NEUROPSYCHOTHERAPY

Issue 45 • August-September 2017

In this Edition

Also:

- Certificate training 2017, Hawaii, Sydney, and Melbourne
- Neuropsychotherapy Conference 2018

Welcome

to this Edition of Neuropsychotherapy!

The year is speeding along and we are well on track towards in our planning for 2018 – presentations, research and workshops – and of course the next International Conference of Neuropsychotherapy!

IN THIS EDITION

In this edition, we share fascinating case studies from three esteemed colleagues in applied neuropsychoterapy: Helen Rathore, Stuart Edser and Jo Wilson.

In her essay, Dr Helen Rathore from New Zealand focuses on the applications of neuropsychotherapy and EMDR with a client suffering PTSD; Dr Stuart Edser from Newcastle, NSW focuses on Neuropsychtherapy in the case of a client suffering Specific Phobia Disorder, and Jo Wilson focuses on a neuropsychotherapeutic approach with a client presenting with Anxiety Disorder with comorbid chronic illness.

CERTIFICATE TRAINING

We have three Certificate trainings coming up shortly –

- Melbourne (Royal Melbourne Hospital) 19-22 September 2017
- Sydney (Portside Convention Centre) 3-6 October 2017 and
- Hawaii (Sheraton Princess Kaiulani Hotel, Waikiki Beach, Honolulu) 16-19 October 2017

The Melbourne venue is almost booked out but there are spots available for Sydney and Hawaii.

In 2018 there will be only two certificate trainings –

- Brisbane 11-14 September 2018; and
- Melbourne 30 October – 2 November

We plan another certificate training in Auckland (New Zealand) early in 2019.

INTERNATIONAL CONFERENCE OF NEUROPSYCHOTHERAPY 2018

After the hugely successful first International Conference of Neuropsychotherapy, Brisbane May 2017, there is a buzz of excitement for the 2018 Conference.

The speakers list for 2018 is almost fully booked and almost 50% of the conference spots are already booked out. Don't miss the opportunity to attend at the lovely, newly built Melbourne Brain Centre and Melbourne Education Centre – 22-25 May 2018. There will be 70+ speakers, 3 pre conference workshops on the neuroscience of resilience and practical resilience measurement tool, the brain and aggressive behaviors and domestic violence, and treatment of bulimia nervosa and binge eating disorder. In addition to the pre-conference workshops, there will be thirty six interactive mini-workshops and many research papers and applied neuroscience presentations.

Registration are open at **www.neuroconference.net**

We look forward to seeing you at the conference!

IACN MEMBERSHIP

Many of you are also members of the International Association of Clinical Neuropsychotherapy (IACN).

Membership fees are very low and we are developing significant incentives for members. However, to sustain our functionality we urge members to ensure their (very small) annual membership fee is paid. We offer many services free of cost (like this e-Journal) but this takes considerable time and effort to develop and prepare. Your contribution by maintaining your IACN membership helps makes these products possible. Thank you so much for your ongoing support.

INTERNATIONAL JOURNAL OF NEUROPSYCHOTHERAPY

Our research/scientific "family member" in neuropsychotherapy – the International Journal of Neuropsychtherapy – is almost ready. The next edition will be available online soon and we will do a mailout to everyone when you may download this edition (open access).

Enjoy the read!

Pieter Rossouw

FROM THE IACN SECRETARY,

Jonathan Wills

IACN International Association of Clinical Neuropsychotherapy

INAUGURAL CONFERENCE OF NEUROPSYCHOTHERAPY

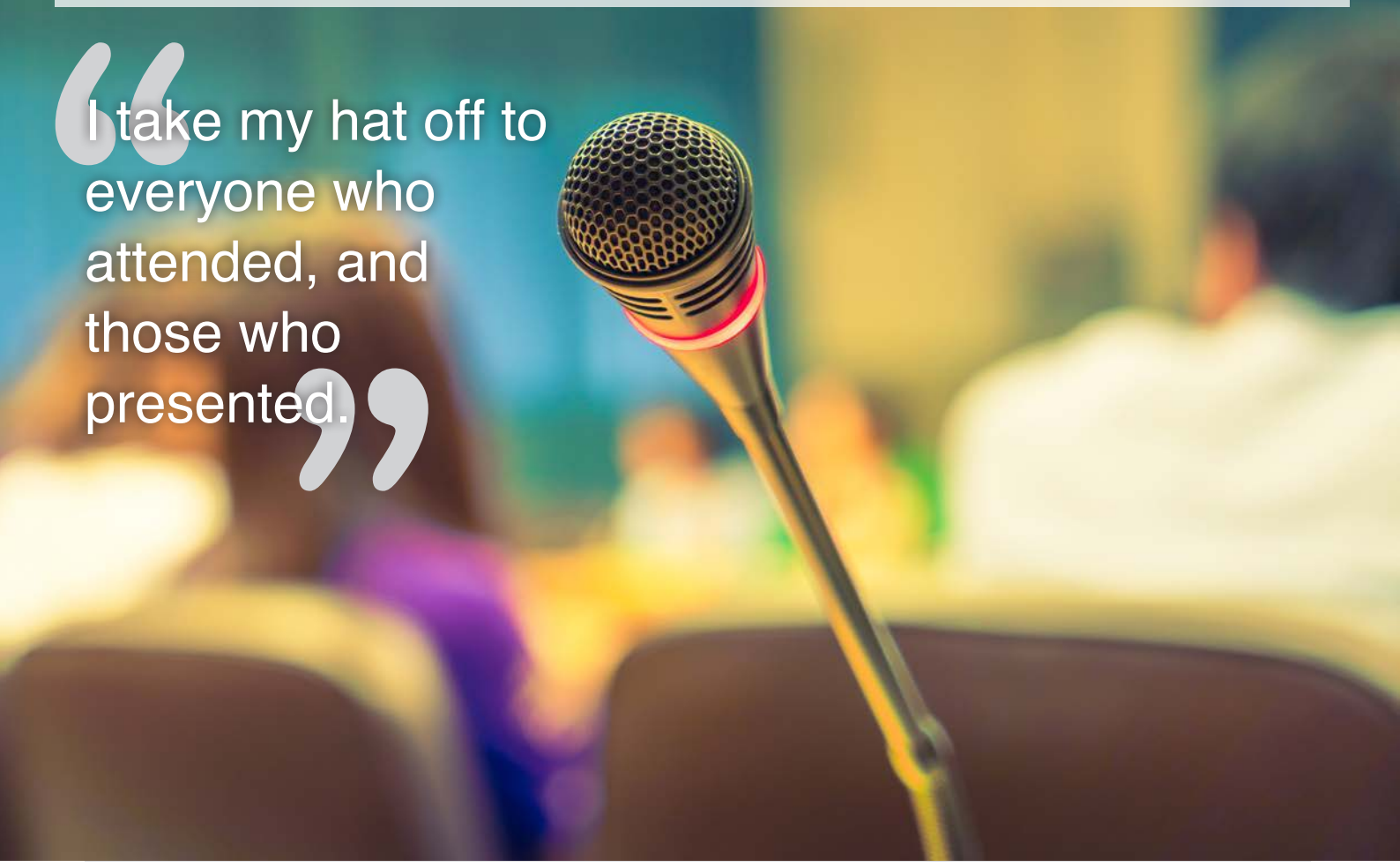
Dear Mediros eJournal readers and IACN members – what can I say? Like Professor Rossouw and the rest of the IACN/Mediros team, I was overwhelmed with the professionalism and sincere and passionate participation during the first Conference of Neuropsychotherapy! I was kept so busy with selling resources, answering queries, catching up with old friends and meeting new ones, that on at least one day my lunch blended into afternoon tea, blended into early dinner! I take my hat off to everyone who attended, and those who presented. And I am so grateful for all your outstanding contributions to strengthening the neuropsychotherapy modality and I marvel at how neuropsychotherapy can be adopted within such an eclectic range of traditional therapeutic approaches. I believe the conference was a resounding success, and I'm not just saying that because I was part of the organising team! I'm reflecting the vast majority of positive feedback which was received, not just face-to-face during the conference, but also from glancing at the summary raw data of the online feedback. So, thank you everyone for making it such a fulfilling and rewarding event. Onward and upward (well southward anyway) for Melbourne in 2018!

In the next issue, I will write more about operationalising the IACN Interest Groups for everyone who has expressed an interest in them.

And finally, many thanks to everyone who responded to the IACN President's call to volunteer with the work of the IACN. I'm sure Prof Rossouw will be in touch with all of your soon, if he hasn't already!

Until next issue – keep safe and warm regards!

Jonathan



WORKING WITH 10 YEAR OLD SEAN, SUFFERING PTSD

Dr Helen Rathore

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HCPC Registered Practitioner Psychologist, NZ registered Clinical Psychologist

EMDR Practitioner

Helen commenced her training by completing her certificate in Humanistic Counselling in 1993. She then worked in a variety of modalities up to 1998, and has practiced in psychology in mental health clinical settings since 1998. Helen also added Mindfulness as an approach to her clinical practice in 1998, and began using this modality when working with clients in 2001. Helen's special interest is in understanding and working with clients with complex stress, distress, trauma, and presentations of dissociation across the life span – within all diagnostic categories. She also has a particular interest in child, adolescent, and family work, stabilisation and resourcing work, and supervision. Her professional practice has developed through a lifelong client-focused approach, and as a newly qualified clinical psychologist, she initially struggled to help clients with complex psychological presentations. Helen now feels her experience and skills set, to which neuropsychotherapy is a recent addition, provide her with a wide range of ideas drawn from different modalities, about how to provide the best therapeutic approach for each client she works with.

Referral

My client was a family referred by their General Practitioner after their 10 year old son, Sean*, was found by his mother in the garage with a rope around his neck, expressing an intent to kill himself, on two separate occasions. The GP referral described Sean as withdrawn/reclusive, with aggressive and violent behaviour towards his mother, as well as being impulsive, highly distractible and having trouble concentrating and sitting still. The explosive outbursts come out of nowhere, over anything, and occurred at home and in public.

Introduction

Sean attended the first session with his mother and maternal grandmother. His mother was very tearful, and reported feeling exhausted, overwhelmed, hopeless, and powerless, and the maternal grandmother was angry and feeling rather punitive towards Sean. His behaviour was reported to have been shown, in a less severe form, for many years, but since the death of a young relative (by hanging) the behaviour had become intensely disruptive in all areas of his life, Sean being unable to tolerate any stressor no matter how small, and becoming increasingly violent, impulsive, and unmanageable.

Sean was initially unable to sit still, or make eye contact; he was jumping about on the chair and fiddling with his cap. Once he had heard that the session was not about blaming him or making him feel bad, and he could listen or not, join in or not, and use the available creative materials if he wished, he settled very well, was able to sit still without a problem, amuse himself, and take part at times. Towards the end of the session he started to explore the room reasonably appropriately. Sean then sought comfort in the form of a cuddle from his mother, which was given. My interpretation of providing a safe space for him to express his feelings was that now he was feeling calmer and safer (with the re-established smart brain operating), and he was feeling some shame and guilt about the earlier explosive outbursts (before the session) and wanted to make sure his mother (attachment figure) was still accessible and to repair any damage.

Sean lives with his mother and twelve year old sister. His parents separated acrimoniously two years ago after some years of domestic violence, some of which was witnessed by Sean. Both children spend alternate weekends with their Dad, who has a strict manner, but a much more relaxed, no rules parenting style, compared to his mother. The children have to negotiate this change of rules every fortnight, and the mother reports they go crazy when they come back to her after a weekend at Dad's. At this time she experiences Sean as violent and oppositional and finds it impossible to control his behaviour. His sleep is very poor, he is awake most of the night and when he does sleep he has nightmares and screams. It was reported that the paternal grandfather died by hanging many years ago and that Sean's father has a very poor relationship with his own family. Sean's teenage relative and good friend had taken his own life (by hanging) nine months earlier.

His mother, Alice appeared very anxious and described herself as walking on egg shells around Sean, having lost all her confidence, and at the end of her tether. She had not been anxious prior to the domestic violence. There was no stability, or consistency in the home, and all relationships were deteriorating rapidly, across home, socially, and school.

Sean was reported to be struggling a bit at school, and even though he has some school friends, currently he is not being invited to any social gatherings because of the severity of his behaviour. He has a reasonably good relationship with his mother, but it is currently under strain, because of his behaviour. Sean has limited awareness of what is bothering him, and seems to respond behaviourally to internal neurobiological dysfunction. He appears rather young for his age, lacks confidence and is very reliant on his mother.

The goal for Alice was to be a "fun mum", Sean struggled to verbalise a goal, but wanted to be in trouble less. They both rated home life as one out of 10. Sean rated his mood as five out of 10. Alice rated her anxiety as 10 out of 10.

Diagnosis

The diagnosis which I believe is most appropriate for Sean is Post Traumatic Stress Disorder (PTSD [APA, 2013]) based on his presentation and history. Attention Deficit and Hyperactivity Disorder (ADHD) was not considered appropriate given the history of domestic violence and emotional loss and trauma due to experience of his friend's recent suicide. The impulsivity, violence, and agitation exhibited by Sean were seen as being PTSD related rather than ADHD related. Sean doesn't appear to show low mood or depression, but I hypothesised that he was experiencing significant shame and guilt.

Formulation

Sean's main carer is his mother, Alice. He has experienced a number of violent incidents between his parents, and has witnessed his mother become more anxious and subservient to his father. This has likely impacted on his sense of safety, activated some trauma responses, and negatively impacted on his ability to self-regulate his anxious affect and downregulate his physiological responses. He appears to have an anxious attachment pattern with caregivers. Sean was already exhibiting some increasingly dysregulated behaviours, and when his relative and good friend died by suicide this totally overwhelmed his coping capacity, and he began having overwhelming outbursts, became violent and aggressive on occasions, and on at least one occasion expressed intent to kill himself. He was blamed for his behaviour by his family which was seen as him being "naughty" and "bad". This lead to him feeling shame, and guilt about the behaviour, losing confidence, losing his support networks and his access to comforting and appropriately regulating adults, undermined his relationships, impoverished his environment, and left him in a lot of trouble all the time. This exacerbated the problem, which further undermined his confidence and his mother's confidence, and annoyed the rest of the family.

Neuropsychotherapy Aspects

"Psychopathology of all kinds – from the mildest neurotic symptom to the most severe psychosis – must be represented within and among neural networks… [therefore]… psychopathology would be a reflection of suboptimal development, integration, and co-ordination of neural networks" (Cozolino, 2010). According to Shapiro (2001) present symptoms are manifestations of past experiences coded implicitly in the brain. The implicit coding transpired either because the experiences occurred prior to the development of brain structures capable of moving information into explicit autobiographical memory, or because trauma and its accompanying dysregulated arousal inhibited the appropriate functioning of brain structures" (Cozolino, 2010; Siegel, 1999; Van der Kolk, 1996; in Gomez, 2013).

It is hypothesised that Sean may have a genetic inheritance vulnerability because two of his close family members have also died by suicide. This, in conjunction with his early safety experience being impacted by domestic violence, together with the fear and anxiety expressed by his main carer (Alice), significantly diminished his felt sense of safety (Rossouw, 2014). There were some enriching environmental factors (Rossouw, 2017) including his good relationship with his mother, some relationships at school, and some friends, but also many compromised environmental triggers (family violence, impulsivity, compromised relationships, fear of father, lack of stability and routine in daily life, suicide of relative, etc.). The feedback from these environmental factors was positive in some aspects (attachment, protective up to a point), but increasingly becoming predominantly negative. This resulted in Sean's brain stem and limbic system becoming dysregulated, and his SMART brain functioning being compromised. His mother's anxiety also likely exacerbated this dysregulation and would have inhibited Sean being able to learn appropriate self-regulation skills from his main carers, and in his carers being unable to provide appropriate regulating support and activities.

Sean developed an increasingly avoidant approach to life, and avoidance neural networks developed, to the point where the emotional impact of suicide by his relative overloaded his, and his families, capacity to regulate his emotional responses. This would explain his presentation of fear driven impulsive acts, explosive violent outbursts, and inability to tolerate any consequences for his actions. His coping strategies were focused on escape. The mirror neuron system together with his empathic response to the loss of his friend may account in part for emulating the suicidal actions (mirroring his relative who he was very attached

to, and who may have been a major coping resource and role model for him), and for his violent behaviour (mirroring his Dad). Sean was not mirroring his mother's anxious submissive behaviour, but his powerful and violent father's behaviour. The incidents with the rope around his neck may also have reflected his feelings of shame and guilt about his behaviour and the impact it had on his relationships with his family, leading to periods of low mood, and anxiety about the future. My concern was, could these attachment ruptures be repaired and could Sean see himself and be seen by others, as good enough, despite his behaviours?.

At the time of referral his need for attachment was compromised with the wider family being angry and fed up with him. His main carer and attachment figure was exhausted, anxious and fed up. This would increase his survival based fears. He had a lot of attention in the family and every one was walking on egg shells around him, but this was not comforting or containing, but terrifying for him. He felt as though he was in charge, but had no idea what to do, or how to comfort himself, which would also have increased his survival based fears. His experience of the world was predominantly one of emotional pain, with very little, or no pleasure. This would increase his survival based fears and his avoidance behaviours. All together these would make it more likely he would behave impulsively and display violent, angry outbursts, and low tolerance for any stressors.

This would have impacted negatively on his sense of self, of being OK or good enough, which would also contribute to his experimenting with the idea of suicide, feelings of hopelessness, and possibly worrying thoughts that life wasn't living, or he didn't deserve to live.

Sean was young, the difficulties had been around for some years, the experiences were intense, and involved people very close to him, so difficulties were stronger than if they had been of short duration, less intense, and involved people not so close to him.

Therapy Processes

We agreed to complete 10 sessions of psychological therapy and then conduct a review. The initial focus for the first six sessions was on getting the home environment and carer attachment safe, stable, and rewarding in order to reduce dysregulation, impulsive behaviours, violence, and risk of suicide and self-harm. This involved initially working with Sean on actions that help children to self-regulate, such as safe place, reinforced using Eye Movement Desensitisation & Reprocessing (EMDR) therapy (Gomez, 2013). However, Sean had trouble engaging well in therapy. We then tried some direct breathing exercises as a prelude to mindfulness, but Sean did not engage with them either and was not keen to practice them. He expressed that he did not really want to attend sessions. The focus therefore shifted to working with Sean's mother, Alice, and helping her understand how to engage Sean in self-regulating techniques at home. This involved some psycho-neuro-bio education about the three brain systems, how positive and negative networks work and are reinforced, how the brain works, what causes dysregulation, what happens when the fear system is activated, how the brain builds networks, and how this helps us build positive networks that help us to be calm, and happy. This information was applied to Sean and Alice's experiences at home, so that Alice could understand what was happening, and why this would be helpful. Alice was motivated to proceed with therapy, and was a great co-therapist.

I worked with Alice on understanding the purpose of using games and activities to activate the brain in healthy ways. We used several games to promote fun, joy, relationship building, motivation, and brain stem and limbic system self-regulation, and positive neural networks through an enriched environment. Part of the idea was to regulate the limbic system through tiny moments of pause and conscious breath, but also to activate both sides of the brain, increase activation of

the hippocampus, and the neo-cortex, to slow things down, to introduce a focus on breath as a window to the regulation of the sympathetic and parasympathetic nervous system, and build new positive networks in the brain. The games included, but were not limited to: the Maori stick game, which utilises cross body movements to switch both sides of the brain on, attunement between the mother and son playing the game with eye contact, mirroring, turn taking, non-verbal communication, and relationship building. We also used "Simon Says"; freeze dancing; throwing a ball hand to hand, or between people; running as fast as possible and then slowing right down to run as slowly as possible and other games into which we incorporated a fast-slow component which involved slowing everything down for a second to start with, and gradually increasing the slow down time. These were intended to be fun as a way to encourage dopamine release from new brain networks, as well as attachment relationship building, therapeutic, and encouraging limbic system regulation.

The family reported that this process was extremely helpful, and at the most recent session both Alice and Sean rated home life as nine or 10 out of 10. School was six out of 10. Things had also visibly improved in the therapy room. Sean's demonstrated behaviour was no longer aggressively demanding towards his mother, involving pulling, careless kicking and hitting as he moved around her, but was much more mindful and thoughtful. He was also calmer in the therapy room. There were many examples of times that had gone well, and shared happy times. Alice now felt able to support Sean in his nascent developing independence by going to the park with his friends, and able to take him to family events and on holiday. His mother and I had planned for the first anniversary of the relative's death with increased parental awareness around stressors and symptoms of anxiety, subtle monitoring, increased support and opportunities to talk, and involving Sean in choices about what ceremonies and anniversary events to attend and how long for, and the family had negotiated that anniversary without any difficulty.

"The family reported that this process was extremely helpful, and at the most recent session both Alice and Sean rated home life as nine or 10 out of 10"

At the most recent session (therapy session six) there had been an incident at school which highlighted Sean's continuing lack of confidence in himself and reliance on others, and also his tendency to follow other more confident children, and to be talked into doing things which he then got into trouble for. I liaised with the school and suggested some ways in which school could support Sean to develop more self-confidence and independence from peers. Now the stabilising work is completed, the focus of therapy is moving to more confidence building work, and internal resource building from session seven onwards. This will incorporate a number of activities, experiential exercises, early developmental stage reinforcement, and resource building techniques reinforced with EMDR bilateral stimulation (Gomez, 2013). Once that work is complete we will check to see if there are any remaining trauma symptoms that need to be addressed, and if so make a plan for treating those further with EMDR and a neuropsychotherapeutic approach.

Conclusions

The stabilising and resourcing has worked well and there are visible positive differences in Sean's behaviour at home and in the family's quality of life by self-reported examples and ratings. This suggests the formulation is valid and the therapeutic work can proceed according to plan. The next stage is planned to focus on building more self-confidence, self-efficacy, social skills, and age appropriate independence supported by the family, school, and some individual work. It is hoped that this work will impact on school and social relationships in a positive way, and will further increase satisfaction with home and family life.

In the absence of any scans or test data, it is hypothesised that the therapeutic input has enabled Sean's limbic system to become self-regulating, and that the safer and positively enriched environment that focuses on approach strategies rather than avoidance (Rossouw, 2017) have been helpful in building safer relationships, increasing nurturance, increasing perceived and actual support, possibly enabled epigenetic change, and a more positive and robust view of self. There is more work still to do around a positive view of self, and self-confidence. There may, or may not be, specific trauma processing to do. If there are remaining unprocessed traumatic event memories then these will be processed using EMDR.

Outcomes

Tensions in the home have dramatically reduced, and the focus at home is now on relationship building, and building up from the positives, rather than blame and punishment for the negatives. The outcome of the work has been that satisfaction with home life has increased

from one out of 10 to nine or 10 out of 10 so far. As children sometimes give ratings of more than 10 out of 10 it is envisaged that further improvement is still possible. Mood has also improved from an initial rating of five out of 10 to a current rating of nine out of 10. Alice rated her current anxiety as three out of 10.

Reflection

My diagnosis was PTSD because that is what made the most sense to me, and in my opinion was the best fit from a neuropsychotherapy standpoint. It was the most helpful way to construe the symptomology and history in terms of helping the family understand what was happening and why, making a plan for therapy, having hope for positive change and hope for the future. There were alternative diagnoses available, but these were not such a good fit when the history was taken into consideration, in addition to the presentation. An alternative diagnosis may have resulted in a different approach being taken. I was constantly reviewing progress to check for any evidence that my diagnosis was not correct and that the therapy plan needed to be amended or changed completely, such as considering medication, or alternative approaches. I did not feel that there was such evidence at any stage, and consequently continued to follow the original plan, to support the parent to become a "fun mum", to support Sean to become self-regulating through the use of specific games and therapeutic relationship building, using approach skills coaching, and enriching the environment generally. The family were aware of the alternative options, and chose to start with my plan and to continue with it. It has been wonderful to see how they have been able to build and repair relationships, attempt to provide support and therapeutic experiences, and learn new skills and try new strategies. I enjoy this more 'coaching' way of working with clients, because while it does incorporate quite a number of traditional psychological therapy skills (albeit used in a conversational coaching style), it is, in my opinion, more empowering for the families who have a greater sense of having accomplished it themselves (with a little coaching) rather than of having received 'therapy' and the success being due to the therapist's work. Others may disagree, but that's my reflection.

**** Names have been changed and this article has been thoroughly de-identified by also changing relevant personal information and circumstances to prevent the client and others being identified. The article is written for professional development exchange and educational purposes.***

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His Health My Health:
PERSPECTIVES FROM CLINICAL NEUROPSYCHOTHERAPY ON WORKING WITH HEALTH ANXIETY

Dr Stuart Edser

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Stuart is a counselling psychologist in private practice in Newcastle, Australia. He runs a busy generalist practice but has particular interest and expertise in both anxiety disorders and LGBTI issues. In 2012, he published his first book Being Gay Being Christian (Exisle) to widespread interest from all sections of the media and the Christian and gay communities. Stuart has spoken regularly on this topic to church goers and wider society audiences. He is a strong advocate for raising awareness of mental health issues and for greater societal acceptance of LGBTI people and has argued for many years in favour of marriage equality for Australians. He is a writer and blogger, and also works yearly in the Medical Faculty of the University of Newcastle teaching counselling skills and about issues around the interface between homosexuality and clinical practice. He favours an eclectic variety of modalities, including; cognitive therapy, clinical hypnosis, acceptance and commitment therapy, schema focused therapy and clinical neuropsychotherapy.

Introduction

The following case study and formulation of the neuropsychotherapeutic model is based on a real client. Adam is male, caucasian, cisgendred, able-bodied, heterosexual, married and has children. His name has been changed and some details around his presentation have been changed in order to protect his privacy and confidentiality. I saw Adam in my private practice in my capacity as a counselling psychologist. He has presented on four occasions for one hour appointments.

Psychosocial history

Adam is 42 years of age. He is well-presented in his dress and grooming and is polite and well-disposed towards office staff and myself. He and his wife have two small girls aged seven and five. He is full-time employed, working in a responsible management position where he consults on behalf of his company. This involves frequent domestic and international travel where his job requires him to close important and lucrative deals and he needs “to be on top of my game”, in control of his capacities, confident and across all the details of often complex business arrangements.

Presenting problem and precipitating factors

Adam presents with uncontrollable persistent rumination around his health. His father was diagnosed in his early sixties with a degenerative brain condition that, although not of the dementia type, has caused significant vision, motor and balance problems, and Adam has watched the significant stress this has caused his father and his mother as carer. Adam is not able to rid himself of the fear that he will acquire this condition himself. He is terrified on two counts: first, for his own health and quality of life, and secondly, that should he become ill, he will become a burden to his wife and children, as he perceives his father has become for his mother. In his parents, his worst fears for himself have been played out before his eyes in real-life, terrifying family technicolour. Adam fulfills the criteria for the DSM V disorder Specific Phobia - 300.29 (American Psychiatric Association, 2013), the disorder specified by its phobic stimulus. It can therefore be viewed as a health phobia or, from a different frame of reference, an illness phobia.

Controllable and uncontrollable incongruence

Adam reported that he has “tried every trick in the book” to stop the catastrophic thoughts, trying distraction techniques or mantras, but all to no avail. He has been told by his doctors that the condition is not hereditary, but despite these repeated assurances, Adam has ‘badgered’ his doctors to order a battery of tests and scans in order to reassure himself that there is nothing wrong. All these tests have returned negative. But his much-de-

sired reassurance has not manifested. Instead, the tests and scans have further undermined his confidence and have augmented his already busy mind in catastrophising his life and future. However lately, he reports that he has been having some trouble with his eyes and this has caused him to start experiencing panic attacks. In response to this, his doctor has given him a referral to see a neurologist. In the neuropsychotherapy model, *uncontrollable incongruence* occurs when desired (motivated) goals are not met and an individual also feels a lack of control – the result is anxious affect. Where this leads to avoidance motivations, psychopathology can result. *Uncontrollable incongruence* occurs when the need for change becomes manifest but unhealthy or maladaptive default neuronal patterns are activated and subsequently strengthened, which is exactly the case for Adam (Rossouw, 2014). His constant pursuit of reassurance is indicative of his experience of uncontrollable incongruence. There is a conscious need for change – incongruence – but only *controllable incongruence* is desirable – this is when neuronal activation moves from one network to another, e.g., from an A - B firing to an A – C firing, new neural networks are formed through learning new behavioural response to stress.

Symptomatology

Along with persistent rumination and a strong emotional fear response , Adam reports that he is not sleeping well and is experiencing significant initial insomnia. The final straw for him just prior to his first presentation was that his anxiety, stress and panic symptoms were of such severity that he was forced to ring his boss and cancel his involvement in an extremely important business trip to Singapore, where people were flying in from all around the world to complete final arrangements for a large multi-million-dollar deal. Adam told me that he was supposed to be "the main guy in the room" and that he was so upset with his worries about his health, he simply could not go. "I just couldn't function", was his explanation.

He was mortified at his "weakness" over this cancelled trip and has been off work ever since. His anxiety now focuses around any physical sensation that feels a bit different. He is hyper-aware of bumps on his skin, aches, pains, twitches, changes in body temperature and tension. Once aware of a physical sensation, he then moves into a mode of 'catastrophic' attribution and a devastating prognosis for himself, followed by a strong sense of guilt that should he acquire a degenerative brain disease, he will become burdensome to his wife and daughters. Given that self-worth is a higher order factor deriving from adaptive and healthy patterns around attachment, control and minimisation of pain (Rossouw, 2014), it is not surprising that Adam's self-worth has taken a battering as evidenced by his view of himself as being weak, resulting in the Singapore cancellation. It was at that point that he decided he should seek professional help and presented to my Practice.

Genetics and epigenetics

We start with Adam's genetic history and any epigenetic environment that may be pertinent to his case. I regularly teach my clients that we should 'go with the evidence not the feelings' as the old CBT maxim would have it. Adam's doctors have assured and reassured him that his father's condition is not a hereditary one and that from an objective medical point of view, he need not fear that his life will replicate that of his father's. However, clearly, Adam is not able to accept this declaration as a source of evidence and his fear has spiralled into psychopathology.

"He was mortified at his "weakness" over this cancelled trip and has been off work ever since."

> Undoubtedly, Adam has grown up in a family of origin environment in which a high-stakes stress response was the norm to challenging situations ...

While his father's condition may not be the result of a genetic predisposition to future neuropathology, Adam's mother and his maternal grandmother have both struggled with anxiety all their adult lives. It is well-known within the family that Mum and Grandma are "nervy" and "easily upset". Undoubtedly, Adam has grown up in a family of origin environment in which a high-stakes stress response was the norm to challenging situations by his principal female care-givers. For a young child in this situation, whose own neural networks are intensively involved in cell birth, migration and axonal and dendritic arborisation at an exponential rate, learning by copying will ensue. The classical behaviourist model can be applied here, in that, with mirror neurons firing, he would be copying his mother and grandmother in their reactions, and learning by default that a hyper-sensitised amygdala response activating his young hypothalamic pituitary adrenal (HPA) axis is the automatic reaction to challenge or threat. This has resulted in Adam being particularly prone to anxiety conditions. Adam does have a history of Generalised Anxiety Disorder (GAD) (DSM V 300.02) (American Psychiatric Association, 2013), which underlies his health phobia.

Survival and safety

The neuropsychotherapeutic model is based fundamentally around the understanding that the brain is wired for two essential functions: survival and neuronal connection. Part of this inclination to survival is the need for a sense of safety. Both physical and psychological safety are paramount in our day to day engagement with the world (Allison & Rossouw, 2013). They are first order factors. When we feel safe in a situation, our motivation will be to use 'approach' systems that see us engage more with the world and other people. However, when we feel unsafe, our motivation will be to use 'avoidance' systems to disconnect and remove us from the source of the distress. Neuronal connection or 'consistency' is an important process in this regard and strengthens these connections. The Hebbian principle, that 'neurons that fire together wire together', indicates that cognitive patterns, be they positively or negatively valenced, will eventually be strengthened as a result of the repetition of neurons firing off in a single direction, with the added 'gluing' influence of astroglial cells which aggregate around frequently-fired connections creating a neuronal bond. With dopamine release increasing repetition via a sense of completion upon certain behaviours, these connections become part of a larger network which itself gets 'glued' in. The result becomes a default neural loop, which if occurring in a negative pattern, will impair the individual's life.

Avoidance patterns

In the case of Adam, he has developed a very negative anxiety loop where, seeing his father decline physically as well as experiencing memories of his illness (contextualised through his hippocampus), which has activated an amygdala mediated HPA axis response, often sending him into a panic. The visual stimulus or the memory stimulus triggers an immediate set of well-worn anxiety cognitions. These are 'what if thinking', 'catastrophic thinking', 'worst case scenario thinking' and especially 'overthinking'. The resultant distress is debilitating and is causing strong avoidance motivation. It is essential to intervene in this phenomenology to avoid the effects of the 'doing nothing is doing something' principle, i.e., existing anxiogenic networks becoming strengthened and augmented and making them even more resistant to change.

Therapeutic process

SESSION ONE

With Adam's psycho-social history I begin to form some differential diagnoses; not in terms of DSM V categories, but in terms of possible conceptualisations of his presentation, eg., it was clear within five minutes that anxiety was a dominant factor. A first session is very much about two things: establishing a therapeutic alliance where rapport is birthed and develops into trust; and 'joining the dots' for the clinician regarding the phenomenology of the client's presentation. As I listened to Adam's narrative, it became apparent that he was highly agitated and was speaking rapidly. He got his story out in great detail and I asked for clarification occasionally.

It was clear to me that I needed to enter into some psychoeducation of the neuropsychotherapy model with him as I knew it would be helpful. But "first things first" according to best practice neuropsychotherapy training. Adam had to settle enough for me to teach him the model in order to get any benefit from it. In the state he was in, there was little access to his Pre-Frontal Cortex, the so-called Smart Brain, as cortical blood flow and serotonin production are both reduced in the presence of a default anxiety loop, a so-called 2-1 system. In order to down-regulate his stress response, I thus taught him a breathing technique called the *4-7-8* which repeats four cycles of breathing in for four counts, holding the breath for seven and breathing out for eight. This last is a controlled breath and helps slow down the heart rate, while the deep breathing signals the brain to relax the stress system. Over the course of the session, I also spoke with Adam in a very gentle soothing voice, smiling regularly and sitting forward on my chair to decrease the distance between us. I also offered him empathic responses regularly to let him know that I was 'on his side'. With the combination of these techniques, Adam did indeed calm down and his speech slowed. I offered him reassurance that together we would find a way through this and with his PFC more accessible to him, I reiterated the message of the doctors and the 'let's go with the evidence not the feelings' approach. He was willing to try this and reported he was keen to learn the 'brain stuff' in the following session.

SESSION TWO

Session two came six days later and Adam was quite agitated, speaking rapidly and prepared to go over the whole saga again in detail. I stopped him and led him in a 4-7-8 breathing technique and slowing my own speech down to 'relaxation induction' speed which I use in clinical hypnosis. After this, I was able to draw a triune brain on the board and take him through the model, explaining the two systems[1]: a 2-1 and a 2-3 system, showing him that he was stuck in a 2-1 default loop that was activating his stress response and causing his anxiety. I was also able to show him that when experiencing this agitated state, cortical blood flow and production of serotonin in his PFC decreased markedly, significantly impeding his ability to think rationally and to make more positive choices in the way he understood his world. Adam followed my psychoeducation well and made some remarks occasionally, and remarked how this was "definitely" what was happening to him. For the remainder of the session, we reviewed strategies for calming down, made a list of them and discussed how using them regularly was vitally important for him if he was to have a break-through.

1 The 2-1 system describes the process where the emotional brain (system 2) and the survival brain (system 1) influence each other potently. The pons and medulla oblongata increase heart rate and change respiration to short shallow breaths, these physical sensations themselves being distressing. This sets up a motivation to avoid. The HPA Axis is activated after an amygdala alert, causing stress hormones to flood the bloodstream and restrict rational thinking in the PFC. The 2-3 system is a description of the process where the emotional brain (system 2) works adaptively with the PFC (system 3), each influencing the other, enabling the individual to thrive and where the motivation is to approach and engage.

SESSION THREE

Session three, a week later, saw me review the previous session briefly and practise some calming techniques. In this session I wanted to look at his relationship to his father and mother, given their lives were so dominant in his thinking. I explained to him the second order parts of the model covering control, attachment and maximising pleasure and minimising pain. He understood these concepts easily and I helped him look at how his parents were coping with his father's condition. It turns out that his mother had developed a routine with his care and was actually coping quite well. Dad himself had adjusted well to the condition, although Adam reported that "he does have good days and bad days". As we discussed, it became apparent that the 'catastrophic thinking' that Adam had engaged in about his parents, was not in fact, the reality of their lives. They were getting on with things and continuing to live life and cope with his father's condition the best they could. Although I felt that Adam's attachment style was basically secure, I was aware there may have at least been some attachment vulnerability (Mikulincer & Shaver, 2007) due to his childhood exposure to his mother's anxiety, perhaps 'priming' him to feel uncertain around her and to more readily predict, falsely as it turns out, her inability to cope with her husband's condition.

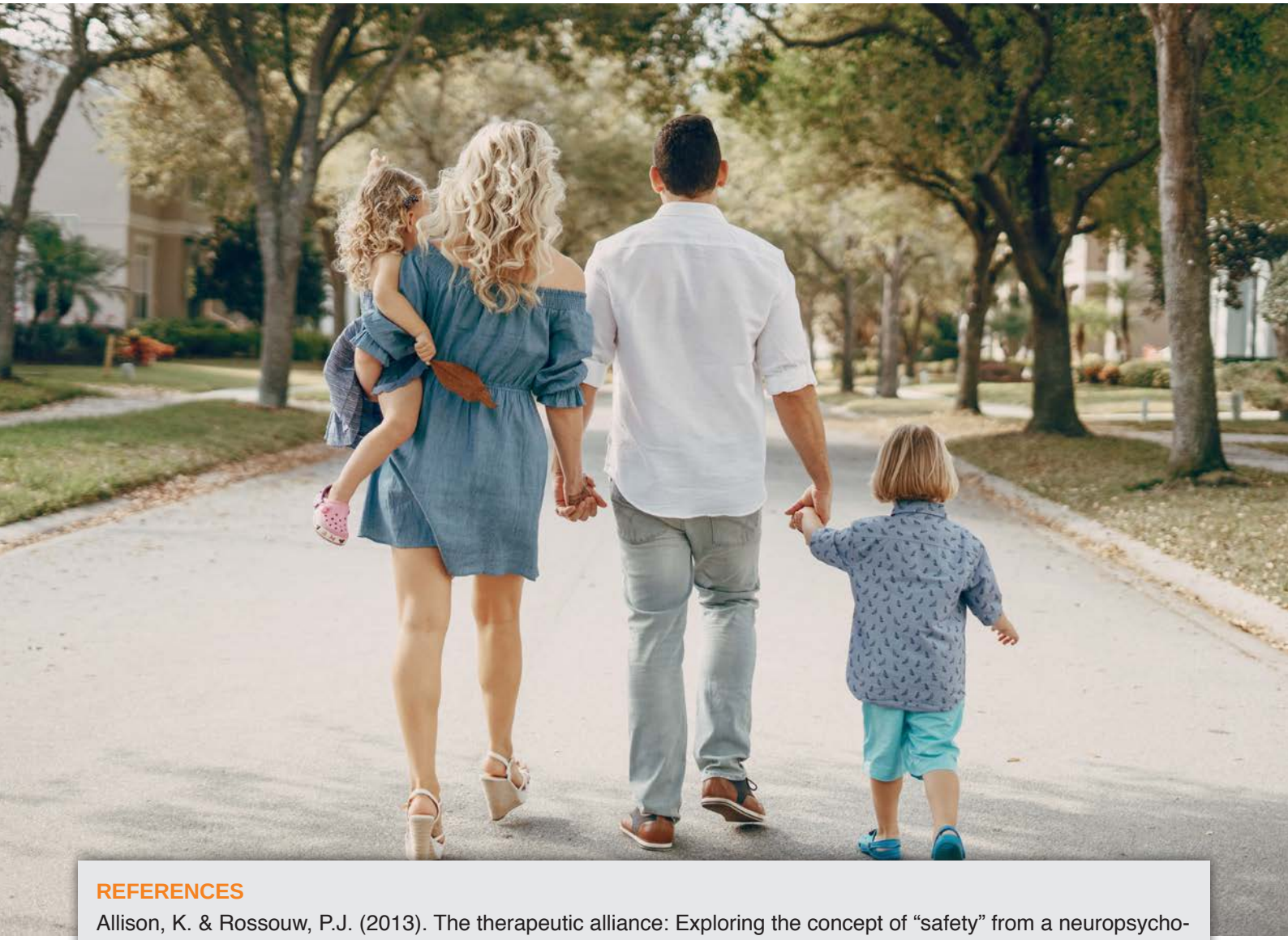
SESSION FOUR

The awaited break-through came in session four. Adam presented feeling calmer, his speech at a normal pace and more able to engage with some cognitive work that I had planned to get to in this and later sessions. He reported that he had been to see a chiropractor a few times to decrease the tension in his body, especially his neck and shoulders; a good sign of resilience, showing vision, reasoning, and collaboration. In this session, I took him through my own 'anxiety 101' psychoeducation, based on some metaphors around the nature of anxiety and how it 'attacks' us. This work is grounded in some CBT and ACT formulations that I have developed for anxiety disorders over many years. Doing some mind-

fulness training in the session, based on hearing and breathing to begin with, Adam started to feel better. His body relaxed while he was talking and he asked me what I thought about his coming neurologist appointment which had been brought forward from about four months away to two weeks away. He was unsure whether to attend it or not, given that he was feeling better, but also for the fact that the earlier appointment coincided with the time he and his wife were having another baby. He reported feeling less anxious and stated that he wanted to engage the whole birth event happily. This was the first sign of a healthy pattern of approach. We discussed the pros and cons, and his use of rational thinking was very evident as he pondered which way to decide. The end of the session saw Adam smiling for the first time in my presence and not looking harrowed. He stated he would like to return after the birth of the baby.

Conclusion

Adam has begun to see that his catastrophic thinking is both harmful and baseless. The neuropsychotherapy model enabled him to see what was happening in his brain and what he had to do to change those patterns. With the addition of some cognitive work at the right time as well as some behavioural adjustment, he has made an excellent start. His calming techniques will need to be reinforced and stress management will have to be a routine part of his life. The neuropsychotherapy model allows us to work with clients on a different level, adding a new dimension that all my clients have found to be fascinating, helpful and motivating. This was certainly true of Adam.



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From *uncontrollable* to controllable incongruence

Belle's story

Joanne Wilson

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Joanne Wilson is a professional relationship counsellor and certified clinical neuro-psychotherapy practitioner, based on the Sunshine Coast.

With caring, compassion and patience, she is acknowledged as a respected counsellor with a balanced career, along-side her commitment to her family and volunteering in her community. Joanne writes a weekly relationship column for the Sunshine Coast Daily newspaper and is regularly heard on local radio as the "in-house expert on relationships". Joanne was the first counsellor in Australia to develop a mobile app designed to support relationship healing between counselling sessions, and has written an eBook, *The Relationship Rejuvenator* which provides succinct information based on her Relationship Seminars.

Joanne's counselling also focusses on clients experiencing, grief, anxiety, and depression and she coaches clients in preparation for marriage. Most of all, she is passionate about launching people to success in their personal and work lives, maintaining a focus on their holistic wellbeing through challenges and maintaining a positive mindset through ill health.

With dedication, she is an avid learner embracing the latest research in her field to ensure the greatest outcomes for clients and advocates, IT IS NEVER TOO LATE TO BEGIN!

Referral

Belle was referred by her ear, nose and throat (ENT) specialist to deal with the "anxiety developed due to an untreatable chronic illness". Belle had just been diagnosed with a chronic inner ear condition which causes her to feel dizzy and off balance most of the time, with bouts of severe nausea lasting for two to three days, caused by motion and acceleration such as car and air travel. During what she refers to as 'attacks', Belle is mostly confined to laying down and sleeping it off as much as possible.

After suffering symptoms for three years following the onset of a common cold, her official diagnosis was provided the month prior to her first consultation with me, being severe damage to the apparatus of her vestibular system in her inner ear, being a form of "Labyrinthitis". Her specialist had suggested she seek my assistance "to adjust with this condition psychologically". She had not received any prior psychological assistance.

Presenting Information

Belle is a 26 year old healthy looking woman whom on first meeting presents as a warm, articulate and poised individual. Aside from this current diagnosis, she takes thyroxine for hypothyroidism. This condition was diagnosed after a miscarriage three months prior to our first session.

Throughout our time together, Belle's ENT specialist was experimenting with medications for conditions similar, but not identical to hers. The first trialled was betahistine and then amitriptyline, which she understood would alleviate headaches.

She is married in what she affirms is a loving relationship having dated for seven years and married one year ago. Whilst this first miscarriage was extremely disappointing, she is more frustrated about not being able to try for children again, whilst she is taking medication and is feeling so unwell.

Belle is close to her family, who live about an hour away by car and can enjoy visiting them if she is in the driver's seat. She feels comfortable travelling to her parents as she knows she can retreat and recuperate if she becomes unwell from the journey.

Belle enjoys her work as a customer service agent. She is extremely organised and receives constant recognition for her good work ethic and was recently awarded a dinner voucher for her hard work.

Current Symptoms

Belle stated she is normally "chilled, but organised and driven" but that at the moment "I am making myself sick with this whole thing."

She experiences frequent anxiety symptoms being a tight sore chest, nausea, the sensation of a heavy pulse, diarrhoea, fidgeting, and sweaty palms. This has led to a sense of hopelessness, frustration, debilitation and frequent crying.

Her most intense bouts of anxiety occurred as a result of fear of travelling and a possible attack of nausea. She is now unable to contemplate flying and struggles to drive the car to visit friends or even manage some chores. Prior to our sessions, her last visit to the hairdresser resulted in vomiting numerous times upon arrival, leaving her feeling embarrassed and frustrated.

History

Belle seems otherwise well-adjusted and has enjoyed the benefit of a supportive enriched up-bringing. Belle's parents have been married over thirty years and are extremely empathetic of her current medical challenges. They appreciate her husband for all the attentiveness and understanding he provides.

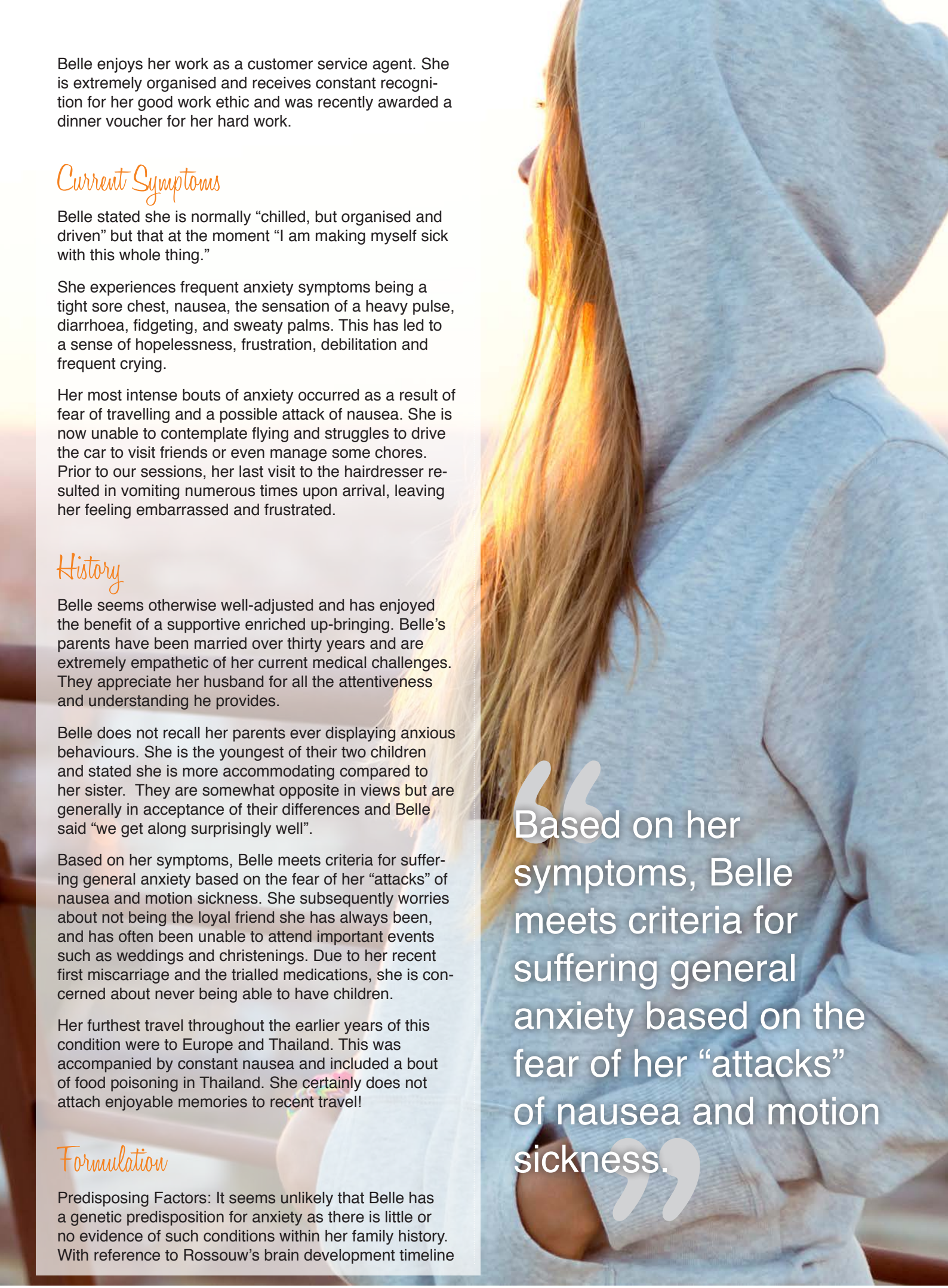
Belle does not recall her parents ever displaying anxious behaviours. She is the youngest of their two children and stated she is more accommodating compared to her sister. They are somewhat opposite in views but are generally in acceptance of their differences and Belle said "we get along surprisingly well".

Based on her symptoms, Belle meets criteria for suffering general anxiety based on the fear of her "attacks" of nausea and motion sickness. She subsequently worries about not being the loyal friend she has always been, and has often been unable to attend important events such as weddings and christenings. Due to her recent first miscarriage and the trialled medications, she is concerned about never being able to have children.

Her furthest travel throughout the earlier years of this condition were to Europe and Thailand. This was accompanied by constant nausea and included a bout of food poisoning in Thailand. She certainly does not attach enjoyable memories to recent travel!

Formulation

Predisposing Factors: It seems unlikely that Belle has a genetic predisposition for anxiety as there is little or no evidence of such conditions within her family history. With reference to Rossouw's brain development timeline



"Based on her symptoms, Belle meets criteria for suffering general anxiety based on the fear of her "attacks" of nausea and motion sickness."

(Rossouw, 2016a) no post birth trauma was evident.

Sociocultural influences mean that Belle feels happy, sad and jealous for her girlfriends of similar age when they become pregnant and start their families.

Precipitating Factors

Belle's current condition has been influenced by trialling medications such as betahistine. Hain (2017) highlights varied conflicting reviews of this medication's side effects such as stomach upset, worsening asthma, headache and chest tightness which is worthy of noting.

Amitriptyline was then prescribed and replaced betahistine to compare her level of wellness. She reported feeling better on betahistine. Possible amitriptyline side effects include; drowsiness, dizziness, dry mouth, blurred vision, constipation and weight gain (WebMD, 2017). Belle has increased weight by 11 kilograms whilst she has been feeling so frequently unwell, and this may be attributed to the medication and reduction in exercise. She also snacks a lot to alleviate nausea.

Perpetuating Factors

Possible grief from the miscarriage three months prior intertwined with the myriad of emotions attached to Belle's condition could not be ignored.

Furthermore, Belle had engaged in active avoidance of motion caused by any type of travel. This has prolonged her frustration and sadness by not being a good friend or a fun and supportive wife for her husband's personal endeavours, such as sport. She has been unable to travel interstate to be a spectator.

The sense of embarrassment from becoming nauseous and unwell in front of people has become a significant factor. Belle was increasingly socially isolated, apart from being with her husband, parents and two close friends. She prefers to stay at home whenever possible in her special "safe" place - on the couch. This avoidance pattern then exacerbates her symptoms of anxiety and she has become trapped in unhelpful patterns of survival.

Neurobiological Markers

SAFETY

With reference to Rossouw's (2016a) diagram of the Integrated Model of Neuropsychotherapy, there seemed little evidence of a compromised environment or gene expression that influences Belle's current symptoms. If anything, this has been a strength that has provided strong neural growth and thriving brain development that may be attributed to her natural empathetic and driven persona. She presents as a very loyal and trustworthy woman who within healthy boundaries "would do anything for her friends and family".

Stephens & Wand (2012) state there are three main determinants of HPA axis activity which control the amount of cortisol a person is exposed to during adulthood, they include; genetic background, early-life environment, and current life stress. In my opinion, it would seem that current life stress caused by Belle's medical condition is the key influencer.

ATTACHMENT

Belle did feel a little isolated for about a month when her husband was focussed on training for an elite sporting evident. She was unable to enjoy their usual attentive connection from quality time. She experienced feeling "destabilised" in managing her condition alone for a number of weeks whilst his training and competing took his focus away from the relationship. It was interesting to note the importance of this connection that supports her.

CONTROL

Perceived control over her symptoms have been a key determinant of Belle's spiral into disconnection from her otherwise interactive and social lifestyle. Furthermore, her need for orientation has been adversely affected. As Rossouw (2014, p 25) observes orientation "…refers to our ability to form an accurate appraisal of a situation, and to understand what is going on. To gain such clarity about one's situation, and what can be done to improve it, is an important aspect of control". The "baffled" doctors who've been unable to specifically diagnose and treat the condition has also been a major factor. It was imperative that Belle and I focus on achieving "controllable incongruence". As Rossouw (2014 p 25) continues, "…satisfaction of the need for control causes a reduction in distress, which in turn strengthens the sense of control". Because Belle has been trying to achieve consistency in her wellness, her coping strategies have been to withdraw to avoid motion and therefore sickness.

MOTIVATION/PAIN PLEASURE

Despite her significant physical and emotional difficulties, Belle is motivated to retain the normal life she once had, to be a loyal friend, a fun wife and daughter. She is especially keen to get better so she can start a family and places much hope in achieving a purposeful role as a mother. She is more grateful than ever for the healthy life she once had, and driven to maximise that pleasurable existence compared to this distressing period she is experiencing.

"The sense of embarrassment from becoming nauseous and unwell in front of people has become a significant factor."

Belle's motivation during therapy is most impressive. Belle is prepared to do her homework and try varied methods in which to "beat this". She consistently and regularly attends counselling sessions and is determined to get better. She is still under the care of her ENT specialist and her GP and is also trying acupuncture to enhance her chances of fertility.

AVOID/APPROACH PATTERNS

Belle is healthily connected to her husband and family, and would not be expected to develop a neural propensity of avoidance. It is clear however, she currently feels unsafe when not surrounded by them and when unable to control her symptoms when experiencing motion.

She is less likely to experience anxious symptoms or nausea when she's driving to her parents' house or home and she drives with minimal consequence the short distance to work. Most other destinations, which may be further away create a sense of fear, anxiety symptoms, then the nausea. Her main goal was to delineate the difference between the symptoms she is now experiencing from anxiety and the actual illness brought on by motion itself.

Belle's limbic system (thalamus, hypothalamus, amygdala and hippocampus) was in a constant state of activation [an up regulation of the hypothalamus-pituitary-adrenal (HPA) axis (Rossouw, 2014)] in the lead up to precipitating stimuli, including, e.g. travel. Belle's avoidant behaviour indicated she was becoming further entrenched in patterns of disconnection from her environment and trapped in default neural pathways representing "comfort in her discomfort". That is, it is easier for her to stay at home despite knowing social interactions improve her well-being.

Belle's repeated symptoms brought on by motion provide another example of how one single event may activate the HPA axis and her lead to behavioural patterns of avoidance. Research has highlighted that thirty repetitions are required to make changes in the motor cortex, and thirty repetitions over six to eight weeks for new behaviours to be created (Sakmann, 2015, cited in Rossouw, 2016b). Belle had decided to attend our sessions regularly and commit to any strategies we collaborated on with repetition and consistency. We discussed how this decision means her brain has already changed!

THERAPY PROCESS

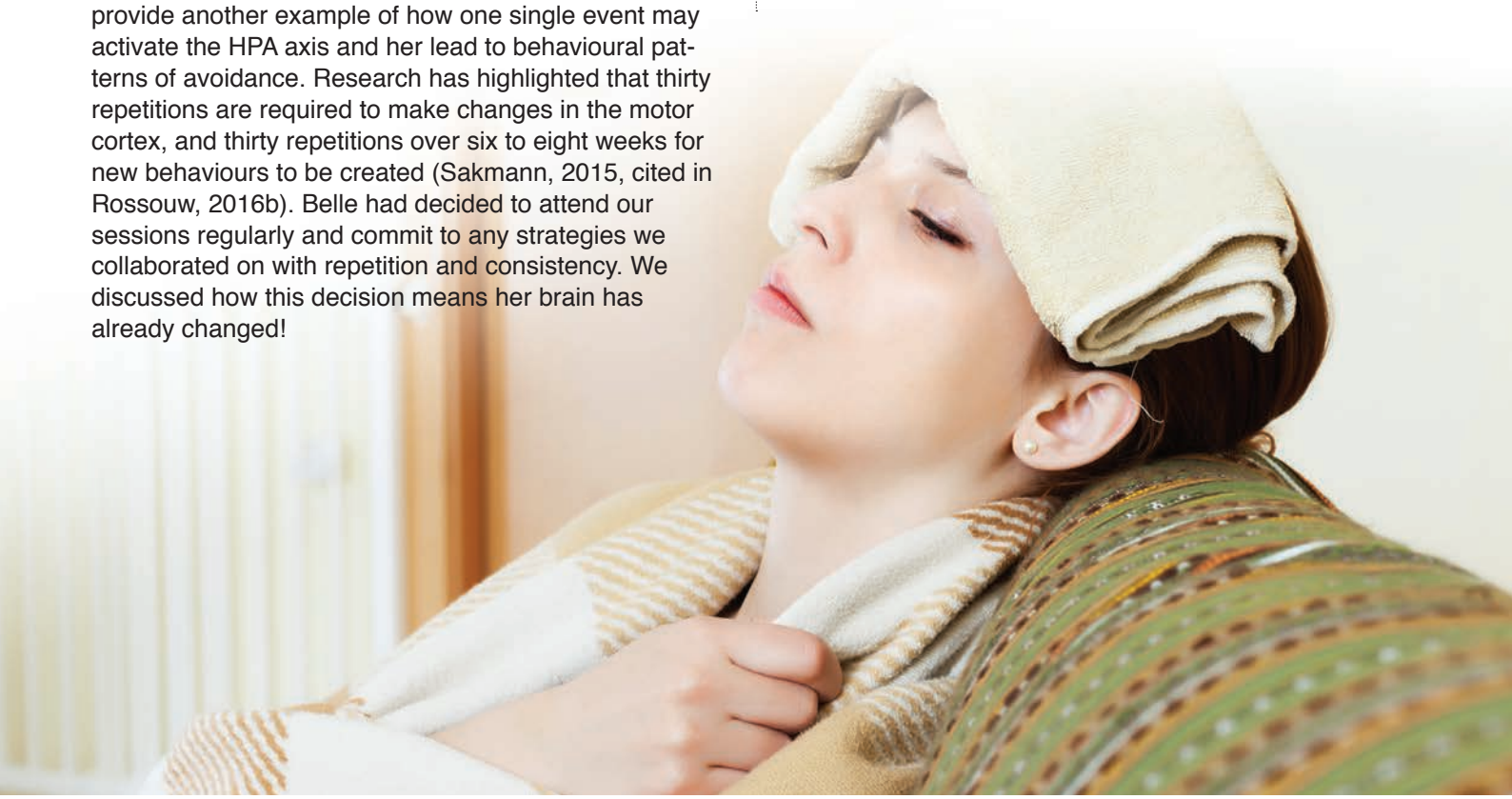
As Belle's "world" was rapidly becoming smaller for fear of the symptoms of her illness, the strong therapeutic alliance that developed was integral to the progression she achieved. Rossouw (2001, p 1) has stated that "Clients need controllable incongruence to facilitate change – this is where a therapeutic relationship becomes a crucial vehicle to establish this shift (controllable incongruence)."

Whilst grief from the miscarriage was not the main focus of our sessions, it felt remiss of me to not ignore this contributing factor to Belle's anxiety. We discussed this unique type of loss that is often considered a helpless, hopeless and lonely grief experience. I introduced Belle to the Kubler-Ross Grief cycle (Kubler-Ross, 1969) of which she could certainly relate.

My treatment plan incorporated Wehrenberg's (2008) Anxiety Management Plan, which commenced with building on a safe and empathetic environment in our sessions (Rossouw, 2016a). She initially reported some double vision and nausea depending upon the intensity of her day at work and the light behind me in the room, however this improved over time as we adjusted the room, and as our sessions progressed.

The concept of controllable congruence as opposed to uncontrollable congruence was highlighted frequently throughout Belle's sessions (Grawe, 2007). In order to reduce Belle's conditioned fear response, we used visualisation from the safety of the therapy room. Being mindful of not progressing too fast, we gradually increased exposure to the point where Belle was able to contemplate other possibilities again in the world.

Belle continues to report a wonderful solid sleep and practises great sleep hygiene. She finds this remarkable as she has always slept well and continues to do so.



She had already cut caffeine out of her diet because she noticed it amplified her "skew whiff" vision. Her overall diet seemed exemplary. Aside from short walks, exercise had stopped. As her sense of wellness improved during the recent month, she signed up to continue her dance classes facilitated by a close friend and went back to gym work.

With reference to Belle's weight gain, the activation of the HPA system from prolonged experience of threat, leads to an over production of stress hormones. Chronically elevated and excessive secretion of stress hormones can result in metabolic disturbances including but not limited to; increased appetite, accelerated muscle breakdown, enhanced fat storage and memory and concentration problems (Rossouw, 2012).

The positive motivation to exercise was not only to lose those 11 kilograms but to achieve the neurochemical benefits of movement and exercise. As Basso & Suzuki (2017) observe, "In addition to activating the HPA axis and a variety of neurotrophins, acute exercise also changes levels of a range of neurotransmitters that have been implicated in both the cognitive as well as mood effects seen with acute exercise. In humans, acute exercise has been shown to increase peripheral levels of monoamines including dopamine, epinephrine, and norepinephrine".

NEURAL LOOPING

Belle thrived on her new knowledge discussed in our earlier sessions around brain physiology. I used a plastic model of the brain and incorporated an explanation of the following Figure 1, to heighten her understanding of her anxiety. She reported feeling a little relieved when discussing the associated emotions and symptoms.

Figure 1. Stress Response (Rossouw, unpublished, 2016a)

I then facilitated a session dedicated to delving deeper into the emotions using "open-board" note taking and reflecting with deep empathy and respect. As a result of sharing these thoughts and emotions, we spent subsequent sessions focussing on unhelpful "morbid" thought processes such as "…just so stuck for the future" and "... bogged down for not being able to do and attend things".

Using insight from Donald Hebb who in 1949 recognised that "neurons that fire together, wire together" (cited in Rossouw, 2013), I incorporated a cognitive behavioural approach. We followed a process to unveil thriving statements to replace those morbid thoughts, such as "I am beating this". Belle and I collaborated on making her nurturing and thriving statements visual in her environment. She recited them during cardio when cortical blood flow increases. Belle set reminders on her phone and wrote them on paper and put them up on her walls. Belle committed to this daily for at least forty days. It was exciting to see subsequent sessions that propelled Belle into thriving versus surviving.

We collaborated on our strategies by naming them -- not dissimilar to an insurance plan to stay a "step ahead" of anxiety. These included daily meditation using an mobile app, mindful breathing; and repetition and consistency of her nurturing and thriving statements. She initiated setting her intention in the evenings for feeling calm and healthy in the morning. We involved her husband in reassuring her with motivating and calming words at night before sleep. Belle loves listening to comedy on podcasts, so we set that as a routine aspect of car travel. She used visualisation by playing with her wedding ring and recalling her beautiful space on the couch when she was feeling uneasy. In summary, her default neural processes now feature a new motivational schema of approach.

CONCLUSION

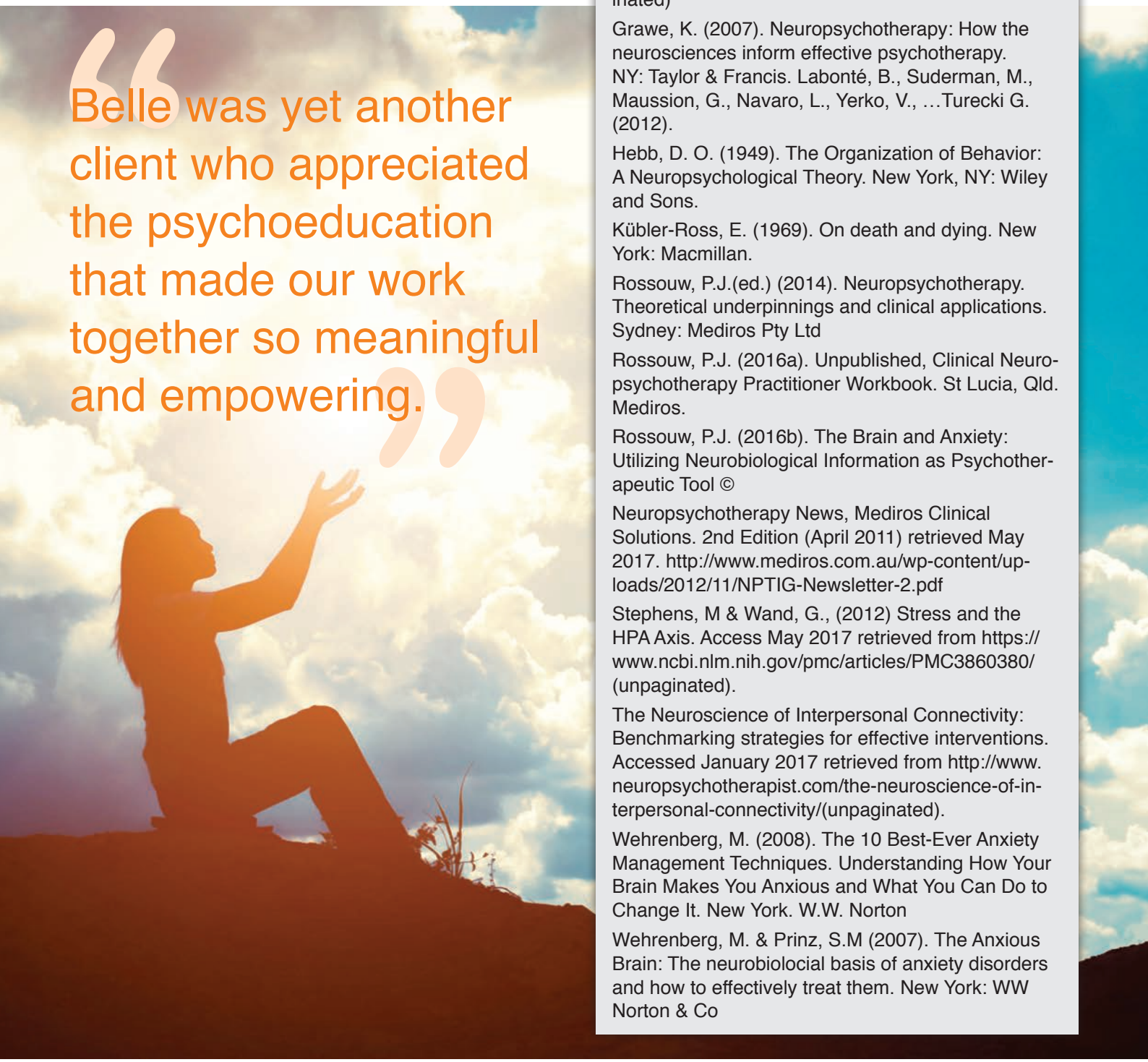
As time progressed, Belle was inherently incorporating the myriad of resources that were proving immensely beneficial. Whilst she knew her efforts weren't infallible, she also couldn't be certain about which of all the tools she was adopting was the main source of her improvement towards wellness (e.g. acupuncture, medication and our therapy). She was extremely pleased with her progression from the previous six months, and so grateful for my journey with her. Her continued frustration about the lack of concrete diagnosis symptoms, as a result of her condition, continues. However, Belle's has developed as part of current lifestyle greater opportunities for learning and achieving controllable incongruence for wellness.

REFLECTION

I am so moved and fulfilled when I have these opportunities to provide a nurturing, therapeutic environment to support clients struggling with such adversity, like Belle. I recognise how through acceptance and patience, this unique and sacred space down-regulates the stress response to increase the level of control, which in turn cultivates hope to move from away from "comfort of discomfort".

I recognise my eagerness to see progression, and so am constantly mindful of not rushing into strategising too early. I acknowledge my skill in rapidly building rapport with a wide range of clientele, however I tend to hasten with the information gathering and ideas. In respect for the client, "…appropriately pacing treatment plays a major role in the establishment of a safe environment…" (Rossouw, 2014, p 59). This will further assist my effectiveness for future client work, ensuring safety is the foundation for this so very effective "bottom up" neuroscientific approach.

Belle was yet another client who appreciated the psychoeducation that made our work together so meaningful and empowering. I am so honoured to journey with people to support, inspire and encourage the full life they deserve using the incredible potential of their brains!



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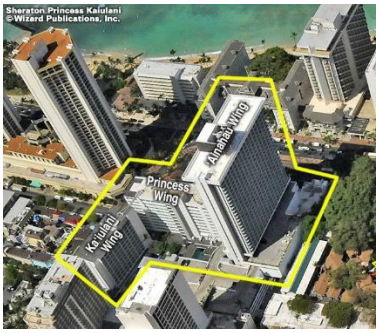
Mail: Mediros (Admin), PO Box 6460, St Lucia, Qld, 4067, Australia

MEDIROS WORKSHOP in HAWAII

Presenter: Prof Pieter Rossouw

Neuropsychotherapy Training – Certificate of Practice – 2017

Workshop attendance – 21 hours (3½ days) Certificate of attendance provided for 21 CPD points



MEDIROS
CLINICAL SOLUTIONS

REGISTRATION AND PAYMENT FORM

Online registration at www.mediros.com.au

NAME: _____Title_____

ADDRESS: _____

PH/MOBILE: _____

E-MAIL: _____

VENUE: **Sheraton Princess Kaiulani Hotel and Resort, Honolulu, Hawaii**

DATE: **16 – 19 October 2017**

FEES EXCLUDE TRAVEL & ACCOMODATION COSTS WHICH ARE THE RESPONSIBILTY OF THE REGISTRANT

	Please Circle	
Early Bird rate (60 days prior)	**AUD $ 1 395.00**	
Standard Rate	**AUD $ 1 495.00**	
Student rate (copy of student card)	**AUD $ 1 350.00**	
Groups (4+ attendees per group, ONE payment)	**AUD $ 1 350.00**	**Please contact admin@mediros.com.au for details**

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Expiry Date: _____ **Three digits on back of card** _____ **Amount: AUD $** _____

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Neuropsychotherapy Certification training, Conference & workshops 2018

MEDIROS CLINICAL SOLUTIONS

Neuropsychotherapy

Recent findings in neuroscience demonstrated the unique contribution of talking therapies to facilitate lasting changes in the brain. Neuropsychotherapy is the "language" used in the interaction between client and clinician in the process of restructuring the brain towards higher levels of functioning and well-being. It uses information from neuroscience to assist clients suffering from a wide range of biological, psychological and social challenges to apply strategies to shift unhelpful response patterns and activate patterns that enhance wellness – the shift from patterns of survival to patterns of thriving.

Certification Training 2018

Certified Clinical Neuropsychotherapy Practitioner Training

Continuing Professional Development Hours –

21 Hours specialised training

Brisbane **11-14 Sept 2018**
Clinical Skills Dev. Service Centre (5th floor)
RBW Hospital, Herston Rd, Brisbane

Melbourne **30 Oct – 2 Nov 2018**
Education Centre, Royal Melbourne Hospital, Grattan Street, Parkville

One-day workshops 2018

Understanding Neurochemicals
Practical Guide for Clinicians

Brisbane **15 Nov 2018**
Clinical Sills Dev Centre (5th floor), RBW Hospital, Herston Rd, Brisbane

Melbourne **31 Aug 2018**
Education Centre, Royal Melbourne Hospital, Grattan Street, Parkville

Sydney **25 Sept 2018**
Portside Conference Centre (5th floor), 207 Kent Street, Sydney

Register online:

e: **admin@mediros.com.au**
t: **07 3217 7266**
f: **07 3294 3220**
Mediros, PO Box 6460, St Lucia, Qld, 4067

www.mediros.com.au

About the Presenter

ADJ. PROF PIETER J. ROSSOUW
MAPS MCCLP MQCA MIACN

Pieter is an Adjunct Professor in Brain-Based Education and research at Central Queensland University. He is also the Director of Mediros and The Neuropsychotherapy Institute – companies that focus on training and research in neurobiology and psychotherapy. To date over 20,000 professionals have attended Pieter's trainings.

Pieter is a member of the Australian Psychological Society and the APS College of Clinical Psychologists. He was a professor in Clinical Psychology in South Africa and the Program Director of the MOC Program at the School of Psychology, University of Queensland (UQ). He also taught at universities in the USA, Holland, China, New Zealand and Canada. He was also the Clinical Director of the St John of God Health Services in Sydney. He is the current president of the International Association of Clinical Neuropsychotherapy.

He has published 10 scientific books and 80 articles and presented over 70 conference papers (many of them keynotes) at international conferences. Pieter's recent books are: *Neuropsychotherapy: Theoretical Underpinnings and Clinical Applications; BrainWise Leadership* (with Connie Henson); *Bullying: Taking Control* (with Melisa Kaya) and *The Predictive 6-Factor Resilience Scale* (with Jurie Rossouw). He received the UQ Dean Faculty of Behavioural Sciences commendation for excellence in teaching and provides global leadership in Neuropsychotherapy.

Pieter is a member of the Global Association for Interpersonal Neurobiology Studies; The Australian Cognitive Neuroscience Society and on the Board of The Neuropsychotherapist. He serves on the editorial board of *The International Journal of Neuropsychotherapy, The Journal of Psychology and Clinical Psychiatry* and *The Journal of Psychiatry and Neuropsychotherapy.*

2nd International Conference of Neuropsychotherapy 2018

23-25 May 2018 Melbourne Brain Centre

24 Continuing Professional Development Hours. Pre-conference workshops (1/2 day each – 3 CPD hours)

21 May 2018

- Treatment of Bulimia Nervosa and Binge Eating Disorder. A neuropsychotherapeutic perspective and practical treatment strategies. (with Dr Roger Mysliwiec) (PM)

22 May 2018

- The Neuroscience of Violence and Aggressive Behaviours (With A/Prof Pieter Rossouw) (AM)
- Wellness and Capacity Development – The Neuroscience of Resilience (with A/Prof Pieter Rossouw) (PM)

80+ Presentations (30+ short, interactive workshops)

Focus streams:

- **Psychopathology**
- **Education**
- **Sport**
- **Expressive therapies**

International speakers

www.neuroconference.net

Registration Form

(you can also register online at www.mediros.com.au)

MEDIROS CLINICAL SOLUTIONS

Certified Clinical Neuropsychotherapy Practitioner Training

Continuing Professional Development Hours 21 Hours specialised training

☐ **Brisbane** **11-14 Sept 2018**

Clinical Skills Dev. Service Centre (5th floor),
RBW Hospital, Herston Rd, Brisbane

☐ **Melbourne** **30 Oct – 2 Nov 2018**

Education Centre, Royal Melbourne Hospital,
Grattan Street, Parkville

Pricing is in Australian dollars

Early Bird Rate (60 days prior)	**AUD $1,395**
Standard Rate	**AUD $1,495**
Student Rate (copy of student card required)	**AUD $1,350**
Groups (4+ attendees per group, one payment)	**AUD $1,350**

One-day workshops 2018

Understanding Neurochemicals Practical Guide for Clinicians

☐ **Brisbane** **15 Nov 2018**

Clinical Sills Dev Centre (5th floor),
RBW Hospital, Herston Rd, Brisbane

☐ **Melbourne** **31 Aug 2018**

Education Centre, Royal Melbourne Hospital
Grattan Street, Parkville

☐ **Sydney** **25 Sept 2018**

Portside Conference Centre (5th floor), 207 Kent Street, Sydney

Pricing is in Australian dollars

Early Bird Rate (60 days prior)	**AUD $435**
Standard Rate	**AUD $495**
Student Rate (copy of student card required)	**AUD $395**
Groups (4+ attendees per group, one payment)	**AUD $395**

Register : www.mediros.com.au

☐ 2nd International Conference of Neuropsychotherapy 2018

24 Continuing Professional Development Hours

Melbourne **23-25 May 2018**

Pre-conference workshops 21 & 22 May 2018 (3 CPD Hours)

☐ 1.Treatment of Bulimia Nervosa & Binge Eating Disorder. A neuropsychotherapeutic perspective and practical treatment strategies.
(Dr Roger Mysliwiec medical specialist, NZ) 21 May (PM)

☐ 2.The Neuroscience of Violence & Aggressive Behaviours (A/Prof Pieter Rossouw) 22 May (AM)

☐ 3.Wellness & Capacity Building - The Neuroscience of Resilience (A/Prof Pieter Rossouw) 22 May (PM)

Main Auditorium **Melbourne Brain Centre,** and **Royal Melbourne Hospital**, Royal Parade/Grattan Street, Parkville, Melbourne, Australia

Focus streams:

- **Psychopathology**
- **Education**
- **Sport**
- **Expressive therapies**

Pricing Conference

	Conf (C)	Pre-conf Eating Dis (E)	Pre-conf Violence (V)	Pre-conf Resilience (R)	Totals (E+C+V+R)
Early Bird	$890	$240	$240	$240	$1490
Standard	$950	$280	$280	$280	$1660
Student	$880	$220	$220	$220	$1410
Group 5+	$825	$210	$210	$210	$1350

All correspondence (workshops & conference)

Mail: Mediros (Admin),PO Box 6460,
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Fax: +61 (0)7 32943220 **www.mediros.com.au**

Please select ☑ training/workshops from above

Title, Name & Surname: _____

_____

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Mobile Number: _____

Phone Number: (+) ( ) _____

Email: _____

TOTAL AMOUNT: _____

PAYMENT OPTIONS

☐ **CREDIT CARD** (Visa or Mastercard Only)

Card Number: _____

Expiry Date: _____ **Three digits on back of card:** _____

Name on Card: _____

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Registration Form

INFORMATION and Online registration available at **www.neuroconference.net**

International Conference of Neuropsychotherapy

Melbourne 2018 - Melbourne Brain Centre and Royal Melbourne Hospital

Int Conference of Neuropsychotherapy: 23-25 May 2018 – 3-day Conference: 24 CPD Points

Pre-Conference *Half Day Workshops – 3-hours each - 3 CPD Points each

***Bulimia Nervosa & Binge Eating Disorder - Dr Roger Mysliwiec – 21 May 2018 – Afternoon Session**
***Neuroscience of Violence & Aggressive behaviours - Adj/Prof Pieter Rossouw – 22 May 2018 – Morning Session**
***The Neuroscience of Resilience - Adj/Prof Pieter Rossouw – 22 May 2018 – Afternoon Session**

Title, Name and Surname: _____

Mobile Phone: _____

Address: _____

_____ Postal Code _____

Email address: _____

PRICING IS IN AUSTRALIAN DOLLARS

Rate	Conference ONLY (C)	Pre-Conf Workshop Eating Disorders (E)	Pre-Conf Workshop Neuroscience of Violence (V)	Pre-Conf Workshop Neuroscience of Resilience (R)	Conference & Pre-Conf Workshops Package (C+E+V-R)
Early bird	$ 890 ☐	$ 240 ☐	$ 240 ☐	$ 240 ☐	$ 1,490 ☐
Standard	$ 950 ☐	$ 280 ☐	$ 280 ☐	$ 280 ☐	$ 1,660 ☐
Student	$ 880 ☐	$ 220 ☐	$ 220 ☐	$ 220 ☐	$ 1,410 ☐
Group 5+	$ 825 ☐	$ 210 ☐	$ 210 ☐	$ 210 ☐	$ 1,350 ☐

TOTAL Amount AUD $ _____

Payment Options: ☐ **Pay now – Please complete Details below** ☐ **Send me an Invoice**

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Card Number: _____ Expiry Date: _____

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Online Registration and Information: www.neuroconference.net Ph +61 (0) 7 3217 7266

Full Day VR Workshop

Virtual Reality Exposure Therapy (VRET)

Virtual Reality Exposure Therapy (VRET) is an exciting and effective tool for the treatment of specific phobias, post-traumatic stress disorder, body dysmorphia, panic disorder, and many other mental conditions.

Learn exactly how it works, why it's so effective, and where you can find it to enhance your practice with this 6 CPD hands-on workshop.

Topics Covered

- ✓ **What is Virtual Reality (VR), Augmented Reality (AR), and Mixed Reality (MR)**
- ✓ **Why is Virtual Reality Exposure Therapy (VRET) so useful**
- ✓ **A review of the 25+ years of evidence on effectiveness of VRET**
- ✓ **Insight from hundreds VRET client sessions with interesting and unique case studies**
- ✓ **Practical demonstrations of different VR and AR platforms, including Apple's ARkit, HTC Vive, Oculus Rift, Samsung GearVR, and Google Cardboard**
- ✓ **Summary and review of currently available VRET applications across different platforms**
- ✓ **Q&A and technical questions answered**

Presented by: Pieter Rossouw, Director of Sydney Phobia Clinic
Pieter (jnr) is the Director of Operations at the Sydney Phobia Clinic and holds a Bachelor of Psychology (Honours) from UNSW. Pieter is also the Founder of Totem Labs, a specialist technology company that builds Virtual Reality solutions for health and performance.

Cost: $364
Date: Friday, 6 October 2017
Location: Sydney

To reserve your place, contact us at
info@ipaphobiaclinics.com
or visit:
www.ipaphobiaclinics.com/training

IPA INTERNATIONAL PHOBIA ASSOCIATION

SPC SYDNEY PHOBIA CLINIC

One day workshop to become a **Certified Resilience Coach**

REGISTER NOW

Gain access to a ground-breaking program based on neuroscience to **assess and build resilience capacity**. This training enables you to integrate automation into your practice to dramatically enhance your services and the difference you can make to the lives of your clients.

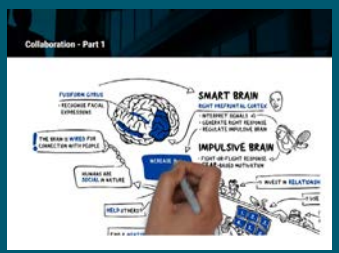
TRAINING **OUTCOMES**

Following this fast-paced and interactive workshop, you will be able to:

- Apply the **Predictive 6 Factor Resilience Scale** to quickly measure resilience
- Apply the **ResiCoach Resilience Development Course**
- Discuss the **neuroscience** of resilience
- Access an **online system** to manage participants, assess and provide training
- Have access to hard copy and online **training materials** and videos for resilience training
- Be registered as a **Certified Resilience Coach**

INSTANT REPORTS

INTERACTIVE TRAINING



VISUAL RESULTS

IN-DEPTH RESOURCES

UPCOMING **WORKSHOPS**

Brisbane	- 9 February 2018
Sydney	- 11 May 2018
Auckland, NZ	- 24 August 2018

Hosted by - **Jurie Rossouw**

Workshop Fee - AU$1050 incl GST

Includes - Attendance fee, online system access, hard copy materials, online resources, 10 PR6 measurement uses.

Register online at resicoach.com

Contact us for a demonstration and further information - **info@rforce.com.au**