AcuDestress Research & Training Institute of Canada
INSTINCTUAL
THINKING
FEELING
www.acudestress.ca

Brian C. Bailey B.A., M.D.
physician practicing psychotherapy
CPSO licence # 21879
499 Sunnyside Ave. #109 K1S 0S8
1355 Bank St. #600
613-319-6750
dr.bailey@acudestress.ca www.acudestress.ca

10 Silent Signs You Could Have Post-Traumatic Stress Disorder

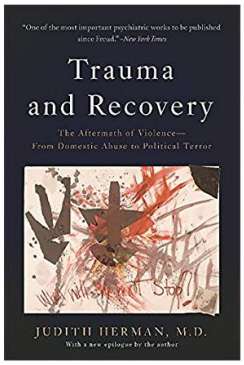
Helaina Hovitz *in Reader's Digest*
If you've ever been through something dangerous, shocking, extremely unsafe or life-threatening, look out for these subtle changes in your everyday life that could be signs of post-traumatic stress disorder.

The importance of awareness

I lived with **Post-Traumatic Stress Disorder** for years before finding the correct course of treatment or diagnosis, and some people go decades longer without ever knowing "what's wrong with them" or "how to fix it." Awareness around the immediate signs of post-traumatic stress disorder (PTSD)—along with the acknowledgment that it isn't only an affliction that war veterans struggle with—has become slightly more prevalent today: nightmares, flashbacks, panic attacks, intrusive thoughts, reliving the event over and over again, fearing for your safety. Examples of include being directly impacted by acts of war, terrorism, or

By Brian C. Bailey M.D.

I chose this excellent article by Helaina Hovitz as the background for my own article directed to PTSD sufferers referred to me or who otherwise find their way to treatment with *Acudestress*. Not everyone who walks in the door knows they have *post-traumatic stress disorder*. In fact, my own experience is that only a quarter of those who show up in the course of our month of treatment have been pre-diagnosed with this condition.



Part of this is because there has been a recent shift in the understanding of post-traumatic stress, largely due to the proposal by New York City psychiatrist **Judith Herman** in her book *Trauma and Recovery, which* includes a condition known as **Complex PTSD**. Herman's book is among the most frequently read by health care professionals who treat trauma. So, gone are the days when PTSD is only about a single incident trauma, like being present in central New York City at the time of the *World Trade Centre* disaster.

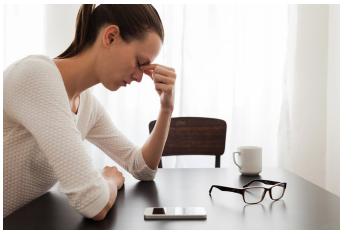
In this age of conveyor-belt medicine, your family doc does not have a lot of time allotted to see you, and if you show up with the symptoms of PTSD, and you don't have the story of major trauma, the chances are that you will be put on an antidepressant and kept on it for months or years. Now the majority of cases we are seeing do not have that story, have a story of shifting moods, and are too often diagnosed as *bipolar disorder*. But first visit *bipolar disorder diagnosis* is wrong 69% of the time. Is this you by chance?

being the victim of a crime, a natural disaster or accident, witnessing or being a direct victim of sexual or domestic abuse, medical trauma, the loss of a loved one, even growing up in a dangerous or impoverished neighbourhood or a dangerous or unstable home or family environment. Sometimes, symptoms take months or years to surface, and, when they do, they can sometimes be hard to detect, seemingly unrelated to anything you went through. For National Stress Awareness Month, I spoke with experts who help connect the dots between some of the pervasive and painful—along with some blink-or-you'll-miss-it—reactions you may be having to everyday stressors and triggers. Try taking these **steps to heal from a traumatic experience**.

Initial signs and symptoms

When looking at the various ways people attempt to cope with exposure to one or a series of traumatic events, it's important to recognize the ways that they may manifest, says **Gary Brown**, PhD, a licensed psychotherapist in Los Angeles who has worked with organizations like NASA and the *Department of Defence* in addition to seeing patients in his everyday practice. *"You probably have a sense that something is wrong, you don't quite feel like you normally do, and might alternate between feeling extremely upset or possibly nothing at all,"* he says.

1.) Hyperarousal



This is an intense experience of thoughts, feelings, behaviours, and physical sensations resulting from the traumatic event. *"The body's chemical reaction to the trauma can put the person in extreme survival mode we know as "fight or flight,"* says Dr. Brown. *"When in a state of fight or flight—and we should really add the element of "freeze" when we become immobilized by fear—we feel completely out of control. Needless to say, this is a very painful and* scary"

I must warn you that very few of you will have the history or the dramatic single event symptoms on the left. If you were to have a typical story of walking down the road in Afghanistan and witnessing your buddies being blown to smithereens, and have been struggling to fit into your family or society on return from a war zone, the diagnosis will be patently obvious, and perhaps even the treatment as well - *Eye Movement Desensitization and Reprocessing (EMDR.)* The vast majority of you will have a story, dramatic or nondramatic of having a difficult time in your early years. That's C- PTSD.

Judith Herman's Delineation of Complex Post-Traumatic Stress Disorder

- • A history of subjection to totalitarian control over a prolonged period (months to years). Examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults. Examples also include those subjected to domestic battering, childhood physical or sexual abuse, and organized sexual exploitation.

- • **Alterations in affect regulation**, including
  •Persistent dysphoria
  •Chronic suicidal preoccupation
  •Self-injury
  •Explosive or extremely inhibited anger (may alternate)
  •Compulsive or extremely inhibited sexuality (may alternate)

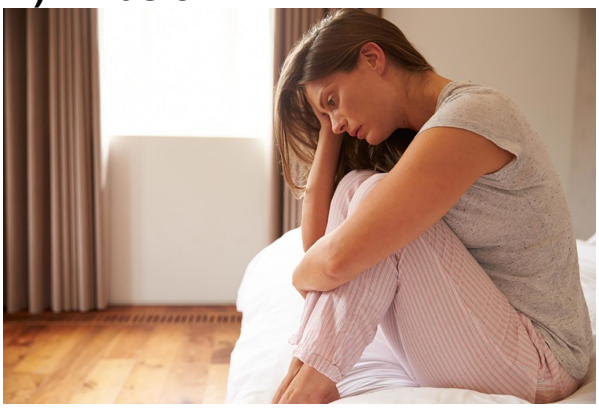
- • **Alterations in consciousness,** including
  •Amnesia or hyperamnesia for traumatic events
  •Depersonalization/derealisation
  •Reliving experiences, either in the form of intrusive PTSD symptoms or in the form of ruminative preoccupation.

- • **Alterations in self-perception**, including
  •Sense of helplessness or paralysis of initiative
  •Sense of defilement or stigma
  •Sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)

- •**Alterations in perception of perpetrator**, including
  •Preoccupation with relationship with perpetrator (includes preoccupation with revenge).
  •Acceptance of belief system or rationalizations of perpetrator

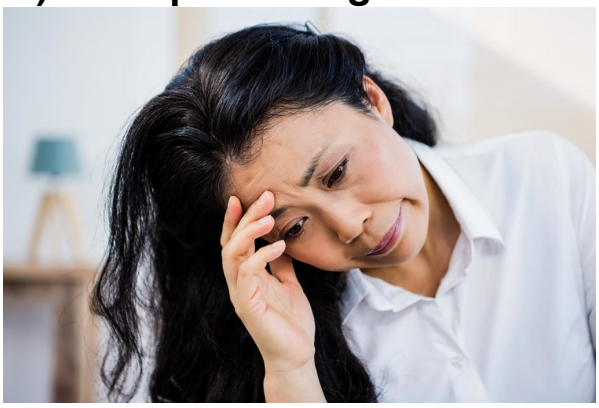
You may find that you get easily overwhelmed or worked up and can't calm down, or can't fall asleep at night.

2.) Intrusion



This is the experience of persistent intrusive thoughts and feelings about the event—and sometimes, they're unrelated but disturbing in nature. *"The more it plays, the more distressed you become, because you are constantly reliving the trauma,"* he says. *"The problem is that you can't find the 'off' switch, and the more it repeats, the worse you feel. Despite your best efforts, no amount of will-power or any form of distraction that you might normally use, you can't stop the loop."* Essentially, it feels like you are out of control of your own mind. Here are **eight warning signs of depression**.

3.) Re-experiencing



This could manifest as flashbacks or nightmares, or feeling like you are re-experiencing or reliving the fear from the event that triggered your PTSD when you encounter everyday triggers around you that remind you of something that has to do

- **Alterations in relations with others,** including a
  - •Isolation and withdrawal
  - •Repeated search for rescuer (may alternate with isolation and withdrawal)
  - •Persistent distrust
- **Alterations in systems of meaning**
  - •Loss of sustaining faith
  - •Sense of hopelessness and despair

The patients we see may not, initially at least, have Judith Herman's long list of symptoms. They're more likely to present initially with symptoms like *migraine headache,* which may or may not seem like it is related to chronic traumatic stress. But we do know that PTSD occurs in 10% of the general population, and that it occurs in 25% of people visiting a headache clinic. We see people for whom medication or psychotherapy has not worked. So why wouldn't we see a lot of PTSD (60%) among our patients? It is highly associated with **alexithymia** (up to 70% of our patients.) We test because we know we can treat it, and because we know how to test patients for *alexithymia (the inability to know precisely how we feel or how others feel, and how to be creative with such reduced feeling states.)*

If you are someone we tested for alexithymia with the often-used *Toronto TAS-20* questionnaire, I can tell you that this questionnaire is a pretty good indicator of underlying PTSD, but it also selects out most people who are *aggressive personalities* (REDs) as identified by **Dr Karen Horney.** So if one is both an *aggressive* and has a story consistent with Complex PTSD, TAS-20 results can be very high (>100 is abnormal.)

Intrusion and re-experiencing are commonly seen in PTSD - **but only in the three quarters of patients who have a tendency to dissociate.** This blatant symptom being more obvious, makes it easier and earlier to get a correct diagnosis. These symptoms are seen in those who have an underlying *withdrawing personality* (Horney's *detached personality*.) Such patients also have a history of unstable attachment - the variation called *disorganized attachment*, (described by John Bowlby) where, as a child, one reaches out towards mother for succour, and mother is not available or even rejecting. Disorganized patients often have one or more personality disorders, the most frequent of which is *Borderline Personality Disorder*. Such people also are reactivated by triggers, reminders of the long-ago trauma they experienced, even when these triggers are not representative of trauma in the present day, but only in the past.

with the event," says Shanthi Mogali, PhD, director of psychiatry at **Mountainside Treatment Center**. She also says to keep an eye out for sudden mood changes. *"PTSD can actually manifest itself as depression or anxiety, or mood changes that make you feel low, high, sad, angry, upset, for 'seemingly' no reason,"* she says. *"This could be a less immediately recognizable sign that a person is really suffering."*

4.) Avoidance

It is common to try and steer clear of anything that could continue to trigger the persistent thoughts and feelings relating to your traumatic experience, says Dr. Brown, who also serves as a **disaster mental health specialist** and has provided on-scene support to various national level disasters including working directly at Ground Zero in the wake of the attacks of 9/11 and both natural and other man-made disasters. *"One of the most common themes associated with this phenomenon is the desire to avoid any people, places, or objects that cause us fear and pain. It's really a very normal response to an abnormal experience. Especially when we're in survival mode. We don't want to continue to experience the pain."*

5.) Risky behaviour

When someone experiences a potentially traumatic event, says **Mallory Grimste, LCSW**, it is likely that person did not have much control over the situation or the fact this event occurred. *"When we feel confident and in control of our lives and circumstances, we tend to feel better in general. People will often attempt to engage in risky behaviours to recreate similar circumstances, or*

Unfortunately, the mood shifts described here by Dr. Mogali are all too often mistaken for *bipolar disorder,* as they mimic the changes seen in such patients. Whenever I see a patient who has been previously diagnosed as *bipolar*, I begin to look for PTSD. This is important, because the drug treatment for *bipolar* can actually be disabling if it is applied to people who are erroneously diagnosed. Sometimes our job is to get people off medication. But we can't do that ourselves, and have to rely on the good offices of colleagues who can reassess people based on new evidence. Some people say that the differentiation may be based on whether the patient has a sleep disorder, which is more common in PTSD than in *bipolar*. This is really the low hanging fruit in diagnosis, as those who dissociate *(split off from memories of trauma)* are the 75% whose diagnosis is obvious.

So let us talk about the ones who are not so obvious. This group is highly represented among our patients. These people are more likely to have had single event PTSD, like being at Ground Zero in the wake of 9/11. But even these people may have predisposing histories, though they are usually less dramatic than the stories one hears of the *dissociative* types, patients we call **BLUES.**

Our remaining patients, the so-called YELLOWS and REDS are harder to diagnose, but easier to treat. These people are hard-wired to withstand traumatic stress. The YELLOWS are naturally hypervigilant, simply because they have a very active limbic brain, and have been using it since the day they were born.

So when trauma hits they're better prepared for it. Researcher **Stephen Wolinsky** *(The Tao of Chaos)* describes hypervigilant personalities as being more highly aware, by birth, of danger and aggression than others. But they also lack the brain's balance to *hypervigilance - "selective forgetting."* This dissociation equivalent is what we use to shut down our memory of the work day on our way home. It's how and tell ourselves when we are on vacation that this is now our life, not the life we have been leading at home. A person with this personality type is less susceptible to hypnosis than the other types. So, employment of *mindfulness* is the choice par excellence for such people. The YELLOW types, who are Karen Horney's *compliants,* cleave to other people, especially when under stress. For this reason they are helped immensely if the people around them recognize that just telling their story to a friendly listener, gives them a leg up on recovery. These people are prone to suffer when they encounter stigma - i.e. others who lack *empathy*.

feelings and experiences related to the original trauma so they can regain a sense of control with the hope that the outcome will be different than the original experience," Grimste says. She notes that it is not always a conscious decision, either—some examples of risky behaviours may be driving very fast or recklessly, walking alone in areas that are known to be dangerous, instigating arguments with others that are likely to result in possible physical fighting or even something like procrastinating on work assignments just to push the envelope.

6.) Inability to trust

This can be related to a lack of trust in other people and the greater world around you but is often more likely rooted in a lack of trust in yourself. "After a traumatic experience, it's common to be generally distrusting of others, the world, and one's self. You might feel like you can't take anything at face value, or you may be subconsciously 'testing' your relationship with people or constantly questioning the other person's commitment or loyalty to you," Grimste says. She continued to explain that you might start looking through another person's phone or emails someone's without their permission, calling or texting often to "check-in," or even showing up to someone's place unexpectedly. "On the other hand, you might have the opposite reaction and have an avoidant reaction, which means you won't engage in any real relationship with anyone because that kind of vulnerability feels very risky," she says. "You might find yourself starting to lie, pretend to like or enjoy something you don't, or becoming paranoid about someone's motivation, or even their lack of response during a certain period of time."

7.) Hypervigilance

Living with trauma can make work, social gatherings, even commuting a terrifying and exhausting experience. Over time, we learn and adapt our behaviours based on our past experiences and how we've processed them. Grimste notes that if you've experienced a traumatic event, you feel that if it happened once, it can happen again. In a way, this hypervigilance provides a sense of security—if someone is always "expecting the unexpected" they can be better prepared and hopefully

Empathy is not sympathy. It is an actual bodily awareness of the feelings and sensations of others. It ceases to be available to those with alexithymia, an entity rarely seen among the YELLOW types. After all, their personalities are built on awareness of connections to other people, so when abandoned to their own devices, and talented empaths themselves, they become even more lost when the people around them are not responding in kind. This alone leads them to lapse into mistrust and to be uncharacteristically aggressive towards other people. This is the type who have to learn the ability to trust others.

REDS While the big emphasis in the medical literature is on trauma cases who dissociate, because of their dramatic presentation, I'll leave that easy-to- diagnose entity to the end. Here I will now talk about the people who have *naturally aggressive temperaments*, who're born to take control of things. They are the most independent of all people and so they usually manage things on their own. Since they (REDs) are more likely to be members of the military because of their natural *aggressive* urges, they are also most likely to be able to *" suck it up"* in the way the military expects them to respond to outside stress.

So rather than being in the therapy room, they are out there doing their best to stuff down their fears, as fear is not something they ever want to admit to. When it arises they tell themselves (as they're prone to tell others) to *"Stop it!"* This is their coping mechanism which is different than a true solution to their problem, and they soon end up applying the same exhortation to others around them. Until they can see beyond their proclivity to be over-independent, their inability to trust is maximized. Their equivalence to *dissociation* is to shut down their feelings, or if that doesn't work, to deny them. *"Who, me. I'm OK, Jack!"* They definitely lack empathy, which was not their strong suit in the first place. They are the last people to benefit from social media, as they tend to use it explosively to blow off stress, convincing themselves that they are invulnerable.

Does this make them hypervigilant? If it does it is not the classical hypervigilance seen in the YELLOWS above. When YELLOWS are hyper-vigilant, they run for cover, and they don't even experience the cover, if they find it, as safe. They have often developed with *ambivalent attachment*. So they rarely find relief anywhere. When REDs are hypervigilant they attack at all costs, and often don't even know, a few minutes later what all the kerfuffle was about. So they wander around lost, until some body finds them.

enact a different outcome than when the trauma happened. It is, in a way, an attempt to protect yourself. *"You are always on the lookout for when the next 'bad thing' is going to happen and actively try to prevent it by anticipating the threat and protecting yourself against it before it's too late,"* she says. *"Unfortunately, the surge of adrenaline that makes us feel on edge, anxious, and panicked, like we have to do something or run, often create even more chaos, problems, and even physical health conditions."*

8.) Social withdrawal

It makes sense that to avoid all of the racing thoughts, anxiety, paranoia and other uncomfortable behaviours associated with the above symptoms that you might try to avoid being around people as much as possible or develop social anxiety. "Many people try to cope by withdrawing from typical sources of support, like family, friends, and colleagues," says Dr. Brown. "The problem with social withdrawal is that we wind up leaving ourselves isolated and alone at precisely the time when we really need to be reaching out to others for help, comfort, and support. By withdrawing, we actually wind up prolonging our suffering." Instead of withdrawing, he suggests, do the exact opposite. "Reach out to at least one or two people that you normally trust, and let them know what is happening to you," he says. "This is one of the very best ways to begin your journey of recovering from the trauma."

9.) Drinking or using drugs

There is a strong connection between PTSD and increased drinking or drug use, a behaviour often referred to as self-medication. *"People suffering from PTSD are often desperate to find a way to soothe these unpleasant feelings, and that's where substance abuse enters the equation,"* says Dr. Mogali. *"They might think that self-medicating will help them feel better, and when they first start using, it does. Increased drinking in general, both alone and in social settings, is a*

Here I agree in chapter and verse with Grimste on the left, especially as it applies to treatment with **Smith's 5-point year acupuncture**. How could anyone possibly talk someone out of *hypervigilance?* This is a bodily response to stress, mediated by adrenaline. You can talk to such a person until the cows come home and it will make no difference. One actually has to alter the brain pathway which leads to the hyper-vigilant response. And while one is doing it one has to reassure the recipient, that when all is said and done, they will still have the hypervigilant response when they really need it. It is not a matter of getting rid of it, as we will still need it, but it is a matter of creating a balancing response, which is often found in *mindfulness; mindfulness* is telling the truth about what is really going on within us, not to others, but to ourselves. This is the royal road to recovery for all our patients.

RED's don't withdraw socially. They have been out there in the fray since birth. They want to *"kick ass and take names."* It is a way of discharging their aggressive approach towards life. In social situations, they find ways to see that the others are the problem, not them. By finding one's RED Resource with a combination of *5-point ear acupuncture, mindfulness training, neuroplasticity practice, and transpersonal psychotherapy*, they fill the bill, and ready themselves to practice this behaviour until perfect in the world at large.

Dissociators So let's talk now about the *social withdrawal* aspect of PTSD. The **BLUE** folk who feature withdrawal in their repertoire have been back-pedalling since the moment they were born.

Here I disagree with Dr. Brown that they can just turn and do what they have done in their whole life. You can't send those who *dissociate* home with instructions to reach out to somebody. It is not their nature. They must discover by trial and error where their comfort zone is. I recently had a woman who had recovered from *Borderline Personality* and was working her way around a strategy to defang C-PTSD. She'd been down the alcohol and drugs escape. She'd managed to blow off all of her friends in the process. As she *"resumed normal behaviour"* she got very good at edging out into the public again. I then discovered that she was becoming quite talented at drawing on her empathy to know what to do to rescue fellow withdrawal oriented sufferers. I saw her going full speed ahead, until I asked her if I could schedule her to do this with other people. She turned and ran in the other direction. This is not something that anyone else can decide for you.

common way that people cope, since it enables you to feel more relaxed when you're otherwise unable to relax." However, things usually don't stay that way for long. Substance use—which commonly includes, in addition to alcohol, the use of marijuana, opiates, and benzodiazepines (Xanax, Clonazepam or Valium)—increases your "feel good" sensations. The way your body is interpreting alcohol or drugs is *"I feel happy and good."* However, she says, these feelings are always temporary, and often keep people from being able to recover from PTSD. In some cases, it can lead to addiction or dependence that only makes things worse. *"You may not feel as depressed or anxious when using drugs, but when they're not using, the anxiety and depression will rear itself in a really intense way. And the more you self-medicate, the harder time you will have in being able to feel in control of your own emotions and able to deal with them in a healthy way on your own,"* says Dr. Mogali. Watch out for these **medical reasons you might be in a bad mood**. PTSD is one of them.

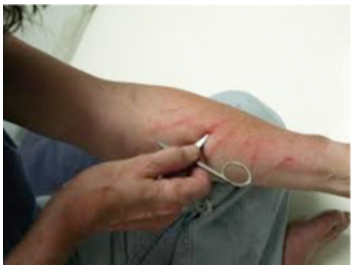
10. Avoiding normal activities

In addition to avoiding people you once held dear, you may also start steering clear of other daily routines that once represented life inside of a comfort zone that no longer exists after it's been so severely disrupted, Dr. Brown observes. *"A good night's sleep has been out of reach for hours, days, weeks, and possibly months, so you may have also stopped engaging in activities that normally brought you pleasure,"* he says. *"Maybe it was going to the gym four days a week, yoga classes, movies on Saturday nights, cooking dinner, a weekly book club, or nightly walk with your partner. Now, you find yourself sitting at home, no longer feeling any pleasure in anything."* Ideally, pushing yourself to show up for these activities or pick the routine back up would be an important way to "fake it until you make it" but if you feel unable to function at all, it's important to contact a trauma specialist, like a therapist, or psychologist, immediately.

This brings me to the medication question. While those allowed to prescribe in such situations often do, they do so on account of desperation not hopefulness. Medication side effects can and do retrigger trauma. Symptom relief is only justified if it provides overarching *integration* of trauma.

I can understand why over-prescribing occurs. If there is nothing to address the whole matter, or if the person is unable to address the whole matter, they yearn for symptom relief. The spectrum of alcohol, drugs, marijuana, and "benzos" do provide a modicum of relief. But it is temporary and the person taking it is prone to addiction - and despair. After all, PTSD is an addiction. It has been shown that naturally circulating opioids are often abnormally low in people with PTSD. Certainly there is an opioid deficiency in the area of the *ventromedial PFC*, and marked lowering of function in this area in those with active PTSD.

So the tendency is to make up for internal lack by taking something from the outside. The ultimate example of this is *cutting* - where the patient augments circulating endorphins by performing an act which is often to them, not even that painful. So we'd like this to stop, but there's no sense putting an order in for it, until the patient's underlying problem is being addressed. If it is, the person will get off medications and drugs by their own timing. If it's not, this will become the main issue of the treatment. It shouldn't be.



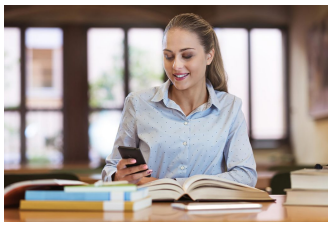
There is a sign at the California-Nevada border: *"Exiting California. Resume normal behaviour."* We would like our patients to resume normal behaviour, and Dr. Brown suggestions are great, but only if the patient has developed some abilities to deal with the everyday world which will become manifest in the activities that they take on. In our treatment with *5-point ear acupuncture,* in the early going most people learn to sleep better. That's sure a good thing to carry into the period of time after therapy.

Whoah! What period <u>after</u> therapy? Doesn't therapy go on forever? In the best of all possible worlds, it doesn't. The patient acquires some new skills, and breaks some old patterns, but there must be some way that the patient can practice the new skills on their own if they are ever to have a good result. To think that help from the outside is going to be required for ever is a self-defeating

Change in sexual behaviour or romantic relationships

Whether you're single, married, in a relationship, or something else altogether, people suffering from PTSD often find that their sexual relationships become dysfunctional or may engage in promiscuous behaviour, says Dr. Mogali. *"The reason for this is complicated, but can involve the trauma leaving behind feelings of worthlessness and beliefs of being unlovable,"* says Dr. Mogali. It can also be a direct result of inhibition being let down by the aforementioned substance abuse or increased drinking, and a tendency to the also previously aforementioned tendency towards risky behaviour. You may notice that the dynamic in your committed sexual relationship has changed, you seem somehow unable to have normal intimate romantic relationships and are shying away from physical encounters with your significant other. Perhaps you're making decisions to have sexual intercourse with people on a whim, or while intoxicated and without thinking it through, or you're cheating on your partner. You may find that you have feelings of low self-esteem when you used to be confident and bold, or that you're suddenly using sex in your relationship as a way to assert control. "Also, those experiencing PTSD may cope by attempting to assert control in their sexual relationships. Performing sexual acts or having intercourse becomes a way of experiencing validation and can lead to an unhealthy way of coping," says Dr. Mogali. "This behaviour actually often results in an even lower feeling of self-worth and encourages a feeling of despair.

Difficulty concentrating



At work, you may find that your mind is wandering mid-conversation with someone, even though you're looking right at them. Or you may find yourself staring into space during a meeting at work instead of focusing on the task at hand. *"Even ordering lunch at your favourite restaurant can become difficult as it's difficult to pick between multiple options. For example, you'll be at the grocery store, but won't be able to remember the items you came to buy,"* says **Ken Yeager**, director of the *Stress, Trauma and Resilence*

proposition. It is absolutely necessary to resume normal activities, but one must do it with more gas in the tank than one's been doing for so long. *So what can you do when you live in a shoe? Moved to a boot and eat sole food!*

How can one adopt a philosophical attitude to one's future? The watchword these days among the **Bessel van der Kolk**'s, the **Ruth Lanius**'s and the **Judith Herman**'s, the trauma experts leading the field, is that the sufferer must integrate three distinct various brain layers into a new way of doing things. Judith Herman in *Trauma and Recovery* reports that 96% of PTSD thinking, is that one was to blame, oneself. Even though somebody else acted as the perpetrator of the trauma, that it was the victim's fault after all.

Since s*hame* and *guilt* interfere neuroplastically in every effort people make to get better until they don't, sex is where the rubber (crucially) meets the road. There is nothing like sex that rivals the sensitivity of the person to self rejection to create a repetitive barrier normal to bedroom activity.

The temptation is rife to see the challenge before one as far beyond their ability to overcome it. On the one hand we have people whose experience has been to see themselves as *Smaller-than-The-World*, that the world is an insurmountable mountain, which everybody else can climb but they can't. They have lots of evidence in their memory bank that they can't do it. I talked on page 6 about when my dissociating patient, who had actually stopped dissociating, but who wasn't ready to *associate*. She was convinced that she just wasn't deserving of the opportunity to be with others, as she'd blown so many opportunities in the past. It's a story that keeps being told, until it isn't. So there's no single way out. One has to get out with all pistons firing, and that means "knowing what to do" intertwined with " having an identity of one's own" and " being anxious to contribute one's empathy and compassion to the world at large without exception" - quite an order to fill unless one is prepared to fill it.

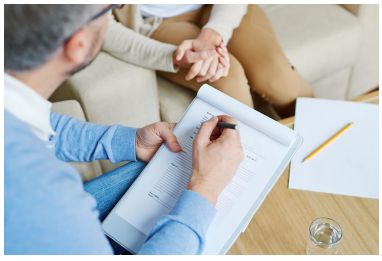
So let's talk about **difficulty concentrating**. This is what the disorganized brain is doing, creating a disorganized mind which keeps true association of other people off the table of consideration. There's nobody for me out there. I might as well exit. And in the bedroom, it is not just having one's body available; it is having a real self available if it's going to be about recovery. **Every nasty thing which envelops one's being in a dim light must be transcended in at least a few moments of pure joy.**

STAR Program at The Ohio State University Wexner Medical Center. *"Now, your brain communicators are all firing at the same time, making it difficult for it to pick out what is important and what is not."* When you're afraid that you can no longer get very basic things done or gain control over your own thoughts, you may find yourself taking part in some of those avoidance behaviours noted earlier. *"This is a very scary space because it becomes a very short jump to if I can't interact with anyone and can't be effective in my life what am I doing here? This is the type of isolating thinking that leads many to consider ending their lives,"* Dr. Yeager says.

Paranoia

In order to keep yourself safe, you may start looking for things—or threats—that aren't really there. "*You can't trust authorities, you can't trust the government, and you can't trust anyone or anything. If you were robbed at gunpoint and now have fear about the world not being safe, watching TV news and seeing stories about robberies and other crimes will reinforce your view that the world is not safe,"* said Dr. Yeager. For example, if you've been the victim of a violent crime, you may feel compelled to constantly read the headlines or watch the news. Or, you may find it impossible to go to a football game or a concert—activities you previously enjoyed—because now there are too many people around and you don't feel safe. *"Nighttime may be your most difficult time, because it's hard to see what's going on around you, and things will start to sound noisy and dangerous. You may decide to stay home, where you feel safe,"* says Dr. Yeager. *"You'll probably have problems with intimacy, and likely can't talk about your traumatic experience because it's just too upsetting."*

Treatment



There are many effective courses of treatment for PTSD ranging from cognitive behavioural therapy and dialectical behavioural therapy to EMDR (Eye Movement Desensitization and Reprocessing), and art

Joy, you say, yes joy! This has to occur and it has to reoccur before one can translate any therapeutically-derived post- PTSD approach to life into a nourishing relationship, or a truly and mutually satisfying sexual encounter.

You already know that in *Acudestress* we kickstart joy with an improbably successful exercise we call *Vulnerability Day*. We have many people who experience pure joy at least fleetingly at the end of their treatment, so we know that solidifying this joy is what we want our patients to do next. We call this process *embodiment*. I'll have much more to say below about *embodiment* as it is really the reason for this tract. So, let's look at the barriers to it, and how to bring the barriers down. When we solve this we have C-PTSD on the run.

Firstly, joy trumps paranoia. Within PTSD we have good reason to be paranoid. We know that it any moment, something beyond our control can come along and throw us into reliving the trauma right on the spot. We have thus avoided *vulnerability* like the plague. Many of you breathed a sigh of relief when I told you at intake we wouldn't be discussing your reason for coming to our treatment. You knew it triggered you. You know when you talked about it, it made things worse not better. So what is adequate treatment but removing the barriers to vulnerability, by uncovering joy? And most if not all of you spoke a 20 minute monologue at trerament's end about how you can now embrace *vulnerability*. So, you can! This vaults you into the phase of treatment you do yourself - the *Embodiment Phase*.

Researchers in the field, and many clinicians disagree with Helaina Hovitz that existing psychotherapy treatments are succeeding in the field. Noted Borderline researchers **Barbara Stanley** and **Larry Siever**[1] declare:

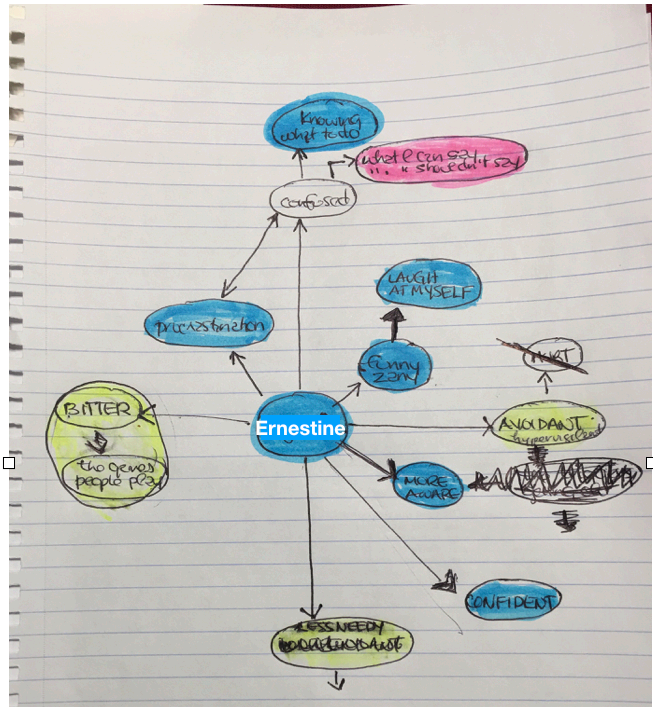
"…A variety of psychosocial treatment options have demonstrated some efficacy in borderline personality disorder - dialectical behavioural

[1] Stanley B., ad Siever L. The Interpersonal Dimension of Borderline Personality Disorder: Toward a Neuropeptide Model Am J Psychiatry. 2100 Jan; 167(1): 24-39

therapy. These are often coupled with medications to treat the anxiety, depression, and insomnia that come along with the PTSD.

A variety of psychosocial treatment options have demon strated some efficacy in borderline personality disorder— dialectical behavioral therapy (144), cognitive therapy, transference-based therapy (145), mentalization therapy (146), and schema-focused therapy (147, 148)—although these treatments have typically shown efficacy for single symptoms. For example, dialectical behavior therapy reduces suicidal behavior and nonsuicidal self-injury, and transference-focused therapy shows efficacy for reflective functioning but not suicidal behavior or self-injury.

Additionally, if you have turned to self-medicating to cope and find that you're facing alcohol or drug addiction, checking out a 12-step recovery program may also be helpful, and of course, a holistic approach to finding inner peace, like yoga, exercise, and medication, are also excellent ways to round out the above courses of professional medical treatment.



"The sooner you ask for help, the sooner you will begin to feel better. Left untreated, PTSD can have a devastating effect on a survivor and her or his loved ones," says Dr. Brown. *"I know, I've been there. The biggest mistake I made when I left the military was not immediately getting the help I needed."* And if getting help for yourself is not a good enough reason, he says, then ask yourself this: Am I the only one impacted by this? How are my loved ones impacted by what is happening with me?Those who reach out to family, friends, colleagues, and professionals trained in the treatment of psychological trauma, have significantly better outcomes than those who don't. Make sure you're aware of these **scary things that stress can do to your brain**.

*Helaina Hovitz is an **editor**, journalist, and author of* **After 9/11**.

therapy (144), cognitive therapy, transference-based therapy (145), mentalization therapy (146), and schema-focused therapy (147, 148)—although these treatments have typically shown efficacy for single symptoms. For example, dialectical behavior therapy reduces suicidal behaviour and non-suicidal self-injury, and transference-focused therapy shows efficacy for reflective functioning but not suicidal behaviour or self-injury…. Exploring new avenues for treatment is particularly important for this disorder because current approaches are far from satisfactory."

AcuDestress stands alone in approaching trauma by strengthening and evolving the host, in contradistinction to programs which try to blunt or block specific manifestations of trauma, like self-harm, suicidal thinking, impulsiveness and the like. If the subject can find ways to release latent abilities (we know at this juncture that there exists an entity they're calling **trait mindfulness)** and readily see it putting in an appearance early in the course of an *Acudestress* session.

This leads to patients discovering their primary colour (here , on the left, **BLUE**), which we see on a *schema* drawn 6 months after therapy as the working result of the *Embodiment Phase*. The traumatized patient has, by devising her own *schema* (not ours) sketched out a plan, for taking control of her treatment and her life, by creating her own map to recovery. Gradually she has coloured in her issues with the brain layer colour which she has by trial and error discovered what exercise and skills will serve to integrate her triune brain into a fully functioning adaptable entity, functioning at a more complex level than at the start. Her *schema* can even be scored, so that she can tell, herself, over time, how she is progressing. Creating a *schema* has seen patients, who are still languishing, suddenly turn a corner to normality - thus bringing therapy to an end.