve multiple loving or committed relationships. It can be useful to make the distinction between commitment and exclusivity. Many polyamorous or nonmonogamous relationships are just as serious, committed, or long-term as traditional, monogamous relationships.

An open relationship usually refers to a pair of committed partners who are open to "secondary" relationships. (In this model, the partner who looks like the traditional spouse/boyfriend/girlfriend is often called a "primary" partner.) In other households, there are three or more adults all committed to one another as romantic or life partners. Some of these households even have kids. Many of them function quite well. There are too many other possible forms of nonmonogamy to list here, but someone somewhere is actually living in just about any relationship structure that you can imagine.

Consensual sadomasochists

You may think that *how* your clients have sex isn't at all relevant to the services you provide as long as you're being sensitive and aware about who they're having sex with, and you may be right. But while consensual sadomasochism (SM or BDSM) is just a way to have sex for some clients, it's a critical aspect of identity, relationship definition, and sometimes spirituality, for other clients. Depending on the service that you provide, it may be helpful to know a little bit about this alternative lifestyle.

Tips

Do not assume; ask instead. I often have clients 'come out' to me about their alternative sexualities because I knew to ask a question that previous therapists hadn't asked. For example, I was once working was a woman in a violent relationship who mentioned that she hadn't seen her abusive spouse the past weekend because the spouse spent the weekend with another woman. If I hadn't been thinking about it, I might have automatically added 'cheating' to the litany of the spouse's offenses. Instead I replied with, "Okay, I see. So does that mean your spouse is cheating on you, or is that a negotiated arrangement between you two?" The client was so grateful to be able to come out about their open relationship without it getting entangled with their abuse issues that she wrote me a letter after we'd terminated to thank me.

The Golden Rule has been updated. Not everyone wants to be treated as we want to be treated. The best way to provide service in San Francisco today is to follow the Platinum Rule: ***Treat others as they wish to be treated.***

This is a generic rule of thumb. It doesn't imply letting other violate your own professional boundaries. If the client's stated needs conflict with your professional boundaries, initiate a polite conversation about that, offer a little respectful education about professional boundaries and the likelihood of another professional in your field being able to accommodate the client's needs, and make a referral if appropriate.

For instance, if you feel that you cannot call a transsexual client by the pronouns that she prefers, the likelihood of her finding another professional who can are good, so a referral might be appropriate. If, on the other hand, you have a self-identified submissive client from the SM community who wishes you to assume a dictatorial or parent-like role, the likelihood that he'll find another professional who finds that appropriate is limited, so he might need to adjust his expectations to respect professional boundaries. The latter example is pretty unlikely; most folks who are sexual minorities have appropriate boundaries. But just with like any other population, there can be rare but unnerving exceptions.

Educate yourself. If you wish to further educate yourself on these topics, here are some excellent resources:

Health Care Without Shame: A Handbook for the Sexually Diverse and Their Caregivers, by Charles Moser

The Ethical Slut, by Janet Hardy & Dossie Easton (about nonmonogamy)

Different Loving, by William Brame & Gloria Brame (about SM)

True Selves: Understanding Transsexualism--For Families, Friends, Coworkers, and Helping Professionals, by Mildred Brown & Chloe Ann Rounsley ∞

Christina Fulmen, MFT Intern is in private practice in San Francisco. She has an extensive background in domestic violence, sexual assault, trauma and anxiety. She welcomes clients from the queer, trans, poly, and BDSM communities. Christina can be contacted at 820-1455 or www.christinafulmen.com

Couples Counseling - Learn to Love the Love of your Life

Couples begin counseling for many different reasons. I believe that there are a diversity of couples and each has their own journey they need to walk for positive hope and healing.

The work I do with couples is informed by my strong belief that relationships are ***sacred work***. ***Sacred,*** because we are engaging in loving another person and empowering them to be their best self. ***Work,*** because it is daily effort that enables us to grow in connectedness with another as we allow them to see our shortcomings and love their shortcomings. I believe relationships are worth this ***sacred work*** and therefore am deeply committed to journeying with couples when they encounter the inevitable impasses along the way. If you and your partner are stuck in an impasse, don't wait. Hope and healing are possible.

Contact:
Samantha Zylstra, MFT Intern
415-585-3132 or
www.samanthazylstra.com

Professional Focus

Amara Glorioso Brown, MFT (#39414) is a therapist in private practice in San Francisco. She welcomes referrals for children, adolescent or adult clients. In her work, she focuses on meeting each client where he or she is and provides opportunities for insight and client directed positive change. She is trained and experienced in both traditional, psychodynamic psychotherapy and in expressive arts therapy. Her office is arranged with materials and space to support work in a variety of artistic modalities ranging from dramatic enactment, sand tray, painting, collage, play therapy depending on the needs and inclination of each client. Her current clients come from many cultural and socio-economic backgrounds and face a wide variety of issues including: depression, anxiety, loss, trauma, abuse, relationships, anger issues, compassion fatigue and adolescent adjustment. She offers a sliding scale for those with limited income and is able to accept some insurance. Please call with any questions, to make a referral or for an initial appointment. **415-391-1741**

Christina Fulmen, MFT Intern (#44550) is a therapist intern in private practice in San Francisco.

Christina is a thoughtful and informed professional who discusses the process of therapy with her clients as well as the outcomes. She focuses on helping couples and individuals create resilient relationships, demystify their lives, and overcome ideas that are no longer useful about how they should be living.

Christina has an extensive background in domestic violence, sexual assault, and trauma and anxiety. She also welcomes clients from the queer, trans, poly, and BDSM communities.

If you like the idea of goal-focused therapy that integrates personal growth and understanding, then consider calling to discuss your options. You can contact Christina at 415-820-1455 or visit her on the web at **www.christinafulmen.com**. Christina is under the supervision of Lori E. Opal, MFT #35754.

Katie Cofer, MFT (#35856) is a Licensed Marriage and Family Therapist in private practice in San Francisco. Her work is based on a fundamental belief in the interconnectedness of mind, body, heart and spirit. She integrates relational talk therapy with somatic, transpersonal, and expressive arts approaches. She is also trained in EMDR, a powerful technique that facilitates the clearing of traumatic memories and emotional stuck points. Through these processes of self-discovery and healing clients may feel more connected with their core self and regain access to their innate vitality and creativity. Some of Katie's areas of expertise include trauma, depression, anxiety, phobias, unresolved grief, blocks to creativity, and cross-cultural issues. Katie also works with children and adolescents and is fluent in Spanish and German. She can be reached at 414-826-2951 or **katiecofer@sbcglobal.net**.

Samantha Zylstra, MFT Intern (#46427) has a private practice in San Francisco. She provides services for couples, adults, and children who desire healing in their lives. Samantha believes therapy is an opportunity for personal growth and lasting positive change.

Samantha's approach to therapy is informed by her desire to meet each client where they are at; creating space for them to strengthen their core self. Her role, as she sees it, is to listen deeply and responding empathetically to help facilitate opportunities for insight and client directed choices for change.

Samantha has a certificate of specialization in the treatment of eating disorders. She runs an eating disorder support group and is beginning an expressive arts therapy group for developing healthy body image.

For more information regarding her therapeutic approach or specialties please call 415-585-3132 or visit **www.samanthazylstra.com**

Samantha is under the supervision of Lori E. Opal, MFT #35754.

Brown, Cofer, Fulmen, & Zylstra
315 Sanchez Street
San Francisco, CA 94114

Bridge Quarterly Journal, Winter 2006 Issue

Bridge is a quarterly journal designed to provide Bay Area helping professionals with up-to-date articles and resources to help us help others.

Please contact us at bridgeinfo@hotmail.com or
Amara Glorioso Brown, 415-391-1741, www.camft.org/Therapists/AmaraBrown
Katie Cofer, 415-862-2954, katie-cofer@sbcglobal.net
Christina Fulmen 415-820-1455, www.christinafulmen.com
Samantha Zylstra, 415-585-3132, www.samanthazylstra.com