

# Cannabis Eases Post-Traumatic Stress

By Tod Mikuriya, MD

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

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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.

*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, benzodiazepenes, 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.*

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.

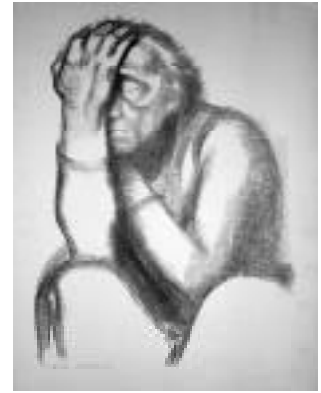
I recommend the protocol J. Russell Reynolds M.D., commended to Queen Victoria: "The dose should be given in minimum quantity, repeated in not less than four to six hours, and gradually increased by one drop every third or fourth day, until either relief is obtained, or the drug is proved, in such case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

*continued on next page*

## A Note on Marinol

Synthetic tetrahydrocannabinol dissolved in sesame oil—Marinol—is available in capsules of 2.5, 5, and 10 mg. It has been my clinical experience that the average effective dose is 7.5 mg. When withdrawing opioids or sedatives there may be a need to increase the dose to as high as 100 to 120 mg daily. At all dose levels the patient is free from discomfort, agitation, or sedation if there is gradual upward adjustment of dose.



**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.



**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 crewmate 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.

**Easement for PTSD** *from previous page*

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.

**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, sedatives, analgesics, muscle relaxants, etc., all of which provide inadequate re-

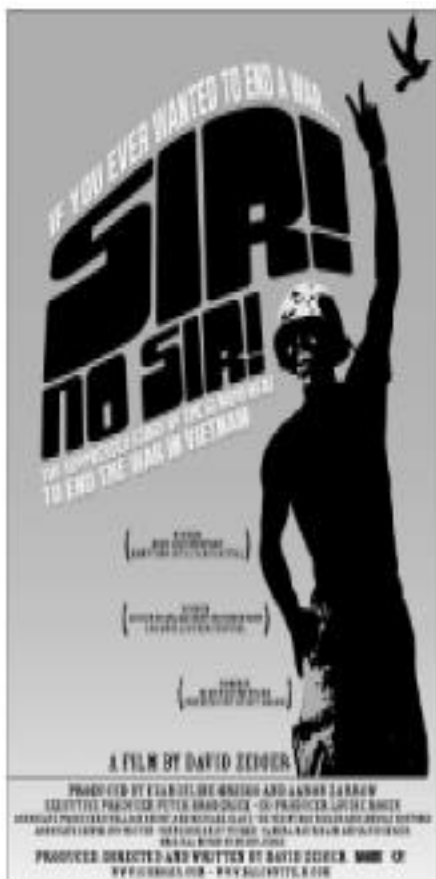
lief and have side effects that soon become problematic. Sedatives, both prescribed and over-the-counter, when used chronically, commonly cause hangovers, dullness, sedation, constipation, weight gain, and depression. See chart at right.

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).

*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.*

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 both 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.



**Forgotten Memories**  
(Just You, Barbara Lee)

*Against the roar of total loss  
REASON lifts a lonely voice  
Ernst Gruening, Wayne Morse  
Trying to make peace a choice  
Back when we had a little more democracy  
Now it's you, Barbara Lee,  
Jut you, Barbara Lee,  
Just you.*

*Underneath the Capitol Dome  
Forgotten are the scents of old Tonkin  
Four-hundred twenty to one  
For war what's another forty billion?  
They've got what's called a gang mentality  
'Cept you, Barbara Lee,  
'Cept you, Barbara Lee,  
'Cept you.*

*HISTORY has a way, they say  
Of sometimes getting repeated  
And those who didn't learn yesterday  
Tomorrow might get de— Shshsh!  
This is still top secret in D.C.  
'Cept to Barbara Lee,  
Just you, Barbara Lee,  
Just you*

**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:*

**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**

**Phenazine**

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, brachycardia (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. **Toprimate** may cause glaucoma, sedation, dizziness, and ataxia.

**Atypical Antipsychotics**

**Risperidone, Olanzapine, Quetiapine**

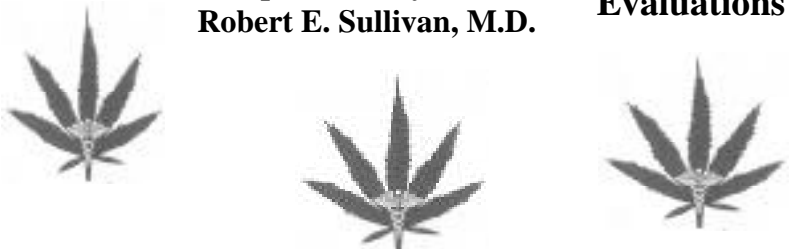
May cause weight gain. Risk of type 2 diabetes with olanzapine

Cannabis as a treatment for PTSD provides effective control and relief of chronic stressors. Its side-effect profile seems especially benign when contrasted with those of the prevailing mainstream treatments. —T.H.M.

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Patients Out-of-Time Perspectives

# The Recurring Terror of Combat

By Al Byrne

My father was an infantryman during World War II —fought his way through North Africa and Sicily. My mother was a US Army dietician in North Africa who became pregnant with me and was sent home. My father wanted to stay in the Army after the war but he got out in 1946.

When I was 17 I got a scholarship to Notre Dame to play baseball. I joined Naval ROTC. Next thing I knew I was in a uniform and I was Marine.

I was sent down to Vieques, Puerto Rico for training in the summer. I got off the boat on a landing craft. I remember hitting the beach. I woke up on a hospital ship, they said I was fine. Blown

*This article, the two preceding and the four that follow are excerpted from talks given at the 4th National Conference on Cannabis Therapeutics, Santa Barbara, April 7-8.*

up by an artillery shell that had landed short. Seven men were killed.

I was commissioned out of Notre Dame as an ensign, transferred to a destroyer in Norfolk. We operated off the Atlantic coast and in the Caribbean. One day we were sent to Africa to rescue some Americans who had to be evacuated. I took in 60 men to get them out, and we succeeded.

After I got out of the Navy I was recalled and sent to Vietnam on my 25th birthday. It was 1970 and it felt like everybody was leaving, I was arriving. The first couple of weeks I was there I ran into what Vietnam was really like. I was moving with a marine patrol, we weren't anywhere in particular, we weren't doing anything in particular,



Al Byrne

there wasn't anything to worry about. But in an instant we were under very, very heavy attack and it turned out to be an attack on our 50 men by about 3,000 Vietnamese. And I thought, "Well, this is where you die."

That didn't happen. We killed 'em all. Burned them. We got on a radio that cost a couple of hundred bucks and a jet came over that cost a couple of hundred million bucks and three thousand people died. And none of us died.

I spent a year there as an adviser. I traveled alone in Vietnam with different units doing different things. The carnage was awesome. It was all scary and pseudo-real like the Navy gunboats in "Apocalypse Now" that fight their way up the river mile after mile after mile and then all of a sudden there's bright lights and a

*"There was no one day of trauma, there was a year of trauma. If you lived."*

Playboy bunny.

I was sitting in a place one night in the middle of nowhere and a helicopter landed and out stepped Tex Ritter and John Ritter. They came to Vietnam to say "Hi."

The people who fought in Vietnam, the kids who are fighting in Iraq today, the soldiers who fought in Korea, they have the worst day of their lives every day of their lives. It never stopped. There was no one day of trauma, there was a year of trauma. If you lived.

After a year they sent me home on my birthday I was now 26. The average soldier over there was 18 and a half and spent something like 350 days in combat. My father, who spent seven years in the Army, was in a combat zone for five years and spent two weeks in combat.

The intensity was enormous. The trauma was enormous. What makes it worse for combat vets in Vietnam is that they were never treated at all. We came back and everybody said "You suck" and we went into the woods. Later on, the Agent Orange project was born. Vets got together and sued our own government because they didn't take care of us. And we got a lot of money from the chemical companies that poisoned us.

I'm a victim of Agent Orange. I've had a rash on my bun for a long time. I sat in the wrong place.

In Virginia we formed an organization that went out into the Appalachian Hills and found vets who had gone into hiding when they got home and never came out. Most of the people I found up there were men and they were drunk. Alcohol was the only drug that they could blot out their memories with on a daily basis.

*"These guys needed to sleep so they'd get drunk and pass out."*

The daytime memories are bad enough, the nighttime memories keep you from sleeping at all. If you can't sleep, your world goes to hell in a handbasket real fast and it doesn't come back until you can get some rest. These guys needed to sleep so they'd get drunk and pass out.

There was as contingent of these guys that had been drunk but didn't drink anymore—they smoked dope. I started going to VA Hospitals and guys would come up to me and say "Al, you see these pills the doctor just gave me—Valium, mood enhancers—you know what we do with these? We take em out on the street and swap em for cannabis."

Because the VA won't give them cannabis. So they take the prescription drugs that they will not use and sell them on the street to get cannabis, because it works. It calms down the emotional responses to problems that seem to flow through you for no reason sometimes.

I can go back to Vietnam in a heartbeat if the smell is right. Just give me the right whiff and I'm there—and I'm terrified, because I was terrified in Vietnam, I was scared to death and anybody who tells you they weren't wasn't there.

And it lets me sleep. It lets me sleep because I do not dream. As a counselor working with other Vietnam vets in the

*continued on next page*

## Common Sense For Drug Policy's Public Service Announcements

# A CSDP Ad Sampler

The public service advertisements depicted here and on the three following pages were produced by the reform group Common Sense for Drug Policy to counter misinformation in the drug war.

The Common Sense public information campaign quotes credible research and leading authorities to provide the public with reliable information and to better inform the debate on drug policy. CSDP's ads appear

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## TO CONVICT ONE DOCTOR, ZEALOTS AT DEA TORE UP PAIN GUIDELINES DEVELOPED OVER FOUR YEARS.

Last August, after an historic collaboration between the Drug Enforcement Administration and the University of Wisconsin's Pain & Policy Studies Group, the DEA published new and widely applauded Pain Management Guidelines intended to protect physicians from prosecution by overzealous federal agents. In October the DEA suddenly withdrew the Guidelines, effectively trashing years of effort. Why?

According to the Washington Post, "The DEA's abrupt turnaround appeared to have been triggered when defense lawyers tried to introduce the new Guidelines in the trial of Dr. (William) Hurwitz"—a Virginia pain specialist accused of over-prescribing. Shortly after the Guidelines were withdrawn, the US prosecutor successfully petitioned the court to exclude them as evidence.

In the Pain Guidelines, the doctors and the DEA had agreed that the government should stop investigating doctors like

Hurwitz simply for being active in pain management -- and stop prosecuting those few who followed the recommendations but unwittingly prescribed opiates to deceitful patients. The DEA arbitrarily reversed that agreement.

Dr. David Joranson, head of the University of Wisconsin Group, says the "DEA's abrupt withdrawal of support for the [Guidelines] without consulting with coauthors about their concerns, raises questions about what advisory role, if any, the pain management community can expect to have with DEA." The agency's changes, he says, "are likely to interfere in medical practice and pain management."

His colleague, Dr. Russell Portenoy of Beth Israel Medical Center, told the Washington Post that the DEA has changed "the tone of the dialogue in a way that is very worrisome. We're seeing more of an emphasis on law enforcement and less on the legitimate use of prescription narcotics."

**Over 30 million Americans suffer from chronic pain. Are we going to let them live in agony because of the misguided zealotry of federal prosecutors?**

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