NEUROPSYCHOTHERAPY

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Dear Colleagues

The start of 2018 has begun by saying goodbye to Pieter Rossouw, the Editor of the Neuropsychotherapy e-Journal. As many of you already know, Pieter passed away unexpectedly during February this year. Mediros will endeavour to continue with the core business of what it was created for - to spread the word of Neuropsychotherapy as one of the most front running modalities of therapy.

Looking forward, Mediros will, with a few adjustments, continue from hereon with a threefold focus, namely:

**INTERNATIONAL CONFERENCE OF NEUROPSYCHOTHERAPY**

Mediros will continue to host the International Conference of Neuropsychotherapy. In collaboration and endorsement from the IACN we believe that this will continue to offer excellent opportunities for clinicians to learn from specialists and peers in the field of neuropsychotherapy.

We are glad to advise that the Second International Neuropsychotherapy is definitely going ahead with more than 50 confirmed speakers who will be presenting in four streams over the three days of the Conference. The Daily Program for the Conference is also now ready for viewing and has been included in this edition.

The Conference will run from 23 May to 25 May 2018 in Melbourne at the Catholic Leadership Conference Centre (CLC), 576 Victoria Parade, East-Melbourne. Two Pre-Conference Workshops will also run the day before the Conference starts - 22 May 2018. Full registration or day registration is available.

We are also happy to announce that for e-Journal subscribers only, the Early bird rate has been extended to Monday 16 April 2018.

Potential attendees are invited to either complete the form in this edition and email it back to admin@mediros.com.au

**ONLINE TRAINING**

Moving forward Mediros will re-focus on providing Online Training. During the second half of this year The Neuropsychotherapy Institute Training Modules will be incorporated by Mediros to provide a platform where any clinician can access 20 online training modules. The modules each consist of a training video and multiple questions. A Certificate of Professional Development Hours (one hour for each module) is issued when a pass is achieved. More about this later this year.

**NEUROPSYCHOTHERAPY E-JOURNAL**

Mediros will continue to with a bimonthly issue of the free e-Journal. The aim is to continue to service the purpose of what this Journal was created for; *the spread of information about the modality of neuropsychotherapy*, *sharing news and training opportunities in the field of neuropsychotherapy* and in the form of reflective essays, *and sharing colleagues’ expertise about the applications of neuropsychotherapy.*

ALSO, a few words about the International Association of Neuropsychotherapy (IACN)

Some of the subscribers to the e-Journal are also members of the IACN. You will have received a message the IACN Management Committee regarding the vacancy of the President’s position that Pieter Rossouw previously held. Mediros endorses that statement and it is our belief that new leaders will step-up and take on the IACN Management Committee key positions to lead Neuropsychotherapy further forward in the international arena of academic, training, research and therapy applications in a wide range of settings.

LASTLY, we want to take this opportunity to say farewell to Pieter Rossouw, our esteemed colleague, our teacher and our good friend. We have dedicated the last page of the e-Journal to Pieter’s tremendous achievements and contributions to the field of Neuropsychotherapy.

**Best wishes, the Mediros Team**
HOW THE INTEGRATION OF NEUROPSYCHOTHERAPY, SCHEMA THERAPY AND HYPNOTHERAPY, EMBEDDED WITHIN A COLLABORATIVE APPROACH, IS ENABLING ANNE TO RECLAIM HER LIFE

By Joy Kinder

Joy has worked as a mental health practitioner in Christchurch for more than twenty years, both within inpatient and outpatient psychiatric care, which has included several years specialising in the treatment of anxiety disorders. She has worked full time in private practice since 2005 and in addition to private work is contracted by a governmental agency to provide assessment and treatment for victims of sexual abuse. Joy mainly work with adults and adolescents in the provision of therapy for a wide range of presenting issues. While predominantly working from a cognitive behavioural approach, over time she has trained in and incorporated several other approaches into her practice, including schema therapy, dialectical behaviour therapy, emotional couples therapy and mindfulness, as well as offering adjunct hypnotherapy. Moreover, her evolving interest in neuropsychotherapy over recent years recently culminated in attaining her Certificate of Neuropsychotherapy Practice enabling her to confidently incorporate a neuropsychotherapeutic approach with her clients which, in her view is the therapeutic “icing on the cake”! Joy’s passion for her work and her interest in applying neurobiology for psychotherapy is limitless, prompting further study this year!(2018).

Introduction

Anne is a very pleasant, engaging, and intelligent 50 year old single mother, of two “amazing” teenage boys, who has very good family and extended support systems in place. Anne works privately as a property developer and an art dealer.

Presentation

Anne self-referred for therapy having recently initiated separation from her narcissistic (wealthy and influential business man) partner of nine years. Over the past ten months her ex-partner has been unrelenting and vindictive in his stance to prevent settlement of a previously established prenuptial property agreement, necessitating her lawyer recently filing a High Court Order to bring about settlement.

Anne has no previous psychological history, and her healthy sense of self is impressive. She has a diagnosis of irritable bowel syndrome (IBS), the onset of which occurred during a turbulent time in her relationship with her ex-partner. She also has periodic sleep problems with onset also coinciding during a distressful time in her relationship. Her General Practitioner (GP) has prescribed a low dose (2.5mg nocte) of Quetiapine (an atypical anti-psychotic) for sleep, which she now only uses occasionally. She is a non-smoker, with low to moderate alcohol consumption and does not use any illicit drugs.

Anne previously sought therapy during her relationship, and more recently with another psychologist following separation. Therapy ceased with the last psychologist in the realisation that she was not attuned to the extent of the toxic and destructive nature of a pathological narcissist, at the high end of the continuum. This became glaringly obvious when her psychologist advised Anne to meet with her ex-partner “to talk things over”. Anne was upset on discovering that neither therapist had steered her in the right direction, but thankful that self-discovery, through her own research, had subsequently directed her down the right path. She felt more informed and self-assured having read that her brain functioning might be impaired as a result of having been in a long term “toxic” relationship, so she searched the internet to find a local therapist who specialised in treating partners of narcissists, but to no avail. She was however alerted to my website informing her that I worked with those experiencing personality disorders, and moreover that I had an active interest in neuropsychotherapy, and was about to undertake a certification course in this capacity.

Relevant history

Anne’s basic needs were adequately met as a child within a stable family environment, her only significant comment being that her father presented as somewhat distant, given that he tended to focus on his own interests and periodically spent time away in pursuit of them – however, a much closer relationship developed into adulthood. Further, she described her mother as tend-
A stressful environment over the last 10 months in particular, has been a major factor in Anne’s presentation.

drive and motivation to carry out necessary chores. He distanced himself from involvement in the planning and building of their new home under construction, which proved to be the last straw for Anne. Anne’s second marriage of nine years to the father of her children ended 14 years ago. While she initially perceived that he would provide what was lacking in her previous marriage, he developed a drinking problem and turned out to be needy and controlling displaying traits of narcissism - towards the mid-end of the continuum. She finally had the courage to leave him when he became financially exploitative of her.

Formulation

Predisposing factors: - Based on the framework of Schema Therapy (Young, Klosko, & Weishaar, 2003), it seems that within her adulthood intimate relationships, Anne may have unconsciously continued to recreate aspects of her childhood experience of detachment from her father. It is also likely that she took on the role modelled by her mother of subjugation and self-sacrificing. My sense is that one of the main solutions to ensuring that Anne is not lured into a toxic relationship in the future, would be the healing of her inner wounds and reactions that are resulting in matching her subconsciously with partners exhibiting varying symptoms of pathological narcissism.

Precipitating factors: - A stressful environment over the last 10 months in particular, has been a major factor in Anne’s presentation. As the relationship with her ex-partner progressed, so did the abuse which over time graduated from covert to overt and became much more mean-spirited. Once separation was finally instigated by Anne the abuse became outright cruel, as demonstrated in her ex-partner’s unrelenting and ruthless attempts to persecute her, mentally, emotionally, financially and socially.

Perpetuating factors: - Anne has continued to fight back (through her lawyer) against her ex-partner in order to preserve her rights and maintain her sense of self. She likens this process to being in a “war zone”. Indeed, a perusal of the multitude of correspondence between her and his lawyers demonstrates a continuous pattern of ‘attack’ by her ex-partner’s lawyer, and ‘defence’ by Anne’s lawyer. Contact between lawyers has now ceased while they await a High Court Hearing. This has to some extent given her Limbic System (emotional brain) a break from the perpetual barrage of attacks she has recently been subjected to.

Neurobiological markers

Safety: - Anne’s sense of safety has been threatened recently with the onset of her ex-partner’s stalking and tracking behaviours. However, her presenting motivation for approach behaviours (rather than avoid stressful situations), facilitates the down regulation of her emotional brain and the activation her left prefrontal cortex (executive brain) through an increase in blood flow to the latter, which serves to modulate her emotional arousal. The repetition of this pattern of ongoing activation over the past months, has built strong networks to her executive brain enhancing response patterns of
Her perception of what constitutes a positive or negative situation is of course dependent upon her intrinsic experiences of her environment and relationships ...

thriving and resilience in the maintenance of healthy neural direction. Further, it is noted that the facilitation of a safe, physical, and emotional environment within our therapeutic relationship, is essential in meeting Anne’s right to have her concerns addressed in a productive manner (Rossouw, 2014a).

**Attachment:** - Attachment is regarded as one of the most important needs in view of its early neurobiological foundation. Even though Anne felt distanced from her father in childhood she had a secure attachment with her mother (and later as an adult with her father) hence she presents with all the markers of a secure adult attachment, including having a good sense of self-esteem, having the ability to access ongoing social and family supports, and to maintain trusting and lasting relationships in which she can confide. In addition to providing a safe environment, the development of a therapeutic alliance of “trust, confidentiality, and connection” is essential in the down regulation of the Limbic System in the activation of patterns of new neural connections (Rossouw, 2014a).

**Control/Orientation:** - The basic need for control is considered to be the most fundamental of all human needs. To quote Dahlitz & Rossouw (2014) “there is a pervasive striving for perceptions of reality that are consistent with our goals, and this striving is a major driver of behaviour and mental processes”. Anne’s striving to gain clarity about her situation and how to improve it, led to her undertaking a relevant literature research, thus increasing available options for control that she is free to act upon in the future (maximising options is characteristic of healthy approach behaviour). This is an important aspect, given that her ability to maintain control initiates a reduction in distress, which in turn strengthens her sense of control, the process of which Grawe, (2007) refers to as “controllable incongruence”. In effect this process initiates neurological changes including, the firing of noradrenergic neurons, more efficient noradrenal flow, and increased sprouting in the frontal cortex (Rossouw, 2014b).

**Motivation - Pain/Pleasure:** - Anne is motivated by her goal for the actualisation of marital settlement, in order that she can move on and live a fulfilling life in the future. In keeping, she is motivated towards pleasant experiences or states (physical, psychological, emotional or social) and the avoidance of painful or unpleasant experiences. Her perception of what constitutes a positive or negative situation is of course dependent upon her intrinsic experiences of her environment and relationships, and the consistency in which these experiences fulfill other basic needs. With regards to her present situation Anne’s motivation to cease contact with her ex-partner, was instigated in the avoidance of further unpleasant situations, and was consistent in meeting other basic needs for safety, control/orientation, and resilience/capacity. Thus, the manner in which she evaluates her situations, orientates her mental activity towards a thriving response, and involving the activation of dopamine release as a result of gaining a greater sense of control and safety (Rossouw, 2014b).

**Resilience:** - The PR6 -Resilience Scale (Rossouw, 2017), identifies six domains of resilience to be worked on to increase momentum of approach and avoidance motivation schemas, and open up new possibilities in the achievement of measured goals: Vision, Composure, Reasoning, Health, Tenacity and Collaboration. While the scale was not formally administered during therapy, indications are that Anne demonstrates a sense of purpose and direction, she connects with others, she maintains composure, she is resourceful in problem solving and moreover she demonstrates lasting tenacity to persevere through difficult times in her life. Thus, our overall focus in therapy will be to ensure that Anne not only builds on her capacity to maintain resilience within her current situation, but that she takes away knowledge, strategies and skills to maintain a lifetime of resilience.

**Schemata:** - The YSQ-L2 Multimodal Questionnaire (Young, 2001), was administered, scored and clearly identified primary schemas of subjugation and self-sacrificing, relating to Anne’s presenting issues. I considered that Anne would benefit from the application of Schema Focused Therapy, in view of her high functioning and given that she presented as being in touch with her emotions.

**Therapy Process**

Within our initial session, with regards to building rapport and outlining a treatment approach, I addressed Anne’s implicit need for the support of a therapist who would understand her unique situation. I acknowledged that while I had worked with other partners of narcissists, as well as a limited number of narcissists themselves, her ex-partner’s presentation was at a higher end of the scale than I was readily familiar with. I suggested to Anne that, as well as drawing on my own knowledge, it might be advantageous for me to review some of her reading material in order to keep me further informed and ensure that we were both on the same page in discussion, to which Anne readily agreed. In addition, she was given two books of relevance to therapy: Reinventing your life (Young & Klosho, 1994); and But he says he loves me, (McMillan, 2007).
Rapport was established through ensuring a safe and empathetic environment. During our initial therapy sessions, we connected in a collaborative process in the unpacking of Anne’s narrative, drawing on her understanding of her situation based on her prior self-research, and by considering options as to how we might proceed in therapy. In consideration of this I introduced The Neural Development Model, (Rossouw, 2016). Anne showed much interest as I sketched the ‘house’, while discussing her idiosyncratic situation from a bottom up approach. We established that we would initially work together in the integration of an enhanced sense of self through the process of building a solid foundation of safety, building supportive connections, building on her sense of orientation/control, and maintaining her motivation to approach or avoid challenging situations in keeping with her goals.

Discussion with Anne revealed that she had already taken precautionary measures towards managing stress, by addressing issues of practical safety, including the installation of cameras outside her house and the removal of tracking devices from her internet, phone and computer. In addition, we uncovered that the ‘pillars’ in her ‘house’ were standing tall thus activating neural connections between her emotional and executive brains. This was illustrated in a simple sketch of the brain, with Anne brainstorming activities that were activating neural connections between the ‘middle’ and ‘upper’ parts of her brain. The list included, regular attendance at the gym, social contact/support, applying mindfulness techniques (previously acquired in group format), taking time out to relax and/or undertaking activities of interest, spending quality time with her boys and practicing self-care through a healthy diet in keeping with alleviating symptoms of her diagnosed IBS.

In order to provide further stress management ‘tools’ in the strengthening of her ‘house’ I introduced Anne to hypnosis early on in therapy starting with a companion progressive muscle relaxation exercise, incorporating diaphragmatic breathing, which was recorded for her to use at home over the next week. Following this hypnotherapy commenced in vivo, with ego strengthening, and general confidence therapy, recorded for her use every third day over the next two weeks, while using the relaxation exercise on the days in between. The next steps involved hypnotising Anne and taking her through the brief steps of putting herself into a hypnotic state, and on awakening practicing these steps to ensure that she could successfully proceed independently. Self-hypnotherapy opened up the opportunity for Anne to quickly put herself into hypnosis and carry out a short exercise in the promotion of sleep, (in the down regulation of hypothalamus activity) and/or give herself some positive affirmations in the process of using her conscious mind while under hypnosis.

Having validated that we had a solid platform from which to step up from, we commenced to undertake ‘repairs’ to the ‘roof’ of Anne’s ‘house’. The first steps included education about schemas, undertaking a review of the questionnaire, clarifying the origins of her schemas and their progression within intimate relationships, and the reviewing of relevant reading material (previously assigned). We were able to generate several real-life

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examples in detail, from Anne’s past and recent experiences that typified her schemas. Cognitive work involved drawing on evidence pertaining to her life experiences, and experiential work involved imagery exercises in which she expressed her grievances towards her parents, her ex-husbands and her ex-partner. The interplay of neural looping between her hippocampus and her right prefrontal cortex was apparent throughout this stage, directing the pace of therapy in accordance with her emotional reactivity. Having completed the cognitive and experiential work - by which time her left prefrontal cortex (rational brain) had claimed dominance - we began to identify specific behaviours in everyday situations that indicated subjugation and self-sacrificing behaviours. We carried out some role-plays in applying assertiveness techniques involving real life situations and set some behavioural assignments to follow. She stated that her boys were now “towing the line”, in tidying up after themselves which was a “real plus” for her. This work also served to further strengthen her sense of control.

The next area of concern to address was Anne’s query, as to what affect her toxic relationship has had on her brain. By aligning and narrowing our joint research, within the experiential context of Anne’s situation, it was hoped that we could begin to address her concerns in an informed manner, mainly by drawing on a collection of essays by Arabi, (2017).

It became obvious that early on in Anne’s relationship her bond with her ex-partner became cemented through his excessive attention, as well as with his emotionality. His excessive attention, as well as with his emotional withdrawal and withholding. Positive experiences would have released dopamine in her brain, generating automatic associations linking her ex-partner with pleasure. The catch was however, that in Anne’s situation dopamine would have flowed more readily based on her experience of an intermittent reinforcement schedule of rewards, rather than a consistent schedule. It follows that the inability of her narcissistic partner to meet her needs, left Anne pining for the good times and continuing to invest in the relationship. Fisher, (2016) explains how the brain of those in adversity-ridden relationships becomes activated in an eerily similar way to the brains of cocaine addicts. Furthermore, each time Anne was coerced back into the relationship following a few reprieves, this reset the reward circuits in her brain and the dopamine effect felt much “sweeter”.

Bonding would also have occurred through the power of touch which, within physical intimacy releases oxytocin (the attachment hormone) that promotes attachment and trust. The fact of the matter is however, that once Anne bonded with her ex-partner sexually she also bonded with him psychologically and emotionally. Research also revealed that when Anne fell in love her serotonin levels would have dropped causing her decision-making abilities and judgement to go haywire. Coupled with this, low levels of serotonin would have encouraged sexual behaviour, making it more likely that she was swept away by bonds created by oxytocin and dopamine as well.

**Reflection**

*The Integrated Model of Neuropsychotherapy* (Ros-

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While we determined that Anne’s brain is definitely not out for her best interest when it comes to toxic partners, Anne was ensured that this does not mean that her brain cannot be rewired for positive change. I pointed out how the process of neuroplasticity has already made it possible for her brain to make new neural connections in a productive way, through her motivation to stand up to her rights, carry out self-research and attend therapy, and furthermore through her participation in hypnotherapy, exercise, healthy social bonds, interests and passions. To illustrate neuroplasticity Anne was introduced to the Hebbian Principle (via a sketch) that ‘neurons that fire together, wire together’ as well as the corollary that ‘neurons that fire apart, wire apart’.

**Outcome**

Anne was a wonderful ‘co-partner’ in unravelling her life experiences which in turn served to form a therapeutic direction with good effect overall. Rapport was readily established, within a right brain to right brain process, and her participation in the therapy process gave her a sense that she was in control of her destiny. She successfully engaged in emotional and cognitive restructuring and utilised self-hypnotherapy in the management of stress. Further she readily adopted the ‘house’ analogy in which she could view her task direction in more of a constructive and light-hearted manner. The shared sense of humour (which admittedly was sometimes black!) that developed between us helped to counteract the stress of the ‘battle’ she is facing. We picked up on her description of being in a “war zone” in relating to her being the ‘commander’ and me ‘protecting her back’ during enemy attacks. Therapy remains ongoing with Anne, with our next step being to consolidate her knowledge of the workings of her brain in order to set boundaries in the formation of future relationships, thus inhibiting a default neural response in the future.
souw, 2014), has been an invaluable tool in which to assess Anne’s situation and therapeutic needs, and likewise Pieter Rossouw’s companion ‘house’ model proved to be a great way to communicate and identify specific areas ‘in need of repair’. The model also complemented the implementation of Schema Therapy, (Young, Klosko & Weishaar, 2003), as well as the integration of hypnotherapy.

In reflection I would like to have provided a more researched based account of hypnotherapy and the brain, which is an area I plan to research in the future. My explanation within a hypnotherapy framework was, that while Anne remained conscious of her surrounding and could hear what I said to her, this information was recorded in her subconscious mind and later drawn upon, but I did not expand on this. Neither did I venture to explore the brain body connection that I expect would be relevant to Anne’s diagnosis of IBS, and therefore deserving of a neuropsychotherapy explanation. Thus, the carrying out of this assignment has generated food for thought that if explored within neuropsychotherapy, may well be incorporated in our future therapy!

REFERENCES


Young & Brown, (1990). *The young schema questionnaire (YSQ-L2).*

Introduction

- Sally is a single 39-year-old female and presented for therapeutic support after making a claim for historical sexual abuse. Sally reported two separate sexual abuse events.

- When age nine years, Sally was a “key kid”, arriving home from school and letting herself into her home. Her friend’s father, aged in his forties, visited Sally’s home and groomed her by providing her with sweets, having fun and becoming over friendly with her. He eventually sexually violated Sally over a period of two years and threatened her and her family if she was to tell anyone. Sally confided that people from the perpetrator’s church would spit in her face after she made a complaint to the police, telling her she was a liar. Her immediate family treated her with no respect after they became aware of the abuse.

- The second sexual abuse event occurred when Sally was sixteen years old, when the biological father of her daughter, raped and beat her a number of times.

SUMMARY OF RELEVANT BACKGROUND AND PERSONAL HISTORY

- Sally reports her family of origin was dysfunctional and that her mother was alcoholic and psychologically and emotionally abusive to her. With an ‘authoritarian’ parenting style her mother was never emotionally available to Sally during her developmental years. Thus, there was no secure attachment formed with either her mother or a significant other. Sally reports she was left alone much of the time, never experiencing her mother in a positive way. Sally described her childhood as problematic and not enjoyable and there was little nurturance or care from any significant family member.

- Although she knew her biological father, Sally had limited contact with him. She recalled being a “loner” in a dysfunctional family which left her vulnerable to the possibility of sexual abuse occurring. She left home when she was fifteen and led an erratic lifestyle with multiple intimate relationships, unplanned pregnancies and a miscarriage. Although her lifestyle was erratic, she noted that she always cared for and protected her two daughters.

- When aged 35, Sally was involved in a motor vehicle accident, although unharmed physically, since the accident she reported periodically re-living experiences, nightmares and flashbacks relating to this accident which has resulted in intermittent awakening and sleep disturbances. Sally does not appear to have come to terms with the accident and she is possibly suffering with sub-clinical symptoms of post-traumatic stress disorder (PTSD) as a result of the motor vehicle accident.

- Sally sought therapy to assist her to manage her depression and anxiety symptoms. She had been in a two-year relationship with her previous partner, which had ended several months earlier, after realising he was too controlling and manipulative. As a result of this break up her living environment was compromised and she had been unable to maintain a healthy diet or support herself financially.
PERSONAL, EMPLOYMENT AND EDUCATION-RELATED ISSUES

• Sally reported no specific cultural or spiritual needs prior to commencing her therapy.
• She regularly drinks alcohol (up to two drinks per night) and regularly smoked cigarettes and marijuana since the age of 30 years.
• Though unable to be in paid employment, owing to her emotional instability and poor psychological functioning, Sally nevertheless enrolled in a training course. Though struggling to maintain regular attendance at the course, she received outstanding grades, coming second in her class during the first year.

RELEVANT MEDICAL HISTORY

• As an adult, Sally had visited her General Practitioner (GP) on a number of occasions to seek assistance for depression and anxiety, and an injury to her hand. Sally’s medical notes (which were requested from her GP) indicated a history of migraines, recurrent endogenous depression and a miscarriage. Sally preferred to avoid medications and was not taking any currently prescribed medication.

PAST PSYCHIATRIC OR PSYCHOLOGICAL HISTORY INCLUDING TREATMENT FOR THE PRESENTING PROBLEMS

• Sally reported her extended family were all dysfunctional, with many of the maternal side of her family experiencing anxiety and depression. Her extended family’s mental health history predisposed Sally, possibly through genetic risk, to develop a dysfunctional pattern of mental functioning with resulting health issues and pathology. Her compromised living environment and adverse life experiences have been precipitating factors in her clinical profile. When aged 34 years, Sally was admitted to the counselling and mental health services (CMHS), after an altercation with her mother. The discharging doctor noted Sally’s longitudinal history suggested a diagnosis of bipolar mood disorder, possibly at a sub-clinical level of severity and threshold. Although, it was later noted that although Sally was agreeable with the diagnosis, with current episodes of hypomania, and willing to take treatment for it, she did not take any medication, and agreed to the diagnosis as a way to be discharged from the CMHS.

• Following Sally’s return to her home town, she sought counselling support from a psychologist, for anxiety and depression. This treatment appears to have been helpful for Sally as her anxiety levels reduced as indicated by the K10 measures during her therapy. She re-engaged with psychological support through her health insurer when aged 38 years.

MENTAL STATE EXAMINATION

• Sally presented for an assessment tidily dressed in casual clothing. She was of below average height and build, was struggling to manage her physical wellbeing. Her overall grooming was adequate and although cooperative throughout the assessment sessions, she presented in a distressed state on this and later occasions. She was reportedly experiencing panic attacks on a weekly basis. Sally presented with a severe bout of depression owing to relationship difficulties, reporting moderate to high levels of distress and anxiety. Her presentation indicated she was experiencing deflate mood and with blunted affect. Overall her affect was characterised by intermittent anxiety, generally associated with loneliness and relationship issues. She commented on her loneliness and disappointment with her past choice of partners.

• Sally was orientated to person, place and time and was cautious in her response to questions put to her, after due thought and consideration. Thus, she responded to queries thoughtfully and insightfully. Her ability to self-regulate and her reasoning had been impacted severely due to her elevated levels of distress.

Sally reported her extended family were all dysfunctional, with many of the maternal side of her family experiencing anxiety and depression.
Sally behaviours are consistent with avoiding people and trying to engage in other tension reduction behaviours, out of fear of further emotional and psychological harm.

She spoke confidently and loudly throughout part the interview, which was I believe clearly reflective of her anxiety - whilst at other times she spoke softly, being reflective of the depression. Her history of sleep deprivation, energy loss, reduced concentration, headaches/migraines and low moods indicate she was prone to a major depressive disorder.

She was able to recall details of her school years and beyond. Thus, her immediate and recent memory was good.

At the time of the assessment, Sally was generally dysphoric and unstable, and struggled with ongoing PTSD symptomology. Sally described dissociation and numbing, but no clear auditory hallucinations.

There were two psychosocial factors indicative of child maltreatment and neglect, which included:

1. Child psychological abuse; and

From the information gathered in the history and examination, the following differential diagnosis was hypothesised:

1. Major depressive disorder
2. Anxiety
3. Post-Traumatic Stress Disorder
4. Panic Disorder

FORMULATION

Sally presented with significant: depression, anxiety, panic attacks, and PTSD symptoms. Sally behaviours are consistent with avoiding people and trying to engage in other tension reduction behaviours, out of fear of further emotional and psychological harm. This was problematic and a barrier to her treatment. Her level of symptomatology prevented her accessing and using beneficial coping strategies, thus leading to increased distress, and consequent aggravation of her symptoms. This impacted on the risk of her continued depressive symptoms and anxiety.

Sally had been living in constant fear since her developmental years, with these fears being exacerbated by sexual abuse over a long period of time being perpetrated by a trusted person, plus other traumas (e.g. car accident, failed relationships). Her adverse life experiences had enhanced firing from the developing limbic system (impulsive network) of her brain, to the brain stem (reptilian/survival brain). This ongoing activation built strong neuro networks between the limbic system to the brain stem, resulting in a constant state of emotional instability and a motivation directed towards survival. This entrenched a pathological pattern of behavior and functioning to ensure survival and to remain safe. Each time Sally perceived danger, the thalamus (relay station for incoming information) activated the amygdala in the limbic system. The amygdala then activated her sympathetic nervous system (including the brain stem), whereby Sally automatically responded to keep herself safe. This activation resulted in numerous physiological sensations, such as: heart racing, hot/cold sensation, trembling, and shortness of breath. As Sally was unable to down-regulate this activation, she experienced severe anxiety and regular panic attacks. Over time, the activation of the limbic system and brain stem developed into becoming her default neural-loop network, resulting in defensive avoidance and other destructive hypervigilant behaviours. The forms of avoidance, caused by the over-stimulated amygdala, experienced by Sally included: escapism, procrastination, safety behaviours and social isolation. These avoidance behaviours worked to reduce her fear, but only over the short term. The more Sally avoided situations, the harder it became for her to resist repeating those behaviours, as they became habits (Arden, 2016). The cortical blood flow trapped Sally in a small brain-mode of functioning (Rossouw, 2016). That is, in “mental stuckness” (memory loops) trapped into a pattern of survival. This pattern gave her a sense of safety, though held her brain captive, and thus affected her ability to function well. The more stress experienced by Sally over time, the more that particular memory loop was reinforced. Over time this hypervigilant state probably led to neural-degeneration, which is likely to have exacerbated her anxiety and panic attacks.

As Sally’s environment continued to be compromised, her need for survival was essential, and she developed a motivational pattern of avoidance, rather than approach. She was constantly functioning in pain avoidance, with no sense of control or attachment (social connectedness). This prevented her from engaging in approaching behaviours to better herself and to establish a higher order of self. The pattern of avoidance, and a constant struggle for safety, resulted in uncontrollable incongruence where she was constantly confronted with triggers that activated the HPA (hypothalamus-pituitary-adrenal) axis, which inhibited the activation of the frontal neural systems (Rossouw, 2014). Ongoing incongruence developed thus trapping Sally into a fear-based neural pattern, and consequently, into survival mode.

The motivational pattern of defensive avoidance included: disrupted sleep; excessive reliance on alcohol; social isolation; poor diet; illicit drug use; disconnectedness from her extended family; ambivalent, insecure,
Sally exhibited good general insight and understanding showing ability to function with some limitations, on a day-by-day basis. and often problematic interactions with others; and a tendency to avoid intimacy and interdependence in relationships. Thus, Sally has been prone to exhibit problematic, self-destructive behaviours as a way to deal with an overwhelmingly conflicted internal state and diminished or underdeveloped affect regulation capacity. This pattern of avoidance prevented the opportunities for Sally to ‘thrive’, leaving her resiliency low when having to cope with behavioural triggers.

Sally was vulnerable to risk factors for PTSD, experiencing greater stress during and after the traumatic events. Her poverty and low socioeconomic status, previous mental health diagnosis of anxiety, depression, and poor affect regulation, along with family discord and insecure attachment, impacted adversely on her resiliency to cope with traumatic events.

STRENGTHS
Sally exhibited good general insight and understanding showing ability to function with some limitations, on a day-by-day basis. She was motivated to bring about desired changes to her functioning and lifestyle, in seeking therapeutic support. She had stable accommodation and limited support from a few close friends. She also maintained a healthy relationship with her two daughters and grandchild.

PROGNOSIS
The major depressive disorder was severe, with recurrent episodes. The course of major depressive disorder is quite variable, with a likelihood of remission (a period of two or more months with no symptoms, or a period of one or two symptoms to no more than a mild degree), being unlikely, without therapeutic intervention. Stressful life events are well recognised as precipitants of major depressive episodes, and Sally did not adapt well to change. Her depressive episodes generally developed against the background of anxiety she experienced, with the depression likely to follow a more refractory course. There is a history of substance use, which suggests a sustained clinical improvement may depend on the appropriate treatment of each of the mental conditions, using a neuropsychotherapy approach.

The co-morbidity of depression and anxiety is not unexpected. Sally had experienced anxiety from an early developmental age, with the depression developing later in her life. Her history of substance use and erratic lifestyle, with an inability to self-regulate, were factors that induced anxiety and panic disorders.

With PTSD, the symptom recurrence and intensification may occur in response to: reminders or triggers of the original trauma, ongoing life stressors, or newly traumatic events. Sally, aged 39 years, did not maintain an exercise program and did not manage her diet well. As Sally engaged in avoidance behaviours, these factors were likely to exacerbate the PTSD symptoms. However, with appropriate support and therapy she may be likely to express fewer symptoms of avoidance, negative cognitions and mood as she get older, compared with younger adults.

Sally did not rely upon medication to cope with her symptoms. As a result, if she were to maintain a healthy lifestyle and regain connectedness to her community and extended family, and engage in approaching behaviours, she would likely to be in a better position to manage the PTSD symptoms. The prognosis for PTSD depends upon the severity and length of time a person has suffered from the disorder. Many people experiencing PTSD respond to psychotherapy. There are often residual symptoms, however, and it is difficult to predict who will respond best. Studies have shown in other conditions such as OCD, that psychotherapy can actually change how the brain’s chemistry and neural networks function. It is reasonable to assume that these changes are also possible in PTSD as well.

TREATMENT CONSIDERATIONS
Sally’s interest in and motivation for treatment was typical of individuals in a treatment settings, higher than for adults in non-therapeutic settings. Her responses suggested an acknowledgement of important problems, and a perceived need for help in dealing with these problems. She reported a positive attitude towards the possibility of personal change, the value of therapy, and the importance of personal responsibility. However, the nature of some of these problems suggests that treatment would be fairly challenging, with a difficult treatment process and the probability of reversals.
Firstly, Sally’s treatment involved her safety and developing a strong therapeutic relationship. The potential for suicidal ideation was regularly evaluated so that appropriate interventions would be implemented, if needed. Concerns about her potential suicide risk were heightened by the presence of: situational stressors, poor impulse control, and a lack of social support.

Sally described her temper as within the normal range, and as fairly well-controlled without apparent difficulty. Particular areas of attention or concern in the early stages of treatment included:

1. She may be somewhat defensive and reluctant to discuss personal problems, and as such she may be at-risk for early termination;
2. Current difficulties in her social support system, which may give a special significance to the therapeutic relationship and any impasse may need to be handled with particular care;
3. She may have initial difficulty in placing trust in a treating professional, as part of her more general problems in close relationships;
4. She may currently be too disorganised or feel too overwhelmed to be able to participate meaningfully in some forms of treatment;
5. She may be reluctant to consider the possibility that her problems have a psychological or brain based origin, and she may be resistant to considering herself in need of any form of psychological treatment;

After careful consideration, a neuropsychotherapy approach was implemented which included the following:

**TALKING THERAPY**

Talking therapy helped Sally to understand the relationship between her thoughts, behaviours, and symptoms. During these sessions Sally learnt how to:

- Understand and gain control of distorted views of stressors, such as other people’s behaviour or life events;
- Recognise and replace anxiety-causing thoughts to help her feel more in control;
- Manage stress and relax when symptoms occur. This helped to activate blood flow to the prefrontal cortex, down-regulating stress hormones to be released;
- Avoid thinking that minor problems will develop into major ones.

Talking therapy assisted Sally to develop resiliency and to cope with everyday life events, where she established clear and healthy boundaries for herself. These assisted her in developing strategies to manage herself more effectively. She was able to control the incongruence, which enabled firing of the noradrenergic neurons, increasing frontal cortex activation and forming new and stronger neural connections. This increased Sally’s brain’s ability to build new neural connections whilst providing her with emotional stability. The positive therapeutic environment assisted in increasing cortical blood flow, increasing glial activity and neural plasticity, whilst reducing unhealthy stress and mental health dysfunctions.

**SELF CARE**

Other than talking therapy, Sally was able to help herself improve by:

- Reducing caffeine
- Reducing alcohol consumption
- Exercising, getting enough rest (sleep hygiene), and eating healthy foods
- Being socially connected
- New learning/education
- Engaging in leisure activities
- Relaxation techniques (for example, breathing exercises, positive imagery)
- Increasing positive lifestyle practices

Specific management of the PTSD symptomology was managed by a combination of clinical Neuropsychotherapy and stress/anxiety management (SIT). A clinical neuropsychotherapy approach also assisted her to reduce and manage her anxiety and depressive moods.

Once Sally’s symptoms were stabilised, she was assisted to establish and retain greater structure and a sense of thriving in her life. Developing life-skills and an enriched lifestyle, where she was able to learn new things, assisted her to gain control and mastery over her life. Sally now manages her wellbeing and has made attempts at bringing about desired changes. With this came emotional stability and a sense of calmness. The neuropsychotherapy approach assisted Sally with managing intrusive thoughts and cognitive functioning more effectively and improved her emotional regulation around PTSD symptoms. This enabled her to develop better distress tolerance and to learn mindfulness for day-to-day living.

**OUTCOME**

Sally commenced therapy two years ago, and has in that time made significant progress both in her day-to-
day functioning, and in achieving emotional stability. She enrolled in a formal course of study, as a way to learn new skills, and has now completed a two year course in automotive engineering. She graduated near the top of her class and has attained a full-time paid position as an apprentice. Whilst Sally continues to work at achieving her therapeutic goals she is now able to socialise and attend meetings without fear. She has continued to approach life with greater resiliency and purpose. With greater prefrontal cortex activation, Sally is now making informed decisions, rather than acting impulsively and defensively. This has increased her self-esteem, and she now feels connected to her community, in control, and motivated to thrive. Though not entirely socially integrated, she is starting to focus on her future and self-actualisation. Sally continues to experience PTSD symptomology, although bouts of depression have reduced, as has her anxiety. There have been no panic attacks for several months.

The neuropsychotherapy approach provided her with an enriched therapeutic environment to change unhelpful default neural-loops that had held her captive in an unhealthy pattern of mental and emotional distress. This unhealthy pattern kept Sally in survival mode, where she made unhelpful impulsive decisions, along with engaging in defensive avoidance behaviours. With appropriate support in a safe environment, Sally was gradually able to down-regulate her over-active HPA system, and is now engaging in approaching behaviours, learning new ways to function and thrive.

PROGRESS REPORT

Over the course of therapy, Sally has made significant progress by applying neuropsychotherapy principles for her day to day functioning. Sally continues to experience some anxiety, yet her resiliency has developed to the extent that she is able to approach life with greater confidence. Sally has managed to break through many of her avoidance patterns. She has continued in her full-time paid employment, and is about to complete her apprenticeship. Sally is considering further training, and is likely to succeed. Attending a reunion recently, and engaging with people she had avoided for many years was a significant milestone. As Sally’s confidence has grown, she is now able to fully emotionally support her daughters and close friends, whilst successfully living in her own home. Her reduced anxiety has enabled her to maintain a greater sense of wellbeing. Her cognitive abilities have improved, which has empowered her in rational decision making.

An ongoing difficulty for Sally is her low self-esteem and limited resiliency. However, the neuropsychotherapy intervention has enabled Sally to move on from being in survival mode. Formerly, she was trapped in an avoidance pattern with dysfunctional decision making, though now is empowered to make rational decisions. With ongoing therapeutic support Sally will be able to continue to build her resiliency. Thus, enabling her to collaborate with significant others in her life and develop her vision for a thriving future.

REFERENCES


Hello again Mediros eJournal readers and IACN members

Allow me to first express my sadness about the loss of Pieter Rossouw and this edition of the eJournal acknowledges his professional contribution to the Neuropsychotherapy modality.

I also want to assure you, our valued Members, that the IACN has a strong impetus to represent and support you as Members and as an independent legal body with transparent and clear processes by offering: Neuropsychotherapy Practitioner Training (recommencing in 2019); professional development opportunities; free resources in the form of published reflective essays and International Journal articles and providing a means by which practitioners can be found though a publicly accessible directory, and linking you via appropriate forums. We will discuss more about these aims at the AGM scheduled for 24 May, in Melbourne.

UPCOMING 2nd INTERNATIONAL CONFERENCE OF NEUROPSYCHOTHERAPY

It has been heartening that there are already more than a hundred clinicians and Neuropsychotherapy Practitioners registered to attend and present at the 2nd International Conference, 23-26 May in Melbourne. I am excited to hear as many presentations as possible, given that I may also be a presentation Chair, and I very much look forward to catching up with as many of you as I can.

ELECTION OF NEW IACN EXECUTIVE AND MANAGEMENT COMMITTEE

If you are a current member you should by now have received an email which advises we have opened nominations for the above-mentioned positions within the IACN. I encourage you all to consider what you have to offer and if you would like to step up and have a hands on role in your Association, please respond to the call for nominations – it is a simple process by sending a good quality photograph of yourself (a smiling head shot!) together with a few words about why you want to perform the role you are nominating for – please send to office@iacn.com.au. Nominations close at 5 pm Friday 20 April and the election will be held online via OpaVote – you will receive further information about the online voting process closer to the time.

Until then – keep safe.
Warm regards
Jonathan

CALL FOR A RESEARCH SUPPORT

Mediros has received a request from Certified IACN Member Paul Potgieter to put the word out that research support is needed to assist with a research project titled “Neuroscience, safety and production”

- This would involve an estimated total time commitment of approximately 30 hours (paid – negotiable)
- Some assistance will be needed with preparing the ethical application, data entry and assistance with reporting the research results
- The person can be located anywhere in Australia as no on-site attendance is needed
- Preferably the person will be a student that has an interest in Neuroscience.
- Please contact Paul Potgieter directly for further details about the project Paul@nutriculapsych.com.au phone 07 4955 5912 or 0424 621 556.
The Second International Conference of Neuropsychotherapy

Catholic Leadership Conference Centre
576 Victoria Parade, East Melbourne

Conference Dates: 23 – 25 May 2018
Pre-Conference Workshops: 22 May 2018

DAILY PROGRAM as on 04-04-2018

22-May-18 Pre-Conference Workshops Page 2
23-May-18 Conference - Day ONE Page 3 - 4
24-May-18 Conference - Day TWO Page 5 - 6
25-May-18 Conference - Day THREE Page 7 - 8

Hosted and Organised by:

MEDIROS CLINICAL SOLUTIONS

Endorsed by:

International Association of Clinical Neuropsychotherapy
## Pre-Conference Workshop ONE - 09.00 - 12.30

**Presenter:** Dr Roger Mysliwiec

**Bulimia Nervosa & Binge Eating Disorder.**
A Neuropsychotherapeutic approach with treatment strategies

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<tr>
<td>08.30 - 09.00</td>
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<td>Eating Disorder Workshop - Session 1 of 2</td>
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<td>10.30 - 11.00</td>
<td><em>Morning Tea Break</em></td>
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<td>11.00 - 12.30</td>
<td>Eating Disorder Workshop - Session 2 of 2</td>
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## Pre-Conference Workshop TWO - 13.30 - 17.00

**Presenters:** Jurie Rossouw and Davinia Glendenning

**Wellness and Capacity Development.**
The Neuroscience of Resilience

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<tr>
<td>13.00 - 13.30</td>
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<td>13.30 - 15.00</td>
<td>Resilience Workshop - Session 1 of 2</td>
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<td>Richard Wall</td>
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<td>Counselling Double Vision: Helping Rewire a Client's Brain</td>
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<td>13.45 - 15.15</td>
<td>Karen Ferry</td>
<td>Dr Tim Moore</td>
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<td>Putting Theory into Practice: Practical Neuropsychotherapy Approaches to Support Clients, Enriching Connections and Promoting Wellness</td>
<td>Factors affecting development during the first 1000 days – evidence and long-term implications</td>
<td>Toddler Trauma</td>
<td>The Body in Therapy. A Neuropsychotherapeutic Understanding of Interoception and Embodied Mindfulness</td>
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<td>Dr Carol Moylan and Loretta Parsley</td>
<td>Peter Janetzki</td>
<td>Pieter Rossouw Jr</td>
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<td>The Partnership of Two Minds: Walking with Walbanja’s First Peoples of the South East coast of New South Wales, Australia</td>
<td>Integrated Process-Based Framework: A Neuropsychotherapy Approach with Couples</td>
<td>Exposure Therapy with Virtual Reality – Changing the Brain with Immersive Technology</td>
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24 May 2018 - Conference - Day TWO

**Location**

Celtic Hall Foyer  
08.00 - 09.00  
Early Morning Coffee and Tea

**Location**

Celtic Hall  
09.00 - 10.00  
Session Chair - Rita Princi

**STATE OF THE ART KEYNOTE**

Thedy Veliz  
The Parent Neuropsychotherapy Protocol: A Relational and Developmental Approach to Working with Youth and Their Families

**Location**

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10.10 - 10.40  
**Dr Roby Abeles**  
Brainspotting™ (BSP) – A 21st century brain-based, body-inclusive, highly attuned, trauma resolution therapy

**Location**

Celtic Hall  
10.40 - 11.00  
Session Chair - Rita Princi

**Morning Tea Break**

**Location**

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11.00 - 12.30  
**Paul Potgieter**  
A Brain based conflict resolution model

**Location**

Celtic Hall  
12.40 - 13.40  
Session Chair - Rita Princi

**STATE OF THE ART KEYNOTE**

Daren Wilson  
Structured Image Framework Theory (SIFT): A brain based therapeutic technique to explain the traumatic experience

13.40 - 14.15  
LUNCH

Afternoon Sessions start 14.15 - please page over
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14.15 - 15.45

**Prof Dirk Geldenhuys**
Organizational neuroscience in practice: Experiencing, validating and refining a group based intervention.

**Dr Jorgen Herlofson**
Clinical aspects of a person-centered brain-based approach to mental health

**Rita Princi and Margot McDougall**
Neuroscience and Education: Introducing the Brain Smart 4 Learning Program

15.45 - 16.00

**Session Chair - TBC**

Afternoon Tea Break

16.00 - 17.30

**Celtic Hall**

**Session Chair - TBC**

**Annual General Meeting**

International Association of Neuropsychotherapy (IACN)

17.30 - 18.30

**Simmons Hall**

**Free Social Event**

Opportunity for Social Liaising - with Nibblies and a Welcome Bubbly drink

*Everyone welcome - Fruit juice also available*
### 25 May 2018 - Conference - Day THREE

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<td>Celtic Hall</td>
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#### STATE OF THE ART KEYNOTE

**Dr David Collins**

**Brain based approaches to working with children and adolescents**

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<td>Seminar Room 3</td>
<td>09.55 - 10.25 Dr Lyle Whan Neuroscience and Learning – Helping Students Learn: Motivation, Music and a Touch of Magic</td>
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<tr>
<td>Seminar Room 4</td>
<td>09.55 - 10.25 Peter Kyriakoulis The implications of the diving response in reducing panic symptoms and cognitions.</td>
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<td>Seminar Room 8</td>
<td>09.55 - 10.25 Karen Ellis A Country Practice: Forensics, Neuropsychology, and the Challenges of Working in a Rural Area.</td>
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<td>Seminar Room 9</td>
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**Morning Tea Break**

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<tr>
<td>Seminar Room 3</td>
<td>10.45 - 12.15 Daren Wilson Structured Image Framework Theory (SIFT): To learn how to use this newly developed brain based therapeutic technique within a group setting and individual therapy session to explain trauma</td>
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<td>Seminar Room 4</td>
<td>10.45 - 12.15 Prof Vijoleta Braach-Maksvytis Yoga: the Neuroscience of Integration. Touching the mind through the body</td>
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<td>10.45 - 12.15 Jan Sky Mapping the Social Landscape of the Brain</td>
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<td>10.45 - 12.15 Mary Bowles Clinical Applications Toward Rapid Memory Reconsolidation</td>
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<td>12.25 - 13h55 Thedy Veliz The Parent Neuropsychotherapy Protocol in Action: A Practical Interactive Skills Based Mini-Workshop on Working With Youth Through Their Families</td>
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<td>Seminar Room 4</td>
<td>12.25 - 13h55 Ellana Iverach Being a Brain Wise Presenter: The neuroscience behind group presentations</td>
</tr>
<tr>
<td>Seminar Room 8</td>
<td>12.25 - 13h55 Jenny Venter Applying neuroscience principles: Facilitating structures of belonging (connection) in compromised environments as a foundation for positive transformation.</td>
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<tr>
<td>Seminar Room 9</td>
<td>12.25 - 13h55 Michael McIntosh The NeuroSmart® Organisation – How the principles of neuropsychotherapy are redefining best practice for leadership, management and organisational development</td>
</tr>
</tbody>
</table>

### LUNCH

Afternoon Sessions start 14.15 - please page over
**Location**  
**Seminar Room 3**  
Session Chair - TBC

**Seminar Room 4**  
Session Chair - TBC

**Seminar Room 8**  
Session Chair - TBC

**Seminar Room 9**  
Session Chair - TBC

---

14.15 - 15.45

**Jurie Rossouw and Davinia Glendenning**  
The Predictive 6 Factor Resilience Scale: Demonstration of a neuroscience-based tool and microtask platform to assess and develop capacity

**Barry Karlsson**  
Emotional contagion, neuropsychology and intellectual disabilities

**Monika Kneusenberer**  
Working toward a turn-around: breaking the vicious cycle of inter-generational trauma

---

15.45 - 16.00  
Afternoon Tea Break

---

16.00 - 17.00

**Location**  
**Celtic Hall**  
Session Chair - TBC

---

**CONFERENCE CLOSING STATE OF THE ART KEYNOTE**  
**Rita Princi**

The Intentional and Diverse Application of Neuropsychotherapy
**Conference Date:** 23 – 25 May 2018 – 24 CPD Points

Pre-Conference *Half Day Workshops – 3-hours each - 3 CPD Points each
* Bulimia Nervosa & Binge Eating Disorder - Dr Roger Mysliwiec – 22 May 2018 – Morning Session
* The Neuroscience of Resilience – Jurie Rossouw and Davinia Glendenning – 22 May 2018 – Afternoon Session

### PRICING IS IN AUSTRALIAN DOLLARS

<table>
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<th>Registration Rate</th>
<th>Conference ONLY 23 – 25 May 2018</th>
<th>½-Day Pre-Conf Workshop Eating Disorders 22 May 2018</th>
<th>½-Day Pre-Conf Workshop Neuroscience of Resilience 22 May 2018</th>
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<tr>
<td>Early bird rate extended to 16-04-2018 for e-Journal Readers only</td>
<td>$ 900 ☐</td>
<td>$ 240 ☐</td>
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<tr>
<td>Please use THIS form to register</td>
<td>$ 950 ☐</td>
<td>$ 280 ☐</td>
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<td>Standard – Rate after 16-04-18</td>
<td>$ 880 ☐</td>
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<td>$ 825/p ☐</td>
<td>$ 210 ☐</td>
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For group registrations please contact: andie@mediros.com.au

TOTAL Amount AUD $ ________________

**Attendee Detail:**

Title, Name and Surname: ________________________________________________________________

Mobile Phone: ________________________________________________________________

Email address: ________________________________________________________________

**Payment:**

Credit Card Number: ___________________________________________________________ Expiry Date: _______________________

(Visa or Mastercard only)

Three digits on back of card ___________________________ Amount: AUD $ ________________

Name on Card: __________________________________________________________ Signed: ___________________________

Please return to: admin@mediros.com.au or andie@mediros.com.au

Neuropsychotherapy Conference Admin, PO Box 6460, St Lucia, 4067, QLD, Australia --- Ph +61 (0) 7 3217 7266
## Registration Form for Specific Day Sessions AM or PM

**Melbourne: Catholic Leadership Conference Centre 576 Victoria Pde, East Melbourne**

<table>
<thead>
<tr>
<th>DAYS AVAILABLE FOR SESSION REGISTRATION</th>
<th>Please Circle</th>
<th>Rate</th>
<th>Complete</th>
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<td>AUD $170</td>
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<tr>
<td>Attending Day ONE: Afternoon Session Half-day</td>
<td>Yes</td>
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<td>AUD $170</td>
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<tr>
<td>Attending Day TWO: Morning Session Half-day</td>
<td>Yes</td>
<td>No</td>
<td>AUD $170</td>
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</tr>
<tr>
<td>Attending Day THREE: Morning Session Half-day</td>
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<td>AUD $170</td>
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<tr>
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<td>Yes</td>
<td>No</td>
<td>AUD $170</td>
</tr>
</tbody>
</table>

**TOTAL**

### Attendee Detail

Visa or Master Card only

#### Attendee Name:

[Insert Attendee Name]

#### Email Address:

[Insert Email Address]

#### Contact Number:

[Insert Contact Number]

### Payment Detail:

Visa or Master Card only

#### Card Number:

[Insert Card Number]

#### Expiry Date:

[Insert Expiry Date]

3 digits at back of Card:

[Insert 3 digits at back of Card]

#### Amount: Australian Dollars:

[Insert Amount]

#### Signed:

[Insert Signature]

Date:

[Insert Date]

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- Be registered as a Certified Resilience Coach

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*Registration closes 20 April 2018
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Melbourne - 23 Nov 2018

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Pieter J Rossouw has made a pioneering contribution to the field of Neuropsychotherapy in Australia, having trained thousands of clinicians and students in this framework.

Pieter had published an online resource Neuropsychotherapy in Australia, later known as the Neuropsychotherapy e-Journal, sharing his knowledge and insights for the benefit of any professional open to learning the latest in neuroscience for psychotherapy. He authored and co-authored many papers over the years, some of which were included in the e-Journal. He also became the Chief Editor of the International Journal of Neuropsychotherapy, an open access journal, for a similar purpose.

Across Australia (and internationally) Pieter produced and delivered workshops which applied the findings of neuroscience to a wide range of disciplines and topics. He brought these together, with additional materials, when the Certified Neuropsychotherapy Practitioner Training was developed and the International Association of Clinical Neuropsychotherapy was created, to promote Neuropsychotherapy. At the same time the Neuropsychotherapy Institute, an online training platform was developed for those who couldn’t attend face-to-face training.

Pieter worked closely with other senior clinicians to bring his insights to bear on organisational psychology in his book Brainwise Leadership, and more recently with Jurie Rossouw, published “Executive Resilience”. And for a general clinical audience he, with many other authors, wrote the clinically orientated Neuropsychotherapy: Theoretical Underpinnings and Clinical Applications.

Pieter developed the Mediros USB animations series, which clinicians have found very useful for engaging with their clients and helping them to understand what’s happening in their brains during times of stress and panic; when suffering with OCD or sleep problems or depression. He went on to co-author with clinician Dr Dionne Shnider a manual and series of worksheets to be used with clients, and specifically with these animations.

Pieter worked with Author and Clinician Melisa Kaya to produce a manual and workbook to help carers and teachers working with children experiencing the trauma of bullying.

More recently Pieter had contributed to the work of Author and Clinician Karen Ferry to produce “Benson the Boxer”, a storybook and clinical manual to assist children experiencing grief and loss. This work was about to be released and will be republished, sooner rather than later, along with further titles in the series.

Pieter worked closely with Rita Princi and others applying neuroscience findings to enhance learning and wellness in educational settings.

During the last two years, Pieter worked with the Christian Heritage College to initiate and offer a Graduate Certificate in Neuropsychotherapy, of which the first unit was taught during the last semester of 2017. This is planned to continue with new lecturers during 2018.

Pieter’s latest and last contribution to the field of Neuropsychotherapy was his chapter in volume one of the title Workplace Bullying and Mobbing in the United States, published by Praeger in 2018 (Santa Barbara, California). Pieter wrote chapter 7, Workplace Bullying and Mobbing: A Neuropsychotherapeutic Perspective, pp 151-169. For those who have a keen interest in bullying and how to work with victims using a neuropsychotherapeutic approach, the title is available via Amazon and other good academic book stockists.

Jonathan Wills, Mediros Registration Officer