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Coping with post - traumatic stress: The Place of Homeopathy☆

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SUMMARY

After reviewing the definition and symptoms of PTSD, the Materia Medica of fifteen homeopathic remedies is studied in relation to the morbid manifestations of fear, anxiety, agitation and sleep, experienced by the patient as a result of a trauma.
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KEYWORDS

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POST-TRAUMATIC STRESS DISORDER (PTSD): PSYCHO TRAUMATIC SYNDROME

According to the International Classification of Diseases ICD-10 (Chapter V: F 43.1) [1] "A situation or a stressful event (short or long) which is exceptionally threatening or catastrophic that could cause clear distress symptoms in most individuals, 'causes' PTSD: a delayed or protracted response" with consequence in 15-35% of cases, depending on the nature of the traumatic event and the subjective experience of the subject".
PTSD can be accompanied by various comorbid disorders that are sometimes the only clinical manifestation of which the patient complains; the latter does not necessarily make a link between his state and the traumatic event [2].
The prevalence of "life-long" PTSD recorded in Europe, according to the study ESEMeD [3] conducted in 2004 on a sample of 21,425 people in six European countries, 2.9% of women and 0.9% of men, is much less than in the US. One should therefore systematically seek a history of trauma in all patients who consult a health professional in order to treat the cause of certain disorders and not only its consequences.
Known since 1915 by doctors of the Military Health Service [4], PTSD is painful for the patient and those around him. Suffering from a psychological trauma syndrome is not comparable to other physical or mental illnesses. This disease can be lived and experienced like a real handicap and durably transform a life, by having serious social, family or professional consequences.
Yet, medically it is possible to treat it. To do so it is essential to recognise the symptoms in order to manage them effectively.
In a stressful situation, the whole body becomes tense. It has an energy cost which causes suffering to various parts of the nervous system, in the form of alterations in brain structures, especially those of the memory. The effects of psychological trauma are memory disorders. The brain, which has been overwhelmed by all the stimuli at the time of the assault, will then play them back exactly as it experienced it.
During the day, like a conditioned reflex in response to a noise or a smell, the images of the assault come back in the memory, interfering with the patient's natural psychic activity. Those are the flashback also called ecmnesia.
At night, during sleep, the same episodes recur. These are what are called traumatic nightmares which involve shouting, combat actions and waking up sweaty. These nightmares and ecmnesia are signs of PTSD.

Intrusion symptoms

Memories, images, smells, sounds and sensations associated with the traumatic event can "invade" the life of the patient. In general, these "intrusions" cause significant distress and sometimes other emotions such as grief, guilt, fear or anger.
Distressing memories or images of the accident;
Nightmares linked to the trauma or other horrible events;
Flashbacks (reliving the event);
Becoming upset by a reminder of the incident;

☆**Translator's note**: In order to avoid the clumsy "he/she" or "his/her", it has been assumed that the patients referred to in this article were male unless the symptoms recorded make it unlikely or impossible. This is a purely arbitrary choice.

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Physical symptoms caused by a reminder of the event: sweating, increased heart rate or muscle tension.
The nightmare is repeated night after night and sometimes returns several times in the night. The dreamer fully relives the traumatic experience, with all its sensory qualities (smell, touch, taste, etc.). Gradually, this sleep is no longer restful and brings a feeling of apprehension. Some even develop sleep phobia. They will then try to "knock themselves out" to fall asleep as quickly as possible by using sleeping pills or alcohol.
Daytime flashbacks: the patient relives the traumatic scene, this time while he is conscious. Unwillingly and without them being able to do anything about it, the scene takes place in the mind and the patient must relive it right up to its tragic conclusion. The intensity of the memory varies. But as in nightmares, the patient may be invaded by different sensations: smells, temperature, sound. The reconstitution is perfect in every detail. At maximum intensity, these flashbacks while being awake could be taken for hallucinations.

The avoidance symptoms

Memories and reminders of traumatic events are very unpleasant and usually lead to considerable distress. This is why the subjects tend to avoid situations, people or events that trigger memories of the trauma. Often, they try not to think about the event, nor talk about it, and seek to cut themselves off painful emotions associated with these memories. In doing so, they distance themselves from their family, friends and society, and become less and less active.
This can be very painful for the family and friends who often feel that the person is simply lazy or acting in bad faith.
Trying to avoid any reminders of the trauma, such as thoughts, feelings, conversations, activities, places and people;
Blanking out - inability to recall certain aspects of the experience;
Loss of interest in normal activities;
Feeling cut off, detached from loved ones;
Inability to experience emotions;
Difficulty in imagining the future.

Symptoms of hyper awakening

After the traumatic event, it is common that the subject perceives danger everywhere and the idea of danger never leaves them. They are on edge and constantly on guard. Sleep disorders are frequent.
Sleep disturbance
Anger and irritability
Trouble concentrating
Tend to be constantly on the lookout for danger
Restlessness, startle response.

Disease progression

The psycho-traumatic syndrome is particular in that it evolves in several stages and remains relatively silent sometimes for lengthy periods (*Fig. 1*).

Military Support measures

The management of psychic injury personnel is at the heart of the priorities of the Ministry of Defence. A comprehensive system which relies on a network of prevention and care of the military and their families has been strengthened since 2010. The unit doctors are essential links in this programme. They inform, detect and guide the injured with PTSD. The latter is then supported by the psychiatric ward of a military teaching hospital or, failing that, by a civilian psychiatrist [4].

Evolution of the concept

Sylvie Jung [5] draws attention to the work of Pierre Janet (1859-1947) a philosopher, psychologist and doctor, on the biology of trauma, amnesia and dissociation of recollections of the trauma. Hermann Oppenheim (1857-1919), in 1889, used the term "traumatic neurosis" to describe the symptoms presented by those injured during the construction of a railway. Then Sigmund Freud (1856-1939), a psychiatrist and psychoanalyst, brought a psychoanalytic response to trauma neurosis. Boris Cyrulnik, a French psychiatrist is working on "traumatic memory" [6], which he describes as being "torn" both by the initial trauma and by the never ending representation of this trauma. The memory is altered: it is fixed on the

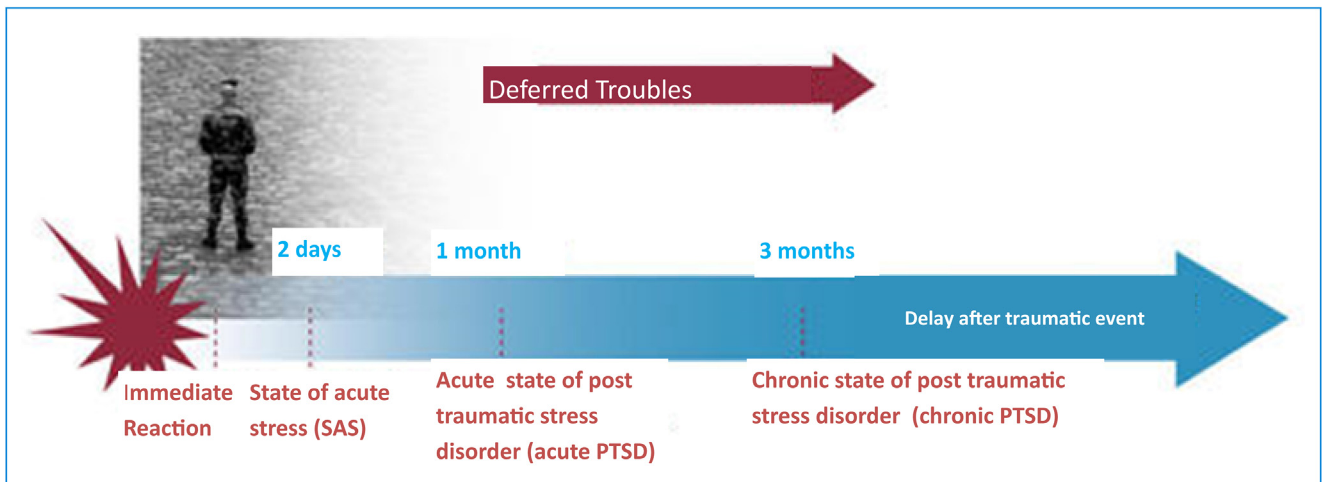

Figure 1. Disease progression.

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