

Cannabis Eases Post-Traumatic Stress

By Tod Mikuriya, MD

Cannabis modulates emotional reactivity, enabling people to integrate painful memories — to look at them and begin to deal with them, instead of suppressing them until a stimulus calls them forth with overwhelming force.

William Woodward, MD, of the American Medical Association, testifying before Congress in 1937 against the Prohibition of cannabis, paraphrased a French author (F. Pascal, 1934) to the effect that “Indian hemp has remarkable properties in revealing the subconscious.” A Congressman asked, “Are there any substitutes for that latter psychological use?” Woodward replied, “I know of none. That use, by the way, was recognized by John Stuart Mill in his work on psychology, where he referred to the ability of Cannabis or Indian hemp to revive old memories — and psychoanalysis depends on revivification of hidden memories.”

For including that reference to Mill (1867) in the list I have been compiling of conditions amenable to treatment by cannabis, I was ridiculed by Drug Czar Barry McCaffrey in 1996. I stand by its inclusion, of course, and in the 10 years since California physicians have been approving cannabis use by patients, I have found myself appreciating and confirming Mill’s insight with every report that cannabis has eased symptoms of post-traumatic stress disorder.

PTSD As a Dissociative Disorder

PTSD—a chronic condition involving horrific memories that cannot be erased—is a dissociative identity disorder. The victim’s psyche is fragmented in response to contradictory inputs that cannot be resolved.

Dissociative identity disorders are expressed in bizarre or inappropriate behaviors with intense sadness, fear, and anger. Repression or “forgetting” of the experiences may develop as a coping mechanism.

When traumatic or abusive experiences cannot be integrated into normal consciousness—as in the case of the Jekyll-Hyde behaviors of abusive parents or caregivers—creation of separate personalities or identities may occur.

For example, the woman who was molested by a family member may have both superficially-compliant and repressed-raging identities. The persona that’s presented to the world can be swept away when a stimulus calls forth the overwhelming rage.

Such fragmenting of the individual personality causes tremendous stress. The psyche is incomplete because of repression and denial. The person tries to appear normal and logical but in fact is in turmoil, angry and depressed. The inability to deal directly with emotional issues results in ongoing splitting and compartmentalization of the personality—and in extreme cases, multiple personalities, hysterical fugue (a separate state of consciousness that the individual may not recall), blindness, paralysis, and other functional disruptions.

In 1994 the term “Multiple Personality Disorder” was replaced with the more widely applicable “Dissociative Identity Disorder.” As an article (by Foote et al) and editorial (Spiegel) in the April 2006 American Journal of Psychiatry attest, it is only relatively recently that PTSD has been characterized as a dissociative disorder.

Easement by Cannabis

Approximately eight percent of the >9,000 Californians whose cannabis use I have monitored presented with PTSD (309.81) as a primary diagnosis. Many of them are Vietnam veterans whose chronic depression, insomnia, and accompanying irritability cannot be relieved by conventional psychotherapeutics and is worsened by alcohol. For many of these veterans, chronic pain from old physical injury compounds problems with narcotic dependence and side effects of opioids.

Survivors of childhood abuse and other traumatic experiences form a second group manifesting the same symptoms—loss of control and recurrent episodes of anxiety, depression, panic attacks and mood swings, chronic sleep deficit and nightmares.

The brief case reports in the box at the right of this page, unique though the subjects may be, typify two different forms that PTSD takes, both of which are eased by cannabis. The recurrent nightmares from the vet’s

traumatic episode took on a life of their own, causing nocturnal turmoil and dread. The repressed memories of the sexually abused and beaten woman were symptoms of a fragmented, dissociative response to the disorder.

Easement by cannabis helped both—the vet by toning down his reaction to the nightmares and restoration of his sleep, the woman by modulating her emotional reactivity and permitting her to process and integrate the experience and give up the fragmented, dissociative defense mechanisms, which in due course she no longer needed.

Repression and suppression are defense mechanisms that break down when the victim is fatigued and/or hurting and subjected to triggering stimuli. With cannabis, vegetative functions necessary for recovery, growth and repair are normalized.

Cannabis relieves pain, enables sleep, normalizes gastrointestinal function and restores peristalsis. Fortified by improved digestion and adequate rest, the patient can resist being overwhelmed by triggering stimuli. There is no other psychotherapeutic drug with these synergistic and complementary effects.

PTSD often involves irritability and inability to concentrate, which is aggravated by sleep deficit. Physical pain, fatigue, and sleep deficit are symptoms that can be ameliorated.

Practical Treatment Goals

In treating PTSD, psychotherapy should focus on improving how the patient deals with resurgent symptoms rather than revisitation of the events. Decreasing vulnerability to symptoms and restoring control to the individual take priority over insight as treatment goals. Revisiting the traumatic events without closure and support is not useful but prolongs and exacerbates pain and fear of loss of control. To repeat: cathartic revisiting of the traumatic experience(s) without support and closure is anti-therapeutic and can exacerbate symptoms.

Physical pain, fatigue, and sleep deficit are symptoms that can be ameliorated. Restorative exercise and diet are requisite components of treatment of PTSD and depression. Cannabis does not leave the patient too immobile to exercise, as do some analgesics, sedatives, benzodiazapenes, etc. Regular aerobic exercise (where injury does not interfere) relieves tension and restores control through kinesthetic involvement. Exercise also internalizes the locus of control and diminishes drug-seeking to manage emotional response.

The importance of sound sleep

PTSD often involves irritability and inability to concentrate, which is aggravated by sleep deficit. Cannabis use enhances the quality of sleep through modulation of emotional reactivity. It eases the triggered flashbacks and accompanying emotional reactions, including nightmares.

The importance of restoring circadian rhythm of sleep cannot be overestimated in the management of PTSD. Avoidance of alcohol is important in large part because of the adverse effects on sleep. The short-lived relaxation and relief provided by alcohol are replaced by withdrawal symptoms at night, causing anxiety and the worsening of musculoskeletal pain.

Evening oral cannabis may be a useful substitute for alcohol. With proper dosage, the quality and length of sleep can be improved without morning dullness or hangover. For naïve patients, use of oral cannabis should be gradually titrated upward in a supportive setting; this is the key to avoiding unwanted mental side effects.

I recommend the protocol J. Russell Reynolds M.D., commended to Queen Victoria: “The dose should be given in minimum quantity, repeated in not less than four to six hours, and gradually increased by one drop every third or fourth day, until either relief

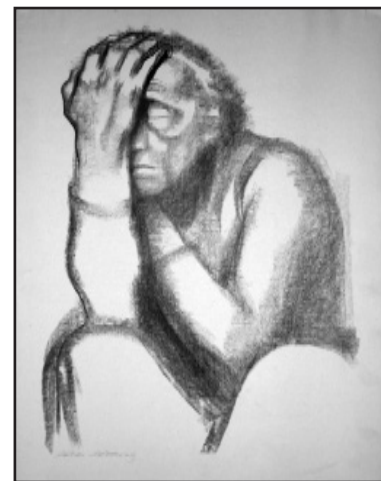
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BY BILL MAULDIN

CASE REPORT: A 55-year-old disabled male veteran had been a naval air crewman on patrol during the Vietnam war. A P2V turbo-prop engine failed to reverse properly on landing. A propeller broke loose, pierced the fuselage, and instantly killed his crew mate who was two feet away. He brought a large binder of documentation of the incident.

His PTSD was expressed primarily through a haunting, recurrent flashback nightmares that replayed the traumatic event. Attendant were the feelings of being emotionally overwhelmed. Sleep deficit was a salient aggravating factor for increasing vulnerability. Cannabis restored sleep and controlled nightmares. Depression and irritability had been eased.



BY KATHE KOLLWITZ

CASE REPORT: A 52-year-old retired executive secretary brought her 20-year-old daughter along to her follow-up interview two years after starting cannabis therapy. During her initial visit she had not disclosed fully the causality of her chronic depression with symptoms of PTSD (nightmares, chronic insomnia, dissociative episodes, rage).

She was experiencing loss of emotional control with crisis psychiatric interventions. Hypervigilance characterized her presentation; she described herself as being “all clenched up.”

On follow-up she reported being able to recover and process repressed memories of sexual abuse from age five to 15 by her father (a preacher) and having been beaten by her enraged mother. She reported the diminution and cessation of dissociative reactions to the painful memories. This permitted her to process and resolve—or come to an accord with—these unthinkable memories. Her continuing psychotherapy focused on these issues. She no longer experienced episodes of loss of control. She was able to relax her hypervigilance. Her self-esteem was significantly improved and she seemed happy and optimistic.

Her daughter confirmed that her mother was less irritable and more emotionally available since starting cannabis therapy. Both described improvement in their relationship.

Easement for PTSD *from previous page*

is obtained, or the drug is proved, in such case to be useless. With these precautions I have never met with any toxic effects, and have rarely failed to find, after a comparatively short time, either the value or the uselessness of the drug.”

The advantage of oral over inhaled cannabis for sleep is duration of effect; a disadvantage is the time of onset (45-60 minutes). When there is severe recurrent insomnia with frequent awakening it is possible to medicate with inhaled cannabis and return to sleep. An unfortunate result of cannabis prohibition is that researchers and plant breeders have not been able to develop strains in which sedative components of the plant predominate.

Modulation, Not Extinction

Although it is now widely accepted that cannabinoids help extinguish painful memories, my clinical experience suggests that “extinguish” is a misnomer.

Cannabis modulates emotional reactivity, enabling people to integrate painful memories — to look at them and begin to deal with them, instead of suppressing them until a stimulus calls them forth with overwhelming force.

The modulation of emotional response relieves the flooding of negative affect. The skeletal and smooth muscle relaxation decreases the release of corticosteroids and escalating “fight-or-flight” agitation. The modulation of mood prevents or significantly decreases the symptoms of anxiety attacks, mood swings, and insomnia.

While decreasing the intensity of affectual response, cannabis increases introspection as evidenced by the slowing of the EEG after initial stimulation. Unique anti-depressive effects are experienced immediately with an alteration in cognition. Obsessive and pressured thinking give way to introspective free associations (given relaxed circumstances). Emotional reactivity is calmed, worries become less pressing.

Used on a continuing basis, cannabis can hold depressive symptoms at bay. Agitated depression appears to respond to the anxiolytic component of the drug. Social withdrawal and emotional shutting down are reversed.

The short-term memory loss induced by cannabis that may be undesirable in other contexts is therapeutic in controlling obsessive ideation, amplified anxiety and fear of loss of control ignited by the triggering stimuli.

Mainstream medicine treats PTSD symptoms such as hyperalertness, insomnia, and nightmares with an array of SSRI and tricyclic anti-depressants, sedatives, analgesics, muscle relaxants, etc., all of which provide inadequate relief and have side effects that soon become problematic.

The Safest Option

In treating PTSD, cannabis provides control and amelioration of chronic stressors without adverse side effects. Mainstream medicine treats PTSD symptoms such as hyperalertness, insomnia, and nightmares with an array of SSRI and tricyclic anti-depressants, seda-

tives, analgesics, muscle relaxants, etc., all of which provide inadequate relief and have side effects that soon become problematic. Sedatives, both prescribed and over-the-counter, when used chronically, commonly cause hangovers, dullness, sedation, constipation, weight gain, and depression. See chart at right.

Cannabis is a unique psychotropic immunomodulator which can best be categorized as an “easement.” Modulating the overwhelming flood of negative affect in PTSD is analogous to the release of specific tension, a process of “unclenching” or release. As when a physical spasm is relieved, there is a perception of “wholeness” or integration of the afflicted system with the self.

For some, this perceptual perspective is changed in other ways such as distancing (separating the reaction from the stimulus, which can involve either lessening the reaction, as with modulation, or repressing/suppressing the memory; walling it off; forgetting).

The modulation of emotional response relieves the flooding of negative affect. The skeletal and smooth muscle relaxation decreases the sympathetic nervous reactivity and kindling component of agitation. Fight/flight responses and anger symptoms are significantly ameliorated. The fear of loss of control diminishes as episodes of agitation and feeling overwhelmed are lessened. Experiences of control then come to prevail. Thinking is freed from attachment to the past and permitted to fix on the present and future. Instead of being transfixed by nightmares, the sufferer is freed to realize dreams.

Based on the safety and efficacy, cannabis should be considered *first* in the treatment of post-traumatic stress disorder. As part of a restorative program with exercise, diet, and psychotherapy, it should be substituted for “mainstream” anti-depressants, sedatives, muscle relaxants, tricyclics, etc.

The Toxic Alternatives

Commonly prescribed medications for PTSD as listed in “*Postraumatic Stress Disorder Among Military Returnees From Afghanistan and Iraq*,” by Matthew J. Friedman, MD, PhD, in the April 2006 *American Journal of Psychiatry*:

SSRIs

Paroxetine, Sertraline, Fluoxetine, Citalopram, Fluvoxamine

May produce insomnia, restlessness, nausea, decreased appetite, daytime sedation, nervousness, and anxiety, sexual dysfunction, decreased libido, delayed orgasm or anorgasmia. Clinically significant interactions for people prescribed monoamine oxidase inhibitors (MAOIs). Significant interactions with hepatic enzymes produce other drug interactions. Concern about increased suicide risk in children and adolescents.

Other second-generation antidepressants:

Trazadone may be too sedating, may produce rare priapism. **Velafaxine** may exacerbate hypertension. **Bupropion** may exacerbate seizure disorder. **Mirtazepine** may cause sedation.

MAOIs

Phenethazine

Risk of hypertensive crisis; patients required to follow a strict dietary regime. Contraindicated in combination with most other antidepressants, CNS stimulants, and decongestants. Contraindicated in patients with alcohol/substance abuse/dependence. May produce insomnia, hypotension, anticholinergic side effects, and liver toxicity.

Tricyclic Antidepressants

Imipramine, Amitriptyline, Desipramine

Anticholinergic side effects (dry mouth, rapid pulse, blurred vision, constipation). May produce ventricular arrhythmias. May produce orthostatic hypotension, sedation, or arousal.

Antiadrenergic Agents

Prazosin, Propranolol, Conidine, Guanfacine

May produce hypotension, bradycardia (slow heartbeat), depressive symptoms, psychomotor slowing or bronchospasm.

Anticonvulsants

Carbamazepine may cause neurological symptoms, ataxia, drowsiness, low sodium level, leukopenia. Valproate may cause gastrointestinal problems, sedation, tremor and thrombocytopenia (low platelet levels in blood). It is teratogenic (induces mutations, should not be used during pregnancy). **Gabapentin** may cause sedation and ataxia (difficulty forming sentences). **Lamotrigine** may cause Stevens-Johnson syndrome, rash, fatigue. **Topiramate** may cause glaucoma, sedation, dizziness, and ataxia.

Atypical Antipsychotics

Risperidone, Olanzapine, Quetiapine

May cause weight gain. Risk of type 2 diabetes with olanzapine