STOP F**KING WITH MY MIND

P.T.S.D

Beverley F. Searle M.P.H.C

Diagnostic criteria for PTSD

There are 4 criteria for diagnosis, they are:

1. Re-experiencing the trauma

- repetitive memories (or flashbacks) that are hard to control and intrude into everyday life
- nightmares
- extreme distress caused by reminders of the trauma
- memories or disturbing thoughts that can be prompted by smells, sounds, words or other triggers.

2. Avoidance

- staying away from places, people or objects that may trigger memories of the traumatic event
- changing a normal routine to avoid triggering memories
- not wanting to talk about or think about the event
- feeling numb.

3. Negative thoughts and mood

- feeling a sense of hopelessness about the future
- negative beliefs about oneself or the world
- blaming oneself or others unreasonably
- intense worry, depression, anger or guilt
- loss of memory of the traumatic event
- no longer enjoying favourite activities
- becoming emotionally detached from others
- inability to experience positive emotions.

4. Increased arousal

- constant, excessive alertness
- scanning the environment for signs of danger
- being easily startled
- irritable or aggressive behaviour
- difficulty sleeping
- poor concentration. (1)

In order to be diagnosed with PTSD, a person must have **three** different types of symptoms: re-experiencing symptoms, avoidance and numbing symptoms, and arousal symptoms. Re-experiencing symptoms are symptoms that involve reliving the traumatic event. There are a number of ways in which people may relive a trauma.

CHAPTER 1: THE MEDICAL MODEL OF TREATMENT FOR PTSD

Scenario

1917: You are a 23 year old soldier who has returned to England after spending over a year in the trenches. You are having violent nightmares, recurring pictures of mates being blown to bits and you have been gassed!

How are you treated? As a malingerer, you were told you had low social fibre, were neurotic, and had an unstable personality.

During that time, in most cases soldiers returning from the war were said to have 'shell shock', were treated as the scenario above.

History

Considerable debate followed early studies on people who have experienced trauma. A few researchers found and attributed the hysterical symptoms were caused by psychological trauma. However, in most cases it was considered that the trauma was not a sufficient cause of these symptoms. Some believed that microscopic particles caused brain damage or spinal cord damage.

Most research into PTSD in the beginning was done with soldiers returning from war with psychological problems

With the returning soldiers from Vietnam displaying unprecedented symptoms much research was conducted to understand their conditions.

Finally, in 1970 PTSD was a labelled a problem for veterans, rape survivors, manmade or natural disasters and determined to be a long-standing psychological issue. In 1980 the American Psychological Association gave post-traumatic stress disorder a diagnostic category DSM– III in the Diagnostic and Statistical Manual of Mental Disorders.

Most people when discussing PTSD only believe that it is servicemen and women who have this disorder, but let's look at some evidence of incidence.

Studies have demonstrated between 20.4% and 30.2% of women and 8.1% and 13% of men who have experienced a traumatic event have PTSD. The traumatic events were not related to serving in the military.

Rape has the highest PTSD rates, but it has been established that childhood neglect and physical abuse, sexual molestation and (for women only) physical attack and being threatened with a weapon, kidnapped or held hostage. Also torture victims, Holocaust survivors and prisoners of war all have high incidences of PTSD.

So how is PTSD treated by the medical model?

A trauma focused approach is recommended. This includes:

- Prolonged Exposure (PE)
  Teaches you how to gain control by facing your negative feelings. It involves talking about your trauma with a provider and doing some of the things you have avoided since the trauma.

- Cognitive Processing Therapy (CPT)
  Teaches you to reframe negative thoughts about the trauma. It involves talking with your provider about your negative thoughts and doing short writing assignments such as journaling.

- Eye-Movement Desensitization and Reprocessing (EMDR)
  Helps you process and make sense of your trauma. It involves calling the trauma to mind while paying attention to a back-and-forth movement or sound (like a finger waving side to side, a light, or a tone).

Other types of therapy has the person practice relaxation skills (such as with mindfulness and yoga), talking or writing through the lifetime of traumatic events to reframe them; to change unhelpful behaviours or thoughts.

After many years of lobbying by advocacy groups for veterans, doctors can now also recommend medical marijuana where it is legal in the states. But many have qualms about this type of treatment due to either it being illegal under U.S. federal law or that there is not enough conclusive medical research.

PsychGuides.com states that "no **cure** exists for **PTSD**, but the symptoms **can** be effectively managed to restore the affected individual to normal functioning. The best hope for treating **PTSD** is a combination of medication and therapy".

What doctors do not want you to know about PTSD?

That talking therapy does not work and that there is a drug free therapy which completely alleviates PTSD within a few hours of therapy.

For a hundred years or more, every textbook of psychology and psychotherapy has advised that some method of talking about distressing feelings can resolve them. However, this is not so, the experience of trauma itself gets in the way of being able to do that. No matter how much insight and understanding we develop, the rational brain is basically impotent to talk the emotional brain out of its own reality.

Why is this so? Because the emotional brain (limbic system) does not have language!

Because our brains are geared for survival.

> *The human brain is organized in terms of a 'mental society'. In other words, alongside our verbal system, there may reside any number of 'mental units' [that] can exist, have memories, values and emotions. All of which can be expressed through any of a variety of response systems.*
>
> *What makes this whole process so eerie is that these systems may not be in touch with the verbal system at all, but rather have their own existence outside of the areas of our brain responsible for our language and our logic. R*

One of these 'mental units' is the limbic system. Through it, the mind deals with dangerous events (whether real or perceived). Anything that is seen as dangerous to you triggers the fight/flight/freeze response, which purpose is to protect and prepare you in dealing with the dangerous situation.

The reaction is instantaneous. Your brain and body are flooded with chemicals that prepare you for running away (flight) or to stand and protect (fight) or become immobile/invisible (freeze). Because of the instantaneous and intense nature of the fight/flight/freeze response, it bypasses the normal recording of events and stores this potentially dangerous information in the limbic system.

An **example** of how this process works with memory is:

Imagine that at age three, your big brother deliberately dropped a spider on you - your response was to run around screaming!

The picture of what happened and your fear is stored within the limbic system. From then on whenever you see a spider, or something drops on you unexpectedly, the picture of the

original experience is triggered, along with your fight/flight/freeze response. The limbic system replays the event, just like a DVD, with the original emotions flooding you. You relive the event out of time and sequence with the original emotions flooding through you.

You can be ninety-three years old and still scream at the sight of a spider!

Why? Because your limbic system does not have linear time! There is no clock in the limbic system to let you know this traumatic event was years ago. This is why childhood beliefs - concepts of yourself as unlovable, useless, dumb, etc. lodged deep in the sub-conscious mind are affecting you even now, decades later.

Case studies and references from clients

*A **reference from Neil after he did the My Envisioned Mind***

I have known Beverley Searle for about 10 years. She would often call in for a coffee and she would talk about her research, which I found very interesting.

Beverley would offer to do her therapy with me, but as I have been in the Mental Illness sector for over 20 years; with many hospital stays in lockup wards, I did not believe other than taking my drugs that things could get better.

I finally said to Beverley I would give it a go!

Five years ago I started doing her therapy. Every 2 months we met to work through the 9 steps of 'My Envisioned Mind' then 'fine tuning' this process to my wants and needs and 'boy did it pay off'.

No longer did I spend much of my day reliving my horrible childhood, I was consumed by my memories of my physical tormentors, and I was frightened much of the time, which led to a form of paranoia and obsession. This fear in conjunction with my bi-polar stopped me from having a full active life.

I had done over 10 years of martial arts but I still had all the fear. Contrastingly the work I did with Beverley was more efficient in restoring my moods and balance, which has led to a better quality of life.

I have been told for years 'be positive' 'cheer up' 'you can do better' but for the first time I was shown a better and gentler way to achieve this. What 'Your Envisioned Mind' has done for me is: minimising the negative memories and giving me a positive future.

I have now finished training for the open work force and have held down my first job in 27 years. I can now drive and park in the city without fretting. There has been subtle progress and I can look back over these last few years and realise 'I can do things now which I have been unable to do all my life'.

Now I am the bloke I should have been!

Neil T. 52. Find on. South Australia https://vimeo.com/232773024

In most cases women with PTSD have not been diagnosed as demonstrated in the following case studies.

1. Phobias

This client had been in the mental health sector for over 24 years with many hospital visits, she had 6 different depression diagnoses and was prescribed over 15 types of medication, none of which alleviated her issues. She had been abused in childhood but never discussed or shared this in her treatment. One way her abusive childhood came out was through her development of phobias especially around any form of insect. She screamed and shuddered if she saw a cockroach on the floor.

While using the My.EM process, she went into her head to find where the insects were stored. In her search she discovered that the area under the floorboards of the ground floor of her home were thousands of insects of all different kinds – centipedes, cockroaches, spiders, flies, millipedes, ants – squirming and crawling over each other and threatening to come into the house. The underpinning of her home in the head was covered in insects. In the earlier work, her basement had been cleared out and sealed off. However, the insects were part of the house structure.

When she saw all these insects she screamed: "Get them out! Get them out!" The My.EM practitioner and she decided on a drastic plan: a crane was brought in and the entire house lifted up. The area beneath the house was heavily sprayed including the floorboards and joists of the house, then conveniently in the air. Then the crane moved the house to a new location, a beautiful spot which she created.

Then the sub-personalities who stored the fear of insects were sent into the healing facility until the fear was washed away. Thereafter, even though the client still doesn't like insects, she no longer has phobia that has her react in terror. Now she is able to dispose of cockroaches or any other insect herself.

Since completing the My.EM process, she has not been hospitalized for over 10 years and shows no phobia symptoms. She has moved forward with her life and finished her high school certificate and completed writing courses and much to her excitement she has been published.

2. Obsessions and compulsions, perfectionism

A young client, 16, who had been in a major car crash at 3, developed excessive and extraordinary control issues. She obsessively arranged her belongings in her bedroom and if anything was out of the order she had chosen, became very upset: yelling and screaming at her parents for going into her room and touching or moving her property.

When using the My.EM process to examine the home in her head to find out how the obsession was represented in her home, she discovered the whole house was riddled with ants. There were thousands of them, crawling over the floor, in the cupboards, on all the shelves and the bed and the chairs. This girl was an environmentalist so she would not accept sprays. She brought in echidnas, beginning with one but in the end she had to bring in six. They licked up all the ants, and as they became fewer, she found the hole in the wall where they were entering her home. She blocked that up and the echidnas went outside, where they followed the ants to their nest, broke it open and destroyed it.

Then she planted her favourite flower – red tulips – and visualized them growing and flowering on that spot. She met the sub-personalities that stored her obsessions and put them through the healing process.

After completing the My.EM process, she keeps her bedroom very tidy but she can tolerate some mess and she gets on better with her parents. She no longer blames her parents for disorder in her belongings and she is successfully in year 11 since doing the process.

3. Bi-polar, mood swings

A forty-year old woman, who was regularly sexually abused by a priest in her childhood had been given a diagnosis of bi-polar. Even though she is a very good singer and actor, she had to resign from a production in which she took the leading role because of her deep depression. She was taking medication for her bi-polar which included major depressive episodes and was regularly attending mental health services.

During the My.EM process she discovered the home in her head was thirty feet up in a tree and only she could use the rope ladder to it. She brought the house down to ground level, set it on a cement raft, with proper footings, so that it was fully grounded.

During the process, it became clear that she had constantly been abused by priests in her childhood. Research has shown that if a person has a home in their head that is high up, or removed from the ground, or on stilts (unless this is normal to where they live, e.g. in the tropics) then there is early psychological damage like abuse, or trauma. In this case being so high up was a form of protection; no one could get into her tree home.

After doing My.EM – evicting the priests and making all the sub-personalities safe and happy – the depression lifted. She then met the sub-personalities that had held the depression

and anxiety and took them through the process: C***hanging the Picture: Emotions. H***er depression was completely alleviated and she successfully finished the production.

4. Depression

A woman in her mid-fifties had experience prolonged trauma by a childcare giver. She had episodic periods of deep depression. In this state she wouldn't shower, couldn't go outside the house, and followed her husband around the house demanding things done her way. She couldn't do any housework or cooking, wash her hair, wash clothes etc.

Her husband called us in and we could do some minor work while she was so depressed. When she closed her eyes, all she could she was blackness. She described it as: "The electricity was off in her brain, like a switch." She would wake up and the switch was on: she never knew when it would happen. Equally suddenly the switch would be off, and she would be in deep depression.

We did the work we could until the switch came on again. Her husband called us and we could do major work. We found the switch. Her house was on stilts, and the switch was bolted under the floorboards. She got a ladder and climbed up to take the switch out, and re-wire the electrical cords running under the house, so that there was no switch to go on or off.

We lowered the house onto a cement slab. We found that the deep depression was caused by a three-year-old sub-personality who could "manipulate the switch". When the three year old was triggered, it switched off the electricity because the three year old was in deep depression.

Lowering the house, re-wiring the electricity and healing the sub-personality stopped her depressive cycle. This took the 9 steps and then we fine-tuned the work by listening closely, accepting what she said, and working with it.

CHAPTER 3 MY ENVISIONED MIND THEORETICAL FRAMEWORK AND EMPIRICAL STUDY

Theoretical Framework

Experiencing the My Envisioned Mind Process: research paper by Udall DeOleo, Ph.D. Student Fielding Graduate University, Spring 2017

Abstract

After interviewing Searle for my radio show, I entered the My Envisioned Mind process as a participant and assessor. Even though I entered the process from a scholarly examination perspective, I entered fully engaged with a focus on healing and releasing any residual trauma from anything that hinders my success, including trauma from my divorce, a previous on-again-off-again relationship, childhood issues, etcetera. Superficially, My.EM. appears similar to other healing modalities I have experienced. However, my intrigue with the process's depth, speed and lack of intrusiveness piqued my curiosity to become a willing participant.

This paper examines the theoretical foundation of the My Envisioned Mind process and provides a general overview of its development. A brief description of my journey through the nine steps of the process demonstrates aspects of the methodology.

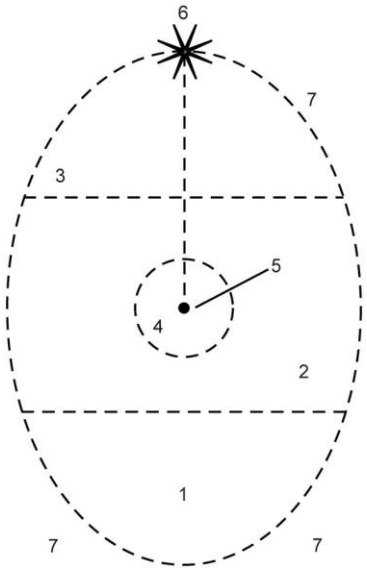
Fifteen years ago, Beverley F. Searle of Australia developed the My Envisioned Mind (MY.EM) process out of the necessity to heal her own trauma. The residual impact of her trauma led to a diagnosis of Dissociative Identity Disorder. After suffering under the weight of various mood altering drugs, she researched and ultimately developed her own cure. The resulting nine-step My.EM process has since been utilized with individuals suffering from various disorders that have been precipitated by trauma including clients suffering with schizophrenia, bi-polar disorder, BPD, panic and anxiety disorders, eating disorders, depression and addictions, as well as DID and PTSD ("The Author Beverley Searle," 2017)

Theoretical framework for MY.EM

The MY.EM theoretical framework combines two theories – Roberto Assagoli's psychosynthesis and Bessel van der Kolk's trauma theory.

Assagoli expounded upon not only the work of his teachers Freud and Jung, but also included and applied the spiritual aspects of human psychology beyond Maslow's exploration of the concept of self-actualization. His psychosynthesis work addresses the multidimensional individual—physical, emotional, mental and spiritual. After serving time in prison under the reign of Mussolini, Assagoli dedicated his work to helping individuals free themselves from inner prisons (Mankoff, n.d.).

Assagioli's dedication and perspective on personality resulted in an egg-shaped Transpersonal Self model that includes several dynamic layers of the self (Assagioli, n.d.):



1. The lower unconscious - contains or is the origin of the dreams and imagination, primitive urges, fundamental drives, pathological manifestations, complexes, and psychological activities which direct the bodily functions.

2. The middle unconscious - experiences and mental and imaginative activities are assimilated and gestated before coming into consciousness

3. The higher unconscious or Superconscious - holds our intuitive and spiritual energies. The source of states of ecstasy, illumination and contemplation.

4. The field of consciousness - the area of personality of which we are aware through the flow of thoughts, sensations, feelings, desire, impulses which we can observe, analyze and judge.

5. The conscious self or "I" - self-awareness, the center of our consciousness accessed through contemplation. Tends to disappear when we fall asleep.

6. The higher self – reflected in the conscious self; remains intact without the stream of the mental or bodily conditions.

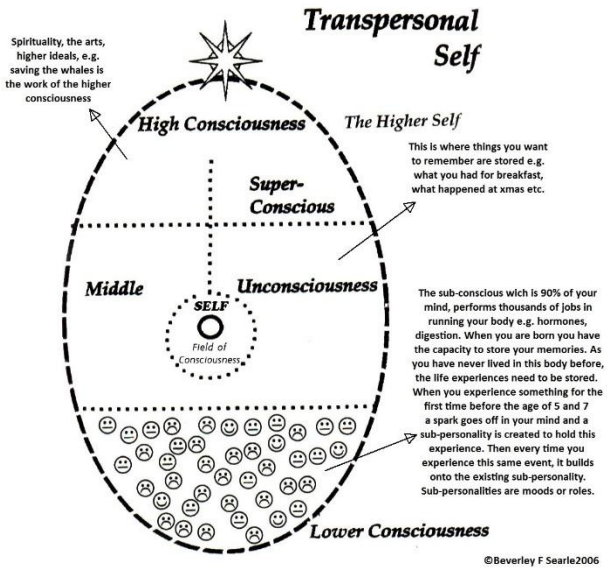
7. The collective unconscious - our connection to all living beings—we are delimited from others, not divided.

According to Assagioli (1995), people tend not to observe themselves and operate primarily in the mind area of consciousness. Thus, individuals are unaware of the dual nature of existence of two selves within them. He indicated that subpersonalities detract from the true self and can cause conflict within the self to rise to the surface prompting anxiety, depression, anger, psychological dysfunction, physical and mental health issues. His

theory and methodology of psychosynthesis “aims to bring together the various parts of an individual’s personality into a more cohesive self so that the person can function in a way that is more life-affirming, authentic and faithful to his or her espoused values” (Boileau, 2009). Assagioli asserts that personality and memory are energetic forms that can be changed.

The MY.EM process relies on the changeable energy of the personality and memory and works within the Lower Consciousness of Assagioli Transpersonal Self model where the subpersonalities and the two selves reside.

Searle (2002) utilized Assagoli’s theory that life experiences are stored by subpersonalities which are formed throughout childhood.



Every new experience built into and accepted by a subpersonality who becomes or takes on a role of the mood or the experience (Searle 2002). Within MY.EM an individual primarily works with the identification, des-identification, healing and management of the subpersonalities which often were created because of trauma or adverse events.

The MY.EM process also encompasses Bessel van der Kolk’s (1995) trauma theory. Van der Kolk (1995) theorizes that the brain’s limbic system stores and responds emotionally to trauma. Trauma is preverbal or without language and resides in the right side of the brain. The limbic system prepares us for survival and serves as the instinctive primitive emotional part of the brain. Within the limbic system triggers of a past trauma may activate an individual into a flight/fight/freeze response. The emotions of the past trauma flood into

the individual's system and the traumatic experience is relived through inappropriate behaviors or actions that are out of place and time (van der Kolb 1995) (Searle 2002).

According to van der Kolk (1995), accessing this part of the brain can be done through visualization or pictures since the limbic system does not function within the verbal system. Since traumatic memories are stored in the limbic system as pictures, working effectively with healing trauma would best be accomplished by using pictures or visualization. Van der Kolk's (1995) demonstrated and tested his theory by using a visualization process with Vietnam Veterans returning from the war with symptoms that would later be classified as Post-traumatic Stress Disorder.

Similar to van der Kolk, Searle (2002) utilizes visualization as the primary vehicle for accessing and healing trauma. Dissimilar to van der Kolk's (1995), Searle's (2002) process occurs without a regurgitation of the trauma through re-enactment or talk. In using visualization, Kolk (1995) encouraged the recall of traumatic experiences and then replaced the vision or picture of the old experience with a new vision or picture. The MY.EM process emphasizes healing the trauma within the subpersonalities and placing in new pictures. Further examination indicates Searle may have inadvertently included additional aspects of Assagioli's (n.d.) theory. Searle uses two selves in MY.EM as mentioned by Assagioli (n.d.): the true self manages the healing process and the clone or other self serves as the housekeeper/director. The MY.EM process further builds around a unified center and a firm organization of the personality which Assagioli indicated as a necessity for psychological well-being.

The MY.EM Process

Searle (2002) combined the common aspects of van der Kolb (1995) and Assagioli (1975) theories which included visualization and healing at the deep subconscious levels to create

MY.EM She used the process with clients, including herself, who suffered with Disassociate Identity Disorder (DID). The process evolved as she discovered that DID clients were missing two things: safety and happiness. As she began helping them to create a safe and happy place in their head she found that they already had a home in their head that was developed since childhood. She modified her process and started guiding clients to finding their childhood home and refurbishing it with the help of their inner self-helper (Searle 2002).

The client visually sets up a home in their head with a housekeeper (Assagioli used the term Director) and meets his/her subpersonalities. The client works with the inner self-helper/director to access the subpersonalities in the subconscious mind. With the assistance of the inner self-helper the subpersonalities who have experienced trauma are submitted to a healing process and integrated as a part of the clients support team.

Searle (2002) expanded MY.EM's applicability by using the terminology "adverse life events" instead of trauma as more people have experienced adverse life events which led to trauma type symptoms including anxiety, extreme stress, physical ailments, etcetera.

The MY.EM guided visualization includes nine steps (Searle 2002). Steps one through four can be completed on one's own. Steps five through nine are best completed with an experienced guide as an individual's experiences could be stored in several ways and troubleshooting may be necessary to continue through the process. The individual's ego may also attempt to protect the subconscious in various ways and troubleshooting may be necessary. Each step of the process uses a check system to ensure healing has occurred prior to moving to the next step. …

A Reflection of My Experience With My.EM

Usually MY.EM spans four to five sessions of one and a half to two hours each. I participated in an accelerated process of three sessions of two and a half to three hours each via Skype because I have a high absorption rate when participating in spiritual and healing work. In accomplishing the first four steps of the process, Searle guided me through an interactive visualization of setting up my safe and happy home/retreat in my subconscious.

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Results

With the completion of the MY.EM process, I was surprised at the immediacy of changes that occurred in my life. My capacity for being focused and organized increased. My anxiety level decreased and procrastination stopped. The simplicity of the process, yet the complexity and depth of the issues addressed through the process positions the My Envisioned Mind as a powerful intervention.

The MY.EM process so impressed me with how I can integrate it into my life's work of helping people to release their chains of slavery that I became a certified MY.EM Consultant. The certification process included five weeks of training, completion of the MY.EM process with Searle, and a practicum with one-client. I will receive additional experience and training as I will also shadow Searle in a trial utilizes the MY.EM as a PTSD intervention.

Conclusion

The My Envisioned Mind process unifies the work of Roberto Assagioli and Bessel van der Kolk into a process that demonstrates the healing theorized by both researchers.

The process is nonintrusive subconscious level and gives the individual the power of self-healing. MY.EM appears in line with other transpersonal therapies that are moving beyond just talk therapy. The primary difference between MY.EM and some of the other therapies lies with the visitation to traumatic feelings. Even van der Kolk's (2014) visualization and experiential three-dimensional exercises revisit traumatic feelings before replacing such feelings with a new way of being.

MY.EM's applicability extends beyond healing trauma. Searle (2017 has already explored using it for anything that blocks or hinders an individual from accomplishing their goals such as in business and with weight loss.

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Empirical Research

PTSD STUDY RESULTS

The PTSD research was a quasi-experimental pre-assessment, post-assessment and follow-up assessment interventional study. The experimental group sample population were 6 women and 3 men within the age group of 36-55 years. The participants were based in the United States of America (U.S.A.) and Australia. The study included men and women who experienced adverse events or trauma in the workplace. Adverse events included: 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.

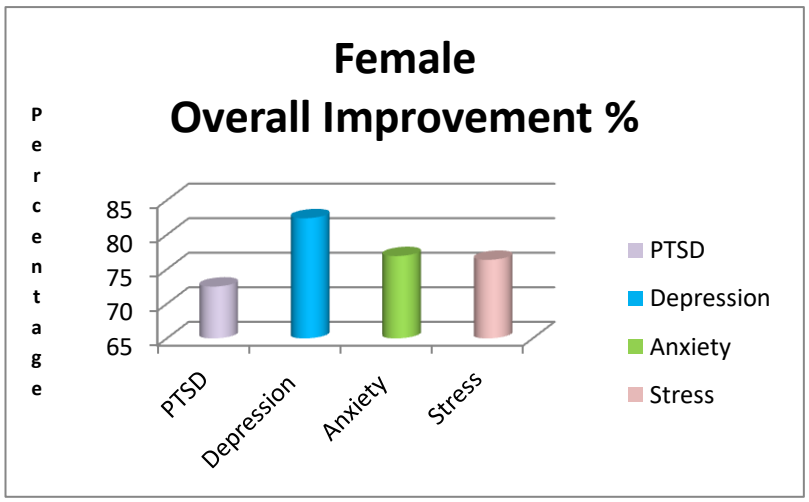
The study aimed at reducing PTSD symptoms through the interventional process My Envisioned Mind (My.EM). My.EM. was administered by the researcher over Skype or in-person. Each participant received 10 hours of individual sessions. The Depression Anxiety Stress Schedule 21 (DASS21) and the Posttraumatic Stress Disorder Checklist Civilian (PCL-C) were administered for the pre-assessment, post assessment and the follow-up assessment. After six months, participants completed a questionnaire developed by the researchers which further explored participants' reactions to the process and PTSD symptom management.

Participants were not impacted by the DASS and PCL-C scoring as this information was not included in the assessments for the study.

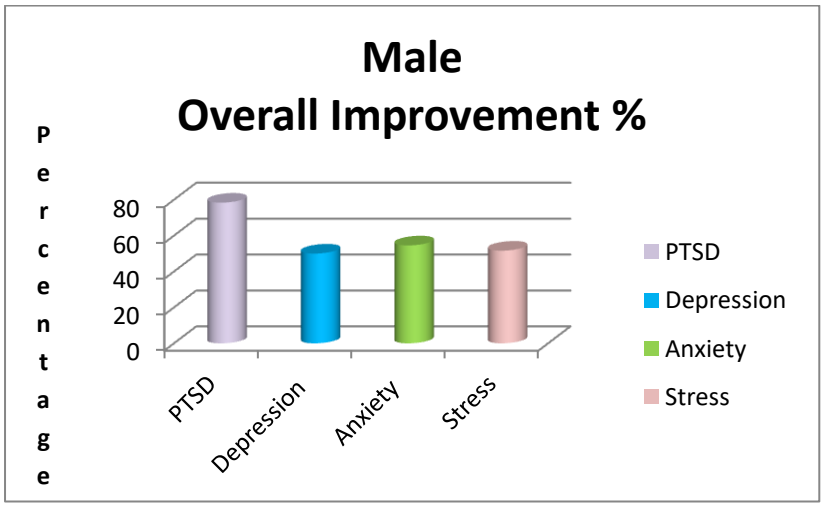
Quantitative Results:

A statistical method ANOVA was used to analyse and compare the scores of the DASS21 and PCL-C scale to analyse the prognosis of the My Envisioned Mind intervention process. In order to compare the scores, the DASS 21 scale and the PCL-C were used as pre-assessments to the MY.EM sessions and at completion or post the 10 hours of the process. The follow-up-assessment DASS21 scale and PCL-C were administered at 24 weeks or 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 scores ranged from 37 to 56 with an average of 53.



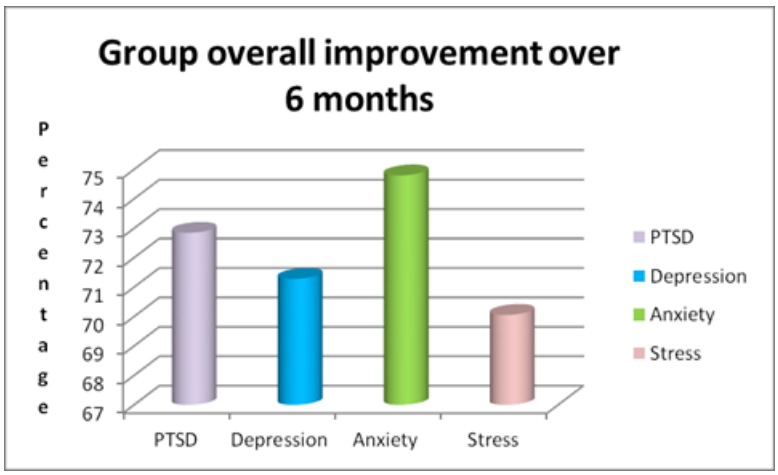
The average pre-test results for women in the DASS 21 scale Depression 21, Anxiety 17, and Stress 21. The average PCL-C score was 53. During the post-assessment at completion of the 10 hours of My.EM, there was a decrease in the average scores of Depression, Anxiety and Stress at 8, 4, and 12 scores respectively. The PCL-C score dropped from an average score of to 44 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. During the post-assessment at completion of the 10 hours of My.EM, there was 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 an average score 6 months follow-up assessment results of 13, 3, and 15 respectively.

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 post-assessment results showed that with the MY.EM process, all participants had a decreased PTSD score under 50 points on the PCL-C with an improvement percentage of 73%. Post MY.EM 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 My.EM process. The results of this study show that Post Traumatic Stress Disorder (PTSD) and its symptoms of Depression, Anxiety and Stress can be alleviated and/or managed systematically through the intervention of 10 hours of the My Envisioned Mind (MY.EM) process.



Qualitative Results:

The second part of the study using the intervention My Envisioned Mind (My.EM) process analysis was conducted through a questionnaire method in which the participants were given a set of questions designed by the researchers about their reactions to the process and how they are managing related symptoms. 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.

CHAPTER 4 CONCLUSION

It Almost Seems Too Easy Doesn't It?

Just like all the people in this book who changed their negative pictures to positive ones, you, too, can do this to all your life's adversities, thus reclaiming your smile.

My Envisioned Mind is the missing piece of the puzzle for PTSD.

It is *NOT TALKING* therapy! It is a gentle and powerful process which allows you to meet and heal the parts of you who hold your PTSD and has an amazing success rate!

Would you like to have a better healthier future with an abundance of freedom not held back by the debilitating PTSD?

If so, join the **My Envisioned Mind** program and allow us to help you alleviate your PTSD?

How does this program work? Well, the program is focused on finding the cause/causes of your PTSD without having you relive them. Then heals them. It is done in the privacy of your own home via the internet using *Skype*. We have recently worked with a client who used her iPhone and the sessions went extremely well.

What you can expect:

- **My Envisioned Mind** is a step-by-step process.
- It is a gentle, but powerful process which allows you to meet and heal the parts of you who hold your eating disorder or other issues.
- **My Envisioned Mind** has an over 95% success rate!
- There is an option available to do the Introduction Kit, with an accredited consultant giving email support.

or

- An accredited consultant via Skype/Zoom can give you personal support to overcome these disorders and to go further with the process for 'fine tuning' of your issues and negative experiences.
- In **a relatively short span of time** you could be well.

To find out more

We are running regular 'Healing Sessions' and register

There will be a Q & A at the end of each session for your personal issues.

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