Intergenerational Trauma in Remote Australia and Papua New Guinea: A Neuropsychological Perspective
From the Editor

Welcome to the September-October 2015 edition of the e-journal.

Neuropsychotherapy in rural and remote communities
We are excited to present a paper on the applications of neuropsychotherapy in rural and remote settings. This is the result of close collaboration between myself and Monika Knausenberger, a senior clinician who apply to principles of neuropsychotherapy in very challenging environments with significant results.

Staffing - Mediros
The lovely changes of season bring renewed energy on many levels. At Mediros a number of exciting new developments have recently emerged.

We welcome Jonathan Wills on board as our Mediros Registration Officer. Jonathan will assist with the registrations of the Certificate Trainings as well as the Neuropsychotherapy Association. He is a qualified clinician with exceptional skills in Neuropsychotherapy. He was also the project manager for my book Neuropsychotherapy: Theoretical Underpinnings and Clinical Applications which was published in 2014. Jonathan can be reached on office@mediros.com.au

Certification training – Clinical Neuropsychotherapy Practitioner
After 6 years of Neuroscience trainings with attendance by over 10 000 clinicians we are ready to take the training into a new level. I will provide Certified Clinical Neuropsychotherapy Practitioner trainings in 2016. The certification trainings are a significant step towards application of the modality of brain-based therapies. Thousands of clinicians are now using Neuroscience information in clinical practice to greater or lesser extent. Guidelines to use neurobiological information and developing skills based applications in day to day practice have become a significant need. A three and a half day training has been developed to understand the modality of Neuropsychotherapy and develop skills to apply these principles in clinical practice. Expressions of Interest were distributed along with the last e-journal resulting in a huge number of clinician's indication the need to attend skills based training.

The "normal" Neuroscience workshops will still run in 2016 as they form the basis of understanding the neuroscience of various conditions (anxiety, depression, relationships, development, ageing, and pain). The certification trainings will result in a certification as Clinical Neuropsychotherapy Practitioner and a register will be available to referring institutions, doctors etc. Ongoing profession development, neuropsychotherapy based supervision, peer support and literature will be available to assist clinicians with enhancing their skills.

These trainings will run in Australia in Melbourne, Sydney, Brisbane, Adelaide and Perth as well as in Bali. In 2017, we plan to offer workshops in New Zealand, Hong Kong and Singapore.

Bali workshop
We are excited about the prospect to run a workshop in Indonesia. There is a big need to expand the principles of neuropsychotherapy in various communities. It also provides the opportunity for Australian clinicians to attend the Certification training in a lovely setting. More details about these trainings are on our website www.mediros.com.au as well as in this e-journal.

Resources
We offer a number of Neuropsychotherapy resources on our website – books as well as short neuroscience animations to explain various mental health presentations. We are also developing a series of neuroscience based tools to assist clinicians working with clients who experienced bullying, trauma, attachment issues, natural disasters and resilience or are from indigenous background to maximise wellness. We will keep you updated when the tools are finalised.

Enjoy the read!

Pieter Rossouw
Intergenerational Trauma in Remote Australia and Papua New Guinea:
A Neuropsychological Perspective

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Pieter Rossouw, M.Clin Psych; PhD.; MAPS;
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Intergenerational trauma could see the rise of a generation of severely disadvantaged and highly vulnerable individuals in localized areas, if no measures are put in place to halt the downward movement of a vicious cycle. In the Kimberley (remote North-Western Australia), the use of alcohol leads to disinhibiting of behavior and an increasing number of violent incidents, which in turn lead to trauma and avoidance behaviors, disrupted families, women raped, children growing up in a dysfunctional environment which sees many of them not being supported to attend school regularly. At any one given day, only 60-70% (or less) of children actually attend school regularly. At any one given day, only 60-70% (or less) of children actually attend school (1); truancy programs are in place but have limited effectiveness (2) while parents don’t collaborate; children coming to school without having had breakfast, and roaming the streets at night until well after midnight because it is more safe on the streets than it is at home. The Regional Education, Skills and Jobs Plan – Western Australia/Kimberley, published July 2013, reports the following findings:

Information provided by the Western Australia Department of Education on its Schools Online website indicates that the attendance rates for all year groups in the region in 2012 is around 77 per cent. For non-Indigenous students the attendance rate is approximately 91 per cent while the rate for Indigenous students in all year groups is about 68 per cent. The attendance rate for primary schools in the region is 81 per cent. The figure falls to 68 per cent for secondary schools. The average attendance rate for all government schools in Western Australia was 92 per cent for primary and 88 per cent for secondary schools in 2012. (3)

The Rural and Remote Education Inquiry Briefing Paper (4) published this briefing:

**National breakdown**

Although there was evidence that Indigenous students in remote locations were at a particular disadvantage in terms of literacy and numeracy skills, such disadvantage was also found in rural and urban settings. In urban locations approximately 35% of Indigenous primary school students had significantly lower literacy and numeracy achievement compared with approximately 43% in rural and remote locations. The percentage of other Australian students with significantly lower literacy and numeracy achievement levels was estimated at 16% in both urban and rural and remote locations (DETYA submission, page 48, reporting findings of research conducted by the Australian Council for Education Research (ACER) in 1994).

‘Literacy Standards in Australia’ (ACER, 1997) showed that in the National School English Literacy Survey, only 19% of Year 3 Indigenous students and 23% of Year 5 Indigenous students met the draft minimum acceptable standard for reading. For writing, only 29% of Year 3 Indigenous students and 24% of Year 5 Indigenous students met the draft minimum acceptable standard (DETYA submission, page 49).

**Regional breakdown**

In WA the Education Department has reported that “the overall performance of Aboriginal students is significantly lower in all learning areas, except physical education, when compared to the performance of non-Aboriginal students”. (4) For example, in 1996 “83% of all Year 10 students met or exceeded...
the Level 4 MSE [Monitoring Standards in Education] requirements for mathematics skills compared to 37% of Aboriginal students” and in 1997 “91% of all Year students met or exceeded [that level] for reading skills compared to 75% of Aboriginal students”

In addition, an erosion of respect for elders, authority, and (self-)discipline can be readily observed. The vicious cycle continues into use of drugs and alcohol, more violence, and girls getting pregnant very early in life (teenage) without the capacity, psychologically as well as economically, to look after their children. There is not much guidance available on how to parent for the next generation, other than the learned behaviors of abusive language, violence, resorting to alcohol and other drugs (marihuana) as a means of coping, and an ever-increasing inability to problem-solve effectively and creatively.

One of the observable effects of alcohol consumption are the ‘alarming rates of fetal alcohol spectrum disorder (FASD) in the Kimberley region of Western Australia’ (5). The paper states that educational level is the biggest predictor of knowledge of safe drinking practice during pregnancy. The ABC on 19th January 2015 reported on ‘Nation’s highest rate of fetal alcohol syndrome documented in WA’s Fitzroy Valley’ and based the report on the Lililwan Study (2002-2003). Alcohol intake during pregnancy, looked at from a developmental cognitive neuroscience angle, can affect the developing brain of the unborn child in numerous ways. Mattson et al (6) highlight an overall decrease in brain size, anomaly of certain brain structures, for example the corpus callosum, ventricles, and cerebellum; changes in brain shape and tissue distribution; reduced size of the basal ganglia, in particular the caudate nucleus, which is

‘...known to have extensive connections to the frontal lobes, and it has been speculated that caudate volume reductions may lead to a disruption in frontal-subcortical circuitry. This disruption may underlie a number of neuropsychological deficits related to executive functions such as planning ability, concept formation, and fluency...’. As with view to traumatic experiences and their effect on the developing brain, research has found that cortisol, a stress hormone, can affect the processes of neurogenesis, synaptic overproduction and pruning, as well as myelination in the brain: ‘High levels of cortisol can interfere with the myelination of corpus callosum axons by suppressing the division of the glial (support) cells that produce the myelin. This results in axons that are less efficient in conducting impulses across the brain hemispheres. Reduced corpus callosum area has been found in several regions of the corpus callosum for children who suffered neglect or sexual abuse compared with children who were admitted for psychiatric care but had not been abused or neglected and control group children’ (7).

From a neuropsychological perspective, the implications are far-reaching without intervention, but there is also hope if effective interventions could be implemented. Since the groundbreaking research of Nobel Laureate, Eric Kandel, the brain can be understood as a neural network that is impacted on by not only nature, but also nurture: it is not only genes, but also the environment that determine brain function and consequent behavior. The consequent experimental research into this dynamic view of the brain and the role which talking therapies play in facilitating change (8) gives reason to invest actively into a psychotherapeutic approach to the problems described above.

Kandel (9) identified five principles of brain functioning that have important implications for psychotherapeutic intervention. Principle 1 concerns the link between brain and environment, and states that all mental processes, including disturbances in brain function, derive from operations in the brain. Principle 2 states that in the communication between neurons, as they build neural networks, genetic codes and their protein play a significant role in managing behaviors, which would play an important role in understanding the pathogenesis of mental illness. Principle 3 is regarding the interconnection between genes and the environment, as genetic expression can change as a result of the interplay with the environment. Principle 4 concerns the effect of changes in genetic expression on neural wiring (patterns) which are responsible for the development of pathology. Principle 5, and this is the most exciting piece to the puzzle, proposes that through psychotherapeutic intervention, synaptic connections in the brain can be altered, effecting long-term changes to behavior.

That permanent changes can be effected in the brain through the use of psychotherapeutic intervention (‘talking therapies’) has been demonstrated
by Thomas Furmark and colleagues (10). This signals a shift away from a neurochemical approach, medicating patients with mental disturbance as a ‘feel-good’ or else sedating method, toward psychotherapy as an intervention that has the potential to fundamentally increase mental health and well-being on a neurobiological level.

The survival pattern of the brain, known to be activated under distress, tends to use the shortest way for protection, which is to override more advanced cognitive functioning (PFC) and revert back to operating from the more implicit memory systems (brainstem, medulla and hypothalamus-pituitary-adrenal axis HPA) to ensure survival (11). This phenomenon is evident by people begging ‘just give me some space’... rather than to develop approach patterns that could help shift this cyclic behavior pattern. The repeated neural activation in this way will initiate the development of neural patterns, and the risk of psychopathology emerges. The question is, how can we assist people to down-regulate the overactive survival patterns in their brain and encourage wider networks of brain activity that has a potential to effectively problem-solve and learn new patterns of behavior?

The situation in the Kimberley has considerable overlap with the situation in Papua New Guinea, partly due to the close resemblance of both cultures and also to the relative isolation of the population. There are some common cultural aspects, such as child rearing practices, conflict resolution predominantly through the use of violence, rape as a common experience, and trauma processing as non-existent due to repeated exposure to stressful and traumatic experiences in the face of limited resources, limited support structures, restricted learning possibilities, loss of community modeling and support, and effectively no access to professional assistance. Also, the experience of violence during pregnancy is an oft-existing experience in both communities. However, Papua New Guinea faces additional difficulties as compared to Australia: Based on WHO statistics (12), in PNG total health expenditure per capita was int $ 151 as compared to Australia’s int $ 4,068, with one doctor per 302 Australians as compared to 0.5 doctors per 10,000 Papuans (13).

In Papua New Guinea, the evidence of the effect of intergenerational trauma is constantly visible. In the highlands, for example, local doctors who have been working in the area for decades report the shift from violence between tribes to violence within the village and family (14). Case examples include a woman’s Achilles being chopped so she can’t run away; another woman’s arm being chopped off because she didn’t please her husband – an injury that renders a woman severely disabled, because with her hands she tends the garden to produce food in the often total absence of shops, she carries everything, including babies, in her ‘bilum’ (handmade bags) that she wears around her head, and she cares for her usually several children (the average number of children per woman is 4.6) (15) which she often has to carry and lead along dangerous and uncleared paths. Polygamy is another huge problem, erasing trust between partners, raising jealousy between wives, and time and again leading to violence between partners and also between competing women. Women are left by husbands due to his many responsibilities to different wives and their children, leaving numerous mothers to bring up their children on their own with very limited resources. Children experience violence from intra-uterine throughout their childhood years, not only learning this to be the only way to resolve conflict, but also compromising their brain development and priming their fear response while lessening their emotional control. Rape is common and often affects young children, in particular girls. The trauma spreads like a cancer slowly and ever increasingly throughout PNG society.

A complicating factor in PNG is the isolation people find themselves in while living in their remote villages, with little opportunity to get away from danger or make any other changes. There is no transport available other than walking through dangerous and hostile environment. Access to education is limited; the literacy rate in PNG is currently 67% for males and 74.8% for females (16). Lack of resources, such as a healthy variety of foods, medical attention, and things we take for granted in the Western world such as paper and pens, let alone books (if one can read), and education feed into the vicious cycle of helplessness in particular in the context of trauma. Internet access, if available, is patchy, slow and expensive thus more often than not inaccessible. Adult learning opportunities are few; this is an area where hospitals play a crucial role in educating patients and training nurses. Access to counseling or social services is largely unheard of.

A further complicating issue is the increased use of alcohol over recent years, usually self-distilled
from pineapple juice and highly potent. Apart from the development of addictions and alcohol as a ‘problem solver’, it also disables the ability of the brain to react in a different way to perceived threat (17). Currently, mainly males use alcohol, due to the male-dominated culture that sees men control resources. Also, Marihuana and betel nut are being used, probably as a way to self-medicate where no other options seem to exist.

Of major concern is the effect of violence on the developing brain, and the consequent long-term changes on neural wiring. Children are exposed to witnessing severe forms of physical violence in their villages and families, priming their own fear response early and detrimentally. Women exposed to trauma during pregnancy, such as by their fathers because of falling pregnant out of wedlock sometimes after rapes, by their partners because of ‘discipline’, and by competing women because of jealousy, give birth to babies who have already suffered intrauterine exposure to severe distress of their mothers. This might prime them to either learned helplessness with a depressive response, or to heightened alertness with a tendency to anxiety and emotional incompetence (18).

When presenting at the hospital, stories are made up to explain the injuries, often under the threat of the partner: for example, a clean straight cut on the left side of the head crossing over the ear was explained as a ‘dog bite’. Laying charges or even trying to get the police involved for protection is pointless within the Melanesian culture, which has the police biased toward their own kin and often simply unable to push for retention of a violent person. At the hospital, the doctors are sometimes asked to take the offending person prisoner and deliver them to the police station, as the police themselves fear getting actively involved with another tribe. At Kudjip hospital, medical staff is overwhelmed with cases, dealing with 150-210 patients at the outpatient clinic alone per day. This is in addition to Accident & Emergency department, and the patients on the ward (max 120 beds). There is simply no time to address the fundamental problems, apart from the lack of training. Why do people not simply speak up? As Rossouw (19) explains, ‘when safety is compromised, fear-based patterns emerge, the amygdala activates the stress response system – the hypothalamus-pituitary-adrenal (HPA axis) system resulting in increased production of CRF, ACTH, NE, adrenalin and cortisol. This compromises cortical blood flow as well as communication to frontal systems like the Prefrontal Cortex’.

However, in my own experience, when offering training for the first time and presenting a simplified version of learning communication skills and later on a basic CBT model, interspersed regularly with short exercises that saw people interact with each other (women usually sit separately from men, and this interaction in same-sex pairs seem to feel safe enough to engage in the exercise) it resulted in a keenness to learn and to continue with the training. One of the effects was that after 2 of these training sessions, a couple and a single person (nationals) started to take up personal counseling, a concept not heard of before and an intervention never encountered before.

For the doctors and medical personnel working under these circumstances, recurring trauma of handling severe cases of abuse and injury leave their traces. There is a growing sense of helplessness in the face of the seemingly insurmountable problem of violence and the lack of conflict resolution skills. At times, competing parties of local villages end up together in the hospital, potentially putting staff at risk. At times, when talking about the effects of witnessing the distress of victims of violence and rape, even though there is a sense of ‘knowing how to deal with this’, I have seen the traces of the maintained stress response in staff, and at times a person breaking down when talking about the experiences. Lack of access to debriefing, or access to creating healthy narratives around the experiences, as well as a probably inadequate preparation for such experiences in the lead up to deployment, all feed into unprocessed traumatic experiences that might hamper or shorten missionaries’ ability to remain on the job long-term.

Gladly, at least in PNG, anti-depressant medica-


From a neuropsychological point of view, attachment gets compromised through trauma experiences. In particular, during the first three years of age, the pre-cognitive phase, deciding factors are the time of trauma / injury or detrimental experience, shaping future reactions, the ability to shift away, and the flexibility to generate new behavior patterns. The earlier the traumatic experience happens, the harder it is for adults later on to recover and learn new behaviors. The ‘consistency principle’ (Donald Hebb), which states that when neuron A fires into neuron B, the probability of neuron A firing into neuron B the next time is higher than for neuron A to fire into neuron C, implies that the impact of early life experiences on the role of the environment are key indicators that shape the activation patterns in the brain (21). Memory systems get primed to high alertness with an overproduction of stress chemicals over sustained periods of time, which in turn compromise brain development and neurogenesis. The survival response, initiated from lower brain areas, initiates fight/flight responses, and constant worry for one’s safety translates into constant arousal of the memory system to be ready to act for survival. A part of the population in the Kimberley as well as in PNG might already live with enlarged Amygdalae, due to the constant threat to personal safety. Due to trauma, up to 20% reduction of hippocampus can be seen, which leads to a slower process of recovery and compromised learning ability. With compromised environments, such as experienced in PNG as well as the Kimberley, learning is inhibited and the sense of self implodes, leading on to mental illness in various forms.

Adding chemicals such as alcohol doesn’t help this process. The analogy of driving a car might help to clarify the concept: if one hits the accelerator too fast, the car will be wrecked; there is a need to slow down on a regular basis to maintain control. Through trauma, the GABA (slow-down) response in the brain is inhibited, leaving the person on hyper-alert 24/7. The release of dopamine keeps the person trapped in patterns of self-preservation such as physical violence, withdrawal and depression, anxiety patterns, incompetent parenting, and learned helplessness. In a sense, people get comfortable with their discomfort. Consequently, people tend to fall back on self-help methods, such as using alcohol and other drugs to balance the chemical overload, as well as establishing patterns of avoidance rather than approach such as developing and employing problem solving skills. However, with simple education in relaxation methods and the use of mindfulness, calming of the brain, healthy sleep patterns, and making use of the mirror neurons to learn new behaviors by copying modeled alternative conduct could be achieved in a much healthier way. Lower areas of the brain that aid survival need to ‘feel safe’ first, before higher regions of the brain can be accessed, such as the PFC to learn new behavior patterns, for example by use of CBT. Before this can be used as an intervention, a bottom-up approach needs to be put into place to achieve readiness for learning. Trust needs to be built before an intervention can be effective. For this trust to be built, the establishment of safety (in a cross-culturally appropriate way) can help build the bridges that are necessary for initiating change in neural firing.

Studies (22) show that prolonged stress compromises the hippocampus, a structure involved with memory, which renders a brain less able to learn and retain new information. This would imply, long-term, that if no interventions are made available, chances for change shrink proportionally. However, we know that a therapist’s wellness has an effect on the client’s un-wellness, and the sense of connection, and feeling understood and valued, helps to create a safe environment in which it is possible to allow new ideas to take hold in the mind. The sooner targeted interventions can be prepared and delivered, the better the overall health outcome will be.

For about 3 years, I have been working in the Kimberley, which has a population comprised of around 45% of Aboriginal people. I have also lived and worked for 4 years in remote Papua New Guinea, and after several years break, recently during the last 2 years worked 6-8 weeks per year in a remote hospital in the Highlands. What is striking is the observation of intergenerational trauma in both somewhat similar settings.

Footnotes

1 Interview with former Kununurra High School deputy principal; May 2015. He reports that ‘the average attendance is in the 70% range. Indigenous attendance, which accounts for 50% of the school, is at least 8% lower and is carried by the higher non-indigenous results... breaking it down further, of the indigenous students about 40% attend over 90% of the time, meaning the remaining 60% of the indigenous cohort of approximately 450 students attend well below 60% of the time. Many are in the high-
risk area below 30%. On any given day you would expect 60% of indigenous students to attend, often higher but by varying degrees. Also, these students do well for a number of weeks, then simply stop coming for days /weeks on end. Reasons vary greatly. Funerals are a constant issue due to high mortality, significant interconnected relationships, cultural obligation and travel - students often are away for long periods of time, often with a [good] reason, but that does not change [that] they are simply not at school for a week or more. These figures are based on an approximation of attendance.


7 Twardosz, S., Effects of Experience on the Brain: The Role of Neuroscience in Early Development and Education. Early Educaion and Development, 23:96-119, 2012; p. 104


12 www.who.int/countries; accessed May 2015, comparing Australian and Papuan statistics


14 Dr Jim Radcliffe: verbal interview 2015. Dr Rad-
Radcliffe has been a resident surgeon at Kudjip Hospital for the last 29 years.


17 Effect of alcohol on the brain: see, for example, Legislative Assembly Parliament of Western Australia, Foetal Alcohol Spectrum Disorder: The invisible disability. Report No. 15, September 2012; p. 5


20 http://www.who.int/workforcealliance/countries/png/en/

21 Pieter Rossouw, Neuropsychotherapy. Mediros Pty Ltd, Brisbane 2014

22 see, for example, JJ Kim, EY Song, TA Kosten: Stress effects in the hippocampus: synaptic plasticity and memory. Stress, March 2006; 9(1):1-11

References


www.who.int/countries; The WHO Representative for Papua New Guinea, Dr Pieter van Maaren, 5896, Boroko, NCD Port Moresby, Papua New Guinea; the WHO Regional Office for the Western Pacific, PO Box 2932, 1000 Manila, Philippines; accessed May 2015, comparing Australian and Papuan statistics


10 Neuropsychotherapy Issue 33
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

Developing Brain and the Neuroscience of Memory and Trauma
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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 specializes 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 till 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 provide 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.

Pieter specializes in neuropsychotherapy and trained over 10,000 clinicians in this modality during the past 5 years. 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 books 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.

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.

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OTHER WORKSHOPS by Dr Pieter Rossouw - not organized by Mediros

07 November 2015 – CAIRNS – Australia
The Brain and Persistent Pain
Dr Pieter J. Rossouw
Contact: - Simone Fischer – simone.fischer@rocketmail.com – Ph.: 0412 470 735

12 and 13 November 2015 – BATHURST – Australia
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**The Neuroscience of Depression: New opportunities for Effective Treatment**
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- **Melbourne** 31 Jul & 1 Aug 2015 Royal Melbourne Hospital, Grattan Street, Parkville [X]

**The Ageing Brain and Neuropsychotherapy**
Continuing Professional Development Hours - 6 hours specialised training
- **Sydney** 20 November 2015 Portside Centre, Level 5, 207 Kent Street, Sydney [X]
- **Melbourne** 5 December 2015 Royal Melbourne Hospital, Grattan Street, Parkville [X]

**Master Class – Applied Strategies for the Treatment of Anxiety**
Continuing Professional Development Hours - 6 hours specialised training
- **Brisbane** 27 November 2015 RBW Hospital, Herston Rd, Herston, Brisbane [X]

**2015 - NEW RELEASE WORKSHOP**

**The Adolescent Brain – Utilizing Neurobiological Information to Enhance Mental Health and Learning.**
Continuing Professional Development Hours - 12 hours specialised training
- **Brisbane** 27 & 28 August 2015 RBW Hospital, Herston Rd, Herston, Brisbane [X]
- **Sydney** 10 & 11 Sept 2015 Portside Centre, Level 5, 207 Kent Street, Sydney [X]
- **Melbourne** 16 & 17 Oct 2015 Royal Melbourne Hospital, Grattan Street, Parkville [X]
- **Perth** 23 & 24 Nov 2015 St Catherine’s Coll, Uni WA, 2 Park Rd, Nedlands, Perth [X]

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Melbourne 25 Nov 2016 Royal Melbourne Hospital, Grattan Street, Parkville

The Brain & Anxiety: Neurobiological information as Psychotherapeutic Tool
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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
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The Neuroscience of Depression: New opportunities for Effective Treatment
Continuing Professional Development Hours - 12 hours specialised training
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Mail: Mediros (Admin), PO Box 6460, St Lucia, Qld, 4067

Mediros Phone Number: 07 3217 7266
Certified Clinical Neuropsychotherapy Practitioner Training

Clinical Neuropsychotherapy
During the past 6 years Dr Pieter Rossouw developed an internationally recognised modality of brain based therapy – Neuropsychotherapy, and provided training to over 10,000 therapists world-wide. Training focused on understanding the neurobiology of wellness, memory, learning and mental conditions – from anxiety to depression, trauma, the developing brain, ageing, and the neuroscience of relationships. The neuropsychotherapy workshops are also the only psychology/clinical workshops that have been extensively researched in terms of the efficacy to change clinical practice* and as such is the gold standard in professional development delivery.

Need
The need to distinguish clinicians as experts in the field to provide clinical therapy from Neuropsychotherapeutic modality perspective has been strongly identified over the course of the past years. In collaboration with the Neuropsychotherapy Institute formal training is now available to become a Certified Clinical Neuropsychotherapy Provider.

Benefits
Being a certified Clinical Neuropsychology Practitioner means you will be:
- recognised by the Institute as Member of the Society of Clinical Neuropsychology Providers. This list will be available to referring practitioners (medical doctors, psychiatrists and mental health NGO’s).
- able to enhance your clinical skills through online forums
- access specialist neuropsychology focused supervision
- access online neuropsychology training
- receive preference to workshops at discounted rates
- linked in with a network of clinicians in your area operating from the same modality for peer supervision.

Who can attend the Certified Training?
All practicing clinicians who are members of a professional body

Process of Certification
- Registration for training
- Pre-training reading materials provided
- Preparation of two short case studies to discuss at the training
- Workshop attendance (3.5 days) 21 hours
- Certificate of attendance provided for 21CPD’S
- Post workshop questionnaire (self-evaluation)
- Presentation of a 2000 word essay demonstrating the application of neuropsychology in a particular case
- Certification as Clinical Neuropsychology Practitioner

Ongoing requirements for certification
- Two (self-directed) Neuropsychology online modules through the Neuropsychology Institute
- OR-
  Attendance of one Neuropsychology (or related) workshop
- One guided supervision session with a Specialist Clinical Neuropsychology provider.
- Membership of the Clinical neuropsychology Society

*References:
REGISTRATION FORM

Neuropsychotherapy Training – Certificate of Practice – 2016

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

NAME: ____________________________________________________________ Title ________________

ADDRESS: ____________________________________________________________________________

PH/MOBILE: ___________________________________________________________________________

E-MAIL: ____________________________________________________________

VENUE AND DATE            Mark with X

Brisbane 31 May – 03 June 2016    RBW Hospital, Herston Rd, Herston, Brisbane
Sydney 08 – 11 Nov 2016    Portside Centre, Level 5, 207 Kent Street, Sydney
Melbourne 07 – 10 Sept 2016    Royal Melbourne Hospital, Grattan Street, Parkville
Perth 26 – 29 Oct 2016    St Catherine’s College, Uni WA, 2 Park Rd, Nedlands, Perth
Adelaide 30 Nov – 3 Dec 2016    Education Centre, 4 Milner St, Hindmarsh, Adelaide
Bali 13 June – 16 June 2016    Courtyard by Marriott, Bali, Seminyak – Contact us for details regarding costs

COST – THREE and a HALF DAY TRAINING – Australia based training

Early Bird rate (60 days prior) $1395.00
Standard Rate $1495.00
Student rate (copy of student card) $1350.00
Previous Workshop attendees & Groups (4+ attendees per group, one payment) $1350.00

PAYMENT OPTIONS

___ CREDIT CARD (Visa or Master Card only)

Card Number: ___________________________ Expiry Date: _____________

Three digits on back of card ___________ Amount: ______________________

Name of Card: ___________________________ Signed: ______________________

___ CHEQUE    ___ BANK TRANSFER - you will receive the invoice & Mediros bank details via email

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Mail: Mediros (Admin), PO Box 6460, St Lucia, Qld, 4067
I am interested in attending the 3.5 day training course in Neuropsychotherapy to become a Certified Clinical Neuropsychotherapy Practitioner and Member of the Association of Neuropsychotherapy Institute.

The 3.5 day training will consist of:

- The neurobiological basis of mental health – wellness and the development and presentation of psychopathology
- The theory of Neuropsychotherapy
- Demonstrations of applications of the theory
- Skills based experiential learning to apply the theory in clinical practice

**Preferred city:**

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Name: ________________________________

E-mail address: ________________________________

Contact Number: ________________________________

Email to: office@mediros.com.au

Fax to: Fax +61 (0)7 329 43220

Post to: Mediros
PO Box 6460
St Lucia
4067, Qld, Australia
Neuropsychotherapy Products: ORDER Form

Name: ____________________________
Address: ____________________________
Email receipt to: ____________________________
Contact Number: ____________________________

☐ BrainWise Leadership 3 8 . 0 0
Practical neuroscience to survive and thrive at work
268 pages 2013  Dr C Henson and Dr PJ Rossouw

☐ Neuropsychotherapy 5 8 . 0 0
Theoretical Underpinnings and Clinical Applications
457 pages October 2014  Dr PJ Rossouw

☐ Think Lean Method 5 3 . 0 0
The whole-brain guide to get lean for life
242 pages 2015  Jurie G. Rossouw

☐ MiBriain animations - USB Format 3 7 . 0 0
6 Neuroscience animations  Dr PJ Rossouw
How the brain develop pathology - Onset of Anxiety, Depression, Panic, OCD, Sleep, How the brain develop -Mandarin version

Total
inclusive of all other costs - for all purchases within Australia

For pricing when order is from outside of Australia please contact admin@mediros.com.au

Payment Method
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