ACCENDUS GROUP

Gregory Koval MSW, RSW, John Machry PhD, C.Psych, Anna Nosko MSW, RSW, Allison Elliot MSW, RSW, Amy Grigg M.A. (Counselling) OACCPP, Anne Rozicki M.Ed, RSW, Mary Jo Franchi-Rothecker LL.B, M.B.A., John Franchi M.A. (Counselling) OACCPP, & Wendy Kenrick M.A (Counselling) (Candidate)

Working with Trauma

By Anna Nosko MSW, RSW

Janina Fisher (2014) a renown trauma psychotherapist and researcher, states that it has only been about 16 years since trauma was diagnosed in the DSM (Diagnostic Statistical Manuel of Mental Health). In the DSM IV, trauma is defined as

Direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness, or horror (or in children the response must involve disorganized or agitated behaviour)…

The major types of Trauma (Briere & Scott, 2013) include **child abuse**- sexual, and physical ranging from fondling to rape and severe spanking to life-threatening beatings, and child neglect; **mass interpersonal violence**-which involves high numbers of injuries or casualties such as mass shootings, terrorist attacks; **natural disasters**- large fires, floods, volcanoes, hurricanes, earthquakes, tornadoes, avalanches etc.; **large scale transportation accidents**- airplane crashes, train derailments, ship accidents; **fire and burns**-house fires, BBQ fires, fireworks, etc.; **motor vehicle accidents**-particularly if there were serious injuries or death or brain injuries; **rape and sexual assault**-non-consensual oral, anal or vaginal sexual penetration with a body part or object through the use of threat, or physical force also forced sexual contact short of rape;

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Autism Spectrum Disorder

By John Franchi M.A. (Counselling), OACCPP

Recent and extensive work with families experiencing the challenges of managing a family member with some degree of autism displays the frustrating nature of this difficult path. The circumstances present a forum for the employment of a high degree of intervention on all the necessary levels. There is substantial interconnection with the various levels of autism. The family and the individual with autism may experience a varied degree of symptoms that are contained in the categorization of autism spectrum disorder (ASD).

ASD is a prevalent condition more often present with young men than with young women. There is a significant increase in the presence of autism, but there may be more cases as a result of better detection in testing and diagnosis. Awareness of the experience of any degree of autism is instrumental in treatment as early intervention can assist in the gains of social skills and language proficiency.

ASD can impact three distinct areas of behaviour – interests and activities; communication; and social interaction. As well, patterns of ASD can be unique to the individual. Early onset may inhibit development during infancy; early childhood development may progress, but then there is sudden loss of social awareness and language skill; and other individuals may experience normal development with suitable language skills and social ability until a point where they experience troubling thoughts or distractive preoccupations. This last segment may suffer the further difficulty of symptoms that are not recognized as products of autism. This missed diagnosis can be the integral cause of treatment for deficiencies, maladies and emotional problems that never address the core issue of ASD.

Major language impairment may highlight that there is ASD difficulty, but unusual behaviours may be considered other issues like obsession, anxiety, depression or anti-social character traits. Too often, dominant elements of ASD are accepted as subtle indicators of other features requiring intervention. As a result the approaches at treatment fail to impact in any meaningful or lasting way.

Family members may see matters are amiss with a child or sibling. The delayed awareness about the presence of ASD – or a prevalent reaction of dismissing signs of ASD as angst or affectation – may lead to an exacerbation of poor or unusual development that adds a crippling degree of difficulty to the range of assistance available. Early evaluation by an experienced professional team may best serve to achieve the best advance and the soundest outcome for the family group and the individual incurring the presence of ASD.

ASD has several forms – Asperger's, Rett syndrome, disintegrative and pervasive developmental disorders, and many other indicators that seem like, but may not yet be included in ASD. The heartening news may be that unusual traits and behaviour are identifiable as ASD and that is a step in the direction of a promising outcome. The frustration attending to this potential promise remains that identifying the outcome is not quite the same as understanding it. For more insights, direction and information about ASD and all attending concerns, please contact John Franchi (direct line, 416-553-8420) at Accendus Group.

First Time Drug Use Intervention Program

By Amy Grigg, M.A. (Counselling), OACCPP &
John Franchi M.A. (Counselling), OACCPP

A growing concern in the family practitioner's examining room is the presentation of the adolescent who has had a first-time experience with alcohol, a street drug, an illegally obtained prescribed medication or some combination of the above. The worried parent brings the adolescent to the family doctor's office looking for answers to a myriad of questions – does the child have a serious problem; is this a one-off rite of passage experience or the start of a chronic substance abuse problem; what should a parent do; what assistance can the parent be to the child; are there ongoing use and abuse risks; what monitors are necessary; what are the short-term and long-term goals and objectives for managing such a situation effectively?

Clinically, the family physician is concerned about the same questions – and, undoubtedly, more – that must be answered to address whether this is manageable youthful angst or the signs of developing substance abuse that may be a cloak around complex interpersonal issues, familial problems, psychological or emotional issues arising from adolescent anxiety and depression. This troubling and expanding patient demographic requires a response. The busy family physician needs a service that will assist in the management of this time-consuming and service intensive examining room problem.

The Accendus Group has prepared a comprehensive assessment and treatment program that specifically directs intervention and treatment to adolescents presenting with this first-time substance abuse scenario. It is critical that the arrival of anxious and angry parents with a resentful adolescent in tow at the physician's office is met with a timely and confident clinical response. Our program's lead clinician, Amy Grigg M.A. (Counselling Psychology) will conduct a detailed initial assessment of the situation and will provide you with an initial report of her findings within 48 hours of the initial referral.

A further detailed treatment response will be outlined for you that will include the consideration of psychological assessment of the adolescent; a family assessment; adolescent and family education regarding substance abuse; ongoing individual treatment; ongoing family intervention and referral to additional specialists where appropriate. We will coordinate further referrals regarding the affected adolescent with your consent and approval as the family physician. You will receive a timely written notification of all developments throughout the assessment and treatment intervention phase. Accendus Group seeks these ways to work with physicians with whom we have been consulting for many years and the means to assist new physicians moving into this area.

As a private service, our fees are typically covered by most insurance plans. Our fees are 100% tax deductible as medical expenses provided that referrals are made in writing by the referring physician. In any case where cost of service may prove problematic, we are pleased to work with our clients to negotiate payment arrangements that are convenient to them.

Referrals can be made by contacting:
John Franchi, MA Counselling Psychology at (416) 553-8420.

stranger physical assault- muggings, beatings, stabbings, shootings, attempted strangulations and other violent actions against a person; **intimate partner violence**- wife battering, spouse abuse, domestic violence; **sex trafficking**-forced or coerced recruitment of individuals for purposes of commercial sexual exploitation; **torture**-any act physical or mental intentionally inflicted on a person with the purpose of obtaining information; **war**- world wars in in specific countries in which atrocities are witnessed or experienced including threat of death; **witnessing or being confronted with the homicide or suicide of another person**- witnessing or confronting death of a friend, relative or loved one and the death is intentional such as murder and suicide; **life-threatening medical conditions**-illness and invasive medical procedures associated with overwhelming pain and/or potential life threats, also heart attacks, cancer, HIV/AIDS, stroke, brain hemorrhage, miscarriage; **emergency worker exposure to trauma**-firefighters, rescue workers, paramedics and other medical personnel involved in identification and handling of deceased trauma victims , emergency mental health and crisis intervention workers.

The critical element that makes an event traumatic is the subjective assessment by the victim of how threatened and helpless they feel. With the passage of time some people are unable to integrate the traumatic experience and start to develop a specific pattern of avoidance and hyperarousal that is associated with PTSD (post traumatic stress disorder). The persistence of intrusive and distressing recollections and the direct experience of the trauma event itself drives the Traumatized people to develop their own characteristic defenses to cope with intrusive recollections and increased physiological arousal.

The neuroscience revolution has helped us greatly in looking at more effective interventions in the treatment of trauma (Fisher, 2014).

Traumatic memory is formed and stored very differently than everyday memory. Instead of forming specific memories of the full event people remember images, sights, sounds and physical sensations without much context. Certain sensations become triggers of the past. This means that a particular traumatic incident may not be remembered as a story of something that's happened a long time ago. Instead it gets triggered by sensations that people are experiencing in the present that can activate their emotional states (van der Kolk, & Buczynski, 2016).

PTSD or trauma is not about the past. It is about a body that continues to behave and organize itself as if the experience is happening right now. Working with traumatized people focuses on helping clients tolerate what is going on in the present because the past is only relevant in as far as it stirs up current sensations, feelings emotions and thoughts. Too often when people feel traumatized, their bodies can feel like they're under threat even if it is a beautiful day and there is no particular danger (van der Kolk & Buczynski, 2016).

Our task as a therapist is to help traumatized individuals recognize that they are safe in the present,

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then to help them with various techniques to self-regulate their emotions and/or physiological sensations; an to update and correct the dysfunctionally stored perceptions including disturbing emotions and physical sensations experienced the time of the trauma.

One significant treatment for trauma and PTSD is EMDR (eye movement, desensitization and reprocessing).

> ...the central thesis of EMDR therapy is that the perceptual information of past experiences, both negative and positive, is conceptualized as stored in memory networks. Natural learning takes place as unimpeded adaptive associations are made. However, if a trauma occurs the system can become unbalanced and the experience is stored dysfunctionally, it has within it the original perceptions including the disturbed emotions and physical sensation that were experienced at that time. Part of the dysfunction is the storage of the experience in neurobiological stasis so that appropriate connections cannot take place. The intellectual beliefs and appropriate knowledge is stored in one network while the disturbing event is stored in another. The two cannot link up. EMDR processing allows the appropriate linkups to occur (Shapiro, 2002, pg.42).

Here at Accendus, I specialize in working with individuals who suffer from trauma.

Anna Nosko MSW, RSW

Step-Parent Support Group Available

Anna Nosko MSW RSW & Wendy Kenrick M.A. (Counselling) (Candidate)

Accendus Group presents:

What you need to know to help you effectively step-parent

Some Issues to be covered:

- How do I fit in with my new family and adjust to my new role?
- What are my responsibilities as a step-parent?
- How do I deal with the other biological parent?
- What is realistic to expect of myself?

This group was created specifically for individuals who are in a step-parenting role either through a blended family or an independent joining a family.

The purpose of this Group is threefold:

1. To answer questions about step-parenting because it can be really challenging,
2. To offer support in the sharing of experiences and exchanging information because you are not alone,
3. To have information from research in the field provided by the group facilitators.

When: Tuesday evenings for 8 weeks starting May 3 through to June 21, 2016, 6:30 pm to 8:00 pm

Where: 345 Lakeshore Ave E, Suite 200, Oakville, L6J 1J5

Fee: $280

Payment options: 10% discount if paid in advance ($252) OR two payments of $140

To register, or for inquires, call Anna 416-729-7350 or Wendy 226-808-0473

Preregistration is required.