Transgenerational Trauma:
Development of a Neurobiological Therapeutic Tool

Issue 35 January-February 2016
Welcome to the first edition of Neuropsychotherapy in 2016.

This year will be an exciting year on various levels for Neuropsychotherapy:

• We will continue to run a wide range of neuroscience related workshops

• We will run an additional series of workshop (25) in collaboration with key stakeholders (Government departments, the Australian Psychological Society, Counselling Associations and non-government organisations – both in Australia and internationally

• We will also present neurobiology related keynotes at 5 conferences (nationally and internationally)

• We are also engaged in developing neuroscience based practice models for one of Australia’s Department of Education as well as a number of NGO’s.

• The Newly established International Association of Clinical Neuropsychotherapy will run its first Certificate trainings. The uptake for these trainings (that will run in Brisbane, Melbourne, Bali, Adelaide, Sydney and Perth) is such that the first training (Brisbane) is now fully booked and a follow-up training is scheduled for early 2017. Training will also run in Auckland early 2017.

• We are in the process of developing a series of trainings in the USA as well as South Africa.

• We are hoping to finalise Neuropsychotherapy assessment and treatment related tools for clinicians and clients and get them published during the course of 2016.

In this edition we publish a study by Cassandra Garmston on intergenerational trauma in indigenous communities – a neuropsychotherapeutic perspective and proposed development of a tool to assist clinicians working in this domain. Cassandra is a previous student and of mine and a close colleague in the field of applied neuropsychotherapy.

Enjoy the read

Pieter Rossouw
Neuropsychotherapy

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

Neuropsychotherapy Workshops 2016

The Social Brain and the Neuroscience of Relationships
Continuing Professional Development Hours – 12 hours specialised training
Melbourne 10 & 11 March 2016
Royal Melbourne Hospital, Grattan Street, Parkville

The Ageing Brain and Neuropsychotherapy
Continuing Professional Development Hours – 6 hours specialised training
Sydney 29 April 2016
Portside Centre, Level 5, 207 Kent Street, Sydney
Melbourne 25 Nov 2016
Royal Melbourne Hospital, Grattan Street, Parkville

The Brain & Anxiety: Neurobiological information as Psychotherapeutic Tool
Continuing Professional Development Hours – 12 hours specialised training
Brisbane 14 & 15 April 2016
RBW Hospital, Herston Rd, Herston, Brisbane

The Brain and Management of Pain
Continuing Professional Development Hours – 6 hours specialised training
Sydney 27 May 2016
Portside Centre, Level 5, 207 Kent Street, Sydney
Brisbane 18 Nov 2016
RBW Hospital, Herston Rd, Herston, Brisbane

Developing Brain and the Neuroscience of Memory and Trauma
Continuing Professional Development Hours – 12 hours specialised training
Brisbane 01 & 02 Sept 2016
RBW Hospital, Herston Rd, Herston, Brisbane

The Adolescent Brain – Utilizing Neurobiological Information to Enhance Mental Health and Learning.
Continuing Professional Development Hours – 12 hours specialised training
Melbourne 14 & 15 Jul 2016
Royal Melbourne Hospital, Grattan Street, Parkville
Sydney 28 & 29 Jul 2016
Portside Centre, Level 5, 207 Kent Street, Sydney

The Neuroscience of Depression: New opportunities for Effective Treatment
Continuing Professional Development Hours – 12 hours specialised training
Sydney 22 & 23 Sept 2016
Portside Centre, Level 5, 207 Kent Street, Sydney

About the Presenter
DR PIETER J. ROSSOUW
MAPS; MCClin.; QCA.

Pieter is the director of Mediros, a company that specialises in Neurobiological research and training. He is also the director of the Neuropsychotherapy Institute, a company that provides online training in Neurobiology.

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 until 2015. He also taught at universities in the USA, New Zealand, China, Holland and Canada. He spearheaded a psychotherapeutic assistance Program for victims of trauma and provided Mental Health training for GPs as accredited training of the Royal Australian College of General Practitioners. He was also the Clinical Director of the St John of God Health services in Sydney.

He has published 7 scientific books and 70 articles and presented over 60 conference papers (many of them keynote lectures) at international conferences. Pieter’s latest book BrainWise Leadership was published with Connie Henson in 2013 and was followed by Neuropsychotherapy: Theoretical Underpinnings and Clinical Applications - published in November 2014. He received the UQ Dean Faculty of Behavioural Sciences commendation for excellence in teaching and provides global leadership in Neuropsychotherapy.


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How the brain develop pathology - Onset of Anxiety, Depression, Panic, OCD, Sleep. How the brain develop - Mandarin version

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Cassandra Garmston  
Bachelor Psychology (Hons)

Cassandra is currently undergoing a Masters of Applied Psychology (Health) at University of Queensland. Cassandra is a qualified Civil Engineer and has recently changed careers into Psychology. As part of her postgraduate studies, she has completed an external placement at the Institute of Urban Indigenous Health (IUIH) where her interest into Aboriginal and Torres Strait Islander population has flourished.
Aboriginal and Torres Strait Islanders have experienced extensive trauma and transgenerational trauma over the decades since white settlement. The population has experienced severe and multiple chronic stresses deliberately inflicted upon them as federal and state governments have attempted to alter cultural norms to form westernised communities. These experiences have been occurring over many generations and have resulted in trauma to modern generations quite removed from the events of past generations and has been passed from adults to children. Such intense trauma changes neural networks to avoidance patterns resulting in over activation of the autonomic nervous system.

This psychoeducational tool investigates the use of traditional Indigenous stories presented to Aboriginal and Torres Strait Islander populations from a bottom up perspective, using the integrated model of the base elements theory of neuropsychotherapy, beginning with establishing safety to provide a healing environment. The cultural focus will aim to establish a thriving environment using elements of basic needs including: pain avoidance and pleasure, control and orientation, and approach attachment patterns. The stories create and provide the power to guide identity by connecting Aboriginal and Torres Strait Islander people with their culture to fulfil their sense of belonging.

Introduction

This psychoeducational tool is provided specifically for Aboriginal and Torres Strait Islander communities who have experienced traumas or transgenerational traumas. Its goal is to educate Aboriginals and Torres Strait Islanders from a cultural perspective in the form of healing, as they traditionally understand it. Traditional stories will be presented to the client based on elements of basic needs including: pain avoidance and pleasure, control and orientation, and attachment once safety has been established. These stories will be the basis for conversations regarding these elements in order to psychologically heal and ensure a traditional approach to the healing process. Aboriginal Elders’ will be consulted in the final version of the flip chart.

Studies show that Aboriginal and Torres Strait Islander communities have great resilience and strengths through their strong sense of cultural self-identity, attachment to their traditions, and social connections through their community. When culture is lost to Aboriginals and Torres Strait Islanders, they become dislocated from their culture, community and their land. This may impact attachment to caregivers, parenting and family functioning, community violence and psychological morbidity. Through the use of the psychoeducational tool, the strengths of the Aboriginal culture will provide the link to guide their healing process.

Aims and Rational

The aims of the tool are to use traditional Aboriginal and Torres Strait Islander stories in order to explain the integrated model of the base elements of the theory of neuropsychotherapy. Due to Aboriginal’s and Torres Strait Islander’s cultural history and bonds to the environment, land, and people, this tool will provide a sense of belonging to the community and to tradition. It will link the internal world of trauma to the external world, giving meaning to the relationship between person and nature, and the inner person and the environment. This will be established through creative experiences of traditional storytelling, as Broca’s area is generally down regulated in traumatised individuals, making it difficult for the individual to identify and verbalise experiences.
Theory

Two theories exist for use when working with traumatised populations: Adaption & Development After Persecution & Trauma (ADAPT) (Silove & Steele, 2006) and Five Essential Elements (Hobfoll et al., 2007). The ADAPT model was developed over time investigating extensively traumatised populations, using the notion of five interrelated ecocultural systems: security/safety, attachment, justice, role/identity and existential meaning.

The Five Essential Elements model was developed by a large expert group who reviewed existing literature in parallel fields due to lack of existing research. The model suggests that the five elements for intervention in traumatised communities are safety, calming, self and collective efficacy, connectedness and hope (Hobfoll et al., 2007).

Both of these models focus on communities, with the aim to approach interventions for a society to guide individual recovery (Atkinson, 2012). These models are relevant to the Aboriginal and Torres Strait Islander population where traumatic experiences are intergenerational and strengthened through early experiences and repeated experiences (Atkinson, 2012). Similarities exist between these models and the model of the base elements of the theory of neuropsychotherapy (Rossouw, 2014).

The model of the base elements of the theory of neuropsychotherapy is a bottom up concept whereby the psychological and physical development of an individual, including their genetic makeup and environment, can affect their feelings of safety. When safety is compromised, behavioural fear patterns are formed, leading to patterns of avoidance. Along with the individuals’ formation of basic needs including pain avoidance and pleasure, control and orientation and attachment, the individual’s self-esteem may become compromised (Rossouw, 2014).

Neuropsychotherapy

During the early years of life, the brain depends upon both genetics and the environment to establish neural networks (Schore, 2002). As an infant experiences its environment, sensory signals are generated and the need to respond to the environment is generated to maximise survival. Once survival needs are met, the neural pathways are enhanced to generate patterns of thriving (Rossouw, 2014). With a supportive, emotionally gratifying and responsive environment, an approach patterns of behaviour are established. However, if traumatic experiences are introduced at an early age the neural networks are wired for avoidance patterns of behaviour. The earlier in childhood the trauma occurs, the more severe the avoidance behaviour patterns (Rossouw, 2014).

The first step in trauma recovery for Aboriginals and Torres Strait Islanders is to create a safe healing environment. When safety is compromised the amygdala activates the fear-based system where the hypothalamus-pituitary-adrenal (HPA axis) is activated to increase production of corticotrophin releasing factor (CRF), adrenocorticotropic hormone (ACTH), norepinephrine (NE), adrenalin and cortisol. Cortical blood flow and frontal systems in the brain are down regulated and the brain is wired for survival with patterns of avoidance forming (Rossouw, 2014). According to Atkinson (2012), the use of stories with Aboriginals and Torres Strait Islanders creates and provides a powerful guide to identity by connecting these people with their culture to fulfil their sense of belonging. Stories can be shared verbally, physically or visually in individual situations or in healing community groups.

Attachment.

Studies have shown the interaction between children and parents determine the child’s brain’s structure, moulding for approach or avoidance patterns. Creative interventions are an important way to change avoidance patterns by changing attachment (Siegel, 1999). Insecure attachment patterns have been found to produce lack of attachment, fear of loneliness and are associated with early childhood abuse and mental disorders in later life (Grawe, 2007). The insecure patterns form early in life during rapid brain development, ensuring strong neural connections for avoidance patterns of survival. For Aboriginals and Torres Strait Islanders, many have experienced forced separation from parents early in life. This experience may lead to insecure attachment and avoidance patterns of survival.

Reducing pain and increasing pleasure.

This basic need is the drive to maximise pleasure and minimise pain, through physical, psychological, emotional, or social states. Grawe (2007) states that an individual is in a maximal state of wellbeing when the perception of an experience is aligned with our intentions. When the intended aligned state is reached between good and bad, the activated mental system is more efficient with less incongruence (Rossouw, 2014). A good or bad evaluation of a situation will trigger an approach or avoidance pattern, depending upon the individual’s prior experience and momentary state (Rossouw, 2014). Malchiodi
(1990) has found that creative interventions had a soothing and safe influence on traumatised individuals by activating the body’s relaxation response.

**Control.**

The need for control begins early as an infant, when the infant may experience levels of incongruence. This is where a misalignment occurs between what the child perceives it needs and what it perceives it has (Rossouw, 2014). When there is violation of the need for attachment, there is often also a violation of the need for control. The need for control includes manipulating or regulating the environment or relationships to achieve goals by having many options to choose from (Rossouw, 2014). The individual’s motivational schemas will determine which options are chosen and how these choices manifest as behaviour. By pacing the neuropsychotherapeutic intervention it will enhance feelings of control for Aboriginal and Torres Strait Islanders and will aid in feelings of safety. By ensuring a safe environment facilitating therapeutic rapport, being sympathetic and down-regulating distress will also increase cortical blood flow to the frontal neural systems so that cognitive functioning can increase to enhance therapy outcomes (Rossouw, 2014).

**Self.**

Self is a result of the wiring of the neural networks instigated by the basic needs (Grawe, 2007). For example the development of pain and pleasure is linked to the development of self (Rossouw, 2014). The nurturing of self-esteem is important for mental health and wellbeing and enhances the development and activation of approach motivational schemas. Motivational schemas are neural networks developed to satisfy and protect basic needs. These schemas come in the form of either approach schemas or avoidance schemas (Rossouw, 2014). When basic needs are compromised, the sense of self is regulated by protection resulting in patterns of avoidance. Research shows that the main outcome of trauma are dramatic changes to the individual’s views of the world and their sense of identity (Gorst-Unsworth, Van-Velsen & Turner, 1993). Aboriginals and Torres Strait Islanders strong sense of self identity in their community was deliberately taken from them as the government attempted to alter indigenous cultural habits to acculturate Western values for both groups and individuals (Frankland, 1994).

**Background**

Aboriginals and Torres Strait Islanders have endured severe, multiple, repeated and cumulative chronic psychological stress as a result of this acculturation process which has been deliberately inflicted (Atkinson, 2008). These experiences have been occurring over many generations and are experienced as trauma by a generation temporally removed from the events and passed from adults to children in cyclic processes. This can be referred to as collective trauma or transgenerational trauma (Atkinson, 2012). It requires an intervention approach which should include collective and community components.

Transgenerational trauma has been shown to become embedded in the cultural memory of Aboriginals and Torres Strait Islanders and passed on by the same mechanisms by which culture is transmitted, resulting in normalisation of mechanisms within that culture (Duran & Duran, 1995). This can impact attachment to caregivers, parenting and family functioning, disconnection from family, culture and society. Children may witness the going effect of the original trauma through the process of vicarious traumatisation in the form of ill health, family dysfunction, community violence, psychological morbidity and early mortality (De Maio et al., 2005). Such intense trauma changes neural networks by developing avoidance patterns resulting in over activation of the autonomic nervous system (van der Kolk, 2005). For children, vicarious traumatisation violates safety needs leading to a loss of sense of self. Furthermore, adolescents may have attachment difficulties, show aggression, with links to suicide, alcoholism, physical inactivity, smoking and obesity. Adults with this childhood history are more likely to develop heart disease, cancer, stroke, diabetes, and liver disease (van der Kolk, 2007).

Many studies have shown the generational layers
of trauma resulting from colonisations within Aboriginal and Torres Strait Islander’s communities (Durante & Duran, 1995). Atkinson (2012) states that traumatic events occur without control of the individual. It is the individual’s experience and perception of the event which determines whether the event is traumatic, not the event itself. The survivor’s beliefs about humanity and the goodness in people may be destroyed, affecting their identity, and resulting in negative effects in mind, body, soul and spirit (Atkinson, 2012).

Historically, healing practices for Aboriginals and Torres Strait Islanders were based around a rationale about the reason for the trauma; a re-telling or re-enactment of the trauma in spoken or written form, dance, or song; and somatosensory experiences through touch, for example. These practices were portrayed within the family and clan ensuring an intensely relational experience, providing safety, control, and attachment with high levels of pain minimisation. These practices are repetitive, rhythmic, relational and respectful and have been shown to alter neural systems influencing cortical, limbic, diencephalic and brain stem systems. Sensory expression has been shown to overcome avoidance patterns in traumatised individuals (Collie, et al., 2006).

The neural systems altered by trauma begin in the brain stem, through activation of dopaminergic, serotonergic, and noradrenergic neural networks and associated hormonal activity. Through repetitive neural activity including primary somatosensory experiences of rhythmic auditory, tactile, visual and motor-vestibular stimulation, the brain stem can be altered to down-regulate the fear response in traumatised Aboriginals and Torres Strait Islanders (Malchiodi, 2008).

As a function of explicit memory, language is generally down regulated after a traumatic experience. This section of the brain, Broca’s area, is affected and makes it difficult for the individual to speak of the traumatic experience (Korn, 2001). Studies have shown that position emission tomography (PET) scans show that trauma induces changes in Broca’s area, a process that is normally accessible via explicit memory (van Dalen, 2001). Traumas are encoded in the limbic system and stored in the memory as somatic sensations and images (Rothchild, 2000). Action-oriented activities can stimulate the limbic system’s sensory memory of the event and combine the implicit and explicit memories (Malchiodi, 2003).

Due to the difficulties identifying and verbalising experiences, and the storage of traumatic experiences as images and sensations, interventions using re-telling of the story via dance, song, touch, and acting-out of the story through traditional methods have been shown to be effective for the Aboriginal and Torres Strait Islander communities (Malchiodi, 2008).

Externalisation through vision and sensations has been shown to help shift traumatic experiences from the present into the past (Collie, Backos, Malchiodi & Spiegel, 2006). In trauma intervention, the process of externalising trauma memories is central in the process of relief and recovery (Malchiodi, 2008). For example, drawing has been shown to reduce anxiety, increase therapeutic alliance and facilitate memory retrieval (Gross & Haynes, 1998).

Creative treatments, as proposed, have not been extensively studied to determine if they qualify as evidence-based practices for trauma intervention. However, Gil (2006) compared evidence-based practices in trauma intervention with creative treatments, finding that both types of interventions use gradual exposure. Furthermore, creative interventions are client led, setting their own pace, depending on the needs for coping, the nature of the trauma, and cultural diversity. Comparatively, evidence-based practices like trauma-focused cognitive behaviour therapy (TF-CBT) have a specific agenda and set instructions for the client, making the treatment therapist directed. Studies have shown that Aboriginals and Torres Strait Islanders prefer education based on learning at their own pace, and not being told the rules (Frankland, 1994).

Early childhood trauma, through transgenerational or chronic trauma, has the greatest impact on the brain through the establishment of early neural networks wired for survival through avoidance behaviours. These networks are exacerbated by repeated exposure to the trauma or through parental effects of trauma, thus altering neurobiological adaptation and strengthening the wiring for avoidance behaviour survival patterns (Schwartz & Perry, 1994).

Collie, Backos, Malchiodi and Siegel (2006) reviewed creative interventions for PTSD finding emphasis on psychological safety, stress reduction, and opportunities for non-verbal expression and processing of trauma narratives through art. This form of intervention is a bottom-up perspective in that safety is addressed initially, and stories learned in one-on-one therapy can be shared in healing groups with their families and communities.
The manual that will be developed through working alongside the Aboriginal Elders’ will be in the form of a flip chart. The flip chart will be used in a one-on-one therapy setting for adults, to instigate discussion around the story provided to relate to the feelings and thoughts of the client. Each page will have an Aboriginal story that focuses on one of the basic needs. An example of one story is in the Appendix focusing on attachment needs. Beginning from a bottom up approach, the first page will link genetics and the environment. This will instigate discussions explaining the link between the parent’s compromised environments with protective patterns formed through genes and the inheritance of these genes. Furthermore, once the individual is born into the compromised environment of the parent, the negative neural loops are strengthened, leading to avoidance patterns of protection behaviours.

Following on, the flip-page on safety will reinforce the need for the individual and their community to create a safe environment. Beginning with the therapeutic alliance, fulfilling the need for safety will down regulate the stress response by providing a supportive, non-directional, non-judgmental approach to facilitate emotional support. By pacing the sessions using traditional stories to promote discussions, individual Aboriginals and Torres Strait Islanders will begin to feel a greater sense of being in tune with their culture and of regaining a sense of control. By ensuring a safe environment, facilitating therapeutic rapport, being empathetic and down regulating distress, this will increase cortical blood flow to the frontal neural systems so that cognitive functioning may work more effectively, and thereby enhancing therapeutic outcomes.

Cultural stories will show the differences between approach patterns and avoidance patterns, using each basic need including pain avoidance and pleasure, control and orientation, attachment and finally the need for self and self-esteem enhancement. Attachment patterns will be a central focus, beginning with the therapeutic alliance between the client and therapist. The right brain cortex functioning (being at the seat of emotional regulation) will become more stable as this therapeutic relationship is developed. This will create scope for dealing with more emotionally deep-rooted problems. Once this first therapeutic attachment is made, the Aboriginal and Torres Strait Islanders will be encouraged to reconnect with family, friends and community. This tool can be developed for use in community settings, once reconnection has been made and safety, attachment, pain and pleasure, control and a stronger self of self has been established.

References


Traumatic%20Response%20in%20Children%20and%20Adolescents.pdf


Appendix

Aboriginal traditional story with a focus on pain avoidance and pleasure

Long ago in the Dreamtime, there lived two fish called Gugu and Boodi. One day Gugu was swimming back to his family after a day of hunting. Boodi had been helping him but was very tired and so he lagged behind. Gugu turned to encourage Boodi to keep up when he was pushed against some rocks by another fast swimming fish. To his dismay he got his fin caught between the rocks and he could not release it. Boodi tried with all his might to release the fin but Gugu didn’t want any help from Boodi and told him to go away. Eventually, Gugu released his torn fin from the rocks and swam away very sad. For a long time Gugu hid his family but Gugu didn’t want to go close to the rock. Eventually, Gugu released his torn fin from the rocks and swam away very sad. For a long time Gugu hid and didn’t want to see anyone, including Boodi and his family. Boodi tried to encourage Gugu to visit his family but Gugu didn’t want to go close to the rock where he hurt his fin, as he felt sad again. So Guru wanted any help from Boodi and told him to go away. Eventually, Gugu released his torn fin from the rocks and swam away very sad. For a long time Gugu hid and didn’t want to see anyone, including Boodi and his family. Boodi tried to encourage Gugu to visit his family but Gugu didn’t want to go close to the rock where he hurt his fin, as he felt sad again. So Guru would swim with Boodi but he would go a very long way in order to avoid the rock. One day Boodi came to him very upset saying his family needed him urgently. Together, Boodi and Gugu swam as fast as they could without realising they had swam right past the rock where Gugu was caught a long time ago. Gugu was amazed that he had not noticed the rock and even had not felt sad. From that day on he swam past that rock every day and was very happy.
The Neuropsychotherapy Institute learning platform has been created for psychotherapists, psychologists, and other mental health professionals, to educate them in the new paradigm of neuropsychotherapy for more effective clinical practice.

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