NEUROPSYCHOTHERAPY

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In this Edition - Neuroscience play-based tool for children
FROM THE EDITOR
Welcome to this edition of Neuropsychotherapy.

Neuroscience, Puppets and managing trauma

In this edition we publish the scientific section of an exciting project – developing a neuroscience play-based tool to guide young people who have been exposed to traumatic experiences. The tool (using hand puppets) to address the emotional aftermath of trauma, is an important and safe medium to guide sufferers of trauma towards healing. We are working to make the tool available for clinicians in the coming months. It will consist of a manual to guide clinicians to effective use the tool, as well as a series of hand puppets to assemble and use in semi-structured play therapy.

Bullying tool

**Bullying: Taking Control** is completed and hot off the press. The workbooks (comic strip based book) explain the effects of bullying on our brains as well as guiding students to manage bullying and take back control, when this fundamental human need is violated. The workbooks are accompanied by a clinician’s manual examining the neuroscience of bullying, the effects of bullying on the developing young brain as well as containing clinical strategies to guide young people to deal with bullying. There is a book review of **Bullying: Taking Control** in this edition. The package (clinician’s manual and 3 workbooks) can be ordered through Amazon (USA) or via our website (http://www.mediros.com.au/resources/order/).

Workshops and Certificate trainings

The last Mediros workshops for 2016 are:
- The neuroscience of Pain – 18 November 2016, in Brisbane and;
- The ageing Brain – 25 November 2016, in Melbourne

There are only a few spots available for these workshops – so be quick!

The last certificate trainings for 2016 are:
- Sydney - 8-11 November (SOLD OUT)
- Adelaide - 30 November – 3 December (a few spots still available)

The 2017 Certificate Training dates Australian and New Zealand venues are up on the website and PLEASE NOTE the popular Hawaii training 16-19 October 2017 is also now open for registrations. This training, being in such a desirable holiday destination, will most likely be booked out very quickly – so first come first served!

In our next edition we will share more information about two brand new 1 Day Workshops for 2017.

Enjoy the read!

**Peter Rosouw**

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**Dr Ken Levy, RFD**

B.A., B.Com., LL.B., Ph.D., FCA, FCPA, MAPS, CTA • Barrister at Law

It is with great sadness that we share the news of the passing of Ken Levy. Ken passed away on 20 January 2016 after a short but intense battle with cancer.

Ken was a great friend, incredible academic and had a very strong interest in Neuropsychotherapy. He attended almost all of the Neuropsychotherapy workshops over the past six years and we had many fascinating conversations on the implications of applied neuroscience in the forensic domain.

Dr Ken Levy was the Acting Chair, Crime and Misconduct Commission, Queensland from 23rd May 2013 to 30th June 2015. He previously was a practising Barrister, with appointments also as a part-time Senior Member of the Administrative Appeals Tribunal (having been appointed in 2004) and was also a Professor of Law of Bond University, teaching the Law of Evidence, Criminal Law, Succession Law, Superannuation law and Taxation Law. He formerly worked in the Queensland Public Service for 38 years, retiring as Director-General of the Department of Justice and Attorney General in Queensland in December 2003.

His professional training qualified him as a Barrister, as an Accountant and a Forensic Psychologist. His doctoral studies were in the area of forensic psychology and the criminal law. He was a member of a number of professional bodies namely, the Bar Association, the Institute of Chartered Accountants in Australia (FCA), CPA Australia (FCPA and Life Member), the Australian Psychological Society (MAPS), the American Psychological Association and the Tax Institute (CTA).

Dr Levy was Queensland President of the CPA Australia in 1999 and National President in 2004-05. He has also been a Fulbright scholar at the University of California at Irvine.

Still further, his contribution included serving with the Australian Army Reserve for over 40 years and holding the rank of Lieutenant Colonel. He has been awarded the Reserve Force Decoration (RFD), the National Service Medal, the Centenary Medal and the Australian Defence Medal.
Neuropsychoeducational tool: Puppets for counselling abused children

Cindy Silva
BEd (Hons)(TESL) MCoun

While living in Malaysia Cindy obtained her Bachelor's degree in education and worked as an editor with Pearson Education and lecturer in English. Before moving to Australia in 2006, Cindy worked for Pathways Life Counselling Center in New York, USA, where she assisted counsellors and therapists with their reports and schedules and led small group sessions for teenagers for self-esteem and grief and loss issues. Cindy also worked for Step by Step Inc. in New York, (a not-for-profit organisation) who assist individuals transitioning from psychiatric treatment centres back into the community.

In 2012, Cindy commenced her Master of Counselling degree at the University of Queensland (part-time while juggling a full-time job and being a mum!). She recently completed her Masters’ in July this year. She is currently working with the Sunshine Coast City Council.

Pieter Rossouw
MClin Psych PhD MAPS MCCLP MQCA, MIACN(Certv)

Pieter Rossouw is an Adjunct Professor in Brain-based Education at the Central Queensland University. He is also the Director of Mediros Clinical Solutions, The Neuropsychotherapy Institute and the BRAINgro Institute. He is an expert in the effects of bullying on the brain as well as strategies to guide young people to take control and change their brains.

Abstract: This psychoeducational tool was created with a focus on working with children suffering trauma as a result of significant negative experiences such as sexual, physical or emotional abuse. This tool highlights the importance of play therapy from a neuropsychotherapy perspective focusing on the importance of safety and creating an enriched environment for the traumatised child or children. This paper highlights the importance of puppet therapy from a brain-based approach by exploring the integrated model of the base elements of the theory of neuropsychotherapy, the effects of abuse on children and the benefits that puppet therapy may have for counselling children who have experienced trauma.

INTRODUCTION

Theoretical Approach

The occurrence of traumatic events during childhood is very common (Felitti et al, 1998). Contemporary brain-based research has shown that there can be serious health consequences for children who are exposed to traumatic events (Vassar, 2011). A child's brain is in a constant state of wiring and rewiring as they reach their teenage years. However, according to research, when a child's brain is constantly exposed to trauma it can have adverse effects, even into adulthood (Vassar, 2011). Therefore, the importance of play-based therapy in helping children process and understand these events is crucial.

Childhood trauma is the catalyst for an array of identifiable psychological behaviours such as the development of impulse control, conscious self-awareness, self-esteem, interpersonal relationships and emotional stability (Friedrich, 2008). According to Epstein (1990), there are four basic needs that are the key drivers of the human condition. They are the need for control and orientation, the need for attachment, the need for pleasure/avoidance of pain and the need for self-enhancement. The violations of these needs can lead to serious psychopathology (Rossouw, 2014). When children experience abuse, some or all of these needs are violated.

Grave (2007) noted that "motivational schemas are the means by which an individual develops in the course of
his or her life in order to satisfy his or her basic needs and protect them from violation". Grawe (2007) also theorised that children who are severely mistreated and abused will continue to experience uncontrollable incongruence. In addition to this, a combination of poor attachment patterns and negative influences can have an immense negative impact on a child’s mental health functioning.

According to Rossouw (2012), the “onset of upregulated limbic alertness, down regulation of cortical neural sprouting, and decreased right frontal cortical development” are the key factors that lead to psychopathology due to the violation of these basic needs. Therefore, as a means by which these needs may be satisfied, the focus of this tool is to explore the child’s emotions and experiences in a safe therapeutic environment through the building of trust. Through the puppet play and re-enactment of stories, the child is given a safe platform to externalise his or her experiences of abuse and their emotional responses, without the fear of being hurt or punished. This tool is useful for enhancing the fulfilment of an important basic need which is the avoidance of pain and maximisation of pleasure. Play enhances pleasure for children and helps down-regulate their stress levels.

Research indicates that the human brain interacts as a ‘social entity’ that survives through its interconnection with its environment. According to Rossouw (2013), the wellness of the human brain depends significantly on the positive connection with its environment and the people in it. Therefore, through the positive use of puppets, and in developing a safe therapeutic alliance, the therapist can facilitate new neural activation patterns in the child. This is based on the neuron principle that “neurons that fire together, wire together” (Rossouw, 2013). Repetitive play using this tool and regular approach schema activation, may also lead to an enhanced mirror neuron effect (empathic development) and creation of new neural pathways for the child.

This tool is useful for the therapist as a “bottom-up approach” when working with abused children. A sense of environmental safety is crucial for children who have experienced abuse. According to Rossouw (2014), the underlying force in neural development is a safe therapeutic environment. Therefore, this tool helps the therapist create that safety for the child in the therapeutic setting through play, by down-regulating their limbic alertness and fear responses. This in turn will help build trust between the child and therapist, which is crucial in the therapeutic alliance.

Research has indicated that children respond well to the opportunity to express themselves through play therapy which also enhances their general abilities through the process of socialisation (Bowlby, 1953). Research also supports the use of play therapy as effective with children experiencing issues such as family separations, illness, neglect, and domestic violence (Reddy, Files-Hall, & Schaefer, 2005).

Play therapy allows a child to express their innermost thoughts and emotions in a natural and non-threatening way. This is especially true for children who are not able to verbalise their thoughts and feelings due to their development stage or trauma experiences (Novotny, 2012). According to Erikson (1964) “to ‘play it out’ is the most natural self-healing measure childhood affords”. Therefore, the use of puppets can help a child maximise pleasure and experience healing through play. The repetition of play can enhance new neural pathways and replace patterns of avoidance with patterns of approach in the abused child.

The use of puppets in playrooms and play therapy has been used by many professionals for many years.

The use of puppets in playrooms and play therapy has been used by many professionals for many years. Overall, the use of puppets in therapy may be seen as a valuable tool in helping children externalise and express trauma and conflict in a symbolic way (Irwin, 1983; Rambert, 1949). The use of puppets in working with abused children allows the child to gradually displace feelings from the significant adult or abuser they are connected with, which in turn provides an increased sense of physical, emotional and psychological safety for them. This provides a platform for the child to express themselves more freely without the fear or risk of retaliation and rejection from others around them. Although the child may experience a level of emotional discomfort whilst in therapy, he or she cannot be hurt or assaulted by the significant abusing adult (Bromfield, 1995). This creates a heightened sense of safety for the child/children in the therapeutic setting.

Puppets allow children to express their fantasies and externalise their fears and anxieties which become apparent in symbolic play. This provides the therapist with greater insight into their conflictual emotions (Barnier, 1983). According to Kors “puppet shows in an unstructured set-up can lead to satisfactory results” (Kors, 1964, p.56).

This paper therefore provides a guideline for how puppets can be used as a brain-based tool in counselling.
therapy with abused children. The therapist has the flexibility to use structured or unstructured activities based on their discretion and the age and development stage of the child/children they are working with.

INTEGRATED MODEL OF THE BASE ELEMENTS OF THE THEORY OF NEUROPSYCHOTHERAPY

The integrated model shown below explains the base elements of the theory of neuropsychotherapy and how this tool promotes safety and enhances the three basic needs of the human condition which are the need for self-control, pleasure maximisation and avoidance of pain; and the need for attachment. This contemporary model recently formulated by Dr Pieter Rossouw, needs to be read from the bottom to the top where the self is viewed as a superior order construct in the culmination of the fulfillment of basic needs (Rossouw, 2014). It embodies an holistic model which focuses on the facilitation of change and the shift in patterns of pathology. This change moving from pathology to wellness, thus enables the client to attain a healthier and more improved quality of life (Rossouw, 2014). This model postulates the important role of genetic influences and its impact on the individual’s exposure to the environment, which results in a myriad of genetic expressions. An enriched or compromised environment leads to the activation of controllable incongruence, which is the core of change, survival or thriving (Rossouw, 2014). Controllable incongruence addresses all three basic needs through patterns of approach. It helps to down regulate the stress response, activates neural proliferation and promotes cortical blood flow to the frontal cortex. However, when safety is compromised, the stress response is activated which initiates the onset of patterns of avoidance (Kostyanaya, 2015).

The brain is seen as a complex network that is vulnerable to the influence of environmental factors. (Kostyanaya, 2015). The need for safety plays a crucial role in the facilitation of the "motivational schemata" in the above model. The key neural principle here is based on the "principle of survival". According to Rossouw (2014), the brain changes to enhance survival - safety leads to approach motivational schemas while compromised safety leads to closed neural loops of protection and avoidance. As a result, safety facilitates controllable incongruence and approach motivational schemas for clients.

The need for control, the need for pleasure and pain avoidance, the need for attachment and pleasure maximisation help activate the basic need for safety. "The self is seen as a higher order construct that results in the culmination of fulfillment of the basic needs" (Kostyanaya, 2015), however in situations of abuse (described below) these needs are violated.

PHYSICAL ABUSE

Children suffering from physical abuse may develop physical and psychological symptoms of unwellness. According to Piperno, Di Biasi, and Levi (2007), some common symptoms of physical abuse are, speech impediments and the inability to verbally communicate effectively, heightened risk to the development of the child's mental health and other behavioural issues. Common internalised behavioural themes which are observed in physically abused children are self-blame, the inability to control anger, feelings of guilt, physical aggression, low self-esteem, academic difficulties, low attention span, bed-wetting, and a sense of loss of control (Kot, Landreth, & Giordano, 1998), (Edgar-Bailey & Kress, 2010). The inability to attach meaning to trauma, conflictual thoughts and feelings (uncontrollable incongruence), distrust of people in authority to keep them safe, detached emotions due to inability to cope with the trauma, the inability or reluctance to socialise with peers and lack of coping skills are also some of the negative impacts that can be observed in children due to trauma experiences (Kot, Landreth, & Giordano, 1998), (Edgar-Bailey & Kress, 2010). According to Edgar-Bailey and Kress (2010), these effects of trauma are "detrimental for the child's future relationships, and connecting with their emotions is essential to their healing".

EMOTIONAL ABUSE

When treating children suffering from emotional trauma, the therapist has to be especially alert because emotional trauma is not as easily identifiable as physical trauma. The visual physical signs are not obvious in emotionally abused children. Some of the common internalised themes that are observed in emotionally abused children will however be similar to those who have experienced physical abuse, and include low self-esteem, short attention span, the lack of impulse
control, physical aggression, the inability to control anger, behavioural problems and academic issues, verbal abuse or passivity, withdrawal and a sense of loss of control (Kot, Landreth, & Giordano, 1998; Edgar-Bailey & Kress, 2010).

Distrust of people in authority to keep them safe, a lack of coping skills when dealing with stressful situations and a decrease in social interactions with non-traumatized peers are some of the negative effects that children experience due to trauma (Kot, Landreth, & Giordano, 1998; Edgar-Bailey & Kress, 2010).

SEXUAL ABUSE

According to Sadowski and Loesch (1993), it is difficult to estimate the prevalence of sexual abuse as it is extremely underreported. Some of the commonly internalized themes that are seen in sexually abused children, which again overlap with other types of abuse include, internally directed anger, feelings of unworthiness, a sense of helplessness, low self-esteem, short attention span, the inability to control anger, behavioural problems, academic issues, verbal abuse or passivity, withdrawal and suppression (Kot, Landreth, & Giordano, 1998; Namka, 1995).

Some of the negative effects of sexual abuse on a child may include flashback behaviours, repetitive re-enactment of the abuse, loss of trust in others to keep them safe, feelings of shame and despair, and heightened arousal and self-consciousness which exacerbates dysfunctional behaviours, and may lead to an increased risk of developing personality disorders or addictive behaviours.

Some of the negative effects of sexual abuse on a child may include flashback behaviours ...

The therapist plays an important role in carefully establishing a healthy and trusting relationship with the traumatized child. According to Edgar-Bailey and Kress (2010), “the ability of a child to trust an adult enough to express painful emotions is a key component to breaking down feelings of isolation, mistrust and cynicism”. The key component here is safety. The therapist plays a crucial role in down-regulating the child’s fears and distress while creating a platform for the child to express themselves in a safe environment.

It is acknowledged that verbal communication may not be the best avenue in working with traumatised children. Speech impediments may develop as a result of such trauma (Piperno, Di Biasi, & Levi, 2007). Grubbs (1994) noted that since it is quite difficult for children who have experienced trauma to acknowledge and verbalise their pain, it is very important for the therapist to find ways for the child to verbalise and resolve their pain and conflict. Research on childhood trauma indicates that play therapy techniques are the most effective, productive and creative way to work with such children dealing with trauma. Thus, the use of puppets, without necessarily requiring that a child comprehensively verbalises their experience of trauma, may be used as a brain-based tool for counselling therapy with traumatised children.

AGE GROUPS

This guidance for using puppets in therapy for children may generally be used with children between the ages of three to nine years old.

HISTORICAL RATIONALE

Children have played with puppets throughout the ages. The use of puppets in play therapy has increased over the years and according to Carter and Mason (1998), the use of puppets in play therapy helps children deal with emotions and feelings that are difficult for them to identify and helps teach them to trust their emotions again and to regain self-confidence. Puppets have also long been used as a diagnostic and projective tool, where clients are encouraged to respond to unstructured or ambiguous stimuli. Puppets help children express buried or unconscious feelings and conflicts that reveal the structure and dynamics of their personality (Bernier, 1989). According to Bender and Woltermann (1941), “through play the child experiments with reality in the physical, social and emotional world”. Freud (1959) explains play as gratification for the child where he or she repeats unpleasant experiences in order to gain mastery over a period of time (Freud, 1959). This shows the importance of play therapy in working with children, hence the rationale for this guidance as a useful brain-based approach with children.

AIMS

The aim of using puppets in play therapy with traumatised children is to help facilitate:
- creating a safe therapeutic environment
- building a therapeutic alliance between child and therapist through the building of trust and safety
- enhancing basic needs such as avoidance of pain and pleasure maximisation
- minimising the behavioural patterns of avoidance and enhancing emotional release
- healing from stressful and traumatic events from the past
the foundation of creative thoughts and new ideas
- building of self-esteem and confidence
- development of language and communication skills, and enabling the communication of concern to others when needed
- overcoming emotional and physical isolation
- expressing of new ways of thinking and behaving
- finding solutions and building coping strategies which helps enhance the sense of control and orientation

Building a safe therapeutic environment and relationship is always first and foremost in any therapeutic setting. This is especially important when working with children who are traumatised. Therefore, it is important for the therapist to get to know the child in the first few sessions.

NON-DIRECTIVE PLAY

Axline (1947) postulated the following principles of non-directive therapy with children:
- Establish a warm and friendly relationship with the child
- Acceptance of the child as he or she is
- Establish an atmosphere of permissiveness and safety
- Be alert and sensitive to the child's feelings (expressing and reflecting those feelings back to the child so that he or she gains insight into their behaviour)
- Maintain a deep respect for the child's capacity to act responsibly
- The child leads and the therapist follows
- Ability to recognise that the therapy development is a gradual process and does not attempt to hurry it along.

THE BENEFITS OF USING PUPTETS IN THERAPY

Bromfield (1995) has outlined some of the major benefits of using puppets in play therapy and they include:
- Children may use puppets to play out interpersonal conflicts
- Puppets can be portrayed as real objects where complex and painful situations may be staged by children
- Puppets allow children to express physical action and non-verbal action which speech does not
- Children may easily use and manipulate puppets to express and share complicated events more quickly and richly compared to the use of words alone
- Children may use puppets to gain control and mastery of helpless and 'out of control' thoughts, feelings and situations
- Puppet play may provide a foundation of protection for children where they may express problem-solving ways to protect themselves
- Puppets allow children to enact scenes that will help the therapist understand what they have experienced - the therapist can gauge if the child is trying to garner sympathy, support or express a cry for help through these enactments
- Puppets provide a safe platform for children to tell their story more openly and realistically without fear of being punished
- Children may feel more comfortable interacting with a puppet than a therapist - therefore, puppets may help children manage their relationship with the therapist and help build therapeutic rapport

THE BENEFITS OF PUPTETS CLEARLY SHOW HOW IMPORTANT AND USEFUL IT IS AS A TOOL TO CREATE A SAFE ENVIRONMENT AND THERAPEUTIC RAPPORT WHEN WORKING WITH TRAUMATISED CHILDREN.

RATIONALE FOR A VARIETY OF PUPTETS

Children have vivid imaginations and due to their ability to pretend and play, a therapist can use almost any object as a puppet (Carter & Mason, 1998). Carter and Mason (1998) note that hand puppets are the simplest and most flexible to use in a therapeutic setting and are the least expensive.

Carter and Mason (1998) also suggest that the ideal number of puppets that children can choose from in the therapeutic setting is between 15 to 20 puppets. It is suggested that the puppets should symbolise a variety of affect such as aggression, friendship and neutrality (Carter & Mason, 1998). Irwin (1991) suggests that the puppets should represent realistic family groups and familiar occupations in addition to the use of symbolic puppets and wild and tame animals.

The above explains the rationale for the inclusion of a variety of puppets when counselling children who have experienced trauma. This is to give children the flexibility and availability to choose what puppet best suits their story or personality.

HAND PUPTETS

Hand puppets may easily be used to depict a family group. This gives the child/children a variety of options with regard to the role they play to use as they immerse themselves in play therapy. It is very useful to have puppets that depict characters in a family unit, because this enables the child to talk more freely about family issues using these puppets. Hand puppets are a practical and functional way for children to play and it gives them the flexibility to use these puppets and operate them in a natural and easy manner.

LOLLIPOP PUPTETS

Lollipop puppets can be in the form of a range of wild and tame animals as well as symbolic figures (e.g., knights, princesses, dragons etc.). Puppets with familiar occupations such as doctor, teacher, policeman may also be used. The variety in characters enables children
to tell their stories in an abstract manner without fear. This enables the child to use metaphors to describe their feelings and emotions. Again, lollipop puppets are easy and comfortable for children to operate in creating their stories.

**FINGER PUPPETS**

Finger puppets may provide additional figures and characters with different affects (angry, sad, happy/friendly, neutral). Younger children are often attracted to finger puppets. Finger puppet plays are a useful tool for getting children's attention. Finger puppets are flexible and inexpensive and can easily be used because they fit well on children's fingers. Finger puppets can be made to make music and creative movement, thus providing greater stimuli so they are more interesting which encourages children to express their emotions and feelings in a safe and enriched environment.

**CONCLUSION**

According to Rossouw (2012), "childhood trauma violates the basic needs of attachment and control". Abuse (physical and/or emotional and/or sexual) up regulates the survival response and inhibits frontal cortical sprouting. Therefore, early interventions to address these kinds of traumatic experience are crucial.

This paper suggests the use of puppets as a therapy tool in helping children deal with such trauma. Trauma causes children to have closed neural systems of protection (Rossouw, 2012). The therapist has to first create a sense of safety and build therapeutic rapport with this group of children. The use of puppets enables the therapist to work with children using a creative approach which allows children to express and answer questions which they might not directly to a therapist or person of authority.

According to Kors (1963), a client is able to show his/her world without the influence of society through the use of puppets. Puppets provide the platform for deeper stimulation and self-reflection which is beneficial to the therapeutic process. Kors (1963), postulates that "Play your play so that the nature of the world in which you are living becomes clear to me".

- "Let's talk together about your play so that the world in which you are living will become clear to you".
- "Let's try to find out why your world is so different from our common, socially constructed world that living in that common world seems to be impossible for you".
- Puppetry can be seen as an effective means of communication for children and as it provides the child with a tool for non-verbal expression, which in turn serves as an eventual channel for verbal expression. As a result it builds a bridge from the world of the child seen through puppet play to the world we share. (Kors, 1963). It creates a sense of safety for the child which is key in new neural development (Rossouw, 2014).

**REFERENCES**


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Working with Julie (mother of three, in her fifties), to relieve work related anxiety and depressive tendencies

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CLIENT DEMOGRAPHICS AND DEVELOPMENTAL HISTORY

Julie, a 52-year-old female, is married and has three grown children. She has a stable marriage and her extended family relationships are compatible and respectful. She is well-groomed and has a warm and friendly personality, demonstrating congruence, clarity and professionalism in her speech and affect.

Julie is the third child in a family of five children. All her developmental milestones were achieved. Julie explained that her childhood memories were a little unpleasant due to her parents divorcing when she was young and she had a mother whom she described as “inattentive”.

CURRENT ANXIETY

Julie presented at counselling in a nervous state and quickly displayed a high level of anxiety as she began to describe her life as a teacher and her recent resignation from her teaching position and her decision not to continue to work in the profession.

Julie had been a teacher for 27 years but she explained how in the last two years she had experienced an “overwhelming and ongoing” fear of underachieving. She felt an inability to cope with the demands and expectations of her job. Despite this recent anxiety, she had experienced 25 successful teaching years, enjoyed the children she had taught, and experienced supportive parent/teacher relationships, and friendly connections with her fellow colleagues.

However, in the past 18 months Julie had felt bullied by the school principal and one of the administrative staff members. She spoke of being the target of derogatory comments, being ignored in staff meetings, not being included in social occasions and frequently being told to improve her performance. This took a toll on her physical health, so much so, that she believed this was the reason she was unable to continue in her teaching career.

Julie has spent the last six months at home. She goes out only when necessary, avoiding all social contacts, believing others also see her as incompetent. She has let her former daily exercise program lapse and has lost motivation to engage in hobbies or social activities that she used to enjoy. Julie told me she would rather spend time in bed, reading or sleeping.

Suicidal and homicidal ideation was not evident. There was no abuse of alcohol, smoking or drugs.

A NEUROPSYCHOTHERAPEUTIC APPROACH TO TREATMENT

An evaluation of Julie’s physical and emotional symptomologies indicated that she was suffering anxiety, evident physically in her report of nausea, abdominal distress, insomnia, and frequent light-headedness. Her symptoms of social withdrawal, sadness, crying and loss of motivation to engage in activities she once enjoyed indicated comorbidity with depression (Maxmen, Ward & Kilgus, 2009).

Julie was apprehensive about her first time in therapy, therefore it was important to provide her with emotional safety in order to down-regulate her impulsive brain (Rossouw, 2013). Neuroscience research explains that when in a state of anxiety or nervousness, cortical blood flows from the prefrontal cortex (PFC) and outer brain regions, where thinking and problem solving occurs, and moves to the limbic area, known as the impulsive brain, in readiness to activate those areas of the brain involved in protecting the individual (Grawe, 2007). Therefore, before effective therapy could occur, it was important to down-regulate Julie’s stress responses and to provide emotional safety (Allison & Rossouw, 2013). Rossouw (2013) refers to this as a ‘bottom-up’ approach, where the fear and anxiety in the emotional brain is down-regulated before attempting thinking and problem solving skills.

Recognising the importance of the therapeutic alliance, Julie was greeted in a warm, friendly manner with an empathetic and understanding approach (Allison & Rossouw, 2013; Sommers-Flanagan, 2009). There was a deliberate avoidance of over-questioning and judgemental tones, so as not to appear accusatory or interrogative and trigger fear memories of the relationship with her past principal.

NEUROPSYCHOTHERAPEUTIC ASPECTS

As Julie told her story I observed that her concept of self
was low. She explained that she had been an effective teacher for many years but now felt worthless, inept, and misunderstood. She felt she had no option but to resign from her teaching position. When I asked if she had ever felt worthless and misunderstood before, she went on to describe that as a child she felt she never measured up to her mother’s high expectations of her.

Julie’s childhood experiences could not be ignored. Neuropsychotherapy research explains how our early life experiences make us more or less vulnerable to change, and this impacts how we will respond to changing environments in our adult lives (Henson & Rossouw, 2013). As Julie described her childhood experiences, it was evident that her mother was not only “inattentive”, but also emotionally abusive. Julie confided that in order to cope, she turned to books and would hide away absorbing herself in a fantasy world. Julie’s childhood experiences, wherein she suffered ongoing criticism and inattention which hampered positive self-efficacy, could be considered a predisposing factor in determining her adult reactions to her recent experience of bullying (Davidson & McEwan, 2012). Grawe (2007) states that failing to fulfill childhood needs can lead to tendencies of vulnerability in future stressful experiences.

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As Julie described her childhood experiences, it was evident that her mother was not only “inattentive”, but also emotionally abusive.

The recent bullying Julie experienced at her work has also violated a number of fundamental psychological needs; the need for positive connections, the need for control and orientation and the need for pleasure and distress avoidance (Rossouw, 2014). Julie experienced a situation where she felt she had limited options, making survival in her workplace challenging. She felt she could no longer rely on others to support her, and alienated herself from the other staff, believing they were all thinking she was incompetent. She battled on alone without sharing her distress. However, in-so-doing, her need for attachment and supportive connections was broken, intensifying the negative view she had of herself (Rossouw, 2014). Her teaching job was now no longer pleasurable and because she felt she could not avoid the distress and discomfort of being at school, she resigned from her teaching position. This left her with a feeling of guilt and disappointment in herself, further damaging her self-esteem, so she withdrew to the safety of her home. Rossouw (2014) explains how patterns of protection/avoidance emerge when basic human needs are violated. The brain therefore strives to maintain consistency and so in order to avoid the feeling of distress, and preserve a positive sense of self, there is a conditioning of fear reactions resulting in the brain developing a motivational schema of ‘avoidance’ (Grawe, 2007).

Julie told me that her home was “the only place where she felt safe”. Avoidance behaviours gave Julie a feeling of safety, resulting in a release of dopamine, thereby motivating and prompting the repeat of the avoidance behaviours, even though the violations had been eliminated (Allison & Rossouw, 2013; Henson & Rossouw, 2013). Repeated behaviours strengthen neural connections due to the Hebbian principal that states, “neurons that fire together - wire together”, (Grawe, 2007; Rossouw, 2014).

Repeated firing results in strong neural connections and Julie found herself stuck in a biological feedback loop of avoidance behaviours (Grawe, 2007, p.163; Rossouw, 2014). The thought of engaging in activities caused anxiety and exaggerated fears, making it difficult for her to approach new situations, but also to engage in activities previously enjoyed (Lintord & Arden, 2009; Siegel & Payne Bryson, 2012).

I explained to Julie that the emotions of fear, hate, anger and panic trigger the survival centres of the brain (the limbic system and the brain stem), causing a release of adrenaline and cortisol which activates the instinctive “fight”, “flight” or “freeze” responses (Howard, 2013; Jenison, 2015). Julie recognised the physiological symptoms evident when her impulsive brain was activated; a pounding heart, quickened breathing, digestive problems, sweaty palms and the inability to think rationally. These reactions are due to the release of the stress hormones, adrenaline and cortisol, which assist the body in short term protective behaviours and are necessary for our continued survival (Medina, 2014; Rossouw, 2011).

A little stress works as a motivating force, and is the basis of learning (Cozolino, 2013). However, when we experience uncontrollable incongruence, a situation of intense and/or frequent emotional stress, when we feel trapped with limited options, the stress response continues to escalate until it eventually breaks over a certain threshold when nuclei in the hypothalamus are activated, causing the hypothalamic-pituitary axis (HPA) axis to activate, and glucocorticoids to be released (Grawe, 2007; Rossouw, 2014).

With the help of a simple diagram I explained to Julie that the HPA axis describes the link between the hypo-
Thalamus, the pituitary glands and the adrenal glands. Stress activates the HPA function and the oversupply of adrenaline from the adrenal glands triggers physical unwellness (Wilson, 2014). Memory is also impaired due to the high levels of glucocorticoids affecting hippocampal function, causing a degeneration of axons and neural terminals (Grawe, 2007). Neuroplasticity (the ability of the brain to adapt to change) and neurogenesis (the growth of new neurons), is compromised (Grawe, 2007; Rossovou, 2014). In severe cases of stress and trauma, previously acquired behavioural patterns can be erased (Wilson, 2014).

**THERAPY PROCESS – A NEUROPSYCHOTHERAPEUTIC INTERVENTION**

A referral for pharmacological treatment was not considered an option at the present time, due to Julie's insistence on not being 'tied' to drugs. She was keen to learn more about the effects of stress on brain development and the more 'natural' approaches she could try. I explained to Julie that chronic stress reduces the production of brain-derived neurotrophic factor (BDNF), a most vital neurochemical needed to sustain wellness (Henson & Rossovou, 2013; Medina, 2014). Low levels of BDNF contribute to mood dysfunction, depression, brain rigidity and poor cellular health (Henson & Rossovou 2013; Wilson, 2014). However, BDNF produced in the dentate gyrus (Wilson, 2014), acts as a buffer against the negative effects of stress, encourages neurogenesis and keeps neuron connections alive and functioning effectively (Medina, 2014; Rossovou, 2013).

Julie was keen to explore her options and become stress free so we began identifying goals relating to lessening the stress. She stated she would like to increase her levels of BDNF, therefore it was suggested that she resume a steady exercise program, as physical activity is known to increase BDNF, and also releases serotonin, a neurotransmitter known to regulate mood, depression and anxiety (Henson and Rossovou, 2013). Along with exercise, Julie was recommended strategies for relaxation, mindfulness and breathing exercises, and learned the benefits of good sleep hygiene, healthy nutrition, with particular increases in Omega-3 rich foods (Henson & Rossovou, 2013).

Solution-focused counselling strategies were used to explore Julie's strengths as a teacher, a wife and a mother. I noted that she had successfully juggled many roles over the years, and had dealt with numerous difficult circumstances, from which she had recovered. She began to recognise her strengths and problem solving skills, and there was a notable brightening in her demeanour as her self-esteem was enhanced. Julie became aware that despite the bullying and unpleasant working conditions, she was still a valuable individual with talent and skills to share.

I asked Julie what life would look like for her, without anxiety and the depressive feelings she was experiencing. It was in identifying how she would like her life to look that Julie arrived at many of her own solutions and was able to set goals to gradually step back into a state of wellness. Julie was offered support to develop plans to eliminate future stress, by firstly identifying problems that caused her stress and then breaking what she perceived as a problem into manageable tasks. She understood that this process satisfied her basic need for control, and motivated her to begin thinking about the possibility of gaining employment again and how she would go through the application and interview process.

It is recognised that the effects of stress and depression can be diminished by connecting with others ...

It is recognised that the effects of stress and depression can be diminished by connecting with others, activating the mirror neuron system and engaging with others where there is resonance, empathy and attunement (Rossovou, 2013; Siegel, 2009; Wilson, 2014). We explored and identified various support people for Julie, and engaged her in cognitive behavioural techniques to address Julie's negative thinking and exaggerated thoughts about how she thought people now viewed her.

The process of brainstorming ideas, setting goals and finding potential solutions stimulated the mirror neuron system and enhanced cortical blood flow to the PFC (Rossovou, 2013). It became evident that engaging Julie in 'talking therapies' was a positive approach to facilitating change. She felt a sense of control and agency over her previous stressful work situation and felt empowered to move forward. Fulfilling her need for control, prompted a feeling of pleasure and began to mend her shattered self-worth.

Gradually introducing Julie to new thoughts and using a narrative approach to help her look for exceptions to stress was beneficial. When Julie began to externalise the bullying incident and see the stress as something she could strategise against, it was easier for her to identify solutions. However, her home became her protective haven and she was hesitant to leave it and reconnect with people outside of her safe environment. Clients can find change difficult, as change challeng-
es the basic human instinct for consistency regulation (Grawe, 2007). Maintaining patterns of behaviour, both positive and negative, become comfortable and the client can instinctively relapse back into default patterns, due to fragile new networks (Rossovou, 2014).

It took slow, supportive, step-by-step exposures to begin the process of change. Being a skilled cook and hostess, Julie began reconnecting with others by inviting one or two friends into her home for afternoon tea, then gradually hosting small dinner parties. It was recognised that playing hostess in the sanctuary of her own home enabled a controlled incongruence where she was stepping out of her comfort zone, but in a manageable and safe environment.

The appreciative comments and affirmations from her friends led to a feeling of acceptance, which enhanced Julie’s self-esteem and feelings of worth. After many months, Julie was finally able to accept engagements outside of her home.

She says the bullying she encountered still haunts her, but when confronted with negative emotions, she replays the discussions we had in therapy and reminds herself of the years of positive teaching she enjoyed. When she slips back into what she terms as ‘the depressed zone’ she frequently reads and reflects on the numerous notes, letters, cards and gifts that have been given to her as tokens of appreciation over her many years of service.

**CONCLUSION**

Reflecting on the privilege of being Julie’s therapist, I found being able to explain the neuroscience behind her emotional responses most beneficial. With the use of basic diagrams and simple explanations I was able to lead Julie to a stage of understanding basic brain functions. There were many ‘ah ha’ moments when she understood how stress affects physical and mental well-being. One of the most important aspects of counselling Julie, from a neuropsychotherapy perspec-tive, was that she felt ‘normal’. This normalcy, in itself, lowered her stress, setting her on the road to recovery.

because I have a professional background in Education, with an understanding of the current education system and the demands teachers are facing, I could closely identify with Julie’s situation so was able to provide genuine compassion, which in turn enabled her to reveal deep and troubling fears she had experienced as a teacher.

Julie still remains unemployed and says she doesn’t want to enter the education system again. To some extent, she still perceives herself as incompetent, in the current education system, which has led her to question her future ability as a teaching professional. I often felt a personal frustration during Julie’s therapy sessions, knowing that another excellent teacher was leaving the profession and no amount of counselling, at this stage, could encourage her to continue the work she once loved. Julie said she will look for alternative employment, as she feels the pressures now placed on teachers are ‘just not worth it’.

**REFERENCES**


Davidson, R.J., & McEwan, B.S. (2012). Social influences on neuroplasticity:


Karen Ferry is an educator with experience in both primary and secondary classrooms. Her roles have included classroom teaching, administration and working with families in home education environments. She has provided professional assistance to educators in Australia and in many developing countries around the world. Karen is also a Counsellor and Clinical Neuropsychotherapy Practitioner. She specialises in childhood trauma, particularly grief, loss and anxiety.

www.brainsmarteducation.com

DISCLAIMER
This case study is written for educational purposes and is not intended to represent the therapy process for any specific individual. The author has disguised names, and other recognisable information to protect confidentiality.

The Neuropsychotherapy Institute
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The Neuropsychotherapy Institute provides you with a sound foundational understanding of the neurobiology of mental life and how that knowledge can inform psychotherapy and increase the effectiveness of your practice. All courses are online video lectures in a cost effective modular design.

TNPTINSTITUTE.COM
During September Mediros completed the 3.5 day Neuropsychotry Practitioner Training (NPT) at the Royal Melbourne Hospital and I was there to provide support and advice about the IACN. It was a pleasure to meet so many highly motivated clinicians and to talk with some about their upcoming reflective essays. I look forward to working with these new IACN Members and providing feedback on their essay submissions and I’m certain that many will be so well written they will be published in due course!

**IACN STREAMS AND INTEREST GROUPS**

Although it may not be immediately obvious (though will become more so as the Association grows), the IACN encompasses at least four current ‘streams’ in which a neuropsychotherapeutic approach is practically applied. These include Psychopathology, Sport and Performance, Expressive Therapies and Organisational Neuroscience streams. And within each stream there are a number of ‘interest groups’ i.e. practitioners with like interests. You will be well aware that practitioners are an eclectic lot and have a wide range of experience and work across many specialisms. And this was certainly evident in Melbourne (such a cosmopolitan city), where a number of new interest groups were identified including, Neuroscience of Mindfulness and Neuroscience of Grief and Loss and Neuroscience of Expressive Therapies. Earlier in June Dr Kate Lemerle also took the initiative by inaugurating the Positive Psychology interest group and I was privileged to attend one of their online meetings via Vsee.

I am aware there are like minded Neuropsychotherapy Practitioners who want to coalesce to form an Expressive Therapies interest group and there may be an interest group that develops around the Mediros Resilience Training being contacted in January 2017. Sufficient to say that the IACN will recognise these groups when the clinician lookup function is finalised on the website and those who take a leading role in each interest group will also be recognised for their contribution (and may, with permission) be featured on the IACN website as an interest group co-ordinator.

We’d like to know what you think about how interest group members can work together and your feedback would be greatly appreciated, so please if you have a special interest or specialism that you would like to lead us know about call (07) 3216 7226 or email me at office@iacn.com.au.

**ENSURING CONFIDENTIALITY – FEEDBACK FROM MEMBERS**

We received some comments from Members on the matter of confidentiality and how to achieve it in your reflective essay. I summarise here some key points to note about how you may de-identify your client by making logical changes to:

- Their name, sex and/or age
- The details of their family system (relationships, e.g., spouse, number of children etc.)
- The place they live (State or town, country or city)
- Their occupational background and/or current working status
- The finer detail of past diagnoses, pathology or referrals (e.g. you may describe symptoms and state they have not been diagnosed, when in fact they may have been).

As a general rule please omit any specific information which (when read in the public domain, i.e. published) another person may use to re-construct your client’s identity. The idea is to write such that your reflective essay may be applied to a general case of its type, without including any identifiable details.

Have a great month and I look forward to addressing you all again in December!
Welcome to the official site of the International Conference of Neuropsychotherapy. The Conference will be held in Auditorium and Education Centre of the Royal Brisbane and Women’s Hospital, Herston, Queensland, Australia.

The theme of the Conference is: “From Science to Facilitating Change” and underpins the focus of the conference – applied neuroscience.

The need for this Conference was born as a result of a stream of research output and clinical trainings in Neuropsychotherapy during the last decade resulting in over 20,000 clinicians trained in the modality of Neuropsychotherapy and a huge output of scientific research in the field of applied neuroscience.

This Conference is for scientists working in the field of applied neuroscience, clinicians who work with clients in the field of mental health.

As President of the International Association of Clinical Neuropsychotherapy, I would like to invite you to this exciting conference!

A WORD FROM IRENE – CONFERENCE COORDINATOR

Welcome to our very first NeuroConference blog. Here I will be providing information about the conference, updates about what we’re all up to here at Mediros and how everything is progressing as well as providing sneak peeks into who some of our speakers are and their topics.

I am the Conference Coordinator at Mediros Clinical Solutions. My role is centred around all things to do with the presenters! Making sure I know what they’re up to, making sure they’re ready and making sure the Conference schedule is filled to the brim with excellent content.

With over 50 speakers lined up there is sure to be quite the variety of exciting topics which combine neuroscience with practice and will provide a wealth of information in how to apply this knowledge to work mental health.

I look forward to introducing you to this Conference and all of its amazing presenters.

THE CONFERENCE IN A NUTSHELL

The International Conference of Neuropsychotherapy is the first of its kind and brings together a multitude of mental health professionals coming from a wide array of backgrounds with a wealth of knowledge ready to deliver to you.

Here are some of the things to expect:

• 50+ speakers
• 4 mini workshops
• 2 Pre-conference workshops:
  - Skills-based workshop on the Neuroscience of Pain (1/2 day)
  - Skills-based workshop on a neuropsychotherapeutic approach to dealing with eating disorders (1/2 day)
• Peer to peer networking and forums
• International Association of Clinical Neuropsychotherapy Annual General Meeting
• Gala dinner to finish and celebrate the event

The conference will cover a multitude of applied neuroscience topics. This includes, but is not limited to:

• Sport and performance
• Psychopathology
• Expressive therapies
• Organisational neuroscience

To register your attendance please visit http://neuroconference.net/
International Conference
of Neuropsychotherapy
Conference Centre – Royal Brisbane and Women’s Hospital, Herston
Brisbane 23-26 May 2017
From Neuroscience Research to Applied Practice

www.neuroconference.net

23 May 2017 Pre-Conference skills-based Workshops (7 CPD)
- The Neuroscience of Eating Disorders (½ day with Dr Roger Mysliwiec)
- The Neuroscience of Pain (½ day with Prof Pieter Rossouw)

24-26 May 2017 3 day Conference (24 CPD)
- 50+ speakers; 4 Mini-Workshops
- Covering 4 specialist applied Neuroscience Streams
- Peer-to-peer networking and forum
- International Association of Clinical Neuropsychotherapy Annual General Meeting

Applied Neuroscience Streams:
Psychopathology
Sport and Performance
Expressive Therapies
Organisational Neuroscience

Applied Neuroscience Mini-Workshops:
Neuroscience in Organisational Settings
Expressive Therapies – Experiential
Neurobiology of Domestic Violence
Neurobiology of Resilience

KEYNOTE SPEAKERS

Pieter Rossouw
Prof Brain-Based Education, CQU
Director Mediros
President IACN
Brisbane, Australia

Roger Mysliwiec
Dr Psychosomatic Medicine
Auckland, New Zealand

Lisa Stevens
Sport Psychologist
Melbourne, Australia

Rita Princi
Clinical Psychologist
Adelaide, Australia

Judith Murray
Prof School of Psychology
University of Qld
Brisbane, Australia

Dirk Geldenhuyys
Prof Industrial Psychology
UNISA,
Rep of South Africa
Registration Form

Online registration also available at www.neuroconference.net

International Conference of Neuropsychotherapy

**Brisbane** 23-26 May 2017 - Conference Centre, Royal Brisbane & Women’s Hospital, Herston

**23 May 2017** Pre-Conference skills-based Workshops - 3¼ CPD’s per workshop
The Neuroscience of Pain (½ day with Prof Pieter Rossouw) 9am–12.30pm
The Neuroscience of Eating Disorders (½ day with Dr Roger Mysliwiec) 1.30pm–5pm

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The first payment of AUD $300.00 deposit will secure your place at the workshops/conference. Payments thereafter can be made in instalments. Fees less than $300 are required to be paid in full at the time of booking.

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**NEUROPSYCHO THERAPY**

ISSUE 40 NOVEMBER 2016 17
Bullying: Taking Control

School-age bullying is a widespread form of trauma that many young people face. While there are a number of current anti-bullying interventions developed to address this issue, the majority of these strategies do not necessarily address the impact of unfulfilled basic neurobiological needs. Specifically, the primary human need to first and foremost feel safe in our environment is often overlooked, which can compromise the effectiveness of therapeutic interventions for victims of trauma. Based on fundamental neurobiological principles, the workbook titled “Bullying: Taking Control” was created to address the issue of school-age bullying. This workbook provides psychoeducational information about neurobiological needs, the human brain, and its response to safe and unsafe environments. The interactive workbook is delivered in a format and visual style appropriate for youth, using a combination of text, pictorial illustrations and guided text boxes for note-taking. Ideally, this workbook is not a standalone tool but offers an extension to other support networks (e.g., counselling, psychotherapy, school support staff, parental care). The aim of the workbook is to empower young people who are victims of bullying to take control and facilitate positive change towards achieving a fulfilling life.

This is a practitioner’s manual for using the workbook titled “Bullying: Taking Control”; a workbook created to address school-age bullying from a neurobiological perspective. The manual provides a brief overview of the bottom-up, brain-based approach of neuropsychotherapy in which the workbook is founded. Additionally, the manual provides an in-depth description of the workbook and detailed guide for practical use. For the time-limited practitioner, short summary quotes can be found throughout the manual which highlight key points made in each section. For the practitioner interested in the research on which the workbook was founded, the appendix section contains the following peer-reviewed articles:

Kaya, M., & Rossouw, P. (2016). Development of a Psycho-educational Tool to Address School-Age Bullying (accepted for publication, 2016).

Authors: Melisa Kaya & Prof Pieter J Rossouw

A structured method for working with clients using a Neuropsychotherapy approach
It’s not always easy to know where to start with any client, but having a workbook which sets out a process for your client to be part of, already begins to raise their feelings of inclusion and heightens their experience of attachment, as well as providing clear guidance about getting to know their brain processes. It also heightens awareness for clients that their own psychology and physiology are intertwined.

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• keep a written record of your client’s progress notes in your clinicians workbook
• have guidance for your client to help them understand how their brain activity influences their behaviour and how they can change it
• have a model for achieving client progress towards wellness.

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Neuropsychotherapy

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Melbourne 19-22 September 2017
Royal Melbourne Hospital, Grattan Street, Parkville

Sydney 02-05 October 2017
Portside Centre, 207 Kent Street Sydney

Hawaii, USA 16-19 October 2017
Sheraton Princess Kaiulani, Honolulu, Hawaii

About the Presenter

Prof Pieter J. Rossoeu
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. 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 keynote) at international conferences. Pieter's recent books are: Neuropsychotherapy: Theoretical Underpinnings and Clinical Applications; BrainWise Leadership (with Connie Henson); Bullying: Taking Control (with Melissa Kaya) and The Predictive 6-Factor Resilience Scale (with Jurie Rossoeu). He received the UQ Dean 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.

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**Aug - Sept - Oct 2016 Form**
Predictive 6 Factor Resilience Scale
and Resilience Development

Become a Certified Brain-based Resilience Coach

A groundbreaking new measure based on Neuroscience to assess resilience capacity

The Predictive 6 Factor Resilience Scale is based on the findings of neuroscience exploring the brain’s domains of wellness. The scale measures the capacity of these domains and direct the user towards strategies to enhance the domains based on the principles of neural plasticity.

6 Online modules (APP format) to develop Resilience capacity

In this training you will be:

- Introduced to the science behind the development of the scale (understand the neural principles)
- Introduced to the PR6 scale
- Guided on how to apply the scale
- Guided to effectively assist your clients to interpret the results
- Introduced to the 6 online modules (APP format) - accessible on all internet-enabled devices
- Guided to effectively assist your clients to maximise the use of the app
- Introduced to capacity to do pre-post measures and see the changes facilitated to your clients
- Guided to utilise the information when running resilience workshops for clients (individuals and corporate settings)
- Become an associate member of the International Association of Clinical Neuropsychotherapy (IACN) - an Australian Registered Association with access to Scientific Journals, Conferences and forums
- Become a Certified Resilience Coach (PR6) endorsed by RForce and IACN

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For more information, email admin@rforce.com.au.
Total cost: $950.00 incl GST

**Included in the programme:**
- Full one-day training package
- Hard-copy PR6 manual and guides
- Registration as PR6 practitioner
- 10 PR6 applications ready to use

**On completion (end of the day):**
- Certification as PR6 Resilience Coach
- Registration as Associate Member of the International Association of Clinical Neuropsychotherapy

**Who is this certification training for:**
- Psychologists
- School psychologists / counsellors
- Organisational psychologists
- Coaches
- Sport and performance coaches
- Wellness professionals
- Trainers

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**About the trainer: Adj Prof Pieter Rosouw**

*MClinc Psych, PhD, MAPS, MClinc, MQCA, MAQCN*

Serving as Chief Academic Officer at RForce, Pieter is also the Director of Mediros Clinical Solutions, The BRAINgro Institute and The Neuropsychotherapy Institute – companies that provide training and conduct research in Neurobiology and Neuropsychotherapy. Pieter is also a Professor in Brain Based Education at Central Queensland University (CQU) and the President of The International Association of Clinical Neuropsychotherapy (IACN). He also taught at Universities in Canada, the USA, New Zealand and Holland. Prior to his role as professor in Education at CQ University, Pieter was the Director of the MCC Program in the School of Psychology at the University of Queensland (UQ).

Pieter specialises in Neuropsychotherapy and is an expert in trauma, anxiety and mood disorders. He has published 6 Scientific Books and 70 scientific articles. He has been involved in research in extensive clinical trials and presented keynote research papers at 50 international conferences worldwide. Pieter’s latest books on Neuroscience are: Neuropsychology – Theoretical underpinnings and clinical applications and BrainWise Leadership (with Condie Henson).

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**Training venue & date**
- **17 January 2017**
- Sydney, Portside Conference Centre
  Level 5, 207 Kent Street, Sydney

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