Work-Related Post-Traumatic Stress Disorder: Efficacy of the MyE.M. Process for Healing PTSD

By Udall Siraj and Beverley F. Searle

Abstract

Objective

This study sought to determine the efficacy of the My Envisioned Mind, an alternative process for treatment and healing of PTSD as an intervening treatment for workplace trauma.

Methods

An experimental study with 10 participants from the United States and Australia using the DASS21, PCL-CL as pre-and post-assessments and the 10-hour MyE.M. process as the experimental intervention.

Results

Post-assessment results indicated all participants had a decreased PTSD score under 50 points on the PCL-C with an improvement percentage of 73%. Post MYE.M. intervention DASS21 scores were within the normal ranges for depression, anxiety, and stress with an improvement of 82% for Depression, 77% Anxiety and 86% for Stress.

Conclusion

Study results yielded sufficient evidence to indicate the MyE.M. process alleviates work-related PTSD and residual symptoms. Such results are ground-breaking and places the MyE.M. process as a possible contributor to the healing of work-related PTSD.

Keywords: *PTSD, Complex PTSD, Trauma, MyE.M., My Envisioned Mind, Post-traumatic stress disorder, stress, work-related stress, occupation stress, work place violence, anxiety, work-related PTSD*

Trauma is defined by an event that threatens psychological well-being (Tedeschi & Calhoun, 1995). The American Psychological Association (APA) simplifies the definition of trauma as "an emotional response to a terrible event" ("What is Post Traumatic Stress Disorder?," 2017). More than half of the adult population has been exposed to a traumatic stressor during their lifetime and respond with post-traumatic stress symptoms immediately thereafter. Those symptoms usually dissipate without intervention. The individual's response to adverse events determine whether an event can be considered traumatic and/or result in PTSD. An individual's management of trauma whether experienced individually or collectively, varies according to the individual's coping skills, personality, experience of similar situations and resilience and hardiness (Tedeschi & Calhoun, 1995; Lepore & Revenson, 2006). Cultural and social factors also contribute to trauma response. Thus,

consideration for an individualized treatment regime might prove more effective than a standardized form of treatment.

The American Psychiatric Association defines Post Traumatic Stress Disorder (PTSD) as a psychiatric disorder that occurs as a result of a person directly or indirectly experiencing or witnessing a traumatic event. Diagnostic symptoms fall into four categories: intrusive thoughts such as recurring memories, avoiding reminders of the event, negative thoughts and feelings about self and others; and arousal and reactive symptoms such as trouble sleeping. The severity of the symptoms varies with individuals and display within weeks or months of the traumatic event (What Is Posttraumatic Stress Disorder?, 2017). According to the Diagnostic and Statistical Manual-5 (DSM-5) (2014), PTSD runs a variable course from acute to chronic starting immediately or delayed over months and lasting for years.

According to APA, a PTSD diagnosis must meet 8 different DSM-5 Criteria. Understandably, the necessity of a set of diagnostic criterion benefits clinics and clients in ensuring accurate diagnosis. Even though the criteria appear to be more expansive than previous versions, the DSM-5 restricts PTSD diagnosis and fails to account for and include the variance of individualized responses to traumatic and prolonged adverse events. Consideration must be given to the lack of distinction as to which trauma results in PTSD and which trauma does not. As various factors may contribute to the individual response resulting in PTSD, a situation may not meet the DSM criterion for trauma, even though the individual poses symptoms and/or behaviours that constitute PTSD. Also, consideration must be given to the individualized response to events – an event may constitute as a trauma for one may not be a trauma for another.

In the past, the average consensus by psychologists indicated PTSD as a condition diagnosed for soldiers/military who experienced combat and fell under such terms as “shell shock” and combat fatigue (What Is Posttraumatic Stress Disorder, 2017). Research has indicated that due to the nature of their work, certain occupations such as the military, police officers, fire fighters and first responder are more inclined to work-related job stress from exposure to traumatic events (Skogstad, et al, 2013). Thus, these occupations have a higher risk of PTSD. According to Skogstad, et al (2013) other positions such as health care professionals, train drivers, divers, journalists, sailors and employees in bank, post offices or in stores may also be more prone to work-related traumatic events and have a higher risk of PTSD.

The Skogstad, et al (2013) research appears to overlook how the workplace has become a source of stress and trauma not just for those in high-risk occupations. Incidents such as the World Trade Centre collapse, London bombings, mass shootings, airline disasters, workplace injury, death, and etcetera, resonate as traumatic for those employees directly or indirectly exposed. After exposure to a traumatic or stressful event which could be work-related, approximately 3.5 percent of U.S. adults will experience PTSD (“What is Post Traumatic Stress Disorder?”, 2017). The current DSM-V covers the diagnosis of the individual’s experience of a one-time traumatic event and even a series of successive traumatic events.

Prolonged chronic stress and changing social, economic and political environments dictate that a broader definition and diagnostic criteria for PTSD would serve populations more effectively (Stein, et al, 2104). It appears that the current definition and criteria fails to account for chronic long-term trauma exposure such as that which may occur in a work environment. A toxic workplace riddled with bullying, harassment, emotional/verbal abuse, sabotage, and job insecurity creates a prolonged stressful and sometimes traumatic

environment for some employees which produces guilt, depression, stress, anxiety, anger, low self-esteem, etcetera. The current definition and criteria also fails to account for cultural, social and psychological trauma that spans months, years and possibly centuries.

According to Dr. Judith Herman, Complex PTSD or Disorders of Extreme Stress Not Otherwise Specified (DESNOS) captures the psychological impact of prolonged repeated trauma otherwise not included under the DSM-V PTSD diagnostic criteria. Field trials indicated that over 90% of those with Complex PTSD also met the criteria for PTSD. However, since Complex PTSD has not been added as a diagnosis under DSM-V, creating a distinction between PTSD and Complex PTSD remains crucial as the need for special treatment appears likely ("Complex PTSD," 2016).

Treatment

Treatment for PTSD primarily consists of symptom management with cognitive behavioural therapies and prescription drugs. This standard of care predominately falls under conventional treatment methods including cognitive processing therapy, prolonged exposure therapy, and eye movement desensitization and reprocessing or some combination of the three (Strauss, Lang, & Schnurr, 2018). This recall type talk therapy possibly becomes a trigger for re-traumatization. Alternative treatment such as yoga and mindfulness at most may alleviate some PTSD symptoms.

In recent years, Complementary and Alternative Medicine (CAM) therapies have been introduced as a means of treatment. CAM often includes using conventional therapies in combination with alternative therapies such as mindfulness and relaxation, acupuncture, and biofeedback. The U.S. Veterans Administration Research Center indicates that alternative approaches such as acupuncture, chiropractic, Emotional Tapping have little, if no empirical research supporting their efficacy as treatments for PTSD (Strauss, Lang, & Schnurr, 2018).

This study specifically determines the efficacy of an alternative non-invasive process and addresses the question, "What is the impact of the My Envisioned Mind process in healing PTSD as a result of work-related trauma?" The My Envisioned Mind (MyE.M.) process appears to align with other transpersonal therapies that are moving beyond talk therapy. Similar to alternative therapies for PTSD, MyE.M. does not require the participant to recall the traumatic experience(s). Dissimilar to currently used therapies, the MyE.M. process non-intrusively minimizes and/or alleviates the symptoms and pain associated with PTSD at the subconscious level through the individual's power of self-healing. The proprietary MyE.M. process contains nine steps which specifically address the trauma held in the limbic system without direct recall of the trauma. Thus, flashbacks or reliving the trauma was non-existent with participants. The primary difference between MyE.M. and conventional therapies, lies within MyE.M.'s capacity to alleviate PTSD without the visitation to traumatic feelings or long-term therapy (DeOleo, 2017). This claim seeks not to dismantle cognitive-behavioural or talk therapy as a viable option for trauma or other issues. Cognitive-behavioural therapy provides ways for coping with symptoms. However, traumatic memories are not stored in the cognitive section of the brain and does not respond to language (Searle, 2002)(Assagioli, n.d.)(van der Kolk, 1995) and requires a more appropriate type of intervention. Thus, consideration for combining cognitive-behavioural therapy with other alternative methods that move participants beyond the cognitive processing of trauma to a shift in behaviour builds a more effective treatment for healing of PTSD.

This study of the *My Envisioned* Mind process contributes to the body of knowledge for alternative treatments for recovering from trauma in general and from PTSD specifically. It serves as a model for qualitative research on alternative treatments for PTSD as well as work-related traumatic events, both of which are lacking in the literature (Strauss, Lang, & Schnurr, 2018). Producing research in these areas with limited literature provides a foundation for further in-depth empirical studies on the application of alternative therapies or interventions with trauma brings benefit to those suffering with PTSD.

Methodology

This empirical research was quasi-experimental intervention study with pre-, post-, and follow-up assessments. The experimental group sample of 10 individuals consisted of 6 women and 4 men between the ages of 36 and 55 years. The participants lived in the U.S. and Australia. Participants were recruited through referrals and social media, specifically Facebook ads. Participant selection criteria are as follows:

- Must have experienced adverse events or trauma in the workplace and/or already have a diagnosis of work-related PTSD
- Between the ages of 25-50
- Have tried different therapies which have failed
- Can be on medication: but not self-administrating.
- Committed to getting well, will fill in all documents honestly.

The participants in the study experienced the following adverse events: armed robbery, sexual harassment and abuse, workplace accident, destruction/loss of business, business partner betrayal, manager bullying, and vicarious re-traumatization and second-hand trauma for first responders.

In using human subjects, United States IRB protocols were established. The risks were minimal to null that the participant would experience any moderate-severe stress from participating in the study. Participants were informed that they could terminate their participation at any time. Information obtained from the participant was held in confidence and used only for the purposes of this study. Field notes, recorded sessions, research interviews, and any identifying materials will be kept under lock and destroyed three years after conclusion of the study.

The informed consent indicated that this research does not serve as a substitution for therapy. As a precaution to participants' welfare, upon completion of the six-month study, additional MyE.M. sessions, as well as a referral to a mental health provider were made available to the participants, if necessary. Participants on medication for PTSD were asked to remain on their medications. Participants in counselling were asked to remain in counselling and share their results with their therapists.

Beverley Searle, the developer of MyE.M. served as the Research Assistant and Administrator of the MyE.M. process to ensure validity and reliability of the utilization of the process. The MyE.M.. process was administered by the researcher over Skype or in-person All sessions were video-recorded with participants' permission. Each participant received 10 hours of individual sessions. Control for the effect of treatment was managed through utilizing the same process administrator/researcher for all participants.

Prior to study participation, potential participants completed an intake questionnaire providing demographical data, PTSD symptoms, medications, and trauma experience. They

were administered via email, the Depression Anxiety Stress Schedule 21 (DASS21) and the Posttraumatic Stress Disorder Checklist Civilian (PCL-C) as the pre-assessment. The pre-assessment determined viability for study participation as well as the severity of PTSD. Only participants meeting the PTSD criteria as set forth in the DASS21 and PCL-C were included as study participants.

The Australian Depression Anxiety Stress Scales (DASS) was preferred over the U.S. equivalent DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult because the latter does not designate stress as an outcome variable and it contains a mere 23 measures to the 42 measures of the DASS21. The DASS21 and the PCL-C were administered for the post-assessment immediately upon completion of the 10 MyE.M. sessions. After 6 months, the DASS21 and PCL-C were administered as the follow-up assessment and participants completed a questionnaire developed by the researchers which further explored participants' reactions to and utilization of the MyE.M. process for PTSD symptom management after the intervention. Scoring of the DASS21 and PCL-C assessments were compiled by the researchers to ensure reliability and to lessen the bias effect of self-reporting. Participants did not receive and/or read the DASS and PCL-C standard scoring information as they were removed from the pre- and post- assessments.

Immediately upon completion of the 10 hours of intervention participants were emailed the DASS-21 and PCL-CL for post assessment. The 6-month follow-up assessment utilized the same forms--DASS-21 and PCL-CL. After completing the follow-up assessment, participants responded to a 6-item questionnaire to determine their use of the process between and after sessions.

Statistical Analysis and Results

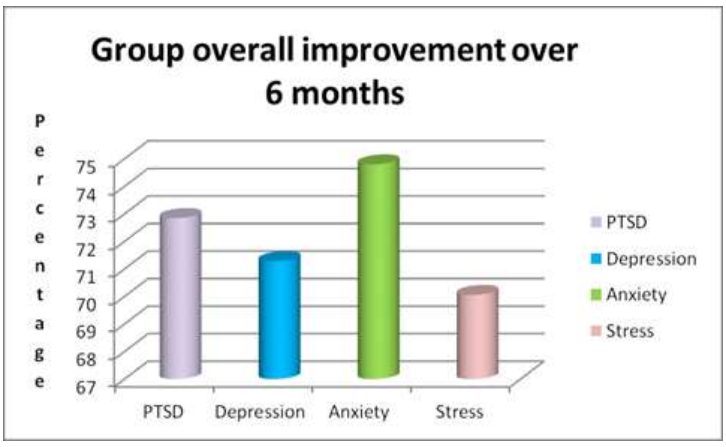
Nine of 10 subjects fully completed all phases of the six-month study. Analysis includes only data for the participating 9 subjects who completed all phases of the study.

Quantitative Results

A statistical method ANOVA was used to analyse and compare the scores of the DASS21 and PCL-C scale to determine the prognosis of the My Envisioned Mind intervention process. For comparison of scores, the DASS 21 scale and the PCL-C were used as pre-assessments to the MyE.M. sessions and at completion or post the 10 hours of the process. The follow-up-assessment DASS21 scale and PCL-C were administered at 6 months.

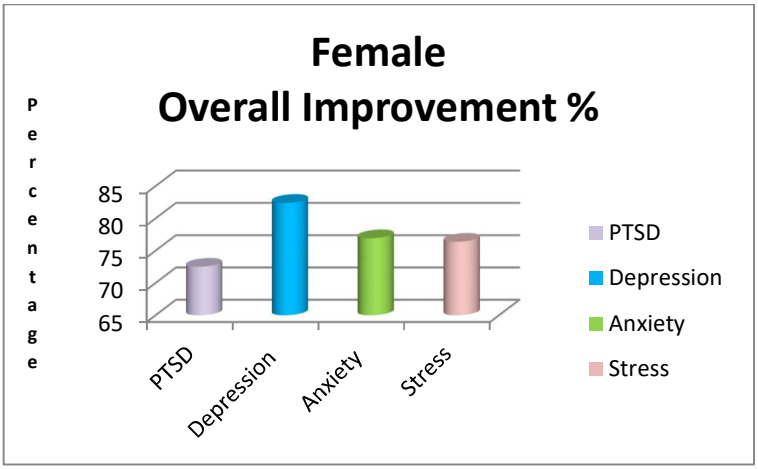
The DASS21 scale at pre-assessment indicated all participants scored within or above the severe range for Depression 21+, Anxiety 15+, and Stress 26+ which are all symptoms and/or the result of PTSD. The PCL-C indicates a PTSD diagnosis for scores over 50. Participants scored an average of 53.

The post-assessment results showed that with the MyE.M. process, all participants had a decreased PTSD score under 50 points on the PCL-C with an improvement percentage of 73%. Post MyE.M. intervention DASS21 scores were within the normal ranges for depression, anxiety, and stress with an improvement of 82% for Depression, 77% Anxiety and 86% for Stress. The follow-up assessment at 6 months indicates the sustainability of the results of the MyE.M. process. The results of this study show that PTSD and its symptoms of Depression, Anxiety and Stress can be alleviated and/or managed systematically through the intervention of 10 hours of MyE.M.



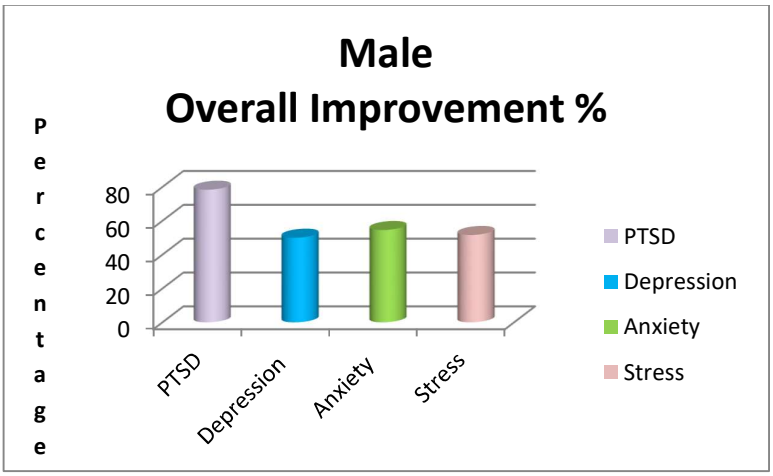
The 6-month follow-up assessment results indicate an overall improvement percentage score of 81% for the participants. Their PCL-C average scores moved under 50 points from an average of 53 to 15 resulting in no diagnosis for PTSD. The results of the DASS21 indicate an improvement for participants of 58% for the participant with Depression, 60% for the participant who was experiencing Anxiety and 59% for the participant facing Stress.

The average pre-test results for women in the DASS 21 scale Depression 21, Anxiety 17, and Stress 21. The average PCL-C score was 53. During the post-assessment at completion of the 10 hours of MyE.M., there was a decrease in the average scores of Depression, Anxiety and Stress at 8, 4, and 12 scores respectively. The PCL-C score dropped from an average score of to 53 to 23. At the follow-up of 6 months, there was a significant improvement in the prognosis of the participants. The overall post-test results for PTSD was 16. Depression, Anxiety and Stress were 4, 4, and 5 respectively.



A similar trend has been observed with the male participants as their average pre-test results of the DASS 21 scale Depression 25, Anxiety 7, and Stress 21. The average PCL-C score was 53. The post-assessment at completion of the 10 hours of MyE.M., demonstrated a decrease in the average scores of Depression, Anxiety and Stress at 5, 3, and 9 scores respectively. The PCL-C score dropped from an average score of to 53 to 27. Male

participants' 6-month DASS21 scores fell within the normal range for Depression, Anxiety, and Stress with average follow-up assessment results of 13, 3, and 15 respectively.



Qualitative Results

The second part of the study using MyE.M. process analysis was conducted through a questionnaire method in which the participants were given six questions to gauge their reactions to the process, continued use of the process, and integration into their daily life. With a 100% return rate from participants, the overall post-test questionnaire analysis indicated that most of the participants found relief from the symptoms from which they were suffering. As a result, they were able to no longer experience the charge or symptoms when thinking of their adverse event or traumatic experience that resulted in their PTSD. Several participants indicated a renewed perspective on life as they were able to participate in activities and engage with people more effectively.

Discussion

The My Envisioned Mind process was developed by Beverley Searle (2002) and is based in the theoretical framework of Roberto Assagioli's (1965) psychosynthesis theory and Bessel van der Kolk's (1995) trauma storage and retrieval theory.

Bessel van der Kolk (1995) found that trauma is stored as pictures by the limbic system, which is the emotional seat of the brain. Triggers may bring a recurrence of the trauma which is experienced as "flashbacks" by people with PTSD. When an individual is triggered by a past trauma, the limbic system is accessed and the resulting emotions flood through the body. The individual relives the traumatic experience leading to emotions and behaviours that are out of time and place.

Assagioli (1965) explored how life experiences are stored by sub-personalities in childhood. With every new experience, the child creates a sub-personality to hold that experience. These sub-personalities are created until approximately five to seven years old. Every new experience is built into and accepted by a subpersonality, who then, over time, takes on a role or a mood.

Searle (2002) combined the theories of van der Kolk (1965) and Assagioli to develop a healing process that guides the participate through a guided visualization of accessing the self-healer and sub-personalities to heal trauma without having to recall and/or relive the trauma.

The primary studies for workplace trauma resulting in PTSD have focused on high-risk occupations such as the military, police officers, and first responders (Skogstad, et al, 2013). One could conclude that researchers have not linked trauma to the general population of employees as they have focused primarily on chronic prolonged stress trauma based on daily or frequent occupational hazard, i.e. police officers and first responders. The lack of an expansive scope of work environments overlooks the prolonged stress of toxic work environments created by prolonged chronic stress trauma such as bullying, manager intimidation, harassment, etc. The introduction of complex PTSD as a separate form of PTSD may stimulate more research as to the impact of prolonged repeated work-related trauma. However, even the examples of trauma situations resulting in Complex PTSD fails to include work-related trauma ("Complex PTSD," 2016).

A review of the literature yielded no empirical studies providing evidence of the success or failure of alternative methods for managing and/or alleviating PTSD and particularly involving work-related PTSD. Since the MyE.M. process is proprietary no other empirical research has been conducted using this alternative process. However, more than one hundred case studies have been collected over the past 15 years as evidence supporting the efficacy of the MyE.M. process.

Several limitations must be considered, although did not distract from the overall results of the study. First, the utilization of the DAS and the PCL-C, both self-reporting instruments, as assessment tools, created a potential for participant responses bias. This limitation had insignificant impact on participants as the MyE.M. administrator substantiated the traumatic events as well as the resulting PTSD symptoms.

The second limitation pertained to the sample size of nine participants. A larger sample size would allow for further generalizations across gender, ethnicity, occupations, and locations. However, a foundational premise of MyE.M. lies in its capacity to not be hindered by such factors as ethnicity, gender, social constructs or location. Within the framework of the process lies customization that accommodates the needs of the participant and focuses directly on the storage and alleviation of the trauma. Since it does not rely on the demographical restrictions, this limitation had relatively low impact, if any.

Third, as Beverley Searle is the developer and only person currently with the full breadth and knowledge of the process, there are limitations on future studies as she would have to be the administrator of the process. Studies could be conducted with more people using a modified version of her process or in having her as the administrator, but not the researcher.

Conclusion

The acceptability and feasibility of alternative methods for treating and healing PTSD are increasing as the general population search for holistic alternatives for treatment from the conventional drug and talk therapies. Even though this study's sample population did not meet the requirements for generalization for a vast population, the theoretical premise and design of the MyE.M. process precludes the demographic and societal restrictions of most methods for treating PTSD. The limitations of the study yielded insignificant impact on the results of the

study. The results for the sample population demonstrates empirical evidence that supports the efficacy of MyE.M. as a viable alternative treatment and healing for PTSD.

The MyE.M. process may have a broader significance, suggesting that not only are the symptoms of PTSD managed—PTSD can be alleviated. Further studies conducted within a larger population of individuals and groups would be advantageous as an opportunity to further explore the effect of MyE.M. on PTSD and Complex PTSD with military personnel, police officers, first responders as well as within toxic and stressful work environments. Research determining the efficacy of the utilization of the MyE.M. process beyond work-related trauma would also prove beneficial with issues such as anorexia, eating disorders, depression, and learning disabilities.

References

American Psychiatric Association. (2017, January). Retrieved from https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd

Assagioli, R. (n.d.). Dynamic Psychology and Psychosynthesis.

Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioural Health Services. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. (Treatment Improvement Protocol (TIP) Series, No. 57.) Chapter 3, Understanding the Impact of Trauma. Available from: https://www.ncbi.nlm.nih.gov/books/NBK207191/

Complex PTSD. (2016, February 26). Retrieved from www.ptsd.va.gov/professional/ptsd-overview/complex-ptsd.asp

DeOleo, U. (2017, November 21). *Experiencing the My Envisioned Mind Process*. Washington, DC.

Lepore, S., & Revenson, T. (2006). Relationships Between Posttraumatic Growth and Resilience: Recovery, Resistance, and Reconfiguration. In *Handbook of Posttraumatic Growth: Research and Practice* (pp. 24–46). Lawrence Erlbaum Associates.

Phillips, M., Bruehl, S., Norman Harden, R. Work-Related Post-Traumatic Stress Disorder: Use of Exposure Therapy in Work-Simulation Activities. Am J Occup Ther1997;51(8):696-700. doi: 10.5014/ajot.51.8.696.

Searle, B. F. (2002). My Envisioned Mind Professional Introduction

Skogstad, M. Skorstad, M. A. Lie, H. S. Conradi, T. Heir, L. Weisæth; Work-related post-traumatic stress disorder, Occupational Medicine, Volume 63, Issue 3, 1 April 2013, Pages 175–182, https://doi.org/10.1093/occmed/kqt003Santiago PN, Ursano RJ, Gray CL, Pynoos RS, Spiegel D, et al. (2013) A Systematic Review of PTSD Prevalence and Trajectories in DSM-5 Defined Trauma Exposed Populations: Intentional and Non-Intentional Traumatic Events. PLOS ONE 8(4): e59236. https://doi.org/10.1371/journal.pone.0059236

Stein, D. J., McLaughlin, K. A., Koenen, K. C., Atwoli, L., Friedman, M. J., Hill, E. D., … Kessler, R. C. (2014). DSM-5 And Icd-11 Definitions Of Posttraumatic Stress Disorder: Investigating "Narrow" And "Broad" Approaches. *Depression and Anxiety*, *31*(6), 494–505. http://doi.org/10.1002/da.22279

Strauss, J. L., Lang, A. J., & Schnurr, P. P. (2018, January). Complementary and Alternative Medicine (CAM) for PTSD. Retrieved from https://www.ptsd.va.gov/professional/treatment/overview/complementary_alternative_for_ptsd.asp

Van der Kolk, B. (1995). *The Body Keeps the Score: Brain, Mind, Body in the Healing of Trauma*. New York, NY: Harvard Press

What Is Posttraumatic Stress Disorder? (2017, January). Retrieved from www.psychiatry.org/patients-families/ptsd/what is ptsd