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 Congresswoman asked, “Are there any substitutes for that latter psychoactive 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 was 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.

Somatic 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. Painful memories or 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 person that’s present in 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 in turmoil 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 insomnia, dissociative episodes, rage.

Depression and irritability symptoms are exacerbated by withdrawal symptoms at night, causing anxiety and sleep deficit. Depression and irritability 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 revision 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 reviving 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 vulnerable to symptoms and restoring 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 characterized her presentation; she described herself as “all clenched up.”

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.

continued on next page
Ease of the 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 or inhaled cannabis for sleep is duration of effect; a disadvantage is the time of onset (45-60 minutes). When there is severe recur- rent 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 corticoste- roids and elevating “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. Sedatives, both prescribed and over-the-counter, when used chronically, commonly cause hangovers, dizziness, sedation, constipation, weight gain, and depression. See chart at right.

Cannabis is a unique psychotropic immunomodula- tor 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 “Posttraumatic Stress Disorder Among Military Returnees From Afghanistan and Iraq,” by Matthew J. Friedman, MD, PhD, in the April 2006 American Journal of Psychiatry:

- SSRI
  - Paroxetine, Sertraline, Fluoxetine, Citalopram, Fluvoxamine (May produce insomnia, restlessness, nausea, decreased appetite, daytime sedation, nervousness, and anxiety, sexual dysfunction, decreased libido, delayed orgasm or ataraxia. 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.)
  - Bupropion may exacerbate seizure disorder. Mitrazapine may cause sedation.

- MAOIs
  - Phenelzine
  - Risk of hypertensive crisis; patients required to follow a strict dietary regime. Contraindicated in combina- tion 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.

- Antidrenergic Agents
  - Prazosin, Propranolol, Conidine, Guanfacine
  - May produce hypotension, brachycardia (slow heartbeat), depressive symptoms, psychotomor slowing or bronchospasms.

- 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. Topirimate may cause glaucoma, sedation, dizziness, and ataxia.

- Atypical Antipsychotics
  - Risperidone, Olanzapine, Quetiapine
  - May cause weight gain. Risk of type 2 diabetes with olanzapine.