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Herbal Support for Post Traumatic Stress Disorder

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Introduction

PTSD (Post Traumatic Stress Disorder) is the name given to a range of symptoms that can develop (in perfectly normal people) following life-threatening or otherwise overwhelmingly stressful situations.

PTSD is a normal reaction to an abnormal amount of stress, it is not a mental illness.

Increasing evidence indicates that many of the emotionally distressing symptoms of PTSD have a biological basis. In short, the symptoms of PTSD are not simply 'in someone's head', but rather are the after-effects of an event or series of events severe enough to profoundly alter a person's thinking, feelings and physical reactions. The psychobiology of trauma is a growing area of research, offering insight into the physiological effects of trauma on the mind-body complex.

The psychological effects of trauma have been written about since World War 1 (WW1), but it is only since the Vietnam war that considerable attention in the western world has been devoted to understanding the impact of trauma. As evidence accumulated about the psychological effects of trauma, PTSD became included as a diagnostic category in the psychiatric classification system in 1980 – finally becoming a 'real' diagnosis. Basically, PTSD is the name given to a range of symptoms that have come to be recognized as often following exposure to horrific, usually life-threatening events. Most of these symptoms are caused by the intense levels of anxiety associated with trauma.

Trauma vs. Stress

The recognition that trauma is qualitatively different from stress is well documented.

Stress can be a normal, healthy physiological reaction to danger, as well as stimulating arousal mechanisms, which energize and facilitate learning and problem solving. But trauma, in contrast, overtaxes the body resulting in profound changes to the nervous system. The nervous system becomes hypersensitive. It is too easily turned on and too difficult to moderate or turn off. The wear and tear of this hypersensitive state takes its toll in physical symptoms and general depletion of energy.

> "The ordinary human response to danger is a complex, integrated system of reactions, encompassing both body and mind. These changes are normal, adaptive reactions. They mobilize the threatened person into action – either fight or flight...
>
> Traumatic reactions occur when action is of no avail. When neither resistance nor escape is possible, the human system of self-defense becomes overwhelmed and disorganized. Traumatic events produce profound and lasting changes in physiological arousal, emotion, cognition and memory...
>
> Traumatic events may even sever these normally integrated functions from one another. A traumatized person may remember the event in great detail, but be disconnected from their feelings and emotions of the event...
>
> Traumatic symptoms have the tendency to become disconnected from their source and to take on a life of their own."
>
> Judith Herman – Trauma and Recovery (1992)

Trauma results in lasting biological changes; it involves dysfunctional physiological reactions, whereby the stress hormones continue and are activated by minor stimuli, not just in emergencies. There is a lack of neuromodulation, which in turn exacerbates and intensifies emotional reactivity.

> "Trauma responses occur when no action is available to escape or avoid the event. The human system of defense is shattered...
>
> To study psychological trauma is to come face to face both with human vulnerability in the natural world and with the capacity for evil in human nature...

At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities...

Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning..."

Judith Herman – Trauma and Recovery (1992)

PTSD: Post Traumatic Stress Disorder

Having PTSD does not mean that a person is mentally ill, nor does it mean that they are weak or somehow deficient. Matsakis gives a good analogy, in saying,

"no matter how strong your leg bones are, if enough force is applied, they will break. Given the proper care they can also heal. In some cases, however, a leg may be so damaged that it can never return to its former state. But even in this situation, with support, one can find ways of coping with permanent loss and discover new reasons for living." (Matsakis 1996)

Although we use separate words for them, the mind, emotions, and body, are parts of one whole. When trauma occurs, it affects the whole being, not just the mind or emotions. Increasing evidence indicates that many of the emotionally distressing symptoms of PTSD have a biological basis. In short, the symptoms are not in someone's head, or a play for attention. Rather they are the after-effects of an event or series of events severe enough to profoundly alter a person's thinking, feelings, and physical reactions (Matsakis 1996).

These events need not have gone on for years, months or even hours. A single life-or-death incident lasting as little as a few seconds can be enough to traumatize. In those moments, one's emotions, identity, and sense of the world as an orderly, secure place can be severely shaken or shattered (Matsakis 1996).

Many of the emotional and cognitive changes that trauma survivors experience are appropriate to the situation of the trauma. And often these changes hold survival value; they may have saved lives during the traumatic episode. For example, victims often describe a kind of splitting of mind and body during torture experience as a way of coping with the unbearable pain. This splitting, while effective and appropriate at the time, later becomes a barrier to open and loving relationships. Part of the healing process involves bridging this split.

PTSD as a Diagnosis

The DSM IV – 'Diagnostic and Statistical Manual'

PTSD was first included in 1980 (only 21 years ago) and is the only condition in the DSM in which the origin of the symptoms is due to external events, rather than due to the individual personality.

In the past, many medical and mental health professionals believed that people suffered from depression, anxiety and certain other symptoms primarily because of internal psychological conflicts and problems, rather than in response to external events. In the case of trauma survivors, ***trauma alone, regardless of any previous psychological problems, can lead to the development of a variety of symptoms. These symptoms are reactions to a single, overwhelming external event, or series of events, far more than they are to any internal psychological problem.***

Ample research shows that, given sufficient stress, other factors, such as an individual's previous mental stability and psychological state, are irrelevant in predicting the development of PTSD (Adler 1990). During World War 2 (WW2) for example, some soldiers with sterling records of mental health and family stability developed PTSD. In contrast, other soldiers who had pre-existing social or psychological problems, did not develop PTSD. The critical variable in the development of PTSD was the degree of exposure to combat – the amount of stress to which the soldier had been exposed (Frye, Stockton 1982; Matsakis 1988).

In 1980, when PTSD was first included in the DSM, the American Psychiatric Association described traumatic events as "outside the range of usual human experience". Sadly this definition does not hold true today, and the current version of the DSM recognizes that many traumatic events are, unfortunately, very much part of usual human experience.

The DSM IV Criteria for PTSD

According to the official definition of PTSD in DSM IV, to qualify as having PTSD one must meet the following criteria.

Criterion A: A Traumatic Event
The person has been exposed to a traumatic event in which both the following were present:

1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to physical integrity of self or others;
2. The person's response involved intense fear, helplessness, or horror.

Criterion B: Re-experiencing
The traumatic event is persistently re-experienced in at least one or more of the following ways:

- dreams
- flashbacks
- intrusive memories
- unrest at being in situations that remind one of the original trauma.

Criterion C: Avoidance
Persistent avoidance of stimuli associated with the trauma, numbing of emotions, and reduced interest in others and the outside world. This may include:

- avoiding thoughts and feelings, or conversations associated with the trauma,
- feeling detached, and
- a restricted range of affect (e.g. unable to have loving feelings).

Criterion D: Hyperarousal
Persistent symptoms of increased arousal:

- Difficulty falling asleep or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response.

Criterion E: Duration
The symptoms in Criteria B, C, and D persist longer than one month.

Criterion F: Disturbs Daily Life
The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of life.

PTSD can either be acute or delayed in onset. Acute PTSD occurs within six months after a traumatic event. In delayed onset PTSD, the symptoms occur anytime later than six months after the event. This can be one year, 20 years, or even 40 years after the traumatic event.

The Three Main Expressions of PTSD

The main cardinal symptoms of PTSD fall into three main categories:

- Hyperarousal – reflects the persistent expectation of danger.
- Intrusion – reflects the indelible imprint of the traumatic moment.
- Constriction – reflects the numbing response of surrender.

Hyperarousal – Persistent Expectation of Danger

After a traumatic experience the human systems of self-protection/preservation go into permanent alert. Physiological arousal continues unabated. It is the first cardinal symptom of PTSD. Chronic arousal of the ANS (autonomic nervous system) exists. Sleep disturbance is a feature of PTSD – takes longer to fall asleep, more sensitive to noise, and experience nightmares. Traumatic events seem to recondition the nervous system.

Abraham Kardiner (1941) who first systemically defined post-traumatic stress in America, noted that sufferers from PTSD continue to live in the emotional environment of the traumatic event. Current research confirms that stress hormones of people with PTSD continue to react to minor stimuli as if they were emergencies.

Intrusion – Reliving the Trauma

- As if time stopped at moment of trauma
- Flashbacks
- Triggers – can be everyday events, noises, sights, smells
- Traumatic nightmares
- Exhaustion
- Increased sympathetic arousal, therefore increased adrenaline and other stress hormones, which affect memory

As if time stopped at the moment of the trauma: the traumatic moment becomes encoded in an abnormal form of memory, which breaks spontaneously into consciousness as flashbacks during waking hours, and nightmares during sleep. What would appear as insignificant reminders can trigger memories and the re-experiencing of the traumatic event. Traumatic memories have numerous qualities. They are not encoded like the ordinary memories of adults in a verbal, linear narrative that is assimilated into an ongoing life story. They have a frozen and wordless quality, encoded in the form of vivid sensations and images.

These unusual features of traumatic memory may be based on alterations in the CNS. A wide array of animal experiments show that when high levels of adrenaline and other stress hormones are circulating, memory traces are deeply imprinted. This is possibly true in humans.

Just as traumatic memories are unlike ordinary memories, traumatic dreams are also unlike ordinary dreams. They

often include fragments of the traumatic event in exact form, and identical dreams occur repeatedly.

Reliving a traumatic situation, whether in the form of intrusive memories, dreams, or actions, carries with it the emotional intensity of the original event. Because of this, traumatized people go to great lengths to avoid them. The effort to ward off intrusive symptoms, though self-protective in intent, further aggravates the post-traumatic symptoms. Attempting to avoid reliving trauma too often results in a narrowing of consciousness, a withdrawal from engagement with others, and an impoverished life.

Constriction – The Numbing Response of Surrender

As a protection from unbearable pain, the person escapes from their situation by altering their state of consciousness. They disconnect, particularly emotionally.

- 'Shutting down' manifests as withdrawal from social participation, avoiding stimulation, looking blank and expressionless, and limited imaginative activity.
- Horrific events can be related without any feeling or show of emotion.

When a person is completely powerless and any form of resistance is futile, they may go into a state of surrender. The system of self-defense shuts down entirely. The helpless person escapes from the situation by altering their state of consciousness. This is often seen in animals which may 'freeze' when attacked. These alterations of consciousness are at the core of constriction, or a numbing response. Sometimes traumatic events may evoke not only terror and rage but also, paradoxically, a state of detached calm, in which terror, rage and pain dissolve. The person may feel that the event is not happening, or feel as though they are 'outside' their body. This state can be seen as a form of protection from the intensity of psychological and physical pain during the event. However, its long-term ramifications prevent the person from living a fulfilling life.

The biological factors underlying these altered states remain unclear. However Van de Kolk suggests that trauma produces lasting alterations in the regulation of endogenous opioids, which are natural substances having the same effects as opiates within the central nervous system. Combinations of the three symptom groups will present in various ways. Constriction and intrusion are often alternating, a person may flip between having no feelings (constriction) to being overwhelmed and reliving the trauma (intrusion).

Other Reactions to Trauma

PTSD is not the only reaction to trauma. Many people with PTSD also suffer from clinical depression, dissociation, or somatization, and some experience these disorders instead of PTSD. In her book *Trauma and Recovery*, Herman points out that many trauma survivors do not develop the full range of PTSD symptoms. Rather, their lives become burdened with other, equally disruptive disorders. She states that there are cases where the person's major response to the trauma is clinical depression, dissociation or somatization – and not the DSM IV symptom picture of PTSD.

The Biochemistry of PTSD

In a trauma situation, the CNS is affected. The greater the intensity and longer the duration of the trauma, the greater possibility that the delicate biochemical balance of the body may be affected.

Despite an increase in research into the biochemistry of PTSD in recent years, there is no definitive theory as to how trauma affects the body. One theory is that trauma destabilizes the ANS, another is that trauma changes body chemistry so that the individual is more prone to anxiety. Another hypothesis is that trauma disrupts certain specific biochemical balances, for example, catecholamine levels (Munroe 1995; McFarlane 1995).

No single biological explanation is satisfactory in that no single theory can explain the wide range of PTSD symptoms in trauma survivors. It is an established fact that PTSD for some has both physical and emotional effects.

Some trauma-induced biological changes are linked to memory tracts in the brain. Almost automatically, in the presence of people, places, objects, or situations that remind a trauma survivor of the traumatic event, these biochemical changes can trigger either the re-experiencing phase or the numbing-avoidance phase of PTSD. In the re-experiencing phase a person can expect to have memories, dreams, or flashbacks of the trauma. In the numbing-avoidance phase they can expect to feel shut down inside and withdrawn from others.

If alterations of biological make-up are significant enough under some circumstances, the body and mind may involuntarily revert to the emotional climate and mindset of the original traumatic event. Healing involves, in part, developing an understanding of the symptoms of PTSD and learning to anticipate and prepare for some of these reactions. When trauma responses can be modified, healing can replace hopelessness.

Adrenaline and Trigger Situations

Adrenaline surge is a major contributor to the hyperalert symptoms of PTSD: startle response, insomnia, nightmares, etc. Situations that remind the person of the original traumatic event may trigger an adrenaline surge, which in turn will activate memories and feelings associated with the traumatic event such as rage, irritability, nightmares,

and flashbacks. Alternatively, there may be a numbing response after exposure to a person, place, or object reminiscent of the original traumatic situation, or alternate between the two. Commonly, people avoid situations, people and places that trigger memories.

When Stress is Prolonged

The adrenals, like the rest of the body, are not designed to handle prolonged stress. When subjected to repeated trauma or emergencies, the adrenals can be permanently damaged leading to over-functioning during subsequent stress, which underlies the hyperarousal and numbing phases of PTSD.

During prolonged stress the biochemistry of the body is under extreme pressure, requiring increased nutritional input. However, one of the effects of prolonged stress is the impairment of digestive function, including a decreased digestive enzyme production, poor appetite and indigestion.

The Therapeutic Relationship

Trauma shatters the individual physically, emotionally, spiritually, and socially. When providing therapeutic care, both psychological and naturopathic, it is essential that the fundamental premise on which that care is based reflects the understanding that most survivors are not psychiatric patients, or even 'ill', but are ***normal people responding in a normal way to extremely abnormal conditions***.

The effects of trauma on the individual cannot be categorized as either physical or psychological. They must be seen as affecting the whole person, as well as the family and community.

Healing Strategies

With the understanding that trauma devastates the body, mind and soul of the individual, healing strategies must provide an opportunity for healing at these levels. Healing strategies should embrace a culturally sensitive attitude, taking care to acknowledge and respect the client's own beliefs about their health.

Empowerment
As the goal of treatment is to support and empower the individual, the emphasis should be on how to build upon the individual's capacity to survive such events, as an integral strategy for recovery.

- Therapy aims to integrate experiences, rather than to 'cure'.
- Survivors are not people with an 'illness' who receive treatment and then are cured, rather they are people whose experiences will remain with them throughout life.
- Through the process of naturopathic treatment, the aim is to help a client understand their experiences, to re-establish trust in others and to see their disturbing symptoms as a *normal reaction to the grossly abnormal assault on their body-mind*.

Relationship
Central to the naturopathic approach is the relationship between client and therapist. Naturopathy, practiced with the understanding that the establishment of **safety and a relationship of trust** are crucial in order to provide effective treatment.

- This is achieved through clear communication with the client about their health and explaining how naturopathic treatment may assist in their healing process.
- Developing intervention strategies with the client allows for the relationship to be a partnership.
- Providing clear assessment, by giving space to hear the client's understanding of their health and validating their symptoms enables common ground to be established between client and practitioner.

Re-establishing Control
Providing a clear rationale of the treatment suggested, and offering them to the client as an option, gives the client the opportunity to take control of their health.

- It can be useful to go through their herbal prescription in quite a bit of detail, explaining each herb and why it is included in their mixture. Patients are usually interested in what they are getting, and also, it often gives them a better understanding of what we are trying to achieve together in our work.
- The same applies for any dietary advice. If suggesting they cut down on coffee for example, it is useful to explain to them the effects of caffeine on the nervous system, how it impacts on sleep, anxiety levels etc.
- As naturopaths, this is often how we practice. However, when treating a traumatized person, it becomes part of the actual treatment procedure, not just routine. The rationale for treatment, how we validate and explain symptoms, how we listen, etc is done consciously to create a specific outcome, of building trust and safety for the patient.

Witnessing
One important aspect of the practitioner's role is to act as 'witness' to the person's story.

The moral stance of the practitioner is extremely important. It is not enough for the practitioner to be neutral or non-judgmental. The practitioner must show their outrage or profound sadness at what they are being told.

- It is so important that the traumatized person is validated by the practitioner. In fact it can be

detrimental to the patient if the practitioner shows a neutral stance.
- Kardiner states that the "central part of the therapy should always be to enlighten the patient as to the nature and meaning of their symptoms", and this should always be done in an empathetic and caring manner.
- The therapeutic relationship does not automatically occur, but rather involves time and effort from both practitioner and patient.

Boundaries
Careful attention to boundaries of the therapeutic relationship provides a relationship of trust and safety.
- The practitioner agrees to be available to the patient within limits that are clear and reasonable for both parties.
- Boundaries exist to contain both the practitioner's needs and ensure a safe environment for the patient.
- Setting boundaries fosters a good working relationship in which the patient will feel empowered and in control, rather than the opposite. Given this, flexibility is also essential.

Aims of the Therapeutic Relationship

To provide a positive experience of relationship with others, in the context of the naturopathic consultation.

Support and Empowerment

- Affirm the value and worth of the individual by showing a caring attitude, genuineness and warmth.
- Recognition of the injustice of the trauma – don't be neutral, as a health practitioner you are witness to an intimate experience in the person's life.
- Validating physical symptoms as a 'normal response to an abnormal situation'.
- Providing the space for the person to express their understanding of their health concerns
- Shared treatment goals.

Restoring Safety, Trust and Enhancing Control

- Clear communication.
- Setting attainable goals.
- Rationale for all treatment suggestions (diet, lifestyle etc), and offer them as an option, in order to give the client the opportunity to take control.
- Encourage the relationship to be a partnership in which you both are working towards healing.
- Informing the client that herbs are safe, non-addictive, and no side effects.
- Explain your herb mix, what each herb does.
- Briefly explain how natural therapies work – aims to enhance their body's own healing capacity, to restore balance and increase vitality.
- Set clear patient/practitioner boundaries.
- Informed consent.
- Fully explain any procedures, such as palpation.
- Confidentiality.

Common Conditions

Herbal treatment aims to provide effective, safe and non-addictive treatment for the relief of these symptoms, without suppressing the psychological causes. The following conditions, commonly described by clients at the Foundation where one of us (Judy Singer) works, are treated using herbs:
- Headaches and migraines.
- Poor sleep patterns, including difficulty getting off to sleep, waking through the night, restless sleep, and nightmares.
- Tiredness, fatigue, and exhaustion.
- Gastrointestinal disturbances, including stomach pains, indigestion, irritable bowel, cramps, nausea, ulcers and poor appetite.
- Muscle pain, stiffness and tension.
- Anxiety, nervousness, depression, panic attacks, palpitations.
- Poor concentration and memory.
- Feeling disconnected from body.

Addressing symptoms at a body level using herbs, in conjunction with psychological care works particularly well with survivors of torture and other trauma survivors. Many symptoms of PTSD, stemming from psychological causes, manifest as physical symptoms. Providing treatment at a physical level, which acknowledges the deeper psychological causes, can therefore provide symptom relief without suppressing the emotions.

Herbal therapies do not 'remove' the symptom, but gently treat the physiological basis of symptoms. They are supportive, nutritive and can facilitate the process of the client getting in touch with their body.

PTSD symptoms are a normal response to the extremely abnormal situation of traumatic events. A naturopathic approach validates the current symptoms and gently encourages the healing process. By placing appropriate emphasis on dealing with the physical symptoms in connection to the trauma, this provides the client with validation for what they have gone through and what they are currently experiencing.

For example, poor sleep patterns are one of the most common symptoms of PTSD. The use of herbs does not remove the reason for poor sleep (fear, anxiety, intrusive thoughts etc), but it can encourage relaxation at a physiological level, enabling the individual to be 'ready for sleep'. The psychological issues must still be addressed, and this may be facilitated by general reduction of tension in the body.

Case Example

'Abdul', Turkish man, presented with a medical diagnosis of irritable bowel syndrome. He experienced constant abdominal pain and bouts of anorexia, which occurred for 2 to 3 days after an episode of nightmares. He also suffered from muscular tension, headaches and poor sleep patterns. During the counselling process the details of his detention were gradually revealed. 'Abdul' described how he was forced to eat food that was spiked with the body parts of rodents. He felt humiliated and disgusted. 'Abdul' regularly experienced nightmares in which he would relive these horrific events. It was after these nights that the abdominal pain and anorexia would intensify. His counsellor referred him for herbal treatment.

The treatment plan involved:

A. Using herbal medicines to:
   - sooth his irritated bowel
   - provide muscular relaxation
   - nutritional support
   - nervous system support.

   Herbs used:
   - Wild yam – traditionally used for bowel spasm and colic
   - Chamomile – relaxing for the nervous system and anti-inflammatory and spasmolytic for the digestive tract
   - St John's wort – nervine tonic and antidepressant
   - Lavender – nervine tonic, relaxing and antidepressant
   - Vervain – traditionally used in the Anglo-American school of herbal medicine as a nervine tonic

B. Provide treatment within the context of a safe environment in which he could explore his physical symptoms.

Herbal treatment in conjunction with counselling encouraged 'Abdul' to connect his physical symptoms with the trauma he had experienced. He began to care for himself, cooking traditional meals, and taking pleasure in his improved appetite. The combination of psychological care and herbal treatment enabled 'Abdul' to connect to his body and to specifically address the physical symptoms without separating them from the deeper psychological distress. With time, his physical symptoms decreased in frequency and intensity. However, whenever 'Abdul' became particularly stressed, the irritable bowel symptoms would return in a milder form. He was able to deal with the symptoms by modifying his diet, taking his herbs and dealing with the stress in a more effective way.

Herbal Treatment of PTSD

Even though PTSD is an extremely complex disorder, herbal treatment does not have to be complex. Herbal treatment of PTSD is essentially based on 'nourishing the nervous system'.

Key herbs used in treatment protocols include:
- Withania (*Withania somnifera*) – a general tonic which has a calming, rather than stimulating effect, so is ideally suited to the treatment of PTSD
- Valerian (*Valeriana officinalis*) – relieves anxiety and insomnia, soothes the nervous system
- Passionflower (*Passiflora incarnata*) – relieves anxiety and insomnia, soothes the nervous system
- Skullcap (*Scutellaria lateriflora*) – nervine tonic, relieves anxiety, very useful for extreme stress and outbursts of anger
- Chamomile (*Matricaria recutita*) – relaxing for the nervous system and anti-inflammatory and spasmolytic for the digestive tract
- St John's wort (*Hypericum perforatum*) – nervine tonic and antidepressant
- Lavender (*Lavandula officinalis*) – nervine tonic, relaxing and antidepressant
- Kava (*Piper methysticum*) – relieves anxiety and insomnia
- Oats seed (*Avena sativa*) – nervine tonic, nourishes the nervous system
- Gotu kola (*Centella asiatica*) – adaptogen and general tonic
- Licorice (*Glycyrrhiza glabra*) – support for the adrenal glands

In addition, other herbs may be required depending on the presenting symptoms (see case histories for some examples).

Case Study

NB: The following is an actual case study, though with personal details such as the client's name, country of origin and other identifying data changed. The naturopathic treatment and herbal formulation remains original.

'Ruie' is a 24-year-old man from 'East Timor'. He was in Australia for 10 months and was currently studying computer science and working shifts in a factory. He was an asylum seeker, currently applying for refugee status on the grounds of his torture and trauma experiences in his country of origin. Ruie is single, has a tertiary education, but was unable to complete his degree due to persistent persecution in East Timor.

He was referred by his counsellor for herbal treatment. The referral stated, "Since Ruie was first tortured at the age of 15 years, he has had constant headaches. This leads to

sleeplessness and poor concentration. He feels that if the headaches could lessen many of the other symptoms would also decrease. He has a high degree of intellectual insight into the causes of his problems."

Presenting Complaints

Headaches
Worse: before bed, and generally at night, after nightmares, if stressed (e.g. if late for an appointment), if he sleeps in the daytime, if he thinks about the past. Sensation of headaches: "heavy burning feeling, like a pressure on the inside". Location of pain: begins at occiput and depending on severity, moves over head to forehead and temples. Occurrence: daily, and usually throughout the day. Duration of pain: anywhere from 20 minutes to one hour to all day. Better for: hot shower, listening to music, being with friends, spicy curries, straight chili (he eats it on apples).

History of headaches: began 9 years ago, after first detained and tortured by the Indonesian military. At that time he was severely beaten over the head. He has experienced the same headache pattern for the past 9 years. Ruie was subsequently detained and tortured on three other occasions, where again he was severely beaten, hung up by the arms and received electrical shock to parts of his body.

Poor Sleep Patterns
Quality of sleep is dependent on severity of headaches. Constant burning sensation at night makes getting off to sleep difficult. He experiences nightmares approximately once a week, and frequently wakes at 3 a.m. unable to get back to sleep. Ruie rarely has a 'good' sleep. Due to this distress, he hates night time.

Body Tension
Jaw clenching, neck stiffness, general muscle tension.

General Health
No other significant health issues. His appetite is good, having two regular meals per day, no digestive disturbance, and a minimal caffeine intake.

Psychological Function
Experiences regular 'intrusion' symptoms of nightmares and disturbing memories of the past. Aeroplanes flying overhead cause his anxiety levels to increase (hyperarousal) and he often becomes more distressed after watching the news, and receiving bad news from home.

Herbal Formula

The main herbs used have included a combination of the following:

- Withania
- Passionflower
- Lavender
- St John's wort
- Ginger
- Wood betony

Rationale

- Nervous system support and nourishment.
- Relaxant effects to assist sleep patterns.
- Provide overall muscular relaxation.
- Pain relief.

Outcomes

Within a fairly short period of time, Ruie's response to herbal treatment was good. Within eight sessions (2 months), his sleep and headache symptoms improved noticeably, and perhaps more importantly, he began to make the connection between his physical symptoms and his emotional state at the time. He became more able to identify what triggered his headaches. The improvement in his sleep patterns was a great relief, which he aptly summarized by saying, "I feel more normal now!" Ruie is still under enormous pressure, and his stress levels require ongoing attention.

Additional Clinical Anecdotes

A herbal tablet containing valerian, passionflower and the Chinese herb Zizyphus seeds has been found to be particularly valuable for the treatment of anxiety and insomnia in several clients. This is illustrated in many of the additional clinical anecdotes described below.

Mr A is a Somali man 25 years of age. Presenting symptoms: severe insomnia, bloating and constipation. History of torture and trauma. Receiving counselling. Herbal treatment: Valerian Complex 2 to 3 tablets at night; herbal liver formula tablet twice a day. Bloating and constipation resolved after 2 weeks plus extensive dietary assistance. Insomnia managed with Valerian Complex.

Mr Y, an Iraqi man of 40 years. Extreme anxiety and depression and severe insomnia (has not had a full nights sleep in over 10 years). Treatment: Valerian Complex 1 tablet 3-4 times a day. Outcome: Mr Y feels less agitated through the day which enables him to have a better quality sleep.

Mrs L, Serbian woman 45 years. Symptoms include anxiety, panic attacks and restlessness. Treatment: Valerian Complex 3-4 tablets during the acute stages of panic attacks would reduce severity and intensity of the attacks. General dose: 1-2 a day when symptoms were mild.

Mrs A, a 30 year old woman from El Salvador. Symptoms: insomnia, headaches, muscle pain and body ache.

Medicine: Valerian Complex 2 tablets at night helped her to get off to sleep and reduce the muscle tension.

Mr S, Bosnian man, 38 years, concentration camp and war experiences over 5 years. Symptoms include: severe PTSD and sudden onset post nasal drip (PND) which began in refugee camp after the war after exposure to extreme cold weather (-15 deg C), PND worse brought on by panic attacks and nightmares. Treatment: Withania tablets (2 b.d.) and antiallergic tablets containing Albizia, feverfew and Baical skullcap (1 t.i.d.) Resulted in reduced PND in relation to less severe panic attacks. Other symptoms of headaches, muscle twitching also reduced.

BIBLIOGRAPHY

Waites, E.A., Trauma and Survival – Post Traumatic Stress Disorder & Dissociative Disorders in Women, W.W. Norton & Company, Inc., New York, 1993

Matsakis, A. Ph.D., I Can't Get Over It – A Handbook for Trauma Survivors, Second Edition, New Harbinger Publications, Inc. 1996

Herman, J.L., Trauma & Recovery – Domestic Abuse to Political Terror, Harper-Collins Publication, 1992

Victorian Foundation for Survivors of Torture Inc, Rebuilding Shattered Lives, 1998

Van de Kolk, B.A., and Saporta, J., The Biological Responses to Psychic trauma: Mechanisms and Treatment of Intrusion and Numbing, Harwood Academic Publishers GmBh, United Kingdom

Creamer, M. PhD, Post Traumatic Stress Disorder, Nature and Treatment, in Psychotherapy in Australia, Vol. 3, No.1, 1996

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, IV Edition 1994

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Over the past 7 years Judy Singer has been working as a naturopath with the Victorian Foundation for Survivors of Torture (VFST), a community-based organization in Melbourne, Australia providing psychological care, natural therapies and advocacy services for refugee survivors of torture and trauma. Her clients come from a diverse range of countries, cultures, religious affinities and socio-economic groups. They have fled their homes due to war and persecution. They have been tortured because of their ethnicity or political beliefs or, simply, they are victims of the insanity of war.

Whilst the clients at the Foundation, as a group, are extreme examples of trauma survivors, the treatment approaches to PTSD arising from other causes such as domestic violence, war veterans, natural disasters, victims of crime or terrorism may equally be applied.

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