HOW TO HEAL

A Practical Guide To Nine Natural Therapies You Can Use To Release Your Trauma

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For everyone who fought battles no one can see, who holds an inner strength greater than many can ever imagine, and who is ready to finally win the war

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Chapter 1: My Experience With Trauma

I can remember the exact place I was standing when I noticed the scars on my friend's inner forearm: the start of the 200m race on my high school's track, facing backwards, lined up and getting ready to run some ladders for agility drills. I also remember exactly what I said to him when I saw them: "Do you have a cat?" He said no. He actually had a cat, but I realize now that his "no" was answering the question that I wanted to ask but didn't. That deeper "no" was also a lie.

It took a few weeks for him to open up to me about his depression, self-harm, and suicidal tendencies. I was about ready to finish up my sophomore year of high school, and from that point onward, I felt the weight of the world on my shoulders. In actuality, it was the weight of his world that I placed on my shoulders. Over the next year and I half, I became his confidante. Every time he struggled, he called me. Every time he cut himself, he called me. Every time he got stuck in his head, he called me. I believed I was

responsible for protecting his privacy and honoring his trust in me, which meant I was lying to my mom, lying to his mom, and lying to the school's counselor. At the time, I was so thankful. I felt important, and I felt like I was making an impact. I felt like I was responsible for his happiness and mental health, and I felt like a success because I believed I was maintaining it. I believed I was the reason he was staying alive.

It turned out that I wasn't bringing him up – he was dragging me down. I remember the first time I cut myself. It was August 12, the day before my junior season of soccer started. I remember the second time I drew blood when I cut. I called him because I freaked out, and I remember he told me that it would become easier to see the blood each time you drew it. I remember being calmed down by him saying that. I also remember all of the times I gave him my body to kiss, to feel, and to be on top of because I believed that if I kept him happy and gave him what he wanted, he would stay alive. I remember being proud of the fact that I would do literally whatever it took for him to stay alive.

I made him promise me that he would give me a hug before he took his own life. It was my way of having some control over the situation so I could stop it, but I told him it was so that I could hold him while he left this earth. I remember the exact moment that he texted me and told me to come give him a hug and say goodbye. I was eating some chicken in my kitchen. I was the only one home. I had just gotten home from school. I vividly remember dropping the chicken on the counter and falling to the floor when I received that text, but the drive to his house is a complete blur.

I know I was speeding. I know I majorly cut someone off getting off the highway. I know that I called my aunt, who is a psychologist, along the way to ask for her help. She told me to call the police and to prepare myself to walk into his house and find him dead. I remember listening to her.

The 911 dispatcher told me to wait for the police to arrive before going into the house because she was worried he would hurt me. I knew she was wrong. He would never hurt me. The cops, when they showed up, were less than helpful. They were only concerned with whether he and I were sexually intimate, and they paid no heed to the fact that I was frantic he was about to kill himself. He kept texting me, asking where I was, asking if I was coming. I kept having to make up lies, telling him that I was on my way, that I got stuck at a red light, that I made a wrong turn, knowing that I was sitting a block away from his house, completely helpless to the fact that I knew he had a knife and a bottle of Aspirin in his hands.

While the cops were asking me about our sexual relationship, my mom got home. I might have texted her while I was driving and told her what was going on, but I honestly don't remember. All I remember is her screaming at me over the phone, cussing at me, and telling me that she needed to be there. I wanted to do this alone, and I didn't feel that I was capable of managing her emotions while dealing with the situation in front of me, so she was instructed to wait for me in a local shopping mall.

When the police finally gave me the okay to approach the house, I walked too fast and too far ahead of them, and they whistled at me to slow down and wait for

them. Though I can't claim to read the minds of the police officers, all their treatment of me did was made me feel like I was overreacting and that my friend's situation wasn't worth serious concern. I remember ringing his doorbell and having him open the door, but I was too ashamed to meet his eyes. I remember whispering "I'm sorry" and stepping out of the way so the cops could do their job. That night ended with me texting his mom, "You need to come home. He just tried to kill himself.", his dad cancelling a business trip, and him being led out of the house in handcuffs.

I remember the first time I heard from him after that night. A text: "I trusted you."

That night broke me. I suppose that my precarious mental state didn't help matters, either, but it has taken me years to believe that I did the right thing that night. I knew how betrayed and angry I would have felt if he did that to me, so I knew I hurt him in the deadliest way that I could have. I took away his control. I know, logically, that I did the right thing. His mom believes that I saved his life, and she's thankful for me. I'm learning to be thankful for me, too.

I went to one day of therapy. I was seventeen. I was so uncomfortable, sitting in this chair and having a stranger pick me apart to the depths of my soul. I didn't trust her. I didn't want to tell her my story. I wanted to get as far away from that tiny room as I possibly could, but I also wanted to get better. I just knew that that environment would not be helpful for me. I was also absolutely terrified that the therapist would tell my mom that I cut myself, so I lied and downplayed my situation. The therapist diagnosed me with

Adjustment Disorder and said that we didn't have to tell my mom anything I said. I felt both relieved and rejected by that statement. I literally ran out of that therapy session and never went back.

I could write a whole book about my relationship with this individual, how it impacted me then, and how it's still impacting me now, but that's not the point of this book. Maybe that will be the next one. I'm writing this book because I was in your position. I have an undergraduate degree in psychology and have interviewed many professionals on the topic of trauma, but I am not writing this book as a professional telling you what to do with your life and your healing journey. I am writing this book as one trauma survivor speaking to another and because I wish that I had known what I'm going to share with you here. I wish I knew that there were other options for therapy than sitting on a couch and having someone stare into the depths of your soul. I wish I knew how to handle my friends and family members as I was healing (and I wish they knew how to help me, too). I wish I knew all of the wonderful people that I've talked to while writing this book; I wish I knew that there were people like them to help me when I needed it most.

I'm writing this book because someone needs to tell you those things. Someone needs to tell you that you're not broken and that your trauma is worthy of healing from. Someone to tell you that there are options for healing from the pain, the anger, the guilt, and the sorrow that do not involve talk therapy. Someone to tell you what happens during therapy so it's not so scary walking into it. Someone to tell you that you are loved, and accepted, and *right*, no matter

how wrong you feel. My hope is that, through my writing and your reading of this book, you can take the first steps toward healing in a way that honors you and is comfortable for you. There is so much understanding to be gained from these pages, about trauma and about ways that you can heal, and I hope that you're able to glean enough of it that you can start your own healing journey. Understand what trauma is and what it does. Learn about the different options of healing from it. Pick one that feels the best to you and finally, *finally*, learn to heal. There's so much life waiting for you on the other side.

Chapter 2: What Is Trauma?

When you hear the word trauma, what do you think of? A veteran struggling with PTSD? A rape victim terrified of intimate contact? A near-death experience, like a horrible car accident? Whatever you think of, I want you to wipe it from your mind. The real question to ask is not what trauma is, but what trauma isn't. Trauma is such an individual experience that it's nearly impossible to classify what is and what isn't trauma. The reason for this is that every single individual responds to an incident in a different way, and trauma lies more in how the individual reacts to a situation than in what the situation was. In other words, while Jane may not consider getting assaulted on her way home from class that big of a deal, Mary may consider it extremely traumatic. For Mary, that assault was a trauma, but not for Jane. It often boils down to whether the individual felt like they were able find a way to feel like they were in control, like they were not alone, and like they were safe. If they were, they are often not traumatized by the event; if they weren't, then that usually becomes a trauma to that person.

It's important to remember this, because categorizing trauma or trying to compare its severity between individuals or circumstances can be detrimental to both parties. When I spoke with Heather Jeffrey, Sally Mixon, and Lynn Moore at Acres for Life, an equine-assisted therapy facility in Forest Lake, Minnesota, I asked them to speak on the fact that many individuals try diminishing the trauma response in themselves or other people. You know what I mean – it's the "there are starving children in Africa so how dare you complain about your own life" criticism, and I'd bet that you either have been told that or have said that to yourself before. When I explained this concept to them and asked their professional opinion to it, I wish I could have captured their responding facial expressions. Their expressions were enough of a response, but I'll do my best to sum it up in words: confused, disgusted, and aghast are the best words I can find. They then went on to say that it's impossible and unethical to compare severities of trauma due to the individuality of the trauma response and the detriment that such a comparison can cause on the healing process. For example, telling Mary that the assault wasn't that big of a deal and that she's being dramatic is completely disrespectful to her and her experience, and can be a huge hindrance in her healing, as she'll begin to believe that there's something wrong with her for feeling the way she does. On the other hand, telling Jane that an assault is a traumatic experience can hinder her because then she, too, begins to believe something's wrong with her because she didn't react emotionally to the assault.

The same goes for you when you're talking or thinking about your trauma. Whether other people think what

happened to you was traumatic or not, you have every right to own your emotions and own your trauma. It is your story, and only you can understand the depth and breadth by which you're affected. Sally, when she was discussing this, said that it's an "intimate, beautiful piece of being human" (as you'll start to see here, one of the goals of this book is to reshape how you view your trauma and help you recognize the positives in your experience – so don't slam the cover and think I'm disrespecting your pain and trauma quite yet!). It is a part of your journey, and you – and your journey – are beautiful and worthy of complete acceptance. There's no need to or benefit in comparing levels of severity of the trauma or trying to decide if you're overreacting. I've been there, and all it does it suck you down in this spiral of shame and confusion. You can't begin to heal when you're stuck there.

But, as I've said before, if you experienced what most people consider a traumatic incident – rape, assault, kidnapping, war, et cetera – and you're not feeling the need to heal because it didn't affect you, that's also just fine. You do not need to fit in some pre-determined trauma box. Basically, what I'm trying to say is that your reaction to whatever traumatic event happened to you is completely okay, completely valid, and completely deserving of healing. Never forget that.

I had a few friends in high school that I thought could be support systems for me, and I ruined that by falling prey to comparing traumas. One of my friends had a severe eating disorder and the other had attempted suicide a number of times, but I didn't know this when I first began talking to

them about my story. As soon as I found it out, I decided that I was unworthy of their help because they'd been through so much worse. I felt like I was complaining about nothing when they had real scars, real battle stories to tell. Needless to say, that ruined my supportive relationship with them and put them in a box that only they were qualified to put themselves in. I learned my lesson from that, and I'm hoping that by my brief story, you won't have to alienate potential support systems by comparing traumas like I did.

That all being said, I believe it's important to define trauma to an extent, because there are characteristics of trauma and its healing process that differ from other mental health struggles. The way one heals from trauma is different than the way one heals from schizophrenia, for example. Heather put it beautifully when she said that trauma is "an intense experience that is stored in the body", no matter if it's something that the survivor themselves experienced or that they witnessed. There's both an emotional component and a physical component, which is something often overlooked when discussing a psychological trauma. This physical component is often something that is not released from the individual and goes with them. For example, some women who survive a sexual assault hold their trauma in their pelvis, causing constant pain and tension. Other people hold their trauma in their throat, perhaps because they were unable to scream during or speak up about their traumatic event. Other people hold it in their legs, other people hold it in their back – you get the gist. Oftentimes in trauma, that experience is not something that can be put into words, which is why the body stores it and shows symptoms of it,

even if the mind doesn't recognize or understand what's going on. The body and the mind can almost become disconnected in this, and a common breakthrough experienced in the trauma healing process is the removal of that physical weight, which allows for the emotional release to follow.

Another key aspect of trauma is that the memories of the event are not encoded in your brain properly. Your brain can handle stressful things generally very well, such as the stress of finals week or the stress of a divorce. When the system gets so overloaded with sensory and emotional stimuli in a very short amount of time, though, the brain doesn't always cope so well. In these moments, some of those emotions and some of that energy that cannot be handled at the present moment are locked away, which contributes to the part of trauma that's stuck in the body. The brain also remembers those traumatic moments differently because of the overload occurring and the interactions of the neurohormones during that time. Cortisol, your body's main stress hormone, runs rampant during a trauma, but it's actually toxic to your hippocampus in large doses. Your hippocampus is involved in memory formation. Therefore, when your body secretes the large amount of cortisol that it does during a traumatic event, those hormones could be interfering with your hippocampus's ability to encode the memories from that situation properly. Reframing this incorrect memory process is a key part in some trauma therapies, such as eye movement desensitization and reprocessing (EMDR).

As we move forward, it's important for you to keep in mind that every experience is individual. There's no "right" or "wrong" way to react to a potentially traumatic

incident, no "right" or "wrong" way to hold your trauma, and no "right" or "wrong" way to heal from your trauma. You need to listen to yourself (and if you feel like you can't, then part of your healing will be to learn to listen to yourself again), recognize your boundaries, and follow what feels right to you through this journey. I and your future therapists are here to suggest, not to direct, as you are the sole individual in the driver's seat of your healing journey.

Are You A Victim, Survivor, Client, Or Patient?

When discussing yourself after a trauma, it can be hard to figure out what to call yourself. Some consider themselves a victim, as something horrible has happened to them that's often out of their control. Some people will call themselves a survivor, as they've been through and kept breathing after a traumatic event. Most mental health professionals use the term "client", though some hospitals and psychiatric units will use the term "patient". All of these different names have different connotations, so finding the right one to call yourself or to be called by a professional can be difficult, and that's the last thing you should be worrying about during your healing process.

The important thing to remember when discussing yourself is that – as I've said – there's no right way to do it! If you feel like a survivor, then by all means, call yourself a survivor! If you feel like a victim, then call yourself a victim! If you feel like a client… you get my point. Most mental health professionals, friends, and family members should and will follow your lead on this one, as the term you select

for yourself is as unique to you as your experience with your trauma. You may already feel like you're being shoved in a box called "sexual assault", "lost a child", or whatever your traumatic incident contained, so there's absolutely no reason you should try to fit yourself in a different box if that title doesn't fit you.

Throughout this book, I'm going to use the term survivor, as changing from calling myself a victim to calling myself a survivor was a huge turning point in my healing process. I also find that it's simplest to stick with one term throughout a book instead of switching back and forth to try to please everyone who reads it. If you don't identify as a survivor, then please don't take offense or feel like this material is not applicable to you. I don't mean to exclude or ignore or invalidate anyone with my terminology, so please feel free to mentally replace the word "survivor" with any word that you feel better suits you and your situation.

Trauma As A Public Health Crisis

When I spoke with Tracey Wilkins of Willow Tree Healing Center in St. Paul, Minnesota, she stated that she believed that trauma was the largest public health crisis in the nation because it is the root of so many physiological and psychological health conditions. Barbara Nordstrom-Loeb, a dance-movement therapist from Minneapolis, Minnesota, agreed, especially when it pertains to psychiatric disorders. "Most of the diagnostic criteria [in the DSM] are the coping strategies, and if you go deeper, it's really trauma. All personality disorders – which never made sense to me when I

studied it – are just people who don't have a sense of themselves. They never got that because of the situation around them growing up. This is just how they compensate for it and protect themselves. Anxiety, depression, eating disorders, addictions – all of that, in my experience, if you really take the time to go deep below the diagnosis, is trauma." While Tracey and Barbara's combined 54 years of professional experience is convincing, a revolutionary study by the CDC and Kaiser backed their claims.

This study examined the relationship of Adverse Childhood Experiences (ACEs) and adult health problems and came to a stunning conclusion: the more ACEs an individual underwent, the more health problems they had in adulthood. This is because those early ACEs, whether they were abuse, neglect, or family struggles, impaired neurodevelopment, which in turn impaired social, emotional, and cognitive functioning. This led to the adoption of health-risking behaviors and, subsequently, disease, disability, and social problems. This ultimately led to increased mortality rates and death at an earlier age.

Unfortunately, ACEs are common, as shown by the 2/3 of participants who reported one ACE and 1/5 of participants who reported three or more ACEs. These ACEs include emotional, sexual, or physical abuse; emotional or physical neglect; witnessing your mother being treated violently; substance abuse, criminal behavior, and/or mental illness in the household; or parental separation or divorce. As the number of ACEs increases, the likelihood for developing a significant health concern or condition increases. These include, but are not limited to:

- Anxiety
- Asthma
- Autoimmune Disease
- Broken bones
- Cancer
- Chronic pain
- COPD
- Depression and suicide attempts
- Diabetes
- Digestive problems
- Early death
- Early initiation of smoking and sexual activity
- Fetal death
- Financial stress, lower reported income, and unemployment
- Heart disease and heart attacks
- Headaches
- High blood pressure
- Intimate partner or sexual violence
- Liver and lung disease
- Multiple sexual partners and STDs
- Obesity
- Poor work performance and academic achievement (including work attendance and graduation rates)
- Stroke
- Substance use and abuse, including alcohol, illicit drugs, and nicotine (smoking)
- Unintended and adolescent pregnancies

How is this a public health crisis? Well, 2/3 of participants in the CDC-Kaiser study experienced an ACE, and over 17,300 people took part in that study. While it's never completely correct to say that the exact results and percentages found in a study apply to the entire population, it's widely accepted that a similar fraction of the general population has experienced an ACE, as well, because of the sheer number of participants in the original study. Furthermore, tens of studies have been completed about ACEs and their effects on adult health after the original CDC-Kaiser one with very similar results. Because of this, it's safe to say that a large percentage of the world has experienced at least one ACE in their life. Therefore, many individuals with the health concerns and conditions listed above may have said concerns and conditions because of (or partly because of) ACEs – because of childhood trauma. Trauma, as Tracey said, is "happening on a systemic level", and it's important to understand that when considering treatment options.

Because of the link between childhood trauma and adult health issues, trauma is also potentially the largest health-related economic crisis in the US. According to a study by Hall and Doran in 2016, the US spends approximately $170 billion per year on direct medical care for adults who smoke and loses $156 billion per year in lost productivity due to premature death and exposure to secondhand smoke. A 2015 study by Greenberg et al. showed that over $210 billion dollars are spent each year in the US on Major Depressive Disorder, split evenly between medical costs and productivity losses. Diabetes? $327 billion per year, according to the American Diabetes Association. Heart disease and

stroke? $330 billion, plus 859,000 deaths per year. Excessive alcohol use? $249 billion. Cancer? Expected to reach $174 billion annually by 2020.

Now, I'm not saying that every person who has cancer has cancer because of an ACE, or that every person who drinks excessively does so because of trauma from their childhood. But let those numbers sink in for a little bit – even if only half of excessive alcohol drinkers drink because of an ACE, that's almost $125 billion dollars per year that could be saved or redirected toward trauma treatment, prevention, and education. For those economists or epidemiologists out there, don't start coming at me for my rudimentary calculations. I am aware that I'm being idealistic – and frankly, unrealistic – by suggesting that the funds currently used for medical care are immediately and completely transferred to helping heal people's trauma. I'm not suggesting a magic cure to the financial setting of our healthcare system. I'm not even saying that it would be a quick, easy, or feasible fix. These numbers are just put out to get you to think about the mass effect that trauma has on the healthcare system and the economy. To repeat: my job and my purpose with this book are not to fix the country's trauma crisis; my job and my purpose are to help people on an individual level see other options for healing their trauma.

Chapter 3: Trauma- and Stressor-Related Mental Health Disorders

I would feel remiss if I wrote a book about trauma but didn't include any information about the psychiatric diagnoses surrounding trauma, but I'm also hesitant to include this information. I just spent a whole chapter talking about how the responses to trauma are incredibly individual, and now I want to plop you in a diagnosis box! In my experience with trauma and mental health, I've found having a diagnosis both helpful and unhelpful. It's helpful because it gives me a bit of clinical understanding to what's going on with me and reassures me that I'm not alone, as there are surely other individuals with the same diagnosis. On the other hand, it isn't helpful for me because I feel like my therapist zeroes in on the diagnosis and ignores the person and emotions surrounding it. Perhaps this was an issue with the therapist and not with the process of diagnosing in general, but it caused a lot of mental turmoil and debate surrounding diagnoses. I'm also not a huge fan of the word "disorder".

While I'm aware that there's something out of sync in the brain when someone is diagnosed with a disorder, I feel like the word "disorder" makes the individual feel less-than or broken, neither of which are helpful in the healing process.

That being said, I recognize that not everyone thinks the same way that I do and that some people find diagnoses very helpful. I also need to recognize that there are individuals – maybe you – out there reading this book who have been diagnosed and want a better understanding of what they've been labeled with that doesn't include loads of technical jargon or a quick print-out that their therapist gave them. Whatever your reason is for reading this chapter on psychiatric diagnoses surrounding trauma, I hope it helps you understand what's going on psychiatrically a little bit more. At the very least, I hope it gives you a peek inside your therapist's head when they gave you this diagnosis. If you're someone who doesn't like diagnoses, then feel free to skip ahead.

If you choose to stay, then welcome to Trauma Disorders 101. You're probably thinking I'm about to talk about PTSD, which I am – but it's not the only psychiatric disorder surrounding trauma. The DSM-5 (the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition) is the handbook for diagnoses for mental health practitioners, and it actually has a whole chapter titled Trauma- and Stressor-Related Disorders that discusses five disorders that can arise from trauma and stress. These disorders are similar in function to anxiety disorders, obsessive-compulsive disorders, and dissociative disorders. Many of them share similarities,

but they are distinct in the medical field, so I'll make sure to highlight the important differences as I discuss them.

Reactive Attachment Disorder and Disinhibited Social Engagement Disorder

Reactive Attachment Disorder and Disinhibited Social Engagement Disorder are diagnoses given to children. Reactive Attachment Disorder appears in children aged 9 months to 5 years, and Disinhibited Social Engagement Disorder appears in children from 9 months to adolescence. Because of the audience of this book, I'm going to skip over the details of these two disorders, but if you're interested in learning more about them, check out a DSM from your local library or look up the information on the American Psychiatric Association's website.

Acute Stress Disorder

Acute Stress Disorder arises immediately after a traumatic event and lasts anywhere from three days to one month after the trauma. If it progresses past one month, it generally transitions into PTSD. In other words, it's a short-term stress response to a traumatic event. In order to be diagnosed with Acute Stress Disorder, you need to experience actual or threatened death, injury, or sexual assault. This experience can come from it happening to you, witnessing it, having it happen to a close friend or family member, or having repeated exposure to such events because of your job. Further diagnostic criteria include the presence of nine or more of the following symptoms:

- Distressing memories of the traumatic event

- Dreams that contain the trauma or themes related to it
- Flashbacks
- Psychological or physiological reactions or distress in response to internal or external scenarios that resemble the trauma
- Inability to experience positive emotions
- Altered sense of reality
- Dissociative amnesia or an inability to remember parts of the traumatic event
- Efforts to avoid memories or thoughts about the trauma
- Efforts to avoid physical objects, people, or places that remind you of the trauma
- Poor sleep
- Irritability and outbursts, often those that are aggressive, verbally or physically
- Hypervigilance
- Concentration problems
- Extreme startle response

In short, Acute Stress Disorder involves an anxiety response surrounding some form of re-experiencing your traumatic event. As the symptom list above describes, these re-experiences can be actual (meaning you see, hear, feel, smell, et cetera, something in real life that reminds you of the event) or psychological (meaning memories, dreams, and the like). An accompanying symptom of Acute Stress Disorder includes strong negative emotions about yourself in relation to your trauma. For example, you could feel guilty about not preventing the trauma or feel incompetent because you

didn't handle the trauma with more "mental fortitude". In addition, panic attacks, impulsivity, grief responses, and post-concussion symptoms are common in those with Acute Stress Disorder.

The rates of Acute Stress Disorder vary based on the type of trauma experienced. For example, less than 20% of individuals who experience a trauma develop Acute Stress Disorder, but only when that trauma isn't an interpersonal assault. When it is – things like rape or witnessing a mass shooting – the rates of Acute Stress Disorder can reach as high as 50%. Women and individuals who test high for neuroticism (one of the Big 5 personality traits) are also at higher risk for Acute Stress Disorder.

Adjustment Disorders

Adjustment Disorders are somewhat of a catch-all group that encompasses any emotional or behavioral symptom in response to a stressor that occurs within three months of the stressor. In order for you to meet the diagnostic criteria for an Adjustment Disorder, your distress needs to be above and beyond a normal grief response or above and beyond the expected normal for someone who experienced a trauma like yours (mm, normal – my favorite word in trauma healing. Take it with a grain of salt. They're talking about statistical averages of severity of symptoms, not societal norms or expectations.) and it needs to impact your day-to-day functioning. Adjustment Disorders are broken down into the following six subtypes:

- With depressed mood
- With anxiety

- With mixed anxiety and depressed mood
- With disturbance of conduct (how you act in society)
- With mixed disturbance of emotions and conduct
- Unspecified, meaning that your reactions warrant a diagnosis of an Adjustment Disorder, but they don't fit into one of the pre-established subtypes

Adjustment Disorders are also classified as acute, meaning that the symptoms last for less than six months after the completion of your trauma, or chronic, meaning the symptoms last for longer than six months.

Fitting in with the catch-all nature of Adjustment Disorders, the stressor or trauma that you experienced can be one event or multiple, recurrent or continuous, and affecting only you or a group of people. Adjustment Disorders are pretty common; 5-20% of outpatients are diagnosed with an Adjustment Disorder, and up to 50% of inpatients are, as well. Finally, Adjustment Disorders are often co-diagnosed with another mental disorder or physical illness, and it's often labeled as the psychological distress accompanying a physical diagnosis, such as cancer.

Posttraumatic Stress Disorder (PTSD)

Ah, the big one – PTSD. This is the most commonly thought of mental health disorder accompanying a traumatic event, likely because it gets the most media and entertainment attention. As with Acute Stress Disorder, those who are diagnosed with PTSD must have, in some way, experienced a traumatic event; the same definition of a traumatic event as

with Acute Stress Disorder applies to PTSD, too. A combination of symptoms is required, as described below:

- At least one of the following intrusion symptoms:
    - Distressing memories of the traumatic event
    - Dreams that contain the trauma or themes related to it
    - Flashbacks
    - Psychological or physiological reactions or distress in response to internal or external scenarios that resemble the trauma
    - Efforts to avoid memories or thoughts about the trauma or physical objects, people, or places that remind you of the trauma
- Two or more of the following emotive and cognitive symptoms:
    - Dissociative amnesia or an inability to remember parts of the traumatic event
    - Persistent or exaggerated negative beliefs about yourself, the world, or the events surrounding your trauma
    - Distorted thoughts about the consequences of the trauma or your level of guilt in its occurrence
    - Negative emotions, such as fear, horror, anger, guilt, or shame
    - Feeling disconnected or pulling away from others
    - Inability to experience positive emotions
- Two or more of the following behavioral symptoms:

- Poor sleep
- Irritability and outbursts, often those that are aggressive, verbally or physically
- Hypervigilance
- Concentration problems
- Extreme startle response
- Reckless or self-destructive behavior

As you can see, PTSD shares a lot of common symptoms with Acute Stress Disorder and, as I discussed in the description of Acute Stress Disorder, the timelines are very important in the differentiation of the two disorders. Acute Stress Disorder lasts for *at most* a month after the trauma, whereas PTSD cannot be diagnosed until the symptoms last *at least* one month after the trauma.

PTSD also has two subtypes: "with dissociative symptoms" and "with delayed expression". PTSD with delayed expression is diagnosed when the diagnostic criteria (the list of symptoms above) are not met until six months after the trauma. PTSD with dissociative symptoms is only diagnosed when the individual experiences consistent depersonalization (feeling like an outside observer of your body) or derealization (feeling like the world around you is distorted or a dream).

The prevalence of PTSD is relatively low; the lifetime risk of PTSD in the United States is only 8.7% at age 75, and it's even lower on other continents. Rates of PTSD are higher in individuals who have violent careers, such as military members or police officers, and the highest rates of PTSD are seen in survivors of rape, combat, internment, and genocide. As with Acute Stress Disorder, women are at

higher risk for PTSD, and their symptoms generally last longer than males. That being said, approximately one half of adults are able to completely resolve their PTSD in three months with proper treatment, though that's definitely not to say that there aren't individuals who suffer from PTSD for years on end.

There's also a significant PTSD debate within the military community, as well, specifically around the word "disorder". I already expressed my beliefs about the word, and many members of the military believe labeling someone with a "disorder" makes them less likely to pursue help. They proposed that it be called an "injury", as that language is less damning and more in line with how members of the military speak. Members of the American Psychiatric Association believe that it's the culture of mental healthcare in the military, not the terminology used, that needs to change, and since they write the DSM, PTSD is staying a disorder for the foreseeable future.

What does this mean for me?

As I discussed in the beginning of the chapter, I'm hesitant to include this information, and I'm definitely not qualified to tell you that you have a disorder or which one you have. This information is also not provided so that you can self-diagnose. All I would encourage you to do with this information is see what feels right to you. Just because you haven't been diagnosed with a disorder does not mean that your symptoms, feelings, and struggles are not valid or do not warrant help; nothing could be further from the truth. On the other hand, just because you've been diagnosed with a

trauma- or stressor-related disorder doesn't mean that your reactions are suddenly disproportionately more severe than others who didn't receive a diagnosis.

More specifically, there are strict requirements for what counts as a trauma for Acute Stress Disorder and PTSD. Instead of deciding what is a trauma by the level of emotions on the part of the survivor, the DSM created a list of what qualifies as a trauma. Sexual assault, for example, would meet the diagnostic criteria for PTSD, whereas an event that causes intense fear or helplessness would not. The reasoning behind this is that the level of emotion does not predict the onset of PTSD symptoms but that there are significant correlations between types of events and the onset of PTSD. After I spent so much time in the first chapter saying that a trauma is whatever is traumatic to you, this definition can come across as stifling or ignorant of the pain you went through and the level of healing you need now. Don't limit yourself to or define yourself by a diagnosis you receive or the information about the various disorders that I outlined above. Your trauma is yours. Your emotions are yours. Your healing is yours. Its severity is not defined or limited by a diagnosis.

How To Heal releases May 5, 2020. Fifty percent of the profits will be donated to the Pararescue Foundation.

Stay tuned for more information!