NEUROPSYCHOTHERAPY
Issue 50: August – September 2018

IN THIS EDITION:

• Complex Trauma and Neuropsychotherapy – A Client’s Understanding of Empowerment of Self
• Working with Katherine: The Importance of the therapeutic Relationship
This is the 50th edition of this free online e-Journal!

The Neuropsychotherapy e-Journal initially started out as a Newsletter but quickly grew to being an informative e-Journal in the practical applications of Neuropsychotherapy in a range of settings.

Currently we are migrating all 50 editions to the newly designed Mediros website and all of the issues will again be available for download before the end of this year. If you need any particular issue, please email us at admin@mediros.com.au

In this issue:

**Reflective essays in article format**

In this edition we share two very interesting articles reflecting on applied neuroscience in clinical practice. The first is an essay by Louise MacKenzie, *Complex Trauma and Neuropsychotherapy – A Client’s Understanding of Empowerment of Self*, Louise works with her client to raise self-awareness and a greater sense of safety. In the second essay, *Working with Katherine: The importance of the Therapeutic Relationship*, Debra Smith focuses on the vital importance of developing and nurturing therapeutic relationship, as explained and demonstrated in the case study of Katherine.

**Inaugural Australasian Conference for Neuroscience, Learning and Wellbeing**

We want to draw your attention to the very exciting news of the Inaugural Australasian Conference for Neuroscience, Learning and Wellbeing which will be held at the Catholic Leadership Centre on the 25 and 26 of March 2019 in Melbourne, Australia. You will find more information about some of the speakers as well as a registration form in the edition.

**Mediros’ face to face training progressing to Online Neuropsychotherapy Training**

Previously all of the Mediros Neuropsychotherapy trainings were delivered face-to-face by Prof Pieter Rossouw, but from June 2018, the Mediros Online Training platform offers online modular professional development training which is easily accessible and affordable. This provides the opportunity for all clinicians, no matter where they are, to access world class teachings and trainings of the late Prof Pieter Rossouw. More about the online training later in this edition.

Lastly, from 2019, the Neuropsychotherapy e-Journal will offer space for advertising. All clinicians, organisations, associations and companies in the field of neuropsychotherapy will be invited to advertise their products, services and training in this e-Journal. As the e-Journal is all about sharing information with fellow clinicians and colleges, the advertising pricing will be very reasonable and will work on a sliding scale, making it great value for private practitioners, organisations, associations and companies, to advertise to a growing e-Journal readership.

Best wishes, the Mediros Team
Louise holds a Bachelor of Counseling and has a varied history of working in both counseling and social work fields in New Zealand and Australia. Louise currently works as a Child, Youth and Family Counsellor with Mercy Community in Brisbane. This role specifically focuses on working with children in the child protection system who have experienced complex trauma including physical, emotional and sexual abuse, and working with families who have sought guidance toward healthier functioning within their family system.

Louise is passionate about working with children, young people and their families who have experienced complex trauma, suicidal ideation, bullying, anxiety, depression, grief and loss and self-esteem issues.

Louise has a gentle, respectful, client-centred approach which holds people’s dignity and wellbeing in the forefront of her interventions, whilst advocating strongly for social justice issues that are present in the worlds of her clients. Louise works from a pluralistic counselling approach and enjoys using Narrative Therapy, Interactive Drawing Therapy and Sand Tray Therapy, whilst using the tenets of Neuropsychotherapy in all interventions.

Louise has also volunteered working with street children in Africa and projects in New Zealand.

DISCLAIMER
Please note that all reasonable precautions have been taken to ensure the anonymity of the client. Names have been changed to ensure confidentiality. If this case study is required for anything other than for the professional development of IACN Members or Mediros eJournal readers, please contact the writer Louise MacKensie on +61 467 296 739. Thank you.

Introduction
I would like to present a case study of a Caucasian female aged 12 years old at the time of referral. Anna currently resides with a female general foster carer in her 40s and has been in this placement for three years. There are no other children living in this foster care placement with Anna.

Anna was placed in the care of the Department of Child Safety (DOCS) at the age of one month old after her biological mother took Anna interstate to follow Anna’s biological father. This act was breaching the terms of the Interim Parenting Agreement produced by DOCS, due to concerns regarding Anna’s father’s age (compared with her mother’s), his history, and other legalities.
A number of foster care placements, with at least one other sibling living with them in the placement. This has been difficult for Anna as she longs to have a sibling live with her, because contact with biological family members has been largely inconsistent.

During an intensive intake process to obtain information regarding Anna's life story, a number of sources were engaged to gain insight into the complex trauma this child has experienced, and this included a thorough case file review of Anna's DOCS files. This, along with referral information, stated that Anna experiences anxiety, especially in crowds and has struggled to self-regulate emotionally and often presents with anger.

Anna presented with an anxious affect for her initial counselling appointment and sat quietly, and withdrawn with her shoulders slumped, head bowed and hair strewn over her face, as if trying to be invisible.

It is important to note that Anna has resided in about ten foster care placements since birth, with the longest being her current placement. Prior to that, Anna's longest placement was around 15 months when she was three months to 18 months of age. This lack of consistency and safety clearly impacted Anna's sense of self in a detrimental way, especially as many of these changes occurred in Anna's formative years.

According to Grawe (2007) approach or avoidance motivational schemas predominantly develop for an individual through the availability and empathy of the primary attachment figure in early childhood. Due to Anna's frequent moves between primary placements, there has not been a primary attachment figure throughout her formative years, and therefore, Anna's survival brain has been engaged from a very young age.

There is an intergenerational history of children in this family being in the care of DOCS due to concerns including drug and alcohol misuse, domestic violence, sexual, physical and emotional abuse, neglect and transience. There are no formal mental health diagnoses known within the history of Anna's biological family, however there are intellectual impairments documented on the maternal side of the family.

Anna attended counselling once before at the age of six, however Anna disengaged from this intervention after only a few sessions due to perceived fear, after a particular disclosure was made. Anna refused to return to counselling at this point.

Anna has a number of biological siblings who are also in the care of DOCS and these siblings are placed in

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in depth, and it was made clear to Anna that the information she shared within counselling sessions would not be communicated with anyone, including her carer, unless there were safety concerns disclosed about herself or others. By discussing this transparently with the foster carer present, it was hoped that Anna would trust in the therapeutic alliance and the enriched care environment that counselling could provide.

According to Rossouw (2014) the principals of bottom up neuropsychotherapy are creating safety, facilitating patterns of approach by down-regulating the limbic system, and therefore down-regulating distress. When establishing rapport, conversations and therapeutic activities were used as an opportunity to activate right-brain to right-brain interaction, mirror neuron activity and facilitate a safe, enriched and empathic environment (Schore, 2012; Rossouw, 2012b). Also, the understanding that providing an enriched care environment where safety was paramount (Siegal, 2010) were all critical parts of the therapeutic engagement process, in order to “enhance therapeutic attachment: the essence of the social brain and the basic need to connect” (Rossouw, 2014, p 60).

It had been evident that Anna’s limbic system had been up-regulated through her life experiences, and regular activation of the hypothalamus-pituitary adrenal axis (HPA axis) consistently initiating the release of neurotransmitters such as norepinephrine, adrenaline and cortisol which stimulate the brain preparing it physiologically for danger (leading to associated psychological stress) (Rossouw, 2012a). This had resulted in high levels of anxiety and flight responses from Anna due to her safety being compromised. Over a prolonged period and with repeated HPA axis activation, this in turn limited activation of the pre-frontal cortex or smart brain (low blood flow), and contributed to creating neural loops of avoidance patterns and ultimately self-esteem issues. An example of this for Anna was her expectation that her foster carer would ‘give up on her’, as she had experienced a number of times in her life, and therefore this had become the default neural pattern that had been formed.

Due to Anna’s experience of rejection and abandonment, the next step in the therapeutic process needed to elevate Anna’s sense of control within the therapeutic setting. This was achieved through non-directive interactions and being mindful of Anna having the control to choose the activities we’d engage in.

**Later sessions**

Around session six of the therapeutic intervention Anna presented to counselling in a distressed state and opened up about her physical aggression toward a peer at school (which had resulted in Anna being suspended). Prior to this event, Anna’s presentation in the therapeutic setting had notably relaxed, with Anna showing and expressing more of her internal world, and shifting her presentation to show more congruence within her sense of self.

In the subsequent sessions, Anna showed a readiness to engage in psychoeducation from a neuropsychotherapeutic perspective, so I asked Anna if she would like to learn more about what happens in her brain when she ‘loses it’ (as per Anna’s choice of language). Anna openly engaged in this psychoeducation phase of the therapeutic intervention, and age appropriate interventions were used to support Anna’s understanding of her responses. As per the referral, some of Anna’s usual responses when she was angry were to kick walls, throw rocks and slam doors, however the most recent response was Anna’s physical aggression toward a peer, resulting in suspension from school. These examples were given to Anna in a gentle, therapeutic way to avoid Anna feeling blamed and shamed.

A model of the brain was used to show Anna the parts of her brain that are activated using the terms ‘survival brain’ and ‘smart brain’. A small model of a skeleton showing the central nervous system was used to illustrate the flight, fright and freeze response, and the Mediros video animations were used to support Anna’s understanding of her responses. This part of the intervention was facilitated over a number of sessions to ensure Anna didn’t feel overwhelmed with the information, and finally, an activity was offered for Anna to visualise her ‘survival brain’ (given the name ‘guard dog’ by Anna) and her ‘smart brain’ (given the name ‘wise owl’ by Anna). This activity included a number of media Anna had shown an interest in. It was hoped that the Hebbian principle could be explained, and by covering this information in a way that was meaningful for Anna, that this would result for Anna, in neurons firing together, wiring together, thus creating behavioural change due to repetition (Hebb, 1961).

A metaphor was created by Anna of ‘two roads of choice’ for responses, one that results in ‘survival brain’ responses such as angrily lashing out at peers leading to suspension, or a path of down-regulating the survival brain (limbic system) in order to increase blood flow to the pre-frontal cortex and engage the ‘smart brain’. Anna provided examples of ways to down-regulate the survival brain including focusing on the body responses she experiences in times of heightened emotion, and remembering calming strategies. These strategies included breathing techniques that had been practiced in counselling sessions, which would, in turn increase blood flow to the pre-frontal cortex supporting her ability to make rational decisions.

Some of Anna’s usual responses when she was angry were to kick walls, throw rocks and slam doors...

Nevropsychotherapy
Conclusions

Around session 13 of the therapeutic intervention, Anna suddenly said during a game of ‘Mad Dragon’ anger control card game ‘that person I was suspended for hitting, came to me today angrily in a physical way, but I remembered my wise owl protecting the guard dog from lashing out. Instead of getting madder, I went to my safe person at the office…and the girl got suspended for what she did to me today’. This incident was used as a scaffolding opportunity to support Anna to reflect on how she felt for being able to identify her feelings and make a wise choice. Anna shared a sense of pride and also a sense almost of disbelief that what we’d been working on had really worked for her. This was reflected back to Anna in an encouraging way and an explanation was given in a child friendly way advising that old behaviours can be changed and that “neurons that fire apart, wire apart” (Bao, Chang, Woods & Merzenich, 2004). Again, the metaphor of the two roads, or the fork in the road, was used to illustrate the new neural pathways being strengthened and Anna drew a picture of the new road, adding colour and pretty things along the road to try to cement this pathway in her mind.

There are a further 13 sessions to complete in this intervention and it is hoped that this will provide Anna further opportunities for ongoing activation of neural pathways toward approach motivational schema.

Reflection

Upon reflection about this intervention, as a clinician I believe I could have worked better by expanding my own greater understanding of the neuropsychotherapeutic process. This would have resulted in more confidence in my own understanding, and for myself realization of the Hebbian principle – neurons that fire together, wire together (Hebb, 1961) would have been engaged, through consistent study of these concepts. Yet in writing this reflective essay, it has supported my understanding of the deeper levels of neuropsychotherapy, and this will allow greater confidence in using this approach in future.

References


Debra Smith has provided psychological services in Gippsland for over 20 years. She offers individual psychological therapy as well as psychological report writing for legal and other purposes, clinical supervision, staff training and Employee Assistance Program services. Debra has an Associate Diploma in Welfare Studies. She worked and travelled in Australia and overseas before completing her Bachelor of Arts (Psychology and Sociology) from Deakin University. She then studied her Master of Letters (Psychology) at UNE. Her book, *Life After Death: Preparing people with intellectual disabilities for grief and loss* was written using her thesis research from this study. She then completed a Masters of Primary Health Care at Flinders University, followed by her PhD in Public Health. Her book, *In Prison* is largely based on her PhD, in addition to her work in a prison for over seven years. Recently she completed an Associate Degree in Dementia from UTAS.

**Introduction**

Katherine is a 42 year old female police officer. She has been in a de-facto relationship with her partner, also a police officer, for eight years, and he has two children who live with them about fifty percent of the time - Katherine plays a significant role in their lives. Katherine’s mother died of cancer when she was ten years old and her father died when she was eighteen. She has a very strong relationship with her sister and is well connected with her cousins, and extended family, and has several strong friendships, both at work, and outside work. She has no prior psychological history.
She presented with symptoms related to two significant traumatic events, a multiple fatality motor vehicle accident and a single fatality motor vehicle accident.
Katherine’s sense of control, which had been strong was significantly diminished and caused her many difficulties. Prior to the traumatic traffic accidents, she had managed herself, her life, her work, her business, very effectively. She was a person who was used to being in control and now she could not even control her urge to eat a box of fundraising chocolate frogs in the workplace. Many people who experience trauma also experience ‘losing control’ and this is a fundamental focus for treatment of trauma, from both a neuropsychotherapeutic perspective and through other treatment approaches, such as acceptance and commitment therapy (Walser & Westrup, 2007).

Issues of avoidance behaviour, which had been ongoing for two years, developed over the course of treatment, together with patterns of disengagement behaviour. Katherine became increasingly trapped in the ‘2-1’ network of brain activation (Rossouw, 2017) and as her world became smaller this closed neural looping was exacerbated, she was unable to continue working. She was experiencing extreme difficulties sleeping, nightmares related to work, and a general lack of motivation, which created further psychological pain and avoidance behaviours, and for Katherine seemingly less and less possibility of her recovery.

In neuropsychotherapy terms her neural loops were becoming ‘smaller and smaller’ with less and less activation of the smart brain (number 3 system) and she was feeling trapped, and unable to act, other than in unhelpful ways, e.g., bad nutrition (comfort eating), excessive alcohol intake, lack of exercise, and an overreliance on medication. She was well aware of the difference in her previous capacity to cope with how she was now, and this reinforced her sense of hopelessness and dismay with using unhelpful strategies. Cozolino (2002) explains how trauma experiences are biochemically encoded in the brain and how treatment which promotes ‘talking through’ of the traumatic experience allows the brain to re-establish neural coherence.

Treatment

Treatment was based first on developing safety, then gradually introducing strategies to improve motivation, connection and control, as provided in the integrated model of neuropsychotherapy (Rossouw, 2014).

Siegal (2012) states that making sense of trauma is a key role of treatment for people experiencing PTSD. The adaptive mechanisms used at the time of trauma can be sustained long term and become maladaptive, such as the production of cortisol, which over time leads to difficulty. Most of the therapy with Katherine was related to making sense of the trauma, and the way she was coping, or not, and how to turn unhelpful coping into helpful coping. Safety comprises several factors, including the

1. The reptilian brain (brainstem and cerebellum) is the number 1 system, the paleomammalian (or limbic area) is the number 2 system and they tend to override more advanced areas, including the number 3 system the neomammalian brain or neocortex. 2-1 refers to the activation of the limbic area eliciting survival responses in the reptilian brain, which may include flight, fight or freeze responses.

Issues of avoidance behaviour, which had been ongoing for two years, developed over the course of treatment, together with patterns of disengagement behaviour.

counselling environment, the therapeutic relationship, and developing the capacity to talk about and work through traumatic memories. Katherine had completed a science degree and worked in research prior to joining Victoria Police and was very interested in ‘brain science’ and what was happening to her. Once she accepted that she had post traumatic stress disorder she was very open to reading relevant books, articles, and developing an understanding of what was happening from a neuroscience perspective. Katherine was very interested in mindfulness and was able to integrate this into her daily life at times. At times her approach pattern/behaviour was highly motivated and very positive, but often it was not sustainable and she reverted to avoidance patterns. She would, for example, give up drinking alcohol, fully aware of the negative effect it had on her, begin to feel better, and then drink again to avoid her negative feelings. Treatment proceeded as a dance between avoidance and approach, hopefully each time a little further down the approach path than the avoidance. Rossouw (2013) indicates that the avoid and approach patterns in neural firing related to behaviour change interact in close proximity and are significantly involved in motivation, which appeared evident in Katherine’s situation.

Therapy process

Her progress has not been linear, it has been all or nothing at times, and this has created a sense of failure when she has been unable to meet the unrealistic goals she sets herself. Her capacity to see and understand what she needs to do and her capacity to actually implement this are often at different speeds.

Katherine had had an effective career as a police officer, working on the front line operations, as a police prosecutor, and most recently as sergeant in charge of station operations. Her sense of control was challenged by her symptoms and one strategy that I used was to ask her to describe part of her work, or seek an opinion on a legal/police matter (eg domestic violence). She was able to shift her thinking to provide a structured, considered and coherent response, an ‘in control’ response, even as she had been floundering in her personal ‘out of control’ space. I used this to help her regain her sense of control and even if this was not sustained she was
able to realise that it was possible.

Given that prolonged exposure (PE) is one of the most common recommended treatments for PTSD Katherine, who had done some research, wondered if she should try this. We discussed a number of ways of deal with PTSD and decided on some brief exposure, and Eye movement desensitisation processing (EMDR). In actuality we have combined some of each, and have made slow but steady progress towards alleviating the traumatic memories of several incidents. Both PE and EMDR address the experience that contributed to the problems (Shapiro & Silk Forrest, 2016), and we worked slowly through the process, (avoid and approach evident in therapy) until we have now reached a point of having resolved most of the traumatic memories. The following is a brief description of two of the more persistent memories, one is one of the two events that caused Katherine to first seek help.

The first incident occurred when Katherine was a young constable and included an arrest that resulted in a highly charged incident where the person being arrested threatened to kill and almost managed to get a hold of one of the officers’ guns. Katherine was able to process this memory in the counselling sessions, using EMDR and she eventually developed an alternative narrative of the event, and her actions, basically that she had done all she could when she had been feeling that she hadn’t.

The second incident was one the motor vehicle accidents that precipitated the need for help. We worked on this in session, using discussions, and EMDR, and recently Katherine said she needed to visit the site. We did this last week, walked through the event, with Katherine using her calming strategies as required, and she could visualise herself managing the scene. She then had nightmares of dead bodies for the next three nights, and has not been troubled by the event since. The revisiting of the scene was four years after the event. In neurological terms she was able to establish a sense of safety with her calming strategies, and having me present, someone she felt safe with, and she connected with herself as a competent police officer, and was able to see the event in terms of a ‘2-3’ network, clearly understanding what she had done and how nothing more could have been done.

Katherine is back at work, not as yet operational, and she still has some work to do to totally regain her sense of herself, and overcome all of her trauma symptoms. She still has difficulty sleeping, although no nightmares, uses alcohol as an avoidance strategy to cope with her relationship difficulties, and is still in a avoid/approach pattern with her self care, although the spikes are not so pronounced. Her amygdala is still prone to overactivity, more in relation to relationship issues than workplace ones, but her trauma patterns of 2-1 systems are well established, and proving difficult to manage at times, although her 2-3 systems are much more evident now than at the peak of her PTSD. In an attempt to increase brain-derived neurotrophic factor (BNDF) Katherine worked on her exercise, walking, gym, yoga and dance. She was well aware of the positive benefits of exercise but had difficulty motivating herself at times. As noted by several researchers, BNDF is an important factor in memory function and helping adapt to change (Hayes, 2014, Arden & Linford, 2009).

Katherine has clear goals, and a strong commitment to her recovery, although continues to grapple with the process on a daily basis. Having a science background she has been interested in the neurotherapeutic approach, and applying it to her situation.

Katherine has clear goals, and a strong commitment to her recovery, although continues to grapple with the process on a daily basis.
Reflection:

One of the issues that I think was important, and created difficulties with treatment, was the caution expressed by the psychiatrist, that the trauma could not be addressed until Katherine had addressed both her sleeping and alcohol issues. Due to the pressures of the WorkCover system and the need to get back to work Katherine agreed to work on the trauma while she was still not sleeping well and using alcohol as an avoidance strategy. She is still not sleeping well and drinking too much, however, she is back at work, (limited hours and duties), and has largely resolved the traumatic memories. This is interesting in relation to the need to develop safety prior to any trauma treatment (van der Kolk, 2015), and the basis of neuropsychotherapeutic interventions, to develop safety first. While some safety issues were addressed, including feeling safe with the therapist, capacity to calm with breathing and meditation, increased physical activity, if we had waited to address the sleep and alcohol it is highly likely that Katherine would not have been able to return to work, which was her primary goal. This identifies the conflict between ideal treatment and the need to meet legislative requirements, in this case WorkCover and return to work timelines.

Another issue with treatment was the length of time it took for Katherine to acknowledge that she was in serious trouble, and could not remain at work. This was partly related to her strengths, and her strong work ethic, and also the opportunity to work in the domestic violence role, which was only possible for a twelve month period. Once she had done this the WorkCover system at least provided the opportunity for her to undertake more intensive treatment.

A fundamental aspect of successful outcomes in therapy is the therapeutic relationship. The role of mirror neurons is critical, and as the therapist it is imperative that we are aware of this, and the role of intent as well as action (Siegal, 2007). On our initial meeting Katherine explained that while she did not know me she had read many of my reports in her role as police prosecutor. I was concerned this may not have been helpful for our relationship as we were always on opposing sides. However, she said it helped due to the obvious care and commitment I bought to my work (even if she didn’t really think the crooks weren’t really worth it!) and she said it would be good to have me on her side. A point of connection was made and we were off to a good start.

There were times in the therapy process that I was frustrated with Katherine’s reliance on the ‘professionals’ and the medication to ‘fix her’, but these periods have not been sustained and she is now working well towards taking care of herself. I don’t think I could have encouraged her out of these periods more quickly although it would have helped her treatment.

References


From the IACN Registrar, Jonathan Wills

The IACN is going through significant organisational and procedural changes at present and the Registrar, Jonathan Wills will be back with comments and updates in the next issue. Until then if you would like to contact the IACN please call 0491 073 689 or email us at office@iacn.com.au

a: PO Box 4445 Forest Lake Qld 4078 Australia w: www.iacn.com.au

Previously all Mediros trainings were delivered face-to-face but, from June 2018, Mediros has progressed to the exciting field on online training only. This now provides the opportunity for all clinicians, no matter where they are, to access the world class teachings and trainings of the late Prof Pieter Rossouw. The online trainings of the Neuropsychotherapy Institute have now been fully incorporated by Mediros. Mediros Online Training is an online learning platform that delivers courses via unique video presentations. The video presentations have been developed specifically for this online training platform, which means that they are not simply a recorded recycled live event. Each neuropsychotherapy course consist of a number of lessons. One course takes approximately an hour to complete and is worth one point/hour of continuing professional development (CPD). There is no expiry or time limit associated with access to the courses, so you can take your time to complete each one. Each course comes with a training video, questions to answer about the course and a certificate upon completion.


This online training is accessible to all mental health clinicians who want to further their knowledge in Neuropsychotherapy. The online training is currently used by many clinicians as a professional development activity to meet their primary professional body’s requirements to maintain their professional development practising licence. However, the online training modules do form part of the International Association of Clinical Neuropsychotherapy (IACN)’s required CPD points/hours that are needed every year to maintain the status of being a Certified Practitioner.

More about some of the specific online courses available in the next e-Journal
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